Testimony before the House Aging & Long-Term Care Committee

On the COVID-19 Pandemic

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Chairman Ginter, Vice-Chair Swearingen, Ranking Member Howse and members of the House Aging & Long-term Care Committee, thank you for inviting comments from Ohio's long-term care community on how our residents, staff and communities have been transformed by the COVID pandemic. I am Judy Budi, and I serve as the President and CEO of Graceworks Lutheran Services, which offers a continuum of services to older and disabled Ohioans, including a life plan community located in Centerville, affordable senior housing located in 3 states and in Ohio Clermont, Logan, Champagne and Montgomery Counties and serve 225 individuals with intellectual disabilities in 46 homes in SW Ohio including 3; 8- or 10- bed intermediate care facilities in Hamilton County for Ohioans with intellectual and developmental disabilities.

My colleague Mike Ray provided a comprehensive overview of the pandemic to-date. My testimony will focus on what I see as today's pressing challenges: namely, how Ohio's long-term care facilities and senior living programs are coping, now that the rest of Ohio is opening up.

Before I begin, I want to point out that while you've requested input on the experiences of nursing homes and long-term care, we are just one of dozens of different types of congregate settings that have the same struggles. Across Ohio, there are also assisted living, senior housing, homeless shelters, recovery housing for those who have experienced addiction, intermediate care facilities for individuals with intellectual and developmental disabilities, and numerous other settings that face the same challenges of managing individuals with complex needs, in very close proximity to one another, with shared staff. As concerned as we are about nursing homes-- and certainly, nursing home residents are the most vulnerable to this illness, by all accounts-- we are as concerned about vulnerable older adults residing in senior housing, for example, where there are no clinical or medical staff on site to provide that first line of support.

As the rest of Ohio begins to open up, our attention has turned to how this opening will impact our communities. While the rest of the world focused on "flattening the curve," those of us who serve older adults have long recognized that we have a long and arduous road ahead of us. Mike outlined some of those challenges: our complete business model has been overhauled, and we've had to employ new technologies and strategies to adapt to this new, socially-distance norm. As a retirement community we have adapted as many Ohio businesses since early March- including gift shops, dining, fitness centers, salons, and all of the programs and services that support community life at each of our locations. Since we serve individuals over the age of 60, all of our

residents are considered vulnerable. As Ohio opens up, we look at each of our services through a different lens- how can we decrease isolation and keep the individuals safe.

While I have been encouraged by our ability to adapt to some of the changes, the fact of the matter is that social isolation is taking its toll on the older adults we serve. Research shows us that social isolation can be as damaging to the health of older Ohioans as smoking, and yet the isolation being experienced in our nursing homes has only been a footnote in the public conversation around the sacrifices Ohioans have made during this time. In fact, all older adults are encouraged to continue to shelter with no end date identified.

We pride ourselves on being able to build community within our walls, but with residents largely confined to their rooms, it is a challenge to do even that. We believe that there are reasonable steps we could take to begin careful visitation with family and loved ones and social engagement between residents, but we can't take any of these steps without a comprehensive system to detect and monitor the virus transmission in the larger community. Ohio is woefully unprepared to support those who are most threatened by the pandemic.

It's been nearly six weeks since we began to realize that a hospital surge would not occur. We have known for that amount of time that nursing homes would, by virtue of the population we serve, be the battleground for this pandemic. We have understood the necessary components for a response: we need cost effective, accessible, rapid testing, PPE in abundance, a layered staffing plan that can surge in when staff must be quarantined, and close partnership between local health departments, congregate care facilities, and hospitals. Ohio has a few examples of these parts coming together to form a cohesive, regional system, but these examples are the exceptions, not the rule. Despite its efforts, Ohio has not been able to assemble these parts into a system that works for every Ohioan, regardless of their zip code.

As an illustration, I would like to share a recent experience that my organization went through, as we worked to access testing on behalf of a resident.

Graceworks Lutheran Services operates an eight- bed intermediate care facility (ICF) in Hamilton County for the developmentally disabled. In early May, we had three staff test positive and three residents test positive for COVID-19 by going to the emergency department for testing. It was a couple of days to figure out which health department had jurisdiction. Once identified, we dedicated an entire week working with the local health department on getting the remaining residents tested. Our options were to take them to the emergency department or load them into the mini-bus and transport to a drive-through testing site. The local health department acknowledged that we were a level 2 priority but noted the system was not yet up and running to meet the needs of our residents. It wasn't until the physician advocated that the remaining five residents were symptomatic that ODH finally agreed to test. Then we paid $90 to have a courier transport them to the ODH lab in Columbus. The local health department seemed as frustrated as we were and was sorely understaffed. They were able to provide the test, but they couldn't take the sample or provide the lab processing. We utilized online education to train our nurse how do take the samples and wear the designated personal protective equipment. They encouraged us to contract with a local hospital lab but days of phone calls

went unanswered. All the time, we were balancing the health and safety of the residents and the remaining employees.

In this example, some of the necessary building blocks were there: we had a cooperative but under-supported local health department, we had tests, but no designated person to take the samples, and no lab willing to process them, we had a protocol that should have prioritized our residents, but it was not yet implemented at this local health department. We had the pieces, but we did not have a solution that worked to produce the outcome we needed. We have participated on many phone calls with the local health department and various other organizations- they have so many different tasks they are assigned through this pandemic, that organizing a system for nursing home testing has not been a focus.

Until we have reliable testing, a more collaborative approach to assist facilities when there is an outbreak on how best to mitigate it, financial assistance to help address workforce issues, long-term care facilities will continue to struggle and those we care for will continue to bear the consequences of this struggle.

Often times, a crisis can offer opportunity for innovation. We already have examples of innovation, with new tests being piloted, Ohio manufacturers retooling to produce PPE, and others stepping forward with technology to sterilize items that previously were single-use. In terms of telehealth technology available to Ohioans and their healthcare providers, the recent flexibilities have enabled us to make large jumps forward. We believe that some of these flexibilities could be made permanent. We have seen rapid deployment of communication technology to facilitate visitation and reduce loneliness, but to date, the cost of these efforts have been born by providers. Some of the regulatory restrictions have removed previous barriers—for example, nurse aide training waivers have allowed us to integrate online learning, a format that was previously now allowed in Ohio law. CMP grants were offered to pay for Ipads to support telehealth visits; we applied within days but have yet to hear if the money has been awarded. Thankfully, a generous contributor supported the purchase of four for our facility.

We would be grateful for any efforts to apply the same innovative thinking and ingenuity to improve Ohio's detection of and response to COVID outbreaks in long-term care. Currently, federal agencies are recommending weekly testing of all residents and staff using an extremely invasive, uncomfortable method of specimen collection. While Ohio has focused on building lab capacity, we still don't have a plan for how specimens will make it to the lab, how the testing will be paid for, and who will help long-term care providers make the necessary changes—staffing support, resident cohorting, or transfer to other facilities—when the test results come back.

Many of us are still working to find out which hospital system will be our designated partner. Early on the hospital systems reached out to us, to confirm we would take overflow discharges. We opted to not set up a designated COVID unit to accept these referrals, and we were subsequently told this could impact any referrals we might receive. This does not form the basis of a partnership in which both parties look for systems and processes to meet the needs of ALL the people we serve.

We can and we must solve these challenges. The alternative—maintaining the current level of social isolation for tens of thousands of vulnerable older Ohioans over the year or more ahead—is simply untenable. We cannot continue to ask families to endure separation because we have failed to mount an adequate response that supports long-term care settings. I believe we can make up for lost time if we chose to channel our energy, ingenuity and resources where it is needed most.

I understand that there is concern that some individuals in nursing homes may be dying alone. Families are able to visit at end of life situations, but that is not enough. We have many couples that live in our community; one in independent living and one in the nursing home. They visit daily and often times many times a day. The same can be said for family members or spouses in the larger community. I have observed firsthand the depression that is occurring with the independent spouse who has been married for 60+ years and is now unable to visit, to touch the person they love. Recently we had a resident who had a stroke and passed away within a day. Her husband was there with her in the last few hours when she was not able to communicate. What did he miss- the last 10 weeks of visits and memories because his visitation was restricted. Yes, there is risk in visitation, there is risk in the health impacts of isolation. As Americans, we have to find an improved solution for the frailest in our society- the people who have given so much for our country previously.

Thank you for the opportunity to provide this testimony before you today, and I am happy to answer any questions the Committee may have at this time.