

Chairman Wood, Chairman Nazarian, Members of the Assembly Health and Aging & Long-Term Care Committees: Thank you for the opportunity to share my thoughts regarding: "The Covid-19 outbreak in Skilled Nursing Facilities and the State's Response: A discussion of what has worked, what has not, and what are plans for the future?"

John F Kennedy quoted the historian Toynbee, *"that a society's quality and durability can best be measured by the respect and care given its elderly citizens."*

How does our society measure up during this pandemic? If we take measure by words and platitudes, we do fine. Federal, state, and local officials, as well as the nursing home industry, have used many of the right words. Words that didn't help George Chin, an 80-year-old man who died in a nursing home from COVID-19 on April 22. George's son Simon reached out to me and wanted to know if his father's death was preventable. The unfortunate answer is yes. The words that the government and industry have been using since March have not saved enough lives. We've needed more action. The type of action that has been taken for the rest of our citizens.

I am the President of the California Association of Long Term Care Medicine (CALTCM, www.caltcm.org). We represent the medical voice of long-term care in California. We value excellent and individualized medical care, a team approach, and the integration of medical science with personalized care. We exist to provide quality education for long term care professionals, as well as to promote effective medical leadership, the ethical delivery of care and the rights of patients. Our mission is to promote quality patient care across the long-term care continuum. On a personal note, I am a geriatrician, and the editor-in-chief of a major geriatric medicine textbook. I am also the Medical Director of Eisenberg Village, a nursing home on the campus of the Los Angeles Jewish Home. Previously, I was the Director of the nursing home arm of our state's CMS contracted quality improvement organization, Health Services Advisory Group (HSAG). And I was first the chief medical officer, then the CEO of Rockport Healthcare Services, a company that oversees the operations of the largest nursing home chain in California. I resigned from that position on November 6, 2018. My views and testimony today are based on that body of experience.

I first want to recognize and thank the incredible people who serve on the front lines in nursing homes. They are incredibly caring and compassionate human beings, many of whom barely make a living wage. Media accounts of nursing home care all too often ignore their efforts. Too many have now given their lives unnecessarily due to the lack of immediate action to this pandemic on the part of the federal government, the state, the counties and the nursing home industry.

On February 29th, with the news of the outbreak of COVID-19 in a Washington state nursing home, the experts in geriatrics and long-term care medicine knew what was coming. Many of us did everything in our power to sound the alarm. Unfortunately, while our voices may have been acknowledged, they were not actually heard in a timely fashion. We must all live with the consequences of that. While I will share what I believe went wrong, I'd rather focus first on what needs to happen in order to protect the nursing home and assisted living facility residents who

have thus far managed to avoid being infected. I do not believe that casting blame, or making excuses, will help save lives. We need to take action, and that action needs to occur immediately.

COVID-19 will ultimately make its way into most nursing homes despite our best efforts. What matters is how the facility is prepared and how it responds. The recent articles and data that suggest no correlation of outbreaks with survey findings or star rating status are limited by a lack of accurate and comprehensive data. As abundant PPE and readily available testing become the norm, we believe that other factors will contribute to outcomes in nursing homes that are exposed to this virus. CALTCM's "Long Term Care Quadruple Aim for COVID-19 Response," developed and shared with CDPH in March, was posted on our website on April 17th, describes the four key elements to combatting this potentially deadly virus. It starts with the need for every nursing home in the state to have an abundance of Personal Protective Equipment (PPE). The state has struggled to overcome the challenges brought on by pandemic supply chain dynamics in order to bring sufficient PPE to every nursing home. On the other hand, I also believe that the real estate owners and REIT's behind the nursing home industry have the ability to leverage their massive assets to acquire PPE. While everyone was complaining about the lack of PPE and the inability to acquire it, nursing home residents were infected with the virus and died. The single most important intervention in nursing homes, assisted living facilities and group homes is an abundance of PPE. As a clinician, I don't care who takes responsibility for the acquisition of PPE. Without PPE, COVID-19 can't be stopped. It is time that the government and the industry transcend all of the obstacles and assure that a lack of PPE will not get in the way of protecting vulnerable older adults.

The second element of the Quadruple Aim is readily available testing. Nursing home staff are the main vector for transmission of the virus. Testing of all staff is critical to protecting both the residents and the staff themselves. Telling nursing homes to come up with a plan for testing is not the complete answer. The state must use its clout and resources to assure that testing is performed and that labs prioritize the processing of the tests. The industry must similarly support testing by actions rather than words. Once again, who pays for the testing should not get in the way of saving the lives of nursing home residents and staff. Blame and excuses will not save lives. Testing will.

Stellar infection prevention is the third element of the Quadruple Aim. The Department of Public Health's HAI program has been working tirelessly to oversee and train nursing facilities to provide stellar infection control. Unfortunately, that approach was always going to be insufficient if the nursing home industry wasn't fully on board with embracing the role of individual facility infection preventionists (IPs) to their fullest extent. On March 13, CALTCM recommended to CDPH that the Governor mandate that every nursing home be required to make their already designated infection preventionist full-time. We are thankful that the Department of Public Health recently made this recommendation part of every nursing home's mitigation plan. We must do everything possible to support the role of the facility IP. Doing this in March would have improved the success of the HAI team's efforts. We applaud the fact that this is now happening. Effectively impacting the operations of nursing homes requires a paradigm shift that begins with a focus on the improved delivery of clinical care. The requirement of a full-time IP is a step in the right direction. We must also find a way to bring similar expertise to RCFEs throughout the state, because most of them do not even have a nurse, or other medical personnel,

on-site. In fact, one of our recommendations has been for the state to train and repurpose the surveyors to go out and act as IPs in RCFEs. There is no need for the state to supply IPs to nursing homes. They already exist and just need to be empowered and supported to do the job they are trained for.

The fourth and final element of our Quadruple Aim is that nursing homes must operate in their emergency preparedness mode. This is essentially a proxy for excellent leadership and management. If COVID-19 has shined a light on one thing, it's the inherent weaknesses in the management structure of nursing homes. Nursing homes are complex small businesses, delivering care to frail older adults with multiple chronic illnesses. They are literally mini-hospitals, but with far fewer resources. Nursing home administrators are not prepared to run a hospital and should not be expected to have the skills necessary to manage a facility during a pandemic. More importantly, running a "mini-hospital" should require the full engagement of physicians competent in the care of complex, frail, older adults. The American Board of Post-Acute and Long-Term Care Medicine (www.abplm.org) provides a certification for nursing home medical directors. There are 1240 nursing homes in California and only 130 certified medical directors. The vast majority of medical directors in nursing homes around the state are neither certified or fully engaged with their facility leadership team. The negative impact of this has been amplified by COVID-19. The state of California should require all nursing homes to have an engaged, certified medical director. Whether in dealing with COVID-19, or trying to provide quality care in the future, it is essential that the clinical experts be actively involved in the day-to-day operations of nursing homes. Medical directors must also be allowed to perform their duties without undue influence from nursing home ownership. Many medical directors appear to be hired only because they can drive admissions to the facility and improve census. They often have no formal knowledge of geriatrics or long term care medicine, nor an understanding of the complex regulatory framework under which nursing homes operate. One of my esteemed colleagues recently lost their medical director position in order to be replaced by a hospitalist. There should be no quid pro quo related to admissions, and medical directors should be free to provide leadership regarding the delivery of care without fear of losing their position.

It is time for the state of California to take the lead in requiring all nursing homes to have an engaged, certified medical director. We believe that the best way to effectively do this would be for the state to set up a nursing home medical director "utility" to provide qualified medical directors to nursing homes across the state. In the meantime, CALTCM has requested a list of all medical directors in the state, so that we might directly communicate with them and offer resources and support for this vital role. Our national affiliate, AMDA – The Society for Post-Acute and Long-Term Care Medicine (www.paltc.org) has also been working with Congress and the Centers for Medicare and Medicaid Services (CMS) to provide a national registry of nursing facility medical directors.

We believe that a significant number of the nursing home deaths brought on by this virus were preventable. If there is an overarching message from the COVID-19 Pandemic, it's the need to actively engage experts in geriatrics and long-term care medicine in the policy and decision-making processes that impact the lives of older adults. To the clinical experts this pandemic has never been about control, money or power. It's only been about saving lives. CALTCM is a non-profit organization with one full-time staff person. All of the efforts we have expended

during this pandemic has been through volunteerism on the part of our many dedicated clinicians, with literally thousands of hours of our time that have benefited long-term care residents statewide and beyond.

Since early March, CALTCM has provided weekly free COVID-19 webinars on a variety of clinical and non-clinical topics relevant to long-term care, featuring numerous statewide and national experts and leaders (<https://www.caltcm.org/covid-19-webinar-series>). On March 5, we proposed Leadership and Management Training for nursing homes across the state, with a specific focus on infection prevention. On March 25, CALTCM proposed the formation of a statewide support and guidance center to oversee the development of COVID-19 positive skilled nursing facilities. This model could have provided the necessary incident command structure to help deliver best practice information to all nursing homes in the state, and in doing so relieve the pressures on nursing homes and hospitals battling the virus.

On April 17, we posted a White Paper delineating this proposal. We have not yet been given an opportunity to engage in a meaningful discussion of this proposal. Our feeling is that despite our best efforts, we have literally had to beg for table scraps to weigh in on policies with CDPH, often after the fact. This feeling culminated in late April when CDPH convened a workgroup composed of CHA, CAHF, Kaiser and Leading Age to develop a “SNF Playbook.” When we inserted ourselves into the process the project suddenly ended. Just as CALTCM has offered to collaborate and provide our expertise to CDPH, we have made similar offers to CAHF since early March. Neither has seen fit to actively include us in planning and discussions regarding policy and programs in response to the pandemic. In fact, our interactions with CDPH have been completely compartmentalized, despite our repeated offers to be an integral part of stakeholder discussions. There is still an opportunity as we move forward to develop guidelines for how nursing homes can more effectively deal with COVID-19.

Another example of the lack of engagement with the experts in geriatrics and long-term care medicine is regarding testing. First, let me be absolutely clear. The experts understood the role of asymptomatic spread in nursing homes by the end of March. The CDC published a paper in the *New England Journal of Medicine* pointing this out. No one from government or industry can reasonably and credibly say that by the end of March they were not aware of this fact. CDPH also has a Testing Task Force. We have been actively promoting widespread testing of nursing home and assisted living staff and residents since late March, when testing began to become readily available. In fact, in late March, the Chief Medical Officer of the Los Angeles Jewish Home, Dr. Noah Marco, was able to get 500 testing kits from the City of Los Angeles. We used them on staff and residents of our facility and shared the rest of them with another nursing home in dire need of testing in Los Angeles. We were able to demonstrate the already evidence-based impact of asymptomatic spread of the virus by nursing home staff and made a major push to get the Los Angeles County Department of Public Health to test all staff and residents of nursing homes in the County. Nevertheless, efforts to assure that testing happened in nursing homes and assisted living facilities across the state continued to flounder. CALTCM convened an expert panel towards the end of April. That panel produced testing recommendations that were recently published in a peer reviewed journal (<https://link.springer.com/article/10.1007/s12603-020-1401-9>), and have been codified by CDPH, CMS and the CDC.

Our struggle to assure the widespread testing of nursing home and assisted living facility staff and residents has been hampered by the fact that the state's Testing Task Force has not developed actionable recommendations as to how to bring about this testing. Despite recent efforts to get actively involved with the Task Force we have yet to be actively engaged. Why the Testing Task Force has never made testing in nursing homes and assisted living facilities, where the largest percentage of deaths occur, their highest priority, makes little sense. It is yet another example of how not engaging the experts in geriatrics and long term care medicine has led to a greater loss of lives.

Another example, with which you are probably aware, was the ill-advised CDPH mandate via AFL 20-32 issued on March 30, 2020, which stated, "SNFs shall not refuse to admit or readmit a resident based on their status as a suspected or confirmed COVID-19 case." In other words, even if a nursing home had no known or suspected cases of COVID-19, when a hospital deemed that a COVID patient was medically stable, the facility was obligated to accept the patient in transfer, no questions asked. Several other CALTCM leaders and I, along with other stakeholders including CAHF, CANHR and others, were unified in opposing this potentially deadly policy. Why on earth would a facility willingly introduce a highly contagious and deadly virus into its vulnerable population when they had no cases? Thankfully, although after the fact, CDPH walked that policy back a few days later in response to the stakeholder and media backlash. If they hadn't, we may have wound up like New York State, which issued a similar mandate that they kept in force for over 2 months. But the point is that if CDPH had engaged CALTCM and other geriatrics and long term care medicine experts before issuing such a mandate, it is improbable that it would have been issued in the first place, and then they would not have been in a position to have to reverse their policy. One of the most frustrating aspects of this pandemic has been the mixed and often conflicting guidance frontline providers have been receiving from various governmental agencies. That conflicting guidance is a direct reflection of the lack of engagement with the clinical experts.

The one notable exception to engaging us in real-time has been the fact that since early May, CDPH has allowed us to participate in weekly calls with Infection Preventionists, which we appreciate greatly. We had requested a daily call, in an attempt to have a greater impact on day-to-day facility operations, but that request was rebuffed. Ironically, on our most recent call, a large number of questions were still in the queue when the call ended. With the ongoing cooperation of CDPH, we are working to evolve the structure of these calls in order to find the most effective and impactful intervention. We've also been given the opportunity to weigh in on the two most recent AFLs, both of which reflected guidance that we've been giving since March. We appreciate the fact that CDPH has ultimately heard our guidance, but continue to believe that a more proactive and collaborative approach could have allowed for earlier action that could have save more lives.

Both the nursing home industry and resident advocates have long complained about the survey process. We believe that they are both right. It is time for California to lead the way in developing an effective oversight and quality improvement process. Traditional surveys should not be happening during a pandemic; they dramatically worsen staff morale and have marginal if any demonstrable benefit. The focus of surveys must be on improving the delivery of care and

protecting the quality of life of the residents. CMS has recently announced an enhanced approach to regulatory enforcement, or essentially stepping up the penalties to nursing homes. CALTCM strongly disagrees with this approach. Ms. Steinecker mentioned efforts to initiate survey reform in California about a month ago, and again during these Committee proceedings. She also mentioned the plan to develop new predictive analytics. As a geriatrician, I have heard non-geriatricians discuss “predictive analytics” and “evidence-based” care for over thirty years. I am dubious as to the ability of CDPH to unilaterally develop meaningful and effective analytics without fully engaging the experts in geriatrics and long-term care medicine. We support active oversight, but believe that it is critical for the Department of Public Health to engage the clinical experts, as well as resident advocates including the ombudsmen, in developing a new and more effective process for carrying out federally mandated surveys. CALTCM is presently planning to convene a group of experts to deliver recommendations regarding this process, and AMDA is also involved in these efforts. . We believe that it is critical to include us in the planning of any changes to the survey process. We have already made that request to CDPH, but have yet to hear anything else about their plan. We welcome the opportunity to contribute our expertise.

We understand the concerns that advocacy groups have regarding liability immunity. However, as clinicians who work in nursing homes, we are well aware of the impact that spurious lawsuits have on facilities. We would therefore like to reiterate our support for limited liability immunity for nursing facilities during this pandemic. CALTCM sent a letter to Governor Newsom on May 5 (https://bit.ly/CALTCM_liability). Nursing homes are already facing extreme challenges, and they do not need another setback as they do their best to provide safe and compassionate care to our vulnerable elders. A surge in poorly substantiated COVID-related elder abuse lawsuits has the potential to bankrupt the industry. Liability premiums are already doubling on average. If many nursing homes and chains go bankrupt, who will provide care to this increasing population? Your support for such an executive order would be appreciated. Please be clear that we do not support immunity for instances of willful misconduct or negligence.

Also a bit off the topic of COVID, but very significant to consider for California’s aging population, is the need for more Medi-Cal waivers so that Medi-Cal recipients who require assistance with some of their Activities of Daily Living (ADLs) may reside in an RCFE setting instead of having to be in a skilled nursing facility. This would create great cost savings (compare a cost of \$100,000 annually for a nursing home to \$40,000 for an RCFE) and would allow these elders to reside in more homelike, less institutional settings. Of course we also support continued emphasis on home- and community-based services (HCBS), in-home supportive services (IHSS) and similar programs that keep Californians at the lowest and least restrictive setting.

There is little disagreement regarding the fact that the financial structure of nursing homes is not conducive to maximizing scarce resources while providing quality care to residents. In my opinion, the separation of real estate, operations and management is a contrivance that leads to unmanageable pressures. The additional pressure from liability insurance costs compounds these pressures. If California is going to lead the way in reforming the nursing home industry, it is time to bring transparent change to the ownership maze and consolidate nursing home ownership so that the full focus can be on delivering care to the residents. That is a complex topic that in and of itself would take a lengthy discussion. I would be more than happy to return at some

point to have such a discussion. In the meantime, I might make a recommendation to help take the pressure off of the nursing home operators during this challenging time. I suggest that nursing homes be exempted from paying rent and liability insurance premiums for the next six months. The costs of this would obviously be borne by the real estate owners and the insurance companies. I believe that it's time for them to do their part while we figure out how the nursing home industry can survive and come out stronger than it was before.

I want to close by reiterating the fact that the California Association of Long Term Care Medicine and other experts in geriatrics across the state and beyond would relish the opportunity to assist in the development of policy related to the health and wellbeing of frail older adults. This is what we've spent our lives training for. Many of us were inconsolable as the federal government, the Department of Public Health and many counties made decisions without the full input of the clinical experts during the first 2½ months of this pandemic. If wildfires were raging through California, we would all expect the Governor to be standing next to a fire chief every day. COVID-19 is a medical emergency that is particularly deadly to frail older adults. The Governor should be standing with the experts in geriatrics and long term care medicine on a daily basis. So must every governmental agency that impacts the lives of our most vulnerable citizens. In 2015, the State Senate Select Committee on Aging and Long Term Care put out a report, "A Shattered System: Reforming Long Term Care in California: Envisioning and Implementing an IDEAL Long Term Care System in California." (<https://bit.ly/CAsenateLTCczar>) One of the recommendations from that report was the creation of a Long Term Care "Czar." Such a position, at the cabinet level, could have gone a long way towards ensuring an effective response to this pandemic. This needs to happen as soon as possible in order to improve the state's ability to implement recommendations from the Master Plan For Aging, which was conceptualized by the 2015 Report.

Thank you for the opportunity to ask a question. My question is directed to Ms. Steinecker. "I've addressed many of the concerns of the committee members in my full comments. Since early March the experts have been trying to share our expertise with both CDPH and CAHF. We knew about facility leadership flaws. In March the experts understood asymptomatic spread. In fact, at the Los Angeles Jewish Home, we tested all staff and residents at the end of March. On March 13, we recommended that the Governor mandate a full-time IP.

We appreciate the commitment to an improved survey process, but it is critical for CDPH to actively and fully engage experts in geriatrics and long term care medicine, as well as resident advocates such as the ombudsmen, in developing this new process. For over 30 years as a geriatrician, I've listened to government officials talk about analytics. With all due respect, I am dubious that CDPH can come up with effective predictive analytics. CALTCM is presently planning to convene a group of experts to deliver recommendations regarding this process, and AMDA is also involved in these efforts. Will Ms. Steinecker commit to a collaborative process that includes us, not just in collecting our recommendations, but in the actual planning for this new approach?"

It is time to learn from the mistakes of the past few months and develop a structure that allows for the development of expert-driven policy. You must find a way to require the direct involvement of the clinical experts as we move forward. If such a process had already been in

place, a significant number of lives would have been saved. Thank you once again for convening this panel. I look forward to answering your questions, and my colleagues and I stand at the ready to assist during this pandemic and beyond.