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

OPERATOR: This is Conference #: 1143564.

Alina Czekai: Good afternoon. Thank you for joining our July 22nd 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 and CDC leaders, as well as providers in the field who have offered to share best practices with you all.

First, I'd 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 very much.

And good afternoon everyone. It's a pleasure to speak with you today. And thank you as usual for all of your hard work that you're doing out in the field. It's really incredible.

The story we hear about how nursing facilities and staff have just stepped up to protect the health and safety of residents from this dangerous disease is just so inspiring. And we're doing whatever we can to support you.

I have just a couple of reminders actually for you before I introduce some – we have some fantastic guest speakers here today.

The first thing I just want to remind you to, to regularly check a few key sources of information.

One, CDC's website. Please monitor their website and their nursing home-based COVID guidance for any changes to any guidance. Whether it be on discontinuing transmission-based precautions or testing or just general guidelines for responding to COVID-19, please continue to check that website as well. And also consult with your state HAI coordinators or Health Departments.

Also, please continue to monitor the CMS website. We have the CMS Emergency page and the CMS News Room are great sources of information that can point you to other places so you can stay up-to-date.

One of the things, I want to switch gears now to just – I'll talk a little bit about the data and the NHSN data that I know you all are familiar with. You've done a great job at reporting. We are continuing to see increased accuracy with reporting. Very, very few facilities are being flagged for having what we believe to be erroneous data. And even fewer facilities are being flagged for not having submitted data.

And I just want to give a few reminders on how to keep driving those numbers down.

First, please make sure that you are submitting data for the right CMS Certification Number of CCN. So you can find that as you're submitting. There were changes to the screenshot where you can see the CCN you were submitting under so that you can ensure that it's going to the right CCN. If you do not submit data for the right CCN, your facility will not get credit for submitting.

And the second thing is facility type. There's a few, and there's maybe three or four types of facilities that you can select as you're submitting - SNF, long-term care facility is one of them. There's a couple of others. Please make sure you are selecting the right facility. If you're not selecting as a skilled nursing facility, or long-term nursing home, you will also not get credit.

Again, very few facilities are not getting credit these days, which again, is – you all deserve kudos for stepping up and reporting as much as possible, and

correctly. But keep those reminders because we don't want to slip. That's on reporting.

In terms of accuracy, there's a couple of other things that I want to remind individuals of.

Number one is, one of the most common error that we see that facilities will report cumulative cases each week instead of new cases each week. So in other words, if the facility has 10 cases one week, and then has two new cases the next week, they will report 12 cases in that week. And that is the wrong way to report.

Facilities need to report the number of new incidence, the number of new cases each week. And why this is important, is that, if you report cumulative cases, it will artificially in place the number of cases that you have.

And this is not only important for cases, resident cases, resident deaths, every field, staff cases, staff deaths, expected cases, expected staff cases – all those fields. Please remember that you need to report the incidents, the number of new cases each week.

The next item I want to talk about is deaths. And just a reminder, and this is also an instruction. You're required to report death that occur of your residents even when they are transferred out of your facility and expire in another setting.

So if you transfer resident to a hospital, or to say an in-patient hospice facility, and the residents passed away in those settings, you need to record that death in NHSN the death to your facility. We need these numbers to really help us all in our surveillance activities of how this disease, where we are on the curve for both cases and deaths.

To help along – to help you all with it, there have been a couple – there's a couple of things that you should check for.

The first thing you should check for, is that, CDC has recently revised the system so you can look at the data that you're about to submit yourself. So

you can go into the system. I have some quick instructions here. Once you log in and you select the COVID-19 dashboard, which is the left navigation pane, and you can review your data summary.

And there are dashboard displays. They're interactive and the dates. And you can review the dates. You can change the dates to correct data entry from these screens. So it's important that not only that you submit the data but also make sure that you look at it before you're submitting to make sure that the submission is an accurate reflection of what you're seeing in the facility.

And if you don't have catch anything on that screen, or even if you do actually, where we post the data on the data.cms.gov website, the data is in a downloadable form. Or you can just look at it right on the screen. There are flags, a yes or no flag for whether or not your facility data passed the CDC's quality assurance check or the CMS quality assurance check.

So please review those, your data on the website. And if it did not pass the quality assurance check, go in, check to see what you submitted. You'll be able – you should be able to see why – by looking at your data, you'll be able to tell if it's accurate or not. If you have questions, you can always e-mail the e-mail addresses that are on the data dictionary page.

But again, thank you so much for all of your attention to detail. The vast majority of data that has been entered is accurate. And more importantly, it's actionable. And we can see where we are on the curve and the trajectory of the disease. So please continue to focus on that. And you can also – as you identify errors in previous weeks, you can go back and correct those errors too.

So we're going to switch gears again. And we're going to talk a little bit about our first guest speaker. And we're going to – I'm sure all of you are aware that recently the Department of Health and Human Services has announced an initiative to deliver point-of-care testing devices to nursing homes throughout our country.

This is a very fast-moving initiative that we've been engaged with. And it is unfolding every day. So we're going to tell you what we know and that could

change tomorrow. More information could come out. It could come tonight, come out tomorrow.

But right now, I'm very pleased to introduce Rachel Kellogg, who's the Deputy Chief of Staff of the Office of the Assistant Secretary for Health to give us an update on this initiative. Rachel?

Rachel Kellogg: Hi. Thank you, Evan.

Good afternoon everyone. And thank you all for allowing me to join today's call.

As Evan mentioned, last Tuesday, the Vice-President announced that the Department of Health and Human Services procured FDA-authorized antigen point-of-care test to be distributed to nursing homes, starting with the facilities in COVID hotspot geographic areas.

This is incredibly important to protect our nursing homes and to potentially save thousands of lives. So we are incredibly – I don't know if excited is the word – but excited for this announcement because we do feel that it is so incredibly important.

So who will receive these point-of-care devices and associated tests? So nursing homes will receive either a Quidel Sofia 2 instrument or a BD Veritor Plus System over the coming months. And to be eligible, nursing homes must have a current CLIA certificate of waiver and meet certain epidemiological criteria. And I will go into that criteria a little bit later.

We hope to post the list of nursing homes. But as Evan said, some more information will come out later this week. We'll be able to provide more details.

So distribution will begin this week to a little over 600 nursing homes that have been prioritized using that epidemiological data that I had previously mentioned.

And as I said, shipping will begin this week and will continue over the course of 14 weeks, and potentially beyond those 14 weeks. But right now, that's what we're tracking. And we are hoping to hit, like I said, every nursing home with a CLIA certificate of waiver.

So how we're sending these allotments? We categorized nursing homes into five different groupings based on their estimated testing needs. So we categorized into small facilities, small to medium facilities, medium facilities, large facilities, and major outlier facilities, some of those mega nursing homes that we have.

And for those small facilities, each will receive 150 tests with one instrument. Small to medium, 240 to 250 tests with one instrument. Medium facilities, 325 to 330 tests with one instrument. Large facilities, 600 tests and one instrument. And those major outliers will receive over 900 tests and two instruments.

And the range accounts for variations in kit size between both BD and Quidel. But this information will hopefully be posted. So once we go into that Q&A session a little bit later in the call, please be assured that we will post all these numbers. So you don't have to ask me to repeat them because we'll make sure that they get out to all of you.

In terms of training, we have asked Quidel and BD to make sure that training is widely available to all nursing homes. And they've done a fantastic job with putting together wonderful all-inclusive training programs for nursing homes to make sure that all the point-of-care instruments are run correctly and set any protocol that they may have in place.

So I previously mentioned the prioritization of the rapid point-of-care devices. So I will quickly go through some of that prioritization that we looked at.

So like I said, the nursing homes must have a current CLIA certificate of waiver.

Next – there have to be three or more confirmed or suspected new cases of COVID-19 in the last seven days. At least one new COVID-19 case in the

last seven days after having zero previous COVID-19 cases. Inadequate access to testing in the last seven days. At least one new resident death due to COVID-19 in the last seven days. And at least one new confirmed or suspected COVID-19 case among staff in the last seven days.

This will be a one-time shipment to nursing homes. Once we send you that instrument that is the property of the nursing home and that is the nursing homes to keep. And we're hoping that the tests that will be provided will be good for a baseline test of the nursing home and staff.

Once you receive those tests, we do ask that the nursing home go directly to the manufacturer or distributor, however they have that in place, to procure additional tests. But that instrument is the nursing homes to keep.

What else do I have for you all? I think that's the high level that I wanted to get across. And like Evan said, we will have additional information, hopefully this week, to post and to pass out to everyone. But I'm sure there will be some questions in the Q&A session.

But I will end it there, Evan. Thank you.

Evan Shulman: Thank you, Rachel. That's wonderful information.

And again, everyone, I'm sure there are a lot of questions on that in this call. Unfortunately, we don't have a lot of time for these questions. But we are fully intending to put a lot of information of how, including frequently asked questions, about this information, on this information over the next few days.

So I'm going to introduce our guest speaker here. I'm pleased to introduce Karyn Leible. She is the past President of AMDA - the Society for Post-Acute Care and Long-Term Care Medicine. She has chaired both to Education and the Public Policy Committees for AMDA. And has been a Member of their Core Curriculum Faculty for over 15 years. She has over 25 years of experience in post-acute and long-term care medicine, both as attending physician and as a medical director.

So Karyn, we'd love to hear from you on best practices for our response to COVID-19.

Karyn Leible: Hi. Thanks Evan.

I had the great opportunity to actually being one of the first nursing homes in the State of Colorado to experience COVID. We actually had a staff nurse come to us on March 3rd. She had been – had a four-hour layover in Seoul, Korea, and then came to work with upper respiratory symptoms.

So we immediately knew that we probably had something going. So we started – this was on March 3rd. We started immediately to sort of monitor temperatures and oxygenation for any of those elders that she had had contact with.

We have three units in our facility. We had our post-acute unit. And we had two long-term care units. And she was actually the staff nurse on the long-term care unit.

So because we had sort of a heads up that we probably had something in our building that helped us a great deal to kind of get things going pretty quickly. Basically, anybody that had a temperature of greater than 99 or any kind of upper respiratory symptoms was evaluated by a provider. And we're fortunate enough to have full-time nurse practitioners. We have two nurse practitioners in the facility. So they were evaluated by a provider. And it was determined whether or not we should be doing testing.

So remember, testing at this point wasn't – the point-of-care testing would be great. And we didn't have testing capabilities immediately available to us at the time. In fact, the nurse's initial COVID test was cancelled by the Health Department until they realized that we potentially did have something going on and then she was tested afterwards.

So we immediately started doing that. And anybody that was – that had any kind of low-grade temp was put on droplet isolation. So we would isolate that individual. And of course, they're all in semi-private rooms, and they're roommates, we put them on droplet isolation.

Our PPE at that time, we did not have N95s. We were just using – we were using the surgical masks. We weren't using goggles but we were using gowns and gloves as we're going into the room.

So we were able to isolate. We did come up with five people within five days that developed fevers and were tested. Two of which were positive. So we have the COVID testing – the positive COVID in our building pretty early on.

And then from there, we also were testing for – because it was large, we still had influenza A, B, and RSV in our building, which I anticipate, when we go back into the fall, that we're going to have to be doing full respiratory panels again in addition to the COVID testing. Currently, we're just doing COVID testing because the influenza A and B and RSV are not as prevalent in our community.

The other thing that we did was we instituted universal masking of employees. And that was really a request of the CDC as well as the Health Department. Again, being one of the first in the state, we had a lot of hands-on help from the Health Department and from the CDC with this initial outbreak. So we were doing universal masking.

We stopped – the minute I heard that we had any temps on the unit, we had our cluster temps on the unit, we stopped all in-out movement on that particular unit. There is no visitation. We just had the same staff working on that unit for the whole time basically. And then we really – we have the two nurse practitioners, as well as myself, as a provider.

I became the main provider for the COVID unit, or what I called the COVID unit. And I didn't – I really minimized my interaction with any patients outside of that unit. If I would see other patients, I would see them in the morning before I went into COVID unit. Once I went on the COVID unit, I didn't cross over to another unit.

And we did have two people that tested positive on our post-acute side and I immediately moved them to our COVID unit. We didn't move anybody off

the COVID unit that was negative but we moved people that were positive on there.

I said it was only two. And that was a decision that I had made to do. It wasn't necessarily what the Health Department wanted me to do initially.

And that's pretty much how we managed to sort of keep it isolated to one unit. The whole total, we had 130 residents at the start of this. Through attrition, we came down to 100. And that was the discharges.

We had 22 people that were affected. We only had six staff. Three of them were hospice patients and one was 100 years old. So we were really effective in sort of isolating it to the one unit and really minimizing the deaths that we saw on our unit.

And we continuously were updating our infections control policies. Whether it be because of recommendations from the CDC or recommendations from the Health Department, we were constantly evaluating our processes of care.

As we got new patients that were tested positive, we would go and do our cross-analysis to see why that was happening. And eventually, we were able to spread everybody out over the unit and stop any kind of joint use of like rest rooms or any kind of joint equipment. And we stopped the outbreak just on that unit. And to this day, it still was only isolated to our one unit.

So that was my story.

Evan Shulman: OK. Great. Well thank you, Karyn.

So I think we're ready to open up the lines. If anyone has any questions for CMS, or for Rachel, or for Karyn, on any of these topics, we're happy to try and answer them.

Operator: As a reminder, to ask a question, please press "star," "1" on your telephone keypad. Once again, that's "star," "1" on your telephone keypad.

Your first question comes from the line of Slavka Partilova. Your line is open.

Slavka Partilova: Hi. Thank you for taking my question today.

I think it's great that the facility is going to have a point-of-care testing. Hopefully that's going to help a lot. But currently, that is not the case yet. And a lot of facilities are doing swabbing for labs.

I do have a question regarding the specimen collection for G2024. I've been going back and forth with CMS. And we've been trying to figure out if the skilled nursing facility would be allowed to bill for it if the swabbing is performed by the skilled nursing facility staff.

We've been told further that's not possible. Then there was a suggestion that that has been actually updated and we will be able to bill for that. But today, again, I received the response that is suggesting that, "No, this is only allowable for clinical labs."

I contacted our intermediary and we actually had some claims processed and paid for this particular approach. And they're saying that as long as the lab is not billing for it, and it is the SNF staff that is collecting the specimen, and the SNF has a valid CLIA certificate, that it is OK for us to bill for this.

So I think at this point, we are very confused. And we are really looking for some clarification on this.

Evan Shulman: Yes. I can hear the frustration in your voice and confusion.

And unfortunately, we don't have – these calls really don't have a lot of – they're not really aimed at billing. They're more best practices and infection control and some other parts of the initiative to respond. So they're not typically in the billing.

However, I guess, a couple of things. Number one, if we – I don't know Alina if there's an e-mail address that we can get this to. And we can try to see if we can include any sort of – this question – any sort of FAQ.

Number two, I know that the MAC have received some information on billing for testing. So that may be something. Maybe check with them or you may

have had already. So we can try and get some information out that way and apologize that we don't have a response to you on this call.

Slavka Partilova: OK. Thank you.

I believe the response from the COVID-19 mailbox, was that, that it really is an update on the SE20011. But that update does not state that the nursing facility can do billing for G2024. And if our intermediary is saying to us that it can, then we're really confused.

And I think it would be really beneficial if this somehow could be looked at again. And perhaps we can get like a clear answer in writing which they'll clearly say yes or no.

Evan Shulman: And that was for G-what?

Slavka Partilova: G2024.

Evan Shulman: OK. OK. Thank you for that.

Slavka Partilova: Thank you so much.

Operator: Your next question comes from the line of Susan LaPadula. Your line is open.

Susan LaPadula: Hi. Good afternoon. And thank you for these calls.

Evan, my question is for CMS. Would you consider allowing the skilled nursing facilities to do point-of-care test for influenza virus? With the fall coming, it's going to be imperative that we can separate any possibilities.

Evan Shulman: I don't know, Rachel – I don't want to put on the spot, you may or may not have this answer.

But I do believe that if there is – if the machines do, do – can do that test. And I'm not going to speak to payment. I can't speak to anything related to payment. I can only speak to if the machines do the test, then the CLIA

certificate of waiver would still apply to doing those influenza tests. And as we get closer into that season, we can definitely communicate more.

I think it's an excellent point because we need to have a full core press not on finding COVID-19 but on finding influenza as well.

Susan LaPadula: Excellent. And I would appreciate that if you could look into that clinically. And we'll keep the reimbursement part for the Tuesday call, if that's OK.

Rachel Kellogg: And Evan, this is Rachel. It's my understanding that the antigen point-of-care test can also run flu and RSV test.

Susan LaPadula: Anything you can do to help us would be appreciated. Thank you so much to your whole team. Very, very grateful to you all.

Evan Shulman: Thank you for all your work out there.

All right. Unfortunately, we'll take one more question. We have a hard stop at 5 o'clock. So one more question please.

Operator: Next question is from Tyler Dominguez. Your line is open.

Tyler, your line is open.

Tyler Dominguez: Can you hear me?

Operator: Yes, we can.

Tyler Dominguez: Yes. My question is about providers who have a CLIA waiver number and yet came up on that list of providers that CMS does not have record of them having a CLIA number. How can you make sure that they can rectify that so that they can get some of these point-of-care devices?

Evan Shulman: Yes. I can give you…

Tyler Dominguez: Is there is an e-mail address or something?

Evan Shulman: There is. Let me get that quickly here. The e-mail address is CLIA, C-L-I-A covidinquiries – all one word. So cliacovidinquires@cms.hhs.gov.

Tyler Dominguez: Thank you very much. I emailed that e-mail address earlier this afternoon and they responded very quickly and were very helpful. But they said that they did not know how to get that rectified or where that list came from.

Evan Shulman: OK.

Tyler Dominguez: They said they could look it up to make sure that you have a valid CLIA but that's easy to know. But they didn't know how to fix your list, or wherever that list came from.

Evan Shulman: Yes. We will… e-mail them again.

I can tell you that literally, we're improving the processes in connecting the dot more important every second. We're basically putting this together in a way that get the machines out to you all as soon as possible while we're still working on some of these questions.

We think it's more important to get the machines out to as many as we can. At the same time that we can reconcile some of these things. And we're happy to – and we're happy to do that.

If you e-mail that address again, we'll reach out to them too and make sure that the link is made there.

Tyler Dominguez: Great. Thank you so much for all that you guys are doing.

Evan Shulman: Sure. Thank you.

So we're going to need to end the call right now.

Again, thank you everyone. Please, as I said earlier, continue to check the website. We all need to do what we can. CMS and the Department of Health and Human Services, we're taking as many actions as we possibly can.

You all are doing great. We all need to make sure that everyone, all of your staff, every unit, every staff member are following the guidelines to prevent

the spread of COVID-19. So please continue to work on that. And thank you so much for all of your hard work.

Have a great evening.

End