Centers for Medicare & Medicaid Services
COVID-19 Call with Nursing Homes
June 24, 2020
4:30 p.m. ET

Operator: This is conference #: 3089577.

Alina Czekai: Good afternoon. Thank you for joining our June 24th CMS COVID-19 call with Nursing Homes. This is Alina Czekai leading stakeholder engagement on COVID-19 in the office of CMS Administrator, Seema Verma.

Today, we are joined by CMS leaders as well as providers in the field who have offered to share best practices with you all. I'd first like to turn it over to Evan Shulman, Director of the Division of Nursing Homes at the Center for Clinical Standards and Quality here at CMS, for an update from the agency. Evan, over to you.

Evan Shulman: Thank you, Alina, and good afternoon everyone. We're excited to be with you again this afternoon. I have a couple of updates for you and we also have another guest speaker who will share some innovative strategies for how to implement some best practices with regard to preventing the spread of COVID-19.

First, earlier this week we released new data about how COVID-19 has affected Medicare beneficiaries. I just want to be clear that this data is not specific to nursing homes. It covers Medicare beneficiaries in general.

The data released includes the total number of reported COVID-19 cases and hospitalizations among Medicare beneficiaries between January 1st and May 16th of this year. It also breaks down COVID-19 cases and hospitalizations for Medicare beneficiaries by state, race, ethnicity, age, gender, dual eligibility and Medicare and Medicaid, also for urban and rural locations.

Again, this is not the nursing home data that you all are aware of. That data will continue to be updated and posted on the data.cms.gov site, that’s the NHSN data. There also a link to the NHSN data through the homepage of the

nursing home compare site. For information on this data released please view the CMS Newsroom homepage.

Also, since last we spoke on June 19th, we announced the members of the Independent Coronavirus Commission on Safety and Quality in Nursing Homes. This is the commission that we previously announced that we'd be forming. This commission provides recommendations to help inform current and future responses to COVID-19 and to prevent potential future infection disease outbreaks within nursing homes.

There's a total of 25 members on the commission. They represent a variety of expertise, affiliation, backgrounds and geography. We have resident advocates, infectious diseases experts, directors and administrators of nursing homes, academics, state authorities, clinicians, and medical ethicists, and of course, a nursing home resident. And more information on this as well can be found on the CMS Newsroom website.

The other update I want to provide to you is something that we released yesterday. This is on the CMS emergencies page. We released a frequently asked questions document on nursing home visitation.

We are all aware of the emotional toll that the visitation restrictions and limitations have placed on not only nursing home residents but their families and loved ones. Since we first issued the first memo on visitation back in March though, we have learned a lot more. And anything we can do to bring residents closer to their loved ones we want to be able to do; however, we also want to make sure it can be done safely.

So, we released a document that covers a few ways that the current guidance can be expanded to include other ways to bring together nursing home residents and their families. The first way is that we discussed compassionate care and the definition of compassionate care situations. All of our guidance on visitation restrictions includes an exception for compassionate care situations and that compassionate care term is accompanied by an example of end-of-life situations. However, that example has never intended to be

exclusive to end-of-life situations and in fact was intended to not be exclusive to that.

So, we state in this document that there can be other types of compassionate care situations where individual should be allowed to come in and conduct safe visitation. We also talked about outside visits and some states have already begun to initiate outside visits. These are visits that are conducted in the parking lot or a courtyard or a separate area outside of the facility. And we believe, of course, with proper social distancing, source control and hygiene, other cleansing of any other common areas that the residents and families may use, this can be conducted safely.

Another area that we wanted to address as communal activities, these are activities that on the surface we have issued guidance that there should not be group activities or communal activities and that really applies to situations where residents are not able to social distance or have the infection control practices maintained to prevent the spread of COVID. But in cases where residents can conduct and be a part of group activities, where social distancing, and where hand hygiene, and where source control can be safely maintained, there can be activities.

It reminds me back, in must be almost two months now, that on this very call, one of our best practice speakers introduced the notion of six-foot bingo. And I think that's a great example of how there can be activities that are still conducted while still maintaining safe infection control practices.

We also go on to mention that there are certain factors that facilities should consider when they're exploring creative ways to enable more visitations. Certainly, an answer for one facility may not be the same answer for another facility. If one facility is in the middle of a very large outbreak, then certainly that facility would not be engaged in some creative ways to engage in visitation as the facility is not only in an area that doesn't have an outbreak but is also in an area that doesn't have any large amount of active cases.

And certainly, all of these must be considered in the context of being able to practice the effective infection control measures that must be taken. At the

end of the day, it is still the facility's responsibility to ensure that practices are maintained that prevent the spread of COVID-19.

We also remind facilities in this frequently asked questions of the responsibility to allow ombudsman access to residents so that – this is also part of the CARES Act - that we want to make sure that residents have access to ombudsman either in person or through telephonic or other communicative means so there's more information about that in this FAQ.

So, in short, we really want to do whatever we can to enable safe visitation between families and loved ones in nursing homes. And if it can be done safely, we want that to happen. But we also need to make sure that facilities are being mindful of the deadly nature that this disease presents. So, it's a very difficult balance, but we think it can be done safely.

I'm now going to introduce Bryan Asher, who is the Director of Quality for Emerald Shelter Group which is based at Tennessee. And he's going to share best practices for winning strategies for long-term care. Bryan?

Bryan, you're on mute if you're speaking. I think we may have lost Bryan.

Alina Czekai: Operator, do we still have Bryan on as our speaker?

Operator: Hi, speakers. I am not seeing Bryan on the line right now, but one speaker is calling in and one of our operators is assisting.

Alina Czekai: Great. Thank you.

Evan Shulman: Well, that's OK. Why don't we go to questions then? And if Bryan is able to pop on then we can reintroduce him, but we can go ahead and take some questions.

Bryan Asher: Hey, Evan.

Evan Shulman: Yes?

Alina Czekai: Do we have Bryan back?

Bryan Asher: Yes. Yes.

Evan Shulman: OK. All right. Well, all right, Bryan, you have the floor for your best practices and then we'll turn to questions from there.

Bryan Asher: All right. Good afternoon everyone. I apologize for that. So, our COVID-19 winning strategies that we adopted and made part of our everyday life we started out on March the 13th. We actually closed our doors and this was really right before the CDC recommended it. This applied to any and all of our consultants, vendors, any of our regional managers, families and visitors. We also limited a one-way entrance path into the facilities and this also was to mitigate risk.

We also then held biweekly calls with organizational leadership. These calls were led by our CEO,COO, legal counsel, our acute hospital representative, our regional director of operations, clinical services, head director of quality, and this also included participation with our facility leadership teams. The discussions would include the latest updates and processes, policy changes that were related to COVID-19 and as we know, it's ever changing.

We then would conclude with round-robin discussions with each of the communities and this was related to challenges in personal protective equipment, par levels, staff/resident/family education needs. And then, as far as the PPE supplies and reserves, we partnered with multiple vendors inside and outside of our organization and that was to control, gap fill, PPE needs and to minimize the price gouging.

We have medical directors that we network with partnering hospitals to utilize telemedicine in lieu of bed site visits. As we know, those practitioners have multiple sites that they go to, so there were some hospitals in areas where some of our communities are located where the medical directors were actually able to participate in telemedicine. And then as an organization, we also partnered with a telemedicine provider as well for a couple of our communities.

Then another layer of protection for our employees is we did provide employee-provided uniforms. This is an extra layer protection for employees.

So, the process kind of mimics the acute space where the employee would arrive. They completely employee-screen, move to their designated area. They would take out a clean uniform, change out of street clothes, store those, and then begin their shift and end their shift with the same process. And the facilities were the ones responsible for keeping the uniforms cleans and ready and available. This also helps with minimizing staff taking things home to families and loved ones.

We also implemented our COVID-19 stop stations at front entrances of all facilities. We follow the American Healthcare Association COVID-19 screening tools and everybody I think is getting familiar with those questions. We will take their temperature, oxygen saturation, and then, of course, ask questions related to symptoms – the cough, sore throat, shortness of breath. We also conduct temps and rounds on all of the residents twice a day and that's still in place as of today.

For all of our readmissions, they were automatically quarantined for 14 days into private rooms. And then, if we have any staff where we are made aware that they were exposed to COVID-19, they also were automatically quarantined for the 14 days.

We also additionally went through our infection control best practices and updated those to reflect the current CDC guidelines. And then we also implemented the COVID-19 QAPI so that each facility has those in place too.

They also implemented the COVID-19 binders and those are made available at all of the nurse's stations and they are kept updated with all of the current information as it free flows our direction. And then, one of the last strategies that we revised was our clinical care meeting into standards care to include that COVID-19 discussion.

And then, at the end of the day, out of all of this work we have a total of nine campuses that are across three states and out of all of those we had one positive case. That person was immediately quarantined and then re-tested and they re-tested as negative.

And those were the best practices that we developed in our organization through the guidance of the CDC.

Evan Shulman: Great. Well thanks, Bryan. After sharing all these best practices, we will open up for questions now. Operator?

Operator: Ladies and gentlemen, if you would like to ask a question you may press star then the number one on your telephone keypad. Once again, if you would like to ask a question you may press star one on your telephone keypad.

We have a question coming from one of our participants. Please state your first and last name and then your question. Your line is open.

Susan Grayson: Hi. This is Susan Grayson and I have – sorry to ask such a benign question - but where do I find the FAQ that you were referring to about visitation?

Evan Shulman: Yes. It's on the CMS emergencies page. If you Google CMS emergencies you can find it that way, or we can try and send out an e-mail from this LISTSERV for this group. But yesI think you should be able to find it on the CMS emergencies page.

Susan Grayson: Great. Thank you. Thanks for this FAQ. It sounds like it'd be a good one. Thank you.

Evan Shulman: Sure.

Operator: Once again, if you would like to ask a question you may press star one on your telephone keypad.

We have another question from one of our participants. Please state your first and last name. Your line is open.

Michael Barnett: Hi. Can you hear me?

Evan Shulman: Yes.

Alina Czekai: Hi. Yes, we can.

Michael Barnett: Hi. Great. My name is Michael Barnett and I am with the National Association for the Support of Long Term Care. And I just got a question regarding CMS' reopening plan for nursing homes and that states that employees and residents need to be tested weekly for COVID-19 and that's in all three phases of the guidance.

My question is, what are nursing homes supposed to do to pay for testing for their employees, both in-house as well as contracted staff?

Evan Shulman: Yes. Thank you for that question. It has come up a lot. There's been a number of ways that facilities have been able to provide testing. Some have been provided by states. The Department of Health and Human Services also provided funding to nursing homes to provide testing to staff. So, I think the best thing to do would be to work with the nursing homes and also work with states to identify what are the best needs for using the funds for testing.

Michael Barnett: Thank you

Operator: Once again, if you would like to ask a question you may press star one on your telephone keypad.

We have our next question. State your first and last name. Your line is open.

Kaye Meier: Hi. This is Kaye Meier and I'm with Masimo. I just had a quick question about remote monitoring and remote patient monitoring and just wonder if you're aware if many of the nursing homes using remote monitoring, meeting at the nurse's station or at the hallway so that the nurses don't have to be going room to room to room, and we know that that didn't end well. So, just wondering about both the support of the agency but then also the nursing homes. Thanks a lot.

Evan Shulman: Thanks for that question and we do know that there are facilities that take advantage of remote monitoring. I think that there are some things that need to be considered such as resident privacy along with this, there's ways monitoring can be conducted that doesn't need to be done through the camera.

So, I think that really depends on the situation. Remote monitoring, say, for a common area is something that does not seem to be a problem. But monitoring a resident's room, I think we'd want to be very, very careful with that, if that's what your question is and that's ...

Kaye Meier: Sorry. No. I'm sorry. I should have been specific, it's the remote physiologic monitoring so that the nurses don't have to be going to the room to take vital signs. I'm so sorry. That's my fault, my fault.

Evan Shulman: OK. Thank you. Yes. You've got me a little worried there. I'm sure that there are facilities, we do know that there are facilities that do have remote monitoring. I think to my experience personally; it depends on the patient. Some have had some facilities perform remote monitoring for patients but not all of them, depending on their clinical condition. I think there's still no replacement for the monitoring that is done in person. And there are safe ways to do that and certainly with – even in spite of COVID-19, but we also recognize the challenges and the risk that could present going from room to room.

So, I think, on the surface there's certainly no provision from CMS on remote monitoring of vital signs. But at the end of the day, the facility would be responsible for ensuring that the resident is well maintained and that they're being monitored and whether it's in any way to make sure that they're not having a significant decline in status.

Kaye Meier: Thank you so much.

Operator: We have our next question. Please state your first and last name and then your question. Your line is open.

Irma Jacobson: Hi. Good afternoon. This is Irma Jacobson) I was calling to ask, on June 19th, CMS published an MLN on the reimbursement for COVID lab tests directing MCOs and Medicare and plans, health plans, to reimburse for the test conducted for nursing home residents. Is it still the intention that those tests are covered from the consolidated billing, for Part A residents?

Evan Shulman: Unfortunately, I don't think we have anyone from our payment side of the house on the line. But we do have Office Hours, Alina, when is the next Office Hours?

Alina Czekai: Sure. Our next Office Hours is next Tuesday at 5:00 p.m. Eastern. And we hold those every Tuesday at 5:00 p.m.

Irma Jacobson: Next Tuesday at 5:00 p.m. OK. Thank you very much. I appreciate it.

Alina Czekai: Thank you.

Evan Shulman: Sure.

Operator: We have our next question. Please state your first and last name and then your question. Your line is open.

Peter Ravel: Hello?

Alina Czekai: Hi. We can hear you.

Evan Shulman: We can hear you.

Peter Ravel: OK. Sorry. This is Peter Ravel. I have a quick question for you relating to the NHSN reporting and CMS' civil money penalties on that. We have a number of members, I am the association exec, we have a number of members who have reported that they've been unable to get registered for NHSN and they requested IIDRs on the original CMPs, but they're continuing to get additional CMPs as time goes by and their question is when will the IIDRs be addressed and what's going on with the additional CMPs when they've filed an IIDR?

Evan Shulman: Yes. It's a good question and we received similar questions here. So, first and foremost, CMS has taken a very flexible position to waving or overturning CMPs when facilities demonstrate that they have been attempting to enroll with the program.

And I also want to mention that greater than 95 percent of facilities have been able to successfully enroll and submit data. So, a very small minority of those

have not been able to submit. That said, I'm certain that for that small minority when they're getting a CMP, it's a big deal.

CMS will definitely reconcile the CMPs so that as long as the facility can demonstrate that they have been attempting to enroll, even if other CMPs come on top of that, we can come back around at a later date and reconcile so that their CMPs haven't been increased because they have continued to not be able to enroll due to technical issues that they may be having.

So, the short answer is we'll reconcile with facilities based on their evidence that they have demonstrated attempts to enroll and even if they have a CMP that is sent to them before they've been able to reconcile or resolve the previous IIDR, we can still come back around a few weeks or a month or so later to make sure that they are only penalized in cases that are warranted.

Peter Ravel: Thank you.

Evan Shulman: Sure. Next question please.

Operator: Thanks. Once again, if you would like to ask a question you may press star one on your telephone keypad. Speakers, there are no more questions at this time. You may continue.

Evan Shulman: Great. Well, thank you everyone again for joining us this afternoon and thank you even more so for your hard work in addressing the COVID-19 public health emergency. We know it's very, very difficult work. Thank you, Bryan for sharing your best practices and we look forward to speaking with you all in another couple of weeks. Have a good day.

Operator: Ladies and gentlemen, this concludes today's conference call. Thank you all for joining. You may now disconnect.

End