Report to the Legislature

Epidemic Disease Preparedness and Response for Long-Term Care Facilities

December 2021

SHB 1218 (2021)

Jointly prepared by:

Washington State Department of Social and Health Services (DSHS) &

Washington State Department of Health (DOH)

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Executive Summary

Substitute House Bill 1218; Chapter 159, Laws of 2021 (SHB 1218) was adopted on May 3, 2021, to improve the health, safety, and quality of life for residents in long-term care (LTC) facilities. This legislation requires the Department of Health (DOH) and the Department of Social and Health Services (DSHS), along with key partners, to jointly develop a report and guidelines on epidemic disease preparedness and response for licensed and certified LTC settings. A draft report is due to the legislature by Dec. 1, 2021. The final report is due July 1, 2022.

This first draft report focuses on the specific issues faced by licensed and certified LTC settings in Washington state during the COVID-19 pandemic and identifies associated needs as required by SHB 1218. It begins to identify major challenges, best practices, and lessons learned about containment and mitigation strategies for controlling the spread of the infectious agent.

The major issues identified and discussed in this report are grouped by topic. Within each topic area, the two departments and stakeholder representatives identified the key challenges to providing services in licensed and certified LTC settings, as well as the LTC system's needs to address those challenges. The topics include:

- Visitation policies that balance the psychosocial and physical health of LTC residents.
- Timely and adequate access to personal protective equipment (PPE) and other infection control supplies.
- Admission and discharge policies and standards.
- Rapid and accurate testing to identify infectious disease outbreaks for resident cohorting and treatment; contact tracing purposes; and protecting the health and well-being of residents and employees.
- Communication, guidance, and regulatory conflicts.
- Ongoing staffing challenges in LTC facilities.
- Emergency and epidemic preparedness in LTC facilities.

The future needs identified in this report are specific to each topic area; however, there are some common themes across each area. These include cross-sector education; funding and access to resources; communication improvements; and increased consideration of behavioral health.

DOH and DSHS will continue to work with the stakeholder workgroup to finalize this report and develop guidelines that build upon the needs identified to date. These guidelines will consider federal rules, the variety of involved provider and facility types, and available resources for infection control. A timeline for implementation and a process to maintain and update the guidelines will be included in the guidelines development process.

Introduction

Authorizing Legislation

Substitute House Bill 1218; Chapter 159, Laws of 2021, (SHB 1218) was adopted on May 3, 2021, to improve the health, safety, and quality of life for residents in long-term care facilities. This draft report addresses Section 30 of the bill, which requires the Washington State Department of Health (DOH) and the Washington State Department of Social and Health Services (DSHS) to jointly develop a report and guidelines on epidemic disease preparedness and response for long-term care facilities, with input and consultation from interested stakeholders, including but not limited to: local health jurisdictions (LHJs), advocates for consumers of long-term care, LTC facility provider associations, and the Office of the State Long-Term Care Ombuds (see Appendix A for a complete list).

SHB 1218 directs DOH and DSHS to develop a report and guidelines on the following timeline:

- Submit a draft report and guidelines on COVID-19 to the Healthcare Committees of the legislature by Dec. 1, 2021.
- Submit a final report and guidelines on COVID-19 to the legislature by July 1, 2022.
- Beginning Dec. 1, 2022, and annually thereafter, review the report and any corresponding guidelines to make necessary changes and add information about any emerging epidemic of public health concern.

This draft report addresses priority areas identified in SHB 1218:

- Visitation policies that balance the psychosocial and physical health of residents.
- Timely and adequate access to personal protective equipment (PPE) and other infection-control supplies so that LTC facility employees are prioritized for distribution in the event of supply shortages.
- Admission and discharge policies and standards.
- Rapid and accurate testing to identify infection outbreaks for resident cohorting and treatment, contact tracing purposes, and protecting the health and well-being of residents and employees.

Also included in this draft report are topics identified by our stakeholders as areas of interest or concern, including preliminary considerations of communication, emergency guidance conflict, and staffing challenges at long-term care facilities; as well as appendices detailing the complexities of the LTC system and describing LTC funding streams.

Methodology

DOH and DSHS convened a stakeholder workgroup comprised of representatives from advocacy organizations, professional associations, health care coalitions, local health jurisdictions (LHJs), the state Long-Term Care Ombuds, state government, long-term care consumers, and other interested stakeholders. The group had six virtual meetings from July through September 2021 to share experiences and lessons learned during the COVID-19 pandemic to inform development of this draft report. Individual interviews and small group discussions with stakeholders were organized to gather additional information. While participants in the group committed to the process and were actively engaged, identifying lessons learned was less clear-cut than initially anticipated due to significant challenges with the rise of the Delta variant and the resultant fifth wave of COVID-19 infections. Identifying lessons learned through COVID-19 will be an ongoing process as the pandemic and associated response continue to evolve.

DOH and DSHS will continue to engage stakeholders to further develop the report and guidelines on COVID-19, so they can be finalized and submitted to the legislature by July 1, 2022. We will reconvene the stakeholder group in early 2022, providing us the opportunity to collaborate on the guidelines and address additional responsibilities identified in SHB 1218:

- Ensure that any corresponding federal rules and guidelines take precedence over the state guidelines.
- Avoid conflict between federal requirements and state guidelines.
- Develop a timeline for implementing the guidelines and a process for communicating the guidelines to LTC facilities, LHJs, and other interested stakeholders in a clear and timely manner.
- Consider options for targeting available resources towards infection control when epidemic disease outbreaks occur in LTC facilities.
- Establish methods to ensure that epidemic preparedness and response guidelines are consistently applied across all local health jurisdictions and LTC facilities in Washington state (which may include recommendations to the Legislature for any needed statutory changes).
- Develop a process for maintaining and updating epidemic preparedness and response guidelines as necessary.
- Ensure appropriate considerations for each unique provider type.

Summary of Best Practices and Lessons Learned Identified by Stakeholders

DOH and DSHS gathered and organized stakeholder comments to identify future best practices and lessons learned associated with each focus area in this report, as well as some overarching needs. These are listed and described at the end of each section. Common themes include:

Education. Several areas of conflict and confusion experienced by stakeholders during the COVID-19 pandemic can be mitigated through education. Local health jurisdictions (LHJs) and state leadership would benefit from information on the complexities of the LTC system. Long-term care facility administrators and other LTC stakeholders need clarity on the role of the LHJ in a public health emergency. Long-term care facility operators and staff need education on foundational emergency preparedness principles.

Policies that consider behavioral health. The behavioral health impacts of the pandemic were a common topic of discussion among stakeholders. Behavioral health supports are needed for LTC facility staff and residents experiencing anxiety and depression as a result of COVID-19 and its societal impacts. Future LTC guidance and resulting LTC facility policies restricting resident visitation during an epidemic need to take residents' emotional well-being into account.

Funding and access to resources. Many pain points identified by stakeholders can be traced back to limited funding and resources. Stakeholders shared that LTC facilities need funding support to reduce staffing challenges as well as improved access to resources, including testing materials and PPE. See Appendix D for a description of LTC funding streams.

Communication. Stakeholders identified many areas in which improved communication would result in improved preparedness and a more efficient emergency response, particularly in situations where guidance is changing rapidly.

The COVID-19 Public Health Emergency

Nationwide Public Health Emergencies

The secretary of the federal Department of Health and Human Services (HHS), under section 319 of the Public Health Service Act, can determine that:

a) A disease or disorder presents a [national] public health emergency (PHE); or

b) That a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists.

According to HHS, there have been 29 nationwide PHEs since 2009. This number includes the initial events and various renewals over time. Examples of diseases prompting a PHE include H1N1 flu, the opioid crisis, Zika, and most recently the COVID-19 (SARS CoV-2) pandemic. The

declaration of a PHE indicates the situation has become emergent (unusual, unforeseen, unpredictable) and the potential harm to health may overwhelm a community's ability to address the emergency. All health care delivery systems have struggled and continue to struggle under the weight of the PHE during the COVID-19 pandemic. The LTC system, in particular, has been severely impacted.

Epidemic/Pandemic in Washington State

According to a DOH report on COVID-19 and the LTC system (published Sept. 14, 2021), 4 percent of the state's cases (22,872) and 40 percent of deaths (2,811) were either associated with or likely associated with LTC facility settings (such as skilled nursing facilities, assisted living facilities, and adult family homes). These cases included residents, employees, and visitors. Not all were exposed at the LTC facility—many had visited multiple locations during their exposure period, and some may have visited a LTC facility after disease onset.

Figure 1 below in **blue** shows the LTC facility-associated cases over time. Figure 2 in **orange** shows the LTC-associated deaths over time.

Figure 1. Long-Term Care Cases Over Time in Washington State

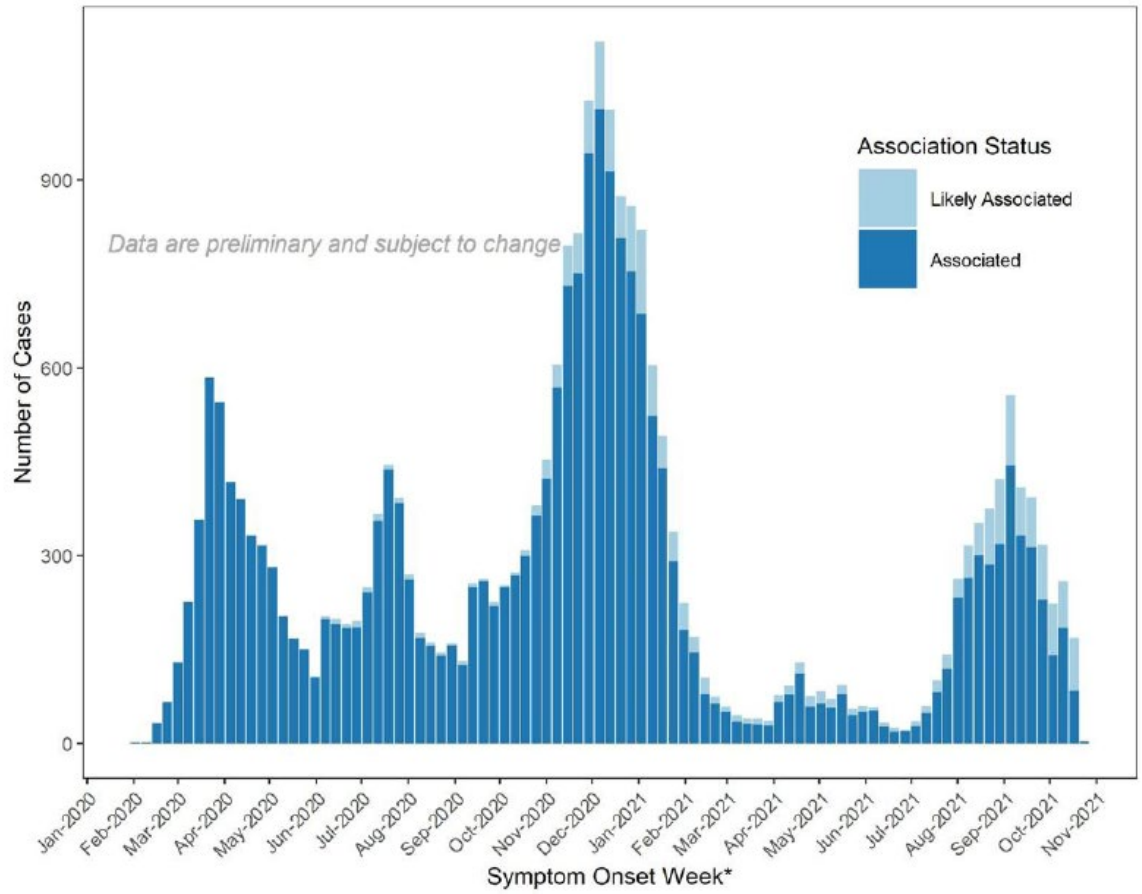
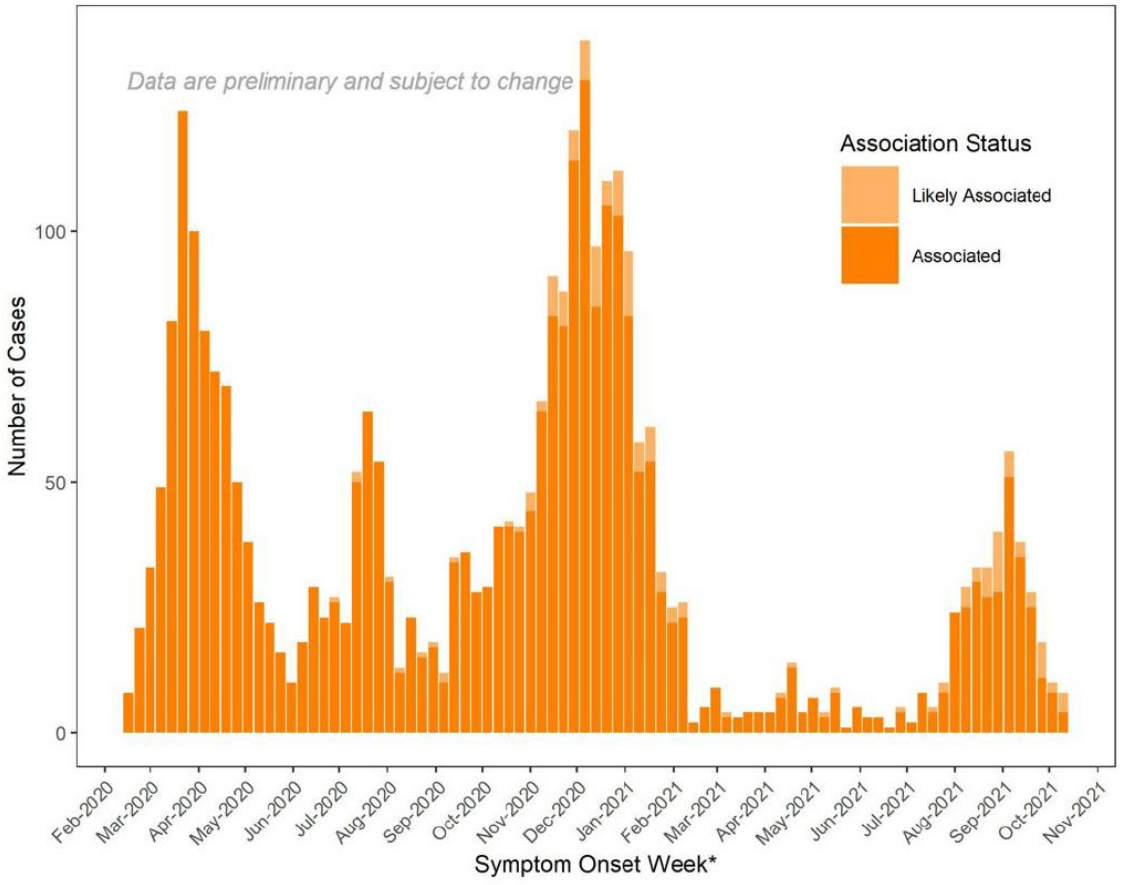


Figure 2. Long-Term Care-Associated Deaths Over Time in Washington State



The remainder of the report describes challenges faced by the LTC system, barriers that were part of the provider experience, trauma experienced by LTC facility residents, and communication challenges between providers and government entities. From these experiences also came lessons learned. At the time of writing this draft report, the state is still in the grips of the COVID-19 epidemic/pandemic. More will be learned over time by all involved in the LTC system.

Specific Issues to Care Delivery During COVID-19

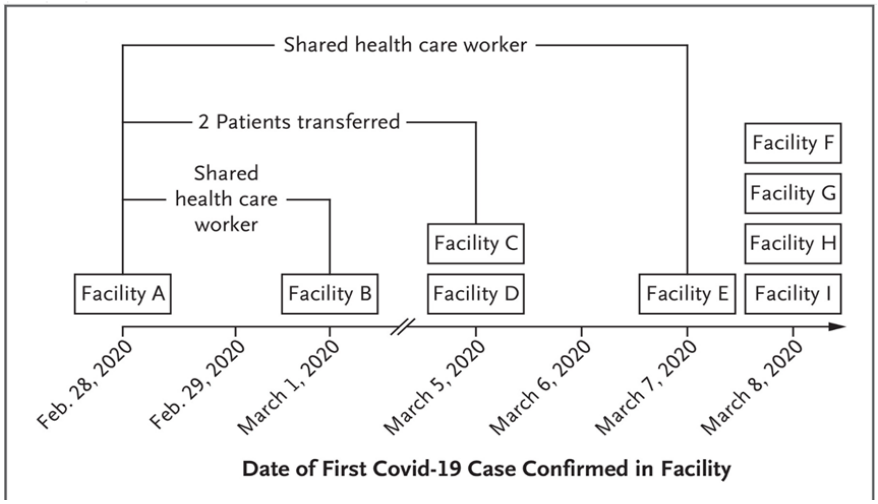
Visitation Policies

The CDC confirmed the first case of COVID-19 in Washington on Jan. 20, 2020. At that time, testing for COVID-19 was done according to limited case definitions that were primarily focused on foreign travel. The extent to which the COVID-19 virus was circulating in the community was largely unknown until a substantial outbreak at a LTC facility in King County, Washington, was identified on Feb. 28, 2020.

A joint investigation by the Washington State Department of Health and Public Health-Seattle and King County was the first to describe how the combination of residents' advanced age, chronic underlying health conditions, and living in congregate settings enables COVID-19 to transmit easily between residents, staff, and visitors and cause significant mortality.

By March 18, 2020, there were 167 confirmed cases of COVID-19 that could be traced back to Facility A in the diagram below. Facility A had approximately 130 residents being cared for by 170 staff members. One of the early revelations in the investigation was an apparent connection between the spread of the disease and the movements of staff and residents between facilities.

Figure 3. Timeline Showing Long-Term Care Facilities in King County with One or More Confirmed Cases of COVID-19 from Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington, McMichael et al., 2020



Early in the COVID-19 epidemic, before the actual mode of transmission was identified (how the pathogen moves from an infected person to a non-infected person), it was clear that movement across facilities was potentially dangerous to staff, residents, and visitors. Of the 167

COVID-19 cases that were traced back to Facility A, 35 individuals died, including 34 residents and one visitor.

As COVID-19 outbreaks escalated in in Washington and nationwide, LTC facilities took steps to keep infected residents, staff, and visitors away from those who had not been infected. Following guidance from national, state, and local public health authorities, LTC facilities put in place enhanced infection-control practices, changed their admission and discharge policies, and implemented visitation restrictions. While the visitation restrictions were important to protect long-term care residents, these resulted in negative, unintended consequences for some.

IDENTIFIED CHALLENGES:

Unintended consequences of restrictive visitation policies. The early days of the COVID-19 pandemic were a difficult and confusing time for the LTC industry. Visitation guidance varied greatly, especially at the beginning of the pandemic when scientists were still trying to understand the transmission modalities of the virus. For most LTC settings, there was a span of time when no visitors were allowed. Even regulatory agency field staff did not visit facilities for surveys, apart from complaint investigations that included allegations of abuse and harm, and CMS-mandated infection control surveys.

In addition to restrictions on families and other visitors, some professional service providers were denied access to LTC facilities:

- Hospice providers whose end-of-life services would normally include physician or medical services, pharmacy services for pain management, nursing services, spiritual care, social work, and bereavement support were denied access. Even when some of the restrictions to visitation were lessened, hospice providers continued to report being told only the hospice nurse would be allowed to visit the facility, denying residents the full array of end-of-life care.
- Home health services (which include skilled nursing, physical therapy, occupational therapy, and other therapeutic services) and home care services providers were unable to access their patients who resided in various LTC facility types.
- The LTC Ombuds Program, authorized as a health oversight agency, was denied access to LTC facilities. Ombuds act as resident advocates, authorized to perform complaint intake and early resolutions at the facility level. Much of their work is done through personal contact and via the trust formed through this contact. LTC Ombuds staff can become a significant part of a resident's support system. In the absence of personal contact, the LTC Ombuds program undertook a massive postcard campaign to keep in touch with residents. As in many other businesses, the Ombuds Program attempted to substitute technology for direct contact but this was not always successful. According to the LTC Ombuds, the program itself suffered a significant attrition of volunteer staff

during the pandemic. This was due to the inability to meet face-to-face with the residents. For some, the face-to-face interaction was the most appealing part of the volunteer role.

- The Office of Developmental Disabilities (DD) Ombuds provides advocate services to persons with intellectual and developmental disabilities. They also work on resolving individual/client complaints in a variety of settings. Their complaint system is designed to work by phone and online. According to DD Ombuds staff, their most productive method—prior to the COVID-19 pandemic—was making in-person visits to their clients' places of residence. Visitation restrictions made this impossible.
    - DD Ombuds staff stated that social isolation was a big problem for this population, as many did not have access to internet services.
    - The DD Ombuds staff noted the nature of the complaints changed during the COVID-19 pandemic. There were allegations by some that the restrictions they received did not match what they understood about the virus. DD Ombuds staff stated, "Our folks had no choices given to them." For example, a DD client complying with physical distancing and wearing a mask might be told they were not allowed to visit the same places the general public could visit, like the grocery store.

Continuing trauma. Many articles have been written addressing the significant mental health impacts to LTC residents who were subjected to prolonged confinement in their rooms. The LTC residents participating in our stakeholder group shared their personal experiences that confirmed the difficulty of this time for them. The experiences, emotions, and concerns voiced by residents during the workgroup include:

- Feelings of isolation, fear, and worry for their fellow residents.
- Feelings of grief and loss for their friends in the facility who died from COVID-19.
- One account of the suicide of a fellow resident.
- Difficulty witnessing the physical decline of residents who were restricted to their rooms and could no longer walk in the hallways, which for many was their primary form of exercise.
- Observing residents with dementia who experienced further cognitive decline.
- Observing a resident who cried daily at the facility front door, asking to be let out.
- Feeling a sense of fear that the caregivers they trusted and often had good relationships with were now a possible source of the virus.
- An overall sense of the loss of ability to "live a life worth living."

IDENTIFIED NEEDS:

Visitation policies that consider resident mental health. Prolonged isolation, even for the best of reasons, can be harmful to the well-being of a LTC resident. Guidance and LTC facility policies and procedures are needed that allow for social interaction, physical activity, and access to family and others significant to the resident's mental health and well-being. Some LTC facilities successfully implemented alternative approaches to visitation, including establishment of outdoor spaces for visitation and remote options using tablets.

Access for Hospice, Home Health and LTC/DD Ombuds. LTC policies and procedures are needed that allow for the delivery of these services and alternative ways of communicating with residents. The use of PPE and infection control training should be part of the protocol.

Increased access to behavioral health services. Behavioral health support is needed for residents and staff who survived the COVID-19 pandemic and are displaying symptoms of adjustment difficulties (comparable to Post Traumatic Stress Disorder-PTSD) or other anxiety/depression disorders. If this is not an area of expertise of the LTC provider, they will need additional behavioral health training and/or resources.

Updated policies. Visitation policies will need to be kept current according to the LTC facility type and the appropriate regulatory entity's guidance.

Timely and Adequate Access to Personal Protective Equipment (PPE)

While Washington maintains a state PPE stockpile (known as "the backstop"), requests for PPE (e.g., masks, respirators, gowns, gloves, and eye protection) early in the pandemic far outpaced the state's ability to source and fulfill orders. State leadership developed prioritization guidelines for PPE distribution, but initial guidelines did not include LTC in the first prioritization tier with hospitals and other medical or medical-adjacent facilities, resulting in LTC facilities not being able to access this resource early in the pandemic.

Ultimately, stakeholders worked with leadership to revise the prioritization guidelines to include LTC in the first prioritization tier. Additional supports were made available at the county level: requests for PPE from the state supply are routed through county-level emergency management agencies and passed to the state if the county is unable to fulfill the request. Some counties were able to acquire a relatively stable supply of PPE early in the pandemic and support LTC facilities in their jurisdiction.

IDENTIFIED CHALLENGES:

Supply chain shortages. At the beginning of the COVID-19 pandemic, shortages of PPE (masks, respirators, gowns, gloves, and eye protection) were a major challenge across the medical industry, including for LTC facilities and services of all types. The sharp increase in demand from both health care and non-health care consumers was further complicated by substantial price increases, supply chain shortages, and goods that did not meet safety standards; these all contributed to LTC facilities' initial struggles to obtain adequate supplies of PPE.

Also in high demand were other supplies essential to infection control protocols, such as hand sanitizer and cleaning supplies. These were necessary for the protection of residents and staff and to remain in compliance with infection prevention guidelines. These issues were particularly problematic for adult family homes (AFHs). Large facilities such as hospitals, skilled nursing facilities (SNF), and assisted living facilities (ALF) typically purchase their goods from medical supply companies. Smaller LTC facilities, such as AFHs, typically use "big box" stores to purchase goods such as cleaning supplies. When the panic-buying of the general public emptied the shelves of grocery stores of all sizes, AFH providers had no way to access these supplies. Since medical supply companies sell in large volumes, this was problematic for AFH owners because:

- An individual AFH owner is unlikely to be able to afford the quantity they would have to purchase from a medical supply company.
- Even if affordable, an individual AFH operator may not have the capacity to store large-volume supplies.

Cleaning and disinfectant supplies come with strict manufacturer instructions for use (IFU), guidance that must be followed for the product to be effective in killing viruses, molds, and bacteria. The most common directive in an IFU is that the product should not be used beyond a designated expiration date. Cleaning and disinfectant supplies purchased in large volumes by a small facility are likely to expire before these can be used in their entirety.

Larger LTC facilities explored contracts with international producers to meet needs for increased PPE with varying results: some orders placed through international suppliers were redirected to the federal stockpile upon arrival in the United States while others were continuously delayed. Smaller LTC facility types such as AFHs, which typically rely on public-facing bulk suppliers, did not have direct access to manufacturers or medical suppliers, creating additional barriers to PPE access for these facility types.

Finding the variety of PPE needed to satisfy infection control guidelines remains a challenge. For example, a facility needs to stock a variety of sizes of gloves and gowns to meet staff needs and infection control requirements, but suppliers may only have gloves and gowns available in one size. While the supply chain for many materials has stabilized as of the writing of this

report, new state and federal testing mandates are creating shortages once again: some facilities are currently reporting a four- to six-week wait for testing supplies necessary for outbreak identification.

Opportunity costs. Early in the pandemic, LTC operators were impacted by heightened opportunity costs, in which time spent securing the necessary quantities and varieties of PPE is time not spent providing care to residents or completing other tasks. LTC operators of all sizes report that working to secure required PPE was the equivalent of a full-time position at the beginning of the pandemic and is again becoming a time burden with shortages and delays resulting from new mandates. Smaller operators are particularly affected.

Early in the pandemic, LTC facilities needed to dedicate time to respirator medical evaluations and fit testing for staff. Fit testing is a 20- to 30-minute procedure to ensure a proper seal between a respirator face piece (including disposable respirators, like N95 masks) and an individual's face. Respirator medical evaluations determine whether it is safe for individual health care workers to use respirators. Workers complete a medical questionnaire to help identify potential health issues with respirator use in a work setting. Some LTC facility types had not previously used N95s or other respirators in their settings and had to establish fit testing procedures for the first time, while other facilities that had previously done fit testing based on specific brands of respirators needed to repeat the process quickly due to receiving unfamiliar types of respirators from a supplier or the state backstop. DOH recommends that only large facilities/agencies conduct their own fit testing due to the significant time commitment required to learn to conduct a fit test. As of the writing of this report, DOH is providing free online respirator medical clearance for fit testing to a wide variety of LTC types, in addition to having engaged fit testing vendors perform free respirator fit testing in each county in Washington.

Cost and quality concerns. In response to increased demand, costs for PPE increased sharply at the start of the COVID-19 pandemic with some LTC facilities reporting up to 35 percent increases in cost for supplies such as masks, gloves, and hand sanitizer. Some supplies received from the federal or state emergency stockpiles were not usable or did not meet the requirements of infection control guidelines. Even without cost inflation, the sheer quantity of PPE needed to meet requirements are cost prohibitive on a long-term basis. For example, some larger facilities are using 300-400 gowns per day, which is not covered by current reimbursement rates and not financially sustainable.

IDENTIFIED NEEDS:

Protections against price gouging. Request legislation from the Office of the Attorney General (Senate Bill 5191, 2021 Legislative Session) was intended to cap price increases on needed supplies to 10 percent during a state of emergency, but this legislation ultimately did not pass.

Washington remains one of 14 states without legislation that expressly prohibits price gouging during an emergency.

Governmental supply. While county- and state-level emergency PPE provisions were eventually made available to LTC facilities, stakeholders report that having this support earlier and in greater quantity will be essential in future crises. Creating a streamlined process to access state stocks of PPE should also be considered, as the process varied by county and was not always intuitive.

Creative options for smaller facilities to access resources. Smaller LTC facility types such as adult family homes do not have access to the bulk suppliers used by hospitals and larger LTC facility types. Creative options for these facilities to access PPE (such as the formation of coalitions in which smaller facilities join together to order and divide large quantities of PPE and infection control supplies) should be considered alongside regulatory solutions.

Infection Control Practices

Infection control was the main topic of two of the stakeholder meetings. Some of the issues raised will be addressed in more detail in other sections of this report.

Discussions with the stakeholder group revealed common challenges across provider types. Examples include:

- Difficulty obtaining personal protective equipment (PPE).
- Difficulty obtaining infection control supplies such as hand sanitizer, disinfectants, and other cleaning supplies.
- Conflicting guidance from public health and regulatory entities.
- Concern that onsite visits from regulatory entities raised anxiety and created additional staff burden during an already stressful time for staff.
- Confusion between providers and public health authorities regarding who was responsible for contact tracing.
- Difficulty with testing of staff and residents for COVID-19 due to:
    - Short supply of testing materials in the early days of the pandemic.
    - Long turnaround times for results at the beginning of the pandemic, making it difficult to make decisions about strategies such as ***cohorting*** (keeping residents together who have been confirmed to have the same disease process).

    - Lack of appropriately credentialed or trained staff (such as a nurse) to perform the testing, particularly an issue for the adult family home operators who do not include nursing staff in their regular staffing model.
- Difficulty in following guidance for creating COVID-specific sections of a residential facility due to staffing shortages.
- Difficulty finding the best method for meeting quality of life standards while also implementing needed infection control strategies such as isolation and quarantine.

DOH to assist LTC providers with the unique challenges of COVID-19.

Some of these guidance documents include:

- Interim Guidance for Long-Term Care: Transferring Between LTC and other Healthcare settings
- Contingency Strategies for PPE Use During the COVID-19 Pandemic
- Respirator and PPE Guidance for Long-Term Care
- Testing in Long-Term Care Facilities
- Risk Assessment for Resident/Clients After Community Visits

Lessons Learned and Best Practices for Infection Control

At the time of this writing, Washington and the nation are in the fifth wave of increased COVID-19 infections. It is difficult to look back and draw conclusions when the situation is changing almost daily. However, insights shared by our stakeholder group may be useful for future planning. These include:

- Community-based settings, such as supported living, found local drive-through test sites useful as some facilities are too small to receive local health jurisdiction (LHJ) support.
- Supported living services accomplished cohorting by moving clients who had tested negative for COVID-19 to an extended-stay hotel and keeping those who had tested positive in their home.
    - However, providers noted it was challenging to staff both environments on a 24/7 basis.
- Some residential facilities carried out rapid construction (such as adding doors to hallways) to create COVID-specific wings. From the resident perspective, these actions were more effective.
- Adult family homes were rarely able to cohort negative and positive residents due to the facilities' small size. Positive residents were moved to COVID-positive facilities.

    - If the staff of the adult family home tested positive in sufficient numbers to compromise care, all residents were moved to alternative facilities until the staff recovered and could return to work.
- When residents met discharge criteria, many were able to go into transitional settings funded by the Federal Emergency Management Agency (FEMA).
- Many LTC facilities strengthened communication practices by establishing channels of regular information sharing (i.e., virtual town halls, telephone conferences, e-newsletters), and stakeholders reported that these measures greatly reduced anxiety among resident family members.

Admission and Discharge Policies

One of the overarching themes in infection control continues to be the challenge of providing adequate staffing to care for LTC residents and those receiving LTC services. A LTC facility may have unoccupied beds, but may not have the staffing available to admit additional residents. Hospital discharge planners searching for a suitable location for a patient to continue their recovery may turn to home health as an alternative, but community-based providers may also have staffing shortages. Our stakeholder group identified the following issues associated with discharging patients from hospital settings:

- In Eastern Washington, many patients required complex care (including behavioral health care) and specialized equipment that was not always readily available.
- State- and FEMA-supported strike teams (who helped fill staffing gaps in LTC facilities) provided much-needed assistance. During the stakeholder meetings, there was a perception that this support is becoming more limited.
- Stakeholders from SNF and ALF raised concerns about closing dedicated COVID-19 units, for which funding ended in June 2021.
- The Developmental Disability Ombuds from the stakeholder group noted that it is often difficult for their clients to find placement after hospitalization. The organization created a document in December 2018 to highlight the problem, titled "Stuck in the Hospital." This problem worsened during the COVID-19 pandemic.

IDENTIFIED NEEDS:

Decision-making tools. A "decision tree" may make it easier for providers to make admission and discharge decisions during an outbreak. Stakeholders suggested this tool might alleviate confusion, especially when guidance is changing rapidly.

Systematic approaches to advance directives. One stakeholder provided the group with an article on "An Advance Care Planning Long-Term Care Initiative in Response to COVID-19" that

explores a systematic approach to advance directives that might include "Do Not Hospitalize" orders which could give the resident or family an opportunity to choose, in advance of need, whether they wish to remain in the facility for the duration of their care for COVID-19.

Increased waiver clarity and tracking. Some regulations in RCW or WAC were waived during the pandemic to help facilitate health care in the new COVID-19 environment. Some stakeholders thought these waivers were useful, but difficult to track. We will explore this topic further in the final version of this report.

Funding support. Stakeholders spoke of continued advocacy to maintain funding that they stated was critical to maintaining a stable workforce, particularly funding to improve staffing and wage support.

Improved discharge processes. Discharge problems were present prior to the pandemic for residents with chronic or serious mental illness, individuals with dementia, residents with short-term skilled nursing stays who were previously unhoused, and others. Stakeholders expressed the need for consistent discharge planning practices to improve the ongoing well-being and safety of residents.

COVID-19 supports. Dedicated COVID-19 units and transitional care units are an ongoing need and will remain critical as long as the pandemic continues.

Staffing supports. Rapid-response staffing teams provided by DSHS filled a critical gap and are needed on an ongoing basis.

Rapid and Accurate Testing

Washington has a statewide COVID-19 testing strategy based on the principle that testing is a critical and essential part of the overall response to COVID-19. Identifying those infected by or exposed to SARS-C0V-2 is necessary in responding to and stopping the spread of infection. The testing strategy calls for the assurance of available testing resources (e.g., specimen collection kits); in-state lab capacity to quickly and efficiently process test kits; and staffing support for testing efforts in settings operated by health care facilities, LHJs, and other organizations and agencies. Testing recommendations are updated as needed and follow the best available scientific guidance. Equitable and widespread access to testing with rapid turnaround times for results is a top priority.

Washington's statewide testing strategy prioritizes people displaying symptoms of COVID-19, close contacts of infected persons, and people in congregate settings where there are confirmed positive cases. In addition, the state's testing efforts work to reach populations disproportionately impacted by COVID-19, including people with lower incomes, people of color, immigrant and refugee communities, and older adults.

There are two kinds of tests to determine if a person is positive, or has COVID-19 at the time of the test: polymerase chain reaction (PCR) tests and antigen tests. The PCR test is a molecular test sent to a lab that looks for virus-related genetic material in a specimen collected from an individual; turnaround time to receive results from a PCR test is usually 24 to 72 hours. Antigen tests look for certain proteins that are part of the virus and return results in around 15 minutes. DOH has provided testing supplies and resources to a number of LTC facilities across the state and continues to work to ensure that staff in congregate LTC settings have access to convenient testing.

IDENTIFIED CHALLENGES:

Testing unavailable early in the pandemic. When testing for COVID-19 began in early February 2020, criteria for testing was limited to those displaying symptoms who had recently traveled to known outbreak areas in China or had prolonged exposure to a known COVID-19 case. Initially, the only test kit designed for SARS-CoV-2 approved by the U.S. Food and Drug Administration (FDA) and available in the United States was developed and distributed by the CDC. Samples needed to be sent back to the CDC in Atlanta for testing, with results taking at least three to five days to be returned. FDA Emergency Use Authorization rules made it difficult for state and hospital laboratories to develop their own test kits even as accuracy issues were discovered with the first version of the CDC test. This gradual ramp-up of testing capabilities significantly delayed outbreak identification in LTC and other settings early in the pandemic.

In March 2020, the FDA relaxed its rules around the development of COVID-19 diagnostic testing, and state and local labs slowly gained the capability and capacity to conduct their own tests. Criteria for testing broadened over time, but test kit supply shortages and lab delays in the first few months of the pandemic continued to limit rapid outbreak identification in all settings, including LTC.

As of the writing of this report, rapid tests are now available for use in LTC settings to quickly identify new COVID-19 cases among LTC staff and residents. However, the current surge in cases due to the Delta variant and new testing mandates at the federal level are again causing concern about testing supply shortages.

Many LTC types need external support for testing. Early in the pandemic, LTC facility types that do not include nurses as part of their regular staff relied on LHJs to provide testing support, but high demand on LHJs and limited testing resources resulted in long delays before testing processes could be established. Home- and community-based LTC settings were largely left on their own to identify available resources. Many were able to use community testing resources (e.g., drive-through testing sites), which became easier later in the pandemic as those resources became more widely available. Depending on the type of test, some facilities were required to

obtain a Clinical Laboratory Improvement Amendments (CLIA) waiver to perform testing, which can be a difficult process for small facilities.

Cohorting processes were difficult to establish without access to rapid and accurate testing. Cohorting, or grouping together patients who test positive for COVID-19 in a single physical area within a facility, is a recommended infection-control strategy. Cohorting allows dedicated staff to work with only COVID-19-positive residents to prevent spreading the virus across facilities, and can extend the use of certain PPE such as masks and eye protection when supplies are limited as they often were early in the pandemic. To successfully cohort positive residents, facilities need to know who (staff or resident) is positive in order to assign staff and residents to appropriate areas of a facility. In the absence of rapid and accurate testing, facilities instead had to use isolation and quarantine measures to prevent the spread of the virus among residents early in the pandemic. Residents were restricted to their own rooms or living spaces, which reduced exposure risk but resulted in increased anxiety among residents and may have contributed to increased risk for other negative health outcomes in the long term.

IDENTIFIED NEEDS:

Rapid distribution of testing resources. For future epidemic planning, stakeholders indicated that producing and distributing rapid tests as quickly as possible will be critical to early outbreak identification.

Staffing

Washington state is experiencing severe staffing shortages across LTC facility types. According to CMS data compiled by the American Association of Retired Persons (AARP), 56.5 percent of Washington skilled nursing facilities reported a shortage of direct care workers in August 2021. While staffing shortages across LTC facilities existed before the pandemic, the situation has grown more serious since the beginning of 2020. In the second week of September 2021, 102 out of 200 skilled nursing facilities in Washington reported staffing shortages in a weekly National Healthcare Safety Network (NHSN) report, compared to 68 in late January 2021 (NHSN, 2021). Nationally, 73 percent of nursing homes and 59 percent of assisted living communities say their facility's overall workforce has declined since 2020, according to an industry group survey.

IDENTIFIED CHALLENGES:

Multiple factors contributing to staffing shortages. Staffing shortages have worsened during the pandemic. Medicaid reimbursement rates are calculated based on cost data that are up to four years old, resulting in rates that do not match current-time costs of care. A general worker

shortage across all industries and a steep increase in wages across all sectors has left LTC facilities, particularly skilled nursing facilities, in a difficult financial position as they raise wages to compete with hospitals and entry-level positions outside the health care sector. Enhanced Federal Medical Assistance Percentage (FMAP) funds are temporarily providing a rate increase to both SNF and AFH, with some organizations using the added funds to support increased staff wages, but these add-on funds will expire on Dec. 31, 2021. Many communities, particularly in rural areas, find that even with increased wages there is a reduced pool of applicants for jobs. See Appendix D for a description of LTC funding streams.

Stakeholders shared that workers in all LTC settings in Washington have been "on the front lines" of the pandemic since the beginning with little opportunity for rest, resulting in widespread staff burnout and exhaustion. Staff have worked extra hours to make up for personnel shortages and have had to quickly learn and implement new safety protocols while taking on additional duties, such as bringing meals to patient rooms in facilities that have closed dining areas due to COVID-19 outbreaks. Many LTC residents received some percentage of their physical care from family members prior to the COVID-19 pandemic; visitation restrictions implemented early in the pandemic meant that staff were providing all care for all residents as family members were not allowed to enter facilities.

In August 2021, Gov. Inslee issued an emergency proclamation mandating that long-term care workers be fully vaccinated against COVID-19 by Oct. 18. Some stakeholders have expressed concern about the requirement, saying that the mandate has resulted in staff departures among workers who do not wish to get the vaccine (direct care, ancillary, and administrative).

Staffing shortages create ripple effects. Personnel shortages impact admissions to LTC facilities. Hospital systems across the state, facing their own staffing shortages, are working to transfer patients to LTC settings as quickly as is appropriate, but some LTC facilities cannot currently admit new residents due to staffing shortages, even if beds or rooms are available. These delays create hospital backlogs, taking hospital beds away from others who may need them.

In a recent survey of AFHs, 30 percent of respondents reported empty beds because of staffing shortages. Many AFHs across the state have indicated that the ongoing staffing shortages may lead to closures, which would displace residents and add additional stress to the LTC system.

Staffing shortages make it challenging for facilities to follow recommended infection control practices, such as cohorting. Cohorting, or grouping together patients who test positive for COVID-19 in a single physical area within a facility, is a recommended infection control strategy during outbreaks. Cohorting allows dedicated staff to work with only COVID-19-positive residents to prevent spreading the virus within the facility. Facilities experiencing personnel shortages have found it challenging to keep staff assigned to one specific part of a facility as shifting resident needs require frequent revisions to staff schedules and assignments to ensure all areas of a facility are appropriately covered.

Unique infection control challenges. A major challenge related to contact tracing in LTC settings is the potential for cross-contamination by staff working in multiple facilities or residences. This has been a particular challenge in supported living (SL) settings. Due to limited hours and low pay, staff often work for multiple SL agencies. Tracking COVID-19 exposure across homes and SL agencies in the event of an outbreak remains a challenge throughout the pandemic.

IDENTIFIED NEEDS:

Relief staff and settings. LTC facilities need additional support to provide rest and time off to staff and to fill in the gaps left by personnel shortages. Stakeholders report that programs like the Rapid Response Crisis Staffing teams deployed by DSHS have been extremely helpful throughout the pandemic. Dedicated COVID-19 units (to which residents testing positive for COVID-19 can temporarily be transferred to receive appropriate care) are another highly beneficial support to short-staffed facilities.

Mechanism to trace staff across multiple agencies. Stakeholders report that a statewide system to track employees who work across multiple SL agencies and LTC facilities for contact tracing purposes will be extremely helpful during future epidemics.

Continuing Care Retirement Communities

Continuing care retirement communities (CCRCs) provide residents multiple levels of care on a single campus, with many offering independent living, assisted living, and skilled nursing. While the assisted living and skilled nursing services provided by a CCRC are licensed and regulated, the independent living sections of a facility function like individual private residences and are not subject to the same regulatory oversight. In Washington state, a CCRC must be registered as such with DSHS to be able to refer to itself in promotional or marketing materials as a CCRC. As of the writing of this report, there are 23 registered CCRCs in Washington, but there are also many facilities not formally registered as CCRCs that mimic the CCRC model and offer a spectrum of care services in addition to independent living.

Because CCRCs include independent living clients as well as residents who receive services in settings licensed and regulated by the state, the application of COVID-19-specific guidance was, at times, challenging and confusing for CCRC operators. Stakeholders report that early in the pandemic some CCRCs applied visitation restriction guidance uniformly across facility campuses, even in situations where independent living clients live in separate buildings from residents living in licensed settings, despite the guidance only being intended to apply to the regulated areas of the facility. In some cases, spouses may live at the same CCRC, with one spouse residing in independent living while the other spouse lives in an assisted living or skilled

nursing setting. Many CCRCs followed infection control practices that restricted movement between parts of the campus; stakeholders shared that this sometimes resulted in spouses being kept apart for prolonged periods of time.

CCRC operators also experienced challenges around applying guidance to spaces and amenities shared by independent living clients and residents receiving licensed care services, such as dining facilities, gyms or fitness centers, and pools. CCRCs had to determine if these specific spaces on a campus should follow LTC facility-specific guidance or if community guidance (intended for commercial businesses open to the public) applied.

Finally, local health jurisdictions interpreting guidance at the county level often did not understand the difference between CCRCs and other types of LTC facilities, which created challenges as LHJs worked to interpret and issue LTC guidance at the county level.

IDENTIFIED NEEDS:

Clear guidance that considers the CCRC setting. CCRCs need more clarity and support to apply guidance across facilities with different levels of care where not all residents may be subject to the same restrictions or recommendations. Stakeholders also identified the need for specific exceptions to visitation guidance that allow spouses residing on the same campus to visit one another, even during periods when facilities may be restricting resident movement between areas.

Education for LHJs about the LTC system is included as a requirement of SHB 1218 section 19; this education should include information about the CCRC model and how LTC guidance may only apply to portions of a CCRC campus.

Emergency and Epidemic Preparedness

Early Identification

The Washington State Department of Health (DOH) and the Washington State Department of Social and Health Services (DSHS) first met with the SHB 1218 stakeholder group on July 6, 2021. As participants shared their experiences with the COVID-19 pandemic, several themes emerged. An initial stakeholder comment of “We weren’t ready” was echoed by others in the group. Another comment was that emergency preparedness was hard for those who had never done it before. The diversity of experiences in preparedness and stakeholder concerns reflected the complexity of the LTC system itself. There was one point of agreement: “We can do better.”

The Challenge and the Approach

One of the challenges (and opportunities) of SHB 1218 is the spectrum of LTC providers covered by the bill. Facility types vary from large facilities with multiple levels of care to individual residences caring for two to six people. LTC services take place both inside these structures and in a variety of other settings including private homes. There is no one-size-fits-all approach to preparedness plans for a wide variety of providers. However, discussions with stakeholders with expertise in emergency preparedness revealed there are common elements to preparedness that can be adapted to each provider's unique situation. To help familiarize the other stakeholders with these, the SHB 1218 team devoted the Sept. 15, 2021, meeting to emergency/epidemic preparedness, presented in a town hall format. Stakeholders with expertise in emergency preparedness and response served as panelists. The format allowed for shared knowledge, perspectives, and experiences, plus audience questions/answers.

Traditional Emergency Preparedness versus Epidemic Preparedness

The expert panel talked about elements of preparedness common across most formal plans. The following components are critical to include in both traditional preparedness (natural disasters like earthquakes, hurricanes, floods, fires), and epidemic preparedness planning:

1. An initial assessment of potential hazards (sometimes referred to as an all-hazard assessment).
2. The development of policies and procedures that are specific to the identified risk.
3. The development of a communication plan.
4. Training, testing, and evaluation of the plan (including after-action reporting).

There are other companion attributes to preparedness planning that cross all types of emergencies. These include:

- The importance of relationship-building within and outside of an organization, including those with emergency response expertise, relationships with public health, and potential partnerships that may serve as resources during the actual emergency.
- The importance of building staff resiliency into the plan (to reduce the likelihood of psychological harm and burnout as a consequence of the emergency).
- Willingness to embrace the planning process.
- Willingness to share failures and lessons learned with others so they can learn from your experiences.

The panelists also identified areas where epidemic preparedness/response is significantly different from traditional emergency preparedness planning. These include:

- Traditional preparedness is designed to manage acute and localized issues. An epidemic response is more widespread and has regional impacts across many sectors (e.g., the impact of COVID-19 on the supply chain for necessary goods).

- Epidemic responses must be persistent and adapt to waves and surges of the disease. The periods in between waves are where planning and restoring/restocking efforts can take place.
- Staffing must be done with the possibility of a long-term response in mind.
- An epidemic is considered a low-frequency, high-consequence event. This means that response plans must be tested frequently (for example, as often as fire drills).

Preparedness for one type of emergency will help preparedness with other emergency types. For example, plans for continuing operations when staff are out can be used if there is flooding or a disease outbreak. **Co-occurring emergency events** have been pervasive throughout the COVID-19 pandemic. During the pandemic, there have been major hurricanes, large-scale forest fires, heat waves, and flooding. Following infection control best practices is more difficult when these natural disasters force people together in congregate settings for shelter.

Training Recommendations

The panelists recommended that at least one person in each LTC organization receive Incident Command Systems Training to familiarize themselves with the system that serves as the nationwide response structure for a variety of organizations, including health care facilities.

Another recommended training technique was the creation of checklists that can be used during the emergency. As one panelist stated, "It can be easier to teach people to remember to look at a checklist with exact instructions and contact information of who to call for further guidance." These checklists can serve as templates so they can be modified for different emergency events.

An excellent resource for planning, particularly for those who are new to the process, is the Community Emergency Response Training (CERT). One of the key elements of this program is **personal preparedness**, the idea being that the more an individual employee is prepared at their own home and with their own families, the sooner they will be able to be part of their organization's response.

The organization's communication plan should include staff training in how to achieve a common message. The panelists advised that training should include advance notice of decisions that may be made outside of their organization's control and the possible impact this may have on the services they provide. An example might be the authority the local health jurisdiction has during a public health emergency. It can also be useful for outside partners to participate in staff training. The partner can share how their organization functions and the role they play during an emergency or epidemic response. During these trainings, partners and staff should discuss available backup resources if a partner organization is unable to respond to the emergency. Forming partnerships prior to an emergency is ideal and can improve emergency response since all partners know each other and understand one another's role.

Resident and Family Involvement
Residents, clients, and their families should be aware of the emergency/epidemic plan. One stakeholder, who is a current LTC resident, told the group that it is important for residents and their families to be able to ask questions of those who manage facilities about the plan, such as "Do you have a plan, what is it? Are you aware of resources that are available to help you do emergency planning?"

IDENTIFIED NEEDS:

Funding. Funding is needed for emergency/epidemic preparedness. Many education resources may be free, but there will still be costs associated with the time it takes to train staff, test the plan, and evaluate the plan on a regular basis.

Access to resources. More clarity is needed to identify and understand what external organizations are available as resources to the preparedness process. Stakeholders commented that it would be helpful to have a repository of preparedness plans they could adapt to their individual LTC organization.

- The expert panel provided the following resources, though there is still a need for a more comprehensive repository that applies specifically to the Washington state setting:
    - https://repository.netecweb.org/files/theme_uploads/LTCPPEEducationFinalRev9.13.2021.pdf
    - https://repository.netecweb.org/exhibits/show/ncov/ncov

Special consideration of adult family homes. There are approximately 3,500 adult family homes across Washington. As individual small businesses, they are often isolated and may have difficulty accessing resources for emergency preparedness. Further planning on how to help this particular provider type is needed.

Behavioral health support. Providers need additional support to reduce the stress and trauma of the COVID-19 response. A stakeholder suggested that additional training is needed in "Psychological First Aid" as a means of assisting with staff resilience and recovery.

Communication, Guidance, and Regulatory Conflicts

Washington state has a decentralized governmental public health system characterized by local control and partnerships. State law gives primary responsibility for the health and safety of Washington residents to 35 local health jurisdictions (LHJs) representing Washington's 39 counties. Each county legislative authority establishes a local board of health which "shall have supervision over all matters pertaining to the preservation of the life and health of the people

within its jurisdiction." Local boards of health are made up of majority elected officials and approve the budgets, programs, and policies of local public health agencies. During the COVID-19 pandemic, information and guidance was issued to LTC facilities via federal (CDC, the Centers for Medicare and Medicaid Services - CMS), state (DOH, DSHS, the Governor's Office), and local-level (LHJ) authorities and regulatory bodies, which sometimes resulted in confusion and guidance conflicts.

IDENTIFIED CHALLENGES:

Initial guidance lacked understanding of LTC. Stakeholders conveyed that early state-level decisions about emergency guidance seemed to be made without thorough consideration of the complexity of LTC. Many LHJs interpreting and applying guidance at the county level may have lacked this understanding, particularly in smaller counties with fewer staff members or counties with high LHJ staff turnover. Some counties initially tried to apply LTC guidance uniformly across all LTC types without an understanding of the different models, rules, and regulatory bodies at play.

Rapid guidance changes were confusing. In discussions with stakeholders, LHJs reported that due to the ever-evolving nature of the pandemic, guidance issued by the CDC and state agencies changed quickly and often and it was not immediately clear what was changing in updated guidance. Guidance would be interpreted and applied differently from county to county, creating challenges for LTC operators with facilities in multiple counties whose administrators were working to keep track of the updates and ensure facilities in all counties had the resources needed to follow protocols. Stakeholders report that communication confusion abounded early in the pandemic, with LHJs being unsure who to call at the state level for assistance in guidance interpretation and LTC administrators being unsure who to call at the state level or at LHJs for clarification and assistance with guidance implementation. Many LTC operators developed strong relationships with LHJs, resulting in faster response times later in the pandemic. However, stakeholders report that LHJ recommendations often come via phone discussion and not in writing, which can later become a problem if a facility needs to show documentation to regulators as to why something was done a certain way.

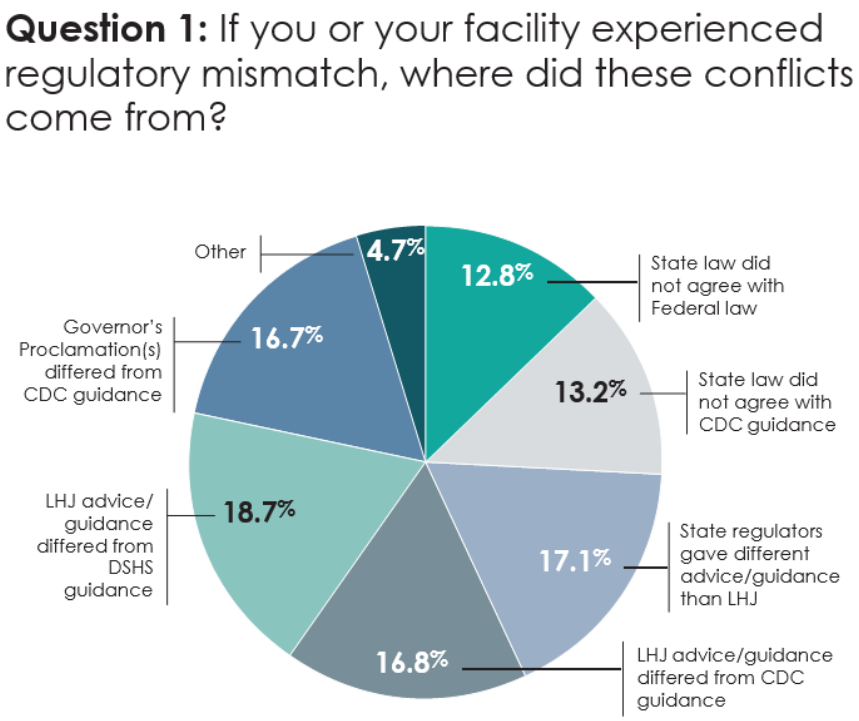
From a resident perspective, some LTC residents report being unaware of even the basics of issued guidance, including what guidance their specific facility was implementing and where that guidance was coming from, particularly in cases where the respective LHJ was implementing more restrictive guidance than the state.

Guidance conflicts. The stakeholder group was asked to complete a survey on regulatory mismatch, or instances in which regulations and guidance received from local, state, or federal agencies seemed to contradict each other. This survey was also shared with LTC association members. The survey received 80 responses from the LTC community.

The survey inquired about the source of regulatory mismatch and respondents were asked to select all applicable answers. The most popular answers were that:

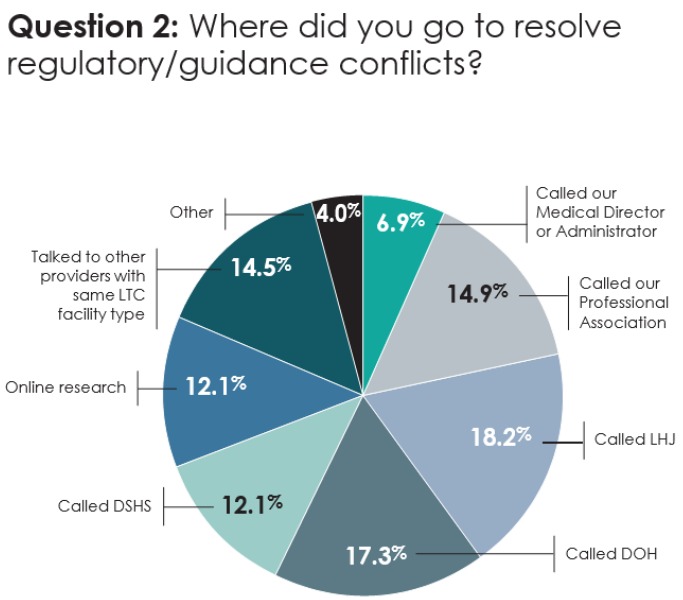
- LHJ guidance differed from DSHS guidance (19 percent).
- State regulators gave different advice or guidance than the applicable LHJ (17 percent).
- CDC guidance differed from a proclamation from the governor (17 percent) or from LHJ guidance (17 percent).

Figure 4



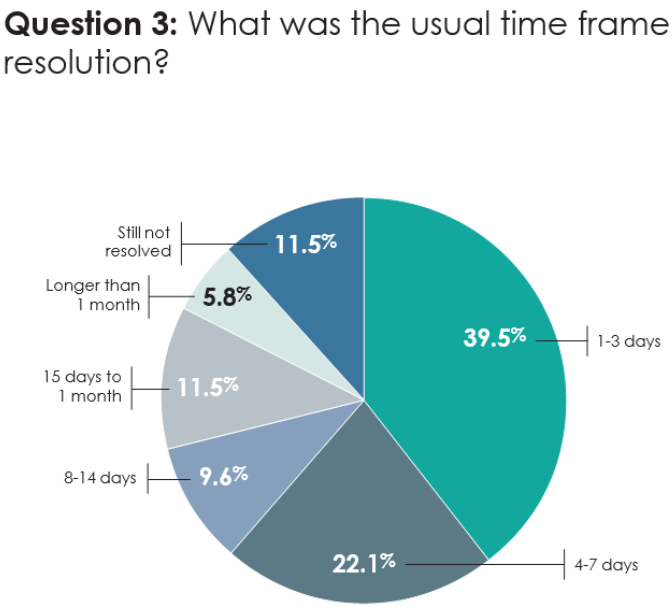
Respondents were asked where they went to resolve regulatory or guidance conflicts and asked to select all applicable answers. The most popular answers were that they called their LHJ (18 percent), called DOH (17 percent), or called their professional association (15 percent).

Figure 5



Respondents were asked about the typical timeframe for guidance conflict resolution. One to three days was the most popular answer (39 percent), but many respondents reported longer time frames (four to seven days, or 15 days to one month were also popular answers), and some respondents indicated that some guidance conflicts impacting their facilities are still unresolved.

Figure 6



Respondents were asked to share whose guidance they ultimately followed, and why. Many respondents said they followed the most restrictive guidance issued in the event of regulatory mismatch, as it felt like the safest option for staff and residents. Some respondents indicated that they followed the guidance issued by their state regulatory body (DOH or DSHS) while others said they followed LHJ guidance due to an understanding that the LHJ is the final authority. Many respondents shared that in instances of regulatory mismatch, they felt caught between the involved entities and that a clear communication plan or avenue for guidance conflict resolution would have been helpful.

Respondents were asked to describe the most common scenarios they faced with regard to regulatory mismatch during the pandemic. They described feeling like the CDC, Governor's Office, DOH, DSHS, and LHJs did not work to align guidance before issuing, and that providers had to spend significant time trying to reconcile differences with lengthy delays in response time, particularly early in the pandemic. Other respondents described scenarios in which guidance changed multiple times within a short time period, necessitating the rapid writing and re-writing of facility policies by administrators to reflect new protocols which in turn created confusion for staff and residents. Many respondents described experiencing confusion over who had final authority, particularly when trying to get guidance for residential providers who have varying licensing and certification requirements.

IDENTIFIED NEEDS:

Education for all parties. A common theme that arose during discussions with stakeholders around guidance conflicts and communication challenges was the need for education for all involved parties. LHJs need to understand the complexities of the LTC system to effectively issue guidance and provide support to LTC operators within their jurisdiction; section 19 of SHB 1218 requires DSHS and DOH to provide this type of training. In addition, LTC operators need training on how emergency guidance is issued and who to contact when resolving guidance conflicts. State leadership involved in the development of emergency guidance needs to understand the major players in the LTC system and know who should be involved in decision making early in a public health emergency.

Relationship building. All stakeholders reported that having strong relationships across sectors was critical for information sharing and guidance clarification. LTC facilities with established relationships with state- and county-level authorities and LHJs with established relationships with state agencies better understood who to call for answers and information early in the pandemic. Developing and maintaining these relationships before an emergency arises is critical for effective communication during a crisis.

Strengthened communication. Stakeholders emphasized that having a streamlined plan for communication and guidance conflict resolution would be helpful when clarifying future regulatory discrepancies. Weekly LTC Q&A calls facilitated by DOH, with panelists from DSHS, LTC associations, LHJs, and others provide the opportunity for LTC providers to ask clarifying questions about guidance and receive advice; stakeholders report that these calls have been helpful.

LTC residents and family members need plain talk materials explaining guidance being followed by their specific facility and how that guidance will impact the delivery of care and services. Interpreters, including deaf and ASL interpreters, need to be considered essential personnel to ensure that all residents are receiving communications.

Many LTC facilities set up regular internet teleconferencing calls (e.g., Zoom webinars) or established processes for sending frequent e-newsletters to share updated information on restrictions and safety measures with resident family members; this had the effect of easing their anxieties while also reducing burden on LTC staff who were fielding a high volume of phone calls early in the pandemic when visitation restrictions were first implemented.

Conclusion and Next Steps

The LTC community faced significant challenges during the COVID-19 pandemic. As of the writing of this report, the rise of the Delta variant and the resultant fifth wave of infections continues to stress the LTC system. DOH and DSHS have worked with LTC stakeholders to understand barriers and challenges, as well as identify lessons learned, best practices, and future needs. This learning will be ongoing as the pandemic continues to evolve.

DOH and DSHS will continue to work with the SHB 1218 stakeholder workgroup to finalize this report and develop guidelines that build upon the needs identified to date. These guidelines will consider federal rules, the variety of involved provider and facility types, and available resources for infection control. A timeline for implementation and a process to maintain and update the guidelines will be included in the guidelines development process.

As required by Section 30 of the law, by July 1, 2022, DOH and DSHS shall finalize the report and guidelines on COVID-19 and provide the report to the healthcare committees of the legislature.

As this process looks toward ways to prepare for the next epidemic, we share a common hope that through collaboration, more lives can be saved.

Appendices

Appendix A. List of SHB 1218 Stakeholder Workgroup Members

Christa Arguinchona, Providence Sacred Heart Medical Center
Sandra Assasnik, Washington State Hospital Association
Heidi Audette, Department of Veterans Affairs
Doris Barret, Developmental Disabilities Administration
Sharla Bode, Washington Home Care Association
Carolyn Cartwright, REDi Healthcare Coalition
Harp Cheema, Whatcom County Health Department
Kim Conner, Washington State Independent Living Council
Karen Cordero, Adult Family Home Council
Robin Dale, Washington Health Care Association
Julietta Davidson, Developmental Disabilities Administration
Leslie Emerick, Washington State Hospice & Palliative Care Organization
Linda Fairbank, Department of Veterans Affairs
John Ficker, Adult Family Home Council
Brad Forbes, Alzheimer's Association
Amy Freeman, LTC Ombuds
Alan Frey, Kitsap Home Care Services
Donna Goodwin, Home Care Association of WA
Amal Grabinski, Provail Supported Living
Peter Graham, DSHS Aging and Long-term Support Administration
Saif Hakim, Developmental Disabilities Administration
Kelly Hampton, Developmental Disabilities Administration
Barb Hansen, Washington State Hospice & Palliative Care Organization
Chad Higman, Puget Sound Regional Services
Laura Hofmann, LeadingAge WA
Todd Holloway, Center for Independence
Patricia Hunter, LTC Ombuds
Angeles Ize, Benton-Franklin Health District
Jacqueline Kinley, Unified Care Systems
James Lewis, Public Health Seattle-King County
Larissa Lewis, WA DOH
Scott Livengood, Alpha Supported Living
Danielle Love, Whatcom County Health Department
Cathy Maccaul, AARP
Elena Madrid, Washington Health Care Association
Barbara McMullen, State Fire Marshal's Office

Vicki McNealley, Washington Health Care Association
Dylan Montgomery, State Fire Marshal's Office
Deb Murphy, LeadingAge WA
Dana Nguyen, Clark County Public Health
Travis Nichols, WA DOH
Jeremy Norden-Paul, Washington State Developmental Disabilities Council
Alyssa Odegaard, LeadingAge WA
Susan Pelaez, Northwest Healthcare Response Network
Sara Podczervinski, WA DOH
Cassie Prather, Spokane Regional Health District
Drew Pratt, Spokane Regional Health District
Sabine Preyss, Washington Society for Post-Acute and Long-Term Care Medicine
Aaron Resnick, Northwest Healthcare Response Network
Lisa Robbe, Developmental Disability Ombuds
Betty Schwieterman, Developmental Disability Ombuds
Katherine Seibel, National Alliance on Mental Illness
Noah Seidel, Developmental Disability Ombuds
Brianna Smith, Comagine Health
Melanie Smith, LTC Ombuds
Lauri St. Ours, Washington Health Care Association
Christina Wells, Developmental Disabilities Administration
Annette, LTC resident
Judah, Resident family member
Julia, LTC resident
Katrina, Resident family member
Randi, LTC resident
Susan, LTC resident

Appendix B. Public Health Language

Throughout this report, we use terminology that is part of public health language. The Centers for Disease Control and Prevention (CDC) provides definitions of common public health terminology. This section of the report refers to general public health terminology and is not specific to how these concepts were applied in LTC. Due to the needs of LTC providers and residents, public health interventions were tailored to this population during the COVID-19 response. In later areas of the report, we discuss how these elements were adapted to the LTC setting during the pandemic.

In this report, there are descriptions of stakeholder experiences with containment and mitigation strategies. **Containment** strategies are used early on in an outbreak to prevent the spread of disease and include (but are not limited to):

- Rapid identification;
- Infection control measures;
- Coordinated response between health care facilities;
- Continued assessment and screening until spread is controlled.

Mitigation strategies, used when containment is unsuccessful, follow these guiding principles from the Centers for Disease Control and Prevention:

- Mitigation efforts aim to reduce the rate at which someone infected comes in contact with someone not infected or reduce the likelihood of infection if there is contact.
- Decision-making by public health officials is based on the level of community spread of the disease and will differ from one community to the next.
- Certain settings in a community with vulnerable populations are high-risk environments for disease transmission. These include congregate settings (living in close quarters) like LTC facilities, correctional facilities, and homeless shelters.
- Two mitigation strategies are isolation and quarantine. Although the two terms sound similar in nature, CDC provides definitions useful in distinguishing between the two strategies:
    - **Isolation** separates sick people with a contagious disease from people who are not sick.
    - **Quarantine** separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick.

Alerting people who may have been exposed is done through a process known as **contact tracing**. This is typically done by the local health jurisdiction (LHJ) but can also be done by other entities with appropriate training. Contact tracing is beneficial because it:

- Will let people know they may have been exposed to COVID-19 and should monitor their health for symptoms of COVID-19.
- Helps people who may have been exposed to COVID-19 get tested.
- Provides instructions on how to self-quarantine if it is confirmed they had sufficient *close contact* to be at risk of becoming ill or to self-isolate if they develop a COVID-19 infection. "Close contact" is defined as being within 6 feet of an infected person for a cumulative total of 15 minutes or more in a 24-hour period.

The Many Names for Disease Occurrence

There are several words that describe infection-related events. It starts with an **index case**, which means the first instance of a patient coming to the attention of health authorities. As the number of cases grows, there may be groupings of cases that have certain things in common like a shared geography or worksite. For COVID-19, a collection of two or more confirmed cases among workers within 14 days is considered a **cluster**. Another term that is used for a similar event is **outbreak**. According to the CDC, an outbreak "indicates a potentially extensive transmission within a setting or organization." The progression from index case to outbreak can happen very quickly.

For a Washington state LTC facility, the interim **outbreak** definition is as follows:

- Licensed or certified long-term care setting-acquired COVID-19 infection in a resident.
- COVID-19 infection in health care workers (HCWs) who were on-site in the long-term care facility or agency at any time during their infectious period OR during their exposure period and have no other known or more likely exposure source.

Between August 2020 and September 2021, the federal Centers for Medicare & Medicaid Services (CMS) required testing in nursing homes if a single new case of COVID-19 was identified in any HCW or any long-term care facility-acquired COVID-19 infection in a resident. This guidance was updated Sept. 10, 2021, and was adopted by Washington state on Sept. 30 to include a focus on unit-based testing instead of facility-wide testing.

As the number of cases grows and exceeds that which may be expected, an epidemic may be in progress. Once the cases with common disease presentation occur in widespread areas, across country boundaries and involving multiple continents, the disease has reached pandemic proportions.

Appendix C. The Complexities of the Long-Term Care System

The LTC system in Washington state is a complex system designed to enable vulnerable adults to meet their physical, mental, and social needs, goals, and preferences. The state Legislature has declared that residents in LTC facilities "should have a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible." The COVID-19 pandemic highlighted the need for a common understanding among public agencies of what services make up the LTC system.

To fully understand how this system works, it is best to start with the basic concept of "home." When one residents in a nursing home or an assisted living facility, their assigned room or apartment is considered their home. A wide variety of skilled medical services are provided in these settings but within these walls, it is still their home. This is why in this report, the recipients of long-term care services are referred to as residents (or clients) and not patients.

There is a great deal of supportive care being provided as a part of the LTC system. For example:

- A person may live in their own assisted living apartment, but could be receiving nursing services or physical therapy through a home health agency or hire a home care aide from a home care agency, either short or long-term.
- A family may have decided that the best care for their loved one is in a smaller facility, such as a licensed adult family home (AFH) where 1-6 residents live.
- A person with behavioral challenges may reside in a community setting, such as an enhanced services facility.
- Persons with intellectual/developmental disabilities may live together in a rented apartment while receiving supported living services.

A person in any or all of these living environments may need assistance with their activities of daily living - ADLs (e.g., bathing, dressing, toileting).

There is one more common element to this network of services. In any of these environments, any of the places the person calls *home,* it may become necessary to receive end-of-life care from a state-licensed, Medicare-certified hospice provider.

Figure 7. Long-Term Care System Components

Not only are there a wide variety of services available within the LTC system, these services are also under the regulatory authority of multiple state and federal agencies. For example:

- **Skilled Nursing Facilities/Nursing Homes:** The Centers for Medicare and Medicaid Services (CMS). CMS is the payment source for many LTC services, including nursing facility services. In order to receive funds from CMS, an organization must comply with certain Conditions of Participation (COPs). These COPs are performance standards of care that are designed to bring about safe care and to restore the person to their highest practicable level of functioning. Nursing facilities also follow state licensing standards. DSHS conducts regular surveys, as well as complaint investigations, to assure compliance with both state and federal standards.
- **Assisted Living Facilities, Adult Family Homes, and Enhanced Services Facilities:** These are state-licensed facilities whose regulations are codified under RCW/WAC and

monitored by DSHS. DSHS conducts regular licensing inspections for compliance with state regulations and investigates complaints.

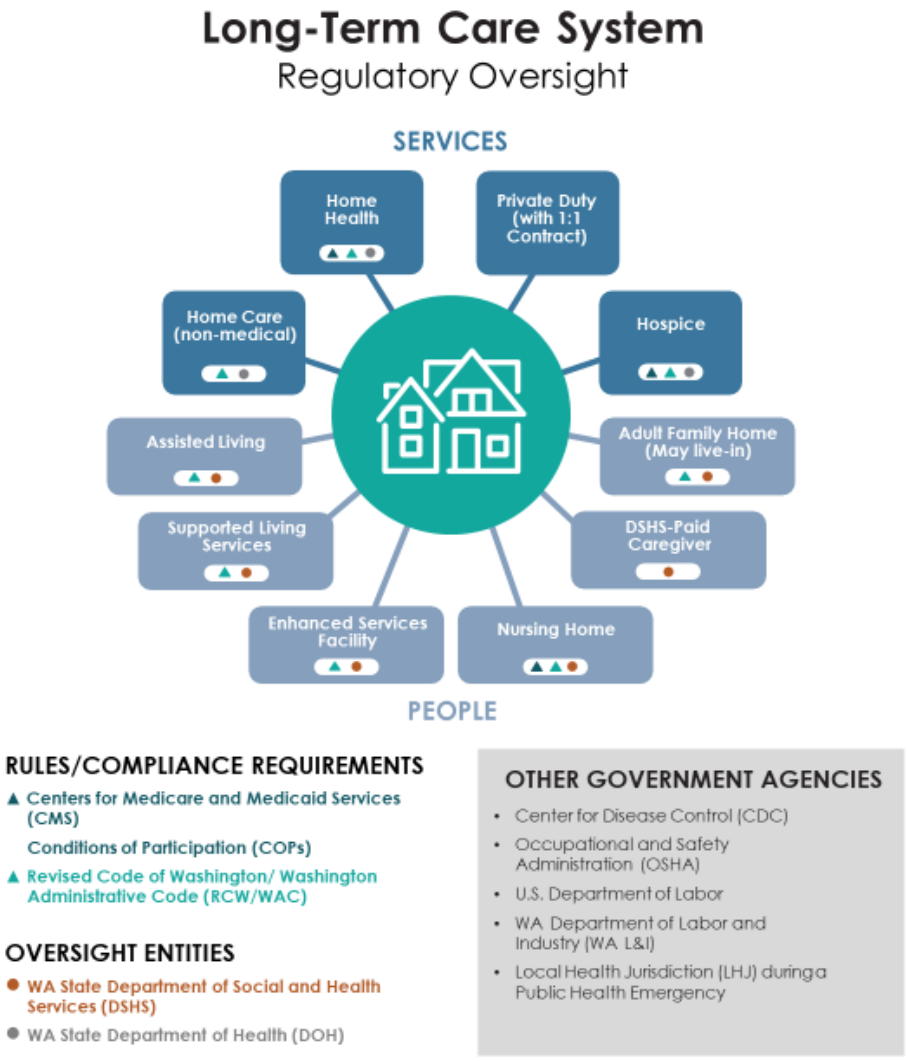
- **Home Health and Hospice:** Home health and hospice agencies are regulated by both CMS and under state RCW/WAC rules. The Washington State Department of Health (DOH) is responsible for regulatory oversight, performing survey services to verify compliance with COPs and state licensing regulations and conducting complaint investigations.
- **Home Care:** Home care agencies are state licensed and regulated by state laws and rules. The Department of Health is responsible for regulatory oversight, survey services, and investigating complaints relating to home care services. It is important to note:
    - If a person hires an individual to perform home care duties and the business relationship is only between the two parties, DOH has no jurisdiction or authority in this scenario.
    - If a person contracts with an individual provider (IP) paid through Medicaid to provide support with ADLs, DSHS contracts with agencies that are the employer of the IP and ensures that training requirements and certifications are met.

Other government entities that may become involved include the Centers for Disease Control and Prevention (CDC), the Occupational and Safety and Health Administration (OSHA), and the U.S. Department of Labor (DOL) or Washington State Department of Labor and Industry (L&I). At the county level, it is the local health jurisdiction (LHJ) that holds local authority during a public health emergency.

These entities may or may not communicate effectively with one another.

Even under the best circumstances, it can be difficult to maintain the balance between ensuring that necessary LTC services are available and ensuring that those services are being provided in a manner that meets regulatory standards designed to achieve safe care.

Figure 8. Long-Term Care System Regulatory Oversight



Appendix D. Funding Streams in the Long-Term Care System

There are a variety of mechanisms to pay for LTC services in Washington. The following is a list of possible payor sources for LTC care. While we have tried to include as many situations as possible, this is not an exhaustive list. It is common for these resources to be used in combination, particularly those from non-governmental sources:

- **Private Pay:** Goods and services relating to LTC are paid for with personal assets, savings, and/or investment income.
- **Medicare**: Eligibility is determined by the federal government. Typically this is age-related, but can also be due to certain diagnoses. For example, a person in renal (kidney) failure who requires dialysis can become a Medicare beneficiary at any age. Medicare is not designed for ongoing, long-duration residential care, but may be the primary payor of rehabilitative care that takes place in a LTC environment such as a skilled nursing facility.
- **Medicaid**: The federal government sets the guidelines for eligibility, but each state operates its own program. States utilize these funds for long-duration residential support in a variety of settings, which may include the provision of services in the beneficiary's own home. Funds may be used to pay for services in a nursing facility or in home and community-based settings (HCBS), such as adult family homes, assisted living facilities, or enhanced services facilities. Because each state develops their own programs, benefits can vary greatly from state to state.
- **Veterans Benefits**: Eligibility is determined by the federal government and tied to the person's military service record.
- **Employer-Based or Corporate (Private Pay) Health Insurance**: This form of insurance may be the primary payor for initial treatment of diseases and/or injuries, but typically has very limited benefits for LTC.
- **Long-Term Care Insurance:** The consumer pays premiums with their own funds for insurance benefits purchased in advance of need. Once a person has a debilitating condition, they are highly unlikely to be qualified to participate by the insurer. If the person is approved to receive benefits by the insurer, LTC insurance benefits can be used in the beneficiary's own home, in a nursing home/skilled nursing facility , in an assisted living facility or in an adult day health setting.

Figure 9. Long-Term Care System Payment Sources

Payment for long-term care services is tailored to each person. Services can be funded by one or more sources to provide the necessary support.

Medicaid Funding and the COVID-19 Pandemic

Federal Medical Assistance Percentage (FMAP) – Due to the rapid spread and high mortality of COVID-19, a nationwide public health emergency was declared by the Health and Human Services Secretary on Jan. 31, 2020. Federal legislation, in the forms of the Families First Coronavirus Response Act and the Coronavirus Aid Relief and Economic Security (CARES) Act,

provided funding support to help states cope with the dual burden of increased health care costs and the economic downturn resulting from the effects of the pandemic.

In Washington, Medicaid funding is typically structured as a 50/50 split (with some small variations among programs) between state and federal dollars. Federal relief packages changed this split, creating *Enhanced* Federal Medical Assistance Percentages (FMAP) funds, which shifted the split to a higher amount of federal dollars and a lower amount of state dollars. Washington invested most of the additional federal match funds back into the Medicaid rates. For example, Washington used the *Enhanced* FMAP funds to provide both skilled nursing facilities and adult family homes with a temporary add-on increase to their daily rates.

The Enhanced FMAP funds are scheduled to continue through Dec. 31, 2021. There are scheduled funding increases to some LTC settings during 2022, but these are not equivalent to what the Enhanced FMAP funds have provided during the COVID-19 pandemic. There will be a six-month gap in funding between when the Enhanced FMAP add-on funds expire on Dec. 31, 2021, and when other Washington state legislature-approved rate increases are available on July 1, 2022.

Stakeholders expressed concern about this gap in add-on funding. One stakeholder shared that these funds were being used to support increased staff wages in some organizations. There were no requirements placed on providers as to how they could use the additional funds. The additional funding was intended to offset a variety of costs related to the pandemic, including the purchase of PPE, hiring of additional staff, and equipment purchases, to name a few examples.

Long-Term Care and Future Funding Possibilities

House Bill 1087 (Chapter 363, Laws of 2019) established the Long-Term Services and Supports (LTSS) Trust program, also known as the ***WA Cares Fund***. This program is a first-in-the-nation, state-funded long-term care insurance. This program was modified by SHB 1323 in 2021. Beginning in January 2022, employers are required to collect premiums through payroll deductions at the rate of $0.58 per $100 earnings. There is no income cap for this contribution. There is no employer contribution required. The first benefits of the program will begin Jan. 1, 2025. An eligible individual is entitled to a lifetime benefit of $36,500 for long-term services and support, which the state will pay to LTC service providers on behalf of the individual.

The federal ***American Rescue Act of 2021*** was signed into law on March 11, 2021. Section 9817 of the act provides states with a temporary 10 percent increase to FMAP for certain Medicaid expenditures for home and community-based services (HCBS). This 10 percent funding can be used over a 4-year period and cannot be used to offset state budget shortfalls. Washington has applied for this additional funding and, at the time of this writing, is awaiting approval from CMS.

The federal ***Care at Home Act*** was introduced on July 29, 2021. This act would provide older adults with up to 30 days of expanded skilled services, post-hospitalization, in their own homes (as opposed to institutional care). Potential implications of this bill would be cost savings to Medicare and increased ability for hospitals to discharge to home. Difficulty with discharges from hospital care has been an ongoing problem during the COVID-19 pandemic.