Montgomery County Council

Committee: Directly to Council
Committee Review: N/A
Staff: Linda McMillan, Senior Legislative Analyst
Purpose: Receive briefing and have discussion – no vote expected
Keywords: vaccine**,** Nursing Home, DDA, COVID-19

AGENDA ITEM #2C
February 9, 2021
Discussion

SUBJECT

Discussion with Maryland Department of Health (MDH): Vaccine Allocation, Distribution and Equity; State and County Responsibilities for Nursing Homes; and Coordination of COVID-19 Vaccinations for Nursing Homes and Developmental Disabilities Administration (DDA) Group Homes

EXPECTED ATTENDEES

Dr. Jinlene Chan, Deputy Secretary for Public Health Services (Acting), MDH
Dr. Mark Martin, Deputy Director, Office of Minority Health and Health Disparities, MDH
Heather Shek, Deputy Director, Office of Governmental Affairs, MDH
Dr. Raymond Crowel, Director, Department of Health and Human Services (DHHS)
Dr. Travis Gayles, County Health Officer and Chief of DHHS Public Health Services
Dr. Odile Brunetto, Chief of DHHS Aging and Disability Services
Dr. Earl Stoddard, Director, Office of Emergency Management and Homeland Security
Enrico Lachica, Clinical Nurse Administrator, Licensure and Regulatory Division Services, DHHS

COUNCIL DECISION POINTS & COMMITTEE RECOMMENDATION

- Discussion and questions/responses with representatives from MDH regarding: COVID-19 vaccine allocation, distribution, and equity; Nursing Home and Long-Term Care Facility oversight; and the ongoing contracts with CVS/Walgreens for nursing homes/long-term care facilities, DDA group homes, and individuals with Intellectual/Developmental Disabilities who do not reside in group homes.

DESCRIPTION/ISSUE

COVID-19 Vaccine Allocation, Distribution, and Equity

The COVID-19 vaccine is currently in very short supply and there is very great demand. While there is short supply it is critical that certain portions of the population are prioritized. The top priorities have been healthcare and emergency response staff, people in long-term care facilities and DDA group homes, and people 75 years old or older. The Maryland roll-out has opened to other priority groups, resulting in many more people in the State being "eligible" than can receive the vaccine in the near term. There is not a clear equity plan regarding the allocation of the vaccine to local jurisdictions. Communities of color that were and are most impacted are not being vaccinated at similar rate as white residents. The registration system is decentralized and confusing. Inequities are magnified because online systems for getting an appointment require internet access, computer skills, and time to be online. Montgomery County is seeing these disparities in the demographics and areas of the County of those signing up in the

pre-registration system. The Council sent a letter to Governor Hogan on January 28, 2021 outlining its concerns (attached pages 1-5). The Maryland Department of Health responded to this letter on February 2 (attached pages 6-8)

On February 2 at the Maryland House Health and Government Operations Committee's hearing on the COVID-19 vaccine rollout, the Committee heard from the Maryland Association of County Health Officers (MACHO). MACHO stated its concerns about the State's expansion to more sites without an additional vaccine supply and under-supporting Local Health Departments' ability to reach most vulnerable. They said challenges include Local Health Departments not being involved or informed in the planning process, unclear guidance on broad priority groups, short notice on allocations limiting the ability to adequately plan, and problems with the State database (PrepMod). MACHO made these requests:

- Prioritize allocations to the Local Health Departments while supply is limited.
- Involve Local Health Departments and Emergency Managers in the planning process.
- Clear and timely notice of vaccine allocations.
- Clear lines of authority for decisions related to vaccinations.

On February 2 the Maryland Congressional Delegation sent a letter to Governor Hogan (attached pages 9-12). These are summary points from the letter.

- Maryland needs a course correction.
- State's lack of guidance to health providers, hospitals, and local health departments.
- Concerned about State's ability to efficiently deploy higher allocation, such as targeting to areas of the State with the higher rates of infection.
- Local Health Departments are grappling with influx of residents from a county where they neither reside or work because of a lack of a simple and centralized system.
- Maryland is immunizing communities of color at significantly lower rates.
- Why are some Local Health Departments facing a reduction in allocation when they meet the previously stated metric of administering at least 75% of doses?
- How will the State keep its commitment not to reduce the doses to these Local Health Department when doses are being re-channeled into distributions to hospitals and private partnerships?
- Federal government has announced it will provide states with three weeks' notice of allocation. How will the Governor's office improve communication about how many doses they will receive?
- How will state-run sites coordinate with Local Health Departments?
- Will the State provide guidance on vaccine administration among priority groups given persistent confusion across counties and limited supply?
- How is the State planning to use the $402 million federal relief dollars for vaccination, testing, tracing, mitigation?
- Maryland would benefit from increased transparency. Requested contracts between State and private sector partners.

Nursing Homes and Long-Term Care Facilities

On December 3, 2020 the Health and Human Services (HHS) Committee was briefed by DHHS on its roles and responsibilities in inspecting nursing homes, the role of the State in inspections, citing facilities and issuing fines and the Long-Term Care Ombudsman Program which was paused when facilities were

closed to visitors. The Council President and Chair of the HHS Committee recommended that the full Council have a similar briefing and that a representative from the State be invited to participate.

Nursing Homes were one of the earliest settings in the United States where the coronavirus spread and deaths from COVID-19 were high. Nationally and locally, deaths from nursing home residents have been a disproportionate number of deaths. By the end of January, nationally over 150,000 residents of Long-Term Care facilities had died.

Montgomery County has approximately 9,000 residents living in 34 nursing homes, 37 domiciliary/large assisted living facilities (17 or more beds) and 233 small assisted living group homes/facilities (3-16 beds).

On February 4, 2021, Montgomery County had 1,280 confirmed deaths from COVID-19. Of those, 716 were residents of Nursing Homes/Long-Term Care and 10 were staff members at these facilities. This means 57% of COVID deaths in Montgomery County are associated with Long-Term Care Facilities. While the State posts data by facility on its website, it is data on cases and deaths only for the facilities where there are one or more active cases – it does not represent the total. For example, the State website on February 5 shows Montgomery County has 2,156 resident cases, 1,853 staff cases, 510 resident deaths, and 5 staff deaths. Deaths at facilities without active cases are not reported in the weekly numbers.

At the beginning of the pandemic, there were many serious concerns and problems related to adequacy of Personal Protective Equipment (PPE), shortage of staff when they became infected and could not work, notice to health officials about outbreaks, and notice to families about outbreaks and status of family members. The County assisted with PPE but the State had responsibilities for response teams that could provide technical assistance or bridge staffing to address infection control issues.

Isolation is also a serious issue. The Long-Term Care Ombudsman Program was paused because of the pandemic and there needs to be support and commitment to resume on-site visits. It is also important to ensure that all long-term care facilities have visitation protocols consistent with the Centers for Medicaid and Medicare and the State.

CVS/Walgreens Contracts for Long-Term Care and DDA Group Homes

The CVS/Walgreens COVID vaccination program is vaccinating residents and staff in nursing homes, assisted living facilities, and for DDA funded group homes. These contracts are federal and state coordinated and do not involve the Local Health Departments. It is important for the Local Health Department to have proactive information sharing to be able to monitor that all facilities in the county have been scheduled (there are at least four organizations with DDA group homes that are for some reason not included.) The County also needs to understand how many people are declining to be vaccinated to determine if outreach and education can be provided.

The CVS/Walgreens contract are set up to provide three phases/clinics for each facility. It is unclear who is responsible for vaccinating people who were not able to be given first and second vaccines under this structure, including new residents who may be frail or have a disability that prevents them from travelling to a clinic.

Attached: **page**

Alternative format requests for people with disabilities. If you need assistance accessing this report you may submit alternative format requests to the ADA Compliance Manager. The ADA Compliance Manager can also be reached at 240-777-6197 (TTY 240-777-6196) or at adacompliance@montgomerycountymd.gov

MONTGOMERY COUNTY COUNCIL
ROCKVILLE, MARYLAND

Governor Lawrence J. Hogan, Jr.
100 State Circle
Annapolis, MD 21401

January 28, 2021

Dear Governor Hogan,

We are writing today to thank you for your recent conversation with County Executive Marc Elrich and your announcement of 18,825 vaccine doses for our shared constituents. We hope that you will continue to increase the number of vaccines sent to Montgomery County, and to help improve the coordination and equity in the rollout of the COVID vaccine. We appreciate your leadership on vaccine rollout and understand that the current federal supply and distribution of the COVID-19 vaccine is unacceptable. We know the 70,000 to 75,000 doses the State is receiving are not adequate. We are hopeful that the Biden Administration's promise to declare war on the coronavirus and the President's commitment to release more vaccine to the states along with the Federal Government purchase of more vaccine will result in big improvements soon.

We hope that you will continue to meet with County Executive Elrich. We are offering to meet with you or Acting Secretary Schrader either at one of our Council sessions or at another time. We will continue to invite the Maryland Department of Health (MDH) to participate in our virtual town halls.

We are sharing the following requests and concerns.

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Distribution of Vaccine

As you have recognized, our County Health Department has been highly successful at getting vaccines into arms. While we appreciate that you allocated 18,825 total first doses to county organizations this week, the number of first doses that came to the County Health Department declined. We have gone from receiving 8,600 first doses the week of January 5 to receiving 5,500 first doses this week.

Montgomery County is well prepared to receive an increasing number of first doses each week. It would be especially helpful to have a known minimum the County Health Department can expect to receive each week (preferably no less than the week before). We are committed to administering all first doses by the time the following week's shipment arrives.

We also ask that if you find one of the other vaccinators in the County is not using their doses, do not reduce the total amount coming to the County, but redirect them to the County Health Department. Your message to hospitals that they will not be prioritized for additional vaccine if they fall short of 75% utilization is on target, but if you find this is the case in Montgomery County, please redirect the vaccine to the Health Department.

Coordination among Vaccinators

We appreciate your announcement to widen the number of vaccinators to serve our residents, but a coordinated system is crucial. Residents are confused about where they should sign up - through the County website, the Giant, Adventist Healthcare, Holy Cross, Johns Hopkins, Medstar, Kaiser, or all of them. Many are frantic to receive the vaccine and are shopping multiple sites and unfortunately, this leads to problems. A healthy 66-year-old should not be able to get a vaccine before an 83-year-old because they managed to get through to a local Giant pharmacy. All the vaccinators in the County should be working together with the same priorities and one unified place to sign up.

Equity

It is critical that we get the vaccine to our most impacted communities, including people of color whom we now know are more likely to test positive and face a higher risk of death. Targeting these high impact zip codes where community spread is higher will also help reduce new cases and help us control spread overall.

The need to intentionally address inequities is evident in the data on people who had pre-registered online as of January 24. In Montgomery County, 19% of COVID cases are Black/African Americans and 40% Hispanic/Latino. Eighteen percent (18%) of deaths are Black/African Americans and 20% Hispanic/Latino. Yet, of the more than 95,000 residents that have pre-registered for a vaccine online, 71% are White, 14% are Asian or Pacific Islander, 7% are Hispanic/Latino, and 6% are Black/African American.

We hope that the State and County can partner to allocate and administer vaccine through equitable channels by reaching out to communities through our networks and assisting them to get pre-registered.

Currently, we are outreaching to our most impacted communities to ensure that they have the opportunity to pre-register. The PrepMod system allows first-come-first-serve access, disregarding the priorities that you have set for vaccination, and disadvantaging persons with limited online access or skills. We would welcome an opportunity to work with the State to have a coordinated sign-up process that will ensure that access to vaccines does not perpetuate healthcare disparities.

Schools and Childcare

We all want our public schools to re-open. We appreciate that a portion of the 8,775 doses allocated to Suburban/Hopkins are for teachers and staff. We need the State to increase this amount. Montgomery County Public Schools has over 24,000 employees. About 56%, or 13,440, are teachers and about 40%, or 9,600, are support staff. Montgomery County Public Schools has been and continues to work on a priority vaccination plan with the County Health Department. Within this group we ask that the staff of licensed childcare providers be included. As schools reopen in-school education childcare will be vital to our success.

Technology - Fixing Problems with PrepMod

The PrepMod system was not built for the unusual circumstances of this pandemic. Unlike flu, the vaccine is scarce, it needs to be prioritized, and it needs to be limited to sequential groups of prioritized residents in specific counties. At the same time, we must have a system that makes appointments, tracks vaccines, and lets people know when it is time for the second dose.

Can the State add safeguards to the PrepMod System that would prohibit people from signing up for an appointment unless they live in the County where the clinic is being held and prevent people from registering with links that have been passed around by e-mails and list serves? At minimum we need strong language telling people that their appointments will not be honored

unless they received the link directly from the county, hospital or pharmacy – not from a neighbor, co-worker for other people who may be passing it along with the best of intentions. It was very unfortunate and upsetting to have people show up for a vaccination at our Quince Orchard clinic and then have to and turn them away – even if they shouldn't have registered. It makes them angry and it undermines everyone's faith in the ability of government to roll out vaccines.

CVS/Walgreens contracts (transparency and accountability)

The County does not have any way to determine when and if all nursing homes, assisted living, DDA group homes, and other congregate settings are being vaccinated. The County should be provided with a schedule of vaccination clinics and the results of each clinic. There are reports that not all group homes or providers are known to CVS or Walgreens. The County is not able to monitor or tell people when a pharmacy is scheduled for a nursing home.

The County received a spreadsheet that showed the partnership assignment between facility and pharmacy but no proactive information on the progress of vaccinations. The County outbreak investigators do collect vaccination information for facilities that are in outbreak status but do not have any data from facilities that do not have any active outbreaks. The County has been told that CVS/Walgreens reports vaccination data to MDH but this is not shared with the county. MD Alert sent out a message saying that all nursing homes in Maryland have been vaccinated. The County cannot confirm this and does not have information on follow-up clinics and second doses.

In addition to your response to this letter about the vaccine, we are hoping that a representative from the Maryland Department of Health can join the Council on **Tuesday, February 9th between 10:00 and noon for our weekly COVID Update to specifically talk about nursing homes and vaccinations for people with developmentally disabilities and their support professionals and caregivers.** With regard to nursing homes, we want to clarify and discuss the roles and responsibilities for inspections and remediation of deficiencies related to COVID inspections. In both cases the Council wants to understand how the State is overseeing the CVS/Walgreens contract to maximize the number of residents and staff that are vaccinated, and how the County can get information about those who decline vaccinations to reach out with additional education on the vaccine.

C: Acting Secretary Schrader, Maryland Department of Health (MDH)
Deputy Secretary Chan, Public Health Service, MDH
Deputy Secretary Ye, Health Policy, MDH
Senator Craig Zucker, Chair, MC Senate Delegation
Delegate Marc Korman, Chair, MC House Delegation
County Executive Marc Elrich
Melanie Wenger, Director, MC Office of Intergovernmental Relations

Tom Hucker
Council President

Gabe Albornoz
Council Vice President

Evan Glass
Councilmember At-Large

Will Jawando
Councilmember At-Large

Hans Riemer
Councilmember At-Large

Andrew Friedson
Councilmember District 1

Craig Rice
Councilmember District 2

Sidney Katz
Councilmember District 3

Nancy Navarro
Councilmember District 4

Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

February 2, 2021

Montgomery County Council

100 Maryland Avenue, 5th Floor

Rockville, Maryland 20850

Mayor and Council of Rockville

111 Maryland Avenue

Rockville, Maryland 20850

Dear Council President Hucker, Mayor Newton, and County & City Council members:

Thank you for your correspondence to Governor Larry Hogan dated January 26 and 28, 2021 regarding Maryland's vaccination efforts. The Governor's Office has reviewed your correspondence and asked the Maryland Department of Health (MDH) to respond as the most appropriate agency.

First, we want to thank you all for your assistance and support during these unprecedented times. We believe that all levels of government share the common goal of ensuring a safe, equitable, and efficient distribution of Maryland's allocation of the COVID-19 vaccines.

To further this shared mission, we offer the following courses of action for your consideration:

Distribution of Vaccine:

We appreciate your continued efforts to vaccinate Marylanders in an efficient manner. Please see the enclosed MDH Provider Bulletin for Week 8, which is publicly available on https://coronavirus.maryland.gov and was distributed to all vaccine providers, including local health departments. The second page includes information on weekly allocation numbers for local health departments.

Coordination among Vaccinators:

Marylanders can access the statewide list of vaccination sites in two ways. For those that prefer to use a phone, they can dial 2-1-1 and press 2, and a customer service representative will walk them through registering at a clinic near them. If they prefer to use a computer, MDH recommends that they visit covidvax.maryland.gov, where they can search for a clinic near them and utilize that provider's registration system. By having multiple reservation options, the website enables citizens to access the vaccine in whatever manner is most convenient for them.

Equity:

The Governor announced the state's "GoVax" grassroots education and outreach initiative, as well as the Maryland Vaccine Equity Taskforce, at a joint press conference on Friday, January 29. This effort includes rolling out a multi-platform, statewide, extensive grassroots education and outreach program that targets minority communities and vulnerable populations in the coming days and weeks. Specific outreach activities include: **Mobile Public Health Education Unit** ("sound truck"): The sound truck will continue to broadcast multi-lingual audio messaging, distribute free masks (3,000 avg.), multi-lingual COVID-19 information sheets/flyers (avg. 3,000) to minority communities; **Clinical Mobile Screening Units** with vehicles located in hard to reach communities and serve as temporary mobile vaccination sites and provide education regarding COVID-19; **Public Gathering Spaces** (i.e., laundromats, transit stops, retail establishments, etc.): Mini-webinars that can be accessed by QR Code or Weblink where the user can watch a 5 minute video that promotes participation in vaccination efforts; **Information Sheets/Flyers**: Continue to distribute COVID-19 information sheets/flyers to minority vulnerable communities; **Historically Black Colleges & Universities (HBCUs)**: Push and promote COVID-19 vaccinations communications and messaging to students, faculty, and staff.

In addition, **we have allocated doses of vaccine to Kaiser Permanente (Gaithersburg), Holy Cross Hospital as well as Adventist Hospital (White Oak)** to focus on those healthcare providers' patient populations. The three locations serve diverse populations representative of Montgomery County.

Additionally, MDH has planned enhancements to the PrepMod registration system utilized by Local Health Departments that include non-transferable links that allow only a single registration and the ability to create a link for a specific clinic location.

Schools and Childcare:

Staff of licensed childcare providers are included in educators who are eligible to receive the vaccine. Please see Sections 6 and 8 of the MDH Provider Bulletin for Week 8 and related Vaccine Distribution for Nonpublic School Faculty and Staff Memo for further details. We remind local jurisdictions that all educators who are eligible for the vaccine be distributed the vaccine equally across all types of educational settings, both public and nonpublic.

Technology:

Please see the information provided above on planned PrepMod System enhancements to address many of the stated concerns.

All State-run vaccination sites will be open to any Marylander eligible to receive a vaccine. Maryland, the District of Columbia, and Virginia are jointly recommending that residents, if they are in an eligible employment category, be vaccinated where they *work*, and residents who are eligible due to age, be vaccinated where they *live*. MDH has allowed Local Health Departments to impose jurisdictional residency requirements at their discretion, however we have recently received guidance from the federal government that requiring proof of residency is prohibited. We are currently seeking clarity from the U.S. Department of Health and Human Services (HHS) on this important issue.

The latest January 25, 2021 guidance from the Centers for Disease Control is as follows:

> **Are there residency requirements with regard to who may be vaccinated with COVID-19 vaccine?**
>
> 1. Any person living in the US, regardless of duration, is eligible to be vaccinated. There is no prohibition on vaccinating non-US citizens or non-residents. Everyone, regardless of citizenship, should have access to vaccine and is eligible to be vaccinated.
>
> 2. CDC cooperative agreements were recently modified to state that recipients "must distribute or administer vaccine without discriminating on non-public-health grounds within a prioritized group."
>
> 3. Most foreign diplomats have health care plans here in the US and they will be vaccinated where they normally get health care and that location [will]can bill the administration fee [costs] to their insurance plan.

CVS/Walgreens:

Each facility has a three-clinic cycle with their pharmacy partner to capture residents and staff who may choose to receive the vaccine after the first clinic.

Our Unified Command Coordinated Outreach Program has already reached out to your office to accept your invitation to participate at the Montgomery County Council's COVID Update on February 9, 2021.

We look forward to our continued partnership in ensuring that COVID-19 vaccines are distributed to Marylanders as efficiently and equitably as possible.

Should you have any questions, please do not hesitate to contact Webster Ye, Assistant Secretary at 410.260.3190 or webster.ye@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary (Acting)

Congress of the United States
Washington, DC 20515

February 2, 2021

The Honorable Lawrence J. Hogan Jr.
Governor
State of Maryland
100 State Circle
Annapolis, Maryland

Dear Governor Hogan:

We write to you today regarding the current status of Maryland's vaccination strategy. Across the state, Marylanders eligible for the vaccine are unable to schedule their appointments and do not know when, where, and by whom they can get vaccinated, leaving people and communities extremely frustrated. It is clear that the State is not meeting the needs of Marylanders, and we urge you to put forth a strategy and clear guidance that significantly improves Maryland's vaccination program.

Since the early stages of the pandemic, public health officials have maintained that widespread immunity via mass vaccination campaigns would be the most effective path to defeating COVID-19 and returning to pre-pandemic life. We have long expected that launching the most ambitious vaccination operation in our nation's history would present many challenges: grappling with initial limited vaccine supply, prioritizing vulnerable populations, combating vaccine hesitancy, coordinating with local jurisdictions, communicating accessibility, reaching hard-to-reach communities, and ensuring vaccination equity among communities of color. We appreciate how difficult these decisions and obstacles are, many of which have unfairly fallen on state and local governments to solve.

Due to actions by the Trump administration, state governments are responsible for spearheading the robust vaccination programs needed to extend immunity across the nation. Such a vaccination strategy is critical to our efforts here in Maryland. Yet, Maryland has been falling far short. In the early stages of vaccine rollout, Maryland was ranked 50th—last among states in terms of the percentage of shots administered. As of writing this letter, Maryland is ranked 41st on that metric and we are concerned about the state's lack of guidance provided to health providers, hospitals, and county health departments. A course correction is needed.

Congress has recognized the constraints states face when scaling up a large vaccination program and last month passed a COVID-19 relief package that included $19 billion to boost vaccine manufacturing and purchasing and $8.75 billion for vaccine distribution, administration, and monitoring. To be sure, much more support is needed, and the Biden stimulus plan includes $160 billion for vaccine and testing efforts, as well as robust funding for state and local governments. In addition, President Biden announced last week that the federal government will purchase 200 million additional doses and increase states' allocation of vaccines by 16%. We are

pleased that the Biden stimulus plan includes $160 billion for vaccine and testing efforts, as well as robust funding for state and local governments. Even with robust support from the federal government, we remain concerned that the State will be strained to efficiently deploy Maryland's higher allocation, such as targeting doses to areas of the state with higher rates of infection. Simply opening up new phases when supply will continue to be limited in the near future amplifies the high demand and logistical challenges that Marylanders are already experiencing.

We are hearing every day from constituents and local officials expressing immense frustration and confusion with the program's inefficiency and inequity. Marylanders that fall in phases 1A-C have been told by the Maryland Department of Health (MDH) that they are eligible to receive the vaccine. Yet, MDH has not released clear directions, nor created a streamlined process needed for Marylanders to actually get a vaccine. More often than not, eligible Marylanders are unable to set up appointments or have had their scheduled ones unexpectedly cancelled. Individuals who are housed or work outside of easily leveraged health care infrastructure—such as self-sufficient seniors—do not know where they should go to get their vaccinations. And schools have been directed to reopen, but educators are unable to find an appointment or location where they can get the vaccine.

Due to the lack of a simple and centralized process, local health departments are grappling with an influx of residents trying to receive a vaccine from a county in which they do not reside or work. This further exacerbates the disparities in vaccine access that demographic data is already demonstrating: Maryland is immunizing communities of color at significantly lower rates. Black Marylanders have received about 16 percent of first doses. Yet they account for approximately 35 percent of COVID-19 deaths and make up 31 percent of the state's population. In the absence of a clearly communicated vaccine strategy, guidance, and transparency, the state's vaccination program is failing Marylanders.

These issues must be addressed immediately. It is critical that the state put forward a strategy that addresses the glaringly apparent disparities in vaccine access and increases equitable vaccine administration to minority communities. Your health officials can increase efficiency by working collaboratively with local jurisdictions to ensure efforts are coordinated and that they have the resources needed to triage vaccine traffic efficiently. Leaving localities to fend for themselves and compete amongst each other is counterproductive. Additionally, MDH must work to provide clear, accessible information and simplify the vaccination process. Similar to other states' systems, we urge you to establish a one-stop website for online appointment booking and a call center to schedule vaccinations for those with limited Internet access—a common problem among seniors. As the State increases locations for vaccine administration that apply different eligibility criteria, too many people do not know where or how they can get vaccinated. This fragmented approach is just not working. A centralized registration website and call center is critical for reducing uncertainty.

We are seeking answers to the following questions:

1. The state previously conveyed that providers may face reduced doses if they fail to administer over 75% of received doses. Yet, certain county health departments have faced a reduction in weekly supply in light of the state's new private partnerships with Giant and Walmart, despite performing above this benchmark. County health departments play a crucial role in ensuring equitable access to vaccinations. How does the State intend to keep its commitment not to reduce allocations to County health

departments that have met their targets? How much of the County and City health departments' allocations have been re-channeled into distributions to hospitals and private partnerships?

2. Counties need a reliable source of vaccines to allow for proper planning and administration of second doses. The federal government announced that it will provide states with three weeks' advance notice of their estimated vaccine allocation to help states with their planning. How will the Governor's office improve communication to counties regarding how many vaccines the state is receiving each week and how many of those will flow to the local jurisdictions each week?

3. How will the State-run mass vaccination sites coordinate with the county health departments to avoid confusion and maximize the doses provided by the federal government?

4. The state has opened up vaccine eligibility to Marylanders in Phases 1A, 1B, and 1C, which represent over two million Marylanders. Thus, the state will need four million doses of two-dose vaccines to complete Phase 1. Yet, the total supply Maryland has received to date is 852,625. If the state continues to receive about 10,000 doses a day and all eligible Marylanders opted to get a vaccine, we will still face a shortfall of 2.8 million doses in four weeks. In many cases, seniors in Phase 1B are struggling to get the vaccine at hospitals or through pharmacies, while individuals in subsequent priority groups can. Counties have applied a tiered system where certain groups in 1A, B, and C are eligible and others are not. In light of persistent confusion across counties and limited supply, does the state intend to issue statewide guidance specifying the order in which vaccines should be administered among priority groups?

5. How is the state planning to use the $402.6 million in federal relief dollars provided for COVID-19 distribution, testing, tracing, and mitigation? Please provide a detailed breakdown of how these public funds will be used.

6. Marylanders would benefit from increased transparency at every level of the vaccine rollout process. Can you provide the contracts between the State and any private sector partners engaged in these efforts?

The lack of state-wide coordination and communication in Maryland's vaccine program has yielded rampant confusion and a disjointed, inequitable roll out. It is imperative we stop issuing sweeping directives without giving county health departments, local jurisdictions, and educators the tools they need to implement an effective vaccination program. We must give county health departments, local jurisdictions, educators, and vaccine eligible Marylanders the tools they need to implement an effective vaccination program. We look forward to continuing to work with you to address the needs of all Marylanders

Sincerely,

Anthony G. Brown
Member of Congress

Chris Van Hollen
United States Senator

Benjamin L. Cardin
United States Senator

Steny H. Hoyer
Member of Congress

C.A. Dutch Ruppersberger
Member of Congress

John P. Sarbanes
Member of Congress

Jamie Raskin
Member of Congress

David Trone
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Member of Congress

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January 26, 2021

The Honorable Larry Hogan, Governor
100 State Circle
Annapolis, Maryland 21401

Dennis Schrader, Acting Secretary
Maryland Department of Health
201 W. Preston Street
Baltimore, Maryland 21201

Dear Governor Hogan and Acting Secretary Schrader,

The Mayor and Council write to share our perspective on an issue of great importance. We are at a critical juncture in the surging COVID-19 pandemic, with more than 416,000 deaths in the U.S. (CDC). According to CDC data analyzed and published by the New York Times (1/24), Maryland ranks near the bottom in vaccine distribution by states with only 46% of available vaccine distributed. Only 5 states had a worse distribution percentage. At this point, MDH data indicates that only 5.47% of Marylanders have received a first dose of the vaccine. The data indicate that Maryland is lagging in distribution compared to other States. We urge improvement in these metrics, as the health and safety of our residents depends on it.

The City is deeply concerned about the low number of vaccines that are being distributed to the Montgomery County Department of Health and Human Services (DHHS), relative to other Maryland jurisdictions. According to the DHHS, in the most recent week they received only 7,300 first doses. Montgomery is the most heavily populated County in the State, with the second highest caseload numbers, at 57,129 (1/25), and a disproportionate concentration of healthcare workers; yet, others are receiving a higher per capita distribution of vaccines. It is critical that the State take these factors into account and make the distribution more equitable. Despite DHHS efficiency in distributing doses, as of today Montgomery County has been unable to move to Group 1B.

To their credit, in the last week DHHS has distributed approximately 99% of vaccine doses received, but faces enormous challenges, due to a high number of eligible residents in each category. For example, there are approximately 60,000 people eligible for Phase 1A, and more than 73,000 residents aged 75 and over that qualify for Group 1B. Clearly, the math is almost insurmountable at the current pace that the County is receiving vaccines.

Additionally, we have significant concerns regarding the communication of the State's vaccine distribution and registration process. This week, the Governor announced that the State moved to Group 1B. It caused major confusion for our residents, as the County has not yet completed Group 1A. Additionally, the State moved to Group 1C today, while Montgomery County remains only able to continue within Group 1A, due to a lack of equitable distribution. This caused further confusion and created unrealistic expectations for thousands of eligible County residents who won't be vaccinated any time soon. Please provide a higher level of planning and coordination with localities, so that these unintended consequences can be avoided.

We request that you provide more detailed information regarding the pilot vaccine distribution sites operating at selected Giant Food and Walmart stores, and coming soon, to Rite Aid and Safeway. It is our goal to share as much vaccine information with our residents as possible, so that they can access these critical services. The vaccines will not only save lives, but are the key to economic recovery, and returning to some level of normalcy in our great State.

We look forward to partnering with you to achieve the timely and successful vaccination of our residents. Together, we can defeat this unprecedented global pandemic.

Sincerely,

Bridget Donnell Newton, Mayor

Monique Ashton, Councilmember

Beryl L. Feinberg, Councilmember

David Myles, Councilmember

Mark Pierzchala, Councilmember

Mayor and Council of Rockville

cc: District 17 Delegation
Montgomery County Council
Montgomery County Executive

Opinion: White Americans are being vaccinated at higher rates than Black Americans. Such inequity cannot stand.

Opinion by Uché Blackstock and Oni Blackstock
Feb. 1, 2021 at 11:15 a.m. EST
Add to list

Uché Blackstock is an emergency physician and founder and chief executive of Advancing Health Equity. Oni Blackstock is a primary care and HIV physician and founder and executive director of Health Justice.

Black Americans have suffered one of the highest death rates from covid-19, with 1 out of 735 Black Americans dying from the disease, according to the latest data. For White Americans, that figure is 1 in 1,030.

Yet White Americans are being vaccinated at rates of up to three times higher than Black Americans, as early data from the 23 states that are reporting racial and ethnic data on vaccinations show. In fact, across the country there are reports of majority-Black areas struggling to deal with nonresident White people traveling to their communities to be vaccinated.

Such inequity cannot stand. The Biden-Harris administration must urgently act to ensure that Black Americans are not left out of the vaccine rollout process. Here are four things the administration can do to stop this from happening.

First, Black people must be explicitly prioritized for the covid-19 vaccine. Despite the disproportionate impact of the pandemic on Black Americans, the Centers for Disease Control and Prevention has not explicitly used race and ethnicity as a criterion to delineate vaccine priority groups. The strategy from the CDC's Advisory Committee on Immunization Practices of using "essential workers" and "people with underlying medical conditions" to include Black Americans is insufficient. In fact, overwhelming data shows that Black Americans have fared worse than others, even within priority groups, such as health-care workers and nursing home residents.

Second, we need to bring the vaccine to the people and meet them where they are. Most notably, the initial phase of vaccine distribution has been predominantly limited to large health-care systems and chain pharmacies, which are significantly less prevalent in Black communities. While locating vaccination sites in Black communities is absolutely necessary, it is insufficient given the lack of Internet access or digital literacy and the pervasiveness of medical mistrust, as a consequence of historic and present-day racism.

Black communities need easily accessible and trusted points of access to the vaccine, such as community centers, faith-based organizations, schools and mobile vaccination units run by

credible and trustworthy community-based organizations. Additionally, vaccine appointments at sites in Black communities should and must be prioritized for people living in that community.

Third, we are running months behind on an expansive public health campaign that would provide education and address concerns about the vaccine. This campaign would provide much-needed information in a clear, digestible and culturally responsive manner. Trusted messengers, including community organizers, barbers and religious leaders, would provide vaccine education and help make vaccine appointments. Community health workers, trained lay professionals familiar with these communities, could also facilitate door-to-door outreach to residents.

Finally, the Health and Human Services Department and the CDC must mandate that states collect complete racial and ethnic demographic data, including Zip codes of those who are vaccinated, to help target public health efforts toward Black communities. As Marcella Nunez-Smith, the head of the Biden administration's Covid-19 Health Equity Task Force and a former co-chair of the presidential transition team's covid-19 advisory board, said: "We cannot address what we cannot see. We are making a choice every time we allow poor-quality data to hinder our ability to intervene on racial and ethnic inequities."

These data would then be published on a public-facing dashboard, updated in real time, and used to inform federal, state and local vaccine distribution and outreach efforts. It would also help to ensure that those in the hardest-hit communities are receiving the vaccine and not being pushed out by people from less-impacted areas.

Some in the public health field have suggested that a focus on equity could slow down the vaccine rollout. While there is urgency to vaccinate quickly, it cannot and must not be done at a cost to equity. We agree strongly with Lawrence Gostin, a professor of global health law at Georgetown University, who argues that, given the detrimental impact of systemic racism on the health of Black Americans, "a racial preference for a Covid-19 vaccine is not only ethically permissible, but I think it's an ethical imperative." In the long run, prioritizing racial equity during the vaccine rollout will result in more lives saved overall, including in the communities that have suffered the most.

If we've learned anything from this pandemic, it's that systemic racism has detrimentally influenced the material living conditions, opportunities and experiences of Black Americans, leading to a devastating human toll. A color-blind approach to vaccine distribution will no doubt prove catastrophic. If we do not act urgently, the pandemic's existing racial health inequities will only worsen. We cannot afford to waste any more time.

Long Term Care & the COVID-19 Pandemic in Montgomery County

FEBRUARY 9, 2021

1

Number of long term care facilities in Montgomery County

- Montgomery County has one of the highest concentrations of long term care facilities in Maryland serving approximately 9,000 residents
  - 34 Nursing Homes
  - 39 Domiciliary/Large Assisted Living Facilities (17 or more beds)
  - 210 Small Group Homes/Small Assisted Living Facilities (3 – 16 beds)

2

County Department Role

- This unit consists of Nurse Surveyors/Inspectors who are certified to conduct complex inspections and investigations of nursing homes. Nurse surveyors determine if nursing homes are in compliance with Federal, State, and County laws and regulations in order to be licensed and eligible to receive Medicare/Medicaid funds.
- Health care facility inspections are unannounced and conducted on and off site.

3

Office of Health Care Quality (State) Role

- Conduct inspections at all Domiciliary/Large assisted living facilities and Group Homes/Small assisted living facilities
- Provide technical assistance and oversight to the County Licensure & Regulatory department in performance of nursing home surveys
- Prepare and issue the survey findings to the facility, including any actions that will be taken and the recommendations, if any that will be submitted to CMS (Centers for Medicare & Medicaid Services)
- Coordinate any legal enforcement actions to be taken, as appropriate
- Coordinate administrative hearing(s), both formal and informal, as deemed appropriate.
- Offer in-service educational programs to the Licensure & Regulatory department staff including Federal training programs

4

Nurse Surveyor Duties (Current during the COVID-19 State of Emergency)

- Act as nursing home outbreak liaison: assist nursing homes in COVID-19 infection control self-assessments, review facility emergency preparedness plans, act as liaison between local and State health department agencies, coordinate local & State "action team" on-site visits, communicate facility PPE & testing needs to emergency preparedness agencies, provide assistance with reporting requirements to local, State, and Federal agencies, and disseminate the latest infection control guidance from CDC (Centers for Disease Control & Prevention), CMS (Centers for Medicare & Medicaid Services), and MDH (Maryland Department of Health)
- Perform pre-pandemic duties, in addition to on-site focused infection control surveys, and communicate noncompliance with facilities and regulatory agencies

5

Fines/Sanctions

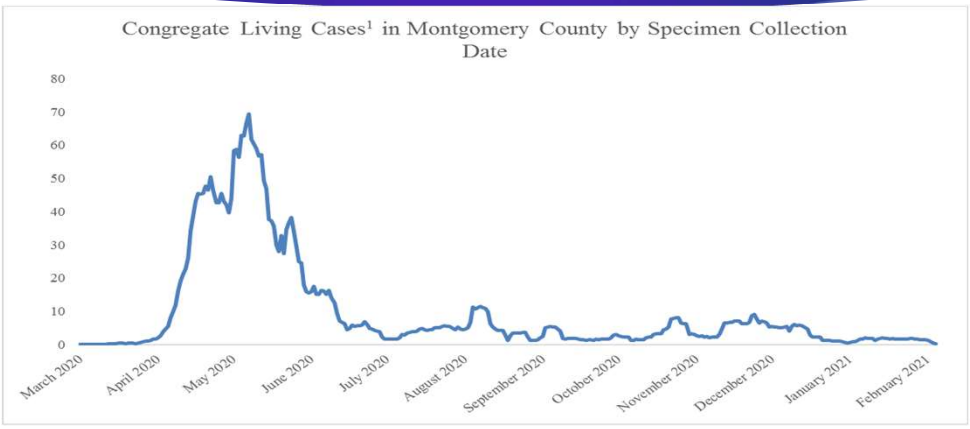
- When a nursing home is cited for a serious health or fire safety deficiency, or fails to correct a citation for an extended period of time, this can result in a penalty. A penalty can be a monetary fine against the nursing home or the denial of payment from Medicare. Penalties are based on the scope and severity of a citation and are determined by Centers for Medicare & Medicaid Services and Office of Health Care Quality
  - Survey results and Federal Civil Monetary Penalties within the last 3 years are published on the Medicare.gov website in the nursing home's Medicare.gov profile.
- Providers can be fined up to $10,000 per day for a harm deficiency
- Payment denial for resident stays
- Withdraw State approval of a nurse aide training and competency evaluation program

6

COVID-19 Response in the Long Term Care Setting

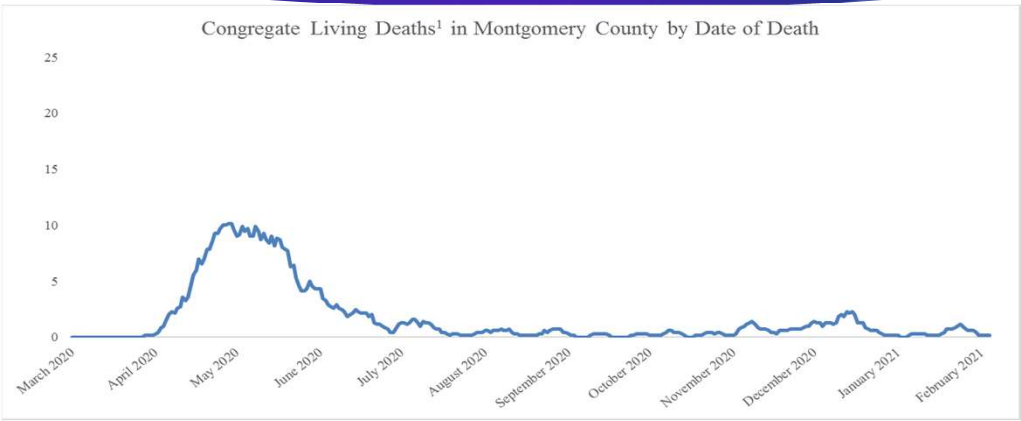
7

COVID testing



8

COVID Deaths in Long Term Care Facilities



9

COVID Testing Requirements at Nursing Homes

- Nursing Homes are required to perform biweekly tests on staff and weekly tests on residents who have not tested positive in the last 90 days until further notice
- Maryland Office of the Inspector General monitors facility compliance
- Outbreak Status (New onset case within the last 14 days)

10

COVID Testing Requirements at Assisted Living Facilities

- Assisted living facilities are strongly advised to test staff weekly. When in outbreak status, assisted living facilities are required to test residents weekly
- State requirements for routine testing at assisted living facilities with 50 or more beds is dependent upon the county positivity rate:
  - ≤5% → facilities are required to test staff monthly
  - 5-10% → facilities are required to test staff weekly
  - >10% → facilities are required to test staff biweekly
- Maryland Office of the Inspector General monitors facility compliance

11

COVID-19 Vaccination

- On October 16, 2020, the US Department of Health & Human Services announced a partnership with CVS & Walgreens to provide and administer COVID-19 vaccines to residents of long-term care facilities (LTCF) nationwide with no out-of-pocket costs
- CVS and Walgreens will schedule and coordinate on-site clinic date(s) directly with each facility. It is anticipated that three total visits over approximately two months are likely to be needed to administer both doses of vaccine (if indicated) to residents and staff. The pharmacies will also:
  - Receive and manage vaccines and associated supplies (e.g., syringes, needles, and personal protective equipment).
  - Ensure cold chain management for vaccine.
  - Provide on-site administration of vaccine.
  - Report required vaccination data (including who was vaccinated, with what vaccine, and where) to the state, local, or territorial, and federal public health authorities within 72 hours of administering each dose.
  - Adhere to all applicable Centers for Medicare & Medicaid Services (CMS) requirements for COVID-19 testing for LTCF staff.

https://www.hhs.gov/about/news/2020/10/16/trump-aministration-partners-cvs-walgreens-provide-covid-19-vaccine-protect-vulnerable-americans-long-term-care-facilities-nationwide.html

12

COVID-19 Vaccination in County Nursing Homes

- Based on preliminary polling of Montgomery County nursing homes as of February 5, 2021
  - All nursing homes have completed at least one of the scheduled three vaccination clinics
  - 80% of residents have received at least 1 dose of the Pfizer/Moderna vaccine
  - 58% of nursing home staff have received at least 1 dose of the Pfizer/Moderna vaccine
- CDC report published on February 1, 2021 stated among 11,460 Skilled Nursing Facilities that participated in the CDC Pharmacy Partnership for LTC program, a median of 77.8% of residents and 37.5% of staff members received at least one dose through the program from December 18, 2020 to January 17, 2021

https://www.cdc.gov/mmwr/volumes/70/wr/mm7005e2.htm?s_cid=mm7005e2_w

13

Education and Outreach to Long Term care facilities

- Nexus Montgomery Primary Care Coalition provided CDC published vaccine education resources to all County nursing home leaders
- Ombudsman outreach to long term care staff regarding vaccine hesitancy concerns and vaccine distribution problems.
- Many facilities are developing their own vaccine education & incentive programs to encourage staff to receive the vaccine

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Long Term Care Ombudsman Program

PRIOR CALENDAR QUARTER CALLS TO ASSURE THEY PRE-REGISTRATION OF STAFF AND RESIDENTS FOR VACCINATIONS WHEN AVAILABLE

ENCOURAGE PARTICIPATION IN WEEKLY LONG TERM CARE PROVIDER CALLS WITH MARYLAND DEPT OF HEALTH

15

Long Term Care Ombudsman Program

Beginning in January, LTCOP current calls and focused sampling provide insight to tell the story behind the data

Many assisted living providers shared issues and frustrations repeated about the logistics and process

34 Nursing Homes

39 Large Assisted Living (17+ Licensed Beds)

210 Senior Group Home Assisted Living (Licensed for 2 – 16 Beds)

16

Long Term Care Ombudsman Program

Senior Group Home Living Providers (Licensed 16 Beds & Under):

- Majority don't participate in provider calls; they express these calls are for larger businesses or they don't have the time to listen
- The majority of the senior group home providers indicate the staff and residents plan to receive the vaccine when offered. Their expressed concerns are getting someone to come to the residential setting and not taking residents to an outside vaccination location

17

Long Term Care Ombudsman Program

Larger Assisted Living Licensed for 17 Beds or More)

- Pharmacies not prepared with paperwork which had been sent over before the on-site vaccination clinics were scheduled; causes confusion, long waiting time to gather individual personal health information and consent again; insurance information; and residents become tired and agitated while staff are attempting to maintain the social distancing requirements in close quarters
- unable to discuss with a "live person" from CVS/Walgreens, the company with the contract to provide vaccinations in Montgomery County to have a better understanding of what to expect during the on-site clinic and prepare staff and residents accordingly
- Reluctance to share statistical date with the ombudsman when they traditionally been more open; they don't want to publicize their vacancy rates, they don't want residents to move because of the number of staff who may not be willing to be vaccinated

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Long Term Care Ombudsman Program

Nursing Homes & Assisted Living Residents

Notable Quotables

Why don't we see "100% Participation in the On-site Vaccination Clinic

Most NH & AL's are sharing very high % of RESIDENTS are receiving the vaccine

*Most often consent is obtained from family members

Advocates Red Flag: Informed Consent? Right to Refuse?

19

Long Term Care Ombudsman Program

- Some residents receive it through other sources. Primarily hearing Kaiser because of the Medicare Advantage Plans
- Some nursing homes and assisted living residents in recovery stages of COVID have been medically advised to wait to receive the vaccine
- Some residents are out of the facility at the time of the vaccination clinic (hospitalized)
- Getting vaccinated is not a condition of residency or listed in resident agreement
- Most NH & large AL's that spoke with the ombudsman program indicate about 30% of staff are refusing the vaccine when offered

20

Long Term Care Ombudsman Program

What about the staff working in Nursing Homes and Large Assisted Living?

Some staff are reluctant due to known medical conditions without enough research assurance to know the side effects and future health impact, including pregnancy

They are waiting for more time to go by to see how well the vaccine works for others

Refusing the Vaccine is a choice with no further explanation; however, appears it may be cultural decision based on country of origin

Some staff are afraid of anything injected and don't get flu shots either

Getting vaccinated is not a condition of employment

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Long Term Care Ombudsman Program

Contact Information

Eileen Bennett, Program Manager II

Main Program Line:

240-777-3369

HHSLTCOMBUDSMAN@montgomerycountymd.gov

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Developmental Disability (DD) Group Homes – Vaccination Update

- HHS reached out to the 31 I/DD Group Home Providers in the County to get an update on their vaccination status
  - 4 providers are not connected to CVS/Walgreens (we are directing them to the State and the County vaccine site to register)
  - 3 providers did not respond to the request for information
  - 24 providers are connected and have either had their first clinic recently or have their first clinic scheduled in the next few weeks.
- Some agencies are opting to hold these clinics at their headquarters (instead of having vaccinators come to each individual house) to try to increase efficiency

23

Concern about Refusal to Get Vaccine

There is still a good deal of resistance to getting the vaccine - primarily among the direct support professionals (DSPs) % of DSPs that are refusing to get the vaccine

- For each agency that had data, the vaccine refusal rate ranged from 7% (there is one agency that is requiring their staff get vaccinated unless there is a medical reason) to 80% of DSPs declining the vaccine.
- CVS/Walgreens are vaccinating agencies in three phases - providers are hopeful that more DSPs will be willing to get vaccinated in phase 2 (after they see that their colleagues were vaccinated and are doing fine)

24

Education and Outreach to I/DD Community

- Primary Care Coalition held a COVID 19 Vaccine Virtual Town Hall on 1/27 to educate DSPs and Families - 445 participants attended
- The Town Hall included a variety of experts and panelists including DSPs that have already received their first dose of the vaccine and were encouraging other DSPs to get the vaccine.
- Some agencies are doing their own videos of their staff that have received the vaccine and sharing it with their team.

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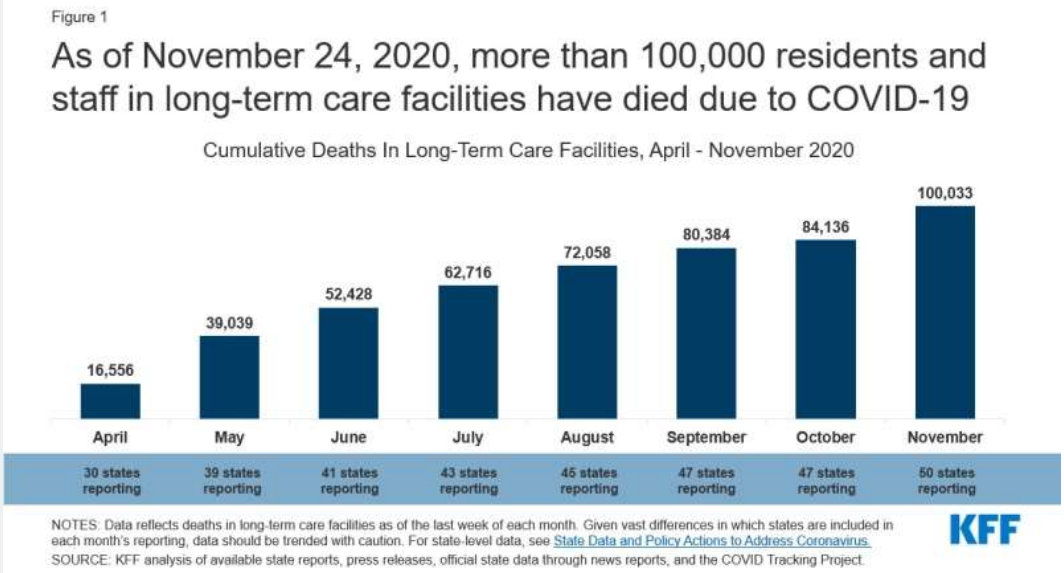
COVID-19 Has Claimed the Lives of 100,000 Long-Term Care Residents and Staff

Priya Chidambaram (https://www.kff.org/person/priya-chidambaram/),
Rachel Garfield (https://www.kff.org/person/rachel-garfield/) (https://twitter.com/RachelLGarfield)**, and**
Tricia Neuman (https://www.kff.org/person/tricia-neuman/) (https://twitter.com/tricia_neuman)
Nov 25, 2020

This week marks a bleak milestone in the pandemic's effect on residents and staff in long-term care facilities across the country. According to our latest analysis of state-reported data, COVID-19 has claimed the lives of more than 100,000 long-term care facility residents and staff as of the last week in November. This finding comes at a time when public health experts are predicting a surge in cases after holiday gatherings and increased time indoors due to winter weather, which will have ripple effects on hospitals and nursing homes, given the close relationship between community spread and cases in congregate care settings (https://www.kff.org/coronavirus-covid-19/issue-brief/rising-cases-in-long-term-care-facilities-are-cause-for-concern/). As the nation braces for the fallout of the holiday, recent data (https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/) on deaths in long-term care facilities highlight the ongoing disproportionate impact on this high-risk population.

Since the start of the pandemic, 100,033 residents and staff at long-term care facilities have died from COVID-19 as of November 24, 2020, according to state reporting in 49 states plus DC (Figure 1). This is likely an undercount, given that five states have not updated their long-term care death values in over one week (HI, ME, MO, NE, and WV) and Alaska still does not provide data on deaths in these facilities. Figure 1 depicts the increase in long-term care deaths since the start of the pandemic. The increase reflects both an increase in deaths and an increase in the number of states reporting over time. Given the vast differences in state reporting between April and November, data in Figure 1 should be trended with caution. See Data Notes below for more details on this increase in deaths.



As of November 24, 2020, more than 100,00 residents and staff in long-term care facilities have died due to COVID-19

Nationwide, deaths in long-term care facilities account for 40% of all COVID-19 deaths. In 18 states, COVID-19 deaths in long-term care facilities account for at least half of all deaths due to the pandemic (NH, RI, CT, MN, KY, PA, MA, NE, ME, ND, OH, DE, WA, OR, IN, VT, MD, NC). In three states, long-term care COVID-19 deaths account for over 70% of COVID-19 deaths in the state (NH, RI, and CT). Many states have consistently reported a high burden of COVID-19 deaths in long-term care facilities, with Minnesota, Rhode Island, and New Hampshire consistently reporting among the highest shares of COVID-19 deaths in long-term care facilities. See Data Notes below for more details on the share of COVID-19 deaths in long-term care facilities.

While early action to prevent the spread of coronavirus in long-term care facilities led to strict protocols related to testing, personal protective equipment (PPE), and visitor restrictions, several of these measures have been reversed in recent months (https://www.cms.gov/files/document/qso-20-39-nh.pdf), and some long-term care facilities continue to report shortages of PPE and staff (https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01269). The disproportionate number of COVID-19 deaths in long-term care facilities serves as a reminder that residents and staff in these places continue to bear a high burden of the uncontrolled pandemic. Post-Thanksgiving surges in cases are unlikely to spare this community and will likely lead to an even higher death toll in long-term care facilities, raising questions about whether nursing homes and other facilities are able to protect their residents and, if not, what actions can be taken to mitigate the threat posed by the virus.

Data Notes

The number of states independently reporting long-term deaths due to COVID-19 has increased from 30 states in April to 50 states (all but Alaska) in November, which suggests that the total number of deaths reported in the first few months of the pandemic is an undercount. States also vary widely in how they report COVID-19 deaths. For example, some states include assisted living and other residential facilities in their total counts, while others limit their counts to nursing facilities. For more details on what states may include or exclude in their long-term care data reporting, see Table 3 (https://www.kff.org/report-section/key-questions-about-the-impact-of-coronavirus-on-long-term-care-facilities-over-time-tables/) in Key Questions About the Impact of Coronavirus on Long-Term Care Facilities Over Time. (https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-impact-of-coronavirus-on-long-term-care-facilities-over-time/)

Data reported by nursing facilities to the Centers for Disease Control and published by the Centers for Medicare and Medicaid Services is more consistent across states but may not consistently include data prior to May 8th and only include federally certified nursing facilities. For more details on the limits and opportunities of federal reporting, see KFF brief here (https://www.kff.org/coronavirus-covid-19/issue-brief/limits-and-opportunities-of-federal-reporting-on-covid-19-in-nursing-facilities/).

For state-level data on share of deaths occurring in long-term care facilities, see our long-term care data at State Data and Policy Actions to Address Coronavirus (https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/). Shares of COVID-19 deaths occurring in long-term care facilities should not be used to compare states since not all states report COVID-19 long-term care facility deaths the same way. For example, New York, unlike other states, does not include deaths among nursing home residents that occur outside of the nursing home (e.g., if the death occurs in the hospital) in its long-term care death count.

Most nursing home workers don't want the vaccine. Here's what facilities are doing about it.

By
Rachel Chason,
Rebecca Tan,
Jenna Portnoy and
Erin Cox
Jan. 27, 2021 at 5:55 p.m. EST

A large percentage of nursing home workers in D.C., Maryland and Virginia have declined to take the coronavirus vaccine, officials say, presenting a major challenge in the region's plans to protect its most vulnerable residents.

Nursing home workers were first offered the vaccine in late December and early January, along with residents of long-term care facilities and other health-care workers. Their wariness, providers and union representatives say, is fueled by online misinformation about the vaccine and historical mistrust of the medical system of which they are a part.

In the meantime, other members of the public are scrambling for the limited supply of vaccine doses available to them, with many elderly adults and some essential workers unable to find appointments or having their time slots canceled in recent days.

In an internal document obtained by The Washington Post, Maryland health officials said that as of Tuesday, only about 58 percent of the doses allocated to nursing home staff and residents had been administered — even though vaccination clinics have been conducted at every facility. Tredonna Kum, an administrative organizer for 1199 SEIU, which represents nursing home workers in Maryland and D.C., estimated that up to 80 percent of members chose not to be vaccinated during the first wave of clinics.

"One of the surprises in the first three weeks was that in health care and in the nursing homes, there was about a 35 to 50 percent uptake. . . . We had expected closer to 80 or 90 percent uptake," Maryland's acting health secretary Dennis R. Schrader told state lawmakers this week.

Questions about the vaccine rollout? We have answers.

Veronica Sharpe, president of the District of Columbia Health Care Association, said the vaccination rate among nursing home staff has been about 40 percent — less than half the rate of those who live in the facilities. Industry representatives in Virginia said they've seen similar trends, though state health officials declined to say exactly what percentage of nursing home workers have been vaccinated.

Representatives for CVS and Walgreens, which have partnerships with long-term care facilities in all three jurisdictions, also said vaccine uptake among employees has been less than expected. CVS spokesman T.J. Crawford said the company tells the state government when it needs fewer doses than initially anticipated. If the company has extra after staging a clinic for a particular nursing home, it reroutes those doses to other facilities.

In North Carolina, the top public health official said in early January that most nursing home workers had declined the vaccine. In Ohio, more than 60 percent of nursing home workers opted out during the first wave of vaccination clinics, said Gov. Mike DeWine (R). Officials in Connecticut have reported similar numbers.

David Grabowski, a Harvard University health policy professor, said the numbers shouldn't surprise anyone familiar with long-term care facilities, where low wages and poor labor conditions — and earlier missteps fighting the coronavirus pandemic — have created a well of mistrust, especially among the Black and Latino workers who dominate the industry.

"This is a forgotten workforce that hasn't been treated well for years," Grabowski said. "We've been slow with [personal protective equipment], we've been slow with hazard pay, and all of a sudden now, they want to go fast with vaccinations. . . . There's good reason they're so distrustful."

Joseph DeMattos, president of the Health Facilities Association of Maryland, said federal government outreach to nursing home workers about the vaccine was "grossly underwhelming."

Although the Maryland Department of Health has been "rightfully focused" on the logistics of vaccine rollout, he said, it "missed early opportunities to partner and communicate with diverse communities the imperative to take the vaccine when it was first offered."

The Maryland Baptist Aged Home in West Baltimore was among the first nursing homes in the state to receive vaccine doses. When CVS conducted a clinic on Dec. 23, only 11 of 41 employees agreed to be injected.

"I was shocked, I mean, just shocked," said the Rev. Derrick DeWitt, director of the facility, which barred visitors and tightened infection-control precautions in late February and has reported no coronavirus cases among staff or residents.

DeWitt said he called dozens of the facility's workers and found many had been influenced by online misinformation about the vaccine and mistrust of the medical establishment, fueled by historical abuses like the Tuskegee syphilis study and the ongoing lack of access to medical care in Baltimore's communities of color.

"These folks don't even have access to a doctor when they're sick. Then suddenly you say, 'Show up in a parking lot and get this mysterious vaccine.' It's hard for them to trust you," DeWitt said. "People of color have become very pessimistic about being guinea pigs."

After that first clinic, DeWitt said, he “used everything in my arsenal” to get his staff to change their minds. He invoked his trustworthiness as a pastor, narrated facts about the vaccine over the nursing home’s public announcement system and reminded staff that nothing had happened to him or the others who had been vaccinated.

During the facility’s second clinic in mid-January, 26 of the remaining 30 employees were willing to get their first shots.

Among them was a registered nurse from Baltimore who spoke on the condition of anonymity to discuss a private medical decision. She was initially worried about the vaccine, especially because she had heard about how quickly it had been created, she said. But after considering her job and the escalating infection rates in the region, she decided it was worse to stay exposed to the virus.

“Based on all that they were saying, I assumed it’s okay,” she said in a telephone interview. “I mean, in this world, nothing is sure.”

In Baltimore, a struggling, black-owned nursing home keeps covid-19 at bay

Many employees at Trio Healthcare’s 11 nursing homes in Virginia, especially in rural parts of the state, initially bought into various myths about the vaccine, said Chief Clinical Officer Melissa Green. These included erroneous rumors about serious side effects, she said, and unproven conspiracy theories about government plans to microchip residents.

It took an active internal campaign that involved fact sheets and posters of employees getting the shots to persuade 80 percent of the staff to be vaccinated, Green said.

When it comes to communicating with workers, it’s not just the information that matters, but how it is delivered, said Grabowski, the Harvard professor. “Webinars or FAQs” are not going to be as effective, he said, as a conversation with a trusted source.

After geriatric nursing assistant Davenia Kemp received her first dose of the vaccine on Dec. 23, in a celebratory news conference attended by Maryland Gov. Larry Hogan (R), she faced questions from other employees at Franklin Woods Center in Baltimore County about whether they should follow suit.

“They had heard about bad side effects and bad experiences,” said Kemp, 25, of Baltimore City. “I told them, ‘I feel fine, I feel great.’ ”

Sharpe, the D.C. industry representative, said the city’s nursing homes have tried to discuss the vaccine with workers one-on-one, rather than in big staff meetings. Providers are looking to identify natural leaders among the staff — whether or not they are supervisors — and asking them to encourage their peers to take the vaccine. Some facilities are also offering incentives. One is entering vaccinated employees in a raffle with monetary prizes.

At one D.C. nursing home that had its second clinic this week, the percentage of staff getting vaccinated increased from 30 percent to 80 percent, Sharpe said. She did not name the facility.

Keith Hare, president of the Virginia Health Care Association, said vaccine uptake is also improving among that state's nursing home staff in the second wave of clinics, many of which are occurring this week. He said wary employees are more likely to feel comfortable once they see that colleagues vaccinated weeks earlier are healthy.

Some local providers, such as Lutheran Social Ministries of Maryland, are taking a stricter approach: requiring their employees to take the vaccine. After the first round of clinics at two facilities in Carroll and Howard counties, more than 50 percent of all staff had been vaccinated, and more are expected to sign up for the second round.

"It's ultimately their choice," said Ken Connelly, vice president of operations. "But if they choose not to get the vaccine, we're going to amicably part ways. . . . The only way we get back to normal is getting everyone vaccinated."

Such mandates have drawn opposition elsewhere. At a Wisconsin facility, some workers quit after being told they had to be vaccinated, one employee told a local television station. In Pennsylvania, a health-care union is pushing back on a facility's decision to require the vaccine.

Isolated residents and an overwhelmed hospital: Covid-19 hits Western Maryland

It's critical for health-care providers to get inoculated because they can help foster confidence — or doubt — in the vaccine among members of the public, particularly in their own communities, said Lyda Vanegas, a spokesperson for Mary's Center, a network of clinics that serves primarily Latino residents in D.C. and Maryland. The center has vaccinated about 60 percent of its 700 staff, Vanegas said, urging them to take pictures of themselves during the process as a way to "spread excitement."

Rebecca Moralez-Fairbanks, administrator of Beth Sholom Village in Virginia Beach, said getting vaccinated was the only way to protect residents she interacts with, including her parents, who live in the facility's assisted-living center.

She's done everything she can think of to encourage other employees to follow suit, including distributing information about what is in the vaccine and possible side effects. As of Tuesday, 75 percent of her employees had gotten vaccinated.

"We are the ones bringing it in," she said. "So we need to be the ones stepping up and preventing illness."

The day she received her first vaccine, she said, was the best she has had since the pandemic started.

FAMILY CAREGIVING (/CAREGIVING/)

Medical

Less Than Half of Nursing Home Workers Got COVID Shots in First Round, CDC Says

Low figure puts pressure on next round of vaccinations, now underway

by Emily Paulin, **AARP (http://www.aarp.org)**, February 3, 2021 | Comments: 4

KAREN DUCEY/STRINGER/GETTY IMAGES

Only slightly more than a third of nursing home workers who have been offered a first round of COVID-19 vaccine have chosen to get it, according to a new Centers for Disease Control and Prevention (CDC) report (https://www.cdc.gov/mmwr/volumes/70/wr/mm7005e2.htm). The findings come just after the federal partnership with CVS and Walgreens to prioritize nursing home residents and staff for vaccinations wrapped up its first round of on-site vaccinations.

Participation among nursing home residents — who have accounted for roughly a quarter of COVID deaths since the pandemic began — was much higher, with a median of 78 percent getting the first of two required jabs. But surveying roughly 90 percent of facilities participating in the federal program that had at least one on-site vaccination clinic between Dec. 18 and Jan. 17, the CDC found that only a median of 37.5 percent of nursing home workers received a first dose of a COVID-19 vaccine.

The numbers are worrying because about 70 to 85 percent of a community needs to get vaccinated to achieve herd immunity (/health/conditions-treatments/info-2020/herd-immunity-covid19.html), according to some medical experts. The CDC report said the low percentage of staff members vaccinated "raises concern about low coverage among a population at high risk for occupation exposure to SARS-CoV-2."

"Barriers to [skilled nursing facility] staff member vaccination need to be overcome with continued development and implementation of focused communication and outreach strategies," said the report, released Monday.

For the latest coronavirus news and advice go to AARP.org/coronavirus (/coronavirus/).

Last week, CVS and Walgreens announced the completion of their first round (/caregiving/health/info-2021/nursing-home-vaccines-slow-start.html) of on-site COVID-19 vaccination clinics in U.S. nursing homes through the federal government's Pharmacy Partnership for Long-Term Care Program (/caregiving/health/info-2020/nursing-homes-covid-vaccine-plan.html). CVS reported visiting all of the almost 8,000 facilities that chose the pharmacy to administer its vaccines, while Walgreens said it visited more than 5,500 facilities.

COVID-19 infections in nursing homes have been spiraling upward in recent months, according to monthly analyses of federal nursing home data by AARP (/ppi/issues/caregiving/info-2020/nursing-home-covid-dashboard.html). Staff cases more than tripled between mid-October and mid-December, as resident cases skyrocketed almost fourfold over the same period. Studies show that infected staff members are one of the greatest drivers of COVID-19 outbreaks in nursing homes.

Because the federal government has contracted with CVS, Walgreens and a few state-level pharmacy chains to perform just three on-site vaccination clinics at each of its partnering facilities, pressure is mounting for the second round of clinics, which have already begun, to produce higher uptake rates.

Elaine Ryan, AARP's vice president for state advocacy and strategy integration, says low participation stems from subpar working conditions (/caregiving/health/info-2020/nursing-home-workers-during-coronavirus.html) that nursing home staff have endured for years. "These workers are poorly paid, get few benefits or sick leave and receive very little information and support when

they need it," she says. "Can you blame them for not rushing to get a shot they know very little about, from [the nursing homes] who have treated them so badly?"

The roots of staff skepticism

The national findings match anecdotal evidence that's been echoing through the states for weeks. Maryland's acting secretary of health, Dennis R. Schrader, pegged his nursing home staff refusal rate at somewhere between 50 and 65 percent. In Virginia, Christian Bergman, a member of the state's COVID-19 long-term care task force, estimated that as many as 90 percent of workers had turned down the vaccine at some homes.

Many long-term care workers are skipping COVID-19 vaccines because they're concerned that the shots are ineffective or unsafe, the CDC says. Worries about potential side effects (/health/conditions-treatments/info-2020/coronavirus-vaccine-side-effects.html), which have so far been minimal from first doses, are also driving resistance. The report cites a recent survey of long-term care workers (https://agsjournals.onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.17022) that found that among the 55 percent of workers in Indiana who said they would decline a COVID-19 vaccine if offered, 70 percent mentioned side effects as the primary reason.

Many long-term care workers are hourly employees with little to no sick leave or benefits and may not be able to afford to get sick from side effects. Certified nursing assistants, who make up the overwhelming majority of care workers at nursing homes, make less than $15 per hour on average, and getting to work is often their top priority.

Added pressure on second rounds

Now, the pressure is on the second round of nursing home vaccination clinics to reach those who've been missed. Both COVID-19 vaccines (/health/conditions-treatments/info-2020/coronavirus-vaccine-research.html) authorized in the U.S., from Pfizer and Moderna, require two doses administered up to six weeks apart. Missing a first dose during the second clinic will make it all but impossible for workers to get fully vaccinated through the on-site program. As Ohio Gov. Mike DeWine said in a December address to his state's nursing home workers — of whom 60 percent were reportedly declining first doses — "The train may not be coming back."

Rina Shah, group vice president of pharmacy operations and services at Walgreens, said in a press briefing that the pharmacy is developing tools to get long-term care workers vaccinated once the program ends. One possibility, she said, is supplying vaccine vouchers to workers who can then take them to a Walgreens clinic to receive a shot. But doing so may put those workers in large queues with millions of members of the general population who are struggling to secure vaccinations.

Mike Wasserman, past president of the California Association of Long Term Care Medicine — which represents doctors, nurses, pharmacists and others in the industry — says the current program needs to be more accommodating. "Instead of a one-size-fits-all, rigid approach," he says, what's

needed is a “more flexible plan that might allow the facility to do its own vaccinations over the course of a week.”

That could also prevent staffing shortages that may arise from inoculating too many workers with second doses at one time. In the Pfizer and Moderna vaccine trials, participants reported feeling worse side effects — mainly fatigue, headache, muscle aches, chills, joint pain and possibly some fever — after their second dose, which could lead to lots of staff calling in sick at once, straining a facility's ability to look after residents at a time of national staffing shortages (/caregiving/health/info-2020/nursing-home-covid-ppe-staff-shortages.html).

Signs of improvement

Anecdotal evidence from second-round clinics now taking place suggests that vaccine uptake among staff is improving. The Associated Press reported that last week (https://abcnews.go.com/Health/wireStory/report-us-nursing-home-staff-decline-covid-shots-75616790), in a meeting on vaccine policy, Amanda Cohn, the CDC's deputy director of immunization services, said more staffers get vaccinated when a second or third clinic is held at a home. And a CVS spokesperson told *USA Today* (https://www.usatoday.com/story/news/health/2021/02/01/nursing-home-workers-reluctant-get-covid-vaccine-cdc-study-finds/6664743002/) that they are seeing a higher uptake by staff members on their second visits.

Sondra Norder sees the improvements at St. Paul Elder Services in Wisconsin, where she is president and CEO. During the first on-site clinic at her skilled nursing facilities, only 66 percent of staff received a vaccine. On Monday, during the second clinic, that number jumped to 75 percent.

Disclosure: Mike Wasserman sits on the board of AARP charitable affiliate Wish of a Lifetime.

More on Coronavirus and Nursing Homes

- New legislation would crack down on poorly performing nursing homes (/caregiving/health/info-2020/legislation-cracks-down-on-nursing-homes.html)
- New York has dramatically undercounted COVID nursing home deaths (/caregiving/health/info-2021/new-york-nursing-home-deaths.html)
- Where is the billions in COVID aid for nursing homes going? (/caregiving/health/info-2020/nursing-home-covid-federal-aid-transparency.html)

Join the Discussion

4 | ADD YOURS

News Article – from the National Consumer Voice for Quality Long-Term Care

CMS Issues Revised Guidance on Visitation in Nursing Homes

September 18, 2020

Consumer Voice is very pleased to announce that yesterday, after six months of strict visitation restrictions in nursing homes, the Centers for Medicare & Medicaid Services (CMS) released a memo significantly easing those restrictions. The new guidance, which is effective immediately, permits outdoor visitation, indoor visitation, and compassionate care visits and lays out a framework for those visits. CMS notes that this guidance replaces all previous guidance.

Consumer Voice, along with other advocates, has been urging CMS to lift visitation limitations, noting the devastating effect being separated from their loved ones has had on residents. We commend the agency for responding to these concerns and recognizing the value and importance of residents' connections with family and friends. We thank CMS for these changes, which will make a critical difference in the lives of residents, and look forward to continuing to work with CMS toward full restoration of residents' visitation rights.

Below are key highlights from the September 17th CMS memo.

General Guidance About Visits

- Visitation should be person-centered, consider the resident's physical, mental, and psychosocial well-being, and support their quality of life.
- Facilities should ensure visits are conducted with privacy.
- Certain core principles apply to all types of visits. Among others, these include screening, hand hygiene, face covering or mask, and social distancing.

Outdoor Visitation

- Visits should be outdoors whenever practicable. Facilities should facilitate outdoor visits routinely except under certain circumstances.
- Facilities should create accessible and safe outdoor spaces and a process to limit the number of visits and people visiting any one resident.

Indoor Visitation

- Facilities should support indoor visitation adhering to the following guidelines:

- No new onset of COVID-19 cases in the last 14 days; facility not conducting outbreak testing.
- Only compassionate care visits if the county positivity rate is greater than 10%.
- Visitors must follow the core principles.
- Facilities should limit number of visitors per resident at one time; total number of visitors in the facility at one time; and movement in the facility.

CMS notes that it does not distinguish between visitors and essential caregivers, but states that such a distinction should not be necessary when a person-centered approach is used.

Compassionate Care Visitation

- Additional examples of compassionate care situations underscore that these visits are not limited to end of life situations, but also include instances of resident decline or distress. See memo for specific examples.
- Visits can be conducted by "any individual that can meet the resident's needs" – for instance, clergy or lay persons offering religious and spiritual support.
- Personal contact can be permitted for a limited amount of time if:
  - The visitor and facility agree on how that can be done.
  - Infection prevention guidelines are followed.

Required Visitation

- A facility must facilitate in-person visitation and may only restrict visitation when there is a reasonable clinical or safety cause.
  - Examples of reasonable cause for restriction: COVID-19 county positivity rate, the facility's COVID-19 status, a resident's COVID-19 status, visitor symptoms, lack of adherence to proper infection control practices, other relevant factors related to the pandemic.
  - Examples of restriction without reasonable cause: when there are no new onset COVID-19 cases for 14 days, county positivity rate is low or medium.
- Failure to facilitate visitation without adequate reason would constitute a potential violation of a resident's right to visitation, and the facility would be subject to citation and enforcement actions.
- Residents who have COVID-19 or are under quarantine should only receive in-person compassionate care visitation, virtual visits, or window visits until they are COVID-19 free or out of quarantine.

Access to the Long-Term Care Ombudsman

- In-person access to residents for Long-Term Care Ombudsmen (LTCO) may not be limited without reasonable cause, such as infection control concerns.
- LTCO continue to have immediate access to residents via phone and other technology.

Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs

- Representatives of the P&A systems are permitted to access all facility residents, which includes the right to meet in person.
- Facilities must comply with federal disability rights laws.
    - Residents that need assistance with communication which is not otherwise available must be permitted to have an individual enter the facility to interpret or facilitate.
        - Facilities may impose legitimate safety measures necessary to adhere to COVID-19 infection prevention.

Entry of Health Care Workers (Non-Employees) and Other Providers of Services

- Health care workers who provide direct care to facility residents, but are not employees of the facility, such as hospice workers, must be permitted to come into the facility as long as they have not been exposed to COVID-19 or have symptoms of COVID-19.
- EMS personnel do not need to be screened.

Communal Activities and Dining

- Communal activities and communal dining may occur, while adhering to the principles of COVID-19 infection prevention.
- Dining:
    - Residents may eat in a common room while social distancing.
    - Facilities should consider additional limitations based on COVID-19 infections in the facility.
- Activities:
    - Group activities may occur for residents who have recovered from COVID-19 and for those who are not isolated for observation or do not have suspected or confirmed cases of COVID-19.
    - Residents must socially distance, use appropriate hand hygiene, and wear face coverings.
    - Examples of activities include: book clubs, crafts, movies, exercise, and bingo.

Use of CMP Funds to Aid in Visitation

- CMS will now approve the use of CMP funds for tents for outdoor visitation and/or clear dividers, like Plexiglass, to reduce the risk of transmission during in-person visits.
- Facilities can apply for up to $3,000 in CMP funds for this use by contacting the person in charge of CMP funds at their state survey agency.