



Secretary of State **Oregon Audits Division**



Advisory Report: Oregon Can Take More Steps to Reduce Infections in Long-Term Care Facilities from COVID-19 and Other Communicable Diseases

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Advisory Report Highlights

By the Numbers

Long-term care residents face high risks; state and local government and long-term care workers are laboring under extremely difficult conditions.

Long-term care in Oregon accounts for:

54%

of COVID-19 deaths as of February 25 *

1,185

COVID-19 deaths as of February 25 *

1,934

cases of COVID-19 among workers in skilled nursing facilities as of February 14

50x

as many flu outbreaks as in hospitals in the last five years

387

norovirus outbreaks over a five-year period

31,581

residents in 685 facilities at risk for communicable diseases

* Includes other congregate settings

Oregon Can Take More Steps to Reduce Infections in Long-Term Care from COVID-19 and Other Communicable Diseases

This advisory report suggests actions the Oregon Department of Human Services (ODHS), Oregon Health Authority (OHA), and the Legislature can take to reduce illness and death from communicable diseases in nursing homes, assisted living, and residential care facilities, now and in the future. For this project, the division consulted with ODHS and OHA leadership, who supported a collaborative real-time review to identify potential improvements in this critical public health area.

Background

Compared to other states, Oregon has had relatively low incidence of COVID-19 overall and in long-term care facilities. However, the pandemic has highlighted the vulnerability of the 31,581 residents of Oregon's long-term care facilities to communicable diseases. These elderly residents are highly susceptible to COVID-19, as they have been for years to the flu and norovirus. A September 2020 federal report on nursing home safety found the pandemic stressed a "precarious care system," hampered by low funding, low pay, and too few staff.

For this advisory report, the Oregon Audits Division reviewed infection control in long-term care facilities to identify gaps in Oregon's statutes, rules, and practices that, if addressed, could help the state contain the COVID-19 virus and prevent future communicable disease outbreaks. We focused on oversight of 685 long-term care facilities: nursing facilities, which are regulated by the federal and state government, and community-based care facilities, which are regulated only by the state. Community-based care — assisted living and residential care — includes almost all the state's memory care units.



This report is a research-based project, not an audit under government auditing standards. It was produced more quickly than an audit and reduced our impact on state agencies as they respond to COVID-19. However, the report has undergone the same quality assurance process as audit reports from the Oregon Audits Division.

Key Issues and Suggested Actions

Lessons learned during the COVID-19 response can help improve infection control in long-term care, interagency coordination, and emergency planning, all areas that need strengthening. These improvements can benefit not only the response to COVID-19 and future pandemics, but also responses to frequent — and deadly — flu and norovirus outbreaks.

Concerning the present and potential spread of COVID-19 infections in long-term care facilities:

- » Since the surge in late 2020, deaths have dropped, coinciding with vaccinations in long-term care. However, throughout the pandemic, new outbreaks continued despite substantial steps taken by ODHS and OHA to prevent them. Memory care facilities are experiencing the highest death rates. Additional monitoring visits could further strengthen facilities' compliance with infection control protocols. [\(pg. 12\)](#)

- » The state can better monitor COVID-19 vaccinations in long-term care, particularly crucial given low flu vaccination uptake rates among long-term care staff.

COVID-19 case and death rates are higher in facilities with memory care services

Facilities	Facilities with an outbreak	Cases per 1,000 Residents/Staff	Deaths per 1,000 Residents/Staff
With Memory Care	74	134	14.8
Without Memory Care	166	70	5.8

Source: OHA COVID-19 Weekly Outbreak Report 12/02/2020

- » The state could require facilities to report staff and resident vaccinations directly to the state to identify facilities that need support. The state could then publicly report facility and staff vaccination rates to enhance transparency. [\(pg. 19\)](#)
- » Response priorities have slowed complaint investigations and halted recertification and licensing inspections, increasing risks to residents. ODHS could work with the Governor's Office and the Legislature to identify staffing necessary for this work. [\(pg. 17\)](#)
- » ODHS and OHA could better incorporate the Long-Term Care Ombudsman's independent, resident-focused perspective into responses to individual facilities and into decisions about regulatory and licensing policies and procedures. [\(pg. 18\)](#)

Concerning the general, ongoing risks of communicable diseases in long-term care facilities:

- » The agencies and the Legislature can address the fragmented authority over long-term care facilities. They can also address minimal state regulations for Oregon's 556 community-based care facilities on staffing, infection control, emergency preparedness, and staff and resident vaccination reporting. [\(pg. 21\)](#)

Concerning future pandemics:

- » ODHS and OHA had not planned basic elements for a joint response to emergencies prior to COVID-19, delaying actions that may have prevented early cases and deaths of COVID-19 in long-term care. The agencies could develop policies and procedures based on lessons learned from the pandemic to ensure continued collaboration on communicable diseases outbreaks. This step would benefit not only future emergencies but the investigation of norovirus and flu outbreaks that frequently afflict long-term care facilities. [\(pg. 26\)](#)
- » Institutional knowledge gained from the 2009 H1N1 pandemic diminished around managing personal protective equipment and other resources before COVID-19 arose. The agencies can use policies and procedures to ensure that problems identified in COVID-19 after-action reports and improvement plans are addressed and improvements retained. [\(pg. 26\)](#)

"Both the pandemic and wildfires highlighted the need for a more solid foundation and investment in response and recovery functions. We are not equipped in state agencies to deal with these types of disasters."
- Fariborz Pakseresht, ODHS

A response from OHA and ODHS is at the end of this advisory report. We greatly appreciate the agencies' collaboration and assistance during this challenging time.

The Oregon Secretary of State Audits Division is an independent, nonpartisan organization that conducts audits based on objective, reliable information to help state government operate more efficiently and effectively. The summary above should be considered in connection with a careful review of the full report.

Background

Residents of long-term care facilities are susceptible to communicable diseases given their age, health status, and close proximity to one another. Oregon's first known case of COVID-19 was reported in February 2020. By February 25, 2021, the disease had claimed the lives of 1,185 residents in long-term care facilities and other congregate settings,¹ accounting for 54% of Oregon's total COVID-19 deaths. COVID-19 is not the only disease to affect this population; Oregon's long-term care facilities also experience norovirus outbreaks and a high number of flu outbreaks. The pandemic's heavy toll has highlighted these risks, giving Oregon an opportunity to improve infection control practices and reduce the spread of communicable diseases in these facilities.

Long-term care facilities in Oregon

Nursing facilities (nursing homes) provide 24-hour nursing care for various needs. Nursing facilities that give high-level care are called skilled nursing facilities.

Assisted living and residential care facilities provide housing and support services to six or more people in a setting that allows for more independence. Collectively they are referred to as "community-based care."

Memory care communities provide a secure environment for persons with Alzheimer's or other forms of dementia. They are most often licensed as residential care facilities.

This advisory report is a research-based, non-audit project. We did not conduct an audit under government auditing standards in order to produce this report quickly and minimize our impact on state agencies as they respond to the COVID-19 emergency. This report has undergone the same rigorous quality assurance process as audit reports from the Oregon Audits Division. For this project, the division consulted with leadership at the Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA), who supported a collaborative real-time review to identify potential improvements in a critical public

health area.

We researched leading practices in infection control for long-term care facilities, focusing on nursing, assisted living, and residential care facilities. We also reviewed infection control measures implemented under the COVID-19 response and looked for gaps in Oregon's practices, statutes, and rules that, if addressed, could reduce the risks to long-term care residents for the COVID-19 virus and other communicable diseases. Taking stronger steps now could help the state protect the lives of long-term care residents during flu and norovirus outbreaks and in future pandemics.

Long-term care encompasses five types of facilities

Long-term care includes five types of facilities: nursing, assisted living, residential care, memory care communities, and adult foster care. Adult foster care was not included in this review.² Under Oregon regulations, assisted living and residential care facilities are described collectively as community-based care and are not regulated by the federal government.

Memory care units can be found in nursing, assisted living, or residential care facilities, but almost all — 214 of the 217 memory care facilities in Oregon — are housed in residential care and assisted living facilities, which are not federally regulated (see Figure 1). The three memory care units in nursing facilities are federally regulated.

¹ OHA's COVID-19 Weekly Outbreak Report does not report cases and deaths by facility type. We analyzed an earlier weekly report to examine deaths in long-term care versus other types of congregate settings, such as retirement communities, and found long-term care accounted for more than 90% of the deaths OHA reported.

² Adult foster/care homes are licensed single-family residences that offer 24-hour care in a homelike setting for up to five people.

Nursing facilities, also known as nursing homes, provide 24-hour nursing care for needs such as physical rehabilitation, recuperation after hospitalization for a serious illness or surgery, and end-of-life care. Some nursing facilities are classified as skilled nursing facilities, with higher-level care provided by professionals or technical personnel. In Oregon, 129 nursing facilities care for approximately 8,500 people. ODHS licenses nursing facilities. These facilities receive Medicare and Medicaid payments and are regulated by both the federal and state government. Patients must meet federal requirements to have Medicare and Medicaid pay for their nursing facility care.

Figure 1: As of 2020, Oregon had just under 700 long-term care facilities

Facility Type	Facility Count	Resident Population Estimate	Federally Regulated?
Nursing Facility	129	8,515	Yes
Community-Based Care:			
Assisted Living Facility	239	12,970	No
Residential Care Facility	317	10,096	No
Totals	685	31,581	

Source: ODHS APD

Assisted living and residential care facilities provide housing and support services to six or more residents in a setting that allows them to remain relatively independent. Both types of facilities provide meals, laundry, housekeeping, social activities, medication administration, and personal care assistance. Assisted living facilities must have private apartments with a kitchenette and private bathroom. Residential care facilities offer shared and private rooms, but they are not required to provide private bathrooms or kitchenettes. These state-regulated facilities are also licensed by ODHS but are not regulated by the federal government. Oregon’s 239 assisted living facilities and 317 residential care facilities are home to 13,000 and 10,000 residents, respectively.

Memory care communities provide a secure environment for people with Alzheimer’s disease or other forms of dementia. Almost all of Oregon’s 217 communities are associated with residential care facilities, except five in assisted living facilities and three in nursing facilities. ODHS endorses these communities, which means the community has met state licensing requirements and requirements to provide specialized memory care services. All staff in these communities must be trained to care for people with dementia. Residents pay privately or through a long-term care insurance policy for the service. Medicare does not pay for memory care, and the federal government does not regulate it, but some people are eligible for coverage under Medicaid.

Long-term care in Oregon is relatively expensive

Oregon’s costs for long-term care are substantially higher than median costs nationally, as shown in Figure 2. In Oregon, the median annual cost for a nursing or assisted living facility ranges from \$56,000 to \$134,000, reflecting increased costs to Oregonians of 8% to 30% over the national median.

Figure 2: The median annual cost of long-term care in Oregon in 2020 was higher than the median cost across the United States

	Oregon	United States
Nursing facility – semi-private room ¹	\$121,363	\$93,075
Nursing facility – private room ¹	\$134,138	\$105,850
Assisted living facility ²	\$55,905	\$51,600

Source: Genworth Cost of Care Survey, 2020

1. Based on 365 days of care
2. Based on 12 months of care, private, one bedroom

While Oregon has had relatively low COVID-19 mortality rates, the state’s long-term care facilities are distinctly vulnerable to communicable disease outbreaks

As of January 2021, Oregon has had relatively low rates of COVID-19 cases and deaths compared to other states, both overall and in long-term care facilities. However, surges in cases, the high proportion of long-term care residents who have died from COVID-19 and past outbreaks of influenza and other communicable diseases illustrate the continued high risk of communicable diseases to residents of long-term care facilities.

Oregon’s relatively low case and mortality rates

Oregon’s COVID-19 cases in long-term care nearly tripled during a late 2020 surge, but the state still ranks low in case and mortality rates.

- **Overall:** Among the fifth lowest states in cases and deaths per 100,000 residents.
- **In Long-Term Care:** Among the tenth lowest states in cases and deaths per 100,000 state residents.
- **In Nursing Homes:** Among the fifth lowest states in cases and deaths per 1,000 residents.

According to data from the COVID Tracking Project from January 20, 2021,³ Oregon had the fourth fewest cases and fifth fewest deaths per 100,000 residents among states. By January 20, 2021, Oregon had recorded just over 134,000 cases, but this reflected a 199% increase over the total through the end of October.

Similarly, the state’s long-term care facilities have experienced relatively low COVID-19 case and mortality rates when compared to other states.⁴ As of the end of October, Oregon ranked 40th in cases and 43rd in deaths in long-term care facilities per 100,000 state residents. Data from

the Centers for Medicare and Medicaid (CMS) confirms Oregon’s relatively low rates within the nursing home population as well.⁵ As of January 10, 2021, Oregon was among the five states with the lowest case and mortality rates in nursing homes.

Cases and deaths in the long-term care system have risen and fallen dramatically in recent months, in Oregon and nationwide. Oregon cases in long-term care nearly tripled from the beginning of November through January 14, 2021, from 3,387 to 9,615. Cases and deaths have dropped since, coinciding with vaccinations in long-term care, to levels seen before the latest surge. However, long-term care residents account for roughly half the COVID-19 deaths in Oregon. As of February 25, 2021, long-term care and other congregate care residents accounted for 54% of Oregon’s COVID-19 fatalities, or 1,185 deaths. This high proportion — substantially higher than the 35% total nationwide — reinforces that the bulk of Oregon’s risk is in long-term care.

Other communicable diseases pose risks to long-term care residents and staff

COVID-19 has been deadly for residents in long-term care facilities, but residents and staff are also at risk for illness and death from other communicable diseases. Over the past five flu seasons,⁶ long-term care facilities in Oregon experienced 442 confirmed influenza outbreaks affecting residents and staff, averaging 88 outbreaks per season. These outbreaks accounted for 63% to 95% of those reported statewide in schools, day care facilities, long-term care facilities, hospitals, and other settings. Long-term care facilities had nearly 50 times as many flu outbreaks as hospitals.

³ The [COVID Tracking Project](#) is a volunteer organization launched from The Atlantic and dedicated to collecting and publishing the data required to understand the COVID-19 outbreak in the United States.

⁴ The COVID Tracking Project defines long-term care facilities as all types of facilities that provide housing and care to seniors and others.

⁵ <https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/>

⁶ Flu season in the United States occurs in the fall and winter. Most flu activity peaks between December and February but can last as late as May.

Across those five seasons, assisted living and nursing facilities experienced the most influenza outbreaks, with average seasonal counts of 31 and 33 outbreaks, respectively. Only flu deaths among children are reportable in Oregon, but nationwide, between 70% to 85% of seasonal flu-related deaths and between 50% to 70% of seasonal flu-related hospitalizations occur in people 65 years of age and older. On average, the estimated annual economic burden of influenza to the health care system is \$11.2 billion.

Outbreaks of other communicable diseases have been reported for Oregon's long-term care facilities. Norovirus, a gastrointestinal illness, is the most common. Norovirus can cause severe diarrhea and vomiting, result in dehydration, and require medical attention. From 2013 to 2017, 387 norovirus outbreaks were reported in long-term care facilities across the state. Each year, on average in the United States, norovirus causes 900 deaths, mostly among adults aged 65 or older. The median yearly cost of norovirus outbreaks to the country is \$7.6 million in direct medical costs and \$165.3 million in productivity losses.

The long-term care industry's ability to respond to additional COVID-19 surges is unclear

Systemic and financial challenges in the nursing care industry, both exacerbated by the pandemic, raise concerns about the industry's ability to effectively respond to the COVID-19 surge.

The U.S. nursing care industry faced substantial challenges well before the pandemic. In September 2020, a federal commission's report on safety and quality in nursing homes said the COVID-19 emergency has stressed "an already precarious care system."⁷ Even before COVID-19, the commission noted, nursing homes were "hampered by too few staff, who are paid too little for physically and emotionally taxing work." Increases in the elderly population have compounded workforce shortages, the report said, as has "insufficient funding for quality nursing home operations."

With limited staff available, surge capacity during an emergency is often unavailable, the commission said. Staff, already stretched thin, have become more taxed while working on the front lines of the COVID-19 crisis, the commission's report noted, exposing themselves and their families to increased risk of contracting the disease.

The industry's finances are also under more strain. U.S. nursing care industry revenues are projected to fall just 1% in 2020, according to industry research firm IBISWorld, in part due to \$4.9 billion in government relief funds for skilled nursing facilities. However, a survey by industry groups in August 2020 found more than half of nursing care facilities were operating at a loss.⁸ Industry groups say payments from Medicaid — a primary funder of nursing home stays — does not cover operating costs. Critics say the for-profit owners have decreased staffing and reduced resident care, as owners keep costs low.

During the pandemic, resident occupancy has dropped overall, in part because patients and their families are more wary of congregate care and because the state restricts admission of new residents once a facility has a COVID-19 case. Staff salaries, testing costs, and costs for personal protective equipment have also risen.

⁷ [Coronavirus Commission on Safety and Quality in Nursing Homes, Commission Final Report](#), September 2020.

⁸ Survey by the [American Health Care Association and National Center for Assisted Living](#), August 8-10, 2020.

Federal, state, and local agencies play key roles in protecting long-term care residents

The responsibilities for licensing, regulating, and overseeing long-term facilities vary according to the type of facility, and agencies at all levels of government have a role. At the state level, ODHS, OHA, the Long-Term Care Ombudsman, and the Office of the State Fire Marshal work with local agencies to oversee and monitor long-term care facilities. The federal government, through CMS, also regulates nursing facilities, but not other forms of long-term care.

The **ODHS Safety, Oversight, and Quality Unit**, within the Aging and People with Disabilities Program (APD), conducts licensing and regulatory oversight of long-term care facilities, except for adult foster homes in Multnomah County, which the county oversees. APD also responds to complaints about the facilities. One group of ODHS surveyors, similar to inspectors in other state programs, visits assisted living and residential care facilities unannounced for biennial recertifications to check if they are meeting minimum state requirements. A second group of surveyors annually monitors nursing facilities for compliance with federal regulations set by CMS.

ODHS places executive orders on long-term care facilities when facilities report a suspected or confirmed case of COVID-19 among their staff or residents. These orders increase communications between the facility and ODHS and serve as a notification to the public about restrictions on admission. Executive orders contain mandated steps that facilities must take before the order can be lifted.

The 2019-21 legislatively adopted budget for ODHS included 15 new positions to help comply with a federal mandate requiring all nursing facility complaint investigations to be handled by APD; federal funding pays for 75% of the work. General Fund and federal matching funds were used for 20 new full-time, permanent, community-based surveyor positions to help reduce a backlog of inspections and to keep up with facility oversight.

The **OHA Healthcare-Associated Infections Program** in its Public Health Division seeks to prevent infectious disease and control pathogens in health care settings, such as hospitals, clinics, and long-term care facilities. Program staff monitor infectious disease statistics for signs of problems in these facilities. Staff also consult with facilities, provide infection prevention technical assistance, and are involved in education initiatives. The program works directly with long-term care facilities to promote health care worker flu vaccinations. It collects data and reports on flu vaccinations of health care workers, including long-term care workers in skilled nursing facilities.

OHA's Immunization Section works to reduce the incidence of vaccine-preventable disease across the state and manages the ALERT Immunization Information System (ALERT IIS). ALERT IIS, Oregon's statewide immunization registry, registers child, adolescent, and adult immunizations given in Oregon. Vaccination providers register immunizations in the system, and health care providers use it to review patient immunization histories. The immunization program also coordinates statewide efforts for school-required immunizations and helped develop Oregon's COVID-19 vaccination plan.

Standard mandates in executive orders placed on long-term care facilities

- Employee and staff COVID-19 testing when a resident or staff has tested positive
- Pre-approval for admissions/readmissions
- Restriction of visitation
- Restrictions on congregate activities and events
- Infection control training for staff
- Grouping residents with suspected or confirmed COVID-19 together, if space is available
- Reporting requirements should a resident's COVID-19 status change
- Notification of family members and authorized representatives
- Weekly status updates to ODHS

OHA's federally funded **Health Security, Preparedness and Response Section** develops public health systems to prepare for and respond to major acute threats and emergencies. The program works with communities, hospitals, and its emergency management partners to improve preparedness for health and medical emergencies.

The 2019-21 legislatively adopted budget for the Public Health Division totals \$731.9 million with 755.5 full-time equivalent staff. More than half of the Public Health Division's budget comes from federal funds.

House Bill 2600, which went into effect on January 1, 2021, affects ODHS and OHA and their oversight of long-term care facilities. Among other steps, the bill requires long-term care facilities to:

- Establish and maintain infection prevention and control protocols;
- Designate an individual with specialized training to be responsible for carrying out infection prevention and control protocols; and
- Train administrators and certain employees in preventing, containing, and reporting disease outbreaks.

The joint ODHS/OHA **COVID-19 Response and Recovery Unit** was launched in April 2020 through the agencies' shared services office. The unit coordinates ODHS and OHA resources and communication as the agencies address the pandemic, including work with long-term care facilities. The unit also worked with the Governor's Multiagency Coordination Group, which stood down on May 31, 2020.⁹

For individual facilities struggling with infection control or other issues, **Interagency Support Teams** coordinate the response of ODHS, OHA, local public health officials, and other agencies as necessary. A team assembled for each facility considers steps needed to address the facility's challenges. The team can create and implement an action plan when needed to stabilize the facility.

Under federal law, each state is required to establish an ombudsman program to advocate for long-term care residents.¹⁰ Oregon's **Office of the Long-Term Care Ombudsman** is an independent, executive branch state agency. In addition to the state's Ombudsman, who serves as the agency director, it is staffed with 10 deputy ombudsmen placed in regions and districts across the state. Volunteers assigned to an average of two facilities also have a large role. The office helps oversee nearly all individual care facilities in the state. Its 2019-21 legislatively adopted budget is \$8.6 million with 29 full-time equivalent staff.

Staff from Oregon's Office of the Long-Term Care Ombudsman were not included in the joint response and recovery unit structure, but the state Ombudsman communicates with ODHS and unit personnel through three 15-minute calls each week.

Specialists within the **Office of the State Fire Marshal's** Fire and Life Safety Division examine the emergency preparedness plans of nursing facilities to ensure they are complying with CMS and Oregon Fire Code regulations. The office's 2019-21 legislatively adopted budget is \$29.6 million with 66.9 full-time equivalent staff. **Local fire authorities** conduct fire and life safety inspections on assisted living and residential care facilities.

⁹ FEMA defines a Multiagency Coordination (MAC) Group as a group of administrators or executives, or their appointed representatives, who are typically authorized to commit agency resources and funds. A MAC Group can coordinate decision-making and resource allocation among cooperating agencies and may establish priorities among incidents, harmonize agency policies, and provide strategic guidance and direction to support incident management activities.

¹⁰ For more information, see the [Long-Term Care Ombudsman website](#).

Oregon's **Office of Emergency Management** leads statewide efforts to develop and enhance preparedness, response, recovery, and mitigation capabilities to protect lives, property, and the environment. During emergencies, roles and responsibilities are aligned under the **U.S. Department of Homeland Security's** National Response Framework, a guide for how the nation responds to all types of disasters and emergencies. Within this framework, emergency support functions (ESFs) delineate areas of resources and capabilities most needed in a response. In Oregon, ODHS is the lead agency for ESF 6 - Mass Care and ESF 11 - Food and Water. OHA is the lead agency for ESF 8 - Health and Medical.¹¹

Local public health authorities take the lead on investigating communicable diseases in their jurisdictions, with OHA providing technical assistance as needed. These investigations extend to long-term care facilities. Under their agreements with OHA, local public health authorities are required to prepare for, and respond to, a range of public health threats with their local partners and stakeholders.

¹¹ ESF 6 describes how the state will address the mass care, emergency assistance, temporary housing, and human services needs of people impacted by disasters. ESF 8 describes how the state will support health and medical care during an emergency or a developing potential health and medical situation. ESF 11 describes how the state will identify food, water, and ice needs in the aftermath of an emergency.

Project Approach

This advisory report — a research-based, non-audit project — included interviews, data analysis, and a review of statutes, administrative rules, and guidance on infection control practices. Those interviewed included:

- the director and deputy director of the COVID-19 Response and Recovery Unit;
- Oregon’s Long-Term Care Ombudsman;
- managers from the OHA Acute and Communicable Disease Prevention Section and the Healthcare-Associated Infections Program;
- managers and staff from the OHA Immunization Section;
- managers and staff with ODHS’s Aging and People with Disabilities Program;
- an assistant chief deputy, interim chief deputy, and deputy state fire marshal from the Office of the State Fire Marshal;
- the director of the Oregon Office of Emergency Management; and
- representatives from the Oregon Health Care Association and SEIU 503, which represents workers in some long-term care facilities.

We also analyzed and evaluated federal data about completed long-term care facility surveys; evaluated laws and regulations in other states; and analyzed state data on influenza and norovirus outbreaks, and state and federal data on COVID-19 cases, outbreaks, and deaths.

We chose to perform this work as a non-audit project to produce this advisory report quickly and reduce the impact on agencies responding to the COVID-19 emergency. Accordingly, the report does not adhere to government auditing standards, including standards for detailed planning of fieldwork steps and internal control reviews of auditees. This advisory report has undergone the same rigorous quality assurance process as does each audit from the Oregon Audits Division, with auditors not involved in the project checking evidence for each assertion in the report. We also consulted with OHA and ODHS leadership prior to initiating the project, provided the agencies involved with a copy of the report, and gave them the opportunity to provide feedback.

Results

This project examined infection control in long-term care facilities to identify gaps in Oregon’s practices, statutes, and rules that, if addressed, would reduce risks to long-term care residents for COVID-19 and other communicable diseases. ODHS and OHA have taken substantial steps to prevent outbreaks of COVID-19 in long-term care facilities and cases and deaths have fallen since vaccinations began in long-term care, but outbreaks continue to occur. Memory care communities and facilities in counties with the highest community rates of COVID-19 are among those with the highest mortality risk.

We identified several areas in which the agencies’ response to the current, and future, pandemics could be improved. The state has limited oversight of infection control training and monitoring of staff practices in long-term care facilities. Pandemic response priorities have further reduced the oversight of facilities; given that outbreaks are still occurring after nearly a year of educational efforts, more proactive actions, including financial penalties, may be necessary to ensure that facilities are complying with infection control protocols. The state also has challenges in tracking COVID-19 vaccinations among long-term care staff and residents, limiting its ability to target facilities that may need support.

We also found that the state has fragmented authority over long-term care. In addition, its regulations around infection control, vaccinations, and emergency management for community-based care—including most of the state’s memory care units—are less robust than those for nursing facilities. Also, ODHS and OHA had not planned basic elements for a joint response to emergencies prior to COVID-19, delaying actions. Legislative action and improved interagency coordination at the state and local level will be required to close many of the identified gaps.

The lessons learned during the COVID-19 response can help improve infection control in long-term care, interagency coordination, and emergency planning, all areas that need strengthening. These improvements can benefit not only the response to COVID-19 and future pandemics, but also responses to frequent—and deadly—flu and norovirus outbreaks.

Better state oversight of infection control and other conditions in long-term care facilities will help to prevent additional cases of COVID-19

In April 2020, ODHS and OHA partnered to implement the COVID-19 Response and Recovery Unit to improve communications and collaboration between the two agencies. Through this unit, the state has performed critical activities to curb the spread of COVID-19 in long-term care facilities. Major steps include conducting state infection control reviews and establishing Emergency Health Care Centers to separate residents with COVID-19 from those who are not ill.

Present and future risks to long-term care residents remain, however. Outbreaks continue, with memory care communities carrying the greatest burden for the disease. Long-term care staff are bringing the virus into facilities, but the state has limited oversight on whether staff have been trained on, and are complying with, infection control protocols. Also, response priorities have reduced oversight of facilities. Recertification and licensing inspections of facilities, which ensure further safeguards for residents, have stopped. Complaint investigations have slowed due to the need to prioritize infection control surveys and other response activities.

“Though a prevailing (and accurate) message is that Oregon is doing well compared to other states, I request that we elevate our overall efforts to still do better on behalf of Oregonians who live in licensed care settings.”
- Fred Steele, Oregon Long-Term Care Ombudsman, November 2020

The state has relied on educational efforts to ensure that facilities are complying with infection control protocols, but additional monitoring visits and financial penalties should now be considered an option for enforcement, particularly when problems are severe or persistent. Lastly, the state's ability to quickly monitor the uptake of COVID-19 vaccinations among long-term care residents and staff may not be adequate to identify and support facilities with low rates.

These risks are tied to the emotional well-being of residents as well as their physical health. Visitation restrictions hinder residents' social engagement with family and the larger community and have contributed to residents' concerns about physical decline and feelings of hopelessness and sadness. Addressing these risks can prevent cases of COVID-19 in long-term care, and in turn, improve conditions for residents, staff, and visitors. ODHS and OHA's COVID-19 Response and Recovery Unit is in a strong position to coordinate efforts to drive improvements and reduce risks.

The state has carried out important activities to prevent cases of COVID-19 in Oregon's long-term care facilities, but outbreaks continue

ODHS and OHA were slow in coordinating efforts to respond to COVID-19 in long-term care, as we note later in the report, in part due to a lack of prior planning. However, personnel from the two agencies have taken substantial steps to help prevent the spread of COVID-19 in long-term care facilities.

At the Governor's direction, the agencies developed and implemented a long-term care facility COVID-19 testing plan. It includes testing long-term care staff every month for the duration of the pandemic. Bed capacity has also been expanded around the state for long-term care residents who have COVID-19. As of December 2020, 237 beds in seven facilities, designated as Emergency Health Care Centers, were available to help residents with COVID-19 recover and separate them from non-infected residents.

Oregon took the early proactive step of performing state infection control reviews in 670 long-term care facilities in March. The state reviews were performed by ODHS surveyors at nursing, assisted living, and residential care facilities, including those providing memory care. At times, surveyors performed federal infection control surveys and state reviews together. The state also began restricting visitors to long-term care facilities in March 2020.

OHA's Healthcare-Associated Infections program hired regional infection control practitioners to consult with long-term care and other facilities for two years. The Centers for Disease Control and Prevention (CDC) funded these positions. This approach improves statewide access to this expertise and will address the COVID-19 virus and other organisms, such as antibiotic-resistant bacteria. By early February, the program had conducted 560 infection control consultations at long-term care facilities since the pandemic began.

ODHS began placing executive orders on long-term care facilities in March 2020 when facilities report a suspected or confirmed case of COVID-19 among their staff or residents. Surveyors visit facilities at least weekly until the order is lifted. If facilities are struggling with infection control, surveyors and facilities can request consultations from OHA and local public health authorities. Facilities are required to be free of suspected or confirmed cases before the orders can be lifted. As of January 19, 2021, the state had placed 2,282 executive orders on 773 unique facilities. According

Oregon's COVID-19 response toolkit for long-term care facilities

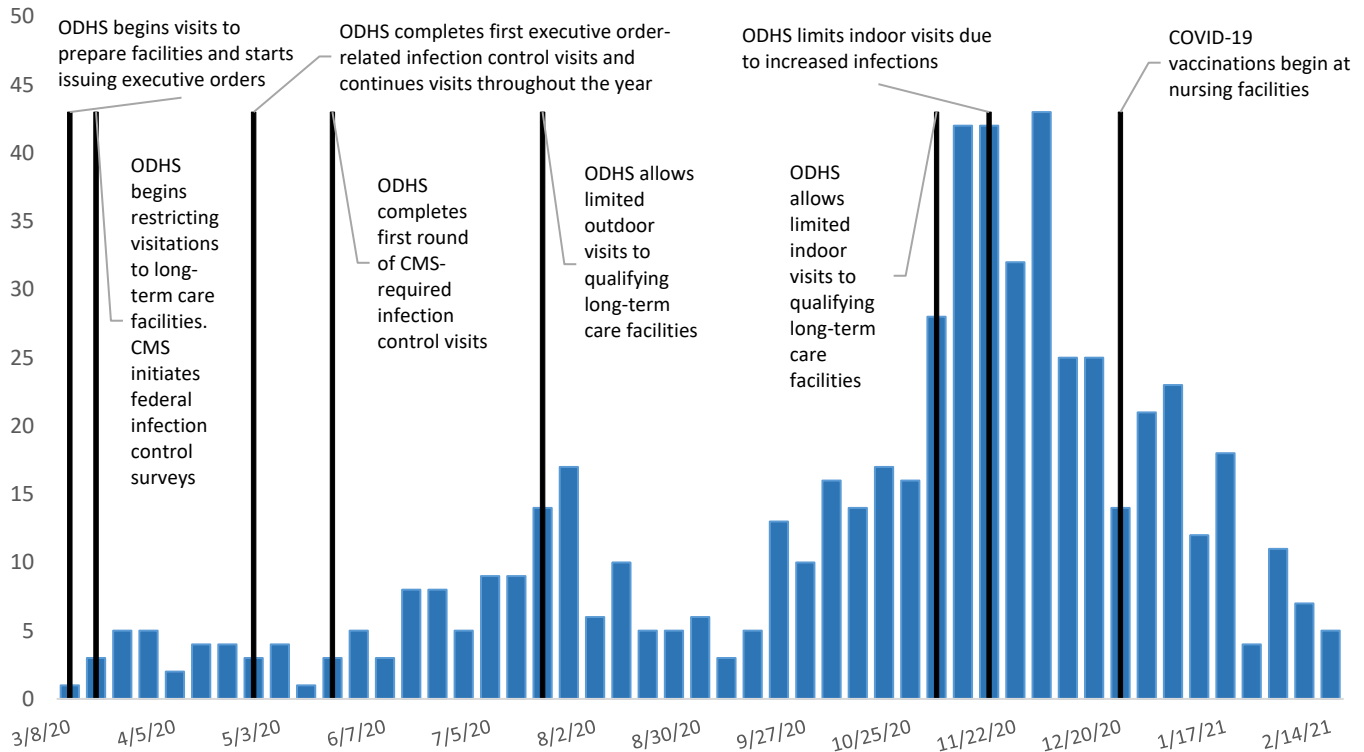
OHA encouraged all long-term care facilities to use its toolkit to revise COVID-19-related policies, procedures, and forms. The toolkit contains:

- A seven-page readiness assessment tool
- An outbreak response tool with action steps to take when a case of acute respiratory illness arises
- Strategies for conserving personal protective equipment
- Contact information for local public health authorities
- A 'no visitors' notice
- A facility entry log template
- A respiratory illness log template
- A resources page

to federal data, Oregon conducted more than 500 infection control surveys at Oregon’s 129 nursing homes alone from March to October 2020, with each facility receiving at least three surveys.

The efforts of state agencies, other regulators, and the long-term care facilities themselves have likely reduced the number of COVID-19 cases, outbreaks, and deaths. Despite these actions, the initiation of vaccines, and a sharp reduction in cases and deaths after the late 2020 surge, however, outbreaks continue. In addition, new surges could come if existing vaccines are not as effective against new COVID variants. Figure 3 shows the number of outbreaks in long-term care and other congregate settings over time, which have increased with each successive surge through 2020. Additional measures, detailed in the remainder of this report, could help reduce the spread of COVID-19 and combat communicable diseases in the future.

Figure 3: COVID-19 outbreaks in long-term care and other congregate settings have continued



Source: OHA COVID-19 Weekly Outbreak Report for 2/24/21.¹² Data reflects the week an outbreak was first reported.

Memory Care facilities and facilities in counties with high case rates appear to be at higher risk

Our analysis of OHA long-term care outbreak data indicates that:

- long-term care facilities in counties with higher case rates in the general population have higher case rates than facilities in counties with low rates;
- nursing facilities had higher case and death rates than community-based care facilities; and
- facilities offering memory care services had substantially higher COVID-19 case and death rates than facilities without memory care.

¹² OHA COVID-19 Weekly Outbreak Reports can be accessed at <https://www.oregon.gov/oha/erd/pages/covid-19-news.aspx>

We analyzed COVID-19 outbreak data for long-term care facilities through November 30, 2020, along with population data, finding three significant relationships.¹³

First, COVID-19 case rates in long-term care facilities are higher in counties that have high case rates in the general county population — in statistical terms, county case rates explained roughly one-third of the differences between facilities in long-term care case rates. Six of the 10 counties with the highest case rates also ranked in the top 10 in case rates for their long-term care facilities. The correlation for mortality rates in long-term care facilities and county populations was not as high.

Second, nursing facilities had roughly 20% higher case and 26% higher death rates per 1,000 staff and residents than community-based care facilities, including assisted living and residential care facilities (see Figure 4). As of November 30, 2020, 76 nursing homes had an outbreak at some point in the pandemic. Nursing homes care for more medically fragile patients, likely contributing to the higher death rate.

Figure 4: Nursing homes have higher COVID-19 case and death rates than Community Based Care facilities

Facility Type	# with at least 1 outbreak	Cases per 1,000 Residents/Staff	Deaths per 1,000 Residents/Staff
Nursing Homes	76	98	9.2
CBCs	178	81	7.3
Total (LTCFs)	254	87	8.0

Source: Auditor analysis of OHA Weekly Outbreak Report from 12/02/2020 and ODHS licensed facility data.

Third, and most concerning, facilities with memory care had case and death rates that were far higher — more than twice as high for death rates — than facilities without memory care (see Figure 5). Case rates in these facilities are nearly twice as high.

Figure 5: COVID-19 cases and deaths per 1,000 residents and staff are substantially higher in facilities with memory care services

Facilities	Facilities with an outbreak	Cases per 1,000 Residents/Staff	Deaths per 1,000 Residents/Staff
With Memory Care	74	134	14.8
Without Memory Care	166	70	5.8
Unknown ¹⁴	14	Unknown	Unknown
Total	254	86	7.9

Source: [OHA COVID-19 Weekly Outbreak Report 12/03/2020](#) and ODHS long-term care facility data

Of the 217 facilities with memory care in Oregon, 214 of them are community-based care facilities, which are regulated by the state, not the federal government. As we discuss later in the report, state regulations around infection control, staffing, and emergency preparedness for community-based care facilities are lacking. Limited regulation may contribute to higher case and death rates, though other factors may also contribute. ODHS officials told us that infection control is more difficult in memory care facilities. A common characteristic of people with dementia is their tendency to wander, they noted, making isolation of infected residents a challenge. It is also difficult for these residents to understand why they need to wear masks. As in all long-term care, staff tend to be low paid and work multiple jobs, increasing their risk of bringing infections into facilities.

We reviewed ODHS surveyor reports on the 10 facilities that had the highest death totals as of early November 30, 2020, with surveyors arriving after the facilities reported initial cases. Surveyors noted infection control problems in three of the six facilities without memory care, but in all four

¹³ A case and mortality map by state and county can be found [online at usafacts.org](https://www.usafacts.org).

¹⁴ We could not determine the facility type for 14 of the 254 facilities in OHA's outbreak data. We conducted additional analysis and confirmed that this omission did not affect our memory care conclusions.

facilities with memory care. At one memory care facility that ended up with double-digit cases and deaths, for example, surveyors cited a lack of staffing to ensure infected residents were properly isolated, noting that six staff had tested positive and that several staff left their positions due to the outbreak. At another, also with double-digit cases and deaths, surveyors noted four staff with masks not covering their mouth and nose. The facility's registered nurse told surveyors that they monitored infection control protocols on an informal basis only.

Using public federal data for nursing facilities, we also examined other potential factors that could contribute to outbreaks and cases in nursing homes. Those factors included facility size, staffing levels, deficiency notices issued to facilities, complaints filed against them, and federal "5-Star" quality ratings. Though these measures varied substantially among Oregon facilities, we did not find any strong relationship between them and COVID-19 cases, outbreaks, or deaths in Oregon's nursing facilities.



National studies of the same federal data have also found that the strongest predictor of COVID-19 outbreaks in nursing homes is per capita cases in the county, but that higher nursing aide hours and total nursing hours may help contain the number of cases and deaths.¹⁵

Long-term care staff are at risk for infection and are a source of COVID-19 in facilities, but state oversight of infection control training and monitoring of staff practices is limited

Workplace risks during COVID-19 have dramatically increased for long-term care workers, who often work multiple jobs and can be exposed to the virus at work. As of February 14, 2021, CMS reported 1,934 cases of COVID-19 among staff in Oregon's skilled nursing facilities alone. The consensus among individuals we interviewed was that staff are also a significant source of the virus in long-term care facilities. Given this exposure potential, preemptive efforts to keep the virus out of the facilities are crucial for containing the spread of COVID-19. We found that the state could do more to ensure that facilities take preemptive measures to protect both staff and residents.

There are multiple reasons that employees and ancillary medical personnel such as physical therapists may carry the virus into facilities. They may be asymptomatic and not know they have the virus. Many are low paid and may come to work when sick because they are not paid to stay home or the facility is short-staffed. That staff are a source of infection would account for some of the cases that arose in long-term care after all visitors were restricted from facilities in March 2020.

Oregon has taken steps to increase infection control in long-term care facilities. The state and federal government have developed training webinars, modules, and other educational materials for this purpose.¹⁶ ODHS surveyors also look at training documentation during infection control reviews at individual facilities. Executive orders placed on facilities require staff to be trained on infection control policies and procedures and list topics to be included in the trainings.

¹⁵ See, for example, "[Staffing Levels and COVID-19 Cases and Outbreaks in U.S. Nursing Homes.](#)" Journal of the American Geriatric Society, 68:2462-2466, 2020.

¹⁶ The required training can include, but is not limited to: how COVID-19 is transmitted from person to person, signs and symptoms of COVID-19, safe coughing and sneezing practices, proper handwashing and hand-sanitation techniques, cleaning and disinfecting surfaces, treatment when symptoms arise, proper use of personal protective equipment (PPE), and when staff are required to use PPE.

Facilities are not meeting CMS training goal

As of November 17, 2020, **only 10 of Oregon's 129 nursing homes** had met the CMS goal that 50% of nursing home staff take CMS's free infection control training.

The state could do more to ensure that facilities are taking preemptive measures. Executive orders only apply to facilities that have had suspected or confirmed cases of COVID-19. ODHS surveyors try to call or visit facilities within 48 hours of a new executive order to review infection control measures, but by the time a case is reported to ODHS and surveyors have reached the facility, the virus has likely already spread. This may be particularly true at facilities with infection control issues. Our analysis of the facilities with the 10 highest death totals found surveyors identified infection control issues at seven of them shortly after executive orders were issued but before substantial deaths occurred. Also, to lift the executive order, facilities are only required to document that residents and staff were tested for COVID-19 and that there were no longer suspected or confirmed cases in the facility. ODHS does not require documentation of how facilities will monitor and document ongoing infection control practices among staff.

The ability to track staff trainings is important for both containing infections and preventing them. As of November 17, 2020, only 10 of Oregon's 129 nursing homes had met the CMS goal that 50% of nursing home staff take CMS's free infection control training.

House Bill 2600, effective January 1, 2021, requires long-term care facilities to:

- adopt specified protocols and procedures regarding preventing and reporting disease outbreaks;
- designate an individual with specialized training to be responsible for carrying out infection prevention and control protocols; and
- train administrators and certain employees in preventing, containing, and reporting disease outbreaks.

Long-term care trade group officials say they assume many staff have received infection control training through other programs, but the state does not have data to confirm the training took place.

House Bill 2600, passed in the 2019 legislative session, could help in tracking facility practices on infection control and staff trainings. The bill requires long-term care facilities to designate a person with specialized training to carry out infection prevention and control protocols and to serve as the primary point of contact for disease outbreaks. That person could take responsibility for documenting staff trainings and the ongoing monitoring of staff practices and send this information to the appropriate state agency. The state could then analyze this information and focus on facilities that need support.

Response priorities have reduced facility oversight, increasing risks to residents

ODHS and OHA have conducted hundreds of infection control surveys and consultations in Oregon long-term care facilities, a critical part of their pandemic response. However, the shift to infection control surveys has been at the expense of far more thorough licensing recertification surveys. The recertification surveys offer more comprehensive evaluations of facility safety and resident well-being.

Pandemic precautions have also reduced the presence of independent observers who can monitor the well-being of long-term care residents. For example, volunteers for Oregon's Long-Term Care Ombudsman, who talk with residents and observe conditions in facilities, are not allowed into these buildings when visitation restrictions are in place. The Long-Term Care Ombudsman's office has been receiving more than 100 calls about complaints and other issues every week from long-term care residents, their families, and staff.

On March 4, 2020, ODHS surveyors stopped doing annual and biennial recertification and licensing inspections of long-term care facilities because CMS wanted states to prioritize infection control activities. Oregon was already behind on these surveys before the pandemic. As a result, by November 1, 2020, Oregon had the second-highest percentage, at 53.5%, of nursing homes without

state recertification surveys completed over the last 18 months. The national average was 21.5%, with Washington and California at roughly 20%. ODHS is hoping that CMS will grant them a reset on when recertification surveys for nursing facilities are due given the delay resulting from the pandemic.

As of November 1, 2020, Oregon had **the second-highest percentage, at 53.5%, of nursing homes without state recertification surveys** completed over the last 18 months

The recertification and licensing inspections are more thorough than infection control surveys, which run hours instead of days and do not include examining resident records or interviewing residents.

When conducting the recertification and licensing inspections, by contrast, surveyors review records, interview staff and residents, and observe staff actions. For infection control, these observations include handwashing by staff, the handling of soiled laundry and medical items, and staff behaviors as they help residents with their meals. A team of surveyors might spend several days in one facility conducting an inspection. Facilities are cited if they do not reach minimum criteria on a wide variety of requirements, from infection control to resident rights to food and nutrition services. If surveyors issue citations, facility administrators receive a report and must put a plan in place to correct the deficiencies. Nursing and community-based care facilities have 50 and 60 days, respectively, from the date of the survey exit to return to compliance. Surveyors revisit facilities to make sure the corrections have been made.

ODHS is also behind on responding to complaints about long-term care facilities. Because of CMS priorities, Oregon is only responding to nursing home complaints that have reached the “immediate jeopardy” level, in which a resident could be harmed. Issues such as quality of life for residents, food and nutrition services, wound care, and lesser allegations of abuse or neglect that fall short of immediate jeopardy are not being addressed.

More proactive actions, including visits to more long-term care facilities and the use of financial penalties, may better protect residents

Officials from the Long-Term Care Ombudsman’s office and ODHS say the time for relying primarily on education efforts to ensure compliance with infection control protocols may have passed. People we interviewed said that while most facilities are doing a good job, a few are not. They have observed the improper use of masks and have been told by facility personnel that personal protective equipment is not necessary.

Federal data indicates ODHS surveyors visited nursing homes roughly 500 times from March to October 2020, issuing infection control deficiency notices in 6% of those visits, below the 9% national rate. Eighteen of the 75 nursing facilities with outbreaks received infection control deficiency notices. However, eight of those 18 facilities received notices only after their outbreaks, despite earlier visits. Three of those facilities were among the five with the most deaths.

In a November 2020 letter to the Governor, Oregon’s Long-Term Care Ombudsman noted that some facilities had shown the ability to limit infection spread and some clearly had not. The Ombudsman called for resources for ODHS and OHA to inspect all long-term care facilities, not just facilities with COVID-19 cases. He suggested separately that ODHS focus more on facilities with known histories of neglect, abuse, and past infection control issues, saying the current regulatory structure caters too much to facilities at the expense of residents. The Ombudsman also called for the use of civil monetary penalties on facilities with egregious conduct related to infection control protocol failures, noting that ODHS had not issued penalties to date though the agency has the authority to do so. However, ODHS officials note that executive orders, which are placed on facilities after an outbreak, shut down admissions. Restricting admissions has financial consequences for facilities.

Oregon regulations allow ODHS to deny, suspend, or revoke facility licenses if the facility fails to comply with inspection requirements. For nursing facilities, regulations allow an emergency

suspension of the license if ODHS finds a serious and immediate threat to resident health and safety. On May 5, 2020, ODHS issued this order to Healthcare at Foster Creek, the long-term care facility with the highest number of deaths in Oregon as of the end of November, and the remaining residents were transferred the same day. However, the May 5 order came nearly three weeks after the facility was cited for immediate jeopardy because of its substandard infection control practices. The delay is an indication of the lack of advance preparation for the pandemic and a hesitancy to take proactive actions in a crucial case. Healthcare at Foster Creek's outbreak was one of the earliest major COVID-19 outbreaks at a long-term care facility. It came as ODHS and OHA were still developing their response, and the lessons learned from the experience helped inform the agencies' response to outbreaks at other facilities.

ODHS may need additional staff to visit facilities that have not had outbreaks. At the height of the surge, with visits only to facilities with outbreaks, ODHS officials said some surveyors worked 10- to 12-hour shifts and on weekends, and had difficulty visiting facilities with executive orders within the 48-hour timeframe. Also, the response may benefit from greater involvement of staff from the Office of the Long-Term Care Ombudsman. The Ombudsman currently speaks briefly, three times a week, with personnel from the COVID-19 Response and Recovery Unit. Given the number of weekly complaints and the office's expertise on long-term care, ODHS and OHA could better incorporate the Ombudsman's independent, resident-focused perspective into responses to individual facilities and decisions about regulatory and licensing policies and procedures.

The state may not be able to track COVID-19 vaccine uptake quickly in long-term care facilities, impeding efforts to identify and support facilities with low rates

Oregon long-term care facilities and regulators have made progress lining up residents and staff for the COVID-19 vaccine. However, the state's ability to track vaccine uptake at individual care facilities appears limited, hampering its ability to support facilities and ensure adequate vaccination coverage. To protect residents and staff, the state must be able to monitor COVID-19 vaccine uptake quickly. Timely information about vaccination rates would allow regulators to ensure adequate coverage within facilities and assist with the monitoring of potential vaccine-related adverse events.

This step is particularly crucial given historically low flu vaccine uptake among long-term care workers in Oregon. In addition, a CDC study published on February 1, 2020, indicated that COVID-19 vaccine uptake may be low among staff in long-term care as well. The CDC study¹⁷ estimated that about 78% of residents in skilled nursing facilities with initial on-site vaccine visits from pharmacies received the vaccine, but only about 38% of staff members did, though it noted some staff may have been vaccinated by other providers. The study said additional resources for staff member outreach and education could help, as could scheduling vaccinations to accommodate shift work and providing paid leave for staff who experience side effects.

The state is participating in the CDC's Pharmacy Partnership for Long-Term Care program. Through this program, pharmacists will provide on-site COVID-19 vaccination clinics, free-of-charge, to residents and staff in skilled nursing and assisted living facilities.¹⁸ As of the beginning of February 2021, OHA records indicate every nursing facility in Oregon had its first pharmacy vaccination clinic. At that point, OHA also expected first clinics for every enrolled long-term facility to be completed by February 15, two weeks ahead of the CDC's schedule. Emergency medical service providers are also a state option for vaccinating long-term care staff and residents.

¹⁷ ["Early COVID-19 First-Dose Vaccination Coverage Among Residents and Staff Members of Skilled Nursing Facilities ...,"](#) CDC Morbidity and Mortality Weekly Report, February 1, 2021.

¹⁸ Pharmacists from three companies will participate in this effort: CVS, Walgreens, and Consonus.

However, tracking COVID-19 vaccinations among long-term care staff and residents, overall and by specific facility, is a challenge, hampering the state’s ability to identify facilities with low vaccination uptake. As it stands now, the CDC is requiring vaccination information to be logged into ALERT IIS, Oregon’s state immunization registry. However, the pharmacies participating in the CDC’s long-term care program do not provide the name of the long-term care facility to the state. The state may instead need to require facilities to report vaccinations directly and quickly, outside of ALERT IIS, to tally staff and resident rates. Given the severity of COVID-19 in long-term care facilities, the reporting should be weekly or at least monthly to allow for intervention at facilities with low rates.



Other options include working with the pharmacies participating in the CDC program to obtain the missing information or obtaining demographic data from facilities and conducting matching analyses in ALERT IIS. However, agency officials say these options would require more staff time than OHA’s Immunization Section has available. One-third of OHA’s ALERT IIS personnel was deferred to help staff the COVID-19 Response and Recovery Unit despite the need to maintain the system for routine child and adult immunizations and track COVID-19 vaccinations. In addition, the program is handling its biggest enrollment of new providers who will give vaccines, which includes connecting them with ALERT IIS.

In the future, the Immunization Section and OHA’s Healthcare-Associated Infections Program may be able to collaborate on calculating uptake rates for flu and other vaccinations of long-term care facility staff and residents. These two programs have complementary information to make the calculations, including staff and resident counts and individual-level data. However, it is not clear that either program has the regulatory authority to report information on staff and resident immunizations, other than staff flu vaccinations in skilled nursing facilities.¹⁹

State officials say they need more investment in data systems to track vaccinations. They also need more experts to intervene and educate when vaccinations rates are low, such as epidemiologists, infection preventionists, and communications specialists.

Monitoring vaccinations is crucial for identifying facilities that may need additional support to immunize their staff and residents. The public also has a strong interest in knowing rates at individual facilities to help gauge facility safety. As we note later in the report, health care workers in Oregon’s skilled nursing facilities have low flu vaccination rates, which raises concerns that COVID-19 vaccination uptake rates among long-term care workers may also be low. The low average rate also masks substantially lower rates at some facilities. For the 2018-19 flu season, health care worker flu vaccination rates for skilled nursing facilities ranged from 11.5% to 100%.

The uncertain outlook for long-term care workers puts a premium on the need to educate them about the COVID-19 vaccine. It also presents another opportunity for collaboration between ODHS

¹⁹ The U.S. Equal Employment Opportunity Commission is responsible for enforcing federal laws that make it illegal to discriminate against a job applicant or employee because of the person’s race, color, religion, sex, national origin, age, disability or genetic information. The Commission has determined that employers can require workers to get a COVID-19 vaccine and bar them from the workplace if they refuse. There is no mandate at the state level to do so, however, and it is unclear if employers will require vaccinations.

and OHA. Educational efforts will come out of the OHA's Immunization Section, but these efforts may fall flat given the difficulties that program has had engaging long-term care facilities around ALERT IIS. Their efforts could be enhanced, however, by the hands-on experience of OHA's Healthcare-Associated Infections Program and ODHS's Safety, Oversight, and Quality Program with long-term care facilities.

ODHS and OHA's COVID-19 Response and Recovery Unit can help improve oversight of long-term care facilities

The response and recovery unit, which coordinates ODHS and OHA efforts, is in a strong position to drive oversight improvements and proactively reduce the risk of outbreaks during the COVID-19 response.

To monitor vaccinations in long-term care facilities, the unit should help staff the ALERT IIS team at OHA so it can quickly produce vaccination rates by facility, and work with the Immunization Section to publicly communicate those rates. For additional surveyor visits to facilities, the unit can work with ODHS and the Governor's Office to enlist supplementary staff. The unit can also initiate discussion of how to best prevent outbreaks in memory care facilities, and whether more active enforcement is called for at this point.

The unit can also coordinate responses to help ensure that all of Oregon's nursing, assisted living, and residential care facilities:

- have identified a point person for disease outbreaks, as required by House Bill 2600;
- provide documentation that staff have received infection control training within an appropriate time period;
- provide evidence that they are monitoring infection control practices among staff; and
- have a plan for vaccinating staff and residents for influenza and COVID-19, including the reporting of those vaccinations to ALERT IIS.

Filling gaps in Oregon's infection control regulations and practices for long-term care would better safeguard residents in the future

The COVID-19 pandemic has highlighted gaps in Oregon's infection control regulations and practices for long-term care facilities. The state has fragmented authority over long-term care, and regulations for nursing facilities are more robust than those for community-based care facilities — assisted living and residential care. In addition, alarmingly low flu vaccination rates among health care workers in skilled nursing facilities and the lack of oversight for staff flu vaccinations in community-based care likely contributes to the many flu outbreaks in these facilities.

The Legislature took an important step toward improving some regulations when it passed House Bill 2600 in 2019. The bill required infection control trainings and protocols, for example, and reporting of outbreaks in long-term care. If implemented thoughtfully, HB 2600 may help close regulatory gaps. In addition, publicly posting long-term care staff vaccination rates by facility would enhance transparency for consumers of long-term care and may prompt facility administrators to improve their staff vaccination rates. Oregon's schools and child care facilities have publicly reported required immunizations by school for several years.

Oregon statutes and rules can better support effective long-term care infection control and oversight

We reviewed Oregon's long-term facility statutes and rules and conducted a limited review of statutes in other states to identify gaps in Oregon's approach that increase risks for residents. We found that Oregon could benefit from consolidating its statutes and rules and adding more specifics

to the rules. The state can also improve infection control training language, increase requirements for community-based care facilities, and increase staffing requirements. Among the most significant issues we found:

Framgmented authority: Oregon’s statutes are split between OHA and ODHS. CDC guidance recommends granting broad regulatory authority to either a state health agency or commissioner of health. CDC guidance further emphasizes that states with separate statutes defining health and regulatory authorities need to closely coordinate to ensure the separate laws and requirements are simultaneously updated. Fragmenting statutory oversight complicates collaboration on prevention and control between two agencies which are critical for long-term care oversight. A safety manager in ODHS’s Aging and People with Disabilities program does help coordinate response to long-term care issues across agencies.

Ambiguity in infection control training rules: Oregon’s statutes and administrative rules do not clarify whether unlicensed front-line workers are covered by statutes requiring infection control training for long-term care employees. Statutes require training for employees, but an OHA administrative rule cites CDC guidelines that refer to health care providers licensed by a state board, not other front-line workers.²⁰ This is a significant gap, as unlicensed front-line workers can also have frequent contact with residents.



Infection control statutes for the State of New York stood out for their clarity. They include language that specifically requires infection control training for all staff, including part-time staff, volunteers, and anyone “serving in any capacity in the nursing home.”

Limited infection control requirements for community-based care facilities: Oregon rules require nursing homes to establish infection control plans and programs implemented and overseen by Quality Assessment and Assurance Committees, which are also charged with monitoring staff performance on infection control. However, the same requirements are not in place for community-based care facilities, whether assisted living or residential care.

HB 2600 does not require infection control plans or programs. It does require long-term care facilities to establish and maintain infection prevention and control protocols and procedures. However, the bill does not specify the topics these are to cover, instead relying on ODHS, in coordination with OHA, to communicate best practices and protocols to facilities.



By contrast, New Jersey’s Revised Statute Title 26 requires all types of long-term care facilities to develop outbreak response plans customized to the facility and in consultation with the facility’s infection control committee, if the facility has one. The statute also sets forth specific items required in each plan, such as isolation protocols, visitation policy, testing, and monitoring of residents and staff to identify signs of a communicable disease.

Consolidation of all long-term facility types into a single statute, both nursing facilities and community-based care facilities, would increase facilities’ understanding of requirements and aid regulatory agencies in holding those facilities accountable.

Oregon should also consider stronger, more specific requirements for infection control, generally, and for community-based care, specifically. Community-based care facilities account for 73% of the long-term care facility population in Oregon. They also include nearly all of Oregon memory care units, which have had the highest case and mortality rates in COVID-19 outbreaks.

²⁰ [OAR 333-019-0061](#)

Oregon minimum staffing requirements for nursing facilities

Registered nurses:

- No less than one hour per resident per week

Nursing assistants:

- Day shift: 1 nursing assistant per 7 residents
- Evening shift: 1 nursing assistant per 9.5 residents
- Night shift: 1 nursing assistant per 17 residents

Source: Oregon Administrative Rules Chapter 411 Division 86

Oregon staffing requirements for community-based care facilities

Licensed nurse (registered or licensed practical nurse):

- Regularly scheduled for onsite duties and available for phone consultation
- Facilities are to assure an adequate number of hours relevant to the census and acuity of the resident population

Source: Oregon Administrative Rules Chapter 411 Division 54

Potentially inadequate staffing requirements:

Our analysis of federal data indicated that Oregon's average staffing levels at nursing homes, adjusted for the number of residents, were typically near or above the national average. However, the September 2020 federal commission report on safety and quality in nursing homes said the nation's nursing homes lacked funding for quality operations and were "hampered by too few staff" even before the pandemic. The level of staffing also varies substantially between Oregon's nursing facilities for nurses, nurse aides, and physical therapists. For example, reported registered nurse staffing hours per resident per day ranged from a quarter of an hour to more than four hours.

The staffing issue needs deeper analysis. Minimum hours for licensed nurses are not well-defined for community-based care facilities. They would be expected to be lower since, by definition, these facilities do not provide nursing care. However, these minimum staffing requirements may need to be raised given the risks revealed by the pandemic. These facilities have similar infection risks as nursing facilities, but fewer infection control requirements, and many are as large as nursing facilities. Roughly 85 of Oregon's community-based

care facilities, or 15%, have as many licensed beds as an average Oregon nursing home.

Publishing staff vaccination rates for individual facilities would improve transparency, provide consumers with information, and may improve alarmingly low flu vaccination rates

Achieving and sustaining high influenza vaccination rates among health care workers is intended to help protect these workers, their patients, and reduce disease burden and health care costs. The CDC estimates that influenza vaccinations during the 2019-20 influenza season prevented 7.52 million illnesses, 3.69 million medical visits, 105,000 hospitalizations, and 6,300 deaths. The estimated average annual total economic burden of influenza to the U.S. health care system and society is \$11.2 billion, including \$3.2 billion in direct medical costs.

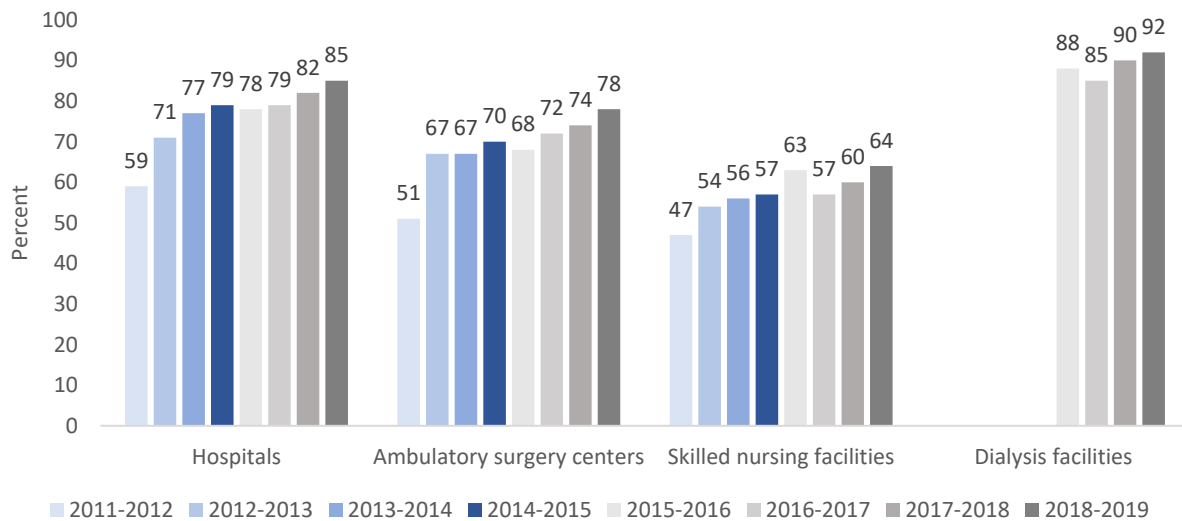
Health care workers in skilled nursing facilities had a **flu vaccination rate of 64%** for the 2018-19 influenza season compared to 85% for health care workers in hospitals. **The national goal is 90%.**

However, health care workers in Oregon's skilled nursing facilities have considerably lower rates for annual influenza vaccinations than other health care workers in the state. These low rates have likely contributed to the many flu outbreaks in these facilities in recent years. The Healthy People 2020 objective for health care worker flu vaccination rates is 90%.²¹ As shown in Figure 6, for the 2018-19 flu season, the rate was 64% for health care workers in Oregon's skilled nursing facilities. That rate is about three-fourths the rate for hospital health care workers,

even though long-term care facilities have had 50-times the number of flu outbreaks as hospitals.

²¹ The [vaccination goal](#) (IID-12.13) is part of The Healthy People's science-based, 10-year national objectives to improve the health of Americans.

Figure 6: Influenza vaccination rates are lowest among health care workers in skilled nursing facilities



Source: OHA 2018-19 Oregon Health Care Worker Influenza Vaccination Annual Report.

The reported average also masks substantial variations in rates across the state’s skilled nursing facilities. For the 2018-19 flu season, rates for these facilities ranged from 11.5% to 100%. Only 19 of 132 facilities active in that season reached the Healthy People 2020 objective of 90%.

Fear of vaccines and doubts about their efficacy are among the reasons for Oregon’s low flu vaccination rates among health care workers in skilled nursing facilities.

The Oregon Nurses Association opposes requiring influenza vaccinations of nurses and other health care workers as a condition of employment but encourages its members to get vaccinated. The American Nurses Association says that all health care personnel should be vaccinated according to recommendations by the CDC and Association for Professionals in Infection Control and Epidemiology. Given the lack of mandates, educational outreach to long-term care staff will be needed to ensure they are vaccinated at rates necessary to protect themselves and residents.

Assisted living and residential care facilities are **not required to report annual flu vaccination rates** for their staff to OHA, as are nursing facilities.

Oregon law does not require health care workers to get vaccinated, but it does require reporting of their annual flu vaccinations. In Oregon, hospitals, ambulatory surgery centers, dialysis facilities, and skilled nursing facilities are required to report, in the aggregate, annual flu vaccinations for their health care worker staff to OHA’s Healthcare-Associated Infections Program. Assisted living and residential care facilities are not

required to do so for their staff. Oregon requirements for reporting staff flu vaccination rates could be extended to other settings that care for vulnerable individuals. Rhode Island and New York report on seven and 12 different types of facilities, respectively. These include adult day care programs, home care providers, hospice providers, and assisted living facilities. OHA officials said it would require a statutory change to have community-based care providers report flu vaccinations for staff into Oregon’s immunization registry.

Oregon's approach for publicly posting school-required immunizations could serve as a model for long-term care facilities

Senate Bill 895 has required schools and child care facilities to publicly and actively share school-required immunization rates for their facilities since 2015. The legislation was driven out of concern about the lack of transparency on this information for parents who were looking for a safe environment for their children.

In Oregon, school children must have at least one shot of required immunizations by the beginning of the school year. Parents have until school exclusion day, in mid-February, to get their child up-to-date on these immunizations or submit exemptions for them. Schools report the immunizations and exemptions to OHA through the school reporting system and schools are asked to verify the accuracy of the data they submit.

OHA's Immunization Section then compiles the data and produces formats, available on the program's website, that schools and child care facilities can use to publish their rates. Schools share the information on their websites and through emails or newsletters and they must have the rates on hand in their school offices. The Oregon Department of Education includes a rate for required vaccinations on their annual at-a-glance school profiles. To protect student confidentiality, the Immunization Section developed a policy on when rates would not be posted for schools and child care facilities with small student populations.

School district employees and critics raised some concerns in the beginning, but OHA program staff told us they heard little criticism of the process after the initial implementation. Staff reported several benefits from the public reporting. These include a reduced workload for state personnel around filling data requests for immunization and exemption rates, greater transparency for those who previously requested the data (e.g., the media, people giving testimony to the Legislature), broad sharing of the information with policymakers, and improved accuracy of the rates because the data was confirmed by schools.

The posting requirement also improved the picture about the level of protection against vaccine-preventable diseases at the school-level. Previously, school-required immunization rates were reported only for some grade levels. As a result of the 2015 legislation, Oregon health officials could see that the high statewide vaccination rates for schools, which were over 90% in 2020, masked variation in rates across schools and facilities. The Immunization Section did not evaluate whether posting the rates increased them. Like individual schools, the 2018-19 rate of flu vaccinations among Oregon's skilled nursing health care workers varied widely, ranging from 11.5% to 100%.

One potential means of motivating health care employers to improve worker vaccination rates is to make those rates public. The American Public Health Association recommends posting health care worker influenza vaccination rates at health facilities and related websites as well as reporting these rates in quality assurance, facility accreditation, and patient safety report cards. Interviewees for this report felt that posting the rates could motivate facilities to improve them. In addition to its annual report, OHA's Healthcare-Associated Infections Program publishes health care worker vaccination rates for individual skilled nursing facilities on a map available through its website.²² These maps are interactive and report important information by facility name: the overall percent, percent declined, the percent unknown, and whether the facility met the Healthy People 2020 goal for staff flu vaccination rates. Medical exemption rates could also be added if confidentiality was not compromised.²³

Expanding current reporting to include more information about vaccination rates for long-term care would give Oregonians better information to make decisions about their personal health care and that of family members. The approach used by OHA's Immunization Section for the public

²² [The Oregon Health Authority's website](#) has more information on vaccinations for health care workers.

²³ Medical exemptions refer to the waivers individuals can receive when they have valid medical contraindications and precautions to immunizations.

posting of rates for school-required immunization, which was in response to legislative direction, could serve as a model for the additional public posting of long-term care facility rates. Schools are required to share vaccination rates on their websites and through emails or newsletters, and they must have the rates on hand in their school offices.

Stronger state and facility emergency response capabilities could protect long-term residents in future outbreaks and in other emergencies

Both the pandemic and wildfires highlighted the need for a more solid foundation and investment in response and recovery functions. We are not equipped in state agencies to deal with these types of disasters.

- Fariborz Pakseresht, ODHS Director, KXCR 90.7 FM Fireside Chat with Senator Arnie Roblan, October 20, 2020

Events in 2020 highlighted the importance of emergency preparedness for state agencies and long-term care facilities, with enormous challenges posed by the pandemic and widespread wildfires that forced evacuations of more than 40 long-term care facilities over three days in September 2020.²⁴ Preparedness minimizes the loss of life and property and the potential for personal trauma and it increases the likelihood that services will be maintained for vulnerable populations.

Yet Oregon has struggled with emergency preparedness. Our 2018 audit report found that the state needed to do more to prepare, including completing and implementing critical plans, fulfilling minimum standards for an effective emergency management program, and adequately staffing the agency charged with coordinating emergency management efforts.²⁵

We found instances of these limitations for long-term care and the agencies that regulate them. Delayed actions around outbreaks in long-term care facilities was due, in part, to a lack of prior planning for a joint ODHS/OHA response, and state regulations for emergency preparedness in community-based care facilities are lacking compared to federal regulations for nursing facilities. More rigorous regulations and interagency assistance at the state and local level will better prepare long-term care facilities for natural disasters, communicable disease outbreaks, and other emergencies.²⁶

Prior to COVID-19, ODHS and OHA had not planned basic elements for a joint emergency response

OHA, particularly OHA's Public Health Division, planned for a potential pandemic in advance. However, due to a lack of prior joint planning, OHA and ODHS spent valuable time during the COVID-19 response developing a response structure, acquiring staff, and determining roles and responsibilities.

Responding well to emergencies requires prior planning, exercising, and the evaluation of exercises and real-life emergencies to improve emergency response plans. Staffing needs must be projected, and response personnel must be trained in emergency management concepts and response procedures.

We recognize that agencies might not get credit for preparing for emergencies that do not occur. They may also not have time to prepare for emergencies given limited resources. Prior to COVID-19, ODHS, with over 9,000 employees, 170 field offices, and many community partners, had just

²⁴ Since September 7, 2020, 21 wildfires occurred in Oregon. Nine people lost their lives, 4,021 homes were destroyed, and 1 million acres of land were burned.

²⁵ [Report 2018-03](#), The State Must Do More to Prepare Oregon for a Catastrophic Disaster.

²⁶ The Audits Division plans to continue audit work on emergency management in its 2021-22 audit plan.

three staff assigned to emergency management for the agency. A newly expanded unit now has 15 staff.

OHA, with over 4,000 staff, is one of the few state agencies to have personnel dedicated to emergencies. The federally funded Health Security, Preparedness and Response Section within the Public Health Division had 23 full-time staff before some were diverted to other positions when COVID-19 arose. This program, among its other responsibilities, maintains:

- SERV-OR, a state emergency registry of health care professional volunteers;
- the Health Alert Network, a notification and information-sharing system; and
- HOSCAP, a hospital capacity web system that allows health care and emergency preparedness partners to share real-time status data.

Emergency Management Accreditation Program (EMAP) standards

EMAP standards for the minimum acceptable performance criteria include 11 program elements. Four of these are:

- Operational planning and procedures
- Resource management
- Training
- Exercises, evaluations, and corrective actions

The Public Health Division has participated in 64 incidents or exercises in the past six years, 14 of which involved communicable diseases. Both ODHS and OHA have worked on statewide responses to wildfires and winter storms.

The magnitude of the COVID-19 pandemic and a flawed federal response have contributed to what might otherwise have been an historic moment for public health agencies, after the work they have done over the years to prepare for a pandemic. The CDC, the nation's lead public health agency, wrote the pandemic response playbook that countries other than the United States have applied with success to their responses.

However, actions taken by ODHS and OHA after Oregon's response to COVID-19 was initiated revealed how the agencies had not planned basic elements for responding together, even though they are responsible for emergency support functions with intersecting obligations. These include how a joint response would be structured, projected staffing needs, and the roles and responsibilities of responders. These elements were developed after the response began, delaying actions that may have prevented illness and death among long-term care residents and staff.

To remedy the lack of a structured approach for a joint response, ODHS and OHA partnered on a management model they felt was sustainable and in line with routine agency operations. The result was the COVID-19 Response and Recovery Unit, a shared service between the two agencies. ODHS and OHA had to hire a consulting firm to develop an organizational structure for the new unit, which serves as a coordinating body for the two agencies. Though the new unit was announced by April 2020, outbreaks that started in March and April resulted in 91 deaths among residents in long-term care.

To staff the response and recovery unit, ODHS and OHA hired new personnel and pulled others from existing programs, some of which were already playing a critical role in the response. This situation required the programs that lost staff to hire new workers, an added burden as they were responding to the pandemic while also performing their regular duties.

The need for the response and recovery unit to pull staff from other crucial areas also highlights previous low investment in responding staff and a lack of planning around staffing needs. We learned that personnel in ODHS and OHA are working long hours and on weekends for the response. That workload is neither healthy for workers nor sustainable for a long-term response. Projecting staffing needs prior to an emergency can help prevent delays to response activities and burnout among responders.

The two agencies also had limited prior understanding of each other's roles and responsibilities, specifically the regulatory duties for ODHS and the outbreak investigation and infection control duties for OHA. Despite the hundreds of norovirus and flu outbreaks that have occurred in the state's long-term care facilities over recent years, Oregon appeared caught off-guard initially by how to respond to COVID-19 outbreaks in those facilities.

Before the pandemic, the ODHS surveyor program, OHA, and local public health authorities had not worked together on investigations of communicable diseases in long-term care facilities, and DHS surveyors had no experience responding to outbreaks. Local public health authorities would take the lead on investigating these outbreaks while DHS surveyors would avoid the facilities until the situation was resolved to keep themselves safe and to reduce the risk of spreading infections as they moved from facility to facility. OHA assists local health authorities with outbreak investigations, as needed.

The response and recovery unit remedied this problem, in part, by conducting an exercise, helping the unit produce a playbook, or strategic reference guide, that established the coordination and response efforts of ODHS and OHA when cases of COVID-19 were associated with a long-term care facility. The state wrote additional playbooks for other agencies experiencing COVID-19 outbreak investigations, but the playbooks all came several months into the pandemic. The unit also initiated Interagency Support Team meetings, which are convened in response to outbreaks at individual long-term care facilities that require a high level of assistance. These meetings include state and local response personnel who help implement action plans to stabilize a facility.

Lessons Learned

For future emergencies:

- Develop an organizational structure that can be quickly scaled up for a joint response
- Ensure personnel are trained on emergency management roles and responsibilities
- Project staffing needs for various-sized events

For ongoing communicable disease control:

- Maintain active Interagency Support Teams for communicable disease response
- Maintain contracts for Emergency Health Care Centers and emergency staffing for long-term care personnel
- Continue collaborative preemptive infection control consultations and trainings for surveyors on infection control practices
- Use cross-agency data to better identify and monitor vulnerable populations

Other details of the COVID-19 response suggest a loss of institutional knowledge about managing health and medical resources, such as personal protective equipment. OHA has long been responsible for the receipt, storage, and distribution of such resources. The agency coordinated this work with partner state agencies during the 2009 H1N1 flu pandemic, receiving and storing personnel protective equipment and antiviral medication from the federal government. However, the Public Health Division shifted responsibility for managing resources from one program to another after the H1N1 flu pandemic. When COVID-19 arose, the agency's knowledge of how to coordinate the distribution of personal protective equipment out of the state's 11-year-old stockpile, as well as staffing for such a mission, was no longer in place. The state's Emergency Coordination Center had to develop a large logistical structure, with heavy reliance on the Oregon National Guard, to do so.

Moving forward, the agencies can incorporate lessons learned from the COVID-19 response into their routine activities, policies, and procedures, so they aren't lost to future emergencies. This step would also benefit the investigation of norovirus and flu outbreaks that

frequently afflict long-term care facilities. One lesson is for agencies to better use the data they already collect to monitor long-term care facilities. Better monitoring would give a ready assessment of the status of long-term care facilities across the state during a future emergency. It would also help inform routine compliance work outside of emergencies. Interagency processes and tools could be developed for this purpose. For example, ODHS could take the lead on compiling

performance data for each of Oregon's 685 long-term care facilities. The data could include key measures from ODHS's long-term care surveys and complaint investigations; local and state fire authority inspections and surveys; and OHA's outbreak, health care worker vaccination, and infection control consultation data. A readily accessible dashboard could display a facility's status on each performance measure, and ODHS and OHA could monitor the contents regularly and share results with facility personnel for continuous improvement. When facilities approach subpar performance, Interagency Support Teams could be convened to work with facilities on corrective action plans.

ODHS and OHA implemented many remedies months into the response reinforcing what we found in our 2018 audit regarding Oregon's struggles with emergency preparedness. Rather than activating existing, well-tested plans, ODHS and OHA had to generate plans and develop a unit for coordinating their efforts during the response, delaying actions that may have prevented early COVID-19 cases and deaths.

Oregon's management of the pandemic increases concerns about the state's ability to build, and respond within, a complete and coordinated emergency management system. Issues include limited understanding among state personnel about emergency management concepts and what can be accomplished within an emergency management framework. Our emergency management audit in 2021 will examine these issues.

Long-term care facilities maintain emergency plans, but state laws for community-based care facilities are not as robust as those for nursing facilities

All of Oregon's long-term care facilities are required to prepare for emergencies, but federal requirements for nursing facilities are more robust than Oregon's rules for community-based care — assisted living and residential care facilities. Differences in requirements are seen in the types of exercises and training required and how plans are reviewed. Assisted living and residential care facilities would benefit from preparedness program requirements more akin to the federal requirements.

By state rule, assisted living and residential care facilities must maintain a written emergency preparedness plan, which includes preparing for a pandemic, and these plans must be reviewed or updated annually. They must also conduct a drill of the plan at least twice a year and one of those drills may be a discussion exercise, commonly known as a tabletop exercise. The only emergency training requirements mentioned in rule for staff in these facilities are trainings on fire safety and emergency procedures during a pre-service orientation, and on preventing, recognizing, and reporting disease outbreaks at the time staff are hired.

Federal rules for nursing facilities, on the other hand, require these facilities to establish and maintain an emergency preparedness program, not just a plan.²⁷ At minimum, these programs must include an all-hazards emergency plan based on a community-based risk assessment, policies and procedures, a communication plan, a training and testing (also known as exercise) program, and emergency and standby power systems.²⁸ Nursing facilities must also complete two annual exercises, one of which must be an advanced functional exercise or a real-life emergency. Many of these elements have annual requirements to ensure that plans are revised, training is ongoing, and procedures are up-to-date. Federal regulations also specify detailed requirements to more adequately prepare care facilities to meet the needs of residents during a disaster or emergency

²⁷ [42 C.F.R. §483.73](#)

²⁸ An all-hazards approach focuses on identifying hazards and developing emergency preparedness capacity and capabilities to address a wide range of natural or man-made emergencies. Exercises should progress in complexity. They range from drills to tabletop, functional, and full-scale exercises.

situation. State rules require nursing facility staff to receive annual emergency preparedness training.

Local fire authorities review the emergency plans of assisted living and residential care facilities to ensure they met Oregon Fire Code regulations. Surveyors with the Office of the State Fire Marshal carry out a contract with ODHS to survey the emergency plans of nursing facilities. State Fire Marshal surveyors conduct their surveys during the same window of time as ODHS surveyors. The State Fire Marshal surveyors look for compliance with the 2012 editions of the National Fire Protection Association (NFPA) 101 Life Safety Code and NFPA 99 Health Care Facilities Code.²⁹ They also refer to relevant appendices in the CMS State Operations Manual for guidance.

State Fire Marshal specialists will refer nursing facilities to their local fire authority or local emergency management if they need assistance in completing the hazards vulnerability assessment tool or to integrate them into planning efforts for local exercises. Given the proper resources, these emergency management professionals,³⁰ in addition to the emergency preparedness coordinators employed by local public health agencies, have the expertise to coordinate and assist with preparedness efforts for all long-term care facilities.³¹ Their combined efforts, along with the potential involvement of Area Agencies on Aging,³² might not only improve individual facility plans, but also enhance long-term care planning on a regional basis, helping to reduce the risks of illness and deaths for residents from communicable diseases.

²⁹ A 2017-18 edition of these codes has been released, but CMS has yet to adopt it.

³⁰ Under state law, all of Oregon's 36 counties are required to have an established emergency management program with a designated emergency manager. Under their Public Health Emergency Preparedness and Response Program agreements with OHA, local public health authorities must identify a preparedness coordinator.

³¹ Our [2018 audit](#) found that counties had minimal staff dedicated to emergency management. On average, responding counties reported dedicating just 1.6 FTE to emergency management.

³² The Older Americans Act of 1965 (amended 2020) allows states to designate planning and service areas to be administered by public or private nonprofit agencies or organizations as [Area Agencies on Aging](#). Oregon's 17 Area Agencies on Aging provide information and services to seniors and people with disabilities across the state. Examples include supportive, nutrition, in-home, and case management services.

Suggested Actions

As this is an advisory report and not an audit, we are not making recommendations that require an agency response. However, we suggest the following actions to help reduce risks to residents in long-term care facilities and better support staff in these facilities, immediately and in the future. Some of these actions would likely require additional resources.

To reduce the current risk of transmitting COVID-19 to long-term care residents and to protect residents' well-being, ODHS and OHA could:

- require long-term care facilities to report the number and percentage of residents and staff who have received COVID-19 vaccinations directly to the state to better target facilities needing support and publicly report these results; and
- work with the Governor's Office and the Legislature to identify whether more staff are needed to support the work of:
 - ODHS surveyors in performing the additional monitoring visits, complaint investigations, and recertification and compliance surveys when CMS allows it;
 - OHA's ALERT IIS team to track COVID-19 vaccination uptake among long-term care staff and residents and enroll new providers in ALERT IIS.

To reduce the current risk of transmitting influenza to long-term care residents:

- ODHS and OHA could ensure that all long-term care facilities have offered flu vaccinations to their staff for the 2020-21 flu season.

To enhance oversight of long-term care facilities for the COVID-19 response and into the future:

- ODHS and OHA could better incorporate the Long-Term Care Ombudsman's independent, resident-focused perspective into responses to individual facilities and into decisions about regulatory and licensing policies and procedures;
- ODHS can conduct additional monitoring visits at all facilities and consider using financial penalties for the few facilities that are not in compliance with infection control protocols; and
- Longer-term, ODHS and OHA could develop a process to jointly track key performance indicators for infection control, staff vaccinations, and emergency preparedness to better target facilities and use limited resources more efficiently.

To reduce the general, ongoing risks of communicable diseases in long-term care facilities:

- OHA, ODHS and, as needed, the Legislature could work together to improve regulations over long-term care, including:
 - Addressing the agencies' fragmented authority over long-term care;
 - Better specifying infection control measures and enhance staff training requirements for community-based care facilities;
 - Requiring long-term care facilities to maintain plans for vaccinating staff during each annual influenza season and future pandemics;
 - Requiring the reporting and public posting of annual flu vaccination, declination, and exemption rates for health care workers in community-based care facilities;
 - Requiring long-term care facilities to routinely monitor staff infection control practices; and
 - Making staffing permanent for the Healthcare-Associated Infections Program's regional infection control practitioners.
- ODHS, the Office of the State Fire Marshal, and as needed, the Legislature could work together to enhance regulations around emergency preparedness requirements for

community-based care facilities. This work could also include exploring ways in which local emergency management, local public health authorities, and Area Agencies on Aging can work with all long-term care facilities to develop, exercise, and evaluate their preparedness plans.

- ODHS and OHA could revise their policies, procedures, and legislation to ensure continued collaboration after the COVID-19 pandemic on preventing and investigating cases and outbreaks of communicable diseases in long-term care facilities. They could also:
 - plan, exercise, and evaluate basic elements of a joint response; and
 - address, in after-action reports and improvement plans, how the agencies will retain institutional knowledge about the COVID-19 response so that it is not lost to future emergencies.
- Oregon's Legislature and long-term care oversight agencies could work with long-term care facilities to ensure funding to maintain adequate staffing levels.

March 19, 2021

Secretary Shemia Fagan
900 Court Street NE
Capitol Room 136
Salem, OR 97310-0722

Dear Secretary Fagan:

Thank you for your comprehensive analysis and assessment of how Oregon Department of Human Services (ODHS) and Oregon Health Authority (OHA) responded to the impacts of the COVID-19 pandemic on residents and staff of long-term care facilities. We appreciate the time and effort invested in your report and the recommendations provided.

We are committed to continuous improvement and believe that our willingness to continually adapt our practices in the event of new information has enabled us to remain among the states ranking lowest in the nation for COVID-19 cases and deaths per 100,000 residents. Specifically, Oregon ranks the 10th lowest in cases and deaths in long-term care, and the fifth lowest for nursing homes. We believe our strategic use of proactive and responsive measures contributed to a significant reduction in positive cases and mortality rates.

Responding to the COVID-19 pandemic required gut-wrenching tradeoffs between community safety and each individual residents' quality of life in large congregate living settings. Residents, their families and friends, and the staff have suffered unimaginable hardship through the pandemic. They deserve credit as well for the sacrifices they made to prevent COVID-19 infections. ODHS and OHA aligned efforts with input from facilities as well as other state agencies and community stakeholders to mitigate immediate and long-term impacts of the COVID-19 pandemic.

We organized this response letter into two parts. Part I is a description of the aligned ODHS and OHA response to date. In part II, we respond to the Secretary of State (SOS) recommended actions for strengthening our future response and describe the strategies and actions we will take to make immediate and ongoing improvement to reduce the spread of COVID 19, and other communicable diseases, in long-term care facilities.

Part I: Oregon's Coordinated Response:

ODHS and OHA are continually improving response strategies to reflect outcome data, lessons learned and best practices. Below is a description of the areas where Oregon already has led and excelled in responding to the COVID-19 crisis:

Oregon’s Performance compared to the national average:

Oregon’s overall performance in preventing and responding to COVID-19 in long-term care facilities is consistently higher than most other states. The White House State Profile Report indicates Oregon’s positivity and death rates remain considerably lower than the national average. For the month ending February 28, 2021 the data demonstrated the following:

	Oregon	United States
Test positivity rate	4.2%	5.1%
Covid-19 deaths	1.4%	4.5%
New resident cases	3%	7%
New staff cases	5%	13%

COVID Response and Recovery Unit (CRRU):

From the onset of the pandemic, ODHS and OHA immediately responded together, recognizing that alignment and coordinated efforts would be key to prevent and contain the spread of COVID-19 in our vulnerable LTCF populations. In February and March 2020, the agencies coordinated prevention efforts and responses to positive cases, testing, and PPE needs. Work done at the Emergency Coordination Center (ECC) helped inform the scope and structure of the COVID-19 Response and Recovery Unit (CRRU). ODHS and OHA directors publicly announced the interagency team structure in early March. The CRRU was operational at the beginning of May 2020, just 60 days following the onset of the pandemic.

Through the CRRU, ODHS and OHA continue to strengthen the structural backbone of the pandemic response. CRRU is composed of cross-agency leadership who manage multi-disciplinary staff including infection control experts, public health clinicians, epidemiologists, policy analysts, research analysts and communications staff. These teams support ODHS and OHA to identify populations at highest risk and develop guidance and plans for prevention, personal protective equipment (PPE) access, testing, outbreak management and vaccine access.

The CRRU model is essential for aligning and managing the complex multi-agency work necessary to prevent and contain the spread of COVID-19 and create a unified voice for Oregon’s COVID-19 response. Since CRRU’s advent, OHA and ODHS have aligned efforts to promote equity both internally and externally. Among other accomplishments, CRRU staff have:

- Developed practical and innovative guidance and policies to prevent and contain the spread of COVID-19.
- Provided comprehensive, ongoing access to infection control experts.

- Updated Oregon Administrative Rules to ensure reporting of COVID-19 to appropriate authorities and compliance with key testing and infection control strategies.
- Provided educational materials and webinars for healthcare providers.
- Designed programs to efficiently respond to facility requests for assistance related to personal protective equipment and testing resources.
- Planned and implemented programs to ensure vaccine is delivered to Oregon's vulnerable populations.
- Developed and implemented testing plans for disproportionately affected groups.
- Collaborated with partners to respond to outbreaks.

As the pandemic response progresses into new phases, CRRU will continue to be essential to maintain the high level of coordination and integration required to support Oregonians. ODHS and OHA have committed to a minimum of two years for this effort, or longer if necessary.

Focus on stopping the virus in LTCF:

ODHS and OHA leadership is focused on the goal of stopping the virus in our long-term care settings. Our strategies are solidly focused on the highest priority efforts to stop the virus in long-term care facilities and are aligned with best practices shared by long-term care regulators and partners across states. To date we have:

- Implemented policies to ensure rapid identification and reporting of COVID-19 in facilities and ensure early containment efforts, through the Executive Order (EO) process.
- Conducted in-depth proactive and responsive infection control consultations for LTCFs.
- Invested in infrastructure for multi-agency outbreak support 7 days a week.
- Implemented strict visitation policies aligned with the Governor's framework to prevent entry of COVID into facilities.
- Deployed routine testing policies with application to community-based care settings, beyond the federal minimum requirements.
- Implemented Inter-Agency Support Teams (IAST) to consult with facilities and local public health to ensure full-support, education-based oversight, and a forum to ensure gradual regulatory-based enforcement.
- Implemented COVID-Recovery Units across the state, including relocating residents who have tested positive for COVID-19 when necessary, to manage outbreaks.
- Expanded COVID-19 Recovery Units statewide, which provides means to ensure care for residents if the facility where they live is unable to manage an outbreak (expansion from 2 facilities/94 beds to current 7 facilities/230 beds is the result of a recruitment process that began in the summer).

- Implemented readmissions/admissions regional discharge planning forums and issuance of best practices guidance to ensure safe and efficient interfacility transfer of residents and preservation of hospital surge capacity.
- Focused on staffing and workforce development with Board of Nursing, including expansion of CNA training, Connectforjobs.com campaign, personal care support training programs and review of emergency staffing protocols from facilities.
- Implemented web-based education series for providers with OHA Infection Preventionists.
- Created learning culture to ensure best practices are shared with local public health authorities.
- Focused on policy development and risk-mitigation with at-risk facilities that had not yet had a COVID case.
- Published Executive Orders, outbreak dashboards and death statistics to assess progress and ensure transparency.
- Partnered with LTCF to ensure vaccine dissemination is prioritized.

Prevention-focused education and toolkit:

ODHS and OHA partnered to provide prevention-focused education, resources and outreach directly to LTCFs. In early 2020, OHA developed a prevention-focused toolkit as a resource for long-term care facilities. The toolkit contains a readiness assessment tool, an outbreak response tool, strategies for use and preservation of PPE, contact information for the local public health authorities, visitation guidance, a facility entry log template, and a respiratory illness log template.

Licensing staff and OHA Infection Preventionists have offered infection control education broadly to all LTCFs, including those without an outbreak to date. In addition, ODHS and OHA continue to build capacity to ensure early containment for outbreaks in congregate settings and are currently working to bring two additional coordinators and two additional epidemiologists on board that specialize in congregate settings. Earlier in the pandemic, we typically convened interagency support team meetings once or twice per week. In November 2020 alone, the teams convened 42 interagency facility support team meetings to consult with facilities on how they were managing COVID-19 cases.

OHA also requested and received Epidemiology and Laboratory Capacity (ELC) CARES funds to build and regionalize infection control capacity through 2022. This will continue to improve the accessibility of our experts for LTCFs responding to and preparing for COVID-19.

Testing:

ODHS and OHA implemented a comprehensive, statewide COVID-19 testing plan for long-term care facilities with more than five residents. The baseline testing started in June 2020 and continued through September 2020. It covered more than 680 large, long-term care facilities statewide. Combined, these facilities provide care for an

estimated 31,000 residents and 29,000 facility staff. Ongoing testing continues for facility staff.

Residents and staff at nursing facilities in Multnomah, Washington, Clackamas, Yamhill, Marion and Polk counties were prioritized as these counties account for most outbreaks in long-term care facilities. The next phase included assisted living and residential care facilities with memory care units in those counties, followed by facilities without memory care. The same sequence rolled out in other counties statewide.

The plan contains a strong focus on equity and trauma-informed testing practices, based on recognition of the presence of historical trauma among marginalized communities. To address these issues, the plan calls for testing services to be provided in a linguistically and culturally sensitive manner, and for the people administering the tests to understand the history of sources of trauma on marginalized communities.

Long-term care facilities are required to report ongoing results to their local public health authority and the ODHS Office of Aging and People with Disabilities (APD).

Vaccine:

There are multiple, simultaneous efforts statewide to serve individuals prioritized under the state's vaccine implementation plan including older adults and people with physical, developmental and intellectual disabilities as well as adults receiving behavioral health services in congregate settings. These efforts have involved collaboration between state agencies, local public health authorities (LPHA), Coordinated Care Organizations (CCOs) and stakeholders.

The CDC Pharmacy Partnership for Long-Term Care Program, or FPP, focuses on individuals who live in large congregate settings. Many of the facilities eligible for the program receive oversight from either ODHS or OHA. The three pharmacies serving facilities enrolled in the FPP are Consonus, CVS and Walgreens. There were multiple efforts to include as many care settings in Oregon in the FPP as possible.

As the FPP launched in December, state support focused first on addressing the disproportionate impact from the pandemic by leveraging this resource to ensure that the FPP reached all large congregate living settings serving older adults and people with disabilities. The team worked with the CDC database to ensure that the state's 688 nursing, assisted living and residential care facilities were matched to a federal pharmacy partner. In cases where the FPP could not serve a facility, it was connected to a vaccine opportunity provided by a LPHA.

After receiving the final list of accepted facilities from the CDC in December, ODHS and OHA leaders in early January sent the names of every facility not accepted into the CDC program to that facility's LPHA so that they could be included in county level vaccine clinic planning. In addition, APD local offices, and local office staff in APD's

Area Agencies on Aging (AAAs) reached out to all licensed adult foster homes caring for older adults and people with disabilities to track staff and resident needs and connections to clinics.

As of March 1, 2021, the more than 1,200 facilities enrolled in the FPP have received a first-dose clinic. All the state's nursing facilities have had first and second clinics. All the state's 558 licensed assisted living and residential care Facilities have scheduled first-dose clinics either through the FPP or through LPHAs. For additional detail on the partnership's progress in Oregon see the CDC dashboard: <https://covid.cdc.gov/covid-data-tracker/#vaccinations-ltc>.

Work is also underway to support vaccination opportunities for smaller care settings, facilities not enrolled in the FPP as well as for individuals receiving Medicaid long-term care services and supports in their own home. Other efforts include:

- Arranging a drive-through vaccine clinic in late March for some designated older adults and people with disabilities.
- Working with House Call Providers, Providence Elder Place and Quad Inc. to provide the people they serve with vaccine opportunities.
- Working with organizations providing home-delivered meals to identify Oregonians who live independently but are unable to visit a vaccine clinic.
- Data matching of Oregonians who need to be served to prioritize future mobile vaccine teams and smaller vaccine clinics.

Promoting Centers for Disease Control and Prevention (CDC) Best Practices:

Through policy development, training and regulatory activities supported by the CRRU, ODHS and OHA are working with LTCFs to develop and implement the following CDC Core Practices for preventing outbreaks and the spread of COVID-19 in LCTF:

- Identify one or more individuals with training in infection control to lead on-site infection control activities and serve as facility representative in the event of an outbreak.
- Rapid identification, isolation, and reporting of new suspected or confirmed COVID-19 cases.
- Implement safe visitation policies consistent with state and federal guidelines.
- Educate residents, healthcare personnel, and visitors about COVID-19, current precautions being taken in the facility, and actions they should take to protect themselves.
- Implement source control measures, including appropriate use of facemasks by staff and residents.
- Create a plan for COVID-19 testing of residents and healthcare personnel.
- Train staff in the appropriate use of personal protective equipment for the care of residents with suspected or confirmed COVID-19.

- Identify space in the facility that could be dedicated to monitor and care for residents with COVID-19.

Regulatory Activities:

Although traditional licensing activities were suspended temporarily, ODHS and OHA regulatory staff remained in close contact with providers and supported COVID response within the programs, including providing guidance for visitation, emergency staffing and outbreak response, and assisting with PPE, testing and vaccination resources. Regulatory staff also continued to respond to complaints and provide timely resolution.

While regulatory work is typically conducted onsite, ODHS and OHA are exploring strategies for closer oversight through desk audits and virtual reviews. This practice is currently underway in the Licensing, Certification and Technical Assistance unit of the Health Systems Division as well as for the Adult Foster Care providers licensed by the ODHS Office of Aging and People with Disabilities (APD). The divisions are sharing information about process and outcomes for future planning.

Additionally, ODHS and OHA are exploring ways to further align regulatory activities to reduce duplication of efforts, ensure health and safety precautions, provide technical assistance and take corrective action when necessary. We will explore the benefits and challenges of conducting desk audits, virtual audits and facility self-report audits. As we learn more, we will take steps to develop new processes to accomplish regulatory goals that are not susceptible to interruption in emergency situations such as a pandemic.

Part II: State Response to SOS Recommended Actions:

SOS Recommended Action: *SOS recommendations to reduce the current risk of transmitting COVID-19 to long-term care residents and to protect residents' well-being:*

Require long-term care facilities to report the number and percentage of residents and staff who have received COVID-19 vaccinations directly to the state to better target facilities needing support and publicly report these results.

State response: OHA has developed and distributed tools to support consistent tracking of staff and resident vaccination in LTCFs. We will request aggregate percentages of staff and residents who have received vaccination weekly starting at the end of March 2021, to monitor facility progress and to inform vaccine resource.

SOS Recommended Action: *Work with the Governor's Office and the Legislature to identify whether more staff are needed to support the work of:*

- *ODHS surveyors in performing the additional monitoring visits, complaint investigations, and recertification and compliance surveys when CMS allows it.*

State Response: ODHS has resumed its survey activities in community-based care facilities. The State has a backlog of overdue surveys due to the focus on COVID over the last year. We will engage with the Governor's Office and the Legislature on resources necessary to normalize our activities. We will also analyze the new funding for survey activities offered in the American Rescue Plan and develop strategies to utilize those most effectively.

SOS Recommended Action: *Utilize OHA's ALERT IIS team to track COVID-19 vaccination uptake among long-term care staff and residents and enroll new providers in ALERT IIS.*

State Response: There are challenges in using the Alert IIS system to track facility level data as well as with the timeliness of the data. ODHS and OHA will explore and adopt the most efficient system to collect vaccination data on an ongoing basis, as needed to inform vaccination progress. We will also assess the staff resources needed to complete this work and determine if the current model is adequate and if LTCFs could enroll as ALERT providers to facilitate timely reporting.

SOS Recommended Action: *SOS recommendation to reduce the current risk of transmitting influenza to long-term care residents:*

- *ODHS and OHA could ensure that all long-term care facilities have offered flu vaccinations to their staff for the 2020-21 flu season.*

State Response: ODHS and OHA have established practices to provide guidance and monitor vaccination for influenza in LTCF. We will continue this annual practice. Additionally, ODHS took additional measures in 2020 to provide access through on-site clinics provided by the long-term care pharmacy partners.

SOS Recommended Action: *SOS recommendation to enhance oversight of long-term care facilities for the COVID-19 response and into the future:*

- *ODHS and OHA could better incorporate the long-term care ombudsman's independent, resident-focused perspective into responses to individual facilities and into decisions about regulatory and licensing policies and procedures;*

State Response: Early in the pandemic, we initiated daily meetings with the Oregon Long-term Care Ombudsman to seek input and ensure collaboration and seamless support to consumers and family members. Based on the level of

need, the meeting has been scaled down to twice per week. The meeting frequency will increase as need dictates. This venue ensures Ombudsman staff have necessary information to resolve complaints and to ensure that consumer and family member perspectives help inform policy decisions.

- *ODHS can conduct additional monitoring visits at all facilities and consider using financial penalties for the few facilities that are not in compliance with infection control protocols;*

State response: ODHS and OHA use appropriate escalation of regulatory tools when needed, but our first approach is to educate, collaborate and focus on continuous improvement, prevention and learning. We have issued civil penalties in both Community Based Care (CBC) and Nursing Facilities totaling approximately \$500,000 for infection control violations over the past year. We also issued license conditions and utilized a technical assistance approach to ensure quick resolution of inadequate practices.

SOS Recommended Action: *Longer-term, ODHS and OHA could develop a process to jointly track key performance indicators for infection control, staff vaccinations, and emergency preparedness to better target facilities and use limited resources more efficiently.*

State response: We agree with this recommendation and plan to explore these and other recommendations to improve our ongoing response and future emergency preparedness. As we transition to the recovery phase of the pandemic, we will dedicate time and resources to reflect on our successes and challenges in responding to COVID-19. We will use lessons learned and our commitment to continuous improvement to identify strategies to minimize the impacts of this and future crisis.

SOS Recommended Action: *SOS recommendation to reduce the general, ongoing risks of communicable diseases in long-term care facilities:*

- 1) *OHA, ODHS and, as needed, the Legislature could work together to improve regulations over long-term care, including:*
 - *Addressing the agencies' fragmented authority over long-term care;*
 - *Better specifying infection control measures and enhance staff training requirements for community-based care facilities;*
 - *Requiring long-term care facilities to maintain plans for vaccinating staff during each annual influenza season and future pandemics;*
 - *Requiring the reporting and public posting of annual flu vaccination, declination, and exemption rates for health care workers in community-based care facilities;*

- *Requiring long-term care facilities to routinely monitor employee infection control practices; and*
- *Making staffing permanent for the Healthcare-Associated Infections Program's regional infection control practitioners.*

State Response: We agree with this recommendation. There are several bills currently pending in the Legislature that address some of the recommendations identified. Once the pandemic recedes, ODHS and OHA plan to debrief, identify lessons learned and develop action plans for improvement in the future.

- 2) *ODHS, the Office of the State Fire Marshal, and as needed, the Legislature could work together to enhance regulations around emergency preparedness requirements for community-based care facilities. This work could also include exploring ways in which local emergency management, local public health authorities, and Area Agencies on Aging can work with all long-term care facilities to develop, exercise, and evaluate their preparedness plans.*
- 3) *ODHS and OHA could revise their policies, procedures, and legislation to ensure continued collaboration after the COVID-19 pandemic on preventing and investigating cases and outbreaks of communicable diseases in long-term care facilities. They could also:*
 - *Plan, exercise, and evaluate basic elements of a joint response; and*
 - *Address, in after-action reports and improvement plans, how the agencies will retain institutional knowledge about the COVID-19 response so that it is not lost to future emergencies.*
- 4) *Oregon's Legislature and long-term care oversight agencies could work with long-term care facilities to ensure funding to maintain adequate staffing levels.*

State Response: We agree with these recommendations and plan to explore these and other recommendations to improve our ongoing response and future emergency preparedness. As we transition to the recovery phase of the pandemic, we will dedicate time and resources to reflect on our successes and challenges in responding to COVID-19. We will use lessons learned and our commitment to continuous improvement to identify strategies to minimize the impacts of this and future crisis.

Throughout the pandemic, Oregon has steadily redirected resources to expand focus on prevention and outbreak management in long-term care facilities. While we believe our strategies to encourage collaboration and partnership between ODHS, OHA, local

public health and facilities in fighting the pandemic together are working, we can always do better and are continuously looking for improvements. CRRU will continue to provide the leadership and coordination for this goal as we continue to review and build on our policies, practices and strategies to ensure we are doing all we can to minimize the impacts of COVID-19 in long-term care facilities.

Thank you for your extensive assessment of the ODHS and OHA aligned response to COVID-19 in LTCF. We value our partnership and look forward to continued discussions and planning.

Sincerely,



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About the Secretary of State Audits Division

The Oregon Constitution provides that the Secretary of State shall be, by virtue of the office, Auditor of Public Accounts. The Audits Division performs this duty. The division reports to the elected Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The division has constitutional authority to audit all state officers, agencies, boards and commissions as well as administer municipal audit law.

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