Centers for Medicare & Medicaid Services
COVID-19 Call with Nursing Homes
Moderator: Alina Czekai
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Operator: This is Conference #: #3770227

Alina Czekai: Good afternoon, welcome, everyone. Thank you for joining our April 15th CMS COVID-19 Weekly Call with Nursing Homes. We really appreciate you taking time out of your busy schedules to join us today.

I'm Alina Czekai, leading stakeholder engagement on COVID-19 in the office of Administrator Seema Verma here at CMS.

Today, we're also joined by best practices experts in the field, here to share some of their perspectives with you. We also are joined by a colleague at the CDC.

Kicking things off, I'd like to turn it over to Jean Moody-Williams. Jean is our Acting Director here at CMS' Center for Clinical Standards and Quality. Jean, turning it over to you.

Jean Moody-Williams: Great, thank you. And thank you all for joining again. I look forward to these calls each week and we have a jam-packed agenda this week. So I'm just going to jump right in.

And of course, we have issued a number of Blanket Waivers over the past several weeks, I've walked through most of those with you. Last Thursday, we announced new Blanket Waivers in addition to those previously released that are in effect due to the public health emergency.

Several of which impact this group directly, and really, they're intended to boost frontline medical staff and organize them in a way that's going to help you as you continue to handle all the work that's involved with handling the

COVID-19 crisis. Within skilled nursing facilities and nursing facilities, we've provided relief related to the provision of physician services.

We are waiving the requirement to allow physicians to delegate certain visits to physician assistants, nurse practitioners or clinical nurse specialists, who meet their applicable licensing and scope of practice by the state law, so that they are able to, in fact, provide these services. And this will allow us to surmise the use of the workforce in long term care facilities.

But I do want to note, however, that we are temporarily modifying this regulation to specify that any task delegated under this waiver must continue under the supervision of the physician as required. So please keep that in mind.

And previously, we waived this, the requirement that all required physician visits must be made in person by the physician or the delegated practitioner, and under the waiver these visits can be conducted via tele-health.

So looking at how you combine these different waivers to really be able to provide coverage for all the work that you're doing, that's the intent of these actions and recognizing, again, thanking you for trying to be creative to really meet a growing demand.

Aside from our newest waivers, I wanted to call your attention to some guidance that we released a few days ago. And this is a response to numerous questions on transferring and discharging residents between facilities for the purpose of cohorting residents based on their COVID-19 status. We noted within the guidance that in general, if two or more certified long term care facilities were to transfer or discharge residents between themselves for the purposes of cohorting, they do not need additional approval to do so, they can just go ahead and do that.

If, however, the certified long term care facility would like to transfer or discharge residents to a non-certified location for the purposes of cohorting, they will need approval from the state agency to do that.

To assist you in making the proper decisions, because we realize this is complex about when you can do this and when you can do something else, as it relates to transfers and discharges, we've created a helpful set of diagrams. Many times if you can see things visually, it helps with some of the complexities.

And it really just walks you through the process. The guidance and the diagrams can be found on the CMS emergency page as well as on our survey and certification page. So if you haven't seen that, I ask you to take a look at it and then also please share it with those that are in the decision-making business around this.

So we're eager to hear your feedback as well on these new workforce waivers for the long-term care setting as well as seeing if the clarification that we've provided is helpful for transferring.

And at this time, I want to turn to one of our partners. All guidance that we're putting out during this time has information about something to do with infection control and prevention. And so we work hand in hand with the CDC on all of this.

I'd like to turn to Nimalie Stone from the Centers for Disease Control and Prevention to share some of the experiences that they have observed in nursing homes as they respond to the outbreak.

So Nimalie, I'll turn it right to you.

Nimalie Stone: Terrific. Thank you so much, Jean, and thanks to all of you for this opportunity to join the call today and share some updates on the work that CDC is doing to support long term care providers and their COVID-19 preparedness and response activities.

Since this is my first time meeting with the group, let me briefly provide an overview of how the CDC long term care team intersects with our larger public health COVID response.

Our team is part of the Division of Healthcare Quality Promotions and we are the group that leads the development of guidance, educational resources and implementation tools for infection prevention and outbreak response programs in nursing homes and other long-term care settings.

Given the incredible impact that COVID-19 has had in long-term care, causing large numbers of infections in both healthcare personnel and residents, there are a tremendous number of activities underway to help strengthen health departments, providers and community responses.

So this afternoon, I'm going to describe sort of three large categories of our long-term care work, much of which has been in collaboration with CMS, as well as our state and local public health programs. And we are informed often by our nursing home and assisted living provider partners as well.

I'm hoping the next time we talk, I'll be able to share some specific examples of lessons learned, successful prevention efforts and continue to provide updates on the other work in these areas.

So the first category of activities is the development of COVID-19 prevention and response guidance along with training resources for long-term care providers and staff.

Just today, I want to make you aware that we have posted new updates with the nursing home infection prevention guidance that is addressing new challenges that we are identifying in real time as we gain more experience with COVID prevention. Such as, for example, the role of individuals, both staff and residents, who can be infected with COVID-19 but show minimal to no symptoms of illness.

So the updated guidance is promoting universal source control by having everyone entering a center wear either a cloth face covering or a face mask. And many of you may already be doing this as part of your own strategies to reduce the risk for infected individuals to spread virus.

The next category of activities is focused on conducting assessments and advising providers on ways to strengthen or expand the implementation of

their COVID-19 prevention work. Some communities where COVID-19 cases have not yet been detected still have an opportunity to review their prevention strategies, such as screening all healthcare personnel with temperature checks and ensuring that these are being performed and documented consistently.

We're working closely with state and local health departments to support their outreach to long-term care facilities and provide refreshers on basic infection prevention practices, such as hand hygiene and donning and doffing personal protective equipment, which we know are still sort of the foundations, as all of our efforts to prevent the spread of infection.

And third, our teams are working with facilities and health departments across the country to identify innovative approaches to guiding COVID-19 response, such as the use of testing to inform ways that residents and staff can be cohorted based on COVID infection or exposure.

These efforts have also included working with nursing home providers and local health departments to identify volunteers who are willing to work with public health to become designated COVID care units that will serve as a resource for continued care of patients recovering from COVID infection in the hospital when they're ready to be discharged.

So I know I covered a lot and I'm going to pause and just thank you all for your time and for the hard work and efforts you are all making to keep your residents, families and healthcare teams safe. Thank you, Jean.

Jean Moody-Williams: Thank you, Nimalie. And we will have a few minutes for questions at the end. Just a reminder that we're reserving our technical questions about labor and those kinds of things for our office hours which we have on Tuesdays and Thursdays. We have all of our SMEs available, Subject Matter Experts available on that call, and we have some available on this call as well for your questions.

But I would first like to go and say it's my pleasure to introduce two special guests who are going to share some best practices or experiences that they're having in the community.

First is Michelle Hart Carlson, the Administrator at Oak Trace which is a Lifespace Community. So let me just turn to you, Michelle.

Michelle Hart Carlson: Good afternoon to everybody. I would also like to thank everyone for providing the extraordinary care to our residents across the country during this difficult time.

We have found some winning strategies that we're happy to share today. One of the first things that we knew would be very important in maintaining the trust of our residents, team members and family members would be communication. So we found creative ways to quickly and accurately communicate to those folks.

For our team members, we utilize an email system which we're able to send out email blasts to inform team members of guidance changes and also to provide some inspirational, upbeat messaging.

Communication with our residents, the initial COVID information, education was completed in person by our IP nurse. She also provided flyers detailing the conversation that the residents could review.

We've also assigned a team member in the health center to specific residents. So when we need to get information out quickly, the team member's inform their assigned resident as well as their family member with a personal call.

Communication with family members has been critical. We utilize an email system in the same way we do reach out to our team members, where we're able to send email blasts. We send them updates, as guidance changes are made, and then we send a weekly general update to the health center family members.

Our Executive Director, sends to all levels of living, a video and uploads it in our in-house television. Those daily messages have seemed to calm our residents.

At our home office, our Senior Vice President of Successful Aging hosts calls twice a week where we're able to share best practices throughout our 15 communities which is in eight states. If you're not part of a chain, you could definitely band together with your local nursing homes and set up weekly calls to share the same.

Our Medical Director has recorded a video message for our residents and team members, reassuring them and also dispelling any myths that might be out there.

Education definitely has been a big part of COVID-19. We found having one-to-one and small groups works best, it allows for social distancing and we have also seen that it alleviates the fear of asking questions in a larger group.

We provide frequent education regarding guidance from the Illinois Department of Public Health, CMS and CDC to our team members and we're able to continue to hold their trust and alleviate their fears.

We provide a support and fact finding small group called, #OakTraceStrong, #GetTheVax. We've added 6 feet space reminders on our floor to help people maintain social distance when they're entering the communities, particularly at peak times when team members are coming in to work.

Our residents, of course, are mostly in their rooms, so we have an in-house television program that we've turned basically into our own TV station. We have programming available from 8:15 a.m. to 7:30 p.m. We have shows such as exercise classes, laughter therapy, sing-alongs, line dancing and joke of the day to name a few. We also have videos of team members and residents sending uplifting messages to each other.

As most of us, we continue to see success with our patio chats, chats through the glass window and FaceTime and Skype.

And last, certainly not least, our team member appreciation. We have established casual days in which team members can wear casual or fun scrubs. And food is always a hit, so we do spontaneous food fun, grabbing donuts in

the morning, deciding to provide fast food for lunch, pizza on the weekend, all while supporting local businesses that's been hit by COVID-19.

As for PPE, our home offices continue to help source larger number of PPE but we have found that by ordering small numbers more frequently, we tend to see those get shipped.

I just want to thank everybody for the opportunity to share some of our wins.

Jean Moody-Williams: Thank you so much for all that information and the television station sounds quite interesting with the joke of the day, we should try that.

I'd like to turn now to Liz Weingast who is the Vice President of Clinical Excellence at The New Jewish Home in New York. Liz?

Liz Weingast: Hi, yes, thanks for having me. I thought I'd share this opportunity since speaking from the epicenter here in New York to let you know about some of the clinical challenges we've had and how we've addressed them. In hopes that it can help others who have yet to contend with this to be best prepared.

My first word of advice is that cohorting residents who do have COVID-19 or suspected COVID-19 is very successful. It has reduced our drain on PPE because you can continue to wear, for example, in a fully COVID unit, you can wear the same gown in and out of other patient's rooms, you don't have to change your mask. And so it is a way to extend the uses of PPE.

A warning about cohorting is that it also is a big drain on the staff who need to do the moves, clean the rooms and so forth. So you do need to ensure that you have the proper support staff in place to make that happen.

A few other items, one is providing a consistent level of care, seven days a week. I know we all do that when we think about nursing care but with COVID in the building, these residents become quite ill and so what we've found is we've spread our medical staff and our administrative staff across seven days a week. We've kind of gotten rid of the concept of the weekend during the crisis and it is extraordinarily helpful in communicating with

families, really giving the best clinical care and, you know, supporting the nursing team who are the ones who are here always seven days a week.

Another aspect which you won't find in your emergency management plan but I think we should all start to build in, is the importance of advanced directive discussions. We found that having these conversations early on, either in the illness or prior to the illness, has been extraordinarily important in supporting the residents who have acquired the COVID illness.

Understanding whether resident's goals of care include, "Do Not Resuscitate", "Do Not Intubate", "Do Not Hospitalize", has really helped guide how we treat our patients. How we help those who do enter an end of life situation and do end up dying with us and help others who would prefer more aggressive care, going to the hospital. Those are extraordinarily important conversations to have and need to be integrated into your planning.

There's a couple other issues, one is supplies in general. I know we're all somewhat obsessed with PPE but I would also warn you that the more COVID residents you do have in your buildings, you're going to be using more oxygen, so working with your vendor on that to make sure there's plenty of supply.

And lots of IV fluids as well, those who become ill with the disease tend to lose their appetite, become more somnolent, not interested in eating and the IV fluids have helped them through that acute period of time. So you may find that you will need more IV fluids on hand and want to talk to your distributors about that.

We found great support in ensuring we had expert advice in advance and somebody who we could call on in a pinch, we used our local hospital epidemiologist as that person. So the real question you might want to ask yourself is, who is your medical director and your infection preventionist? Who are they calling? And who are they depending on for guidance?

Of course, CMS is putting out guidance along with the CDC in every state. But sometimes you need a local person to bounce ideas and thoughts off of.

And so I would just encourage you to kind of figure out who that person might be in advance of any problems.

And finally, of course workforce is extraordinarily important. A system for addressing sick calls, we've actually beefed up a whole occupational health program having several nurses calling our sick employees, encouraging them to seek appropriate care but also to get back to work in a timely manner when their period of illness is done. And we have found that we've needed a significant support from the agency or other staffing routes to back up the staff who are sick.

So it was really the same timeline as our residents started getting sick, our staff started getting sick. So that's something you'd want to certainly plan in advance for.

Those are my pearls of wisdom from here in New York and I hope they are helpful.

Jean Moody-Williams: Thank you so much, Liz. I think that you can hear from both of our speakers a consistent theme, but certainly the importance of communication, involving the staff, finding new and different ways to do that and keeping the residents engaged in this critical time is important. As well as the planning, thinking ahead, advanced directives, et cetera, is critical. So thank you for highlighting those for us.

And Operator, I'd like to open up the lines for questions, please, for either CMS, CDC or our guests.

Operator: Thank you, Ma'am. As a reminder, to ask a question you will need to press "star" "1" on your telephone. To withdraw your question, press the "pound" key. Please standby while we compile the Q&A roster.

Our first question is from the line of Stacey Bryan from the Missouri Department. Please ask your question.

Stacey Bryan: Yes, I was wondering for the homes that are bringing people in and they're keeping them in quarantine for 14 days before they allowed them to be with

the other residents. If they end up not having the COVID-19 or no symptoms of it right now, the RAI Manual states to code isolation on the MDS, they have to have an active infection. But is there a consideration for this special circumstance that it can be coded as isolation even if they end up finding afterwards that they don't actually have the infection?

Evan Shulman: Hi, this is Evan Shulman. Do we have anyone, unless you already have someone from our Center for Medicare on to answer that. But we are happy to take that question and get you an answer and also we're working on some frequently asked questions for some of those technical questions, just like the one you just asked.

Stacey Bryan: And then the other question about coding isolation would also be for, there was an expert that said that cohorting of the positive confirmed COVID-19 cases was being very successful. So I was wondering for homes that are doing that, one of the requirements to code isolation on the MDS is that the resident has to be in the room alone.

So if you could take that into consideration for this special circumstance, if they're cohorting COVID positive patients, if they could also code isolation on the MDS. Has anyone – has there been any exception for that for this circumstance?

Evan Shulman: Again, I know that we're working on some, getting some information out about some of those specifics and sorry, we don't have it out yet but we're working as fast as we can to get it out.

Stacey Bryan: OK, thank you.

Jean Moody-Williams: OK, thank you, we'll take another question, please.

Operator: We have our next question from the line of Mark McDavid. Your line is now open.

Mark McDavid: Thank you so much. This is Mark McDavid with Seagrove Rehab Partners. Just had a question about therapy staff performing custodial services as it relates to the PBJ. You know, as we've had nursing staff attrition with CNAs

and such. Some of our therapists have essentially been drafted to help with ADLs and passing trays and those kinds of things. And we're definitely happy to do that, we just want to know if anybody on the line can tell us about how to code that time on the PBJ, does that stay as therapy time or do we remove that time or where does it go?

Evan Shulman: All right, thanks for the question and appreciate you continuing to work on the PBJ reporting. It's really important if you can. It is one of the things that is part of our Blanket Waivers, so I just want to make sure that everyone is aware of that. But we definitely, if you can report it, it would be great.

I'd ask you to look in the PBJ manual to see, we have some examples and there's also an FAQ on the PBJ website that can – that speaks a little to what the person's primary role is, is typically what they should be coded as. However …

Mark McDavid: OK.

Evan Shulman: … for those types of questions, please send them to NHStaffing@cms.hhs.gov and we'll be happy to respond to those individually as well.

Mark McDavid: OK, thank you.

Jean Moody-Williams: Thanks. I think we have time for one more question, please.

Operator: Yes, Ma'am. Next question is from the line of Jo No from Health Systems. Your line is now open. Again, Jo No, your line is now open. Ms. Jo No, you might be on mute.

Alina Czekai: Operator, we'll take our next question, please.

Operator: OK, thank you, Ma'am. Next question is from the line of Kim Cox. Your line is now open.

Kim Cox: Yes, thank you. I was wondering if the suspension of enforcement actions is being extended beyond the three-week timeframe that was indicated in the CMS memo during the prioritization period?

Jean Moody-Williams: Go ahead, Evan.

Evan Shulman: Sure.

Jean Moody-Williams: This is, Evan.

Evan Shulman: OK, sorry. So yes, we are working on broader information about that, but right now we have instructed that agencies continue with the same process that we outlined in that memo and CMS locations. Because of the current conditions, we have not resumed operations as normal so those conditions are still in effect. And we will be – and it will be in effect until we communicate anything differently.

Kim Cox: Yes, thank you.

Jean Moody-Williams: Thanks, Evan. I was going to say the same. When we noted in there, we said at least three weeks because we knew that this was an evolving situation that would warrant us checking back in periodically.

So thank you all again for joining this call. For some of the more specific questions, join us on Thursday for the Office Hours and you can even send questions in ahead of time. I'll turn to Alina to see if there's anything else.

Alina Czekai: Great, thanks, Jean. And thanks everyone for joining our call today. As Jean mentioned, we hope you will join us tomorrow for our COVID-19 Office Hours, that's at 5 p.m. Eastern and we will have technical Q&A with our CMS subject matter experts. And in the mean time, you're welcome to direct questions to our COVID-19 mailbox, which is COVID-19@cms.hhs.gov. Again, we really appreciate all that you are doing for nursing home residents and their families around the country as we address COVID-19 as a nation.

This concludes today's call, have a nice evening.

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