Department of Health

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Members of the Senate and Assembly,

With a large number of the essential workers coming from communities of color, these New Yorkers face an increased risk of contracting the virus simply due to the nature of their work.

I am writing in response to the questions you submitted as follow up to the Legislative Hearings on COVID-19 in long-term care settings and hospitals. Thank you for your interest in these issues, please see information below:

Surge and Flex:

Prior to COVID-19, individual hospitals and hospital networks rarely worked together or coordinated as a unified healthcare system. Operational challenges threatened to overwhelm our entire healthcare system at the apex of the curve. To address these challenges, we needed to develop a new and innovative approach with unprecedented coordination, cooperation, and agility. In March, Governor Cuomo directed the New York State Department of Health ("the Department") to establish a coordinated statewide public healthcare system.

"Surge and Flex" was created to allow the state flexibility to move personal protective equipment (PPE), supplies and ventilators and redeploy healthcare staff where and when they are needed - where and when the surges hit. As part of this statewide coordination and planning effort, the Department had daily calls with hospitals and healthcare officials around the State to prepare for system surges and new hot-spots. Surge and Flex helped the State transfer thousands of patients and prevented the catastrophic healthcare system failures that we saw in Italy and other countries.

To deal with future waves or new pandemics, the Department issued emergency regulations that provide a structure to much of what has been accomplished during the emergency through Executive Orders (EOs). The regulations seek to maximize the efficiency and effectiveness of the state's health care delivery system, mitigate future threats, and institutionalize the "Surge and Flex" operations to allow the State to quickly activate while also giving hospitals the time and guidance to adequately prepare for the future. The proposed regulatory amendments establish ongoing emergency planning requirements and require hospitals to: develop disaster emergency response plans; maintain a 90 day supply of PPE, ensure that staff capable of working remotely are equipped and trained to do so; and report data as requested by the Commissioner of

Health. The text of the regulations can be found here: https://regs.health.ny.gov/regulations/emergency

Testing:

Nursing Homes:

Assistance with testing and training nursing homes on COVID-19 testing has been ongoing since last March. In addition, the Department's Wadsworth Center laboratory was the first lab outside of the Centers for Disease Control and Prevention (CDC) to be authorized to test for COVID-19, prioritized testing for nursing homes. The Department completed resident testing at all 613 nursing homes in New York State on June 7th. Resident testing continues when warranted.

When the Department conducted baseline testing of residents in nursing homes in May and June, results were provided the day after sample receipt, i.e. within 48 hours of swabbing. The Department and its Wadsworth Center continue to perform nursing home testing for residents when there is concern about a potential case or outbreak.

NYS has to-date provided free of charge more than 3,743,100 test kits for RT-PCR sample collection. In addition, the Department distributed 1,095,040 Abbott BinaxNow COVID-19 rapid antigen tests free of charge to approximately 600 nursing homes to assist facilities in performing staff testing. The U.S. Department of Health and Human Services (HHS) is continuing to allocate rapid test capabilities to NYS nursing homes and they are anticipating that their distribution will continue into March 2021.

Turn Around Time:

The Department is monitoring turnaround time on a daily basis for all laboratories. In addition, the Department has developed a weekly survey for all labs performing testing for COVID-19 to obtain information about testing capacity and challenges. To a large degree, the longest turnaround times were seen in the large, out-of-state commercial laboratories, which were overwhelmed with testing demands from southern hotspot states during the summer surge. The Department now posts a list of labs – updated weekly – with an average turnaround time of less than four days on its website in order to help entities seeking lab services find lab providers. When there is concern about an outbreak at a nursing home or a concerning case/exposure, Wadsworth will support the nursing home and the Department's epidemiological team's investigation and infection control efforts by conducting testing.

In addition to supporting nursing homes in their testing activities, the Department has developed a post long-term care facility partnership vaccination program to ensure long-term care facilities continue to have vaccination access after the federal program has ended. In this capacity, New York State will serve as a leader and example for other states.

Currently, New York's public and private labs average approximately 1.4 million tests a week, with a median turnaround time of 24 hours. As of early February, approximately 82% of test results were reported to patients within 48 hours of sample collection.

Pooled Testing and Testing Advances:

Pooling protocols work well when there is a low prevalence of infection in a geographic area, although there exists a possibility of missing "low positives" in the pool if the correct protocol is not followed. Several laboratories in the State are already successfully using approved pooling approaches.

New diagnostic assays are continually being developed and reviewed by the FDA process. While some rapid tests have reduced sensitivity as compared to laboratory-based tests, when used in the right setting and in the context with the patient's situation, the rapid availability of the test result can be of great public health value.

Cost of Testing:

State operated testing locations do not charge individuals for the cost of COVID-19 testing. The State is incurring these costs in the first instance and will seek reimbursement as applicable through Federal funding sources. Where the state is not administering COVID-19 testing, facilities should be seeking insurance reimbursement in the first instance, and consistent with the Department and the NYS Department of Financial Services (DFS) guidance. Where the State is not administering the test, the locality or municipality would incur the expense in the first instance and then submit a claim to Federal Emergency Management Agency (FEMA) for reimbursement going back to the date of Disaster Declaration. Additionally, claims for payment of uninsured testing costs may be submitted to HHS through the COVID-19 Uninsured Program Portal.

Personal Protective Equipment (PPE):

With respect to PPE training, including appropriate PPE and how to properly use it, nursing home providers have a responsibility to educate, train and evaluate the effectiveness of training on adequate use of PPE for all staff providing care and services in the nursing home. Each nursing home is required to have an emergency preparedness plan in place which provides a minimum for the appropriate training of staff for any/all emergency situations.

Guidance on COVID-19 and PPE was provided as early as January, before actual declaration of the public health emergency. In addition, the Department has taken the lead from the Centers for Medicare and Medicaid Services (CMS) and has invested a great deal of resources on training nursing homes over the past several years on

emergency preparedness activities, including not only COVID-19, but also other infectious diseases such as H1N1, Legionella, Ebola, and Candida Auris. Prior to the pandemic, on January 29th, the Department issued a Dear Administrator Letter and infection control and prevention assessment, further demonstrating efforts taken to ready the industry for COVID-19.

On April 10th, the Department issued a COVID-19 Infection Prevention and Control (IPC) preparedness checklist. Given the widespread transmission within some facilities, it was imperative that facilities took steps to prevent introduction, recognize staff and residents with possible COVID-19, and minimize transmission within the facility, while keeping staff safe from further illness. The checklist directed facilities to:

- Take stock of currently available PPE and think about future needs, based on number of staff and residents; supplies should include (depending on availability) hand soap, paper towels, hand sanitizer, gloves, masks, gowns, eye protection (goggles or face shields), and sanitizing wipes.
- Know how to order more PPE before it runs out; this could include ordering from your usual suppliers, requesting from your professional organization, or contacting the local Office of Emergency Management.
- Review PPE conservation guidelines, available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.

The Department continues to work with nursing homes and other providers to obtain the necessary PPE and access staffing resources needed to provide safe care to nursing home residents. In addition, regulations have been promulgated (10 NYCRR Section 415.19) and training provided requiring nursing homes to have a 30-day PPE supply on hand by August 31st and a 60-day PPE supply by September 30th, 2020.

PPE	**Nursing Homes**	**Adult Care Facilities, Home Health Agencies, Hospice**	**Total**
N95 Masks	2,224,140	584,178	2,808,318
Surgical Masks	4,764,902	2,319,697	7,084,599
Gloves	8,788,495	2,324,109	11,112,604
Gowns	2,320,200	628,309	2,948,509
Face Shields	2,131,193	623,923	2,755,116
Total	20,228,930	6,480,216	26,709,146

Request for Delay of Medicaid Budget Actions:

These actions were agreed to as part of the budget process and delays would impact any associated savings.

Visitation:

Guidelines to allow expanded visitation have been issued for pediatric skilled nursing facilities, adult care facilities and nursing homes in New York State.

Nursing homes are allowed to resume limited visitation for facilities that have been without COVID-19 for at least 14 days, a revision to the 28 day guidelines previously set by CMS. The updated guidance will allow eligible visitation in over 400 of the state's 613 nursing homes.

These guidelines, which became effective September 17th, require visitors to present a verified negative test result within the last seven days. Visitation must be refused by the facility if the individual fails to present a negative test result, exhibits any COVID-19 symptoms, or does not pass screening questions. The number of visitors to the nursing home must not exceed ten percent of the resident census at any time and only two visitors will be allowed per resident at any one time. Visitors must undergo temperature checks, wear face coverings and socially distance during the visit and visitors under the age 18 are prohibited. Nursing Homes accepting visitors will be required to send their visitation plan to the Department to affirmatively attest that they are following the guidance.

The Department will continue to be guided by science and concern for residents' welfare and will monitor facilities that host visitors, to ensure this action does not lead to an increase in cases.

Staffing:

Nursing homes are required by Department regulations to have the appropriate staff to assure that each resident receives treatments, medications, diets and other health services in accordance with individual care plans.

In addition, on March 31st, the State launched an online staffing portal. The portal has successfully assisted hospitals and healthcare facilities across the state connect with over 96,000 volunteers with healthcare workers who have volunteered to work on a temporary basis during the COVID-19 pandemic. 460 nursing homes/adult care facilities and 98 hospitals requested and were given access to the portal.

In mid-January, the Department announced that if a facility is experiencing a staffing shortage and is seeking a healthcare professional(s) to assist in providing medical services at their nursing home, they could access the COVID-19 Profession Request form that is available on the Health Commerce System (HCS) and is

accessible to the Administrator, Operator, Director of Nursing and Case Manager at https://commerce.health.state.ny.us/doh2/applinks/medprofreq/Home.

Surveillance Cameras in Nursing Home Resident Rooms:

Nursing homes and families have been using surveillance cameras for years. On May 22nd, 2012, a Dear Administrator Letter was issued detailing the requirements for audio or video surveillance equipment in nursing homes. Specifically, the guidance reiterated that homes have the right to develop policy and procedures regarding the use or the non-use of video and/or audio surveillance equipment in any part of their facility including resident rooms. Written policies must adhere to established regulations, including 42 CFR §483.10(e) Privacy and Confidentiality and §483.15(a) Dignity.

The regulation at §483.10(b)(1) Notice of Rights and Services, further requires that the nursing home provider inform the resident, both orally and in writing, in a language that the resident understands, of his or her rights and all applicable rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility policies on camera use should specify how the resident and his family/representative would be informed, at admission and thereafter, regarding the installation, placement, and use of security cameras.

Access to Behavioral Services:

The Department works closely with the Office of Mental Health (OMH) in the oversight of jointly licensed psychiatric units of Article 28 general hospitals to ensure appropriate access to and safe operation of these programs. The process for establishing or making changes to Article 28 inpatient psychiatric beds is delineated under the Department's Certificate of Need (CON) and OMH Prior Approval Review (PAR) processes, through which local governmental units, and in cases of significant actions, the Behavioral Health Services Advisory Council and the Public Health and Health Planning Council, advise the respective Commissioners.

The process of determining what a mental health service system "should" look like involves local needs assessments and plans, which are required to be completed annually by the local Departments of Mental Health as part of system planning. Based in those plans, the OMH, in conjunction with the local government units and provider community, makes plans and adjustments to the local system, which often includes determinations of where and how to spend reinvestment dollars.

Furthermore the FY2022 Executive Budget authorizes the Department of Health, Office of Addiction Services and Supports, and the Office of Mental Health to establish a single integrated license for outpatient mental health, addiction, and physical health services. This will expand access to behavioral health in all parts of the state by reducing administrative barriers to creating multi-service single stop facilities in which New Yorkers can receive the care they need.

When needs have been identified for any type of program development or expansion, OMH works closely with impacted local governmental units (county mental health authorities) and other stakeholders to fund and design programs to meet the needs of the population. In addition, the PAR process requires providers that are changing service delivery to have prior consultation meetings with the local Departments of Community Services and impacted stakeholders, thereby ensuring a public-private collaborative approach to system design and service delivery.

Service needs, outcomes, access, and performance indicators have all been established and are provided to local governmental units and other stakeholders to service planning. Most of those reports and dashboards are available online at https://omh.ny.gov/omhweb/statistics/index.htm.

The permanent expansion or reduction of inpatient psychiatric capacity in any county must still follow the CON and PAR process, which in most cases includes prior consultation with the impacted local governmental unit(s), the Behavioral Health Services Council, the Department, and OMH. We welcome input from the Legislature and any other interested parties during that process.

OMH constantly monitors bed utilization (daily) and temporary closures, which can be due to emergencies like COVID, or more routine staffing issues, construction, or other temporary situations. It is the expectation, absent a PAR application, that all beds taken off-line, for any of the above purposes, will be restored following the resolution of the issue that necessitated the temporary closure. The timing of any restoration of beds is related to the cause of the temporary closure.

Specifically, on HealthAlliance, during the peak of the COVID pandemic in April 2020, the Health Alliance Mary's Avenue facility was announced as a potential COVID only acute care facility, and emergency approval was given under Executive Order authority to allow Health Alliance to make the facility ready to accept acute care patients at this time. This facility's capacity was ultimately not required. Since this time, OMH and the Department have been in frequent discussions with Westchester Medical Center (WMC) regarding the beds that were taken offline in Ulster County to support the COVID-19 surge. It is our understanding that WMC is also working with county mental health leadership to ensure that local residents' needs to inpatient and other mental health services continue to be met throughout the pandemic. The permanent expansion or reduction of inpatient psychiatric capacity in any county must follow the CON and PAR process, which in most cases includes prior consultation with the impacted local governmental unit(s), the Behavioral Health Services Council, the Department, and OMH. The DOH and OMH have not received the required regulatory filings from Health Alliance to make these bed changes permanent.

The Department of Health recently secured Federal State Plan approval to implement Medicaid rate increases for inpatient psychiatric services including a 25% increase to the differential for children's services effective July 1, 2018 and a 5% increase to the statewide base rates effective October 1, 2018. The State will continue to advance

strategies to enforce mental health parity laws and to preserve access to, and viability of these services.

Nursing Home Inspections and Enforcement:

The Department routinely receives complaints from a multitude of sources including current and former nursing home staff. Information about how to file a complaint is available and required by regulation to be posted in every nursing home and on the Department's website. The Department is responsible for investigating complaints and incidents for nursing homes in New York State that are related to a State and/or Federal regulatory violation.

The investigations determine whether a facility has failed to meet federal and/or state requirements. In cases where the Department determines the nursing home has violated regulations, the Department will issue a citation to the nursing home. The facility then must submit a plan of correction that is acceptable to the Department and correct the deficient practice. The Department protects the identity of any whistleblower to the maximum extent permitted by law, including redacting identifying information in response to any FOIL request.

Both the Department and the Centers for Medicare and Medicaid Services (CMS) conduct unannounced surveys and inspections. The expectation is that nursing homes are always prepared for an unannounced inspection, and recertification surveys are conducted every 9-15 months.

The survey process is publicly available on the CMS website, providing yet another tool for nursing homes to be successful in providing high quality resident centered care. In addition, the Department conducts unannounced complaint investigations based on allegations received from a multitude of sources, including facility reported incidents. Facilities are expected to adhere to all state and federal requirements governing their license and Conditions of Participation.

- Epidemiological assessments – gaining better understanding of the number of suspected cases, positive cases, required transfers, etc.
- Clinical status – Learning more about the health conditions of the residents, symptoms, severity of those symptoms, etc.
- Reinforcing infection control practices: Putting in place best practices that can help slow spread, cohorting residents (when appropriate), environmental cleaning, social distancing, hand hygiene.

In addition to focused infection control surveys in response to complaints, concerns, and regular schedule during the COVID-19 pandemic, the Department conducted a focused infection control survey at all 613 nursing homes in New York State between May 3 and July 8, 2020. As of February 4, 2021, the Department has completed 2,284 focus infection control surveys since the start of the pandemic and issued a total of 170

violations related to COVID-19 infection control concerns, of which 11 were cited at the Immediate Jeopardy level. All 170 violations were referred for further enforcement action.

Immunity from Liability:

Provisions related to the provision of immunity from liability for health care providers and facilities were negotiated with and voted on by the Legislature, recently revised through the legislative process and signed by the Governor.

The intent was to allow volunteers, facilities and providers to make the right medical decisions, rather than having to be influenced by legal implications. Immunity is available if the care was pursuant to a COVID-19 emergency rule, impacted by decisions or actions in response to the COVID-19 outbreak, and the care was delivered in good faith, but immunity is not available if harm was caused by an act or omission constituting criminal misconduct, gross negligence, recklessness or intentional infliction of harm.

March 25th Advisory Memo

The March 25th advisory memo issued by the Department (not by executive order), was not a change in law or regulation, and it did not impose new responsibilities on nursing homes. The document follows federal guidance from CMS and CDC, as previously stated and confirmed by the Attorney General:

> *"At the same time, the March 25 guidance was consistent with the CMS guidance on March 4 that said nursing homes should accept residents they would have normally admitted, even if from a hospital with COVID-19, and that patients from hospitals can be transferred to nursing homes if the nursing homes have the ability to adhere to infection prevention and control recommendations. It was also consistent with CDC Published Transmission-Based Precaution (T-BP) guidance, which was referred to in CMS's March 4 guidance, and which stated that if T-BP were still required for a patient being discharged to a nursing home, the patient should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of residents with COVID-19."*
> Nursing Home Response to COVID-19 Pandemic Report, Page 36

CMS guidance stated nursing homes "should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present" and when addressing the question of "When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital," stated that "a nursing home can accept a resident diagnosed with COVID-19…as long as the facility can follow CDC guidance" that is designed to limit transmission. On March 23, CDC issued guidance "For Patients Discharged to Long-term Care or Assisted Living Facilities" stating that "transferred COVID-19 patients…should go to a facility

with…an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients."

The Department's March 25th advisory memo followed this federal guidance, and any nursing home that allowed admission of a resident without the ability to provide the precautions required by state and federal guidance to guard against COVID transmission would have been in violation of Title 10 of the New York State Code of Rules and Regulations, section 415.26, which clearly states a nursing home can "accept and retain only those nursing home residents for whom it can provide adequate care."

The March 25th advisory memo was not a directive to nursing homes to take residents for whom they could not provide care, and as shown by the data, admissions were clearly not a factor in introducing COVID for at least 98% of nursing home facilities that had admissions between March 25th and May 8th:

- A July report issued by the Department shows that from March 25, 2020 - May 8, 2020 approximately 6,326 COVID-19 patients were admitted from a hospital to a total of 310 unique nursing homes. Of the 310 nursing homes, 304 — or 98% — already had COVID present in the facility, as evidenced by having reported at least one COVID-positive resident or staff member or COVID fatality prior to the admission of a single COVID positive patient from a hospital. This data demonstrates that in these cases, the patient admitted from the hospital did not introduce COVID-19 into the nursing home.

- A report issued by the NYS Attorney General in January 2021 stated: 'While some commentators have suggested DOH's March 25 guidance was a directive that nursing homes accept COVID-19 patients even if they could not care appropriately for them, such an interpretation would violate statutes and regulations that place obligations on nursing homes to care for residents. For example, New York law requires a nursing home to "accept and retain only those residents for whom it can provide adequate care." See 10 NYCRR § 415.26(i)(1)(ii). Preliminary findings show a number of nursing homes implemented the March 25 guidance with understanding of this fundamental assessment.' (Pg. 72, footnote 45)

The May 10th guidance requiring hospitals to obtain a negative test prior to discharging a resident to a nursing home didn't supersede the March 25th guidance – rather, it added a new requirement that took advantage of New York's increased testing capacity to add an additional precaution. The May 10th guidance speaks specifically to new admissions to nursing homes from an Article 28 general hospital. Nursing homes have always been allowed to transfer and receive admission/transfers from other nursing homes, assisted living and adult care facilities.

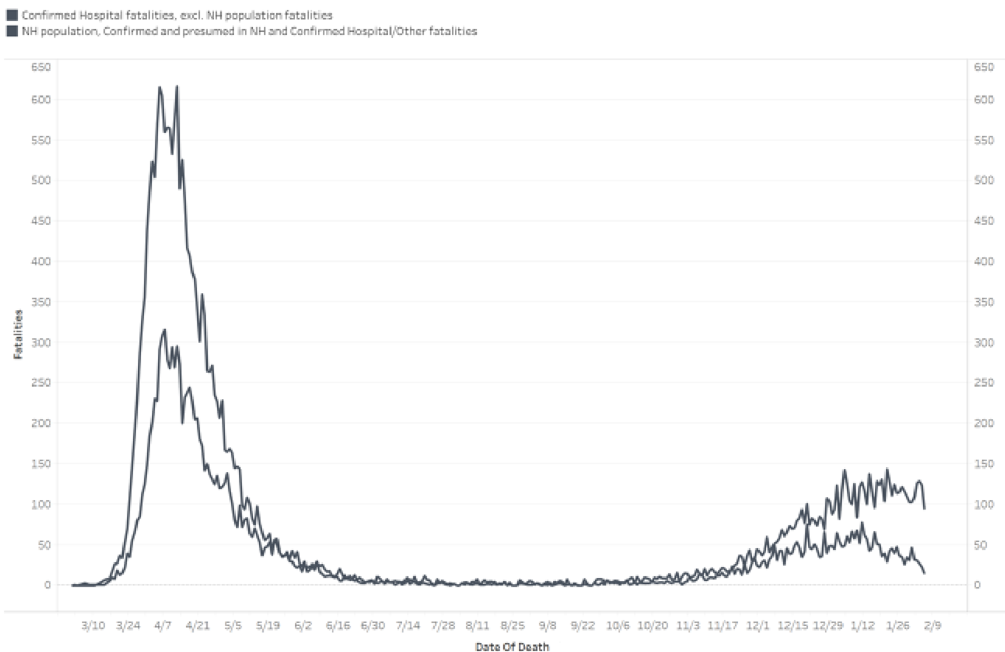
Much like provisions put in place in the 1980's to prevent HIV/AIDS patients from being denied care, then and now, nursing homes cannot discriminate against COVID-19

patients and they cannot accept patients if they aren't able to provide adequate care, including staff screenings, PPE, and infection control measures like cohorting.

The Department's July report which was prepared after an in-depth analysis of self-reported nursing home data from March through June found that COVID-19 fatalities in nursing homes during this time period were related to infected nursing home staff:

> *According to data submitted by nursing homes, in many cases under the penalty of perjury, approximately 37,500 nursing home staff members—one in four of the state's approximately 158,000 nursing home workers—were infected with COVID-19 between March and early June 2020. Of the 37,500 nursing home staff infected, nearly 7,000 of them were working in facilities in the month of March; during the same period, more than a third of the state's nursing home facilities had residents ill with the virus. Roughly 20,000 infected nursing home workers were known to be COVID-positive by the end of the month of April. These workforce infections are reflective of the larger geographic impact of the virus's presence across the state.*
>
> *NYSDOH further analyzed the timing of the COVID-positive staff infections and the timing of nursing home deaths. Based on published data, the average length of time between COVID-19 infections to death is between 18-25 days. Therefore, the link between the timing of staff infection and nursing home mortality is supported by the fact that the peak number of nursing home staff reported COVID-19 symptoms on March 16, 2020—23 days prior to the date of the peak nursing home fatalities, which occurred on April 8, 2020. It is likely that thousands of employees who were infected in mid-March transmitted the virus unknowingly—through no fault of their own—while working, which then led to resident infection.*

An analysis of fatality data from last March through this past January shows that "curve" of nursing home fatalities closely tracks the "curve" of non-nursing home related COVID fatalities. When COVID spreads in the community at a high rate, fatality rates within a community, including within nursing homes, increases. Data, as plotted on the below chart, shows that the proportion of NH fatalities in and out of the facilities compared to the community was similar in the spring and the current second case increase period in NY: In March 2020 – May 2020 and November 2020- Jan 2021 the proportion was approximately 35% for both time periods.



Nursing Home Communications:

The Department has maintained ongoing communications with providers, their associations and relevant stakeholders prior to, and during the duration of the COVID-19 Emergency.

As referenced by the various provider associations during the hearings, the Department had routine conference calls with provider associations, sometimes daily and also on weekends, to listen and provide valuable information to protect the health and safety of residents and staff. In addition, webinars and written communication was provided as information became available and education needed.

Since March 1st there have been 8,294 such interactions with providers by our Public Health staff in the form of infection control calls, video call assessments ("COVID-19eos") and epidemiological site visits and over 2,284 unannounced onsite Focus Infection Control Surveys and over 30 calls per day 7 days a week made by the Department's surveillance program to nursing homes across New York State to assess COVID-19 activity and provide any additional support to the nursing homes.

Data Collection and Discrepancies:

The Department has collected unprecedented levels of data which helps guide every aspect of our public health response. We are also displaying data – in real time – that helps provide as clear a picture as possible of the human impact of this pandemic.

To date, the federal government has not mandated states report data in a uniform way. As a result, there's a lack of consistency in data reporting nationally. As an example, 13 states do not share any data at all regarding long term care facility related fatalities, and only 9 states, including New York, reports COVID nursing home fatalities that are 'presumed' rather than confirmed by a lab test. That inconsistency can skew the numbers.

NYS DOH, similar to numerous other public health agencies across the nation, has encountered challenges in simultaneously providing real-time data to the public while also performing the required verification work to ensure data accuracy. A New York Times report last week examining public health departments retrospectively adjusting their publicly reported fatality records stated:

> *"In a presentation on Wednesday, Dr. Kristina Box, the Indiana state health commissioner, spoke of the challenges of trying to keep precise tabs on an epidemic of this magnitude as it is unfolding. "Please understand that never before have local and state departments of health had to present data in real time, before it was vetted," Dr. Box said. State auditors identified the added deaths by matching every death certificate that indicated a coronavirus infection as a cause of death, or as a contributing cause, to a positive test, Dr. Box said. Indiana's addition appears to be one of the largest death-toll adjustments that any state has made so far, but there have been a number of others. One reason is that it can be difficult to rule out other causes of death in some cases. The state of Washington announced in December that it was reviewing a number of previously reported coronavirus deaths, and was removing 214 deaths from its state Covid data dashboard, at least temporarily. Officials said at the time that they expected to add about 152 of them back again once they had been more thoroughly investigated."*

To assist in data collection efforts, the Department utilizes the Health Electronic Response Data System (HERDS). HERDS is a statewide web-based data collection system linked to health care facilities through a secure site that allows facilities to relay resources or needs to the Department during emergencies, or to respond immediately to rapid request surveys in preparedness planning efforts. The HERDS contains patient identifying information and as such, specific data is not made publicly available. The aggregate HERDS data was included in the information posted on the COVID-19 dashboards.

The Department routinely collects data from Hospitals (Statewide Planning and Research Cooperative System, SPARCS), laboratories (Electronic Clinical Laboratory Reporting System, ECLRS), nursing homes/adult care facilities (Minimum Data Set, MDS) and Syndromic Surveillance. In addition, the Department utilizes the Health Electronic Response Data System (HERDS) to disseminate rapid request surveys to healthcare facilities. During the COVID-19 pandemic, daily HERDS surveys allowed hospitals, nursing homes, and adult care facilities to provide information on PPE, cases, and deaths and communicate resources and/or needs to the Department. The

aggregate HERDS data was included in the information posted on the COVID-19 dashboards.

HERDS data cannot be directly compared against hospital records, laboratory data and death certificates because the data set does not have the same personal identifiers. The Department has undertaken the task of triangulating the different data sets to obtain additional information and to identify areas of potentially discrepant data.

After finding numerous inconsistencies including duplicative records and clearly erroneous entries in HERDS, the Department undertook an extensive audit of fatality reports submitted by nursing homes to ensure the numbers presented to the public were accurate. As fatality reports are verified, they are added to the Department's website and fatalities that have already been publicly reported are found to be erroneous, they are removed. Although the audit remains ongoing, the Department has updated the online tracker to include for both nursing homes, assisted living facilities, and other adult care facilities the number of fatalities of facility residents believed to have occurred outside the facility, such as in a hospital. The following data is as of February 9, 2021:

Nursing homes:
Confirmed in facility fatalities: 6,218
Presumed in facility fatalities: 2,957
Confirmed out of facility fatalities: 4,122

Assisted Living Facilities:
Confirmed in facility fatalities: 126
Presumed in facility fatalities: 24
Confirmed out of facility fatalities: 653

Other Adult Care Facilities:
Confirmed in facility fatalities: 40
Presumed in facility fatalities: 30
Confirmed out of facility fatalities: 879

Some nursing homes have reported certain fatalities for residents who died outside their facility, after those individuals were no longer under their care, where the facility suspected - but lacked confirmation - that the cause of death was COVID related. During data verification attempts by DOH, nursing homes have indicated that these reports are unreliable because they speculated from incomplete medical information, and could not confirm that information with the facility at which the patient died. There are 330 such reports that DOH continues to attempt to independently verify, including by examining lab data and records from the facilities where these patients died, and will update its reported data on a rolling basis as appropriate. There are 60 such reports that DOH believes are not COVID related based upon laboratory data; there are 281 cases in which no data exists to corroborate the initial unverified characterization by the nursing home.

Confirmed nursing home fatalities represent 28% of New York's 36,619 confirmed fatalities — below the national average. Nationally, state's have reported 150,572 nursing home fatalities to date, 32% of the 466,465 total fatalities reported by the CDC in the United States to date. For context, states with many fewer total deaths had a similar number of nursing home related deaths, including:

- Pennsylvania with 11,739 nursing home deaths
- Florida with 9,881 nursing home deaths
- Massachusetts with 8,255 nursing home deaths
- New Jersey with 7,826 nursing home deaths

However, it remains challenging to conduct true state by state comparisons as 13 states report no information on nursing home fatalities and only nine states, including New York, report nursing home fatalities that are 'presumed' COVID and not confirmed COVID.

Nursing Home Assistance/Transfers:

While a transfer is always an option, it is not always the best option. It is critically important to consider the care and comfort of the resident when determining whether to make a transfer.

To date, the Department has assisted with a total of 60 resident transfers of nursing home residents. In addition, the Department has created a Nursing Home Assistance and Coordination Center (NHACC) to respond to urgent requests from nursing homes statewide. The NHACC staff is assisting nursing homes in identifying solutions through a dedicated toll-free number, and is operational 24 hours a day, 7 days a week. The Department continues to provide support and oversight of resident transfers as needed.

In addition, starting in November the Department launched an effort to establish COVID only nursing homes consistent with Executive Order 202.81. The homes were established to allow the transfer of MEDICALLY STABLE, BUT persistently positive COVID-19 nursing home eligible patients from Article 28 hospitals to these nursing homes to further their recovery prior to discharge to home or another nursing home. As of February 4, 2021, there are nineteen (19) such sites scattered spanning all regions of the state with a total of 1,941 beds approved to meet the needs of this special population.

Article 81 Guardianship:

Article 81 of New York's Mental Hygiene Law authorizes a court to appoint a guardian to manage the personal and/or financial affairs of a person who cannot manage for himself or herself because of incapacity. Guardianship orders are specifically tailored so that the powers that are granted to the guardian are those that are specifically necessary to meet the needs of the person who is incapacitated.

In person visits of Article 81 guardians are authorized in nursing homes where visitation can resume pursuant to Department guidelines. Guardians are also encouraged to continue to communicate using remote or telephonic needs.

Role of Compassionate Caregivers
Compassionate Care Visitation for end of life and hospice is currently permitted even when a visitation is not otherwise permitted in nursing homes (such as when a facility is in a micro-cluster zone or has had an outbreak in the past 14 days). Guidance that would expand the definition to include bereavement, severe emotional distress, religious/spiritual support is pending.

State and Federal Funding
New York State has spent and administered more than $12 billion to address the COVID-19 pandemic in nursing homes and hospitals, including $36.2 million in state funds, including:

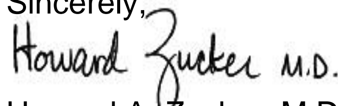
- Nearly $9.2 billion in federal provider relief for state hospitals and $520 million for state nursing homes.
- A total of $1 million to more than 300 facilities for the purchase of communication devices (including iPads, Kindle Fires, assistive/adaptive equipment, headphones, and other equipment and devices) to facilitate virtual visiting and communication between residents and families impacted by the COVID pandemic.

- A total of $1 million to up to 333 nursing homes to support in-person nursing home visitation with the necessary safety precautions (e.g., plexiglass or similar product, including installation) to mitigate exposure to infection. Awards will be made in February or March.

- Approximately $25 million in support for COVID resident testing and inspection in nursing homes.

Thank you for your interest.

Sincerely,



Howard A. Zucker, M.D., J.D.
Commissioner of Health