

Centers for Medicare & Medicaid Services

National Nursing Home Stakeholder Call

July 13, 2022

03:00 PM - 04:00 PM EST

Recording: <https://cms.zoomgov.com/rec/share/CgPrGVLXz9a4Su1JkCvDX0Eiq6LHmo9eakcfzBcEAWDAgEEbqSFkI2ffUcs71MzH.XohW8w4Whxj13MUf>

Passcode: *3Hv&53X

Jean Moody-Williams: Good afternoon. I still see people joining. We'll get started in just a few seconds here. Ok. I think it is slowing down a bit. Thank you for joining the call today. I'm the deputy director for the Center for clinical standards and quality, and I appreciate you joining us. Before we get started, I want to share some housekeeping items -- I want to share some housekeeping items. The webinar is being recorded, it will be posted to the podcast page. All participants have been muted, although you will have the ability to ask questions in the Q&A section. And, we encourage that. Put your questions in at any time and we will be looking at those throughout the course of this event. Closed captioning is available via the link in the closed caption window. You should see that at the bottom of your screen. Members of the press may be on the call today, however all press related questions that be submitted to the CMS media inquiry form. And I believe you know where to find that at [CMS.gov/newsroom/media-inquiries](https://www.cms.gov/newsroom/media-inquiries). As always, I am thankful for the time you are taking to join these calls, and your continued commitment to really caring for the nation's disabled population, our elderly population, all of those in our long-term care system. Now, as you know, at the beginning of the pandemic CMS issued an unprecedented array of temporary regulatory waivers and flexibilities, either through the waiver process or emergency rule making, really working to ensure that the health-care system had the capacity to effectively manage the surges we were seeing. Now we are working to thoughtfully reinstate certain regulations that exist, and they exist for the health and safety of our nursing home residents, that is why they were put into place in the beginning. And we put those flexibilities in to ensure that they continued to get their care during uncertain times, in a time when the flexibilities were needed. But we are looking, and giving thought to, and we have received a number of comments along the way, which we always solicit. And summer asking that we speed things -- some are asking that we speed things up so we can return back to, let's say the pre-COVID state, although I do not think it would be a return necessarily back to that state, but that we will move forward. We have been asked to reinstate regulations and we probably see just as many asking that we slow it down given the staffing concerns and situations that continue to exist in our country. What we have to do is think about this. While some flexibilities have already ended, we are working to find the right balance. And the residents, families, and caregivers are always at the center of our thinking and thought process. I do not have any information for you to on when and how the PHE will end, but I can assure you as I did in prior calls, that we are committed to preparing our system for operation at such a time when it does end, so we can continue to solicit your comments. We have working groups here at CMS thinking about each and every decision that needs to be made. As you probably know, on June 29, we released a large set of new guidance for nursing homes. Soon after that, we announced the methodology for integrating and

stacking measures into are five-star quality rating system. That is what we plan to spend time on today. We will, go through those changes take time -- we will go through those changes, take time to answer questions. But before that, I want to make note of the fact that this past March, President Biden put forward a national strategy to really tackle the country's mental health crisis. On June 16, 2022, in just a few days from now, our partners at the substance abuse and mental health services administration, working with the federal communications commission and the Department of Veterans Affairs, will transition suicide and crisis lifeline using the 988-dialing code. It is important that this get out throughout the country because it will become the universal telephone number for America's suicide prevention and mental health crisis hotline. It will replace the 1-800 number. So, just like in the community, nursing home residents suffer depression, contemplate or complete suicide, so it is important that you have this information and know that there is a toolkit with key messages, media and other materials on the suicide and crisis lifeline that we want to encourage you to make available. Please, let your staff know that the number is available. You can find that on the website. And, I believe we also have representatives on the call, so if you have questions, put them into the Q&A, and we will take the time to address those as well. Or refer them, if we do not have the answers. As we get started with today's agenda, before we get to turning to walking through the guidance, I want to get some updates to you from our colleagues at the CDC, particularly on the enhanced barrier recommendation updates. It is always my pleasure to turn it over to Kara and Heather to provide updates.

Kara: it is always our pleasure to have the opportunity to join you today. We appreciate this chance to provide updates to you. And as wasn't shared, the updates I want to share today are not specific to COVID-19, these are actually updates to the guidance that preexisted the pandemic, guidance that came out in 2019 that introduced enhanced barrier precautions. Today, I want to run through some slides with you to talk a little bit more, for those who are not yet familiar with enhanced barrier precautions, what is. And for those who are, the changes that we have just updated, as of yesterday, to the website. So, I want to let you know that these slides are available currently online. We have them together with a script you can use to share this information with others. Let me share that. Are you able to see my slides? Ok. It sounds like you are.

Jean: we see the slides.

Kara: I am just making sure you are seeing the presented slides here. The actual slide itself.

Jean Moody-Williams: yes.

Kara: perfect. Ok, the presentation, or through this presentation I want to introduce you to enhanced barrier precautions. Apologies for the delay. I think it should be moving through now. So, quickly I want to touch upon terminology. An MDRO, multi-drug-resistant organisms, these are germs like bacteria or fungi resistant to multiple different antibiotics or antimicrobials. This would be things like carboplatin, those that are resistant, and MRSA. Some have been referred to as nightmare bacteria. When these infections develop, or infections develop from these germs, they can be difficult to treat. This is one of the reasons we talk about these. When we talk about colonization, that is germs on the body or in the body but are not at the time causing infection. The presentation will walk through

the impact and burden of multi-drug-resistant organisms in nursing homes, they need for enhanced barrier precautions, referred to as EBP, indications and use for EBP, and how to successfully implement EBP. What we have learned from outbreaks, from studies and investigations, is many nursing home residents or unknowingly: Eyes to with an MDRO. And this is especially for those who have risk factors for colonization, like indwelling medical devices or wounds. Those who were colonized are at risk of developing a serious infection, such as a bloodstream infection, and they can remain colonized for a long time. The germs can also spread to other residents through the contaminated hands and clothing of health care personnel. So, in this slide, we are trying to help visualize how common MDROs are. This shows data from a study conducted in nursing homes. Including a subset of nursing homes, we referred to as ventilator capable nursing homes, those that provide care to ventilator dependent residents. In this middle column, these are percentages of residents who had documentation in their medical records of the presence of an MDRO colonization or infection. It is about two out of every 10 across nursing homes. We already know that they have a multidrug-resistant organism. During the study, they were tested to see if they were colonized with an MDRO, so the last column in red shows the percentages of residents who had an MDRO after testing was complete. As you can see, and those that did not provide ventilator care, almost six out of every 10 residents were found to have an MDRO. In the ventilator capable nursing homes, that number went up. So, if you're nursing home care is for those of ventilators, and you have about 100 residents, this is saying that there could be as many of 80 of those 100 who are: Eyes. -- colonized. This data shows that there are many nursing home residents who are colonized with MDROs, and we are not aware of most of them. The numbers are higher in those that take care of the most complex residents, such as those on ventilators. So, this is a method that has been used for those who are actively infected with an MDRO, they may be treated with antibiotics for the infection. It requires the use of gowns and gloves upon each entry into a room. The recommendation is for that resident to be placed in a single room and for them to be restricted from group activities, isolated to their room except for medically necessary care. However, as we showed, far as I showed with the study, the problem with MDROs is larger, so focusing only on interventions that -- focusing only on interventions for those with an active infection is not sufficient. Further contact precautions is very restrictive, especially when you are putting it into place for prolonged periods. We also know that doing so can have negative consequences. So, there is a need for an intervention to reduce the spread of multi-drug-resistant organisms that does not require isolating residents for long periods, but that also considers at the extent of the duration that residents can remain colonized. So EBP is a method for reducing the spread, while also reducing the isolation of residents, by using a gown and gloves to prevent contamination of the health care personnel, their hands and clothing, during activities that have been demonstrated to be the highest risk for transfer of MDROs to the hands and clothing of health care personnel. EBPs are indicated for those who have an infection or known colonization when contact precautions do not otherwise applied. There are situations where contact precautions should be used, like when somebody has acute diarrhea, draining wounds, or secretions at that cannot be covered or contained. And may also be used for a limited time during the investigation of a suspected or confirmed MDRO outbreak, in consultation with public health. Additionally, EBP are indicated for those who have wounds or indwelling mega little -- medical devices, because they are at risk of being colonized. While prior guidance focused on MDRO outbreaks, limited areas in a nursing home that were experiencing an outbreak, EBP is no longer limited to outbreaks or specific MDROs, and it should be applied broadly to those who meet the criteria on this slide. Specifically, EBP involves the use of a gown and gloves

during high contact resident care activities. This includes dressing, bathing, showering, performing transfers, changing linens, providing hygiene, assisting with toileting, care of an indwelling medical device like a central line, catheter, feeding tube, as well as when performing wound care on any skin opening that requires addressing -- a dressing. A private room is not required for EBP come and residents can continue to participate in group activities. They are not restricted to their rooms. It is different than contact precautions. This recommendation is intended to be used for the resident's entire length of stay, or until those devices are removed or the wounds have resolved. Then, additionally for enhanced barrier precautions to be successful, the use of EBP must be incorporated with the other infection prevention practices that you are performing, including hand hygiene, environmental cleaning, and appropriate use of PPE, as well as communication about the residents who have an MDRO, can your facility and outside of your facility -- in your facility and outside of your facility. Here we have links to the current guidance and we strongly encourage you to look at this, as well as a link to frequently asked questions about EBP. We have numerous resources that we have made available, including this presentation itself. As well as, a letter to residents themselves, families, friends and nursing home staff. With that I will say thank you. And I have Heather Jones on the line as well, who is able to help answer questions, so feel free to submit them and we will look through and try to address them as best we can. Apologies for technical difficulties. Thank you so much for the opportunity to share. And we are happy to continue to answer questions as you all learn about this. Thank you so much.

Jean Moody-Williams: Thank you. I do see a question already in the chat regarding the presentation. And I think that Heather is working to address it. So, I want to shift us into some CMS updates. First, we will talk about the five-star measure update, then we will walk through the revised guidance. We'll wrapped the updates up with words about the nursing home staff study, and then we will save time for addressing questions and answers. So, I will go to Evan, I think you are going to start is with the five-star measures?

Evan Shulman: Good afternoon. We will have folks go over the changes that Jean Moody-Williams mentioned, so I will turn it over to Danielle now, to go over highlights.

Danielle Barr: Great, thank you. As mentioned previously, we recently announced the methodology for integrating new staffing measures into the nursing home care compare five-star quality rating system. As most of you know, we have been posting staffing information on nursing home care compare for several years. In January, we began posting new measures, weekend nurse staffing and staff turnover. At that time, we also announced we would be integrating the use into the five-star rating system in July. So, effective with the July 2022 refresh, the staffing star rating will be based on six separate staffing measures, so in addition to the existing measures of registered nurse and a total nurse hour, the new staffing methodology will include total nurse hours on weekends, total nurse turnover within a given year, registered nurse turnover within a given year, and the number of administrators who have left the facility within the given year. So, the updated staffing rating methodology is described in the five-star technical user guide, but I will give a brief summary. Similar to how the quality measures are calculated, we are now using points to calculate the staffing rating. A facility receives points based on their performance on each measure, then the points are totaled and compared to thresholds for each star rating. The user guide lists

specific numbers of points available for each measure, you'll see that there are more points assigned to staffing level measures than turnover measures. This is because of the more well-established relationship between staffing level and quality. After the points are calculated for each facility, we use staffing star rating thresholds to determine the star rating. And similar to the staffing threshold methodology implemented in April of 2019, the five-star rating threshold is based on staffing levels of nursing homes with high performance on quality measures. The remaining thresholds are assigned to produce four equally sized groups to identify the thresholds from one to four stars. Rating thresholds are set based on this distribution, but they remained static over time and it allows facilities to demonstrate improvement by giving a static target. Also, adding the staff turnover measure helps provide another avenue that facilities can use to improve their staffing rating, besides just the staffing levels. So, in addition to adding the weekend staffing and staff turnover measures to the system, we are also no longer adding one star to the overall rating of facilities that have a four-star staffing rating, only those with a five-star staffing rating will get an increase in their overall star rating. So, as expected, these updates will cause changes in facility staffing and overall star ratings. As I mentioned, the detailed methodology, including the measure specifications, is included in the five-star technical user guide. And facilities will also receive a preview of their ratings in their July provider preview report. The provider preview report also includes guidance on where facilities can direct questions, if needed. So that sums up the five-star measure updates. I will pass it to my colleague, Deb Lyons, to cover the revised long-term care surveyor guidance.

Jean: There are a lot of questions coming in, some asking if it is a new regulation. It's not a new regulation, we are providing this information to you and we are capturing -- there's a lot of questions-- so we are capturing that and I am sure we can work with the CDC to get your follow up responses.

Deb Lyons: Hi, everyone. On June 29, as mentioned, CMS issued QSO memo, 2219-MH, releasing a long body of surveyor guidance, which supports the implementation of the revised long-term care requirements for participation, published in 2016. It clarifies regulatory requirements and provides information on how compliance can be assessed. In addition, CMS is revising guidance to state agencies to strengthen the management of complaints and facility reported incidents. These will be incorporated into the long-term care survey, and will begin to be surveyed on October 24 2022. This advanced release allows of surveyors and nursing home providers to review the training and become familiar with the changes. Our team will share some of the significant changes in this release. And we will start now.

Enrico Lachica: The first topic is abuse, neglect and changes to chapter five in the state operations manual. We have clarified expectations for compliance, abuse reporting, including a sample of templates, and providing examples of abuse that, because of the action itself, would be assigned a certain severity level. We streamlined the guidance by removing one F tag for abuse reporting and combining information from of the root boost of reporting -- abuse reporting. We deleted 608 and integrated it into 607 and 609. For F607, we added policies and procedures related to the allegations of retaliation by the facility against the covered individual. For F609 we added policies and procedures related to the reporting of crime. And we added a table of examples of reporting abuse allegations or suspicion of crimes. CMS revised guidance in Chapter five related to the state operations manual, to strengthen the oversight of nursing homes complaints and facility reported incidents. We revised the

time frames for investigation of complaints to ensure that serious threats to residents were investigated immediately. And CMS will work with states on the implementation of it. We also revised guidance for all Medicare certified providers and provider types, to improve consistency across the state agencies and communication to complete. The next area is admission and discharge. Here we clarified requirements for facility-initiated discharges, added guidance related to leaving against medical advice to ensure facilities to not pressure or intimidate residents from leaving. Clarified a facility's requirements when a resident Medicare coverage may be ending, but the resident continues to need long-term care services. And provided new guidance for when the facility alleges it cannot meet the resident's needs and has not allow the resident to return from a hospitalization to ensure an appropriate discharge is not occurring. Next, we will send it over to my colleague, Christine, to continue.

Christine Teague: Next, we would like to talk and highlight the changes in the mental health and substance use disorder revised areas in appendix PP which addresses residents' rights and behavior health services for individuals with mental health needs and substance use disorder. We added guidance to help facilities address potential substance use issues while adhering to resident right and any guidance to address supervision of residence, you may leave this facility and use illicit substances. In regard to nurse staffing and payroll-based journal, we revised guidance using payroll-based staffing data to trigger deeper investigations and added examples of non-compliance with CMS nurse staffing requirements. For resident rights, we imported guidance related to visitation for memos issued related COVID 19 that enabled maximum visitation

To address concerns of potentially inaccurate diagnosis or assessment, we clarified expectations in situations where practitioners or facilities may have inaccurately diagnosed or coated a resident with schizophrenia in the resident assessment instrument. Under pharmacy services, you will see new guidance clarifying the requirements pertaining to psyche a psychotropic medication. Also applied to medications not classified as anti-psychotic anti-depressant anti-anxiety or hypnotic medications but can affect brain activity, such as anti-convulsive medications used to treat seizures and other disorders. Under infection control, facilities are now required to have an infection, preventionist at least part time. The IP role is critical, the mitigating infectious diseases throughout an effective infection Prevention and Control Program. While the requirement is to have an infection preventionist is at least part time the infection, prevention is must meet the needs of this facility. This may even more the use of an infection, preventionist is full time CMS and the CDC have collaborated to create free specialized training for infection preventionist, which is available on the CDC nursing home website.

Rufina Tu: Arbitration requirements went into effect on September 16, 2019. The new guidance clarifies the residents may be offered agreement but cannot be required to sign as a condition of admissions. We update it to clarify the applications of the reasonable person concept and severity levels for deficiency Including how to determine the severity of the outcome. -- and physical environment are considered misguided. You should know that CMS Miranda 2019 included recommendations related to resident's room capacity. There are no new regulations related to resident's room capacity. However, CMS is highlighting the benefits of reducing the number of residents in each room, even the lessons learned during the COVID-19 pandemic. For preventing infections and the importance of resident's rights to privacy and a homelike environment. Training is now available on [QSEP](#) which further explains that regulations and interpretive guidance. Thank you and let me pass it to Pauline Martin.

Pauline Karikari-Martin: I am here to provide a brief update on the nurse staffing study. As we all remember, in February 2022, the president announced a comprehensive set of preforms aimed at improving the safety and quality of care within the nation's nursing homes so that seniors, people with disabilities, and others living in nursing homes receive the safest possible high-quality care that they deserve. One key initiative ensures every nursing home provides a sufficient number of staff who are adequately trained to provide high-quality care. To achieve this objective, the Centers for Medicare and Medicaid services intends to propose minimum staffing requirements that nursing homes must meet. It is important to note that the Centers for Medicare and Medicaid services is using a multifaceted approach to propose minimum staffing requirements. We initially published a request for information on minimum staffing requirements in April of this year. We received over 3000 comments specific to minimum staffing requirements, which were valuable. We thank everyone who submitted comments. We continue to review carefully all comments which are being used to inform our research study design and to draft a proposal of minimum staffing requirements in nursing homes for 2023. Our second approach is to conduct a new mixed method research study. To ensure that residents receive safe and quality care in Medicare and Medicaid certified nursing homes. While we are still working on the final methodology for the study, we can say that together the quantitative and qualitative analysis will ensure we have comprehensive research findings to inform our draft proposal minimum staffing requirement in nursing homes in 2023. In addition to reviewing comments received and conducting a new research, CMS will consider input from stakeholder listening sessions which will be held in August of this year. This will be used to inform our research study design and to draft a proposal of minimum staffing requirements in nursing homes for 2023. This an incredibly important body of work which will help to ensure nursing home residents are receiving safe and quality care that they need. We know that everyone listening to today's call has diverse experience and expertise. And as such, we encourage you to provide additional feedback on aspects we should consider or any evidence you may have that could be useful in informing our overall approach. Additionally, we hope you would spread the word that CMS is eagerly engaging to give first-time experience and you all are engaged as possible. At this time, I will turn it over to Evan.

Jean Moody-Williams: thanks, Pauline. Before we go to Evan, we will go back to the top. We have a lot of questions about masking. I'm going to go back to CDC for just a minute to see if you can say anything about that. And then we will come back to the CMS updates. Kara?

Kara Jacobs Slifka: I am trying to work with the camera on this computer that is not cooperating at the moment. I know there are a lot of questions and concerns related to masking and will there be changes coming in the future. When might be considered rolling back some of the recommendations we have. We have had questions that have come to us asking about differences being observed across different health care settings and how this applies to nursing homes specifically. What I can tell you at this point is that we hear you. We have been working on updates pending for a bit that will move our recommendations where we are trying to go with this pandemic at this point. This is long-lasting but we need to consider where we are at in terms of what community transmission and what infections and vaccination status, taking all of these things into account. At this time, our guidance has not changed as of today. Our guidance is really, we make the same guidance in terms of masking across health-care systems. Whether it is an acute health care system, a long-term health care system, a nursing home. At this time, guidance focuses on source control being important, especially in-patient care

areas. There will be some changes coming in the near future. That is what I can share this point. Thanks.

Jean Moody-Williams: thank you, Kara, there were so many. I thought we needed to circle back. Evan, now back to you.

Evan Shulman: there have been a number of questions coming in on the track -- on the chat. One is about the changes to the staffing rating measures. Questions coming in are like, why now? Why make it more difficult to achieve a five-star rating at this point in time question mark really it comes down to a few things. The moment that we learn of a new way to improve quality, we want to put that information out as soon as possible.

Also, why make it harder? Some nursing homes have clearly achieved the five-star rating. While there are many reasons why nursing homes may be staffed differently than others, the relationship to quality remains unchanged. Because of that, consumers, families, residents and facilities, we believe they deserve to know a level of staffing and quality that each nursing home provides. With that, we have changed the five-star rating system. We will continue to look at this and review your feedback as we progress. Also review the findings from the staffing study that Pauline mentioned. We are trying to use everything we can to how we improve report quality and how we improve staffing. Switching gears, a little bit to some of the questions we have received prior to this call. One of the questions we get often is about the nursing home waivers. Those that were waived and those that were terminated. One of the questions we get is on the three-day hospital stay waiver. No surprise here, folks. We cannot comment on the status of this waiver at this time. At this time, the waiver is still in effect. Any changes to this waiver or waivers we have been issued during the PHE will be mentioned on your CMS memorandum or on the CMS website. Another question, received is about the nurse aide training and competency waiver. The competency waiver was really helpful to help retain staff through the pandemic. We also need to make sure these individuals get trained. Rico, in accordance with the termination or modification waiver, one of the nurses need to be certified if they were higher before or during the time that the waiver was in place?

Rico: Nurse aides hired before or during the time that waiver was in place have until October 7, 2022 to have a state approved nurse aide training competency evaluation program. Including the completion of a minimum 75 hours of training and passing the exam. Complete the training, submit an application and pass test within four months starting from June 6, 2022. For more information you can refer to QSO-22-- 5-NH.

Evan Shulman: along with that, the memorandum released gave flexibility in that we do not want to be a barrier. Those cases with individual trying to get trained, trying to get certified, trying to take their training and exams but have barriers, they can still work under this waiver. One of the questions we receive, what documentation can I show that I am trying to get certified? Rico, can you answer that?

Enrico Lachica: Each state may have additional specific requirements and processes therefore facilities and individuals should contact state officials for more information. To demonstrate attempts to meet federal and state requirements, facility and individuals should retain documentation such as application to enroll in a program or test and or responses to the nurse training competency program stating they cannot be accommodated at this time. Documentation can be a form of email, letters or

documenting the date of a phone call with the contact person's main information provided. CMS is continuing to look at this issue and will provide more information at a later date.

Evan Shulman: people have asked what does having a part-time infection preventionist mean. Christine, what does part-time mean?

Christine Teague: The requirement is have a preventionist at least part time. the facilities are responsible for a program and ensure the role is tailored to meet a facility's needs. This means a number of hours worked, will vary from each were silly. With emerging and infectious diseases, like COVID 19, CMS believes that the role is critical for facilities efforts to mitigate the onset and spread of infection.

Evan Shulman: I think we have time for one more question. A lot of questions were related to abuse and neglect. A lot of this was around the reporting of abuse and neglect which is a requirement. Rico, I am wondering if you or anyone else can go into a little bit more detail what the requirement for reporting neglect and abuse are and what classifications were made for the guidance in this report.

Enrico Lachica: The guidance clarifies expectations for compliance reporting includes reporting sample templates and provides examples of abuse that because of the action itself would be assigned to certain severity levels. A summary table of reporting requirements can be found in the interpretive guidance of 609 on page 148 of the appendix of that state operation manual.

The most severe instances of abuse, which would include serious bodily injury needs to be reported within 2 hours and other instances need to be reported within 24hours. This is based on federal law and regulation.

Evan Shulman: there have been a lot of other questions coming in about the intersection between CDCs new guidance on enhanced better precautions and CMS guys to servers and facilitators. CDC guidance is not new regulation. CMS encourages all facilities to follow CDC guidance. We have not provided guidance get. We remind facilities that they are required to follow the national standards that exist in a few places. We will get back with everyone on any future changes to survey processes. Thank you all for your time, your energy and all of your work on the ground to help nursing home residents. Jean, I will turn it back to you.

Jean Moody-Williams: Ashley I do see a couple questions about the transcript and where it is posted, how people can get it. Can you say anything before we close out?

Ashley Spence: Sure. Good afternoon everyone. We will post the slides on the CMS transcripts and podcast page. It is where we post all of these transcripts. We will continue to do so for this call as well. It does take us about a week or so just to get the transcript completed and posted but we do post as soon we are able.

Jean Moody-Williams: great. Thank you. We appreciate everyone's attendance. We do capture these Q&A's so we do have them. We try to group them together to get to as many as we can. Certainly, I think you know we have used your comments in the past to help shape our policy decisions moving forward. This will be no exception. With that we will end this call and thanks again.