



# A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities

**Interim Report**

**August 14, 2020**

**DPH #2021-0041**

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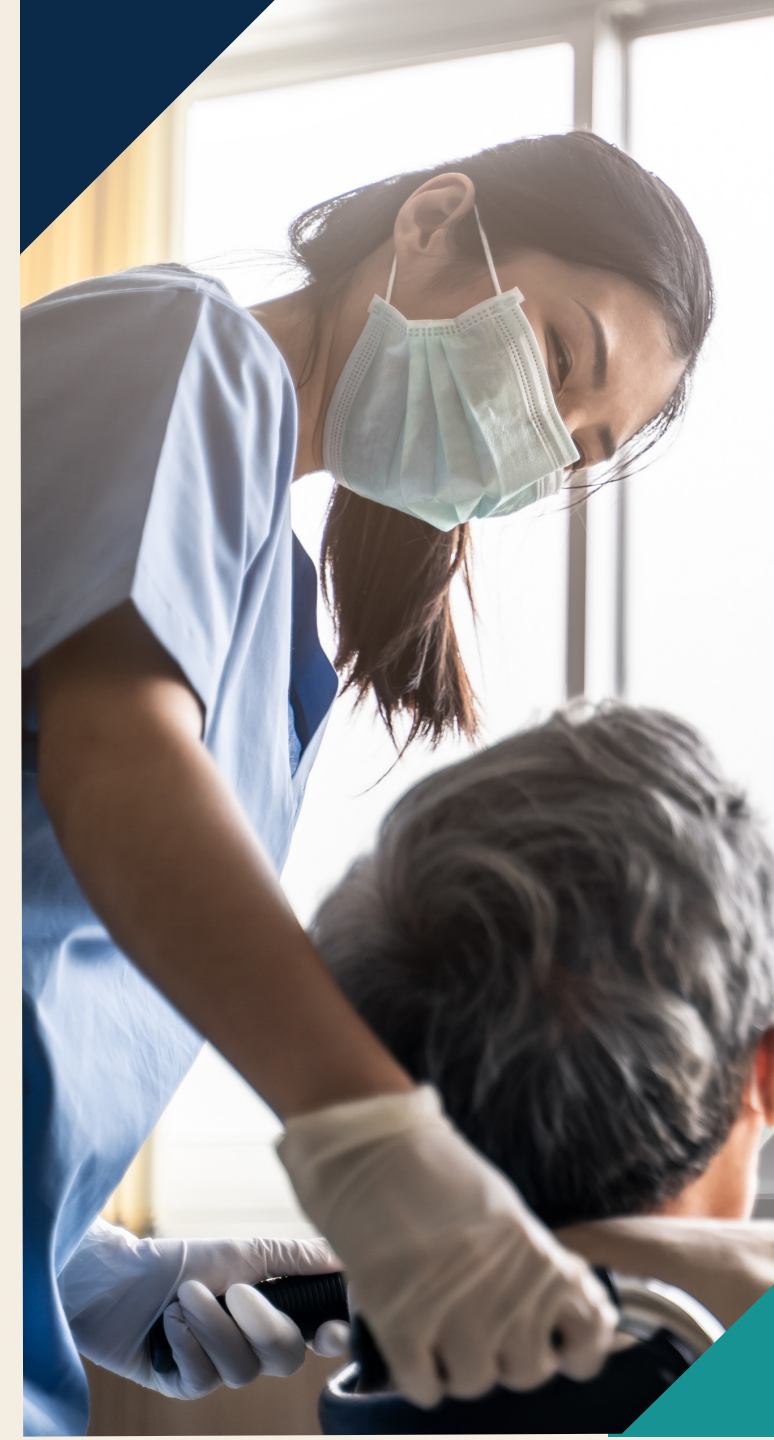
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# Organization of this report

- / **This report organizes findings and recommendations into eight categories represented by the icons to the right.**
- / **It uses these icons to orient the reader to these categories.**



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# Project motivation



# Project motivation

- / Older adults living in long-term care (LTC) facilities are at greater risk of complications from COVID-19 than non-residents.**
  - The increased risk comes from underlying clinical conditions, the transmissible nature of the virus, and the frequent interactions common in congregate care.
- / COVID-19 has had a disproportionate impact on residents of nursing homes and assisted living facilities.**
  - Nationwide, more than 40 percent of all COVID-19 deaths have occurred among LTC residents.
  - In Connecticut, more than 3,000 LTC residents have died, accounting for 74 percent of all COVID-19 deaths in the state as of July 30.

# Purpose of the interim report

- / On June 8, 2020, Governor Ned Lamont ordered an independent assessment of the impact of COVID-19 in the state's nursing homes and assisted living facilities.**
  - This report presents a preliminary assessment and interim recommendations for short-term changes the state and industry can take to mitigate a potential second wave of COVID-19.
  - The final report will have a more complete assessment of the preparedness and response.
- / This interim report has three goals:**
  - Describe the impact of COVID-19 in Connecticut as a whole and in LTC facilities compared with other states in the region and the country.
  - Assess the state and LTC industry's preparedness and response to the COVID-19 outbreak.
  - Identify immediate and achievable steps the state and LTC industry can take to prepare for a second wave of COVID-19.

# Sources

## / This report is informed by the following:

- Mathematica's review of information provided by the Connecticut Department of Public Health (DPH) and other relevant state agencies
- 30 interviews with about 60 people conducted from July 13 to August 7

## / Mathematica interviewed a sample of state agency staff, facility administrators, trade association representatives, labor representatives, legislators, and family members with loved ones living in LTC facilities.

- Appendix B contains the organizational affiliations of the people interviewed.
- Interviews are ongoing, and those conducted after August 7 will inform the final report.

## / See Appendix A for more information about the scope of this report.





**Interim recommendations to mitigate a second wave of  
COVID-19**



# Person-centered care

- ✓ **Balance strict measures designed to limit the spread of the virus with the need to support the physical, emotional, and psychosocial needs of LTC residents.**
  - The state and LTC industry must continue to prioritize person-centered care, which is care that meets their physical, emotional, and psychosocial needs and gives residents choices and control over their daily lives.
- ✓ **Resident care plans should reflect COVID-19-specific impacts on individual residents.**
  - Resident care plans should address social supports, a plan to prevent isolation, any risk factors for depression, and how nursing homes are meeting resident needs when family members are not allowed in the building.
- ✓ **Facilities should continually assess the appropriateness of any policy that restricts the movement of residents within their facility.**
  - The state should support facilities with appropriate guidance based on prevalence of COVID-19 in each facility and the community and with input from representatives of the LTC industry, resident councils, family members, the LTC ombudsman, and state regulators.
- ✓ **The state should ensure continued support for the Money Follows the Person program.**
  - Ongoing support for this program will ensure that LTC residents who want to return to a home or community-based setting have the support to do so.



# Surveillance and outbreak response

- / **The Connecticut DPH should continue infection control focused surveys, targeting more frequent surveys in nursing homes with ongoing or increasing infections.**
- / **DPH should ensure that all temporary survey staff, including National Guard personnel, complete basic and ongoing training to conduct surveys consistently and thoroughly, including training on infection control and prevention.**
  - Industry stakeholders reported that survey teams can be an important source of communication and guidance. To this end, it is critical that all personnel conducting infection control focused surveys receive basic and ongoing training on how to conduct surveys and issue citations consistent with Centers for Medicare & Medicaid Services (CMS) guidelines.
  - Opportunities for ongoing communication and guidance to surveyors are also important. DPH should continue to assess the frequency of meetings with surveyors and consider providing written summaries for those who cannot attend.
- / **All Facility Licensing and Investigation Section (FLIS) staff or other personnel conducting in-person surveys in nursing homes should be regularly tested for COVID-19 to ensure that surveyors do not become a source of possible resident or staff infection.**
- / **The state should explore ways to reduce duplicate resources and case reporting to minimize burden on facilities and reduce the risk of data errors.**
  - Facilities currently report daily to the Mutual Aid Plan and the FLIS portal on topics such as number of cases, stockpile of personal protective equipment (PPE), resident census, and so on. In addition, they are required to report weekly to federal agencies via the National Healthcare Safety Network.



# Screening and testing



- ✓ **DPH should continuously revisit its guidance on testing LTC facility residents and staff as new information becomes available to ensure testing capacity remains ample.**
  - Current policy does not require ongoing testing of residents or staff who have previously tested positive for COVID-19. As new evidence emerges on how long immunity lasts, DPH should revisit this guidance and consider broader testing among people who have previously tested positive, particularly if community prevalence rates increase.
  - As testing capacity and turnaround times improve, DPH should revisit its guidance on how frequently staff and residents should be tested. Current guidance allows for testing to stop after 14 days of no new cases, but that approach might inadvertently miss asymptomatic spread of COVID-19 without detection.
  - Widespread availability of rapid testing might also allow for changes to visitation restrictions as appropriate.
- ✓ **DPH should assess the Care Partners testing program to ensure that it is meeting its intended goals.**
  - The Care Partners program is intended to provide a dedicated testing partner to each nursing home in the state to process tests of residents and staff. DPH should examine how well these matches are working and ensure that assignments take into consideration geographical distance between facilities and Care Partner contractors and that they allow for some flexibility for facilities to continue using their existing lab relationships as appropriate.
- ✓ **As new testing technology receives Food and Drug Administration approval, the state should revisit its Medicaid reimbursement approaches to ensure they incentivize efficient use of resources.**
  - For example, if a combined COVID-19 and influenza test becomes available, Medicaid reimbursement policy should ensure that facilities are not incentivized to test separately, which could create undue pressure on laboratory capacity.



# Infection control in LTC facilities

- / The state should continue its work with federal partners and private industry to procure and distribute PPE to LTC facilities as needed.**
  - Although PPE provided by DPH to facilities represented only a fraction of the necessary PPE, industry stakeholders reported that having DPH act as the supplier of last resort was important and should continue in anticipation of a potential second wave of COVID-19.
- / The state should designate qualified staff or contractors who can provide technical assistance to LTC facilities regarding infection control guidelines.**
  - DPH employees in the Infectious Disease section reported providing significant assistance to facilities during regular provider calls, which industry stakeholders reported was helpful.
  - To the extent possible, the state should explore whether additional resources can provide further technical assistance given the demands on the time of infectious disease staff. Staff providing technical assistance should have education and experience in infection control and prevention, epidemiology, and the regulatory requirements of LTC facilities.



# Facility staffing and workforce availability

- ✓ **Facilities should adopt staffing policies that can help limit potential exposure for staff and residents such as the following:**
  - Facilities can use two 12-hour shifts instead of three 8-hour shifts to limit entry and exit of staff to the building while maintaining staffing levels.
  - Facilities should also explore strategies to limit the number of staff working in multiple facilities (for example, fewer staff who are “moonlighting”).
  - Facilities should consistently assign staff to work on the same unit and with the same residents.
- ✓ **The state should extend the temporary suspension of in-state licensure requirements through the end of the calendar year or for as long as the public health emergency is in effect.**
  - Before the pandemic, Connecticut was one of only 10 states without a nurse licensing compact in place to allow licensed staff from out of state to work in its health care facilities. The temporary lifting of licensing requirements has given the LTC industry needed flexibility to bring in staff from out of state.
- ✓ **The state and industry should partner to develop and implement strategies to supplement and strengthen the LTC workforce.**
  - The state created a temporary nurse aide position that allowed people with nominal training to provide limited care in facilities. The state should explore whether similar options could be extended to family members or volunteers if they comply with screening and testing requirements. The state and LTC industry should also expand initiatives designed to build the pipeline for LTC staff.





# Communications

- ✓ **DPH should supplement its weekly calls with LTC facilities by providing written summaries following each call and archiving guidance in a central place (for example, via “blast faxes” or the Mutual Aid Plan website).**
  - To share information provided through these calls with all state survey staff and facility administrators, the state should create short summaries of or record or transcribe the calls and then post the links on its website. For example, New York provides weekly summaries of written guidance to its health care providers and archives these summaries on its website.
- ✓ **DPH and individual facilities should make concerted efforts to allow for safe visits between residents and loved ones.**
  - As the ability to conduct outdoor visits is limited by weather, facilities should increase the number of opportunities provided for families to connect with their loved ones through video calls or window visits. Video calls or window visits should allow for as much privacy as is feasible.
  - DPH should consider creating objective criteria based on the community prevalence of COVID-19 that could serve to guide gradual reopening of facilities to in-person visitation. These criteria should be clearly communicated to facilities, residents, and families.
- ✓ **Facilities should ensure that family members can obtain accurate and timely information on residents’ health and well-being.**
  - Family members reported challenges obtaining information on their loved ones from facilities. Facilities should consider providing weekly written updates on the situation in each facility and dedicating a point of contact for family members to request updates on individual residents.



# Emergency response

- ✓ **State plans for a potential second wave should be developed in consultation with representatives from the LTC industry, residents, and family members.**
  - Early planning and response efforts focused on hospital capacity, with nursing homes viewed primarily as a backstop to alleviate high demand for acute care beds. Ongoing planning efforts should include representatives of the LTC industry and LTC residents and family members to address their unique needs.
- ✓ **The state should begin planning now to scale up COVID-19 recovery facility (CRF) capacity as needed and deploy it quickly in response to the scope and severity of a second wave.**
  - LTC facilities should continue to have the option to transfer COVID-19-positive residents directly to a CRF without first transferring them to the hospital.
  - DPH has developed three CRF models; Mathematica recommends DPH use Models 2 and 3 for ongoing CRF capacity.
    - Model 2 designates vacant facilities or other buildings as CRFs.
    - Model 3 designates units within existing facilities that have separate entrances as CRFs.
- ✓ **The state should explore executing per diem contracts for staff extenders now to ensure resources are available for a timely response to a potential second wave.**
  - State agency staff reported using outside contractors for subject matter expertise and general staff extension in the first wave of the COVID-19 response. Contracts for similar resources could be put in place now (for example, with testing lab care partners, housing contractors to house staff that need to quarantine, and per diem staff) to quickly scale up the state's response to future waves.



# Reimbursement mechanisms

- / The state should continue to assess how it supports facilities with the cost of widespread resident and staff testing.**
  - The state announced on August 5 that it would continue to cover the cost of testing LTC facility residents and staff through October 31.
- / The state should continue to assess options for enhanced Medicaid reimbursement to nursing homes.**
  - The state should continue to assess options to increase funding to nursing homes to ensure adequate access to post-acute and LTC services in the short-term and cover increased costs associated with staffing and PPE.



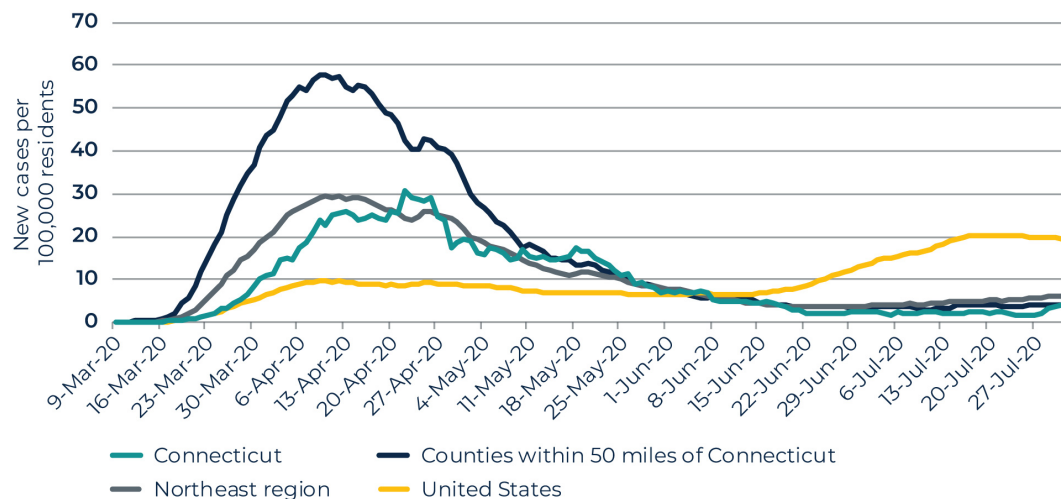


**Impact of the COVID-19 outbreak in Connecticut as a whole**

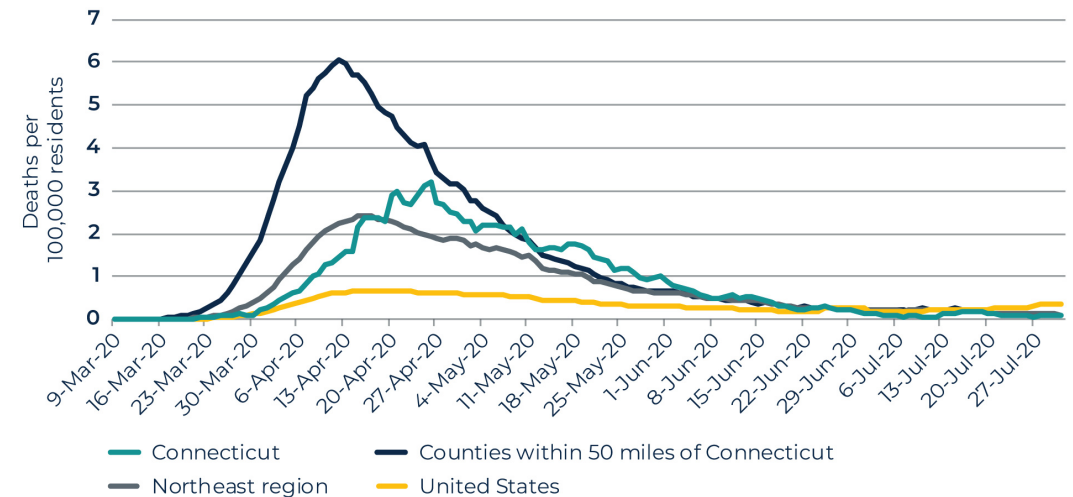
# COVID-19 outbreak in Connecticut

- More severe than in the United States as a whole.
- More cases and deaths than the Northeast region, but fewer cases and deaths than counties in neighboring states.

## New COVID-19 cases



## New COVID-19 deaths

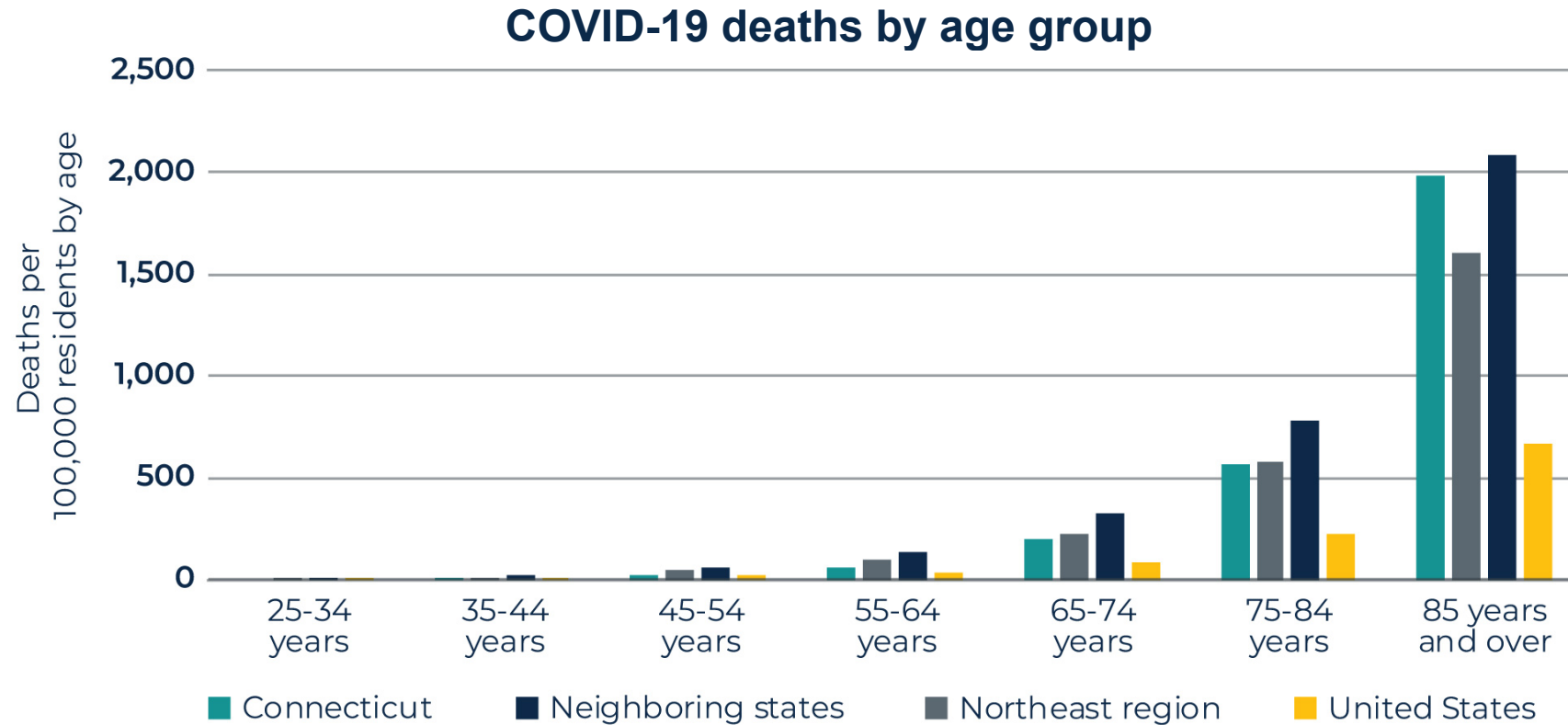


Sources: Mathematica's analysis of data collected from Johns Hopkins University and the New York Times.

Notes: This slide depicts the seven-day moving average of new COVID-19 cases and deaths. The Northeast region includes Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington, DC.



# Connecticut adults over 85 were most severely affected

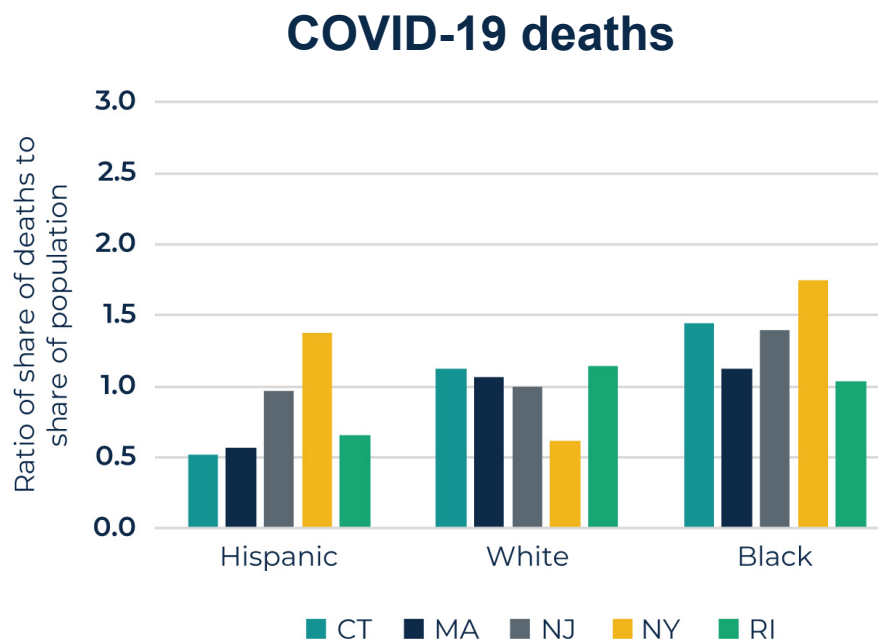
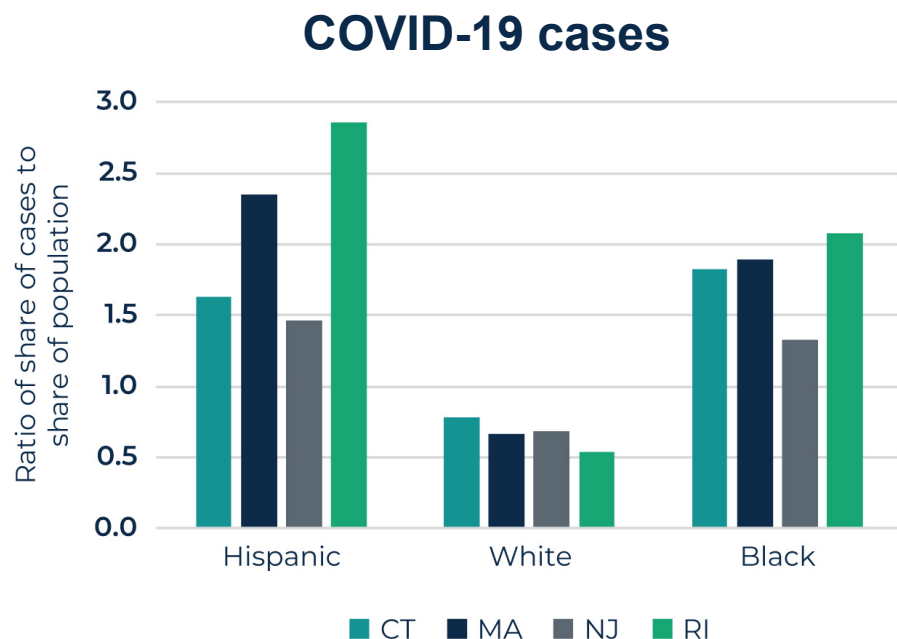


Source: Mathematica's analysis of data collected from the Centers for Disease Control and Prevention.

Notes: Neighboring states includes Massachusetts, New Jersey, New York, and Rhode Island. The Northeast region includes these four states plus Delaware, Maine, Maryland, New Hampshire, Pennsylvania, Vermont, and Washington, DC

# Patterns by race and ethnicity

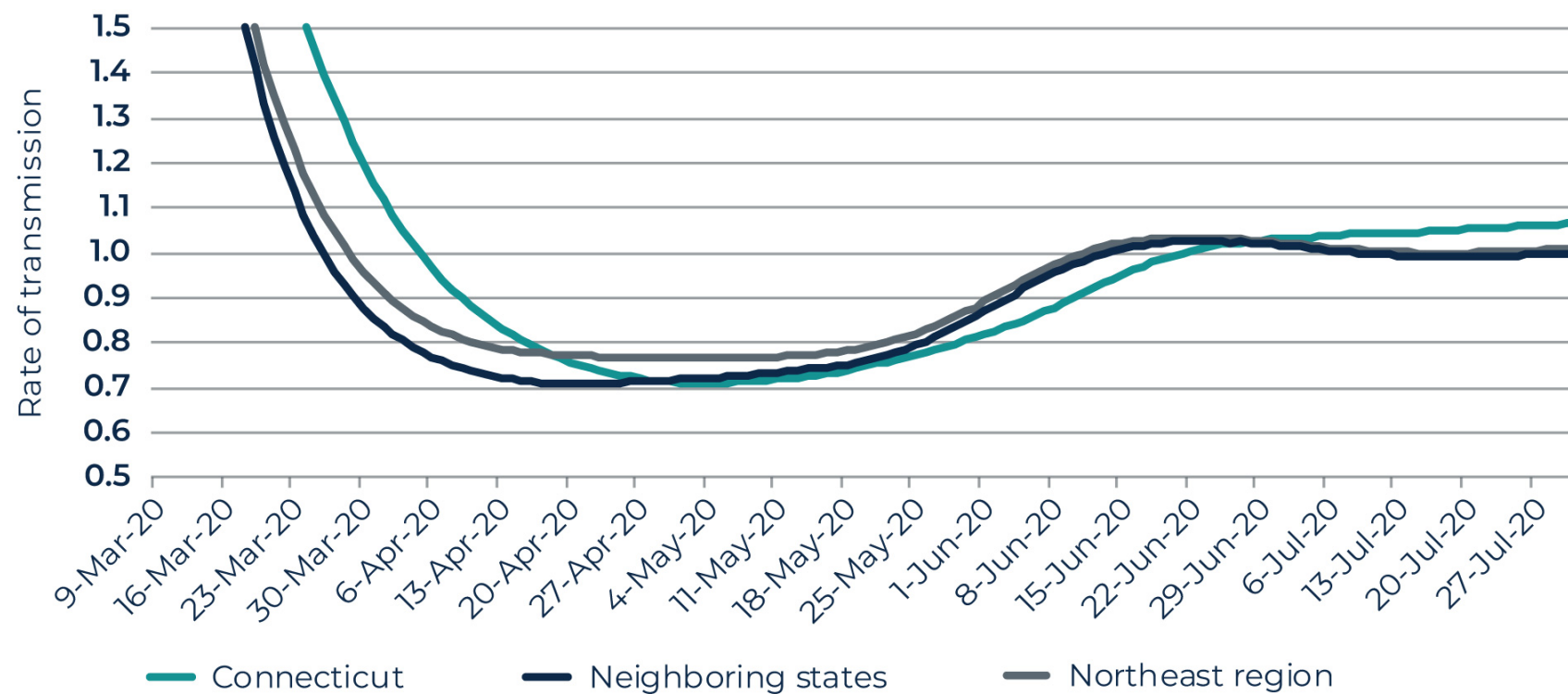
- COVID-19 cases in Connecticut were disproportionately higher among Hispanic and Black residents than White residents.
- Deaths attributable to COVID-19 in Connecticut were higher for Black residents and lower for Hispanic residents relative to Whites.



Sources: Mathematica's analysis of data collected from the COVID-19 racial data dashboard as compiled by the [COVID Tracking Project](#) and Census Bureau estimates.

Note: Each bar represents the ratio of the share of COVID-19 cases for that race or ethnicity group divided by the group's share of the general population. New York is excluded from the ratio of cases because it does not report the racial composition of cases.

# Rates of COVID-19 transmission were comparable across states in the Northeast



**Connecticut has had a slightly higher (1.06) recent rate of transmission compared with neighboring states (1.00) or states in the Northeast region (1.01).**

Source: Mathematica's analysis of transmission data compiled by rt.live.

Notes: Neighboring states includes Massachusetts, New Jersey, New York, and Rhode Island. The northeast region includes these four states plus Delaware, Maine, Maryland, New Hampshire, Pennsylvania, Vermont, and Washington, DC. The rate of transmission is estimated as the number of new people each infected person gets sick.



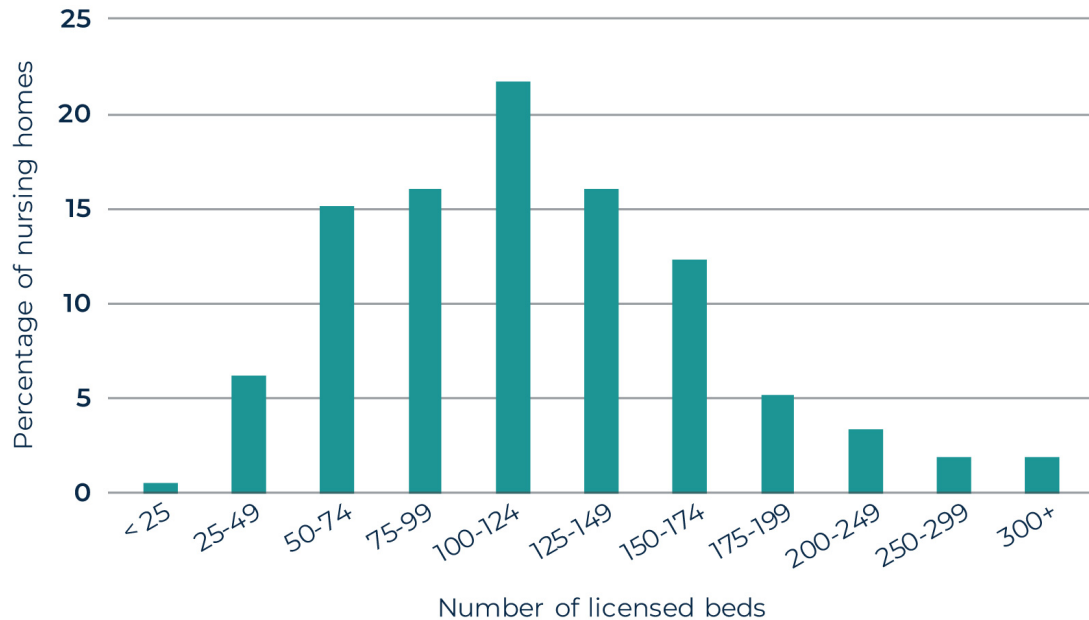


**Impact of the COVID-19 outbreak in Connecticut nursing homes**

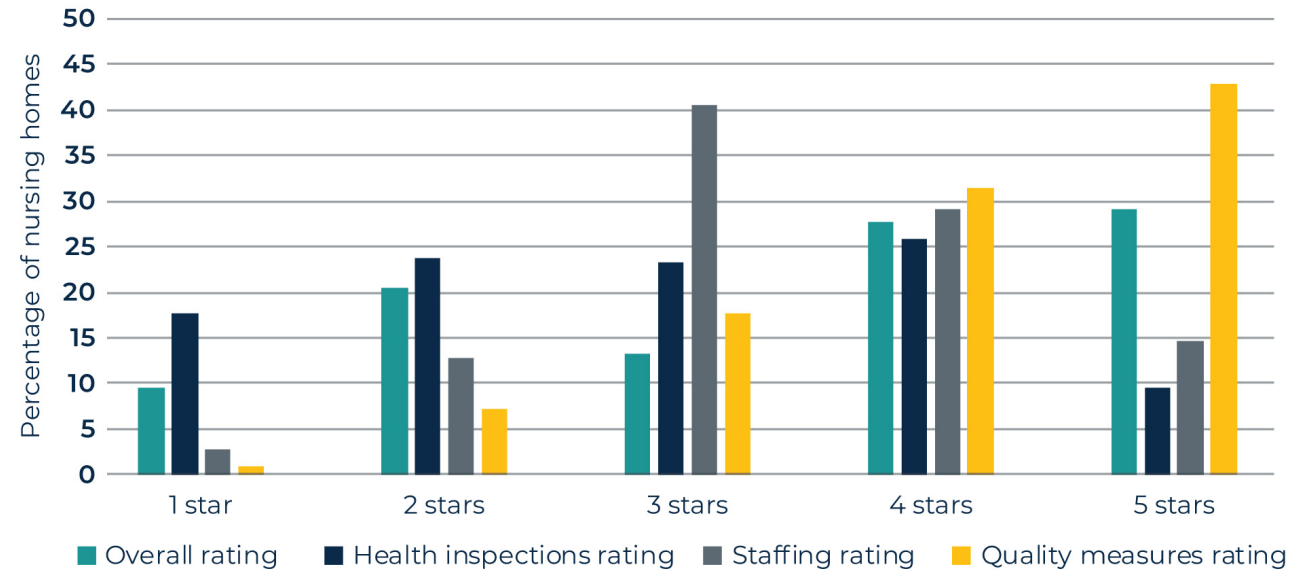


# Characteristics of Connecticut nursing homes

## Distribution of nursing home size



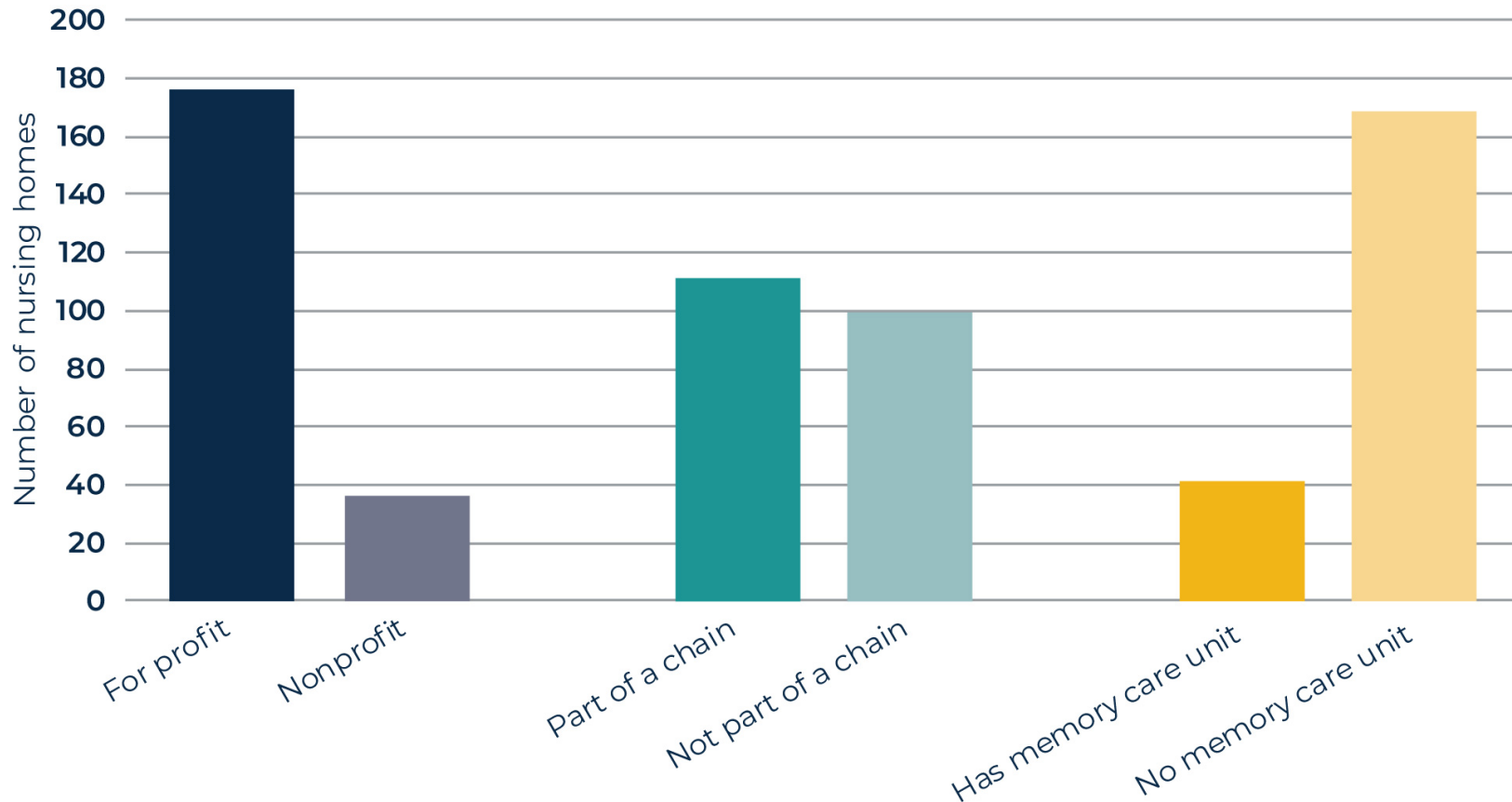
## Distribution of nursing home star ratings



Source: Mathematica's analysis of Nursing Home Compare data.

Note: This includes 212 licensed nursing homes in the state of Connecticut with data on COVID-19 cases and deaths that could be matched to data reported by Nursing Home Compare

# Characteristics of Connecticut nursing homes

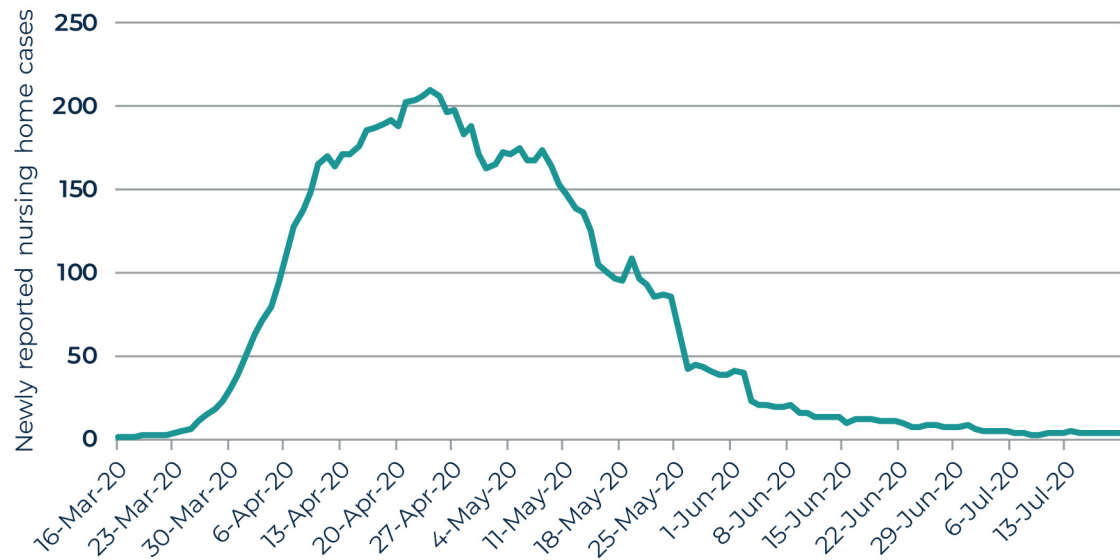


Source: Mathematica's analysis of Nursing Home Compare and LTC Focus data.

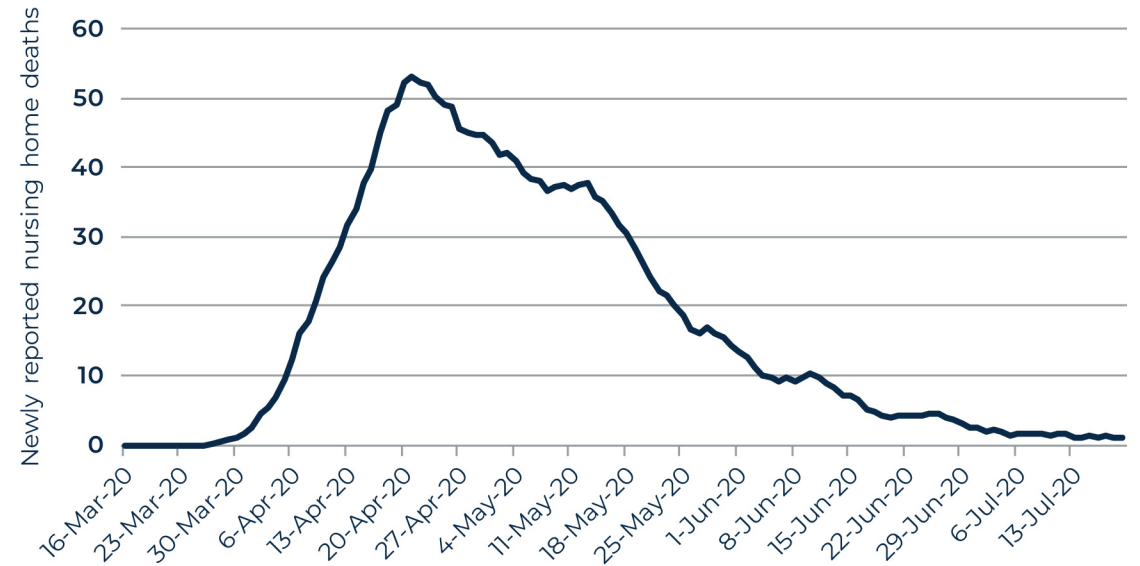
Note: This includes 212 licensed nursing homes in the state of Connecticut with data on COVID-19 cases and deaths that could be matched to data reported by Nursing Home Compare.

# The COVID-19 outbreak in nursing homes peaked in mid-April, with an average of more than 200 new cases and 50 deaths in nursing homes reported daily

### Cases in nursing homes



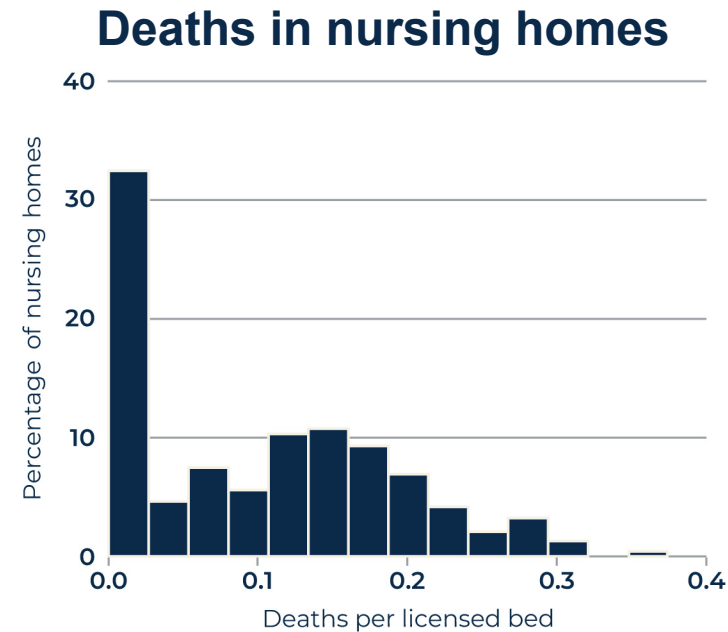
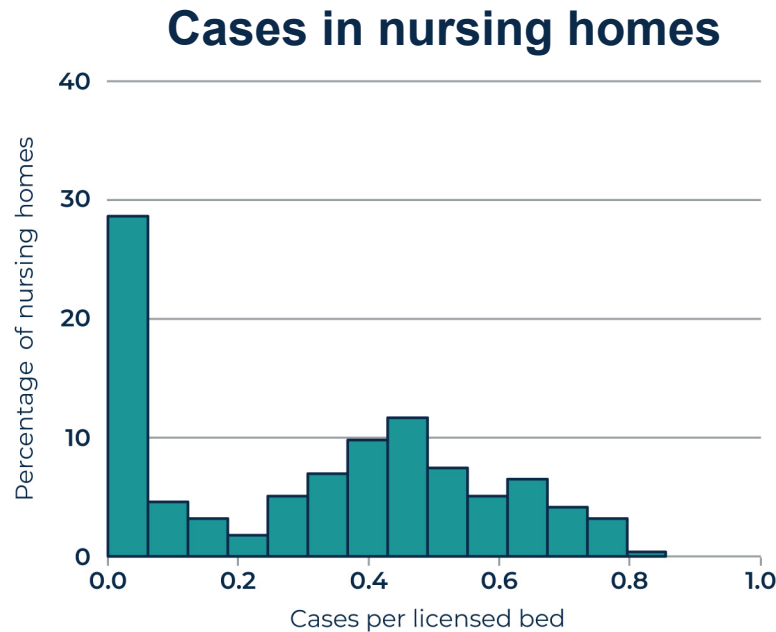
### Deaths in nursing homes



Source: Mathematica's analysis of Connecticut DPH FLIS portal on individual resident data, as reported by nursing homes.  
Note: This analysis only includes cases and deaths with a non-missing date.

# COVID-19 cases and deaths were concentrated in certain nursing homes

- At least 50 percent of residents contracted COVID-19 in about 1 in 4 (26 percent) of nursing homes, and at least 20 percent of residents died in 1 in 7 (15 percent) nursing homes.
- About 30 percent of nursing homes had very few or no cases or deaths.



Source: Mathematica's analysis of Connecticut DPH FLIS portal on individual resident data, as reported by nursing homes.

Note: Deaths include both confirmed and probable deaths attributable to COVID-19.



# Relationship between nursing home characteristics and COVID-19 outcomes

## / **Mathematica assessed whether certain nursing home characteristics were predictive of more cases and deaths:**

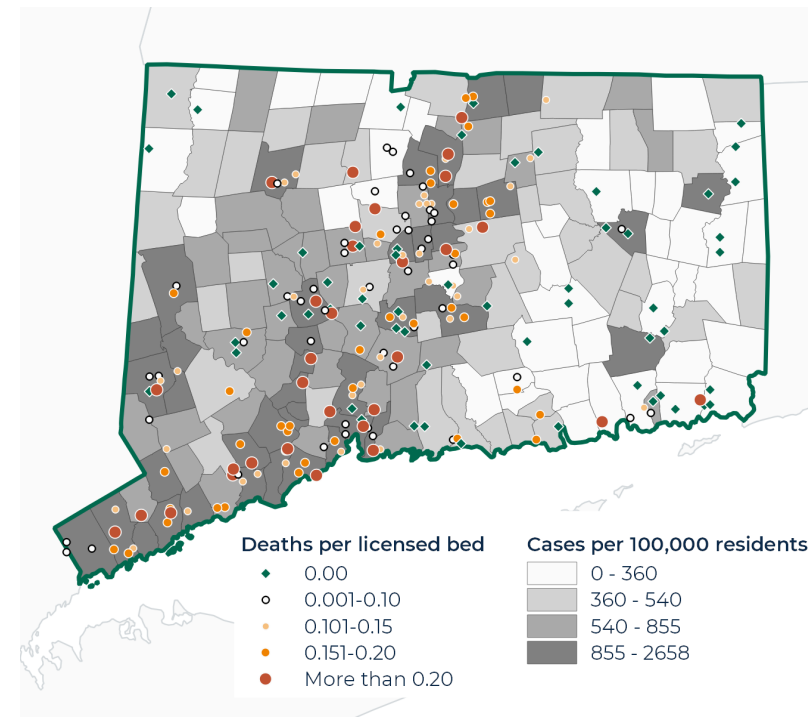
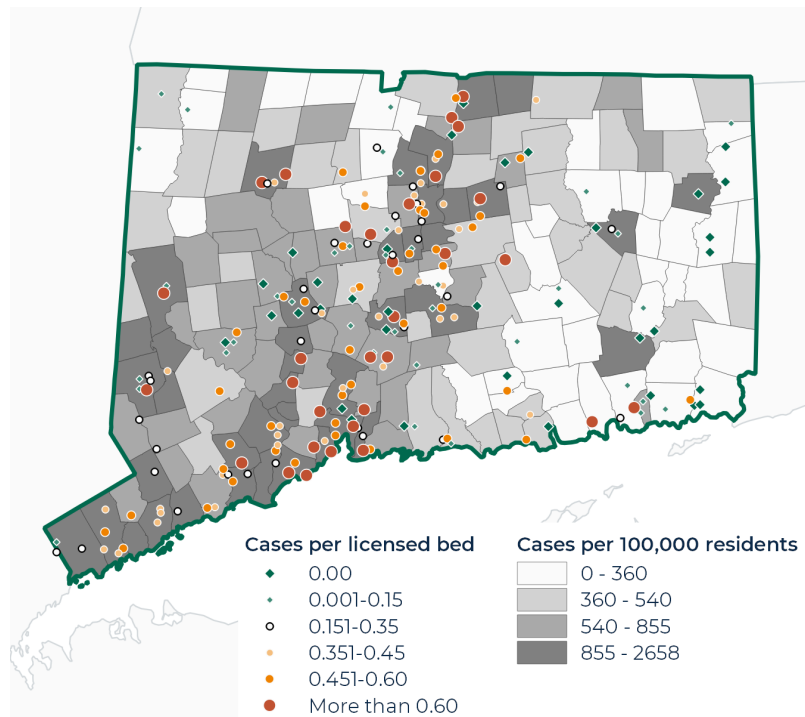
- Geographic location
- Size
- Profit and chain status
- Presence of a memory care unit
- Star ratings

## / **These analyses can help to distinguish where COVID-19 was more pervasive and which types of facilities are more susceptible.**

- The findings allow the state to target its resources and response in the event of a potential second wave of COVID-19.

# Prevalence of COVID-19 in the surrounding community was a major predictor of its effect on nursing homes

**Nursing homes in towns with more cases per person in the community as a whole had more cases and deaths per licensed nursing home bed.**

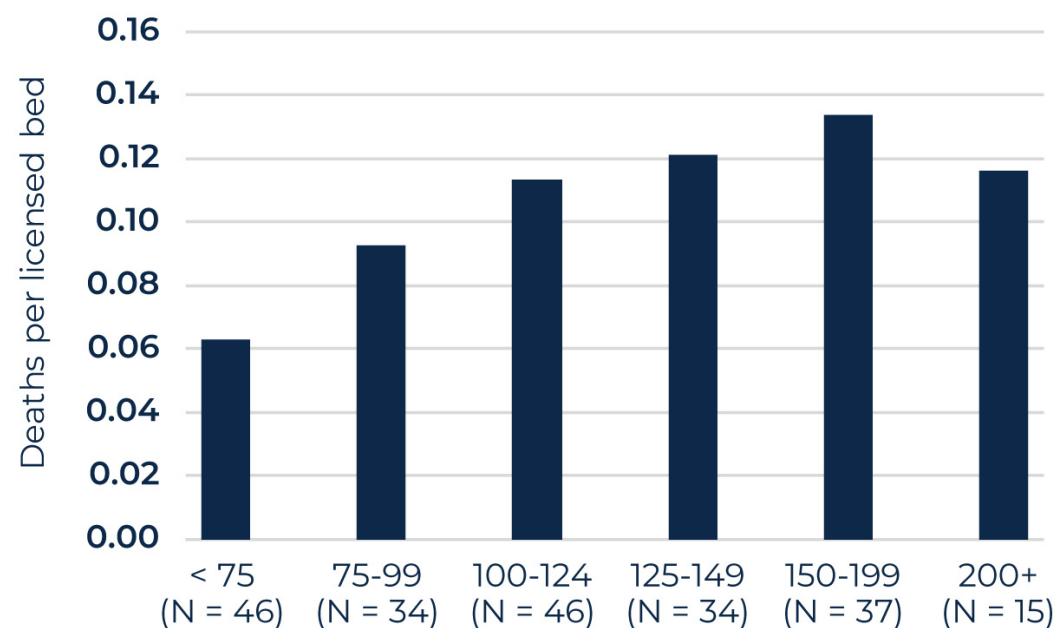
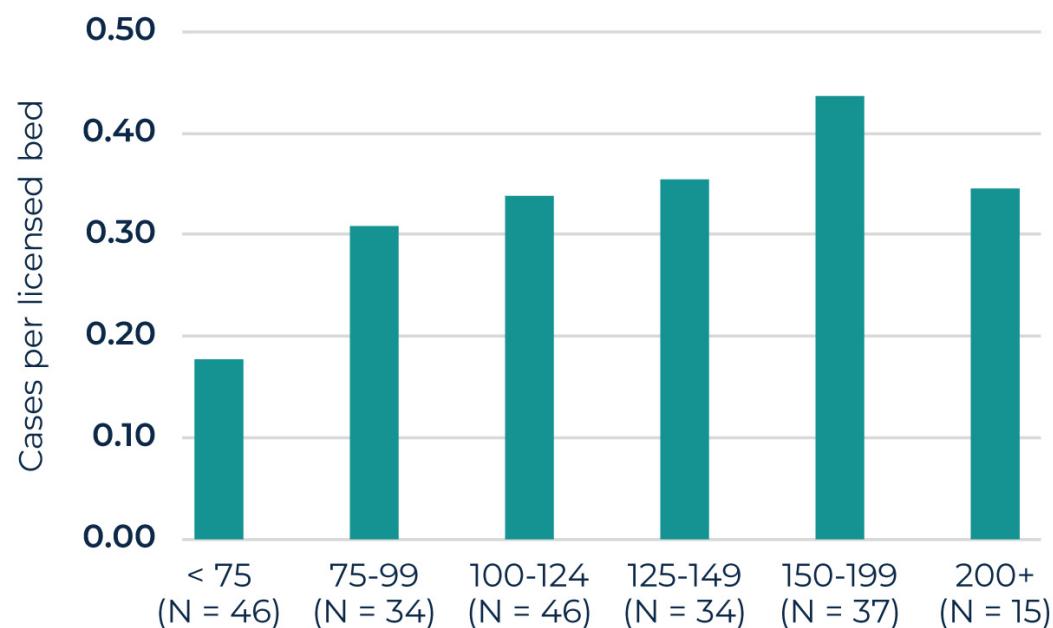


Sources: Mathematica's analysis of nursing-home reported data included in Connecticut's FLIS system and DPH Vital Records data.

Notes: The relationship was highly statistically significant for cases ( $p = 0.003$ ) and deaths ( $p = 0.004$ ). Deaths include both confirmed and probable deaths attributable to COVID-19. Cases in each town exclude all cases reported in nursing homes and assisted living facilities within that town.

# Larger nursing homes had more COVID-19 cases and deaths per licensed bed

## Cases and deaths per licensed bed, by size of nursing home



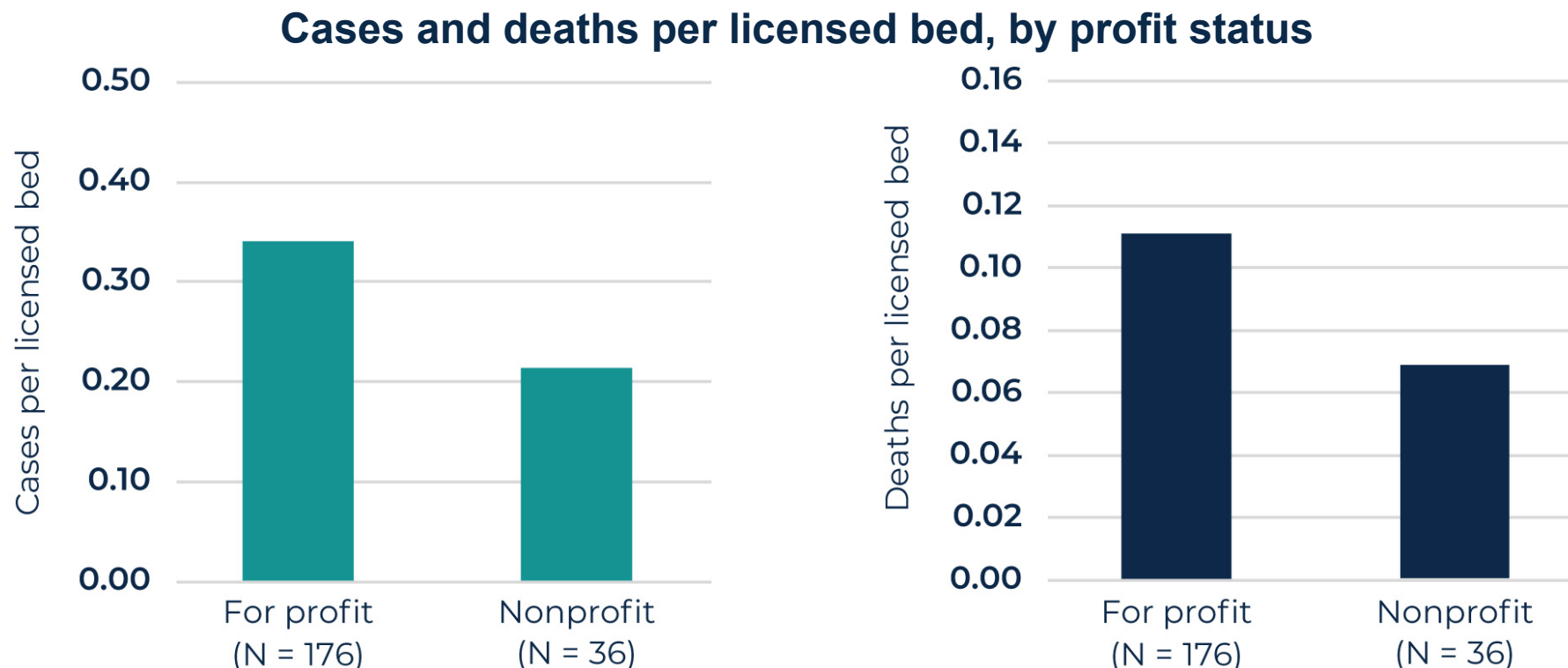
Licensed bed capacity

Licensed bed capacity

Sources: Mathematica's analysis of nursing-home reported data included in Connecticut's FLIS system and Nursing Home Compare data.

Notes: The difference was statistically significant for both cases per licensed bed ( $p < 0.001$ ) and deaths per licensed bed ( $p = 0.001$ ). Deaths include both confirmed and probable deaths attributable to COVID-19.

# For-profit nursing homes had about 60 percent more cases and deaths per licensed bed than nonprofit nursing homes

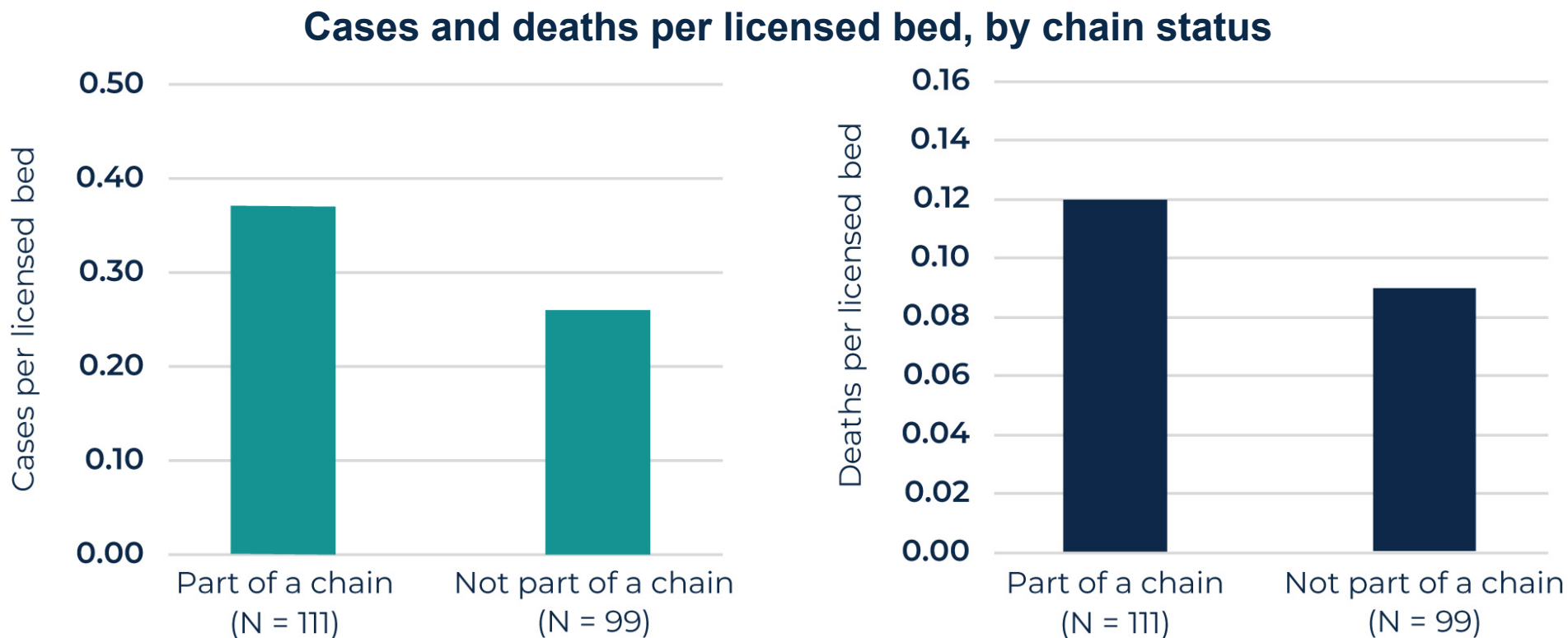


Sources: Mathematica's analysis of nursing-home reported data included in CT's FLIS system and Nursing Home Compare data.

Notes: The difference was statistically significant for both cases ( $p = 0.002$ ) and deaths ( $p = 0.012$ ). Deaths include both confirmed and probable deaths attributable to COVID-19.



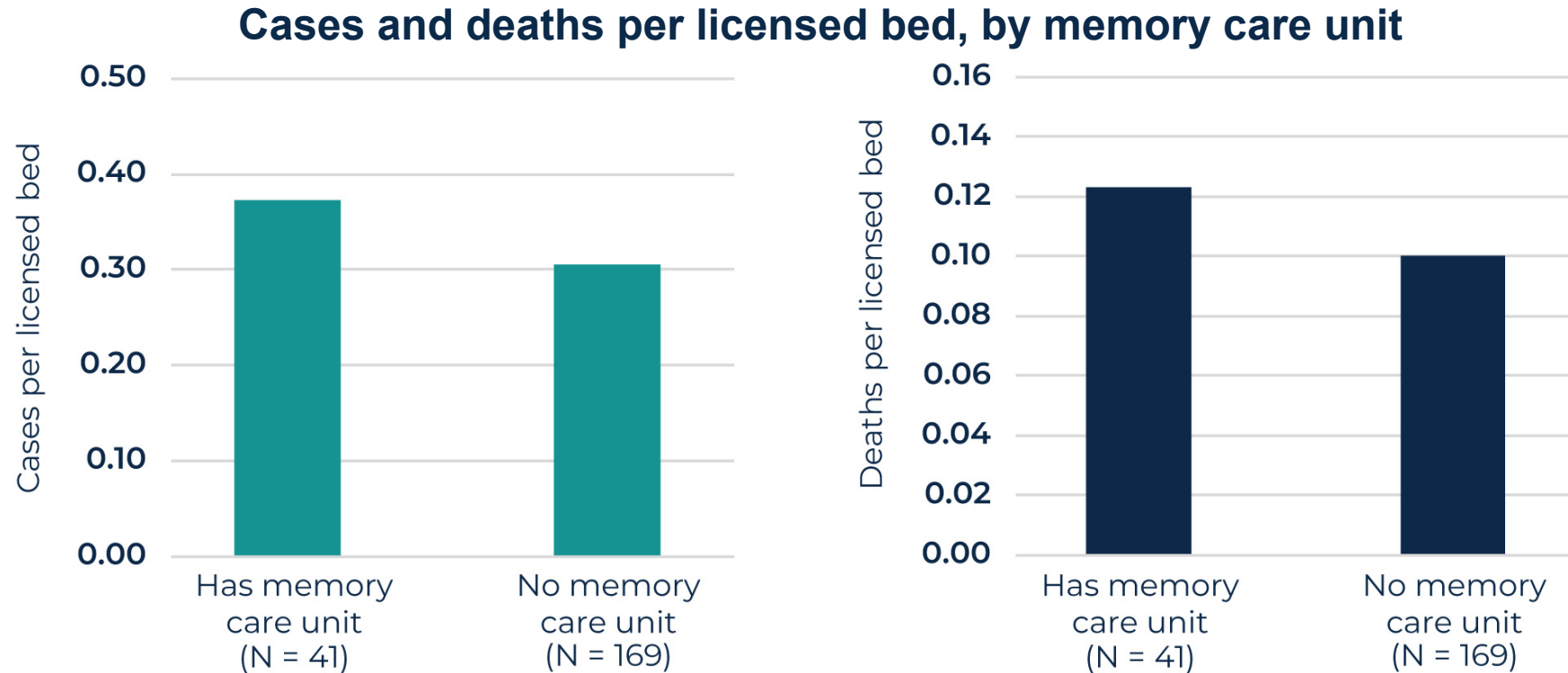
# Nursing homes that were part of a chain had about 40 percent more cases and deaths than independently owned nursing homes



Sources: Mathematica's analysis of nursing-home reported data included in Connecticut's FLIS system and LTC Focus data.

Notes: The difference was statistically significant for both cases ( $p = 0.001$ ) and deaths ( $p = 0.005$ ). Deaths include both confirmed and probable deaths attributable to COVID-19

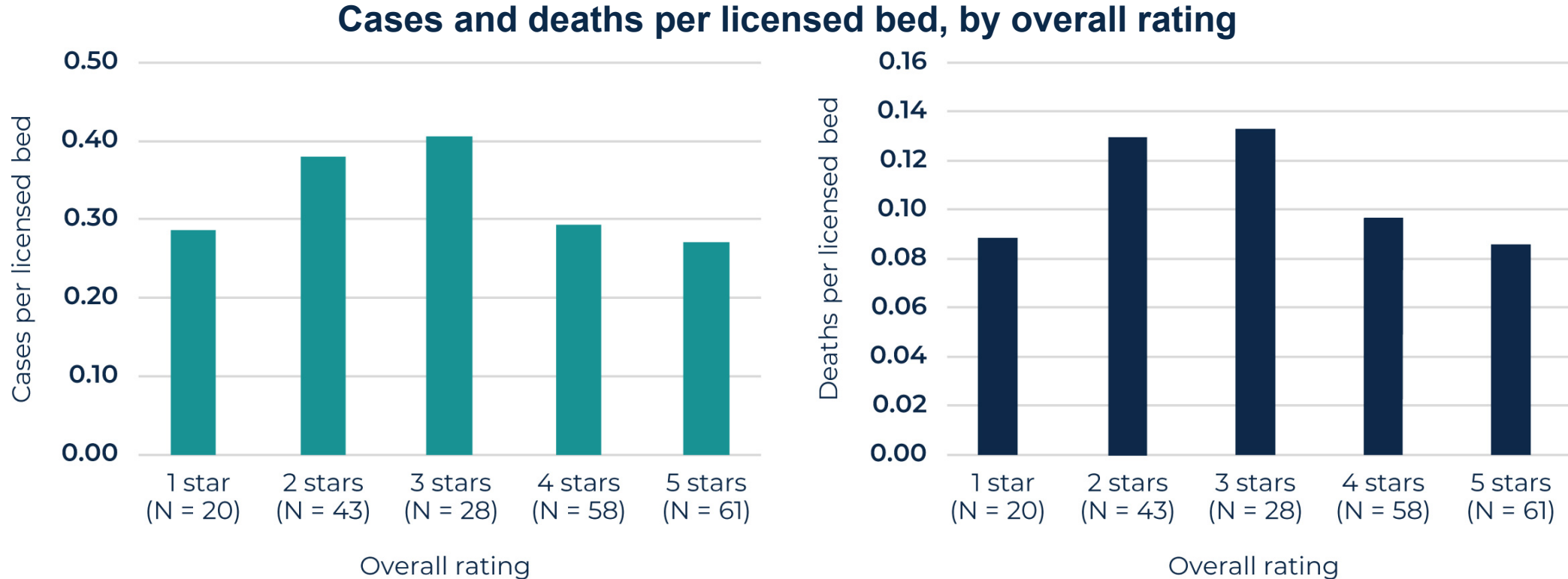
# Nursing homes with a memory care unit had slightly more cases and deaths per licensed bed



Sources: Mathematica's analysis of nursing-home reported data included in Connecticut's FLIS system and LTC Focus data.

Notes: The difference was not statistically significant for cases ( $p = 0.144$ ) or deaths ( $p = 0.154$ ), though this could be because of the small number of nursing homes with memory care units. Deaths include both confirmed and probable deaths attributable to COVID-19.

# Higher rated nursing homes had fewer COVID-19 cases and deaths

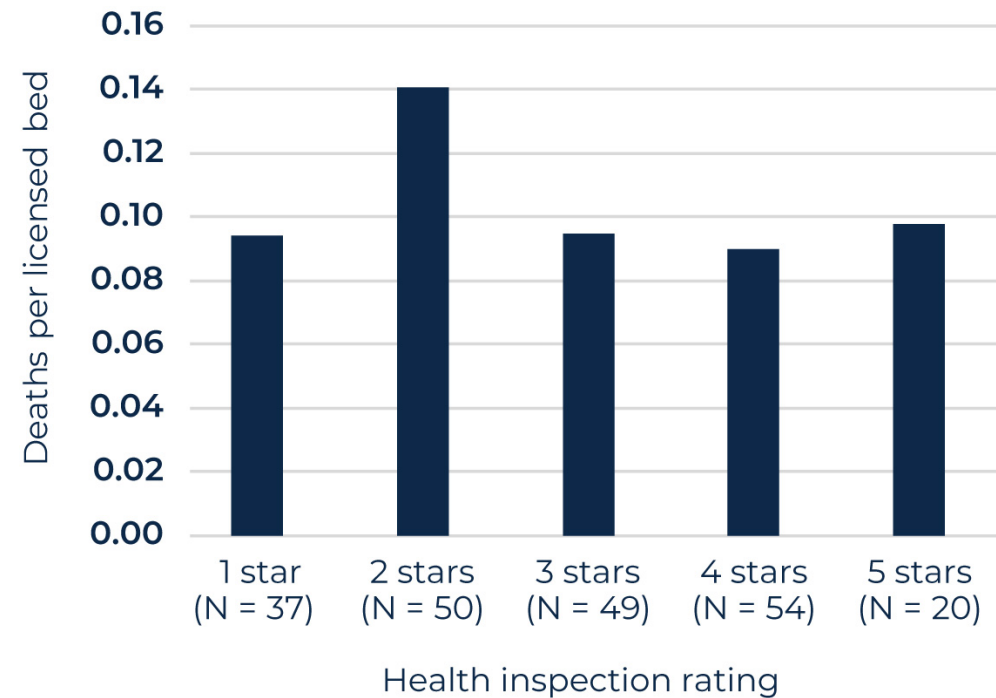
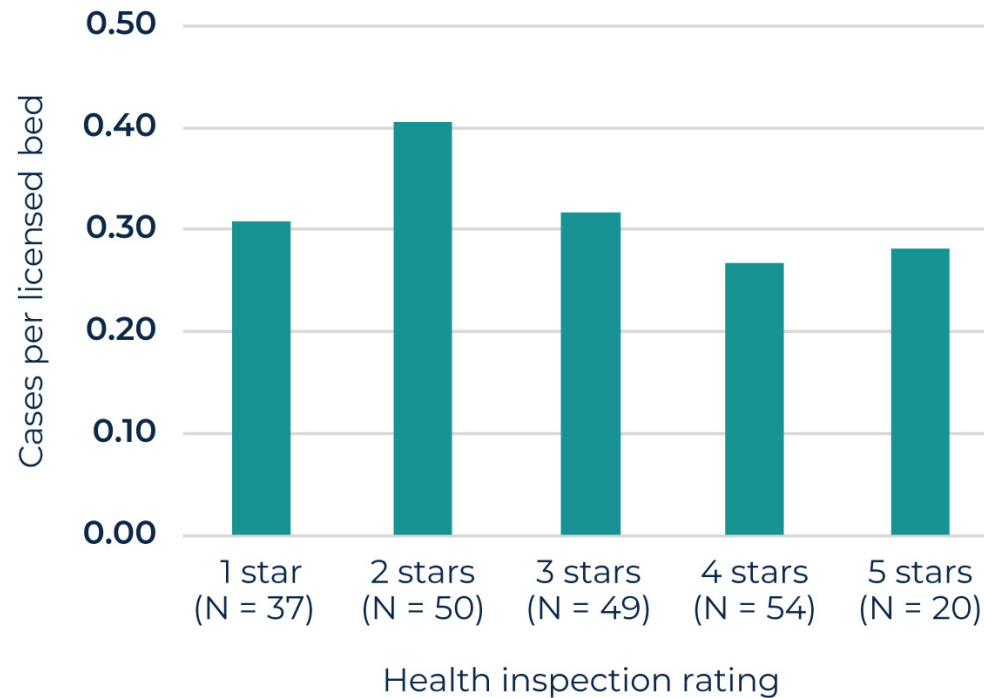


Sources: Mathematica's analysis of nursing-home reported data included in Connecticut's FLIS system and Nursing Home Compare data.

Notes: Comparing nursing homes that had a 4- or 5-star overall rating with those that had a 1-, -2, or 3-star overall rating, we found statistically significant relationships for both cases ( $p = 0.008$ ) and deaths ( $p = 0.010$ ). Deaths include both confirmed and probable deaths attributable to COVID-19.

# Nursing homes with fewer health inspection deficiencies had fewer cases but not fewer deaths

Cases and deaths per licensed bed, by health inspection star rating



Sources: Mathematica's analysis of nursing-home reported data included in Connecticut's FLIS system and Nursing Home Compare data.

Notes: Health inspection star ratings are calculated based on performance on inspections conducted by DPH. Higher ratings indicate better performance on inspections that result in fewer deficiency citations. Comparing nursing homes that had a 4- or 5-star health inspection rating with those that had a 1-, -2, or 3-star health inspection rating, we found a statistically significant relationships for cases ( $p = 0.032$ ) but not deaths ( $p = 0.130$ ). Deaths include both confirmed and probable deaths attributable to COVID-19.



# Nursing homes with higher staffing ratings had fewer COVID-19 cases and deaths

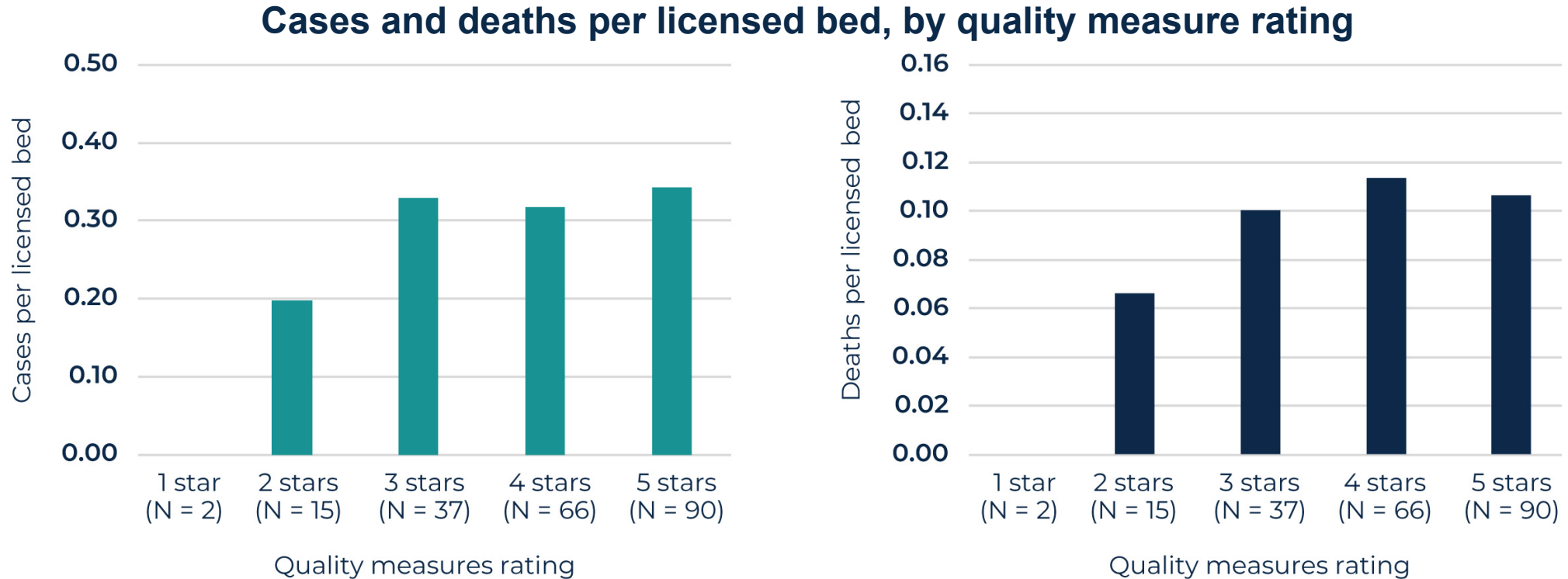
Cases and deaths per licensed bed, by staffing rating



Sources: Mathematica's analysis of nursing-home reported data included in Connecticut's FLIS system and Nursing Home Compare data.

Notes: We compared nursing homes that had a 4- or 5-star staffing rating with those that had a 1-, 2-, or 3-star staffing rating and found a statistically significant relationships for cases ( $p < 0.001$ ) and deaths ( $p < 0.001$ ). Deaths include both confirmed and probable deaths attributable to COVID-19. Outcomes for categories with fewer than 10 nursing homes are omitted.

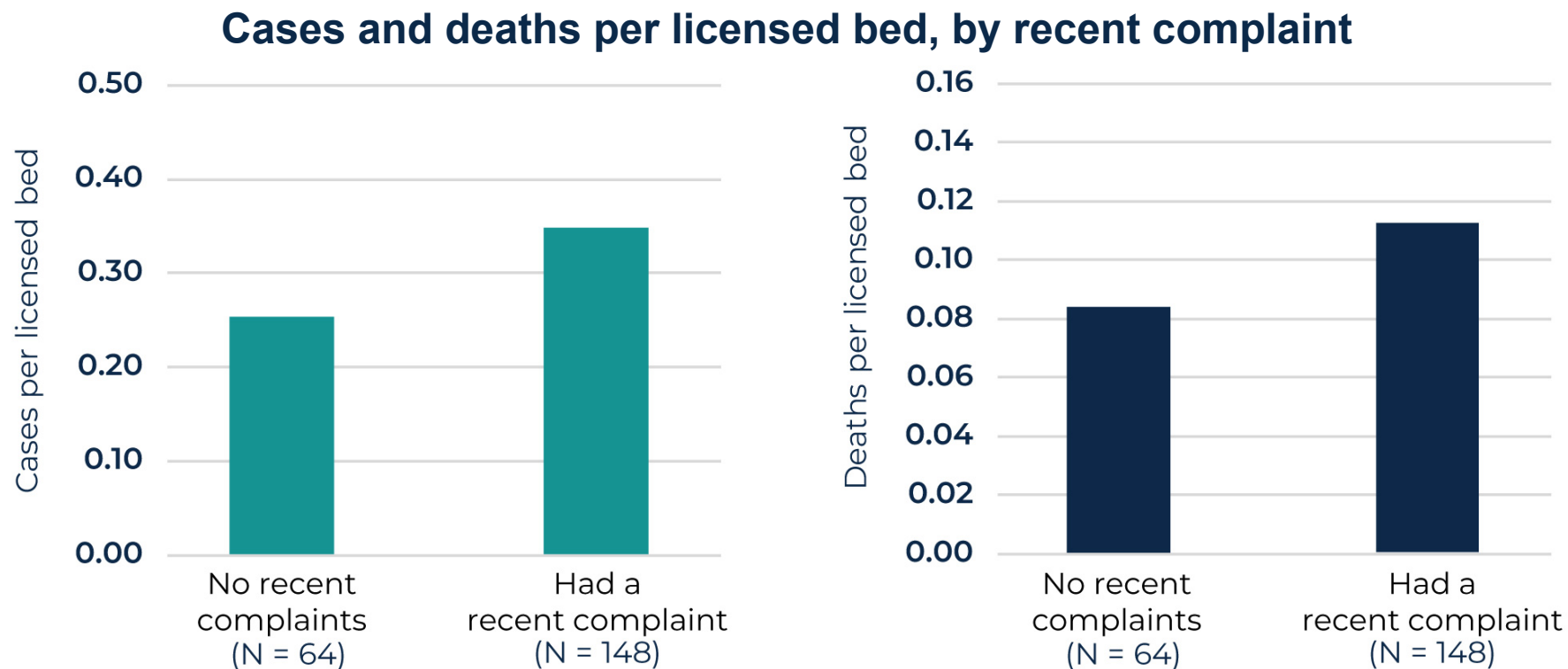
# Quality measure ratings were not predictive of cases and deaths



Sources: Mathematica's analysis of nursing-home reported data included in Connecticut's FLIS system and Nursing Home Compare data.

Notes: We compared nursing homes that had a 4- or 5-star quality measure rating with those that had a 1-, -2, or 3-star quality measure rating and found the relationship was not statistically significant relationships for cases ( $p = 0.345$ ) or deaths ( $p = 0.263$ ). Deaths include both confirmed and probable deaths attributable to COVID-19. Outcomes for categories with fewer than 10 nursing homes are omitted.

# Nursing homes with a recent complaint in the last three years had about 35 percent more cases and deaths than those without a recent complaint



Sources: Mathematica's analysis of nursing-home reported data included in Connecticut's FLIS system and Nursing Home Compare data.

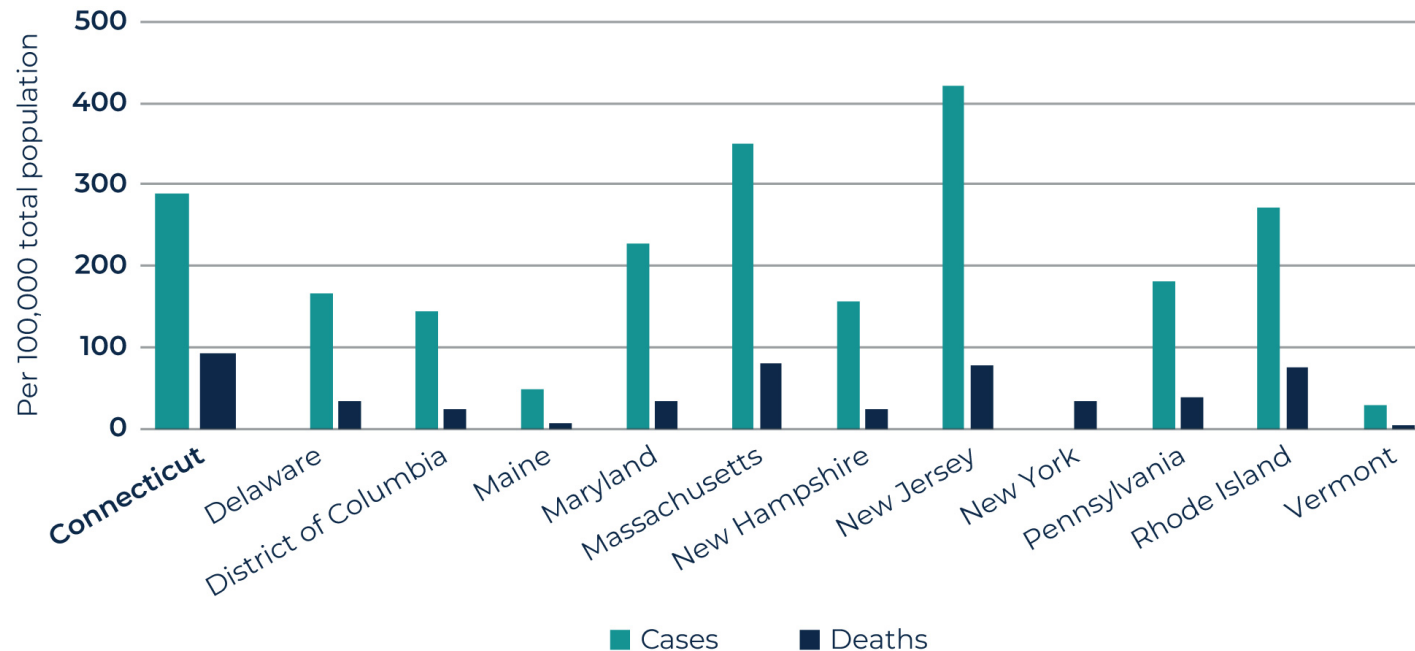
Notes: The difference was statistically significant for both cases ( $p = 0.012$ ) and deaths ( $p = 0.029$ ). Recent complaints are defined as those within the past 36 months. Deaths include both confirmed and probable deaths attributable to COVID-19.

# Data available for individual nursing homes, by state

	Connecticut and comparison states (see next three slides)				Other Northeastern states							
	CT	MA	NJ	RI	DE	DC	ME	MD	NH	NY	PA	VT
<b>Cases by nursing home</b>	■	■*	■	■*	No	■	No	■	No	No	■	No
<b>Deaths by nursing home</b>	■	■	■	■	No	■	No	■	No	■*	■	No
<b>Staff counts by nursing home</b> (after 06/17)	■	■	■	No	No	■	No	■	No	No	■	No

Notes: Cases in Massachusetts are reported only in ranges of 0; 1 to 10; 11 to 30; and greater than 30, combining staff and resident cases. Rhode Island only reports cases in discrete ranges of 5 cases (for example, 41 to 45). New York death data only includes deaths that occurred in the nursing home.

# Although many Northeast states had severe outbreaks in LTC facilities, Connecticut had the highest death rate per population (91 per 100,000 total population)

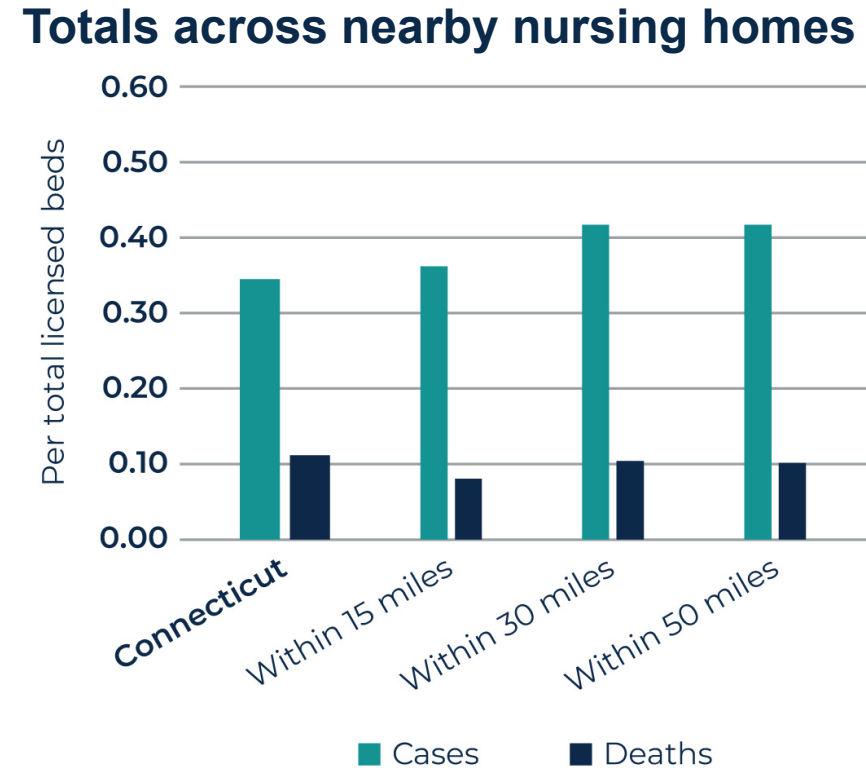
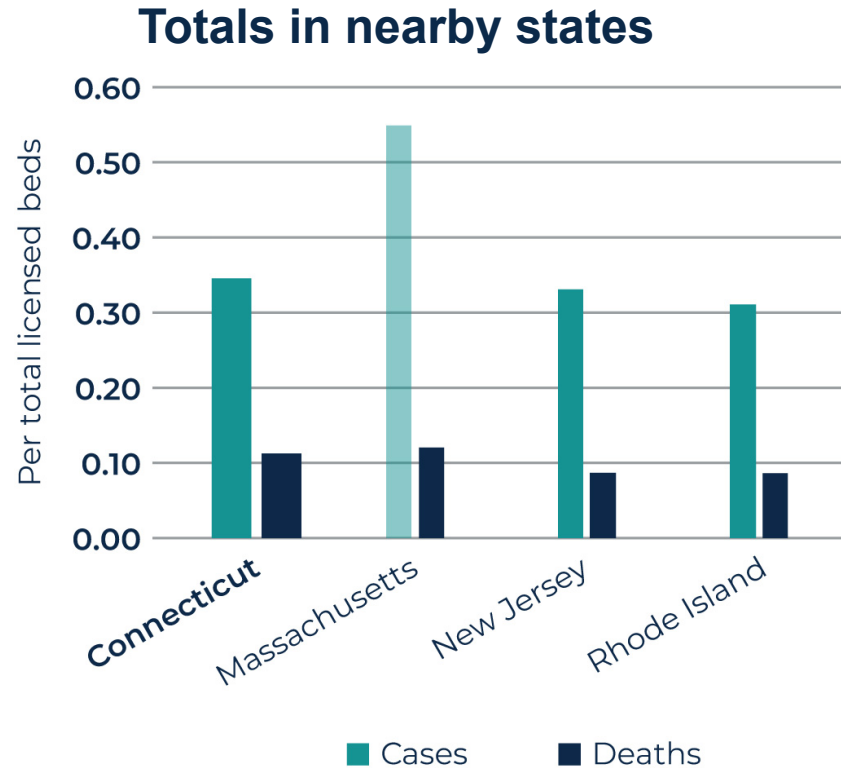


- **Connecticut, Massachusetts, New Jersey, and Rhode Island had more than 70 deaths in LTC facilities per 100,000 total population.**
- **Maine and Vermont had fewer than 10 deaths per 100,000 total population.**

Sources: Mathematica's analysis of aggregate LTC facility data across states reported by the New York Times combined with Census Bureau population estimates.



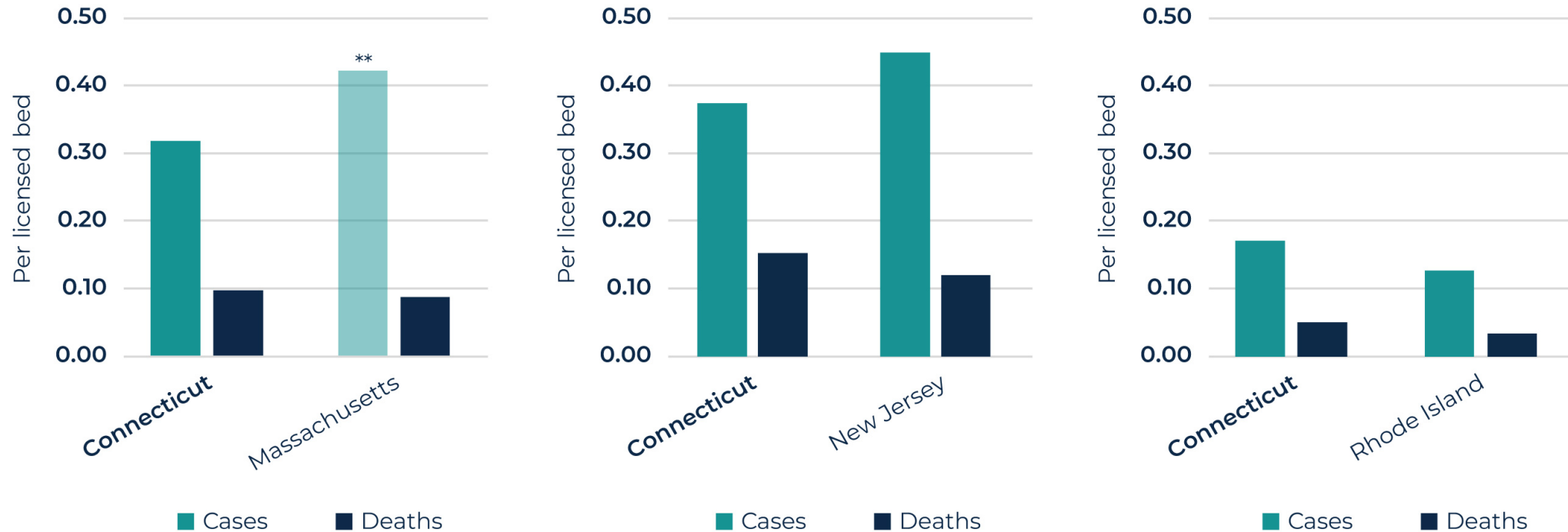
# Total nursing home cases and deaths per licensed bed did not vary much across nearby states



Sources: Mathematica's analysis of state-reported data by individual nursing home matched to Nursing Home Compare data.

Notes: Cases in Massachusetts nursing homes are reported in ranges. We used the number of deaths to impute the number of cases, resulting in total cases that approximately matched the total nursing home cases reported across the state. See appendix for details. Rhode Island and New Jersey do not report information on nursing homes that had zero cases or deaths; the licensed nursing homes not included in the state's data are assumed to have zero cases and zero deaths. Our analysis of nearby nursing homes excludes New York because of data reliability concerns. However, it includes the imputed case counts for nursing homes in Massachusetts.

# Adjusting for nursing home characteristics, deaths remain similar in nursing homes across nearby states



Source: Mathematica's analysis of state-reported data by individual nursing home match to Nursing Home Compare data.

Notes: Cases in Massachusetts nursing homes are reported in ranges. We used the number of deaths to impute the number of cases, resulting in total cases that approximately matched the total nursing home cases reported across the state. See appendix for details. Rhode Island and New Jersey do not report information on nursing homes that had zero cases or deaths; the licensed nursing homes not included in the state's data are assumed to have zero cases and zero deaths. For comparisons with other states, we only included facilities that were within 50 miles of the Connecticut border. Additionally, we only included Connecticut facilities in counties that were sufficiently close to the comparison state, which explains the difference in outcomes for Connecticut. For the comparison with Massachusetts, this included Litchfield, Hartford, Tolland, and Windham; for the comparison with New Jersey, this included Fairfield; for the comparison with Rhode Island, this included Tolland, Windham, New London, and Middlesex.

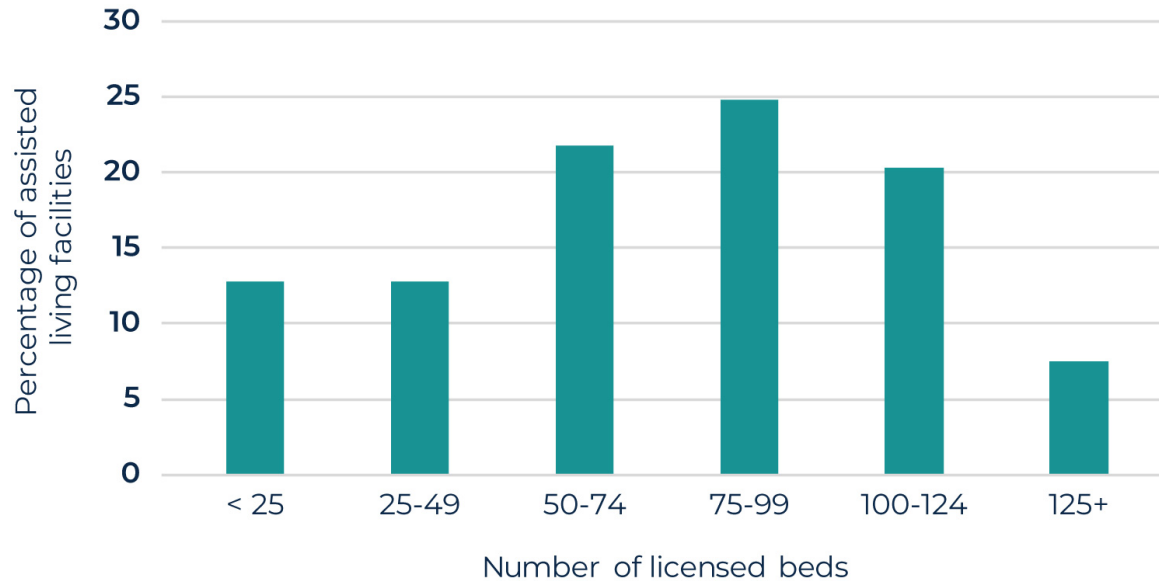
\*\* = statistically significant difference from Connecticut at the 5 percent level.



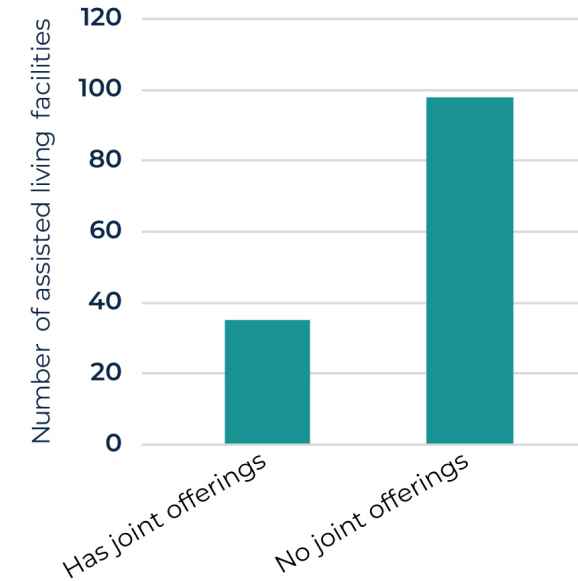
**Impact of COVID-19 outbreak in Connecticut assisted living facilities**

# Characteristics of Connecticut assisted living facilities

## Distribution of assisted living facilities by size



## Distribution of assisted living facilities by joint offerings



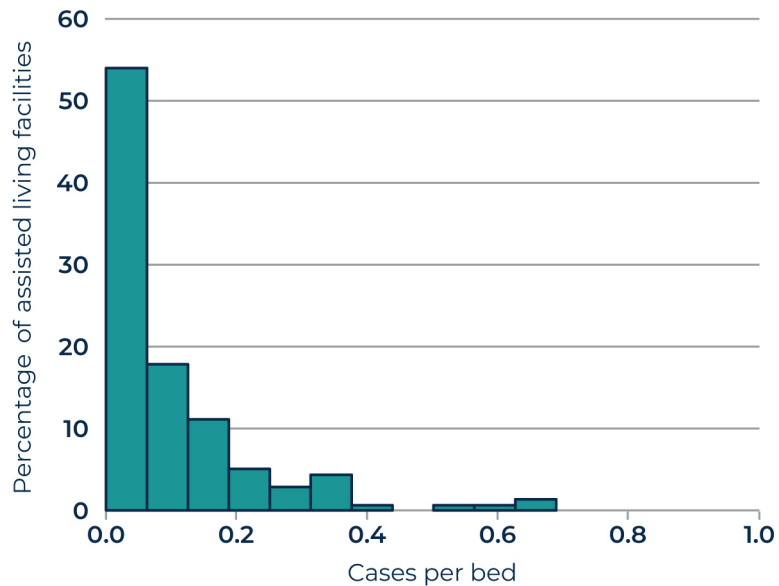
Source: Mathematica's analysis of Connecticut DPH FLIS portal on individual resident data as reported by assisted living facilities.

Notes: This includes 133 assisted living facilities in Connecticut that reported COVID-19 cases or deaths. Joint offerings include those that also have a nursing home, senior independent living, or residential care facility at the same location as reported by assisted living facilities to DPH.

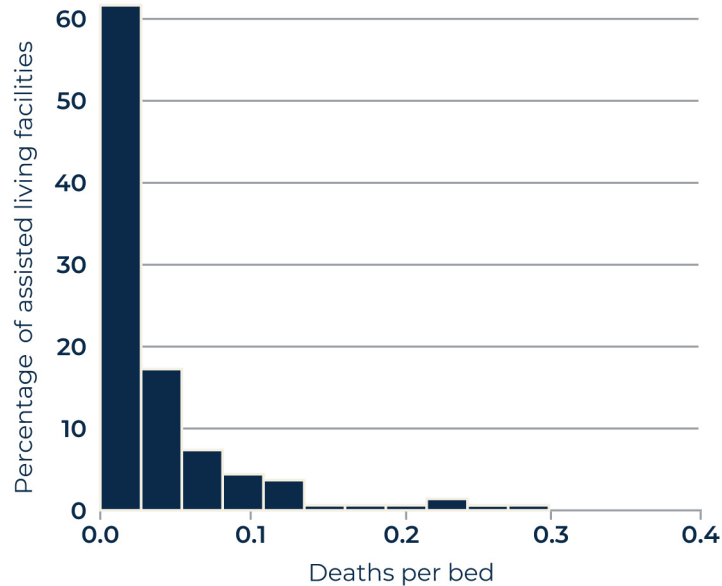


# Many assisted living facilities saw COVID-19 outbreaks, though it was less severe than in nursing homes

### Cases in assisted living



### Deaths in assisted living

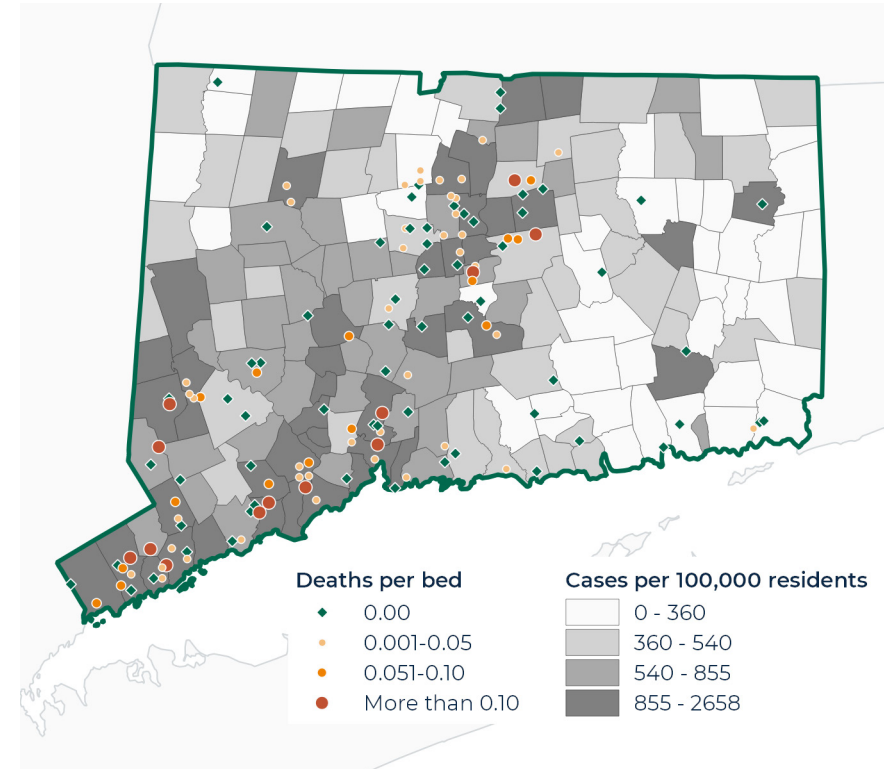
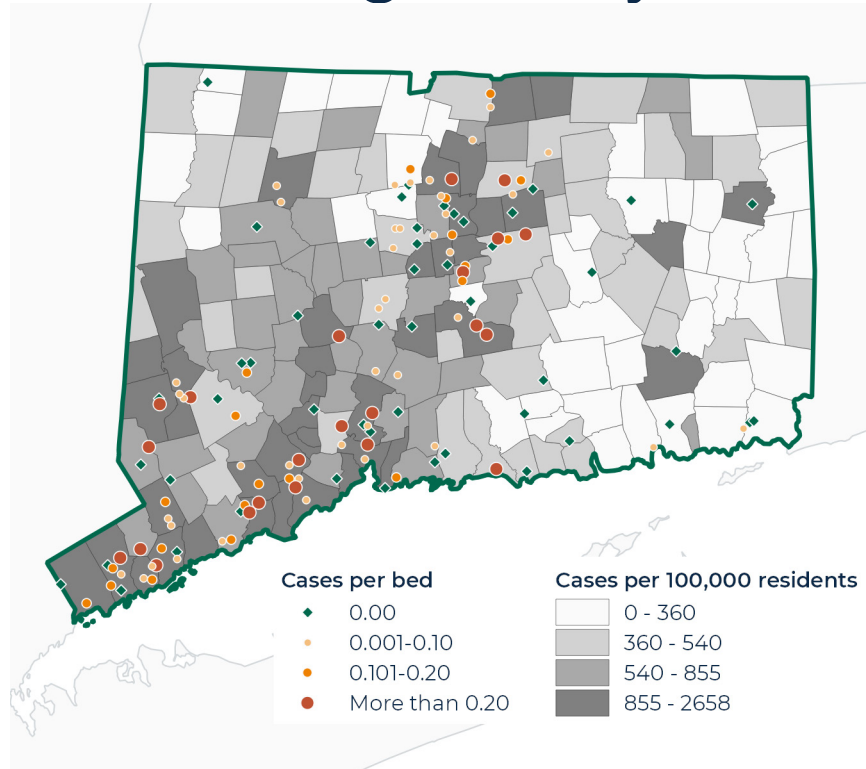


- Only 3 percent of assisted living facilities had more than 50 percent of residents contract COVID-19, and only 3 percent had more than 20 percent of residents die.
- 37 percent of assisted living facilities had zero cases and deaths.

Source: Mathematica’s analysis of Connecticut’s DPH FLIS portal on individual resident data as reported by assisted living facilities.  
Note: Deaths include both confirmed and probable deaths attributable to COVID-19.



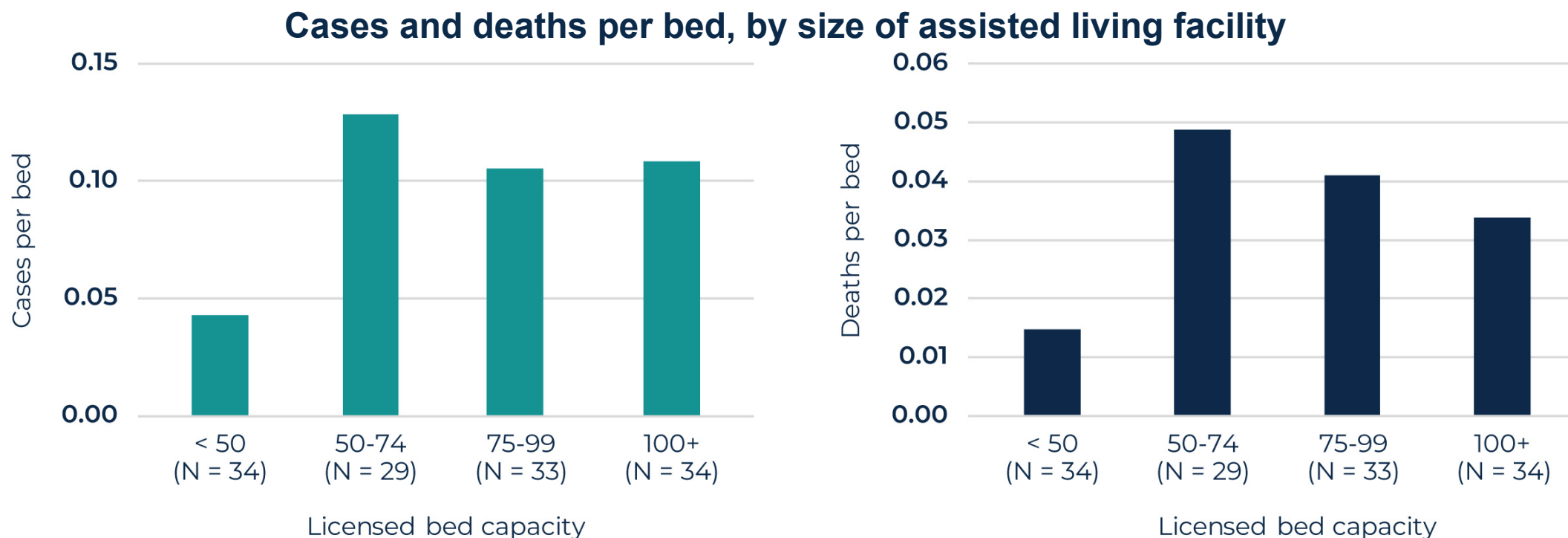
# As in nursing homes, prevalence of COVID-19 in the surrounding community was an important predictor of assisted living facility cases and deaths



Sources: Mathematica's analysis of assisted-living reported data included in Connecticut's FLIS system and DPH Vital Records data

Notes: The relationship was highly statistically significant for cases ( $p = 0.035$ ) and deaths ( $p = 0.023$ ). Deaths include both confirmed and probable deaths attributable to COVID-19. Cases in each town exclude all cases reported in nursing homes and assisted living facilities within that town.

# Larger assisted living facilities had more COVID-19 cases and deaths per licensed bed



Sources: Mathematica's analysis of assisted-living reported data included in Connecticut's FLIS system and DPH Vital Records data.

Notes: The relationship is significant for both cases per bed ( $p = 0.018$ ) and deaths per bed ( $p = 0.049$ ). Deaths include both confirmed and probable deaths attributable to COVID-19. The size of the facility was missing for 28 assisted living facilities; in these instances, we used the current census as the size. Some facilities also might have reported their current census rather than the potential size as the size.

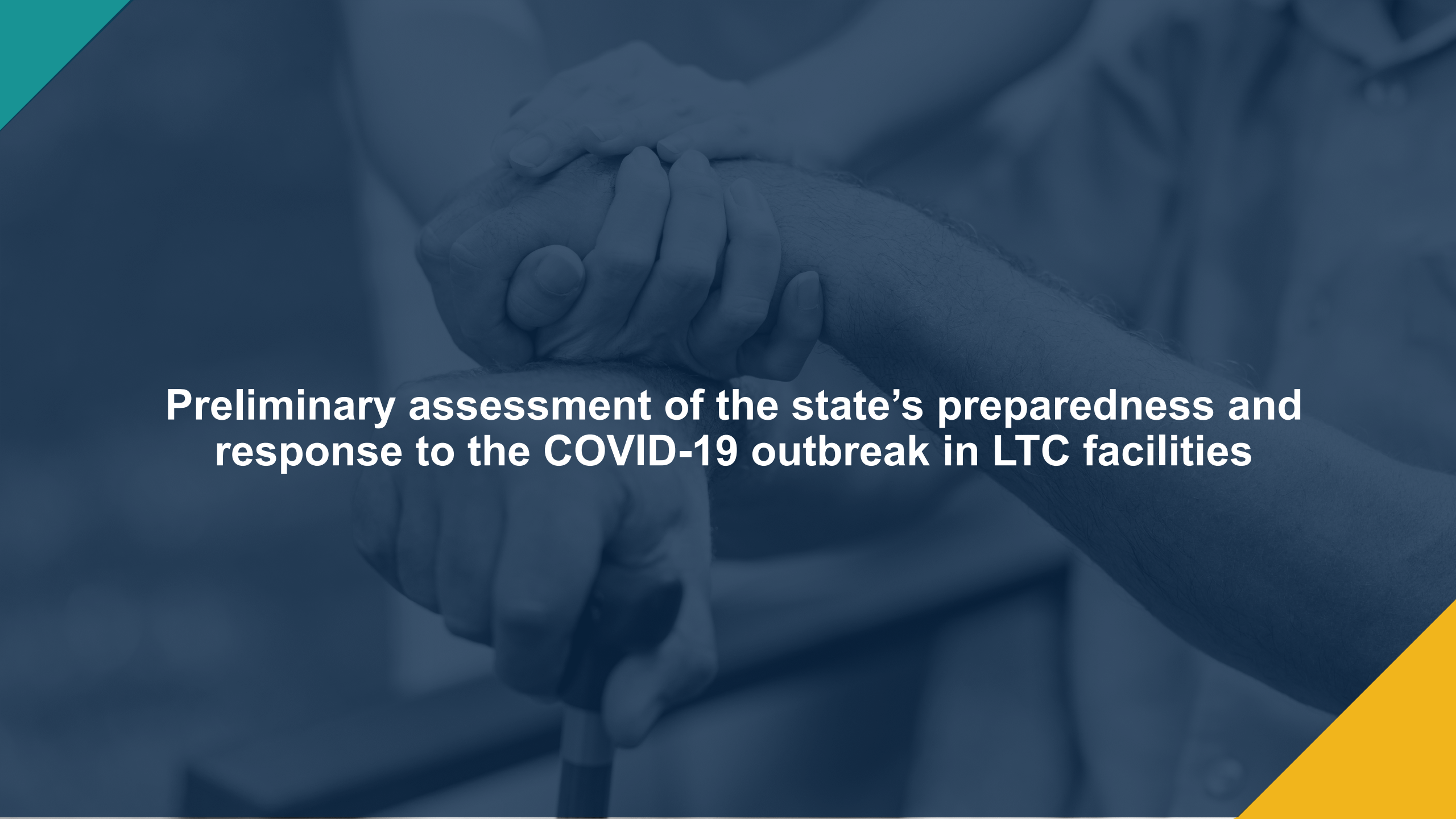
# Reliably comparing outcomes in assisted living facilities across states is challenging

## / Though some states report cases and deaths from COVID-19 in individual assisted living facilities, differences exist in the structure of the data:

- Massachusetts only reports cases in broad ranges, such as with nursing homes; because they do not report deaths, we cannot estimate the true case counts.
- New Jersey does not indicate the type of facility and includes more than 500 total LTC facilities in its data; we could identify comparable nursing homes by merging with [Nursing Home Compare](#).
- Rhode Island only has 12 assisted living facilities with reported data.

## / We therefore do not compare assisted living facility outcomes across states.





**Preliminary assessment of the state's preparedness and response to the COVID-19 outbreak in LTC facilities**

# Regulatory framework for LTC facilities in Connecticut

- ✓ **Nursing homes that are Medicare or Medicaid certified are regulated by a federal or state partnership:**
  - CMS sets the conditions of participation for certification and oversees state compliance with inspection requirements.
  - The state's DPH conducts regular inspections (known as surveys) of licensed nursing homes to ensure compliance with federal and state requirements.
- ✓ **Infection control requirements in LTC facilities:**
  - Nursing homes are bound by federal requirements (42 CFR §483.80b) and the State Public Health Code (§19-13-D11t) to have a dedicated infection preventionist and an infection control committee that meets at least quarterly.
  - The infection preventionist must have primary professional training in nursing, medical technology, or other fields but does not need to be full-time at the facility.
  - Assisted living facilities must be licensed by DPH but are not subject to the same infection control requirements that govern nursing homes.



# State preparedness

## Surveillance and outbreak response

- DPH and FLIS data collection systems were paper or faxed-based at the beginning of the COVID-19 outbreak; daily electronic reporting from facilities to the state did not begin until May 8, 2020.
- The data system that DPH used to monitor infection control outbreaks did not sufficiently capture cases in nursing homes and assisted living facilities, so the state had to develop new systems and refine existing systems to monitor COVID-19 by type of facility.

## Infection control

- Similar to other states, Connecticut had insufficient PPE at the start of the outbreak in the state's LTC facilities.



# State preparedness (*continued*)

## / Emergency response

- Existing emergency response and surveillance systems were insufficient for the COVID-19 outbreak.
  - Connecticut's DPH had a robust emergency response continuity of operations plan that outlined roles and responsibilities, the structure of the joint incident command, and communication expectations, but the plan focused exclusively on hospitals and did not explicitly address LTC facilities.
  - The plan assumed a sufficient supply of PPE and that only non-infected staff would work in health care facilities.
- As of January 2020, 6 of 9 positions in the Office of Public Health Preparedness and Response were vacant. These positions were filled by July 2020, but the vacant positions in January indicate insufficient capacity to monitor and manage emergencies at the start of the pandemic.

# Overview of the state response

- / Early responses to the COVID-19 outbreak were undermined by gaps in scientific knowledge about how the virus spreads, the range and severity of symptoms (especially in older adults), and underlying factors that might place an individual at greater risk.**
  - Scientific knowledge and understanding of the virus has evolved over time, but much remains unknown.
- / State officials made policy decisions and issued guidance based on the available knowledge at the time from national and state epidemiologists and public health experts.**
- / The rationale for all ongoing state decisions should be continually assessed based on the following:**
  - Daily monitoring of new cases and deaths in LTC facilities and the state as a whole
  - Newly emerging evidence
  - Updated guidance from the Centers for Disease Control and Prevention and state public health experts



# State response

## / Surveillance and outbreak response

- The state required LTC facilities to report detailed data via the DPH FLIS portal on cases, deaths, transfers to the hospital, available beds, and other critical indicators.
- In accordance with federal requirements, Connecticut stopped normal survey operations and focused its resources on conducting surveys focused on infection control and following up on complaints that represented immediate jeopardy to residents.
- The state used National Guard resources to conduct focused surveys and hired per diem nurse consultants to augment existing survey staff. The National Guard also counted PPE supplies to ensure DPH had accurate information to inform distribution of PPE.
- Beginning in May, the state assigned surveyors to each region to ensure continuity between surveyors and nursing homes.
- According to [CMS reports](#) of nursing home surveys conducted between March 4 and June 28, 2020, Connecticut did not issue any citations for infection control-related deficiencies to any nursing homes.
  - Mathematica will examine the state's survey data for the final report to determine whether the absence of citations during this period was justified by the survey results.



# State response (*continued*)

## / Infection control

- State guidance on infection control tended to follow federal guidance rather than proactively respond to the rapidly evolving situation in Connecticut and neighboring states.
  - For example, Connecticut issued a universal masking order for personnel in all health care facilities on April 4, 2020, one day after the U.S. Coronavirus Task Force called for universal masking for the general public. In contrast, New York implemented a masking order for personnel in all health care facilities on March 13, 2020.
- Starting in April, the state began to distribute PPE to facilities weekly. Facilities did not place orders or request specific supplies but were provided with equipment based on their size and the extent of the outbreak in each facility. Industry stakeholders reported that although the state-provided PPE comprised a small share of their total PPE, the state played a useful role as supplier of last resort.
- DPH's Infectious Disease section and local public health nurses provided guidance to LTC facilities on infection control. Infectious Disease section staff reported being challenged by the need to directly help facilities while balancing surveillance duties, and some public health nurses reported they did not have the guidance they needed from DPH to help support facilities directly.



# State response (*continued*)



## Emergency response

- The state partnered with the industry to open four CRFs across the state. Planning for these facilities began in mid-March, and the DPH commissioner granted authority to operate on April 11.
  - Initially, CRFs only allowed admissions from the hospital; this was later amended to allow LTC facilities to voluntarily transfer residents to CRFs if they could not care for them in place.
  - Industry stakeholders supported the establishment of CRFs and believe they could play a critical role responding to a potential second wave of COVID-19.



## Staffing and workforce availability

- Connecticut has implemented a variety of strategies to address LTC workforce availability shortages.
- The state authorized the creation of a temporary nurse aide position to address LTC facility staffing shortages, which enabled people who completed eight hours of online training to work under the supervision of nursing staff with residents who were COVID negative.
- The state temporarily allowed staff licensed in other states to temporarily work in Connecticut health care facilities.



# State response (*continued*)

## / Screening and testing of residents and staff

- Testing in March was limited to hospital staff and patients, so LTC residents were transferred to hospitals for testing and care.
- The state laboratory expanded its testing capacity by doubling staff with the competency to test for COVID-19, but social distancing requirements and material shortages limited capacity. The state laboratory also called on partner labs to ramp up to prepare for increased testing.
- The state conducted a point prevalence survey in mid-May to test all nursing home residents for COVID-19. This survey excluded residents who had previously tested positive and did not include LTC facility staff.
- After ordering on June 1, 2020, that LTC facility staff and residents had to be tested on a weekly basis, DPH implemented a Care Partners program that paired facilities with one of eight designated testing contractors and funded these partners to order, conduct, and report testing results to the state.
  - The state initially committed to covering the cost of testing through August 31, and, on August 6, extended the policy for at least two more months.
  - Industry stakeholders appreciated the dedicated capacity of this partnership, but some facilities felt that partner assignments interrupted their existing (and carefully negotiated) testing contracts with private labs.



# State response (*continued*)

## / Reimbursement mechanisms

- Connecticut provided a 10 percent across-the-board increase in Medicaid payments to nursing homes for the period March 1 through April 30, which was applied to employee wages, new costs related to visitor screening, PPE, and cleaning and housekeeping supplies, and other COVID-related costs.
  - o The state also distributed funding from the Coronavirus Relief Fund to nursing homes (except COVID Recovery Facilities). The targeted funding level for this funding approximated the value of an additional 10 percent increase in April and 20 percent for May and June.
- In addition, facilities could apply for hardship grant applications for consideration of expenses that exceeded those covered by these additional funds.
- The state paid a flat rate of \$600 per bed per day to COVID Recovery Facilities.
- LTC facilities appreciated the state's financial support to help offset increased facility costs and lost revenue, but many believed it was still insufficient to cover the increased costs of staffing, PPE, and changes to the physical environment.



# State response (*continued*)

## / **Communications with LTC industry stakeholders**

- DPH regularly met with the LTC industry. The Mutual Aid Plan website became a repository for recordings of these calls and other written guidance for facilities.
  - Stakeholders reported that the quality of the communication from the state improved over time. In addition, they appreciated the use of the Mutual Aid Plan website as a central location for relevant information.
  - Some facilities reported that written guidance came out weeks after calls with DPH. In the meantime, facilities, in some cases, were unsure how to implement policies discussed in these calls.
- DPH distributed iPads to all facilities to enable video calls between family members and residents.





**Preliminary assessment of the LTC industry's preparedness  
and response to the COVID-19 outbreak**



# Industry preparedness



## Surveillance and outbreak response

- Before the COVID-19 outbreak, industry practice was to report infectious disease outbreaks when there were three or more cases of a lab-confirmed infection.



## Infection control requirements

- Before the outbreak, 68 percent of Connecticut nursing homes had been cited for an infection-control deficiency at least once in the previous three years of inspections.
- Interview respondents cited high turnover among infection control staff, resulting in many positions being filled with inexperienced staff or going unfilled.



## Staffing and workforce availability

- In the first quarter of 2020, unemployment in Connecticut was less than 4 percent. A tight labor market exacerbates existing challenges hiring staff for low-wage jobs in LTC facilities.
- In the final quarter of 2019, Connecticut nursing homes reported staffing levels largely in line with the averages across the United States, with slightly lower registered nurse hours per resident than New Jersey and Rhode Island, and slightly higher nurse aide hours per resident than Massachusetts and New Jersey.

# Industry response



## / Infection control

- Facilities differed in their approach to caring for COVID-19-positive residents. Many nursing homes could care for positive residents in place with changes to their physical environment, but most assisted living communities chose to transfer residents to skilled nursing facilities or the hospital rather than providing care in place.
- Facilities made numerous changes to their physical environment to control the COVID-19 outbreak:
  - Cohorting residents based on their COVID-19 status, which allowed for physical separation of COVID positive residents from those who were negative
  - Taking advantage of the decreased census to allow for more private rooms and to use other areas of the facility, such as dining rooms or activity rooms. to spread residents out
  - Restricting the number of entrances and exits to a facility to enable monitoring of everyone entering facilities, using HEPA air filters, and, in some cases, using negative pressure machines in rooms of COVID-19-positive residents.
- As with other health care settings, LTC facilities struggled to acquire adequate supplies of appropriate PPE at the beginning of the outbreak.
  - Facilities that were part of larger corporations were often able to leverage their size and purchasing power to negotiate PPE with suppliers. Others turned to nontraditional suppliers, such as eBay or Amazon, to procure the necessary equipment.
  - The state required that LTC facilities conduct fit testing for N95 masks, but facilities reported challenges scheduling fit tests for their staff in a timely manner.

# Industry response (*continued*)



## Staffing and workforce availability

- Staff absences: Facilities reported increased staff absences as a result of difficulties related to childcare, staff preexisting conditions that placed them at greater risk of coming to work, and fear of catching the virus or bringing it home to their families.
- Staff shortages: Facilities had to compete for direct care staff throughout the region, including in New York City where hospitals and other settings were offering very competitive financial incentives.
- Incentives: Facilities used both financial and non-financial incentives to attract and keep staff, such as bonuses, hazard pay, and provision of meals during shifts.



## Screening and testing of residents and staff

- Industry approach to screening and testing was largely driven by changing guidance from the State and Federal agencies as the scientific understanding of the virus evolved. The response was further driven by limited testing availability, particularly in the early stages of the outbreak.
- Early screening and testing of residents was limited to individuals exhibiting COVID-related symptoms. With the support of DPH, a point prevalence survey was conducted over a three-week period in May 2020 to universally test all LTC facility residents.
- Early screening of staff focused on symptoms and travel outside the region but evolved to include temperature checks and more specific screening questions about behavior outside of work. Facilities differed in their approach to the screening, with some asking staff to self-report symptoms and temperatures, and others dedicating staff to physically conduct this screening of all staff every day.



# Industry response (*continued*)

## / Communication

- Industry stakeholders reported that the quantity and clarity of the communication received from DPH and other state agencies improved over the course of the outbreak.
  - Industry stakeholders also praised the role of the two nursing home trade associations in disseminating information from the state and serving as a liaison to the state.
- The residents and family members we interviewed reported mixed experiences with the communication from their facility to residents and family members.
  - Some facilities struggled to provide adequate and timely updates to family members on the status of the outbreak in the facility as well as specific updates on individual residents as needed.
  - Facilities that designated family member liaisons to provide regular updates or answer family member phone calls seemed to do a better job disseminating information in a timely manner.





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## **Appendix A: About this report**

# Appendix A: About this report

This report is based on data collection and analysis conducted from July 13 to August 7, 2020, using publicly reported information, data provided by the Connecticut Department of Public Health to Mathematica, and interviews with key stakeholders. Mathematica did not assess the specifics of any individual facility's or resident's experience.

This report examines state policies for, and responses by, nursing homes and assisted living communities. Mathematica uses the terminology long-term care facilities when the finding or recommendation is relevant to both settings. Mathematica did not assess intermediate care facilities or other residential care settings beyond nursing homes and assisted living communities.

Mathematica did not conduct any in-person visits to nursing homes or assisted living communities because of state requirements restricting visitation in these settings. Instead, Mathematica conducted all stakeholder interviews by telephone and video conference. Interviews were conducted with a sample of state agency staff, facility administrators, trade association representatives, labor representatives, legislators, and family members of residents living in long-term care facilities. Interviews to inform the final report are ongoing at the time that this report was published.

The preliminary recommendations contained in this interim report are intended to inform the state and industry's near-term response to a potential second wave of COVID-19. A final report will be submitted by September 30, 2020, that will focus on longer-term changes the state and industry can make to prevent and respond to future infectious disease outbreaks. The recommendations contained in this interim report are based on Mathematica's professional expertise using the information available to Mathematica at the time. Therefore, these preliminary recommendations might not represent the full spectrum of actions that the state and industry could consider in response to a potential second wave of COVID-19.





## **Appendix B: Methodology**

# Analysis of data in Connecticut nursing homes

## / Connecticut provides weekly updates on cases and deaths in individual nursing homes.

- In this report, Mathematica used data as of July 30, 2020, specifically focusing on the cumulative data reported to DPH through July 21, 2020.
- The list of 212 nursing homes was matched to Nursing Home Compare and LTC Focus to get nursing homes characteristics. Using the licensed size of the facility, Mathematica calculated the number of cases and deaths per licensed bed in each nursing home.

## / We then described the characteristics of the nursing homes. Additionally, we reported on outcomes by certain characteristics of the nursing home.

- Mathematica calculated mean COVID-19 cases and deaths per licensed bed and used statistical tests to assess if the characteristic was associated with outcomes.
- For all characteristics except town cases per capita and size of the facility, Mathematica did a bivariate comparison that tested for a significant difference in means.
- For characteristics defined by facility star ratings, Mathematica compared those with a high rating (4 or 5 stars) to those with a lower rating (1, 2, or 3 stars). For town cases per capita and size of the facility, Mathematica used a linear regression model to assess if more local cases or a larger facility were associated with more cases and deaths in the nursing home.



# Comparing nursing homes in Connecticut and other states

- ✓ **Massachusetts, New Jersey, and Rhode Island all report cases and deaths in individual nursing homes.**
  - For each state, Mathematica used data reported by July 31, 2020.
- ✓ **Massachusetts reports case counts in ranges of 0; 1-10; 11-30; and more than 30.**
  - To impute the number of cases, Mathematica first calculated a potential number of cases by multiplying the number of deaths by 4.75. For those with cases in the 1-10 and 11-30 range, if the number of potential cases was larger than the midpoint of the range (i.e., 5 or 20) but smaller than the maximum value, then we used the number of potential cases. If the number of potential cases was below the midpoint, then we used the midpoint. If the number was above the maximum value, then we used the maximum value. For those with more than 30 cases, if the number of potential cases was larger than 30 but less than the number of licensed beds, we used the number of potential cases. If the number of potential cases was less than 30, we estimated the nursing home had 45 cases. If the number of potential cases was more than the number of licensed beds, we used the number of licensed beds. After imputing, the total number of cases summed across all individual facilities (24,148) nearly exactly matched the aggregate numbers [reported](#) by the state as of July 29 (24,124).
- ✓ **Rhode Island reports case and death counts in ranges of 5 (e.g., 45-49).**
  - Mathematica imputed the number of cases or deaths to equal the midpoint (e.g., 47).

# Comparing nursing homes in Connecticut and other states *(continued)*

- ✓ **After making any adjustments to case and death counts, we matched the individual nursing homes with Nursing Home Compare data. If a nursing home could not be matched to Nursing Home Compare, it was excluded from the analysis.**
  - For example, Massachusetts reported data on nursing homes that do not accept Medicare payments and are thus not regulated by CMS; these nursing homes were excluded as outcomes might inherently differ.
  - Because New Jersey and Rhode Island did not report information about nursing homes that had zero cases and deaths, nursing homes with data in Nursing Home Compare but were unmatched to the state data were included and assumed to have zero cases and deaths.
- ✓ **We then estimated a regression model comparing outcomes at nursing homes within Connecticut but close to the neighboring state to outcomes at nursing homes in the neighboring state that were within 50 miles of the border with Connecticut. Results were approximately similar if using facilities only within 35 miles of the border.**
  - For the comparison to Massachusetts, Connecticut counties included Litchfield, Hartford, Tolland, and Windham; for the comparison to New Jersey, Connecticut counties included Fairfield; for the comparison to Rhode Island, Connecticut counties included Tolland, Windham, New London, and Middlesex.
  - The regression model controlled for the number of licensed beds, the overall rating, the number of cases in the county per capita, the number of reported total nurse hours per resident per day, the percentage of licensed beds typically filled, and whether the nursing home was for profit, part of a chain, or had a memory care unit.

# Analysis of data in Connecticut assisted living facilities

- ✓ **Connecticut provides weekly updates on cases and deaths in individual assisted living facilities. In this report, Mathematica used cumulative cases and deaths as of July 30, 2020.**
  - The Department of Public Health provided Mathematica with a list of assisted living facilities and their licensed size. For facilities that did not have a licensed bed size, Mathematica used the total number of beds included in the weekly report from [June 19](#).
  - After this, 28 facilities still did not have a licensed bed size. For these 28 assisted living facilities, Mathematica used the current census as the number of beds. Based on the number of beds, Mathematica then calculated the number of cases and deaths per bed in each assisted living facility.
- ✓ **Mathematica then described the characteristics of the assisted living facility. Additionally, we then reported outcomes by certain characteristics of the facility.**
  - For town cases per capita and size of the facility, Mathematica used a linear regression model to assess if more local cases or a larger facility were associated with more cases and deaths.

# Approach to document review and stakeholder interviews

## / Document review

- Upon contract award, Mathematica requested a list of relevant documents from state agencies for review. These included Continuity of Operation Plans for relevant state agencies, documentation related to the emergency response structure and Joint Incident Command, regulations governing nursing homes and assisted living facilities, documentation of facility inspections, and documentation related to facility reporting requirements. As we learned about the existence of additional documentation from interviews, we supplemented our initial request to add new sources.
- Each document was reviewed by at least two members of the Mathematica team and relevant takeaways were extracted and coded according to category and themes (personal protective equipment, testing, communications, regulatory framework, reimbursement, facility staffing, COVID-19 recovery centers, infection control, and other).

## / Interviews

- Mathematica conducted 30 interview sessions with about 60 people from July 27 to August 7. Interviews were semistructured to ensure we obtained comparable information from each interview while allowing for enough open-ended discussion to solicit unique experiences and recommendations.
- Interviews were conducted with a sample of state agency staff, facility administrators, trade association representatives, labor representatives, legislators, and family members of residents living in long-term care facilities. Interviews are ongoing, and those conducted after August 7 will inform the final report.
- Interviews were recorded with permission, and summary notes were generated from each interview. A systematic analysis of interview notes is ongoing and will serve to inform the final report.

# Organizational affiliations of stakeholder interviews

## Elected officials

Representative Cathy Abercrombie

Senator Cathy Osten

Representative Toni Walker

Senator Paul Formica

Representative Gail Lavielle

Representatives for Senator Len Fasano

Representatives for Representative Joe Aresimowicz

Senator Mary Abrams

Representative William Petit

## Executive branch officials

Deidre Gifford, Acting Commissioner of the Department of Public Health and Commissioner of the Department of Social Services

Amy Porter, Commissioner of the Department of Aging and Disability Services

Melissa McCaw, Secretary of the Office of Policy and Management

Facility Licensing and Investigations Section at the Department of Public Health, including nurse consultant surveyors

Healthcare Associated Infections and Antimicrobial Resistance Section at the Department of Public Health

Public Health Section at the Department of Public Health

Infectious Diseases Section at the Department of Public Health

Representatives from the Connecticut 211 Hotline

Representatives from the Connecticut Medicaid program within the Department of Social Services

Representatives from the Department of Public Health's Public Health Laboratory

Representatives from the Long-Term Care Ombudsman Program

## Industry stakeholders

Representatives from LeadingAge and the Connecticut Association of Health Care Facilities

Representatives from the Connecticut Assisted Living Association

Leadership from iCare Health Network

Leadership from Genesis Health Care

Leadership from Arbors of Hop Brook Limited Partnership

Leadership from Greenwich Woods

Leadership from Brookdale Assisted Living

Leadership from Mansfield Center for Nursing and Rehabilitation

Leadership from LiveWell

## Resident, family, and staff stakeholders

Six family members of residents in LTC facilities

Representatives from the Consumer Advisory Council at the CT Office of Health Strategy, including former LTC residents

Representatives from the New England Health Care Employees Union, District 1199





## Appendix C: Timelines

# Appendix C: Timelines

- / Timeline of select federal policy and guidance in response to the COVID-19 outbreak**
- / Timeline of select state policy and guidance in response to the COVID-19 outbreak**

## Federal-level timeline of policy changes and guidance

### JANUARY 2020

**January 31, 2020:** The U.S. Department of Health and Human Services [determines](#) a public health emergency exists and has existed since January 27, 2020.

### MARCH 2020

**March 6, 2020:** President Donald Trump [signs an \\$8.3 billion spending package](#), the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 (CARES Act) (COVID-19 Package #1), which provides supplemental funding for the Department of Health and Human Services, the State Department, and the Small Business Administration to respond to the coronavirus outbreak.

**March 8, 2020:** The Centers for Disease Control and Prevention issues [guidance](#) prioritizing testing of symptomatic people who are hospitalized, in a high risk group, or who had close contact with a suspected or confirmed COVID-19 case.

**March 13, 2020:** The [president declares a national emergency](#).

**March 13, 2020:** The Centers for Medicare & Medicaid Services [announces the activation of blanket 1135 waivers](#). Blanket waivers activate to ease certain requirements for providers to respond to COVID-19, including providing flexibility and relief for state Medicaid agencies via 1135 waivers and temporary suspension of non-emergency survey inspections (allowing for a focus on infectious disease and other most serious health and safety threats).

**March 13, 2020:** The Centers for Medicare & Medicaid Services releases memo [QSO-20-14-NH](#), which directs nursing homes to restrict all visitors, including non-essential workers. The memo provides additional guidance to help nursing homes improve infection control and prevention practices to prevent transmission of COVID-19.

**March 15, 2020:** The Centers for Disease Control and Prevention issues [guidance](#) recommending that gatherings of 50 or more people should be canceled for the next eight weeks.

**March 18, 2020:** The federal government enacts the [Families First Coronavirus Response Act](#) (COVID-19 Package #2), which included paid sick leave, insurance coverage of coronavirus testing, nutrition assistance, and unemployment benefits

**March 23, 2020:** The Centers for Medicare & Medicaid Services releases memo [QSO-20-20-All](#), which announces changes to the nursing home inspection process, including a new COVID-19 infection control survey. This guidance establishes a three-week time period during which only complaints, targeted infection control surveys, and self-assessments would be conducted. It stipulates that surveyors should not enter facilities if they do not have the appropriate personal protective equipment to do so.

**March 24, 2020:** The Federal Emergency Management Agency announces [use of Defense Production Act](#) to acquire 60,000 coronavirus testing kits.

**March 27, 2020:** The [president signs the CARES Act \(COVID-19 Package #3\) into law](#), which includes direct payments to Americans, extended unemployment benefits, and more than \$140 billion to support



the U.S. health system, including funding for personal protective equipment, testing supplies, and workforce supports, as well as funding to states.

### APRIL 2020

**April 3, 2020:** The Centers for Disease Control and Prevention [issues a recommendation](#) encouraging the use of a cloth face covering when out in public.

**April 6, 2020:** The Centers for Medicare & Medicaid Services publishes [Interim Final Rule I](#), regulations retrospectively effective March 31, 2020. The rule changes payment policy to allow Medicare-certified providers flexibility to use remote communications technology (telehealth) to minimize COVID-19 exposure risks.

**April 19, 2020:** The Centers for Medicare & Medicaid Services releases memo [QSO-20-26](#), Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons under Investigation) Among Residents and Staff in Nursing Homes, summarizing new facility reporting requirements that would soon be released through rulemaking.

**April 21, 2020:** The U.S. Department of Health and Human Services [renews](#) determination that a public health emergency exists and has existed since January 27, 2020.

**April 23, 2020:** The U.S. Department of Health and Human Services announces [funding to states](#) through the CARES Act; Connecticut will receive \$20,252,520.70 total funding.

**April 27, 2020:** The Trump Administration [releases](#) a testing blueprint for “[Opening Up America Again](#),” outlining roles of federal government, states, and private sector.

**April 30, 2020:** The Centers for Medicare & Medicaid Services and President Trump announce the formation of the Coronavirus [Commission](#) for Safety and Quality in Nursing Homes that will conduct a comprehensive assessment to help inform immediate and future responses to COVID-19 in nursing homes.

**April 30, 2020:** The Federal Emergency Management Agency announces (Release No. HQ-20-126) it is coordinating [two shipments](#) totaling a 14-day supply of personal protective equipment to nearly 15,000 nursing homes across the U.S.

### MAY 2020

**May 6, 2020:** The Centers for Medicare & Medicaid Services publishes [interim final rule/QSO-20-29-NH](#), Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes, which requires nursing homes to report COVID-19 facility data to the Centers for Disease Control and Prevention, their residents, and their residents’ family members and representatives.

**May 8, 2020:** The Centers for Disease Control and Prevention shares the Infection Prevention and Control Assessment Tool ([ICAR](#)) for Nursing Homes Preparing for COVID-19, provides guidance for nursing homes and assisted living facilities on topics including visitor restrictions; education, monitoring, and screening of staff; education, monitoring, and screening of residents; ensuring availability of personal protective equipment and other supplies; ensuring adherence to infection prevention and control practices; and communicating with the health department and other health care facilities.

**May 11, 2020:** The Food and Drug Administration [issues](#) guidance, effective immediately, providing policy to accelerate COVID-19 testing for the duration of the public health emergency.

**May 11, 2020:** In a [call with state governors](#), Vice President Mike Pence states that the federal government recommends states test all nursing home staff and residents over the next two weeks.

**May 12, 2020:** The Centers for Disease Control and Prevention issues [guidance](#) on infection control processes for memory care units in long-term care facilities (for example, considerations of potential risks and benefits of moving residents out of the memory care unit to a designated COVID-19 care unit).

**May 13, 2020:** The Centers for Medicare & Medicaid Services [publishes](#) the first version of the Nursing Homes Best Practices Toolkit, a resource cataloging innovative practices on a variety of topics key to nursing home operations and infection control collected from states, provider associations, and other stakeholders.

**May 15, 2020:** President Trump announces the creation of [Operation Warp Speed](#), an administration task force meant to help develop a coronavirus vaccine.

**May 18, 2020:** The Centers for Medicare & Medicaid Services issues guidance memo [QSO-20-30-NH](#), Nursing Home Reopening Recommendations for State and Local Officials, which establishes three phases of reopening and included general and recommendations specific to phases one to three regarding (1) the criteria for relaxing certain restrictions, (2) visitation and service considerations, and (3) types of surveys conducted.

**May 22, 2020:** The U.S. Department of Health and Human Services announces a [~\\$4.9 billion distribution to nursing facilities](#) impacted by COVID-19. The department will distribute relief funds to skilled nursing facilities on fixed and variable bases; each facility receives a fixed \$50,000 distribution and then an additional \$2,500 per certified bed.

**May 29, 2020:** The Centers for Medicare & Medicaid Services updates [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19](#) (not specific to long-term care or nursing homes).

## JUNE 2020

**June 2020:** The U.S. Department of Health and Human Services' Office of the Inspector General [rolls out](#) two long-term care investigations: (1) a study focused on the overall industry response to the COVID-19 pandemic and (2) an evaluation study of the ongoing federal effort to compile comprehensive data on COVID-19 deaths and infections in nursing facilities.

**June 1, 2020:** The Trump Administration [announces](#) enhanced enforcement activities based on nursing home COVID-19 data and inspection results. It notes that states that had not completed 100 percent of focused infection control surveys for their nursing homes by July 31, 2020, would be required to submit a corrective action plan to the Centers for Medicare & Medicaid Services and be subject to potential reductions to their CARE Act funding.

**June 1, 2020:** The Centers for Medicare & Medicaid Services and the Centers for Disease Control and Prevention issue [a joint letter](#) to governors. The letter outlines the importance of completing infection control surveys and reporting COVID-19 nursing facility data (including cases and deaths) to the recently implemented nationwide COVID-19 surveillance system via the Centers for Disease Control and



Prevention’s National Healthcare Safety Network for America’s Medicare and Medicaid-certified nursing homes. The letter describes technical assistance to states being provided by Centers for Disease Control and Prevention consultants and by Quality Improvement Organizations, notes that the Centers for Medicare & Medicaid Services has tied survey funding to State Survey Agency performance and completion of infection control surveys, and urges states to create a comprehensive testing plan and submit the plan to the Centers for Medicare & Medicaid Services.

**June 4, 2020:** The Centers for Medicare & Medicaid Services posts the [first set of COVID-19 nursing home data](#) and results from targeted inspections conducted by the agency since March 4, 2020, linked on [Nursing Home Compare](#).

**June 19, 2020:** The Centers for Medicare & Medicaid Services announces the Membership of Independent Coronavirus Commission on Safety and Quality in Nursing Homes. [Commission members](#) will conduct a comprehensive assessment of the overall response to the COVID-19 pandemic in nursing homes. Commission recommendations will be included in a final report to be released in fall 2020.

**June 23, 2020:** The Centers for Medicare & Medicaid Services releases a set of [frequently asked questions](#) on nursing home visitation that covers topics such as considerations before reopening and clarification the definition of “compassion care situations.”

**June 25, 2020:** The Centers for Disease Control and Prevention updates its [Preparing for COVID-19 in Nursing Homes](#) webpage. Changes to guidance include tiered recommendations to address nursing homes in different phases of COVID-19 response, a new recommendation to assign an individual to manage the facility’s infection control program, additional guidance about new requirements for nursing homes to report to the National Healthcare Safety Network, and a recommendation to create a plan for testing residents and health care personnel for COVID-19.

### JULY 2020

**July 1, 2020:** The Centers for Disease Control and Prevention releases updated [Testing Guidelines for Nursing Homes](#).

**July 9, 2020:** The Centers for Medicare & Medicaid Services shares the [video](#) Five Things to Know About Nursing Homes During COVID-19, reiterating federal actions and recommendations in response to COVID-19.

**July 10, 2020:** The Centers for Medicare & Medicaid Services announces a [targeted approach](#) to provide additional resources to nursing homes in COVID-19 hotspot areas. It plans to deploy Quality Improvement Organizations to provide immediate assistance and implement an enhanced survey process tailored to meet specific concerns of hotspot areas and coordination among federal, state, and local efforts to leverage all available resources to the facilities

**July 10, 2020:** In an updated [COVID-19 Guidance for Hospital Reporting and FAQs document](#), the Trump Administration and the U.S. Department of Health and Human Services direct hospitals to report COVID-19 data to a central departmental database in efforts to streamline real-time data gathering and assist the White House task force in allocating resources; hospitals will no longer report data to the Centers for Disease Control and Prevention.

**July 14, 2020:** The Centers for Medicare & Medicaid Services and the U.S. Department of Health and Human Services [announce](#) COVID-19 point-of-care testing kits will be sent to nursing homes. Nursing

homes would receive devices in an order ranked by the administrator of the Centers for Medicare & Medicaid Services and her team. Point-of-care tests are described as rapid on the spot and can test 20 people per hour.

**July 16, 2020:** The Centers for Medicare & Medicaid Services and Quality Improvement Organization Program hold a [webcast](#) called Establishing an Infection Prevention Program in a Nursing Home, With an Emphasis on COVID-19.

**July 17, 2020:** The administrator of the Centers for Medicare & Medicaid Services holds a [webcast](#) called COVID-19: Lessons from the Front Lines Call — July 17 with the commissioner of the Food and Drug Administration and the White House Coronavirus Task Force. The webcast urges physicians and other clinicians to share experiences, ideas, strategies, and insight related to COVID-19 response as well as to ask questions.

**July 17, 2020:** The Federal Emergency Management Agency shares [COVID-19 Best Practice Information: Considerations for People with Disabilities](#), addressing several areas including public assistance from the agency, technology, and COVID-19 testing. The document shares areas of improvement and mitigation actions related to nursing homes, assisted living, and group homes:

- I. The challenge of instituting infection disease prevention protocols because of limited access to personal protective equipment and ventilators
    - a. Mitigating action: The Centers for Disease Control and Prevention guidance documents for nursing home to ensure safety of patients and staff
  - II. Resident isolation from families and support networks
    - b. Mitigating action: Use technological solutions to interact with loved ones
  - III. Barriers people with disabilities might face transitioning out of nursing homes and assistance care facilities because of limited staff and house for in-home care
    - c. Mitigating action: Find government and local disability program and services
- The Federal Emergency Management Agency identifies a potential best practice: The state of Alaska developed and published guidance to support people with disabilities and their caregivers and family members. Specifically, resources on the page address assisting people with disabilities and face coverings.

**July 22, 2020:** The Centers for Medicare & Medicaid Services and the Trump Administration [announce](#) new resources to protect nursing home residents against COVID-19, including a provider relief fund to long-term care facilities such as nursing homes.

- New funding: The U.S. Department of Health and Human Services will devote \$5 billion to the Provider Relief Fund under the CARES Act to long-term care facilities and nursing homes. To receive funding, nursing homes must participate in Nursing Home COVID-19 Training.
- Enhanced testing: The Centers for Medicare & Medicaid Services will begin requiring, instead of recommending, that all nursing homes in states with a 5-percent or greater positivity rate test all nursing home staff each week. More than 15,000 testing devices will be deployed over the next few months; 600 devices will be shipped this week.

- Technical assistance and support: The Centers for Medicare & Medicaid Services reports deploying technical assistance and education efforts in 18 nursing homes in Illinois, Florida, Louisiana, Ohio, Pennsylvania, and Texas from July 18 to July 20.
- Weekly data on high-risk nursing homes: In addition to collecting data from all nursing homes weekly, the Centers for Medicare & Medicaid Services will release a list of nursing homes with an increase in cases that it will send to states each week.

**July 23, 2020:** The U.S. Department of Health and Human Services [renews](#) determination that a public health emergency exists and has existed since January 27, 2020.

**July 23, 2020:** The Centers for Disease Control and Prevention updates its [Considerations for Retirement Communities and Independent Living Facilities](#) COVID-19 webpage. The page redirects those seeking guidance for long-term care facilities to the [Preparing for COVID-19 in Nursing Homes webpages](#), last updated on June 25, 2020.

## State-level timeline of policy changes and guidance

### FEBRUARY 2020

Feb 5, 2020: [Department of Public Health Directive](#)

- Connecticut's Department of Public Health adds coronavirus to list of reportable diseases, requiring any physician in the state to report a case or possible case to the department.

Feb 28, 2020: [Governor Lamont Press Release](#)

- The state announces that the Department of Public Health's laboratory in Rocky Hill received approval from the Centers for Disease Control and Prevention to begin testing samples itself rather than delivering all samples to Centers for Disease Control and Prevention testing sites in Atlanta.

### MARCH 2020

March 8, 2020: [Governor Lamont Press release](#)

- Governor Lamont announces that the Department of Public Health State Laboratory has confirmed the first positive case of coronavirus involving a Connecticut resident.

March 9, 2020: [Governor Lamont Press Release](#)

- The second positive case of COVID-19 was identified in Connecticut, bringing the state's total to two.
- The state receives a second COVID-19 test kit, which boosted state testing capacity to about 1,200. The lab can complete 15 to 20 tests per day, and each kit allows for 600 people to be tested.
- LabCorp becomes fully operational with COVID-19 testing. Quest Diagnostics expected to have testing available soon. All people being tested by these facilities must receive advance physician referral.

March 9, 2020: [Department of Public Health Directive](#)

- The Department of Public Health restricts visitors entering nursing and convalescent homes to only those visiting someone residing at one of these facilities in hospice or end-of-life care, and the visitors must wear proper personal protective equipment.

March 10, 2020: [Declaration of Public Health and Civil Preparedness Emergency](#)

- Governor Lamont declares civil preparedness and public health emergencies.
- The Connecticut Insurance Department notifies travel insurance companies about the emergency declarations and begins monitoring their compliance with the terms of their policies.
- The declarations trigger price gouging laws and make clear that municipal leaders have emergency powers to mitigate disasters and emergencies.
- This provides the governor with the authority to take specific, swift actions determined necessary to protect the safety and health of residents in the state, including temporarily suspending certain state laws and regulations.

March 11, 2020: [Governor Lamont Press Release](#)

- The Department of Public Health confirms a third presumptive positive COVID-19 case in the state.
- Governor Lamont made an emergency request from the Strategic National Supply for a total of 540,000 additional N-95 protective masks.
- To make testing more widely available, the department is working on obtaining alternate sites approved at local hospitals at locations around the state. Those hospitals will work with commercial testing labs by Quest Diagnostics and LabCorp to complete the testing.

March 12, 2020: [Executive Order No. 7](#)

- This order prohibits gatherings of 250 people or more for social and recreational activities (excludes churches).
- It creates a waiver of the 180-day school year requirement.
- It enables the Commissioner of Public Health to issue restrictions on the number, category, and frequency of outside visitors and on the screening and protective measures in nursing homes, residential care homes, or chronic disease hospitals.

March 13, 2020: [Executive Order No. 7A](#)

- This order grants the Commissioner of Public Health authority to restrict visitors at nursing homes, residential care homes, and chronic disease hospitals. Note this order supersedes Executive Order No. 7.

March 15, 2020: [Executive Order No. 7C](#)

- This order cancels classes in public schools for at least two weeks.

March 16, 2020: [Executive Order No. 7D](#)

- This order further limits recreational and social gatherings to 50 people. It closes gyms; sports, fitness, and recreational facilities; and movie theaters.

March 18, 2020: [Governor Lamont Press Release](#)

- This statement regarded the first death in Connecticut because of complications from COVID-19. The person was an elderly patient who had been a resident of an assisted living facility in Ridgefield.

March 18, 2020: [News Article](#)

- Governor Lamont reports that the state is currently able to conduct hundreds of COVID-19 tests per day compared with 20 or 30 people per day in the prior week, at which time testing was “focused mainly on those who are very sick in the hospitals.”

March 20, 2020: [Executive Order No. 7H](#)

- This order places "Stay Safe, Stay Home" restrictions on all workplaces for non-essential businesses.



March 23, 2020 [Executive Order No. 7K](#)

- This order temporarily suspends the requirement to submit background checks to the Department of Public Health before extending an employment offer to long-term care service providers or volunteers.

March 24, 2020: [Executive Order No. 7L](#)

- This order extends the time period for nursing home transfers. It grants additional flexibilities for residents that might have to move or transfer facilities based on their COVID-19 status.

March 24, 2020: [Department of Public Health Guidance](#)

- This guidance from the state's Department of Public Health regards personal protective equipment stewardship and conservation.

March 26, 2020: [Department of Public Health Guidance](#)

- This is the first nursing-home specific guidance from the state's Department of Public Health. The recommendations include assessing symptoms and temperatures for all staff at the beginning of the shift, limiting staff movement within the facility as much as practicable, social distancing guidelines, cleaning and janitorial services, assessing residents for symptoms at least once daily, and guidance on testing for symptomatic residents only.
  - It also includes guidance on appropriate transfers of residents with confirmed or suspected COVID-19 to and from hospitals.

March 27, 2020: [Centers for Medicare & Medicaid Services Section 1135 Waiver Response](#) (First Request)

- Connecticut receives approval of its 1135 waiver, with a retroactive effective date of March 1, 2020. The waiver included the following:
  - Suspension of Medicaid fee-for-service prior authorization requirements
  - Extension of existing prior authorizations through the end of the public health emergency
  - Modification of timeframe for managed care entities to resolve appeals
  - Temporary enrollment of providers enrolled with another state Medicaid agency (out-of-state providers) or Medicare and may reimburse payable claims, which applies to the Children's Health Insurance Program as well
    - For providers not already enrolled with a state Medicaid agency or Medicare, approved waiving payment of application fee, criminal background checks, site visits, and in-state or territory licensure requirements
  - Temporary ceasing of revalidation requests from providers located in the state
  - Full reimbursement for services rendered during emergency to an unlicensed facility that meet minimum standards (nursing facilities, intermediate care facilities for individuals with intellectual and developmental disabilities, psychiatric residential treatment facilities, and hospital nursing facilities)

- State plan amendment flexibilities to provide or increase beneficiary access to items and services related to COVID-19 (for example, cost-sharing waivers, alternative benefit plans to add services or providers)

March 27, 2020: [Centers for Medicare & Medicaid Services Approval Letter](#) and Waiver Approvals

- Nine Section 1915(c) HCBS waivers received time-limited amendment approvals (retroactive to March 16, 2020), including the following:
  - Temporary increase in cost limits for participants necessary to assist with continued safe support in the community and to avoid institutionalization
  - Temporary permission to pay for services (companion services) rendered by family caregivers
  - Temporary modification to level of care evaluations or reevaluations (allowing these to be conducted virtually) and delay of reassessment of up to one year
  - Allowance of electronic method (that is, telephonic) for case management, monthly monitoring, and counseling or day programs
  - Adjust prior approval and authorization elements in waivers
  - Add electronic method of signing off on person-centered service plan

## APRIL 2020

April 3, 2020: [Press Release](#)

- The governor announces that the state’s 213 nursing homes are receiving a 10-percent across-the-board increase in Medicaid payments to help meet extraordinary costs from the public health emergency.
- The 10-percent funding increase runs from April 1 to June 30, with an initial payment of \$11.6 million scheduled to be received by nursing homes on April 7. The three-month increase is expected to total \$35.3 million.

April 4, 2020: [Department of Public Health Guidance](#)

- This guidance requires all health care personnel in all settings to be universally masked while working in facilities, including long-term care facilities.

April 6, 2020: [Section 1115 Waiver Application](#)

- The state requested flexibility for a number of provisions for its 1915(i) state population, including waiving face-to-face requirement for assessments, cost limit service changes, and electronic provision of mental health and adult day health counseling via a Section 1115 demonstration application. (The application was later withdrawn because the Centers for Medicare & Medicaid Services notified Connecticut that the requested flexibilities were already allowed under blanket waivers that it issued.)

April 8, 2020: [Governor's Press release](#)

- The governor announces a partnership with Connecticut’s long-term care facilities to collaborate on a medical surge plan that includes the establishment of COVID-19 recovery centers in nursing homes to accept patients who can be discharged from acute care hospitals but are still impacted by COVID-19 infection.

- In total, the state designated four COVID-19 recovery facilities in Torrington, Bridgeport, Meriden, and Sharon with a total of 500 beds across them.
- The Department of Public Health is working with hospitals to ensure more people can meet the requirement of negative tests 24 hours apart before being discharged back to a nursing home.
- The Connecticut Department of Social Services and the Office of Policy and Management determined a payment rate of \$600 per day for the COVID-19 recovery centers and additional payments of 10 percent across the board for all nursing homes in Connecticut during the pandemic.

April 11, 2020: [Executive Order No. 7Y](#)

- This order implements a nursing home surge plan for the duration of the public health and civil preparedness emergency, allowing flexibility in transfer of residents to and from the hospital, a COVID-19 recovery facility, or discharge from institutional setting.

April 15, 2020: [Executive Order No. 7AA](#)

- This order grants the Department of Social Services the authority to approve temporary additional nursing home beds for COVID-19 recovery.

April 16, 2020

- The first COVID-19 recovery facility opens for hospital discharges.

April 17, 2020: [Executive Order No. 7BB](#)

- The governor issues a statewide order that cloth face coverings or higher level of protection required in public wherever close contact is unavoidable.

April 19, 2020: [Governor's Press Release](#)

- The governor announces that he is directing his administration to boost Medicaid payments for all of the state's nursing homes by an additional 5 percent above the recently announced 10-percent increase.
- The state will provide an across-the-board rate increase of 10 percent for non-COVID beds retroactive to March 1 (previously, the 10-percent increase was to occur April 1).
- The state will provide an additional across-the-board rate increase of 5 percent for non-COVID beds for the period of April 1 to June 30, bringing the total increase during this period to 15 percent.
- The state's advance of \$11.6 million from the initial 10-percent rate increase, which was received by skilled nursing facilities on April 7, is now being extended back to March 1, adding \$12 million in immediate revenue.

April 22, 2020: [Executive Order No. 7DD](#)

- This order adds to existing list of out-of-state health care providers not required to pursue licensure, certification, or registration for a period of 60 days and allows them to render services if appropriately licensed, certified, or registered in another state or territory.
- New providers include occupational therapist, alcohol and drug counselor, radiography, and others.

April 23, 2020: [Office of Policy Management Guidance](#) and [U.S. Department of Health and Human Services Funding Announcement](#)

- Connecticut was allocated \$1.382 billion by the U.S. Department of the Treasury for the Coronavirus Relief Fund established by the CARES Act (Public Law 116-136).
- This established allocation for \$600 per diem, per bed grant to COVID-19 recovery facilities and alternative COVID-19 recovery facilities. Note that this is the sole reimbursement for these facilities from the state; the guidance indicates that the Department of Social Services would conduct a cost audit for expenses in excess of the \$600 per diem payment. The \$600 per diem is more than double the standard Connecticut Medicaid per diem for nursing home services. It established grant payments of a 10-percent increase for April and 20 percent for May and June 2020 for nursing homes that are not COVID-19 recovery facilities or alternate COVID-19 recovery facilities. These increases are intended to be used for employee wages (including staff retention and overtime), costs related to screening visitors for COVID-19, personal protective equipment, cleaning and housekeeping supplies, and other COVID-related costs.

April 23, 2020: [Executive Order No. 7EE](#)

- This order mandates nursing homes and residential communities in the state to provide daily status reports in the form and manner required by the Connecticut Hospital and Long-Term Care Mutual Aid Plan.
- It establishes civil penalties for failure to comply with mandatory reporting.
- It gives the Commission of Social Services (where Medicaid resides) the ability to waive certain Medicaid prior authorization requirements as the commissioner deems necessary.
- It waives Medicaid bed reservation requirements for residents on leave from intermediate care facilities for people with intellectual disabilities in the hospital or on home leave.

April 24, 2020: [Press Coverage](#)

- This article indicates testing capacity of the state public health lab in Rocky Hill has expanded from 15 to 20 tests per day at the start of the pandemic to 80 to 160 tests per day. In addition, reports that “multiple commercial, university and medical laboratories around Connecticut have also since been certified for COVID-19 testing.” The biggest factor limiting ability to test is a shortage of key materials.

## MAY 2020

May 3, 2020: [Governor’s Press Release](#)

- Governor Lamont, along with New York Governor Andrew M. Cuomo, New Jersey Governor Phil Murphy, Massachusetts Governor Charlie Baker, Rhode Island Governor Gina Raimondo, Pennsylvania Governor Tom Wolf, and Delaware Governor John Carney, announce a joint multi-state agreement to develop a regional supply chain for personal protective equipment and other medical equipment and testing.

May 7, 2020: [Press Release](#) and [Department of Public Health Implementation Order](#)

- The state announces expansion of testing for COVID-19, including increased screening of asymptomatic people in nursing homes
- The state suspends regulation requiring prior referral for COVID-19 test from medical providers, enacted through an implementation order from the Department of Public Health.

May 7, 2020: [Executive Order No. 7KK](#)

- This order modifies state statute to allow pharmacists to order and administer tests approved by the Food and Drug Administration for COVID-19.
- It requires pharmacists to report all testing activities and any other information required by the Department of Public Health in accordance with applicable orders, guidelines, or other directives issued by the Commissioner of Public Health or her designees.

May 9, 2020: [Department of Public Health Guidance](#)

- The Department of Public Health issues guidance for ensuring that long-term care facilities take reasonable and practicable alternative means of communication between residents and family members. This included window visits, virtual visitation, social media communications, and phone calls that should occur on at least a weekly basis.

May 10 2020: [Press Coverage](#)

- The governor issues an order implementing standards at nursing homes to ensure loved ones can speak with their families either through windows or video conferencing.

May 11, 2020: [Department of Public Health Guidance](#)

- This interim guidance regards COVID-19 point prevalence survey testing and cohorting in nursing homes.

May 11, 2020: [Department of Public Health Memo](#)

- This memo provides sample long-term care cleaning protocol guidance for nursing and environmental services personnel when cleaning and auditing cleaning in areas where people with suspected or laboratory-confirmed COVID-19 have been.
- It includes guidance from the Centers for Disease Control and Prevention on personal protective equipment use, cleaning of high touch services, and aerosolization (increasing airflow in rooms).

May 12, 2020: [Centers for Medicare & Medicaid Services Section 1135 Waiver Response \(Updated First Request\)](#)

- The Centers for Medicare & Medicaid Services temporary approves the state's request to provide services in settings that have not been determined to meet the home and community-based settings criteria under the 1915(c) HCBS waiver program, 1915(i) home and community-based services state plan benefit, and Community First Choice State plan option at 1915(k).



May 13, 2020: [Executive Order No. 7NN](#)

- This authorizes the Office of Policy and Management to direct the Department of Social Services to provide Coronavirus Relief Fund distributions to nursing home facilities.
- It also authorizes the Office of Policy and Management to direct the Department of Social Services to provide Coronavirus Relief Fund distributions to COVID-19 recovery facilities and alternate COVID-19 recovery facilities
- It authorizes additional COVID-19-related hardship relief funding under the Coronavirus Relief Fund to nursing home facilities.
- It waives certain limits on the amount that could be provided to caregiver relatives.

May 20, 2020: [Press Release](#), [State Guidance](#), [Press Coverage](#)

- This outlines phase one of reopening for businesses.
- Businesses reopening during phase one include outdoor dining, offices, retail and malls, museums and zoos, university research, and outdoor recreation businesses.
- It includes restaurant-specific guidance: only outdoor dining permitted (open up to 50-percent capacity and no bars open); retail and malls open up to 50-percent capacity; offices allowed to open up to 50-percent capacity, but employees should work from home when possible; and museums and zoos can open outdoor exhibits at up to 50-percent capacity.

May 24, 2020: [Press Coverage](#)

- This article compares progression of testing for asymptomatic patients in nursing homes and staff of nursing homes in Connecticut.
- The state announces broader testing efforts in nursing homes on May 7, but states in the New England region such as Massachusetts expand testing of asymptomatic residents on April 13, and state officials send testing kits to nursing homes and arranged for mobile testing at the facilities.
- The article says the state cites a lack of testing supplies as delaying widespread testing.

May 27, 2020: [Executive Order No. 7SS](#)

- This order creates a temporary nurse aide position in nursing homes. People holding this temporary licensure must complete eight hours of online training and work under the supervision of nursing staff, and they are ineligible to work with COVID-19 positive residents.

## JUNE 2020

June 1, 2020: [Executive Order No. 7UU](#)

- This order mandates COVID-19 testing for staff of private and municipal nursing homes, residential communities, and assisted living agencies. It requires nursing homes and assisted living facilities to test staff at least weekly for the duration of the public health emergency; this order specifically includes agency staff and contractors.
- It requires testing to begin no later than June 14, per Department of Public Health guidance.

June 1, 2020: [Press Coverage](#)

- This outlines a modified phase one, which includes reopening of hair salons and barbershops.

June 5, 2020: [Department of Public Health Memo](#)

- This memo includes COVID-19 guidelines for infection control in nursing homes.

June 5, 2020: [Executive Order No. 7XX](#)

- This order suspends the involuntary discharge of nursing facility residents and residential care home residents who could previously be discharged to homeless shelters, except during emergency situations or with respect to COVID-19-recovered discharges.
- It modifies safety rules for drive-in religious gatherings and safety rules for drive-in graduations.

June 8 2020: [Department of Public Health Guidance](#)

- This blast fax provides guidance on resident quarantine/isolation, cohorting, testing, visitation and outdoor time
- Topics include: new admissions and readmissions, residents leaving for medical appointments and other visits, testing staff and residents, contact tracking within the nursing home, use of air conditioning and fans, resident room doors, recreation and outdoor time by cohort, and visitation by cohort.

June 17, 2020: [Executive Order No. 7AAA](#)

- This order updates Executive Order 7UU regarding mandatory COVID-19 staff testing of nursing facility and ALFs as follows:
  - Only staff who have not previously tested positive for COVID-19 must be tested weekly. Weekly testing should continue until the facility has no new cases of COVID-19 for at least 14 days. Weekly testing must restart whenever there is a new positive case in the facility among residents or staff.

June 17, 2020: [Centers for Medicare & Medicaid Services Section 1135 Waiver Response \(Second Request\)](#)

- This is the Centers for Medicare & Medicaid Services response to the second Section 1135 Waiver request from Connecticut:
  - The Centers for Medicare & Medicaid Services approves the state’s request to modify the deadline for initial and annual level of care determinations required for the Section 1915(k) state plan benefit.
    - The state does not need to complete assessment before start of care, and reassessment can be postponed for one year.
  - The Centers for Medicare & Medicaid Services approves the state’s request to modify the timeline for initial evaluations and assessments and reevaluate and reassess the Section 1915(i) HCBS state plan option.
    - Similar to Section 1915(k) provisions.

- The Centers for Medicare & Medicaid Services approves the waiver of written consent from beneficiaries for services delivered under Section 1915(c) waiver program, Section 1915(i) home and community-based services state plan, and Section 1915(k) Community First Choice programs.

June 17, 2020: [Press Coverage](#), [State Guidance](#), and [Press Coverage](#)

- These outlines set forth phase two of reopening businesses and recreation with capacity limits and requirements for compliance with health and safety guidelines, including all personal services (nail salons, tattoo parlors, and so on); movie theaters; outdoor arts, entertainment and events up to 50 people; bowling alleys; social clubs and pools; indoor restaurants; hotels (but no bars); museums; zoos; outdoor amusement parks; public libraries; and youth sports.
- Any business seeking to reopen in phase two must complete a self-certification and receive a Reopen CT badge. They must also comply with industry-specific health and safety guidelines; a non-exhaustive list includes personal protective equipment for employees, provided at no cost to the employee; a cleaning plan; training programs to ensure all workers are aware of the details of the state’s reopening guidelines and cleaning requirements; adjustment of the physical space in the business to encourage social distancing; avoidance of unnecessary physical contact or the use of shared items; and increased ventilation where possible.
- It provides additional sector-specific capacity guidelines including, for example, that restaurants with indoor dining can open at 50-percent occupancy (outdoor dining is still encouraged).
- It allows for private (in-home) gatherings of up to 25 indoors and 100 outdoors.

June 22, 2020: [Department of Public Health Memo](#)

- This memo includes updated COVID-19 Infection Control Guidelines for Nursing Homes from the Connecticut Department of Public Health Infectious Diseases Section supplements and updates prior Department of Public Health guidance. It addresses common questions regarding resident quarantine and isolation, cohorting, and testing.

June 24, 2020: [Press Coverage](#)

- A travel advisory requires people coming from states with (1) a positive test rate higher than 10 per 100,000 residents or (2) a 10-percent or higher positivity rate over a seven-day rolling average to self-quarantine for 14 days.
- At the time of this advisory, the requirement affected travelers visiting Connecticut from a total of 19 states.

June 25, 2020: [Press Release](#) and [Executive Summary of Reopening Model](#)

- Governor Lamont announces plans for 2020–2021 school year with an aim of allowing all students opportunity to access in-school, full-time instruction at beginning of 2020–2021 academic year, if it is supported by public health data.

June 29, 2020: [Press Coverage](#)

- Summer day camps reopen (overnight camps not included).

- Puts into place guidance including health screenings, limiting group size to no more than 10 children, requiring that employees wear cloth face masks, implementing hand and respiratory hygiene, developing protocols for intensified cleaning and disinfection, and implementing social distancing strategies.

### JULY 2020

July 6, 2020: [Press Coverage](#)

- Establishes that K–12 summer school can reopen with limits on group size and requires using face masks, employing social distancing (maintaining six feet between students), developing protocols for sanitizing and cleaning bathrooms, and restricting sharing of materials (that is, books).

July 10, 2020: [Press Coverage](#)

- Pauses phase three of reopening, keeping the state at phase two.

July 14, 2020: [Executive Order No. 7EEE](#)

- This order authorizes **continued** temporary suspension of the requirements for licensure, certification, or registration of out-of-state providers. It allows the commissioner of the Department of Public Health to temporarily suspend the requirements for licensure, certification, or registration for certain out-of-state health care providers in order to supplement the state's ability to respond to the pandemic.
- It supersedes Executive Order No. 7DD, which suspended requirements for licensure for a period of 60 days issued on April 22, 2020.

### August 2020

August 6, 2020: [Press Release](#)

- Announces that Connecticut will continue covering the costs of COVID-19 testing at long-term care facilities at least an additional two months.