Centers for Medicare & Medicaid Services
COVID-19 Call with Nursing Homes
Moderator: Alina Czekai
April 22, 2020
4:30 p.m. ET

OPERATOR: This is Conference #2672118

Alina Czekai: Good afternoon, thank you for joining our April 22nd CMS COVID-19 weekly call with nursing homes. We appreciate you taking time out of your busy schedules to join us today. This is Alina Czekai, leading stakeholder engagement on COVID-19 in the office of CMS administrator, Seema Verma.

Today we are also joined by CMS Leadership, CDC officials as well as providers in the field who have offered to share best practices with you all today.

I'd first like to turn it over to my colleague, Jean Moody-Williams. Jean is the Acting Director at the Center for Clinical Standards and Quality at CMS. Jean will be providing a brief update on the agency's latest guidance in response to COVID-19. Jean, over to you.

Jean Moody-Williams: Thanks so much. Good afternoon everyone. We do have a few updates for you, before we get into -- with our guests this afternoon, which I'm really looking forward to.

First, just to let you know, we are constantly working to try and support the activities across all our settings of care -- all of our providers, but in particular, for the work that's going on in nursing homes.

We really do appreciate all that you're doing under very challenging circumstances with the residents and having to work with them, not only to take care of their needs but also, in many cases, their social needs because of the ways that they're now having to interact with their family.

And we've been hearing great stories about the different things that you're doing to do that, and to keep them engaged and just really, really do appreciate your efforts.

One of the things that we want to make sure is, that we have -- to the extent possible, maximum flexibility for the workforce. We know that workforce in the best of times is an issue, and certainly as we're dealing with COVID-19 situations and employees that may be ill and other challenges, and so we did release a COVID-19 workforce virtual toolkit which is a resource for healthcare decision-makers. I want to call your attention to that.

You can find that on our website. It's a new toolkit that helps pull together various resources that are available. It outlines some of the waiver flexibilities that CMS has put forth. We did this in collaboration with the Assistant Secretary for Preparedness and Response, ASPR.

They have other information in there that you might find useful as well, an assistance center, information exchange, case studies, peer-to-peer communications, that is really geared toward local communities. So, I invite you to take a look at that and I hope that that will be a good resource for you.

We also announced new recording requirements, and as many of you are likely aware, as I've mentioned, a number of guidances to assist you as you are caring for residents.

Beginning April of last year we actually unveiled a five part approach to keeping nursing home residents safe during the pandemic. And, so we continue to improve upon that.

Our approach to oversight of nursing homes is constantly evolving. This past Sunday we announced a joint effort undertaken with CMS and CDC, related to new data reporting requirements for nursing homes, that allows us to monitor the current rate of transmission in facilities and helps us to identify ways to protect vulnerable residents.

More specifically, we required nursing homes to now report new cases of infections directly to the CDC and to, in cooperation with the agency's surveillance effort, to stem the coronavirus spread.

As part of this effort, CDC will provide a reporting tool based on the NHS platform that will support federal efforts to collect nationwide data that can be used to determine what's going on in the country, where the needs are, what things need to be deployed where.

Nursing homes will establish and maintain infection and prevention control measures to ensure the safety of residents while reporting the infection disease cases to state and local health departments.

Currently nursing homes do not report this kind of data nationally to CMS or CDC, and subsequently there's a critical gap in monitoring standardized COVID-19 specific cases nationwide, so ideally this will change and again, help to create a more uniform system.

We will be providing more details about the tool, including instructions, specific implementation requirements, when you must begin to report. That information will be coming out very shortly.

I assure you, we are working to find the most efficient way to collect this valuable standardized information in the least burdensome manner possible. And we also thank you and continue to expect your cooperation with the CDC as they come into facilities and conduct surveillance activities for suspected cases. I think that's been a great partnership that has really been a benefit across the country.

So, those were the major announcements I wanted to highlight today because I want to leave plenty of time for our speakers and for questions.

So, let me first introduce Dr. Nimalie Stone, the medical epidemiologist for long-term care in the division of Healthcare Quality Promotion from the Centers for Disease, Control and Prevention. So, Nimalie, I'll turn to you.

Dr. Nimalie Stone: Thanks so much, Jean, and thanks so much for the opportunity to share with this group. It's always wonderful to be able to connect with and hear some of your experiences, and share some of the activities that we're able to do, with state and local health departments to support all of your efforts. And I really want to echo Jean's appreciation for all of your efforts to implement preparedness activities and early and aggressive responses to COVID-19 infections in your centers, so that you can protect all of your residents, staff and families.

I wanted to just take a few minutes to share one example of how CDC has supported providers out in the field, and in this particular field investigation, we were asked by a local health department to help engage nursing home providers in preparing for care of residents and patients who may be hospitalized from COVID-19, in an effort to have some capacity in their community if cases started to surge and increase.

Our team was able to work with the local health department and some key partners in the area, to identify centers who were interested in exploring how to dedicate space and create a dedicated staff who could provide care for residents known to have COVID-19 infections, and really gave us an opportunity to see how partnerships within a community could support the whole healthcare system.

So, when we first arrived, we were able to connect with some of the local EMS -- Emergency Medical Services preparedness people, some of the local hospital centers, and all of the providers -- nursing home providers in the local health jurisdiction, to talk about this effort and how the health department and CDC could offer support to facilities who were interested in evaluating their capacity and the steps that would need to go into place in order to designate a unit and be prepared to care for residents with COVID-19.

And through our partnerships we were able to identify several centers who had not had any exposure to COVID-19 yet, but had already started putting plans into place to anticipate how they would safely manage residents, and we were able to go and walk through their centers with them and talk about the

different considerations for how to develop a unit dedicated to this kind of care.

So, just to share a few of the different areas that we reviewed with these providers. We looked at the space that they were able to set aside and dedicate to care of these residents with sort of a clear separation from other care areas in the building.

They were able to identify space for staff who were designated and were providing care to residents in that unit, to have their own break areas, restroom areas for their PPE supplies, for safe donning and doffing.

And they had already started talking with some of their staff about interest in volunteering for being a part of this team and thinking about how their staffing model would allow them to dedicate nurse assistants and nurses to be the primary care providers on these dedicated units.

And through that conversation, they also thought through what kind of supplies, training in terms of PPE, and other actions like having observers to support say, stocking and PPE handling, when the staff were working with residents.

We talked about working in coordination with EMS and the local hospitals in the community to support and facilitate safe transfer between these designated care centers and hospitals, both to receive residents but also if there was a need to escalate their level of care.

And we learned from them some of the important considerations in terms of support for their staff, how to message and communicate, not just with staff but also families and residents about the plans being put into place and the preparations that were going into becoming a center that could dedicate space and staff to care for residents with COVID-19.

And through this experience we were able to learn from several nursing home providers. Their interest, their commitment to caring for residents with this infection, how they could support the healthcare community by going through these preparedness efforts, and it allowed the local health departments to also

be aware of the capacity that all of these centers could offer and prioritize them for resources if they were activated to serve in this capacity.

I'll stop there and just say that, I know many of you are probably doing similar activities in your centers, and want to acknowledge the incredible work and commitment that you and your staff are making in order to create this capacity for your residents and other residents in the community.

Jean Moody-Williams: Thank you so much, and thank you for the work that you're doing as well. And now, to hear from the field. It's my pleasure to introduce Deke Cateau who's the Chief Executive Officer of A.G. Rhodes Community of Nursing Homes. Deke…

Deke Cateau: Hey, thank you very much, Alina, thank you, Jean and thank you Dr. Stone. So A.G. Rhodes -- very quickly -- is a group of non-profit nursing homes, three nursing homes in the metro-Atlanta area, 418-bed capacity in total. We have about 500 full-time employees and about 120 contracted employees, through rehab and our data services department.

I guess the first thing I want to say is, it's good and bad news and I'm just giving a little bit of our experience and how we could properly maintain and motivate staff, and keep staff morale high. So I just want to talk a little bit about some strategies that we think have been important, and have worked for us.

The good and bad news part of it is, I honestly don't think that's a culture that you could build now, overnight during COVID, but I do know that a lot of our nursing homes across the country have done a great job over the years in building this culture. So hopefully nothing I'm saying here is going to be anything strange to anyone.

So, we have long advocated as an organization, that our staff is our most precious resource. We've grown up in an industry where we've always been taught that the resident always comes first, the resident is always right, the resident always comes first.

And because of that, we I think a lot of times have de-emphasized the importance of our staff. So we've called our staff, for years, our secret sauce and I think this shows more now in this period than not, because the staff are in a very peculiar situation.

Of course, they are as scared as many residents are, they are as much at risk, in many cases, due to illnesses and other co-morbidities. But 81 percent of our staff, for example, are African American and have a lot of other clinical co-morbidities that put them at risk as well.

So, very early on, we made some conscious decisions with how we are going to tackle this pandemic and how we work with our staff. I would say, probably the most important thing firstly is communication with our staff. We've long had a strong history of communicating with all stakeholders -- families of course, and CMS as we have different entities.

But we wanted, and are just as transparent with our staff, as our staff communication. So just as this week, the latest advice this week was that we tell our families our numbers, our coronavirus numbers and stats. Similarly, we are doing that with our staff.

So from the start, from day one we let our staff know what these numbers are. Our website is very, very transparent. I should've also started by telling you all, in our nursing home system right now, we have 26 residents and 17 staff members with COVID right now, diagnosed with COVID.

So, communication is just key. Honest and open communication as often as you can. You know, we don't believe -- and I don't think any of us should believe in holding back any information that would be pertinent to them. I think that would allay and ease a lot of their fears with just open and honest communication.

As far as a leadership team goes, I think leadership is so important here. I have a wonderful team, including my HR director and my communications director whose response will follow that communication, but also our COO,

our clinical director, we make sure to put boots on the ground, in those homes. And all depending on the size of the organization, this may not be possible.

And I know it's pretty controversial, especially now, we're talking about risk and isolation. But I think as leadership, if we are showing, or if there's any instant that we are afraid to come to those homes, why should we expect a CNA or an LPN to want to come to work if we are afraid to lay boots on the ground, so to speak.

Similarly, we've taken a controversial decision with a lot of our management staff in the nursing homes, that do jobs that probably can be done at home.

But our biggest fear and concern is a CNA or an LPN coming to work and to walk into a ghost town of a nursing home, where there's no administrative staff and they're expected to go on to the floor in these difficult war-like situations.

So, yes, we have cut back on where we ask the staff to go. We advise them to isolate as much as they can in their offices, you know, not put themselves in any difficult situations there.

But we expect them to be at work and we, sort of, have shifted around the work times as much, to make this happen. But we expect them to be at work. Again, I know that's a little bit controversial with some of the guidance we've gotten, but I just think, having your management team there, shows a big, big statement to the CNAs and the LPNs, who are expected to go out there and do so much.

Back a little bit to communication. I see it all the time, I'm inundated in my emails with these emails from the CEO or the COO -- all the stuff he emails, which I think is not reaching a lot of our audience and that audience is our staff. So, the other thing we have done, I think pretty successfully, is use video communication.

Everyone has a smart phone or an iPhone now, and there's no reason that any of our leadership cannot pick the phone up or ask their kids to help them. My daughter does it for me. Shoot some really small poignant videos.

Real videos, speak from the heart, no big production, nothing produced but just speak from the heart, to your staff about what they're going through now and about how much you feel for them.

The other huge demographic we have, is we have a lot of single mothers here in our homes, we have a lot of staff who have told us that their loved one or their husband or their spouse has been, you know, furloughed due to this as well. So, we just want to be sensitive to those situations and understand, and talk to them, listen to them as much as possible.

The obvious one that everyone goes to is pay, and we -- like everyone else -- have had to do that, we've had to look at bonus pay, as I'm sure many on this call have as well.

We've had to do those things, but there are also a lot of other intangibles. Most nursing homes have lunches, and many of them charge for lunches, so we -- very early, that was an easy cost, we thought we could tackle that one quickly and just offer free lunches to our staff.

So that's one less thing they have to think about, other than -- they're already thinking about child care and other issues. At least we could handle the lunch side for them, and that does not cost much to do, but it goes a long, long way of making the staff feel and know that you care about them, as a leadership and as an organization.

Really, no easy answers to this. I can't purport to have all the answers to it. You know, I started by saying, I think -- I think a lot of this kind of depends on a culture that was already ramping up to be a strong culture, that staff trust leadership in the homes, and I think that's the biggest word we could use.

I think trust is a huge issue, I think honesty is a huge issue, I think we need to be honest with them on what we have, the supplies we have and the supplies we don't have. The worst thing you could do is have someone go out there, thinking they have supplies that you do not have because then they can't protect themselves or prepare themselves.

So, if you don't have gowns, you might as well say, "We don't have gowns," and also a solution on an alternative to the gown, rather than having someone go through and then realizing they don't have the PPEs or the supplies they need to do it.

The other thing I would recommend from a management, a senior management perspective, is take as much off of the home that you can. So my feeling, and my COO who is on this call, we have been doing most of the supply ordering. It's actually good because we also have the checkbook, so we can get this stuff to them a lot quicker.

And that's taken a lot of strain and stress off of them, just knowing that we're dealing with that, and it's an opportunity for when we visit the homes and we pull up with supplies. You know, staff see that, they love that, they see that management is supporting all of their difficult efforts that they're having to do on the ground.

That pretty much is it, not an easy answer or solution to any of this. I think, just a culture of putting staff first. Letting them know that you're concerned about them, that they are your secret sauce as well, so to speak. And I think we'd all see our way through this with just some of those measures. Thank you.

Jean Moody-Williams: Thank you so much for sharing all of that information and all the tactics that you used, and we appreciate that. And, now I want to, Operator, open up the call for questions for our speakers or for CMS. We have time for a few questions.

Operator: All right then ladies and gentlemen. To ask a question via phone please press "star" "1" on your telephone keypad. To withdraw your question, press the "pound" key. Again, in order to ask a question, please press "star" "1". And we have a question from Danielle Hegg. Your line is now open.

Danielle Hegg: Hi, I was wondering if we have any timeframe that has been laid out yet, as to when we're going to hear when the RAI may be updated, or at least a decision when we may hear back as to the possibility of revising the isolation sections.

Jean Moody-Williams: So let me…

Evan Shaw: Hi.

Jean Moody-Williams: Go ahead, Evan.

Evan Shaw: Hi, this is Evan Shaw from the Division of Nursing Homes. I believe that right now the instruction is to continue to follow the RAI manual as stated for isolation, and also again, we're happy to answer questions through the email box if you send those through, but I believe that those are the latest instructions.

Danielle Hegg: Right. I just didn't -- I thought that they were taking back the possibility of being able to code the presumed COVID diagnosis when testing wasn't available or precautions were necessary per the CDC recommendation, you know, two weeks coming into the nursing homes. I was just wondering if there was any further time frame on that or discussion?

Evan Shaw: No further time frame right now, just follow the instructions in the manual as they are, they're still in effect.

Danielle Hegg: OK, thank you.

Jean Moody-Williams: Thank you. Operator, next question, please.

Operator: Yes, your next question is from Rastis Maff, your line is now open.

Rastis Maff: Yes. Thank you for hosting these calls, they're very helpful. My question's related to application of the 1135 waiver for the beneficiaries and skilled nursing facilities who have been impacted by the COVID-19 emergency.

We have residents in our facilities that meet the criteria for the 1135 waiver regarding the three-day qualifying stays or completion of the spell of illness.

These residents are receiving skilled services related to the COVID-19 emergency, specifically they're on isolation and are receiving skilled nursing, observation and evaluation because they're exhibiting symptoms of COVID-19 such as cough, R05, shortness of breath, R06.02, fever, R50.9.

Or are under observation for suspected exposure, coded as Z03.818. These are the codes recommended by the CDC for these COVID-19 related conditions. The barrier we're experiencing, to giving these beneficiaries access to their benefits outlined in the waiver, is that none of these codes just listed, map to a PDPM category.

These residents may have other conditions which map to a PDPM category, but those other conditions are not the primary reason for the SNF stay. The primary reasons for the SNF stay are the codes I listed, for their COVID-19 related symptoms or suspected exposure.

So, this lack of mapping to a PDPM category mean that these beneficiaries do not qualify for their part A benefit under the waiver, or should we code some other active diagnosis that does map to a PDPM category as the primary reason for the SNF stay, even if it does not relate directly to COVID-19? Thank you.

Jean Moody-Williams: So, thank you for laying that out so clearly. Do we have anyone from CM on the call? OK, I don't think we have our payment folks on, but if you can send that -- it sounds like you may have been reading that, so if you could send that in exactly as you just stated it, and we'll also bring that up with them, and get a response to you.

Rastis Maff: Thank you.

Jean Moody-Williams: Yes. And then also encourage everyone to -- we have all of our subject matter experts on the actual Office Hours call, and I know a lot of the specific billing questions come up at that time and they'll be able to answer. Operator, next question, please.

Operator: Yes, your next question is from Nosah Arnold. Your line is now open.

Nosah Arnold: Hi, thank you. I was wondering when we can expect clarity on the reporting component that you mentioned at the start of the call? What we're concerned about is, we have to report to state and city and now this is going to add a

federal component. Is there any talk about making a unified system so we don't have to be reporting in triplicate?

Jean Moody-Williams: And the very last part you said, is there any thought about -- what was that? I couldn't…

Nosah Arnold: Making a unified system -- sorry -- together with…

Jean Moody-Williams: OK.

Nosah Arnold: … the state or local authorities, so nursing homes won't have to be reporting in triplicate.

Jean Moody-Williams: OK, thank you -- thank you for your question, and I understand, as I mentioned, we're trying to make this with as few burdens as possible.

We are in the national interest, trying to come up with a single reporting platform for the federal reporting which of course if CDC and CMS will share the data, so we're not going to have it reporting -- two different places. So we've streamlined that.

But at this point, the states will continue to have the ability, for their reporting template, and we'll continue to look at how we can work together. But this is consistent with many of our Federal reporting requirements, as you're aware.

States are welcome to utilize these federal reports as well, to met their needs. But I know they have needs in addition to what we will be asking for, for this COVID reporting.

And we will be getting out instructions very soon, hopefully when we have this call next week, we'll be able to provide you with even more detail than we can today. So, I encourage you to dial back in at that time.

Nosah Arnold: Thank you.

Jean Moody-Williams: Yes, and I think that's all the time we have for questions. I really do appreciate. Again, dial back in next week and we will have more

information we'll be able to provide to you, and we thank you again. Thank you.

Operator: And ladies and gentlemen, this concludes today's conference call. Thank you for participating, you may now disconnect.

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