MARQUIS
COMPANIES

**To: House Health Care Committee, COVID-19 Subcommittee Chair Dexter, Vice-Chair Hayden, and members of the committee**
**From: April Diaz, RN, BS Vice President Clinical Services, Marquis Companies**

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Marquis Companies includes a broad range of senior living options, such as skilled nursing/PAC, assisted living, memory care and more. We treat the person, not the disease, and put each individual's choices and experiences at the forefront of their care. Our facilities consistently rank highest in the nation for quality outcomes, we provide residents with on-site health care and cutting-edge clinical services, which include pharmacy, rehabilitation, and other personalized recovery plans to fit Oregonians needs. Providers like Marquis have been substantially impacted by the COVID-19 pandemic from every angle; maintaining our standards of care in an unprecedented environment while serving highly vulnerable populations, supporting residents and their families through the impacts of social isolation and uncertainty, increased costs, decreased revenues and census, PPE shortages and constant changes to clinical guidance in response to the pandemic and more.

I'm here today to express support for HB 2327, and I'd like to focus my comments today on highlighting some key experiences during the pandemic from the perspective of a provider and how this will allow us all to be better prepared for the next public health emergency. Like all providers in LTC, we have had the unfortunate experience of managing through the heart ache of COVID19 outbreaks in facilities, the constant stress that our dedicated staff go through daily in their fight to protect their residents and their own families. As we all know LTC has been one of the most impacted healthcare settings in both cases and mortality throughout the pandemic. At the onset of the pandemic, providers like us turned to ODHS, the agency that oversees our sector, as well as OHA. What we found was a lack of collaboration between the agencies and challenges in getting answers and guidance that made sense for our unique settings. While this is understandable in a pre-COVID-19 world, the misalignment proved frustrating for providers and dangerous for our resident and staff safety.

I would like to share with you the story of one outbreak facility, to help illustrate this point. The outbreak occurred in early June, just after Memorial Day weekend. This was still in a period of time where access to testing and PPE was a day-to-day effort to secure. The outbreak started with two employees with low-grade fever, who were removed from schedule and quickly tested, result positive.

The very next day we were able to secure testing via hospital lab to test 100% residents, unfortunately we did not have access to testing for staff from the hospitals or public health for another 72 hours. The resident test results were received within 24 hours (unheard of at that time) and 38 of 39 residents tested positive, with 4 now showing a low grade temp – no other residents yet with symptoms. Three days later we tested 100% staff and identified 38 of 100 staff positive, by this time we had 8 of the staff exhibiting symptoms, 30 did not. This was very early in the COVID pandemic, little was understood at that time about the role of asymptomatic/pre-symptomatic positive transmission seen with COVID19. Routine testing was not yet in guidance and access to testing was very limited for LTC providers. What we did know, is that we quickly identified a very large outbreak and despite the high level of precautions, PPE, screening and environmental cleaning that was in place, the virus crossed our defenses.

The facility immediately reached out to both ODHS (mandatory reporting) and OHA for infection consultation. Visits by both OHA and State surveyors twice that first week, with state surveyors twice weekly for next 4 weeks. No identified deficiencies were cited by surveyors. Recommendations were made by OHA related to allowing the asymptomatic positive employees to care for positive residents, due to severe workforce shortages this facility was now experiencing. ODHS agreed with the recommendations by OHA. The facility proceeded and implemented all recommendations as outlined by OHA. The next day, OHA reversed that decision. Facility would be unable to staff to care for the positive COVID patients, if unable to proceed. A second call was made between facility, OHA and ODHS – with support by ODHS agreement was made to continue the plan as previously agreed upon.
These conflicting situations often pull key leadership resources of the facility away from the direct health and safety needs of the residents, staff and family members. Fortunately, as a company, we were able to keep the focus of the facility leadership to stay purely on the rising clinical needs of their residents and staff, while myself and Phil Fogg - Marquis CEO, took lead on the calls with ODHS and OHA.

This is not to imply that OHA or ODHS did not have the best interest in managing the pandemic and supporting the facility, but that a united decision-making process was not in place to ensure safe and consistent guidance/support for the facility. The proposed HB 2327 would have been the ideal conduit for these decisions and provide consistent guidance to our LTC communities. The conflicting decisions/guidance continues today, in many areas that remain poorly defined for LTC such as double masking, AGP and room placement for those not on isolation, and increasing need for guidance in the response for potential new variants. HB 2327 would be able to provide the platform for rapid and evolving decision making, with guidance to be issued by ODHS based on the response team.

Knowing what we know now, and knowing more than ever that long term care is particularly vulnerable to the impacts of public emergencies given the populations we care for, the need for a common table where agencies and stakeholders can communicate and coordinate is imperative. HB 2327 sets this table by establishing the Long Term Care Emergency Preparedness and Response Team.
Lastly, we are pleased to support the inclusion of a PPE reserve provision. The struggle to source and purchase adequate PPE for the long term care sector is substantial. The per unit costs of gowns increased by 2,000% and N95 masks costs increased by an astonishing 6,136%. Overall, the total daily

average cost for PPE for a facility went from $35 pre-COVID to $2,510.25 per day during the pandemic, without an end to this ongoing usage in sight. Colleagues of mine have been put in the position of placing PPE orders from companies they've never heard of and paying invoices of upwards of $1 million not knowing when ***or if that*** order would be received. PPE was essential to providing care before the pandemic, during the pandemic and no doubt will continue to be after the pandemic. HB 2327 helps ensure that the long term care will have a safety net of PPE incorporating best practices regarding distribution and shelf life.

Long term care providers like me know that quality resident care outcomes, a healthy workplace and providing a community setting are mission critical. To achieve these ends, we must restore stability to the sector and lay the groundwork to prepare and rapidly respond when the worst happens -- from pandemics, public health emergencies to wildfires and other natural disasters. If 2020 taught us anything, it's that the worst can happen. But I believe it also taught us that if we act on the lessons learned and work together, the best is yet to come. That's why I am asking for your support for HB 2327. Thank you.

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