Wasserman October 28, 2020 State Assembly Testimony
Assembly Budget Committee Comments

Chairman Ting, members of the Assembly Budget Subcommittee No. 6: Thank you for the opportunity to share my thoughts and recommendations today. I am the immediate Past 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 this pandemic.

I previously testified before the Health and Aging & Long Term Care Committees on January 9th. I continue to stand by the testimony that I gave that day (https://altc.assembly.ca.gov/sites/altc.assembly.ca.gov/files/Wasserman%20Assembly%20Hearing%20Full%20Statement%2006-09-20.pdf).

Anyone who says that we didn't know what was coming to nursing homes in March and April weren't listening to the experts in Geriatrics and Long Term Care Medicine. On March 9th, I told NBC News that the coronavirus was "the greatest threat to nursing home residents that we have seen." On March 25th I told CBS that nursing homes could become our "killing fields." My experience as a clinical and quality expert, in addition to having been the CEO of the largest nursing home chain in California gave me a unique perspective into COVID-19, and the measures that need to be taken to reduce its impact and devastation.

I want to thank Assemblyman Wood for bringing AB-2644 into law. Its requirement of a full-time equivalent of an infection preventionist in every nursing home is the type of workforce change that is necessary to protect vulnerable nursing home residents. But, it's only the beginning. I come here today, as Immediate Past President of the California Association of Long Term Care Medicine, and current chair of CALTCM's Public Policy Committee, to make recommendations that are actionable and sustainable as we move forward.

Today's nursing homes are essentially "mini-hospitals," regardless of whether they deliver post-acute care or provide long-term care to the most frail, complex and challenging population of

patients in our history. The average nursing home resident has multiple chronic conditions, cognitive impairment and requires professional oversight and care from a broad array of caregivers and health care professionals.

Historically, a major role of the nursing home administrator has been to put "heads in beds." The medical director, by federal regulation, is supposed to be the "clinical leader" of a nursing home. In usual practice, unfortunately, medical directors are often separated from clinical policy discussions and decisions. Registered nurses, as professionals who are trained to assess patients, are sometimes not available to make necessary assessments in real time.

How do we run "mini-hospitals" without the clinical leadership and staffing that are so vital? COVID-19 has brutally exposed this weakness. There is now ample literature to demonstrate that 24 hour RN coverage and a minimum of 45 minutes of RN staffing per resident per day, along with enough LVN and CNA coverage, leads to fewer COVID-19 outbreaks and deaths. Consultant pharmacists must also be engaged to the fullest extent.

I can tell you, based on over thirty years of experience in the field of geriatrics, that having a competent and engaged medical director to work with the nursing staff and the infection preventionist, as well as to guide administrators who have little clinical expertise, has played an important role in battling this scourge throughout the state and country.

I am a faculty member for the American Board of Post Acute and Long Term Care Medical Director Certification course. As I recently participated in the 3-day course that completes the training, all I could think of was what a difference it would have made if every nursing home had a Certified medical director over the past 8 months. I guarantee you that if that had been the case, and in conjunction with the appropriate nurse staffing levels, far fewer nursing home residents would have died. Every nursing home in the state already has a medical director, and nursing home owners already spend a significant amount of money on medical director stipends. By requiring Certification, you will assure that nursing home medical directors have the tools, the skills and the professional obligation to provide qualified oversight. This will not increase costs to the state or the industry, but it ***will*** improve quality and accountability.

There is also evidence-based literature that demonstrates a correlation between for-profit status and the size of COVID-19 outbreaks and deaths. The motivation for profit must sometimes be reined in to avoid harming the customer. Manipulation of existing related party transaction reporting can skew actual facility level profitability. This is why we must have complete transparency around the ownership structure as well as giving strong consideration to a "medical loss ratio" parameter for nursing homes. Last, but certainly not least, CNAs, the true heroes of this pandemic, must be treated with the respect and dignity they so richly deserve, and finally earn a living wage.

I also encourage you to pay extra attention to the comments of Nicole Howell and Dr. Charlene Harrington. I respect and value their insight and opinions. In reviewing the background paper

for this hearing, I have taken the liberty of providing responses for many of the questions that were posed.

Personal Protective Equipment

COVID-19 will find its way into most nursing homes. What matters is how a nursing home responds to the virus. There is growing evidence that supports the fact that the quality of the nursing home makes a difference.[1] Nevertheless, there is a reason that the first element of CALTCM's Quadruple Aim is abundant PPE.[2] Without PPE, nursing homes lose the COVID-19 battle. The literature and experience is quite clear on this. There are absolutely no excuses for a nursing home not to have PPE, with some caveats. Once we move beyond the issue of PPE, quality definitely matters. In regard to PPE, non-profit nursing homes and sole owner nursing homes will struggle with pandemic supply chain dynamics and definitely need help. Most nursing homes lack the capital at the operational level to leverage in order to acquire abundant PPE. However, nursing home real estate owners and REITs certainly have more than ample assets to leverage to provide PPE to their facilities. They are under no fiduciary obligation to do so, but the legislature might consider a PPE "tax" on large nursing home real estate owners and REITs to assure that this happens. Furthermore, while CDPH has said that there are no longer shortages of PPE in nursing homes across the state, we MUST make absolutely sure that this is the case. We must also make sure that nursing homes are not concerned about future shortages, lest they improperly utilize the PPE that they have.

Testing

The second element of CALTCM's Quadruple Aim is readily available testing. CALTCM's first Expert Delphi Panel published recommendations regarding testing in May.[3] We are pleased that state surveyors are finally required to follow the same stringent testing requirements as nursing home staff. We absolutely believe that nursing homes be in the highest priority tier for test results. Nursing homes can not afford to wait 2-3 days, much less than 7-10 days for results. We MUST work towards a time where we have low cost, rapid turn around, testing for nursing home residents, staff and visitors. This is essential if we are to open up nursing homes to a greater degree of visitation.

Visitation Policies

CALTCM's Visitation Delphi Panel recently published a paper with key visitation recommendations.[4] These are as follows: 1) maintain strong infection prevention and control precautions, 2) facilitate indoor and outdoor visits, 3) allow limited physical contact with appropriate precautions, 4) assess individual residents' care preferences and level of risk tolerance, and 5) dedicate an essential caregiver and extend the definition of compassionate care visits to include care that promotes psychosocial wellbeing of residents. CALTCM has supported the goal of returning ombudspersons into SNFs since late March, and believes that the state must do everything in its power, utilizing necessary PPE and testing, in order to bring this about. Similarly, we must find operational ways to support bringing our recommendations to fruition.

Staffing Challenges

The COVID-19 literature has supported the need for appropriate nursing home staffing levels.[5,6] In order to assure that there is 24/7 availability of a professional who can assess a resident, it is essential that, at the very least, there is 24/7 RN coverage. That is not enough however, as it is not uncommon for there to be situations where there are multiple residents with problems, especially during the COVID-19 pandemic. This is why we also strongly support 0.75 RN hours per resident day staffing levels. As clinicians, we don't understand the purpose of waivers in relation to necessary clinical care. All that waivers do is to allow for understaffing, which serves no practical or positive clinical purpose. CALTCM also supports assuring that there is appropriate total staffing of CNAs, LVNs and RNs relative to the acuity of the residents that a facility is caring for. We believe that many facilities in California have inadequate total staffing numbers. Finally, it is time that we look at how we train and prepare CNAs. We encourage you to listen carefully to Nicole Howell's excellent program, The Healthcare Career Pathway, as a model for what we need to do in this regard.

SNF Financing

CALTCM's members have limited experience to opine on Medi-Cal payments. I, however, as the former CEO of an organization that oversaw the largest nursing home chain in California, am very comfortable with commenting on this topic. Not for profit and solo nursing homes have limited ability to find the financial resources to pay for increased staffing or wages without an increase in Medi-Cal payments. On the other hand, as noted previously, the owners of large amounts of nursing home real estate have ample assets that could be leveraged to improve staffing levels and wages for front line staff. That is why this issue is not "one size fits all," and must be looked at from a more comprehensive perspective. Furthermore, it is essential that ALL related parties be looked at and considered in the Medi-Cal cost reports. This includes looking at whether all payments meet fair market value requirements. This is particularly important as it relates to COVID-19 Federal Relief Funds. CALTCM does believe that 100% of these funds should go toward the direct care of residents for increased pay, PPE, testing, infection control measures and training. Again, if this money is paid to related parties, it should be at fair market value.

CDPH Regulatory Oversight

CALTCM strongly believes that the present survey system is inadequate and ineffective. We appreciate the attempt by CDPH within the Center for Health Care Quality (CHCQ) to improve this process and make it more effective. We believe that it is very difficult to fully ascertain the effectiveness of the proposed program without ultimately diving into the full details of implementation. We are pleased to be working collaboratively with CHCQ regarding the ongoing education and training of state surveyors as it relates to their interactions with nursing home medical directors and consultant pharmacists, both of whom should be intimately involved in quality improvement efforts within their respective facilities. We are also working with CHCQ to help evaluate and develop more effective predictive analytics.

Vaccinations in SNFs

CALTCM has grave concerns regarding the present plan for vaccinations as they relate to nursing homes. First, the recently named Vaccine Workgroup does not include any experts in geriatrics or long term care medicine. Considering the sheer number of nursing home resident and staff deaths, we believe that there must be significant representation on this workgroup from experts who have experience with this vulnerable population. Most of the vaccine trials have very little representation from complex, frail older adults, and almost no representation from nursing home residents. Yet, as soon as these vaccines are approved, they will supposedly be shipped out immediately for usage. We are also greatly concerned about the level of vaccine hesitancy amongst front line nursing home staff, most of whom come from communities of color that have a significant history of vaccine hesitancy. We can not ask this group of incredible caregivers to be amongst the first wave of healthcare workers to accept this vaccine without making considerable efforts to make the process acceptable to them. There are still significant questions regarding how the vaccine will be brought to nursing homes. To this extent, CALTCM has convened another expert Delphi panel to make recommendations around how vaccination efforts will impact nursing homes.

Engaging Experts in Geriatrics and Long Term Care Medicine

Since the outset of this pandemic, the experts in geriatrics and long term care medicine have desperately been trying to provide our expertise at the Federal, State and County levels of government. Unfortunately, while we have finally been allowed to have our recommendations heard, we still have not been made a significant part of the policy making process. We do not consider ourselves to be "stakeholders." We do not have a business interest when it comes to the health and wellbeing of vulnerable older adults in California. We represent the medical voice of long term care and have been working hard to help the state implement effective policies since the first week of March. Many of our recommendations have proven to be prescient and have found their way into policy, including the requirement for a full-time equivalent of an infection preventionist in every nursing home. However, during a global pandemic that has devastated the nursing home population, if we had been fully engaged early on, these decisions could have been made sooner and could have saved countless lives. We are not asking for decision making authority. We are just asking to be included in daily discussions where most of those having such discussions lack our expertise. My colleagues and I have spent our careers in order to be prepared for the COVID-19 Pandemic. Please help us find ways to more effectively share our expertise.

Respectfully submitted,

Michael R. Wasserman, MD, CMD
Immediate Past President,
Chair, Public Policy Committee
California Association of Long Term Care Medicine

[1] He M, Li Y, Fang F. Is There a Link between Nursing Home Reported Quality and COVID-19 Cases? Evidence from California Skilled Nursing Facilities. J Am Med Dir Assoc. 2020 Jul;21(7):905-908. doi: 10.1016/j.jamda.2020.06.016. Epub 2020 Jun 15. PMID: 32674817; PMCID: PMC7294249.

[2] CALTCM'S Long Term Care Quadruple Aim for COVID-19 Response, published April 17, 2020. https://www.caltcm.org/assets/CALTCM%20COVID19%20QUADRUPLE%20AIM%20FINAL.pdf

[3] Wasserman, Michael & Ouslander, J. & Lam, A. & Wolk, A. & Morley, J. & Preyss-Friedman, S. & Marco, N. & Nazir, A. & Haimowitz, D. & Bessey, F.. (2020). Diagnostic Testing for SARS-Coronavirus-2 in the Nursing Facility: Recommendations of a Delphi Panel of Long-Term Care Clinicians. The journal of nutrition, health & aging. 24. 10.1007/s12603-020-1401-9.

[4] Christian Bergman, Nathan M. Stall, Daniel Haimowitz, Louise Aronson, Joanne Lynn, Karl Steinberg, Michael Wasserman, Recommendations for Welcoming Back Nursing Home Visitors during the COVID-19 Pandemic: Results of a Delphi Panel, Journal of the American Medical Directors Association, 2020, ISSN 1525-8610, https://doi.org/10.1016/j.jamda.2020.09.036.

[5] Li, Y., Temkin-Greener, H., Shan, G. and Cai, X. (2020), COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates. J Am Geriatr Soc, 68: 1899-1906. doi:10.1111/jgs.16689

[6] Harrington C, Ross L, Chapman S, Halifax E, Spurlock B, Bakerjian D. Nurse Staffing and Coronavirus Infections in California Nursing Homes. *Policy, Politics, & Nursing Practice*. 2020;21(3):174-186. doi:10.1177/1527154420938707