

As Phil Kerpen argues, “The majority of the COVID-19 disease burden in the United States is in long-term care facilities.”

COVID-19 overwhelmingly spares the young. This fact has been poorly communicated to the public and has not adequately driven the targeting of policy responses. This is the current age stratification of United States COVID-19 deaths, with about 60 percent of deaths at age 75 or older:

	COVID Deaths	Total Deaths	COVID Deaths as Share of Age Group Deaths	Population	COVID Death Rate Per 100,000	Age Group % of U.S. Population	Age Group % of all COVID Deaths
Under 1 year	5	5,732	0.1%	4,128,810	0.12	1.23%	0.01%
1-4 years	3	1,109	0.3%	16,438,858	0.02	4.91%	0.00%
5-14 years	13	1,638	0.8%	41,008,879	0.03	12.26%	0.01%
15-24 years	116	10,141	1.1%	43,106,877	0.27	12.89%	0.12%
25-34 years	640	21,548	3.0%	46,889,936	1.36	14.02%	0.67%
35-44 years	1,649	31,028	5.3%	42,627,770	3.87	12.74%	1.72%
45-54 years	4,588	58,956	7.8%	40,841,936	11.23	12.21%	4.80%
55-64 years	11,439	139,380	8.2%	43,019,365	26.59	12.86%	11.96%
65-74 years	19,857	214,427	9.3%	33,075,174	60.04	9.89%	20.77%
75-84 years	25,520	267,201	9.6%	16,639,323	153.37	4.97%	26.69%
85 years and over	31,778	340,096	9.3%	6,726,530	472.43	2.01%	33.24%
All Ages	95,608	1,091,256	8.8%	334,503,458	28.58	100.00%	100.00%

CDC NVSS Deaths, Wonder Population Estimates. February 1, 2020 to June 1, 2020. As of June 10, 2020.

Phil Kerpen: “Yet we have pursued extremely expensive lockdown policies, closed schools despite the fact children are at far less at risk from COVID-19 than seasonal flu, shuttered millions of businesses, and frightened low-risk adults and children – all in the name of saving vulnerable seniors – but while simultaneously sending infectious patients into nursing homes. It is a national tragedy and scandal.”

Phil Kerpen: “Indeed one of the most disturbing facts in the April jobs report – the worst in our country's history – was that long-term care facility employment dropped by 113,000 that month. A crashing tide sinks all boats, economically, to invert a metaphor. That left facilities seriously understaffed while managing the most at-risk population while, sadly, many states seemed more concerned about preserving hospital capacity than saving the lives of long-term care residents. It was a recipe for disaster.”

Phil Kerpen: “To understand the true size and shape of the coronavirus disease burden in the United States we should consistently report the numbers in long-term care and separately the numbers for the rest of the population. The advanced age, comorbidities, and limited mobility of long-term care residents make them overwhelmingly more at risk – so much so that this group of less than 5 million total people or 1.5 percent of the U.S. population comprises about 55 percent of the total COVID deaths. That means the disease risk for everyone else in America is much less than generally perceived from the reported headline numbers....If there is a second wave, it will be imperative to avoid the upheaval of another broad lockdown and instead focus on having sufficient resources and systems in place to protect long-term care facilities.”

COVID-19: The Nursing Home Disease
Phil Kerpen, President of the Committee to Unleash Prosperity

Testimony to the House Select Subcommittee on Coronavirus
June 11, 2020

The majority of the COVID-19 disease burden in the United States is in long-term care facilities.

COVID-19 overwhelmingly spares the young. This fact has been poorly communicated to the public and has not adequately driven the targeting of policy responses. This is the current age stratification of United States COVID-19 deaths, with about 60 percent of deaths at age 75 or older:

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This age stratification is similar to what was apparent from Chinese and European data at the beginning of the pandemic. The related vulnerability of long-term care facility residents, who accounted for about half of all deaths in most European countries, should also have been clear.

Yet we have pursued extremely expensive lockdown policies, closed schools despite the fact children are at far less at risk from COVID-19 than seasonal flu, shuttered millions of businesses, and frightened low-risk adults and children – all in the name of saving vulnerable seniors – but while simultaneously sending infectious patients into nursing homes. It is a national tragedy and scandal.

Indeed one of the most disturbing facts in the April jobs report – the worst in our country's history – was that long-term care facility employment dropped by 113,000 that month. A crashing tide sinks all boats, economically, to invert a metaphor. That left facilities seriously understaffed while managing the most at-risk population while, sadly, many states seemed more concerned about preserving hospital capacity than saving the lives of long-term care residents. It was a recipe for disaster.

My father contracted COVID-19 in a New York nursing home in March. Fortunately he had a mild case. But tens of thousands of nursing home residents have suffered severe disease and death, much of it avoidable with better policy decisions and targeting of resources.

We at the Committee to Unleash Prosperity have been compiling state-by-state data on COVID-19 mortality daily on a [publicly available Google Docs spreadsheet](#). Here is the latest summary:

	Data Reporting Status	last update	LTC COVID Deaths	State deaths on date	Total Deaths Minus LTC Deaths	LTC Share of COVID Deaths	Total LTC Population, 2020 (AHCA/NCAL)	COVID LTC deaths as % of LTC Population
Alabama	Media - USA Today	2-Jun	335	653	318	51.3%	31,669	1.1%
Alaska		10-Jun					2,858	0.0%
Arizona	Maricopa/Mohave/Pima	10-Jun	487	732	245	66.5%	42,849	1.1%
Arkansas	Media	8-Jun	64	154	90	41.6%	24,995	0.3%
California	LA Times	10-Jun	2,424	4,854	2,430	49.9%	258,294	0.9%
Colorado	Best data - Wed	10-Jun	846	1,573	727	53.8%	35,670	2.4%
Connecticut	Best data - Thu	4-Jun	2,879	4,007	1,128	71.8%	24,480	11.8%
Delaware	Best data - Friday	10-Jun	263	413	150	63.7%	6,173	4.3%
DC	Best data - daily - staff	10-Jun	157	499	342	31.5%	2,934	5.4%
Florida	Best data - daily	10-Jun	1,454	2,801	1,347	51.9%	157,983	0.9%
Georgia	Best data - daily - staff	10-Jun	1,119	2,329	1,210	48.0%	60,741	1.8%
Hawaii	Media	10-Jun					8,125	0.0%
Idaho	Best data - weekly	10-Jun	52	83	31	62.7%	12,473	0.4%
Illinois	Best data - Fri	5-Jun	3,053	5,795	2,742	52.7%	89,387	3.4%
Indiana	Best data - Mon	8-Jun	1,011	2,135	1,124	47.4%	43,135	2.3%
Iowa	Best data - daily	10-Jun	312	630	318	49.5%	50,394	0.6%
Kansas	Best data - Mon/Wed/Fri	10-Jun	127	240	113	52.9%	26,105	0.5%
Kentucky	Best data - daily - staff	10-Jun	313	484	171	64.7%	31,179	1.0%
Louisiana	Best data - Mon - staff	8-Jun	1,224	2,931	1,707	41.8%	32,059	3.8%
Maine	Media	1-Jun	50	89	39	56.2%	13,579	0.4%
Maryland	Media - Wed - staff	10-Jun	1,750	2,719	969	64.4%	36,751	4.8%
Massachusetts	Best data - daily	10-Jun	4,671	7,454	2,783	62.7%	53,450	8.7%
Michigan	CMS - thru May 31	31-May	2,297	5,491	3,194	41.8%	68,002	3.4%
Minnesota	Best data - daily	10-Jun	984	1,236	252	79.6%	82,776	1.2%
Mississippi	Best data - daily - staff	10-Jun	447	868	421	51.5%	22,034	2.0%
Missouri	CMS - thru May 31	31-May	311	772	461	40.3%	59,840	0.5%
Montana	Media - USA Today	10-Jun	7	18	10	38.9%	9,148	0.1%
Nebraska	Press Conference	28-May	90	163	73	55.2%	21,744	0.4%

Nevada	Best data - daily - staff	10-Jun	122	448	326	27.2%	13,018	0.9%
New Hampshire	Best data - daily	10-Jun	247	301	54	82.1%	11,382	2.2%
New Jersey	Best data - daily - staff	10-Jun	6,327	12,377	6,050	51.1%	62,095	10.2%
New Mexico	Combined Media	10-Jun	166	410	244	40.5%	10,605	1.6%
New York	BAD data - daily - missing data	10-Jun	6,318	24,404	18,086	25.9%	145,720	4.3%
North Carolina	Best data - daily	10-Jun	637	1,053	416	60.5%	68,821	0.9%
North Dakota	Best data - daily	10-Jun	55	73	18	75.3%	9,570	0.6%
Ohio	Best data - Wed - staff	3-Jun	1,641	2,299	658	71.4%	121,138	1.4%
Oklahoma	Best data - Friday - staff	5-Jun	184	344	160	53.5%	28,104	0.7%
Oregon	Media - staff	9-Jun	90	169	79	53.3%	35,563	0.3%
Pennsylvania	Best data - Daily - staff	10-Jun	4,199	6,062	1,863	69.3%	133,551	3.1%
Rhode Island	Best data - Friday	5-Jun	615	772	157	79.7%	11,623	5.3%
South Carolina	Best data - Tue/Fri - staff	9-Jun	260	568	308	45.8%	33,540	0.8%
South Dakota	Media	13-May	25	39	14	64.1%	9,998	0.3%
Tennessee	Best data - Friday	5-Jun	155	408	253	38.0%	45,472	0.3%
Texas	Best data - daily - staff	10-Jun	878	1,885	1,007	46.6%	153,635	0.6%
Utah	Best data - daily - staff	10-Jun	55	128	73	43.0%	14,001	0.4%
Vermont	Best data - Fri - staff	10-Jun	28	55	27	50.9%	5,377	0.5%
Virginia	Best data - daily	10-Jun	853	1,514	661	56.3%	58,311	1.5%
Washington	Media	1-Jun	690	1,128	438	61.2%	57,162	1.2%
West Virginia	Best data - daily - staff	10-Jun	43	84	41	51.2%	12,272	0.4%
Wisconsin	Best data - daily	10-Jun	281	671	390	41.9%	68,031	0.4%
Wyoming	Media	10-Jun	4	18	14	22.2%	3,733	0.1%
Total, NY doubled to compensate for exclusion of hospital deaths			56,918	104,333	47,415	54.6%	2,421,549	2.4%
Total excluding NY			44,282	79,929	35,647	55.4%	2,275,829	1.9%

Despite inconsistent data from a number of states, some broad trends have become very clear.

Excluding New York – which changed its reporting at the beginning of May to exclude long-term care residents who die outside the walls of the facility – more than 55 percent of all COVID-19 fatalities in the United States were residents of long-term care facilities. Not all states differentiate between nursing homes and assisted living communities in their data, but in the ones that do the nursing homes make up a large majority of the long-term care deaths.

There are seven high mortality states that combine to account for nearly two-thirds of all COVID-19 deaths nationally: New York, New Jersey, Connecticut, Pennsylvania, Massachusetts, Illinois, and Michigan. All of these states pursued some version of the policy of admitting or readmitting infectious patients to nursing homes as soon as they were clinically stable, regardless of whether they were still

infectious and – in practice, at least – regardless of whether the receiving facility was properly equipped and staffed to prevent secondary transmission.

New York

New York's initial policy was implemented via a March 25 advisory (since deleted from the web but [archived here](#)) from the New York State Department of Health to Nursing Home Administrators, Directors of Nursing, and Hospital Discharge Planners. The advisory went out under the names of Governor Andrew Cuomo, Commissioner Howard Zucker, and Executive Deputy Commissioner Sally Dreslin.

The document was unambiguous:

"all NHs must comply with the expedited receipt of residents returning from hospitals to NHs. Residents are deemed appropriate for return to a NH upon a determination by the hospital physician or designee that the resident is medically stable for return... **No resident shall be denied re-admission or admission to the NH solely based on a confirmed or suspected diagnosis of COVID-19.** NHs are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or readmission." (emphasis in original)

This policy was met with forceful but ultimately ineffectual pushback. The statement that day from AMDA - The Society for Post-Acute and Long-Term Care Medicine was sadly prophetic:

"we find the New York State Advisory to be over-reaching, not consistent with science, unenforceable, and beyond all, not in the least consistent with patient safety principles... Decisions on transfer are not at the sole directive of the hospitals or hospital physicians. Decisions to transfer are joint responsibilities since the impact may likely have dire, indeed fatal, consequences.

"Unsafe transfers will increase the risk of transmission in post-acute and long-term care facilities which will ultimately only serve to increase the return flow back to hospitals, overwhelming capacity, endangering more healthcare personnel, and escalating the death rate."

We do not have any accurate count of the number of nursing home residents who died in New York while this policy was in effect, because without giving any justification New York changed its counted method between its April 28 report and its next report May 3.

Prior to the change, New York, like other states, reported the number of residents of long-term care facilities who died, regardless of the place of death – albeit incompletely.

They promised a comprehensive review and more accurate count, and in fact the reported number of nursing home deaths rose substantially during this revision from 3,025 to 4,813. But the number of deaths reported from adult care facilities actually fell. And the May 3 report also carried a footnote that has stayed on every subsequent report:

"This data does not reflect COVID-19 confirmed or COVID-19 presumed positive deaths that occurred outside of the facility."

The policy remained in effect until May 10, when it was finally reversed via [Executive Order 202.30](#).

New York presently reports 6,299 deaths that occurred in long-term care facilities. Unless the state becomes more forthcoming, we will not know the total number of long-term care residents who died of COVID-19, but based on the experiences in other states with similar policies, anecdotal reporting, and the fact that normal procedure for nursing homes is to call 911 and transfer a patient with acute illness to a hospital, it is reasonable to assume the number of New York long-term care residents who died of COVID-19 is at least double their "place of death" number – and possibly much higher.

New Jersey

On March 31, New Jersey [issued a guidance memo](#) from state health commissioner Judith Persichelli. It went out to Nursing Home and Comprehensive Rehabilitation Hospital Administrators, Directors of Nursing, and Hospital Discharge Planners. It said:

"During this global health emergency, all post-acute care settings must comply with the expedited receipt of patients/residents discharging from hospitals. Patients/residents are deemed appropriate for discharge to the post-acute care setting upon a determination by the hospital physician or designee that the resident is medically stable for return...

"No patient/resident shall be denied re-admission or admission to the post-acute care setting solely based on a confirmed diagnosis of COVID-19. Persons under investigation for COVID-19 who have undergone testing in the hospital shall not be discharged until results are available. Post-acute care facilities are prohibited from requiring a hospitalized patient/resident who is determined medically stable to be tested for COVID-19 prior to admission or readmission."

(emphasis in original)

The policy was [modified on April 13](#) by memo titled "Emergency Conditional Curtailment of Admissions Order," which prohibited admissions or readmissions to any long-term care facility that could not cohort residents, follow CDC guidelines, and maintain adequate staffing.

A [recent letter from whistleblowers](#) alleges that this "curtailment" was ineffective:

"Much ado has already been made about the Commissioner's order to make long-term care facilities take residents back from hospitals, even without negative tests. This administration's defense has been, "well, we did require them to be able to cohort residents in order to do so!" Of course, we do know that many nursing home administrators probably did lie so that they could take residents back and charge for their stays. But allow us to offer you a reality check: very few of these nursing homes were tangibly ready to take these residents back based on the Commissioner's criteria because the state failed to allocate enough PPE and staffing resources to them to do so. And with a former hospital CEO at its helm, the Department of Health was only focused on the acute care hospital piece of the health care system."

As of June 9, New Jersey reported a total of 6,299 confirmed or probable deaths of long-term care residents and staff. This is more than 10 percent of the state's total long-term care population.

The state itself owns and operates three long-term care facilities for veterans. These facilities have had 385 cases with a shocking 145 deaths; one of them, in Paramus, has had 80 deaths.

New Jersey has about 24,000 resident cases in nursing homes, about 35 percent of its total nursing home population and has had over 10,000 staff infected.

And the governor paid outside consultants \$500,000 of New Jersey taxpayer money for a glossy report full of more promises to finally fix the issues.

Pennsylvania

On March 18, 2020 the Pennsylvania Department of Health issued an interim guidance that ordered:

"Nursing care facilities must continue to accept new admissions and receive readmissions for current residents who have been discharged from the hospital who are stable to alleviate the increasing burden in the acute care settings. This may include stable patients who have had the COVID-19 virus."

While state health secretary Rachel Levine defended this policy, [ABC27 in Harrisburg reported](#) that she had her own mother moved from a nursing home to a hotel.

In Philadelphia, one nursing home medical caretaker, Dr. Anish Koka, [described the brick wall Department of Health policies presented to him](#):

"Two weeks into the lockdown, Philadelphia hospitals had been emptied waiting for a New York-style surge that never came. But at this point the nursing homes unfortunately had started to see their first infections probably seeded from the nursing home staff. A nimble response at this point would have been to utilize the excess capacity of the hospitals and shelter the early positive nursing home patients. Hospitals had well trained, relatively highly paid staff, adequate PPE, and negative pressure rooms. Nursing homes had lowly paid workers with 10:1 patient ratios (ancillary staff) that were poorly equipped to effectively quarantine a patient with COVID. But nursing home patients were treated like patients from the community who were too well to be admitted to the hospital – they were sent home. The consequences of keeping these patients at the nursing home meant the health system had to eventually deal with the entire nursing home being infected.

"We asked the DOH to allow us to test everyone at the nursing home in order to effectively cluster everyone with COVID in one unit. They refused because the guidelines didn't recommend this for those that were asymptomatic. We asked to utilize a large room to cohort patients with COVID. Nursing home administration and the DOH said this wasn't possible...

"I spoke to a nice hospitalist at another large health system who was very receptive to the idea of boarding COVID positive patients from the nursing home in the half-empty hospital to avoid the entire nursing home eventually being infected. An email chain followed to get permission from administrative units. Absolutely not was the answer. I was told the more fruitful endeavor was to discuss advance directives with the residents. Did they really want to be resuscitated if

they got too sick? And if they didn't want to be resuscitated did they really want to go to the hospital?

"The implicit message: Keep the residents away from the pristine hospital. If they get too sick, hopefully they don't need to be resuscitated. It's sad."

This directive remained in effect until it was partially [superseded on May 1](#) by an advisory stating requiring hospital discharge to a facility prepared to implement infection control protocols.

Pennsylvania ended daily reporting of its long-term care fatalities on May 18 and began instead issuing sporadic reports with numbers from individual facilities that were inconsistent with each other and with public statements from state officials.

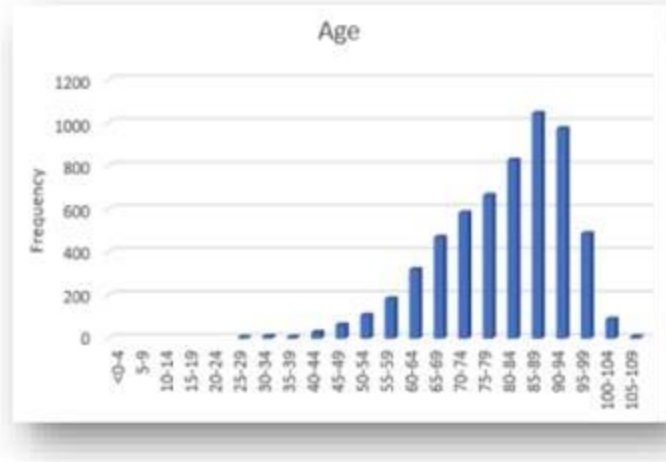
On June 8 the [governor announced a new plan](#) to address the issue starting with universal testing of long-term care residents and staff – but not immediately. He set a July 24 deadline.

Also on June 8, Pennsylvania resumed what will apparently be daily reporting. Pennsylvania now reports (as of June 10) 4,199 COVID-19 deaths in long-term care facilities, more than 69 percent of all the COVID-19 deaths in the state.

This chart shows Pennsylvania's extreme age stratification, with more COVID deaths over age 100 than under age 45.

AGE

Age	# of Deaths
<0-4	*
5-9	*
10-14	*
15-19	*
20-24	*
25-29	6
30-34	10
35-39	7
40-44	29
45-49	64
50-54	109
55-59	185
60-64	321
65-69	471
70-74	583
75-79	665
80-84	828
85-89	1045
90-94	974
95-99	487
100-104	90
105-109	8



*Counts less than 5 are suppressed.

Massachusetts

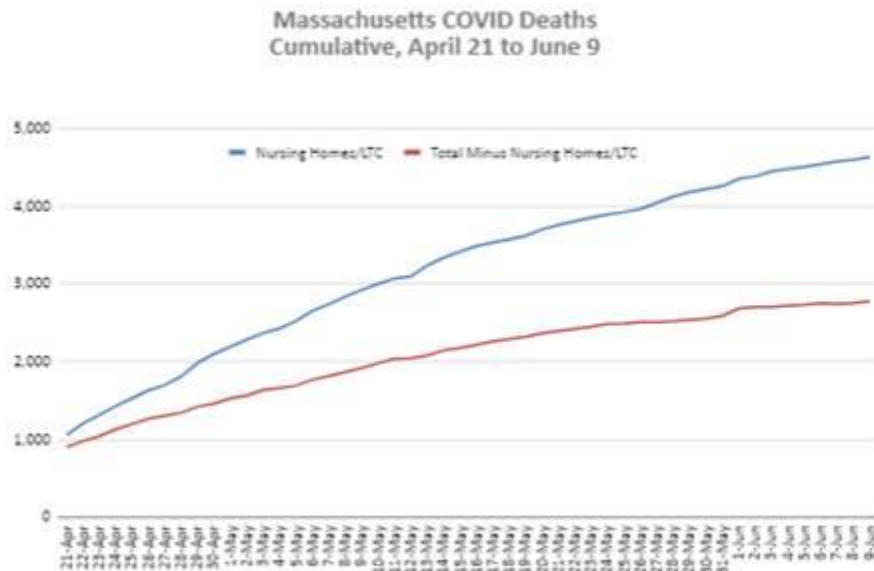
Proving that nursing home meltdowns are not the special purview of Democratic governors, Charlie Baker has presided over an epidemic that has been heavily and increasingly concentrated in long-term care homes.

Massachusetts adopted mandatory infectious readmission [on April 6 in a memo](#) that said:

"When a long-term care facility resident is transferred from a long-term care facility to a hospital for evaluation of any condition, including but not limited to, COVID-19 care, each long-term care facility must accept the resident's return to the facility when the resident no longer requires hospital level of care."

The memo was [updated on April 29](#) to add language specifying that "Whenever possible, hospitalized patients who are confirmed to be infected with COVID-19 and require skilled nursing level of care should be admitted to a designated COVID-19 nursing home or a facility with a designated COVID-19 isolation wing or unit," that updated memo however also retains the same must-admit language from the earlier version.

Massachusetts began daily reporting of long-term care deaths on April 21. Total deaths up to that first report were 1,059 in long-term care facilities and 902 deaths in the rest of the state population. That was a share of 54 percent. Since then over 65 percent of all COVID deaths have been among LTC residents, a total of 3,571 since April 21 compared to 1,463 in the rest of the state population.



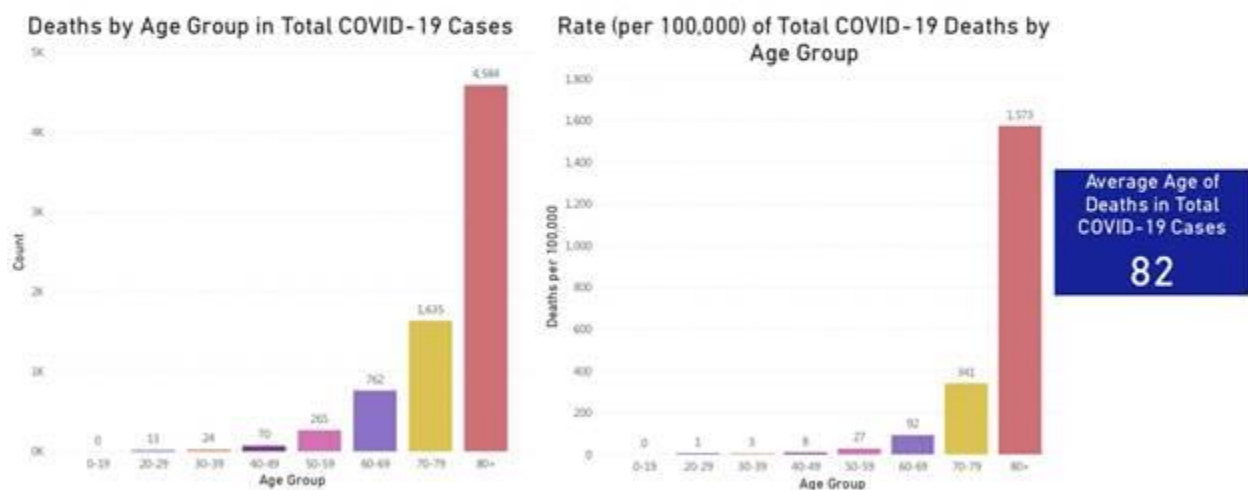
Overall Massachusetts reported (as of June 9) 4,630 long-term care deaths, which comprise 62.5 percent of all COVID-19 deaths in the state.

This chart shows the extreme age stratification:



Massachusetts Department of Public Health COVID-19 Dashboard - Monday, June 08, 2020

Deaths and Death Rate by Age Group



Data Sources: COVID-19 Data provided by the Bureau of Infectious Disease and Laboratory Sciences and the Registry of Vital Records and Statistics; Population Estimates 2011-2018; Small Area Population Estimates 2011-2020, version 2018; Tables and Figures created by the Office of Population Health.

Connecticut

Connecticut adopted two policies on nursing homes: a policy of standing up COVID-only recovery facilities and a blanket liability waiver that offered, in effect, zero risk revenue for regular nursing homes to accept infectious patients. Unfortunately, the latter policy appears to have rendered the former ineffective.

According to the [Washington Post](#):

"The immunity measure in Connecticut, where state officials have reported 2,500 covid-19 deaths linked to nursing homes, came after a group of health-care associations banded together to appeal for relief. In a March 31 letter to the governor's office, reviewed by The Post, the group proposed wording for an executive order. Five days later, Lamont issued an order using some language from the letter.

The liability waiver language in Governor Ned Lamont's April 5 [Executive Order No. 7U](#) is broad:

"Protection from Civil Liability for Actions or Omissions in Support of the State's COVID-19 Response. Notwithstanding any provision of the Connecticut General Statutes, or any associated regulations, rules, policies, or procedures, any health care professional or health care facility shall be immune from suit for civil liability for any injury or death alleged to have been sustained because of the individual's or health care facility's acts or omissions undertaken in good faith while providing health care services in support of the State's COVID-19 response, including but not limited to acts or omissions undertaken because of a lack of resources, attributable to the COVID-19 pandemic, that renders the health care professional or health care facility unable to provide the level or manner of care that otherwise would have been required in the absence of the COVID-19 pandemic and which resulted in the damages at issue, provided that nothing in this order shall remove or limit any immunity conferred by any provision of the Connecticut General Statutes or other law."

As the Hartford Courant reported, the [designated facilities are mostly empty](#) as most nursing homes in the state have decided to admit COVID positive patients:

"On many days there have been as few as four patients in the 90-bed COVID-19 recovery center that state officials opened in Meriden, and sometimes the three other recovery facilities are so empty that the provider hired to run them has asked the state to either close them or expand the patients they can accept...

"It is unclear why hospitals haven't been sending patients to the COVID-19 facilities, the first of which opened in mid-April, weeks after Gov. Ned Lamont originally announced the plan.

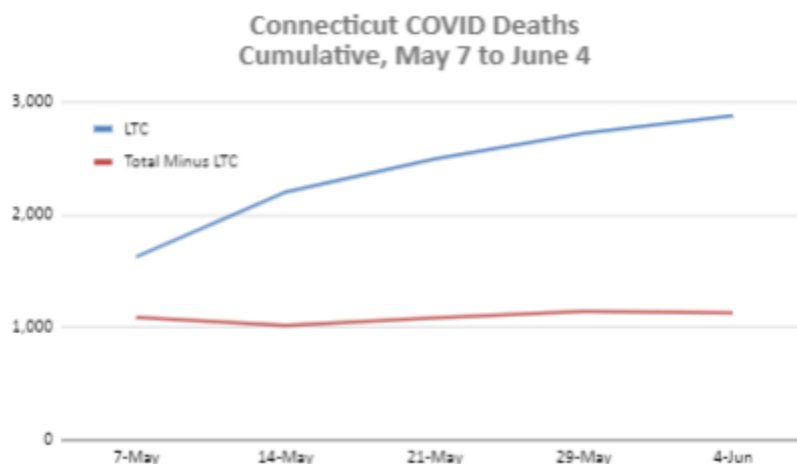
"The facilities are supposed to be taking in nursing home patients who are leaving the hospital and aren't yet ready to return to the long-term care facility they came from, or haven't tested negative twice in 24 hours for the coronavirus."

On its own, a broad liability waiver may make sense to maximize health care providers to participate without fear in pandemic response activities. But if the state's intended policy was for hospital

discharges to go to designated COVID-only facilities, then it should have enacted a *requirement* for that to occur if it was going to remove the strongest disincentive for other facilities to decline readmission, which is fear of liability.

The numbers in Connecticut have been bad. We estimate that about 11.8 percent of the state's long-term care population has died of COVID-19, the highest rate in the country. Overall long-term care deaths according to the most recent report were 2,879 with 1,128 in the rest of the state's population. That makes long-term care deaths 71.8% of the state's death toll.

As the chart shows, virtually all of the reported COVID deaths in Connecticut in the past month have been among long-term care residents.



Illinois

Illinois issued a [must readmit order on April 7](#):

"Patients who resided in a skilled-long term care facility prior to transfer to the hospital that receive a COVID-19 positive test should be discharged back to the facility of residence once they are medically stable."

There may be a modified version of the directive, but if so it is not posted on the Illinois Department of Public Health website. The [website includes slightly different language](#) presently:

"Facilities should be able to accept COVID-19 residents from the hospital if clinically stable."

The state had limited reporting until recently, often showing well less than half of its deaths in long-term care facilities. It now looks like those numbers were never accurate. As reporting has improved, deaths in recent weeks have been heavily in nursing homes.

Illinois reports weekly, but as of last Friday they reported 3,053 COVID-19 deaths in long-term care facilities accounting for about 53 percent of the state's total COVID-199 deaths. The deaths in that week were more than 58 percent in long-term care facilities and we expect the percentage to continue to rise.

The City of Chicago continues to report mostly non-LTC deaths, which may indicate a reporting deficiency or a different disease profile there than in the surrounding suburbs and the rest of the state.

Michigan

Michigan [issued its version](#) of the "must-admit" order on March 24:

"If a COVID-19 test was not warranted based on CDC or MDHHS guidance, then a patient does not need to be tested prior to discharge from a facility. Residents with COVID-19 that require hospitalization can and should be discharged back to the facility of residence once they are clinically stable regardless of whether COVID-19 testing is still positive or not. Continued hospitalization until residents' test negative will overwhelm the healthcare system and should be avoided."

It does express a preference for a COVID-only facility:

"Discharge of residents with confirmed COVID-19 disease to the originating facility or a separate facility with known COVID-19 cases is preferred as opposed to discharge to a facility without known cases of COVID-19."

On May 13, Governor Gretchen Whitmer issued [executive order No. 2020-50](#) to define her nursing home policy and hospital discharge policy. It reiterates the must-readmit policy but does require facilities have a dedicated unit and adequate PPE. Otherwise patients are instead discharged to an alternative designated so-called hub facility.

While the governor claims that the hub facilities are equipped to isolate the infectious patients, that has been widely contested and these facilities do have a substantial population of non-COVID residents.

Given the large, almost completely vacant surge hospital capacity that was built in Michigan it is hard to understand why those facilities are not being used for fully dedicated post-acute care.

Michigan has still not reported fatality data for most of the state, but the recently released CMS data showed the state had at least 2,297 long-term care deaths on May 31, which was about 41.8 percent of its reported total deaths on that date. Given the CMS data is far behind state-source data in all other states we expect that the number of deaths in Michigan nursing homes and the share of all state COVID deaths are both much higher.

Louisiana, Florida, Texas, and Tennessee

Protecting long-term care residents, given their very high vulnerability, is going to be a challenge even with the best policies -- and there are certainly tragedies in nearly every state. But the states that most proactively deployed National Guard to assist understaffed nursing homes, restricted -- as opposed to mandating -- admission and readmission, deployed their testing capacity rationally to the highest risk group, and cohorted, preferably at the facility level, had markedly better results.

The states that have had better outcomes were more proactive and crucially stuck to the usual principle of not admitting or readmitting infectious patients to nursing facilities unless the facilities were well-equipped to prevent secondary transmission.

Louisiana was praised for its approach in an [April 20 NPR article](#):

"Some other states are taking a different approach. Some are reviving closed nursing homes or empty wings to exclusively treat coronavirus-positive patients.

"In Louisiana, which has clusters of COVID-19 patients in more than 60 nursing homes, a facility is prohibited from admitting people who have tested positive for the virus or who were treated for respiratory problems, unless it can show it has the capacity to care for them.

"What we were looking at is really what makes the most sense for the patients themselves and the other residents," says Dr. Alex Billioux, the assistant secretary for Louisiana's Office of Public Health.

"Louisiana has what he calls Tier 2 hospitals, as well as new care facilities, such as the one at the convention center in New Orleans. (Tier 2 facilities don't have emergency room capabilities and are more likely to be specialized facilities, such as psychiatric or rehabilitation hospitals.)

"Individuals who were still too ill to return back to a nursing home could be sent to those Tier 2 facilities — where they're still getting nursing care and attention," says Billioux. "And we know that the majority of these individuals will recover and then be able to be moved back to a nursing facility."

Louisiana was a high disease burden state early from community spread around Mardi Gras so they were starting with a substantial number of nursing home outbreaks. Nonetheless, the state presently reports only 41.8 percent of its COVID-19 deaths among residents of long-term care facilities.

Florida adopted similar measures. As National Review explained in an interview with Governor Ron DeSantis:

"The state took precautions with its seniors generally. 'We advised, before there was even mitigation,' DeSantis points out, 'if you're 65 and older, stay home as much as possible and avoid crowds. And that was just something that made sense.'

"But the nursing homes represented a different level of risk. 'It was clear to me,' says Mary Mayhew, 'that there were much higher standards related to infection control being outlined by the federal CDC that well exceeded what our nursing homes traditionally have been expected to adhere to. So we never had false expectations.'

"Florida, DeSantis notes, 'required all staff and any worker that entered to be screened for COVID illness, temperature checks. Anybody that's symptomatic would just simply not be allowed to go in.' And it required staff to wear PPE. 'We put our money where our mouth is,' he continues. 'We recognized that a lot of these facilities were just not prepared to deal with something like this. So we ended up sending a total of 10 million masks just to our long-term-care facilities, a million gloves, half a million face shields... If I can send PPE to the nursing

homes, and they can prevent an outbreak there, that's going to do more to lower the burden on hospitals than me just sending them another 500,000 N95 masks."

Florida's long-term care COVID deaths as of June 10 total 1,454 –half of Connecticut's total. It is less than 1 percent of Florida's total estimated long-term care population.

Texas reports 873 long-term care COVID deaths, less than half its overall COVID fatalities and an estimated 0.6 percent of the state's long-term care population.

The most remarkable success of all might be Tennessee. A medium-large size state with a population about equal to Massachusetts, Tennessee reports (as of June 5) just 155 long-term care COVID deaths, compared to 4,630 in Massachusetts. Tennessee has implemented [aggressive testing](#) of its entire long-term care population at state expense and with staffing supplemented where necessary by the National Guard. They expect to have the entire long-term care population tested by the end of this month and to test all staff at least weekly.

Significantly, no state that has done well appears to have an operative version of the "must admit" orders common in the states discussed above.

California -- a Quick Reversal and a Much Better Outcome

Not every large state is at the top of the bad outcomes list. Policy matters. The largest state, California, nearly followed the same path as the meltdown states but instead adopted a quick course correction and has benefited enormously from that decision.

California is often mentioned as a state that adopted the "must admit" policy, it is important to recognize that Governor Newsom heard the immediate backlash and modified the order quickly.

On March 30, California issued [substantially the same policy](#) as the meltdown states: "SNFs shall not refuse to admit or readmit a resident based on their status as a suspected or confirmed COVID-19 case."

Just two days later the order was modified to require consultation with local health officials before admitting infected patients to nursing homes. By April 10, the state had adopted a [markedly different policy](#), including using the USN Mercy hospital ship to relocate COVID-negative nursing home residents out of Los Angeles area facilities so they could be used to serve COVID-only cohorts.

California presently reports 2,398 COVID-19 deaths in long-term care – less than little Connecticut's total – which is about 0.9 percent of the state's total long-term care population and about 50.5% of the state's COVID deaths. Both of these numbers are comparable to Florida's.

The Problem with the CDC Definition

The CDC definition, as implemented in most states, counts all or nearly all deaths in the presence of a positive SARS-CoV2 test as a COVID-19 death, regardless of the cause of the death. Colorado recently became the first state to report both CDC-definition COVID-19 "deaths among cases" and a smaller category of "deaths due to COVID-19" in which the virus caused or contributed to death. There is more than a 20 percent difference between the numbers, but they do not report how many of the CDC-definition-only cases were in long-term care facilities.

There is no doubt this virus flashed through nursing homes with devastating effect.

But if CDC does not fix its definition or require dual reporting, the residents of nursing homes, which are now being tested wholesale for coronavirus, who have mild or asymptomatic infections will show up in the count when they die from any of the maladies from which people die. The median nursing home stay before death is just five months. If this definitional problem isn't fixed, there is a danger that the official counts could lose contact with reality, with attendant public panic and additional economic hardship.

Conclusion

To understand the true size and shape of the coronavirus disease burden in the United States we should consistently report the numbers in long-term care and separately the numbers for the rest of the population. The advanced age, comorbidities, and limited mobility of long-term care residents make them overwhelmingly more at risk – so much so that this group of less than 5 million total people or 1.5 percent of the U.S. population comprises about 55 percent of the total COVID deaths. That means the disease risk for everyone else in America is much less than generally perceived from the reported headline numbers.

If there is a second wave, it will be imperative to avoid the upheaval of another broad lockdown and instead focus on having sufficient resources and systems in place to protect long-term care facilities.

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