June 5, 2020

SENT VIA EMAIL

Senator Karin Housley
3217 Minnesota Senate Building
95 University Avenue West
St. Paul, MN 55155

Dear Senator Housley,

I am writing in response to the specific questions in your letter of yesterday. I will respond separately to the prior letters you referenced, recapping the responses we have given either in committee testimony or conversations with you.

As we have discussed many times, the Minnesota Department of Health is grateful you share our priorities to protect the health, dignity, and rights of the people living in and receiving care from all parts of the health and human services delivery continuum. However, your assertion that you "have received little indication to suggest the administration views the situation in long term care as a priority" during the COVID-19 pandemic is inaccurate. Indeed since my first presentation before your committee on February 19, I have stressed the higher risk faced by the elderly and those with various underlying health conditions. We created our Long-Term Care Battle Plan specifically to address the urgent need for action to slow and stop the transmission of the virus in these facilities. The material which I had prepared to give to your committee on Tuesday of this week, which unfortunately I was not allowed to present, contained significant detail on the Department's and the Administration's efforts specifically focused on long term care, with important data to demonstrate the significant improvements that have been made in identifying and containing the spread of COVID-19 in various congregate care settings. I trust we will be able to review all of those data with you and the Committee in your next hearing.

Some of the most salient points in the presentation we prepared for your committee include:

- Direct comparisons can be misleading due to states' reporting differences.
- Minnesota has been transparent and diligent about reporting COVID-19 deaths since the outbreak first hit the state in March.
- Minnesota reports deaths in all LTCs including assisted living facilities, group homes and other congregate settings whereas many other states report only deaths in nursing homes.
- Earlier this week CMS released new data on nursing homes which shows that the average number of cases in nursing homes per 1000 is 62 nationally and is 39.9 in Minnesota. The

average number of nursing home deaths per 1000 is 27.5 nationally and 12.7 in Minnesota. In addition, while nationally only 54.1% of nursing homes have had infection control surveys, 100% of nursing homes in Minnesota have had these surveys.

- Nearly half of Minnesota's LTC deaths have been in settings other than nursing homes. If pattern is similar in states reporting only nursing home deaths, their true numbers are higher than what is currently attributed.

- State comparisons can be informative, but no matter what the data show there are reasons for concern about the safety of residents and staff in long-term care facilities during the COVID-19 outbreak.

- From the data we have available, no outbreaks were caused by positive COVID-19 cases admitted from hospitals.

- National study indicates primary drivers of higher rates of infection are large facility size and counties with higher prevalence rates.

- Among those with active cases, today there are 281 stable long-term care facilities, which means that they have the same or fewer cases than one week ago.

We are committed to providing information to help all Minnesotans better understand COVID-19 and its risks. To that end, we have answered your questions to the best of our ability within the time constraints provided, with one exception. Several of your questions seek the disclosure of information at a level of detail which would compromise private health information of individuals that is protected by law. Just as we take seriously our responsibility to provide information about public health risks, we take seriously our responsibility to not violate the trust placed in us when people share sensitive, personal information related to disease investigations. Where your questions risk disclosure of protected information, specifically when there are 10 or fewer residents at a facility, we have aggregated that information. The data practices act prohibits the disclosure of even summary data if individual information could be ascertained. Minn. Stat. 13.02, subd. 19.

1. How many *active* COVID-19 cases are present in each Minnesota county? Please provide a specific breakdown by county.

   Please see attachment "Q1 – Cases by county"

2. How many confirmed positive cases of COVID-19 have occurred at each long-term care facility in Minnesota? Please include a specific breakdown of cases by facility.

   Please see attachment "Q2-3 – Cases and deaths by facility"

3. How many COVID-19 deaths have occurred at each long-term care facility in Minnesota? Please include a specific breakdown of deaths by facility.

   Please see attachment "Q2-3 – Cases and deaths by facility"

4. How many COVID-19 cases and deaths have occurred in each type of long-term care setting, including skilled nursing facilities and assisted living facilities? Please provide a specific breakdown by facility.

   Please see attachment "Q4 – Cases and deaths by facility type"

Deaths per living setting, as of 6/1/20 (n=1072)

Living Setting	Deaths
Private residence	184
All congregate settings	888
Skilled nursing facility (SNF)	561
Assisted living	256
Memory care	39
Group home	23
Other*	9
TOTAL	1072

*Includes adult foster care, treatment centers, and hospice

5. Since March, how many COVID-positive patients have been discharged from hospitals to long-term care settings? What are the locations of those facilities? Please provide a specific breakdown.

To date, 319 of the 863 outbreak facilities have had a COVID-positive patient transferred from another facility or discharged back to a facility from the hospital (typically back to the facility where they resided prior to their hospitalization). These data were obtained via a combination of our LTC database and the case database, looking for discharged hospitalizations and patient transfers. The names and locations of facilities with hospital discharges that meet our data privacy criteria (have > 10 residents, and are classified as either a skilled nursing, assisted living, or memory care facility) are included in attachment "Q5 – Facilities with Hospital Discharges."

There are no facilities whose outbreaks started because they accepted a COVID-positive patient from a hospital.

6. Which facilities have been designated by MDH and/or the State Emergency Operations Center (SEOC) as 'COVID Support Sites'? Please include the name and location of each facility.

At this time there are no designated "COVID Support Sites." Hospitals discharge patients and long-term care facilities conduct admissions if they meet the criteria of the patient needs of care. If the patient is

positive for COVID-19, it is expected that the facility will follow the MDH guidance on this in the MDH Long-Term Care Toolkit: https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf.

For nursing facilities, MDH enforces CMS regulations for transmission based precautions. These regulations have been updated to provide specific requirements for caring for individuals with known or suspected COVID. These include:

- For a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available.
- If there are COVID-19 cases in the facility or sustained community transmission, staff implement universal use of facemasks while in the facility (based on availability).
- When COVID-19 is identified in the facility, staff wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability).

Also, see page 5 of guidance from CMS: https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

CMS guidance on admission of residents is at the bottom of page 4 of QSO 20-14 https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

The MDH toolkit contains instruction for isolating and restricting incoming residents discharged from hospitals, or other facilities, to their room for 14 days at the bottom of pages 13 here: https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf

7. What are the processes by which MDH chooses long-term care facilities to undergo COVID-19 testing?

We ask facilities to submit requests for testing support—or inform us of their testing plans—via a REDCap data submission portal. When we receive a request, we look at which of the testing guidance criteria the facility meets (positive case, symptomatic residents or staff, etc.). We also look at whether the facility is considered a high-risk facility based on the assessment of the case manager and previous concerns related to infection control.

See attached list of facilities (attachment "Q7 – Testing Report") that have been swabbed by the National Guard, or that have indicated to us that they plan to do their own testing without assistance from the State. This is likely an undercount, as there are facilities that have moved forward with testing without informing us.

8. What is the department's plan to complete universal testing of all residents and staff at all of the 1,700+ long-term care facilities in Minnesota? Specifically, what is the department's timeline, how often will residents and staff be tested, and who will pay for the testing?

We are moving ahead with testing of all residents and staff at facilities that meet the recently-released MDH guidance for point prevalence surveys, which call for a baseline survey, followed by re-surveys at 7 and 14 days. This includes any facility with a single positive test (resident or staff), or more than one person with symptoms consistent with COVID-19. This approach is also consistent with CDC guidance for testing in long term care facilities. Many facilities have already tested all residents and staff, and we are

working closely with them to ensure appropriate infection control and other protective measures are in place after the testing occurs, and that the facility is taking all appropriate actions to limit spread of the disease.

We do not believe that the National Guard strategy is sufficient for LTC testing, nor are they intended to be. We ask facilities to work with their existing provider partners, or use their own trained staff for swabbing where appropriate. We are working to finalize contracts with health systems around the state to expand our capacity for full-facility testing in LTC. Each health system under contract would establish a swabbing team that would be deployed within their region to do testing in congregate settings. We will make use of the lab capacity the State purchased from Mayo and the University of Minnesota to analyze the samples.

In cases where facilities already have the infrastructure to bill Medicare for the costs of their residents' tests, they can continue to do so. In other cases, the performing lab will bill insurers for resident or staff tests. The State will cover any costs that aren't covered by insurance, via our Mayo/UM contract. The goal is that costs will not be a barrier to testing for any congregate care setting.

As of today we have tested in 189 facilities, nearly 26,000 have been swabbed by the Guard or health systems, or by facilities themselves. Of the facilities that have requested mobile swabbing units that have not yet been scheduled, fewer than 40 meet the criteria outlined in the LTC battle plan.

The testing guidance is available at:
https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html

9. Specifically, which portions of the governor's 'five-point battle plan' have been implemented beyond having 'discussions' and 'conversations'?

As we provided for the June 2 hearing and was sent to the committee, below is an update on the progress of the 'five-point battle plan."

Point 1: Expand Testing

We've developed a process to schedule long-term care facilities to be tested by a state swabbing team, including all required logistical supports. To date, the National Guard has swabbed more than 51 long-term care facilities across the state, including over 14,000 residents and staff. Roughly 140 facilities have done full-facility testing on their own, using their own staff or an existing provider partnership. In addition, more than 53 facilities are scheduled for initial or follow-up National Guard swabbing over the next week. The Testing Workgroup presented a funding proposal to the LCRC this afternoon of $3M for a Nurse Triage Line that will help remove barriers to testing in long term care facilities, allowing us to test more facilities with ease. A speedy approval of that particular proposal will allow us to stand up the line in under a week.

Point 2: Provide Testing Support & Troubleshooting

We've reduced barriers to testing in facilities, including complications around billing and ordering physicians. We've implemented a new billing process with Mayo and the University of ensuring that long-term care facilities don't face administrative burdens related to resident and staff testing—or face bills from the laboratory or health system after the fact. We rolled out the REDCap survey tool where

long-term care facilities can request testing for their facilities. More than 500 facilities have responded, of which over 200 responded that they have plans to test on their own. In addition, we updated and posted online a FAQ, testing checklist and related forms to help facilities prepare to be tested.

Since March MDH has hosted weekly webinars for long-term care facilities, with between 1000-1500 facilities participating each time. On May 14, we held a special webinar to go over the LTC testing/guidance plans with 1407 attendees. We've also trained and deployed 60 National Guard members to test in long- term care facilities—these teams have the capacity to test up to 2000 people per day. We are also training an additional Guard members to increase our capacity by 500 additional people tested each day.

Point 3: Get Facilities Needed Protective Equipment

We have twice proactively pushed out supplies of PPE to long-term care providers and provide PPE to any facility in need with an identified outbreak. As of June 2, 2020, approximately 1,400 requests have been made by long-term care facilities, approximately 62% of which have been fulfilled. Long-term care requests account for about 55% of the total number of requests to date. As of June 3 we have distributed: 126,000 cloth masks (18% of total distributed), 605,000 face masks (54% of total), 10K face shields and other eye protection (63% of total), 3.4 million gloves (66% of total), 100,000 gowns or gown alternatives (62% of total), and 108,000 N95 or similar respirators (18% of total).

While the worldwide shortage of PPE continues to be a challenge, the Administration is working daily to procure additional PPE for state back-up supply should a provider's private supply run short. We have twice proactively pushed out supplies of PPE to long-term care providers and provide PPE to any facility in need with an identified outbreak. We are also working with EMS statewide to have an emergency supply of PPE available to deploy to long-term care facilities in an urgent situation.

Point 4: Ensure Adequate Staffing Levels

We finalized and released the Aladtech volunteer management system which connects facilities to actual healthcare workers near them, in anticipation of staffing shortages. Staffing in the facilities are stable and currently there are no facilities in staffing crisis. We are also working to grow the number of staff we can call on to fill shifts, including from the federal VA and National Guard.

Point 5: Leverage Partnerships

MDH finalized and distributed a long-term care toolkit to over 2500 long-term care facilities. The toolkit is also available on the MDH website with over 1,450 clicks since this week and has been highlighted on the weekly calls with long-term care providers. Further education on the toolkit was provided to county local public health representatives via a webinar which was recorded to be viewed again at a later time. We launched new case management model at facilities, leveraging local public health and regional coalitions to provide facilities with the pre- and post-testing supports that they need. MDH has also provided assistance to 654 facilities on infection control measures, how to properly use PPE and other how to prevent, prepare for and respond to a potential outbreak. Since April 16, MDH staff have conducted infection control and technical assistance onsite visits with 207 facilities, and more are scheduled in the coming days. MDH has more than tripled our staffing levels to ensure this service continues to accelerate. MDH has also completed onsite visits at all 362 nursing homes in Minnesota with a special focus on infection control.

10. Specifically, what guidelines have been developed by MDH to ensure adequate staffing levels at all long-term care facilities? Are those guidelines fully implemented?

Federal guidance for requirements on staffing can be found in 483.35 Nursing Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

State guidance for requirements on staffing can be found in 144A.4791 Subd 4. Acceptance of Clients: https://www.revisor.mn.gov/statutes/cite/144A.4791#stat.144A.4791.4

In addition, due to the COVID-19 pandemic we have put tools together to assist facilities in matching volunteers with staff including a statewide software system (Aladtec). We also have use of the National Guard and VA nurse teams that are on 5 day rotations. Facilities are advising us of not only emergency staffing needs, but optimal staffing as they sign up to test and we are trying to coordinate through Aladtec to assist.

With this said, the SHCC at the SEOC, has created a plan for facilities to implement when they need assistance with staffing. This can be found in the MDH LTC Tool Kit for COVID19: https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf

There is also a pending proposal requesting funding from the Coronavirus Relief Fund to create an Emergency Temporary Staffing Pool with at least 1,000 licensed and unlicensed staff available to work temporarily at settings with a COVID-19 staffing crisis. The Emergency Staffing Pool will be jointly managed by the Department of Human Services and Department of Health. The Commissioner of Health (MDH) and the State Emergency Operations Center (SEOC) will determine through diagnosis testing and follow-up that a setting is currently or will soon experience a COVID-19 staffing crisis impacting the normal operations. We would appreciate your support of this proposal.

11. How is MDH prioritizing who has the ability to receive personal protective equipment (PPE) via the state's stockpile? Please include the department's specific guidelines and/or policies in this area.

The Critical Care Supplies work group began in mid-March. Because of extreme difficulty in sourcing PPE, we required hospitals and other facilities to be in crisis inventory situations (meaning they had only 0-3 days of supply) before the state would fulfill their PPE requisitions. Because we have developed a more stable supply chain, we are now able to fulfill requisitions from hospitals and other facilities when they reach a less critical 4-7 day inventory. The warehouse is currently averaging 80-100 shipments daily.

The state's PPE warehouse inventory is intended to be supplemental. All facilities that receive PPE are expected to continue to source PPE through their usual supply chains. In addition, they are expected to use the conservation guidelines issued by the CDC and MDH. Hospitals and clinics that are conducting elective surgeries should not requisition the state for PPE.

The top priority for PPE is distribution is hospitals, long term care facilities with COVID outbreaks, and EMS.

The second priority facilities include police and fire stations, health clinics, and other types of congregate care facilities such as residential settings and shelters. In the event that any of these facilities

has a known COVID positive resident, they become a top priority for PPE distribution. Daycares and other non-residential settings can request source control such as cloth masks, hand sanitizers, and infrared thermometers.

12. Specifically, how many requests for PPE have been made by long-term care facilities to MDH? Of those requests, how many were fulfilled? How much PPE is going to each facility? Please provide a specific breakdown, including the locations to which PPE has been distributed and the volume of PPE sent.

As of June 2, 2020, approximately 1,400 requests have been made by facilities that self-identified as "long term care" or "assisted living" through the MDH intake system. Approximately 1% of them are currently being processed and 62% of them have been fulfilled. Long term care and assisted living requests account for about 55% of the total number of requests through MDH to date.

For warehouse distribution, we use MDH licenses to determine what is considered "long term care", and we include nursing facilities, skilled nursing facilities, boarding care facilities, and assisted living facilities in that category. As of June 3, 2020, approximately 1,100 facilities have received items (some are duplicates due to slight variation on facility names). The total quantities of the six main types of PPE or source control sent to long term care are: 126K cloth masks (18% of total distributed), 605K face masks (54% of total), 110K face shields and other eye protection (63% of total), 3.4M gloves (66% of total), 100K gowns or gown alternatives (62% of total), and 108K N95 or similar respirators (18% of total). The attached document provides a breakdown of items provided to individual facilities currently identified as long term care.

Please see attachment "Q12 - LTC shipped PPE."

13. What are the results of MDH's inspections of long-term and congregate care facilities? How many facilities are non-compliant on MDH's infection control standards?

The HRD staff have been providing off-site outreach and onsite visits using MDH or CMS tools for guidance to providers licensed by HRD since March.

MDH Infection Control Assessment and Response Program (ICAR) is a CDC sponsored program focused on supporting state-driven efforts to improve infection control across Minnesota. The ICAR program developed a COVID-19 Action Plan for Health Care Facilities, this plan was used for off-site outreach and onsite visits for home care providers and federal nursing homes.

- CMS created a COVID-19 assessment tool to determine whether the facility is implementing proper infection prevention and control practices to prevent the transmission of COVID-19.

Between March 31st and April 10th, staff from HRD provided outreach to 1,045 home care providers to actively deliver support and technical assistance per CDC and MDH recommendations. Since April 16, HRD staff have conducted 207 onsite visits to home care providers and nursing homes using the ICAR COVID Action Plan to help mitigate the spread of COVID-19 with support, assistance, and education to ensure the safety of home care and assisted living clients. Areas covered include, but are not limited to: surveillance, education, hand hygiene, transmission-based precatutions, personal protective equipment (PPE), environmental cleaning, and cleaning equipment. Currently, signage on proper DON/DOFF of PPE posted inside and outside of COVID positive resident's rooms was the area of lowest percentage being seen or observed while onsite.

Table 1. Lowest Response Rate from HRD COVID Onsite Visits			
Area	Question	Response	%
Visitor Entry	Facility has one Entrance/Exit for access	Yes	85%
Facility Process at Entry	Required to wear facemasks and eye protection	Yes	84%
Guidance for Visitors	There are signs posted about the Facility of these reminders	Yes	74%
Hand Hygiene and PPE	Signage on the proper DON/DOFF of PPE posted inside and outside COVID+ resident's room	Yes	67%
Cleaning	Clean and disinfection Log being kept	Yes	70%
Resident	If residents leave their room, are they wearing a facemask?	Yes	72%
Training related to COVID-19	Staff trained for proper cleaning of surfaces	Yes	84%
Crisis Plans	Does the facility have a staffing shortage?	No	77%

*Date range of data as of May 28, 2020

Between March 24th and June 2nd 2020, L&C has completed, scheduled, or is currently in the process of completing 430 surveys (infection control focused or stand alone complaints) for nursing homes. Currently, 29% of completed surveys resulted in findings that the facility was not in compliance with infection precention and control practices as per CMS guidelines and were issued infection control citations as a result.

Table 2. IC Citations issued to nursing homes for completed or underway COVID-19 surveys	
Completed	
Total tags issued for completed surveys	101
Proportions of completed surveys resulting in IC citation	29%
Underway*	
Total tags issued for underway surveys	62
Proportions of completed surveys	67%
All Surveys	
Total tags issued	163
Proportion of completed or underway surveys resulting in IC citation	39%
*Citations issued for surveys currently underway are subject to change and are not final until the investigations is completed.	

In CMS QSO Memo 20-33 (listed below), CMS has indicated they also are posting state inspection findings and reports on the Nursing Home Compare Website found here: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg

CMS QSO Memo 20-33: https://www.cms.gov/files/document/qso-20-33-nh.pdf

14. How many individual remains are stored in the warehouse facility purchased by the State of Minnesota for $6.9 million on May 19?

No bodies have been stored to date. This facility is to serve as backup in case it is needed. Based on the experience we saw from other states, we wanted to make sure that the bodies of Minnesotans would be able to be handled with dignity and respect.

15. What, if any, guidance is being considered and/or drafted for residents to receive visitors?

We know that it's important for residents of these facilities to have visitors. MDH is actively working on developing guidance so that residents can have visitors safely. This will include guidance for window visits and outdoor visits.

16. What, if any, guidelines are being considered and/or drafted for on-site beautician services?

We know that it's important for residents of these facilities to have access to these services. MDH is actively working on developing guidance so that these services can be performed safely.

17. What are MDH's guidelines for furniture in public space in long-term care settings?

The disinfecting guidelines for furniture in public space in long-term settings can be found in MDH's Long Term Care Toolkit, on page 16.
https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf

Sincerely,

Jan K. Malcolm, Commissioner
Minnesota Department of Health

Attachments:
Q1 – Cases by county
Q2-3 – Cases and deaths by facility
Q4 – Cases and deaths by facility type
Q5 – Facilities with Hospital Discharges
Q7 – Testing Report
Q12 – LTC shipped PPE