Centers for Medicare & Medicaid Services
COVID-19 Call with Nursing Homes
Moderator: Alina Czekai
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Operator: This is Conference #: 7983218.

Alina Czekai: Hi. Good afternoon, everyone. Thank you so much for joining our call today on COVID-19 for Nursing Homes. We really appreciate everyone carving aside time to connect with your CMS colleagues and your nursing home colleagues from around the country as we face COVID-19 as a nation.

I'd like to turn it over to Jean Moody-Williams right now. Jean Moody-Williams is the Acting Director at the CMS Center for Clinical Standards and Quality. Jean, I'll turn it over to you.

Jean Moody-Williams: Thanks so much and welcome. Thank you all for joining and taking time away. I know the awesome responsibility that you all have for taking care of patients. We know that there are a couple of thousand of people who have tuned into this call as we all are looking to give information and get information on the situation at hand.

According to the CDC data, more than 150 nursing homes in about 27 states have at least one resident with the coronavirus. CMS and CDC, we are collaborating in real time. We meet at least twice a day, and most days more than that, with the focus on nursing homes that have active cases of coronavirus or that have the possibility of acquiring it.

We recognize that this crisis represents too many challenges for providers, for those caregivers, and families, and residents, everyone involved. And so, we want to try and provide the latest information that we have. But I think just more importantly we found, and we tried this yesterday, hearing from the field at this point is important. We put out a lot of guidance. We'll continue to do that. But what are those real life day-to-day things that are working that people are finding.

So, that's what we want to save time to do today. I will give a couple of highlights before we get into that. On Monday, we released a memo about how we are adjusting our oversight during the COVID-19 pandemic and these actions really impact all providers, not limited to nursing homes. But here are a few of the highlights.

For the next three weeks, we really are only going to focus on two types of surveys, inspections related to situations that put patient's health and safety in immediate jeopardy, and targeted surveys that focus on infection control. And we created and released a new survey process. It really builds upon existing infection control survey processes.

So, it's not like we're introducing anything that's brand new. But it is streamlined to adjust to the most pertinent issues based on coordination with the CDC and the latest guidance about preventing the spread of COVID-19.

The process will be used on all of the complaint surveys for immediate jeopardy and then on additional surveys that the state is conducting. So, we want to be clear about that. There still will be surveys that the states are conducting. They will be selected in coordination with the CDC and the fellow surveyors will be using the same tool that the state survey is on.

We are planning to conduct them in facilities that do not have active COVID cases but are in areas with cases in the surrounding community or other areas. The objective of this is to ensure that facilities are doing what they can to be prepared to prevent the transmission of COVID in their facilities. What we're learning, what we're seeing in other places, and able to learn from those facilities to share with others as well. And I think that this is going to be really important since things are moving so quickly.

Now, as it relates to enforcement, if it is an IJ, states and CMS will follow their normal process, which includes onsite verification that an IJ has been removed and then the regional office will follow its normal policies and procedures. But if it's a non IJ finding, the facility will still be cited, but we are not conducting revisit surveys at this time.

We want to postpone those enforcement actions. I understand facilities will not have necessarily the opportunity or time to demonstrate compliance. As we progress, we'll communicate additional information, such as how, when normal surveys will resume and other operations.

We're also urging facilities to use a self-assessment tool that was provided with the release. Again, it reflects the latest information from the CDC and we think it will be very handy as you go about looking at your own operations.

We know there are still questions about the guidance, such as scenarios related to visitation. We've been getting some of those questions. We will release a frequently asked questions document in the next few days to provide guidance from the questions that we are hearing.

And we're also going to issue additional waiver documentation. It will be not limited to nursing homes, but for all provider types. I encourage you to look at that document because things that impact the hospital may directly or indirectly impact you as they're looking at alternative sites. So, please pay attention to that when that does come out.

And obviously, we can't address every specific scenario. We are getting some questions along those lines. And try as we might, we will never be able to cover every specific …

Dan Ryngel: Hello. This Dan Ryngel joining.

Jean Moody-Williams: Thank you, Dan. We won't be able to adjust every single scenario, but use the guidance to the best of your ability to figure out how it should occur in a particular situation. And obviously, we're all aware of what we're doing.

Now, lastly, since the President – we talked about the waiver. So, I wanted to remind you of that. And then I wanted to mention – I want to open up for questions and see if you have a couple of those. We'll take a few of those. But as I mentioned, we have some folks from around the country who are

joining us to share a few minutes of what they're doing in their communities and in their nursing facilities that have been found to be successful.

So, operator, let's take a few questions and then we'll turn to some of our speakers and then we'll go back to questions.

Operator: At this time, if you would like to ask a question, please press star and then the number one on your telephone keypad. Again, that's star and then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Jean Moody-Williams: And while we're compiling the roster, I'll ask Kathy Owens, Chief Clinical Officer of Avalon Health Care to share a little with us, please.

Kathy Owens: Oh, sure. Thank you so much and thank you for this opportunity. What we've been asked to share is some of our practices that have set us up to be successful in managing during these very uniquely challenging times.

We, of course, as an organization, many of you have done creative policies, tools, forms. What's been unique about this scenario is being able to be fluid with those and to routinely update them with the very critical guidance that we're getting. And I want to thank CMS and CDC both for the great guidance because it has been very helpful for us to be able to meet this challenge.

We, as a company, developed a progressive management tool and we divided scenarios around COVID-19 into four different components or levels. Then we went through all of the different services that we provide in our facilities and those services differ given our level. If it's COVID in the nation but not in your state, COVID in the county but not close to your facility, or COVID within a certain geographical area, or COVID actually in your facility. And that's been a really helpful tool and it has given us a common language and has also provided quick guidance on what do I do next when I have this new development in my facility.

We also early on did a preparedness checklist and established pandemic committees in all of our facilities. Those have been really very helpful for the facilities to feel prepared to meet this challenge.

Some of our processes around communication, I think, have been exceptionally helpful for us. We're having company-wide calls twice a week that have been very well received, and we take questions, and we're developing our own FAQs as well from that. We sent letters out to families, employees, and the residents, as I know many of you have as well.

We've also been having our Chief Medical Officer, Dr. Sabine von Preyss, hold weekly Medical Director calls, and that has been very helpful and very well attended by our medical directors. That role is so critical with this type of a disease process that we're dealing with. It's just been extremely helpful to have that communication.

Another process is doing daily PPE inventory and we're really holding true to that. I'm just so impressed at how our facilities have mobilized around gathering that level of detail. And then we have incident command calls where we hear what's happening with potential COVID positive cases in our facilities. We also quickly look at what's going on with isolation practices and what is our projected need for PPE and how does our supply meet those needs. And that helps us to stay in communication with our procurement department who has done a phenomenal job with helping us get sources for PPE.

We do not currently have a COVID positive patient in our facilities. We have 45 facilities across six states. But we have had suspected cases. And we have developed the checklist for those suspected cases. So, we go into action when there's a suspected case. Many of you are as well, not waiting until it's presented or confirmed. And that's been really helpful for us, to periodically revisit our practice to make sure that our systems and processes are fully in place.

We also start a copy plan, a four-step copy plan when we have a suspected case in the facility that marches us through, do we have all of our systems in place, and that has been extremely helpful and very calming for the facility teams because they feel confident in what they're providing.

And I'll end with just saying it really takes a village. This has been a partnership and it's a partnership with the facility and our organization. Alan Hash is our CEO and he has just provided great leadership around this as well. We used Pat Preston as a national infection control consultant and he's been invaluable in helping us with our processes. And then I've had a lot of conversations with colleagues that I'm sure are on this call, and we've been sharing best practices across the country.

I want to end with saying that what a privilege it is to be associated with our profession. It's been wonderful to watch how the post-acute long term care profession has mobilized around such a critical issue, and I just really want to thank you for the opportunity to be in this space. So, thank you.

Jean Moody-Williams: Thank you. And we obviously applaud you in using existing tools and new tools and just great to hear that. I want to ask Dr. Noah Marco if he could give us a few words as well. He's from …

Dr. Noah Marco: Oh, it would be my honor and …

Jean Moody-Williams: Let me just say you're Chief Medical Officer from Los Angeles, which of course I know has been really active, Los Angeles Jewish Homes.

Dr. Noah Marco: Yes. I'm very honored to be on this panel of such esteemed colleagues and leaders in our industry. At the Los Angeles Jewish Home, we care for 1,100 seniors who live with us and we have about 3,000 out in the community in our various community-based programs. We are a very complex organization.

And across the organization, we've created an acronym that we follow called, EMPOWER. E stands for we Empowered our infection preventionalists. We told our ITs that they have no other duties but to facilitate disease transmission reduction. We ended secret shoppers for hand washing surveillance and expect everyone to provide immediate coaching to those not practicing ideal hand hygiene.

M in our acronym is Medication reduction. Our pharmacist consultant with our NPs and physicians reviewed our residents' medications and stopped all medications that are not essential in current daily health, things like vitamins,

PPIs, PRN medications that are not recently used, even if cognitive enhancing meds like Memantine, hand-held nebulizers to reduce transmission. We are even trying to change some of our residents from warfarin to direct oral anticoagulants so we can reduce lab draws.

P stands for Prepping for isolation patients. Rooms were created where we literally took out the glass window and installed fans with filters. In these rooms, we used plastic sheeting with zippers to create spaces for PPE donning and doffing. And we're preparing for, god forbid, needing to use isolation wings where we are getting more carts. We're separating medication carts to each wing rather than to each shift. And a plan for separate staff separation was created. And we are constantly ordering more isolation supplies.

O is Only essential visitors. For us, visitors to residents rooms must not only be screened and demonstrate good hand hygiene, but they must be deemed essential on the care plans of our residents. We even added a question to our vendor screening tool, where have you been prior to coming here? So, in case that we hear of a COVID case in another facility in our community, we can help the Department of Public Health track the potential vectors.

We purchased electric palette jacks so that our vendors who are bringing in big supplies, don't have to come into our facilities and our buildings, but our own staff can grab it through these devices.

Our W is, of course, Washing hands technique and we educated that. We put flyers all over the place. And we even created a video of one of our beloved doctors washing her hands to our nurses singing happy birthday.

E, Employment agreements and policies, we boosted existing contracts to fill vacancies if a staff shortage occurs and our H.R. department is constantly reviewing our employee policies, comparing them to the Department of Public Health and CMS recommendations, and modifying them as needed.

And R is that we Repurpose staff since the Adult Day healthcare portion of our PACE program is closed, that staff was shifted over to our nursing facilities to help clean and monitor infection practices. Our staff is facilitating phone calls between our residents and their families. And our PACE

participants, because they're out in the community, are being called daily by our staff just to check in to see how they are doing and provide emotional support.

Jean Moody-Williams: Thank you so much and thank you for that acronym because that's very helpful in remembering what it is we are to do. Operator, can we take a couple of questions, please?

Operator: Yes, we sure can. One moment please. Your first question comes from the line of Kimberly Gimaro.

Kimberly Gimaro: Hi. Our facility is doing many things that were outlined by the previous callers. My question is about the self-assessment tools that were provided through the focused survey. The CDC also issued coronavirus preparations checklists for long-term care settings. And my question is, will either be acceptable if a survey team arrives on site for infection control focus survey?

Jean Moody-Williams: Sure. I think I'll let Evan answer that because he's worked specifically on the tools. I will say that you should see some similarities in the tools. But Evan, do you want to address that, please?

Evan: Sure. And thank you for the question. We worked hand-in-hand with the CDC on our tool and on their tool as well. So, there's a lot of cross over. Surveyors are going to ask for our tool. They're not really going to know to ask for the other tool. But when they're on site, they're still going to do an assessment. They're not just going to take whatever tool they're handed and assume that it's OK, they're still going to do an assessment.

What we're trying to do is to put out the tool so that in the cases that surveyors can't get to, facilities have something that they can be working off to ensure that they're implementing the latest guidance from both CMS and the CDC. So, if facilities are doing the CDC self-assessment, that's fine. When we show up on site, we're still going to probably ask for the CMS tool, but we'll also still do the infection control survey.

Kimberly Gimaro: Thank you.

Jean Moody-Williams: OK. Let's take another question.

Operator: Your next question comes from the line of Tom Sherman. Mr. Sherman, your line is open. Please check to see if your phone is on mute.

Jean Moody-Williams: OK. Next one.

Operator: OK. Your next question comes from Michael Blisco.

Jean Moody-Williams: OK.

Michael Blisco: Hello.

Jean Moody-Williams: Yes. We can hear you.

Michael Blisco: Hi. I was just trying to get clarity because we seem to be getting mixed views and opinions from the various hospitals and the various states that we operate in terms of admissions or readmissions into our facilities where the hospitals, for the most part, are refusing to test patients that have all the textbook signs or symptoms and are insisting that the nursing facilities, at least if it's a readmission, must admit them.

Now, I know that guidance has been provided in terms of isolation and designated rooms, et cetera, but I mean, the exposure and the challenges that we find is that it kind of varies, in terms of the hospitals, in various different states, and insisting, because of their bed problems, that we admit them, and refusing to test the residents.

How do we navigate through that and how can we get a consistent either policy or message across to our hospital partners so that we could work together and not put our vulnerable population at risk, despite all the isolation that we're putting into place?

Jean Moody-Williams: Yes. Absolutely. Thank you for that question. And that is something that we've heard about, the inconsistencies, and we do have a team of our clinicians that are looking to get some guidance out related to getting the patients into facilities or, alternative settings, or even more guidance about if they must be treated in place.

So, we will get that information out as well. We had a provider call yesterday and they expressed concern that they are not able to return patients to nursing homes, that nursing homes are not accepting them back. So, we have to look at both ways and ensure that we are getting patients at the most appropriate place for the care that they need. And I have taken your inquiry and I will make sure that our clinician team that's working on this addresses that.

Michael Blisco: Thank you.

Jean Moody-Williams: Sure. I want to see if Carol Meyer, if you could give us just a few words on some of the things that you're doing.

Carol Meyer: Yes. Hi. I am a nurse consultant with Hampton Hunter and Company (unclear if this is the name of the company.21.45 on the recording) and we have clients all the way across the country and I'm representing Alpacan (this is inaudible. At 21:46 on the recording) as well. But I live in Washington State and the majority of my clients are in California. So, we're kind of in a hot bed of what's going on.

I want to start with Washington. When I worked with Leading Age – and I'm going to tell you about what I'm going to consider best practices learned the hard way because we were the first to deal with this. And one of the main things is we have to be ready. We have to have an isolation plan in place.

And so, you have to look at your facility and figure out where would you put isolation cases if you were required in a case of admission/readmission from the hospital or the community with the symptoms or an actual positive case, how many beds would you have available, and how are you going to staff it, do you have enough equipment, and do you have enough PPEs available, so a plan, a place, and the staff, and equipment.

Number two is the communication plan and I think you heard from the other speakers that this one is really key and the communication plan, if you have a company or facilities that it's between all of your facilities, but you also need to have a communication plan that includes how are you going to notify the Department of Health and the emergency medical services, the EMS, and

hospitals of an outbreak in your facility, and that you do need to notify EMS and the hospital prior to transporting a resident to them.

Number three, order your supplies now. I know a lot of things are back ordered, but back order them, don't wait for a crisis.

Number four, plan for x-ray and lab. In the Kirkland facility, where this all started, 90 percent of the lab techs were affected. And so, it really shutdown all of the testing and lab capabilities. So, talk to your lab about how to limit the lab person who comes in, just not going to be the same one each day so that you don't end up with a situation like that because it's very disruptive of service.

Lack of PPE, of course, was a problem. And the other thing they noticed in Washington is we could kind of map the outbreaks from staff who work in multiple facilities. And so, take a look at your staff and see. I'm sure you probably have quite a number of nurses and CNAs who work in other facilities.

But also think about your therapist and if you have a therapy vendor company, did the therapist work in other facilities as well? Now, we have to keep an eye and do a community surveillance on those facilities and hospice. And so, again, limiting outside people to try to limit the spread, if that would be the case.

Our clients were starting the very first weeks of March to create policies and procedures. They limited non-essential travel, canceled group education, tried to make it all telehealth – not telehealth – but webinars and those kind of ways of education. And they are having calls weekly with each of their facilities and talking about the policies, procedures, what the issues are, and then weekly also having just a call with the consultants and directors of nursing and staff developers or DSVs about the issues and the training and the surveillance and infection preventionist.

We're doing daily surveillance on staff to make sure they are compliant with hand washing and also using PPE correctly. And they do have a form that

they're using for that surveillance. And they're training their nurses on how to do the nasal swabs and the oropharyngeal swabs for testing.

They're also looking at environmental cleaning and keeping a log and a schedule for the environmental cleaning to make sure all of the high touched areas are cleaned and the isolation rooms are particularly staffed with remote access or working from home and they're keeping a log of who is there. Of course, before the shift begins, everyone has their temperature taken and they are asked about symptoms, but we're asking them to report where else they worked. And so, we have a log of all of that.

The administrators are having calls each day to talk about the COVID possible new cases in isolation and communication with hospitals and Department of Health. And every one is watching all the training all the time. They are setting up group text to help with communications between their clinical leaders so that information can be disseminated quickly. And they are sending each facility updates daily by e-mail, trying to not make it white noise, but a one e-mail per day about all of the incoming information, and then they're training on the waivers and also billing, et cetera.

And I think the other part of this is my main purpose is MDF and we're talking about how to get the work done without wasting PPE, if necessary, and talking about working together as a team so that a nurse or a therapist in the room could do the MDF interviews and section changing.

Jean Moody-Williams: Great. That was very comprehensive. Thank you for taking that complete system-wide approach to looking at what's being done, really appreciate that. I see that we are at time. We did have a couple of other people that wanted to present. I'm going to ask their indulgence if they would join us next week, we want to have this call every week and get questions and share best practices, if they would please join us next week and then we can give them the floor.

I know that you may have additional questions, hopefully guidance that will come out of the next couple of days will adjust that. But if not, we will designate a sufficient length of time for questions next week. We knew we

have a big list of questions that we think we're going to be able to answer for you this week already. So, if we don't, next week, we'll take the time to get more of your questions.

So, with that, I want to turn it back to Alina to tell people where to send questions.

Alina Czekai: Terrific. Thank you so much, Jean. And thank you to our speakers and everyone who joined our call this afternoon. We know with handling patients around the country and dealing with these challenges, 30 minutes is a lot of time to take away from your desk. So, we really appreciate it.

If at any point you have questions about COVID-19, you can direct them to one of our public mailboxes and that is 1135waver@cms.hhs.gov. And again, if you maybe received this invitation by forward from a colleague or someone that sent this on to you and you would like to be on this distribution, please feel free to e-mail me and I'll make sure that you get on this distribution. My e-mail address is alina.czekai@cms.hhs.gov.

I'd like to once again thank everyone and hope you all have a great night. Thank you so much.

Operator: Thank you for participating in today's conference call. You may disconnect at this time.

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