Centers for Medicare & Medicaid Services
COVID-19 Call with Nurses
Moderator: Alina Czekai
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OPERATOR: This is Conference #: 2874976

Alina Czekai: Good afternoon. Thank you for joining our May 21st CMS COVID-19 call with nurses. 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 Jean Moody-Williams, acting Director at the Center for Clinical Standards and Quality for an update on the agency's latest guidance in response to COVID-19. Jean, over to you.

Jean Moody-Williams: Thank you so much and hello everyone. Great to be with you this afternoon. I am excited to get to our guest speaker that we have. As Alina just said, before we do that, I wanted to give you a few updates about guidance that we issued at the end of last week primarily related to nursing homes, but with implications for much of the work that nurses do in the nursing home, but in other settings as well: home health, hospice, and hospitals as well because as you're doing your discharge planning and thinking through where patients will be located, this information, I think, will be useful to all regardless of the setting.

So, as you know, we have been working closely with the care and infection control and prevention in nursing home. And since February, as a matter of fact, we've issued a total of 11 guidance documents based on existing infection control requirements. And we've updated that and – from learnings, from the Center for Disease Control and Prevention as well as from our federal oversight surveys.

So one of the guidances that we issued in March relayed the very difficult decision to restrict non-essential visitors from nursing homes and we fully appreciated how painful the separation would be for residents and those who love them, but it was one that – a decision that we had to make for the safety of the residents and for the staff. And of course, if you are working in other settings, you've had to make some of these same decisions yourselves.

The difference, of course, being in the nursing home, is that's where the residents live. It's not as if they're going to be in that place for a short period of time and go home. So while many areas of the country continue to grapple with the virus, some areas of the country are seeing declining caseloads. And they're starting to reopen many businesses.

So CMS, in close collaboration with the CDC and the coronavirus task force, developed, in working with states and localities, new recommendations that propose a phased-in approach to reuniting nursing home residents with their loved ones, as well as loosening some other restrictions that have been in place regarding the workforce essential personnel and services to be provided.

Now this is guidance for states and localities and given the vulnerabilities of nursing home residents, we are using extreme caution in our approach and we want to be methodical and we want it to be data driven. So, because the – and the one thing that we did do as well – we tied to the phases in the President's opening up America again guidelines, which can be found on the White House website.

And if you've seen that guidance, there are three phases. And so, in working with that, we have tried to align with that. Because the pandemic is affecting communities in different ways, several factors have to be considered in forming a decision about relaxing restrictions in nursing homes, including obviously, the case status in the community.

So state and local officials will have to look to see what – how many new cases are in their communities, what's happening in the hospitals, what's ICU capacity, what's home health capacity to care for patients, what are the various factors that go into determining the community status.

Obviously, you have to look at what's happening in the nursing homes. The absence of new nursing home cases or new onset of COVID-19 in resident or staff. Adequate staffing – does the nursing home have the staffing to care for residents? Because when they have residents or residents are being transferred to them, the expectation is that they would accept them when they have the ability to provide the proper care and the proper isolation precautions – transmission precaution.

So, all of that has to be considered. The guidance emphasizes proper screening entrance into the facilities, appropriately using PPE, ability to cohort, etcetera. So at a high level, CMS is recommending that nursing homes avoid relaxing restrictions and advancing through the reopening phases until all residents and staff have received a test to look at the – to ensure that there is no COVID-19 within the facility and to know what that status is – whether they are pre-COVID or no COVID or pre-symptomatic or whatever the case may be.

In addition to the baseline test, we recommend that nursing homes screen all staff daily and test them weekly. And the guidance recommends screening steps such as temperature checks, questions about symptoms – all the things that you're currently doing, but that would continue on. Facilities may also need to continue testing residents if symptoms of COVID-19 are present which would allow nursing homes to take appropriate infection control measures proactively.

So, if a facility identifies a new nursing home onset of COVID-19 cases in the facility, while in any phase, that facility goes back to the highest level of mitigation to ensure that they are implementing the appropriate precautions. We are also – another important factor is looking at the declining caseloads in the state, as we've said – so state and local officials, as well as individual nursing home and communities need to evaluate the current environment and tailor their approach accordingly.

So I know part of reopening, one of the main questions we receive and you certainly probably do as well from either your own personal family members

or others or from patients that you care for – when will visitation be allowed again?

So the answer will depend on a variety of factors, but in general, aside from compassionate care situations, essential healthcare workers, nursing homes can begin receiving visitors in Phase 3 and in Phase 2, they can also begin to have some of the non-healthcare essential personnel come in that are important to quality of life. And so they can begin to look at that. But in Phase 3 is when you can begin receiving visitors.

And when the time does come to allow that, it will be important that they are screened, that they are wearing cloth face coverings to avoid and limit potential exposure. It's also important to note that these are recommendations. The final decision does rest with state and local leaders who are most familiar with their communities and so we're urging them to work with their communities.

So that what it might mean is that a given state may allow all nursing homes in that state to open at the same time or perhaps they'll have county or even individuals. So last week the Administrator had a productive call with the governors of all the states and they will begin to think about how they will approach this reopening process.

But in any event, we are committed to working with you, with the state and local leaders, with the families and the advocates to make sure that we come to the best decision possible – weighing all the benefits and the risk of relaxing restrictions.

So that's what I really wanted to bring to you today so you can have an idea of where we are with that. Happy to answer any questions, but before we get to the Q&A, I am so pleased to welcome Amanda Chaney. Amanda is a AANP fellow and nurse practitioner in liver transplant at the Mayo Clinic in Florida and the chair of Mayo's advance practice provider subcommittee. So let me turn to Amanda. Thank you.

Amanda Chaney: Hi, thank you. So really happy to join you guys today and talk to you a little bit about COVID preparations and things that we've done in our organization to try to help with some of the possible surge planning and/or definite uncertainty of the state of events that we're now in. Some of the – some of the best practices that I can speak to that we learned from after much trial and error and much discussion. All of our nurse practitioners and physician assistants at Mayo Clinic in Florida are in different departments.

And so obviously – many different specialties, whether it's hospital, acute care or family practice or just clinic-based. And so when we were thinking about surge planning for COVID-19 in the event that we had 200, 300 COVID patients in the hospital – thinking that worst case scenario that is, in fact, where we would be – we had to think about who and – who would be caring for those patients and how would come up with the best practice of how those patients would get the care that they need.

A couple of strategies we put into place revolved around figuring out which APPs had experience in the hospital settings, and then prioritizing those individuals based on whether they were a best fit or a poor fit for an acute care sort of practice situation.

And so we developed a very elaborate Excel sheet, going through – we had about 250 APPs on our Florida campus and so we prioritized based on their past experience, whether they had even nursing experience in the hospital setting and then ranking them on a 1 to 4 scale whether or not they were a best fit or a poor fit for care of a patient in the hospital setting.

We wanted to make sure that patients – even if they were a poor fit they still would have a role to play. So we thought about things like just order entry or being a runner for certain things if it came to that and it was like a true vast casualty sort of situation where we really needed all hands on deck, what would the roles and tasks to be individualized for each person and how would go about that.

So, we came up with a surge plan and we ended up training about 80 APPs of about 250 to be cross-trained in the hospital setting. So our internal medicine

team was absolutely amazing and developed an onboarding black board curriculum – going through some very specific hospital medicine sort of typically common diagnoses that we see in the hospital setting and then doing like a review of those things along with a quiz to make sure that they retained content.

And, then we had them go over to the hospital internal medicine practice for a three-day shadowing experience so they could actually see those – that curricula and academic piece into action. And so, we had 80 APPs go through that process and so in the event of that worst-case scenario, which we all were praying we weren't going to get there.

We did have a plan to be able to give the best care to those patients who needed it. And so that was back in March. I will say now in our current state, we did not face that surge as we once feared. Our hospital census is about the same as a normal functioning about this time last year.

So, all of that's been good and now we're making efforts as we've had some executive mandates and orders being changed and allowing surgeries and things to happen at this point in all of this. We're having clinic appointments becoming – opening – opening up and going –moving forward with opening up the clinic side of the practice. Along with that, we still obviously see patients with COVID-19 who are doing well now.

And so we wanted to make sure that we had an area for those patients to receive care and even, you know, primary care sort of visits – if they had a cough or if they had, you know, an adjustment of their diabetic medication – where would those patients be seen –in the hopes of isolating them to prevent further spread of infection to anyone else.

And our leaders decided to create one of our off sites into a COVID unit eventually for outpatient practice so that those patients could get the necessary tests and labs and things they needed, but still remain isolated from the rest of our practice so that we would, you now, practice, the social distancing and all the things that we need to do per CDC guidelines.

I'm trying to think if there are any other things that have come along. Telemedicine definitely is another one that we have had crash courses on and have done that very successfully. Our primary care family medicine group is shining in that area right now. They're doing a ton of video visits and doing a great job with that way and we've had some really great patient satisfaction as a result.

Patients are relieved that they get to have the care that they need, but they can have that from the comfort of their own home. So that's been a really great thing that we've been able to provide for patients.

Jean Moody-Williams: Great. Thank you so much for bringing forth that information. It's always great to hear practical suggestions, recommendations and knowing how they work. I would like to open up for questions. We could take a few questions and I'll ask the operator if she could give instructions.

Operator: Certainly. And for everyone, if you would like to ask a question, please press "star," "1" on your telephone keypad. Again, that is "star," "1" on your telephone keypad.

Jean Moody-Williams: And I said questions, but we also – if you have some innovative ideas or things that's working for you, you can feel free to share that as well.

Operator: We have a question from a participant. Please state your first and last name and ask your question. To the person who pressed "star," "1", your line is already open.

Michelle McLure: Hi. My name is Michelle McLure and first of all, thank you for taking the time to do these calls. It's very helpful with moving forward with all of the changes. I do have a question as it relates to the new CMS update you had spoke of from May 18th. You stated that any new onset of – the nursing home onset of a COVID-19 case would put you back even if you were in Phase 3 going back to Phase 1.

As I read through this memo, that definition of nursing home onset only speaks of a resident's case and not associate's and I can't find throughout the memo that it necessarily says that any positive associate cases. It just says

you start from the beginning if any resident tests positive. Can you clarify that?

Jean Moody-Williams: Yes, and thank you for pointing out that that definition is there in case anyone has missed that because the intent is not to stop nursing homes from accepting patients, but it's looking within the facility to see if there's a reason to – if there's something new going on and a reason to begin precautions again.

And we did not specify associates but – so we will get back to you on that, but I would think that you – whenever – you would have to start with looking to see what was the contact the – if that's a confirmed case, etcetera, and what's the risk.

But, let me get back to you specifically as far as the going back and starting again – and a lot of this, you know, you're going to have to – because this is guidance and you are going to have to look to see really what's going – those things that I listed – in your nursing facility and how it's going to best impact you.

Michelle McLure: OK. Thank you. I also have one more question if I could proceed. It does state this is more nursing home guidance. Could you clarify is that consistent of our AL as well as our CCRC campus?

Jean Moody-Williams: Yes, so because CMS put the guidance out, our authority, as it were, relates only to Medicare certified facilities and so this does not speak to assisted living or continuing care retirement communities. It is specific to nursing homes, however, some folks have told me that they are at least looking at this to see how they would use it for their facilities, but we didn't necessarily write it for those facilities.

Michelle McLure: Thank you.

Jean Moody-Williams: Other questions?

Operator: Again, for everyone, if you would like to ask a question, please press "star," "1" on your telephone keypad. There are no further questions at this moment, you may continue.

Jean Moody-Williams: OK, great. Thank you. So again, we appreciate your participation and your feedback, which is always helpful to us as we continue – I like to once again thank Amanda for joining us and I'll turn it back to Alina.

Alina Czekai: Great. Thanks Jean and thanks everyone for joining our call today. We hope that you'll join us later today for our CMS COVID-19 office hours at 5 p.m. eastern, where we'll have all of our CMS subject matter experts on the line to address your technical questions and in the mean time you can continue to direct your questions to our COVID mailbox, which is covid-19@cms.hhs.gov.

Again, we appreciate all that you are doing for patients and their families around the country as we address COVID-19 as nation. Have a great rest of your day. This concludes today's call.

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