Topics for today

- QSO-20-39-NH
- New guidance from DHSS for visitation and Essential Caregiver
- QSO-20-41-ALL
- Reporting POC test results to BRDI
- County positivity rate- changes
- Performance-based monthly payments
- DHSS survey for vaccine distribution
- Nursing home commission report
- PPE supplies
Memorandum Summary

• CMS is committed to continuing to take critical steps to ensure America’s healthcare facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).

• Visitation Guidance: CMS is issuing new guidance for visitation in nursing homes during the COVID-19 PHE. The guidance below provides reasonable ways a nursing home can safely facilitate in-person visitation to address the psychosocial needs of residents.

• Use of Civil Money Penalty (CMP) Funds: CMS will now approve the use of CMP funds to purchase tents for outdoor visitation and/or clear dividers (e.g., Plexiglas or similar products) to create physical barriers to reduce the risk of transmission during in-person visits.

Guidance

• Visitation can be conducted through different means based on a facility’s structure and residents’ needs, such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission:
Core Principles of COVID-19 Infection Prevention

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions or observations about signs or symptoms), and denial of entry of those with signs or symptoms
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose)
- Social distancing at least six feet between persons
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)

Core Principles of COVID-19 Infection Prevention

- Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR 483.80(h) (see QSO-20-38-NH)
Outdoor visits

- Preferred whenever practicable due to lower risk of transmission
- Should be safe and accessible (can use tents)
- Have a process to limit size and number of simultaneous visits
- Reasonable limits to amount of people visiting a resident at one time

Indoor visitation

- Facilities should accommodate and support indoor visitation, including visits for reasons beyond compassionate care situations, based on the following guidelines:
  - a) There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing;
  - b) Visitors should be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;
Indoor visitation

- c) Facilities should limit the number of visitors per resident at one time and limit the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors; and
- d) Facilities should limit movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Visits for residents who share a room should not be conducted in the resident's room.

NOTE: For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.
Indoor visitation

• Also use county positivity rate: Low (green) and Medium (yellow) can allow general visits with core principles of COVID-19 infection prevention and facility policies. High (red) can only allow compassionate care visits with infection prevention and facility policies. Also monitor ED admissions and positivity rates of adjacent counties. NOTE: County positivity rate does not affect outdoor visits.

Visitor testing: Encouraged, not required

Compassionate care visits:

• A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support.
• A resident who is grieving after a friend or family member recently passed away.
• A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
• A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).
Restricting visitation

- Except for on-going use of virtual visits, facilities may still restrict visitation due to the COVID-19 county positivity rate, the facility’s COVID-19 status, a resident’s COVID-19 status, visitor symptoms, lack of adherence to proper infection control practices, or other relevant factor related to the COVID-19 PHE.
- However, facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v). This can result in a citation.

Visitation not family/friends

- Visitation for ombudsman, protection/advocacy personnel.
- Health care workers who are not employees of the facility but provide direct care to the facility’s residents, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after being screened.
**Use of CMP funds**

- CMS will now approve the use of CMP funds to purchase tents for outdoor visitation and/or clear dividers (e.g., Plexiglas or similar product) to create a physical barrier to reduce the risk of transmission during in-person visits.
- Applications should be submitted to slcr@health.mo.gov.

**DHSS GUIDANCE 9-22-20**

**Visitation**

- Outdoor visits: Residents who are negative/asymptomatic AND not suspected of having COVID-19; previous positive individuals released from isolation.
DHSS GUIDANCE 9-22-20

Visitation

- No cases or 14 days since last case.
- For residents who are negative/asymptomatic AND not suspected of having COVID-19; previous positive individuals released from isolation.
- Indoor- a space accessible without going through building, not accessible by other residents
- Visits in resident’s private room- if resident bedbound, with full PPE (at facility’s expense)

DHSS GUIDANCE 9-22-20

Visitation

- Up to 5 visitors total
- Up to 2 visitors at one time (with IC), may use plexiglass barrier
- Limit on total visitors in building at one time
- Schedule visitors (monitor for IC)
- Allow evening/weekend visits. (Continue to limit duration, quantity)
Visitation

• Visitor screening (COVID-19 diagnosed, 10 days post-symptomatic) may use testing
• Visitors must be without any COVID-19 symptoms and able to use PPE properly
• Optional: Use consent form to acknowledge facility’s policies on visitation and IPC

Visitation

• Keep visitor logs (in case of outbreak)
• Sanitize all areas, equipment used during each visit
• Restrict visits (except compassionate care or outdoor visits) if a resident/staff has COVID-19 or a positive staff has been in the facility within 10 days prior to positive test
Essential Caregivers

• Individual (including clergy) who is given consent by resident/legal representative to assist with ADLs, or improve quality of care/life. Care plan should reflect this assistance (e.g. assistance with bathing, dressing, eating, and/or emotional support)

Essential Caregivers

• Optional: Use consent form to acknowledge facility’s policies on visitation, IPC and risk
• EC screening: (COVID-19 diagnosed, 10 days post-symptomatic) may use testing
• EC to notify facility of COVID-19 symptoms within 14 days prior to visit
• Keep EC logs (in case of outbreak)
 DHSS GUIDANCE 9-22-20

Essential Caregivers

- EC to wear full PPE (gown, mask, gloves) at all times in facility
- Find mutually agreeable schedule
- Work to mitigate concerns, but restrict visits if ICP, facility policies are not followed
- Restrict visits if a resident/staff has COVID-19 or a positive staff has been in the facility within 10 days prior to positive test
- EC to maintain 6 feet social distancing

QSO-20-41-ALL

EP drills


Emergency Preparedness update: If a provider experiences an actual natural or man-made emergency that requires activation of their emergency plan, inpatient and outpatient providers will be exempt from their next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of the actual event.

- Also, workshops can qualify as an exercise of choice.
**REPORTING POC TEST RESULTS**

**New reporting format**


**COUNTY POSITIVITY RATE**

**Changes**

- During the week of Sept 14, 2020, the following updates were made to the county percent test positivity characterization methodology. In order to use a greater amount of data to calculate percent test positivity and improve the stability of values, the indicator was expanded to include 14 days of data instead of 7 days. Further, because there are instances where counties with high test positivity rates may reflect low testing levels rather than high levels of viral transmission, additional criteria were added to re-assign counties with low testing volume to lower nursing home staff testing tiers (i.e., communities with low levels of testing and high test positivity (>10%) are reassigned to either yellow or green testing tiers). Nursing homes may set their testing frequency based on the color-coded reassigned positivity classification.
Country Positivity Rate

Changes

• Counties with test percent positivity <5.0% or with <20 tests in past 14 days: Green; test percent positivity 5.0%-10.0% or with <500 tests and <2000 tests/100k and >10% positivity over 14 days: Yellow; >10.0% and not meeting the criteria for “Green” or “Yellow”: Red. Test positivity is rounded to the nearest tenth of a percent before classifying.

HHS Incentive Payments

https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html#targeted

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To be eligible for an incentive payment, nursing homes “must have an active state certification as a nursing home or skilled nursing facility (SNF) and receive reimbursement from the Centers for Medicare & Medicaid Services (CMS).”

2 Gateway tests

- A facility must demonstrate a rate of COVID infections that is below the rate of infection in the county in which they are located. This benchmark requirement for infection rate reflects the goal of the incentive program to recognize and reward facilities that establish a safer environment than the community in which they are located.
- Second, facilities must also have a COVID death rate that falls below a nationally established performance threshold for mortality among nursing home residents infected with COVID.
Gateway #1

- Infection Measure (80% of incentive payment dollars): The infection measure will be calculated by taking the total number of non-admission COVID infections divided by their total number of resident-weeks reported in NHSN (used to “scale up” for the nursing home’s patient volume). This rate will be compared to the county infection rate.

Gateway #2

- Mortality Measure (20% of incentive payment dollars): This measure will be assessed for those nursing homes who have at least one non-admission COVID infection and will be risk-adjusted with “relevant health and demographic data (e.g. number of co-morbidities).
  - It will also use NHSN data including:
    - Total number of COVID deaths resulting from in-facility infections
    - Total number of non-admission infections.
DHSS SURVEY - VACCINE DISTRIBUTION

https://www.surveymonkey.com/r/BYJKMDQ

NURSING HOME COMMISSION REPORT

Current supply

- The Department of Health and Senior Services has gowns, alcohol prep pads, surgical masks, and shoe covers that can be ordered by long term care facilities in bulk. Please follow the survey monkey link (https://www.surveymonkey.com/r/KPY7ZWW) to place your order.

Abbott BinaxNOW Antigen Test

Latest distribution

- Latest POC antigen test to be sent to facilities.
**Infection control surveys**

- DHSS will be doing infection control focused surveys starting today (20% of facilities).

**Let Us know how we can help**

**Evaluations**

LTC Leadership Coaches

- Nicky Martin, BSA, LNHA, CDP, QIPMO Team Leader
  573-217-9382
  St. Louis/Southeast/Southwest
  martincaro@missouri.edu

- Mark Francis, MS, LNHA
  417-499-9380
  Kansas City/West/Southwest
  francismd@missouri.edu

- Libby Youse, BGS, LNHA, CDP
  660-651-3778
  Central/Midwest/North
  youseme@missouri.edu

Nursing Home Help
We can do virtual visits via zoom!

- Wendy Boren email: borenw@missouri.edu
- Katy Nguyen email: nguyenk@missouri.edu
- Crystal Plank email: plankcl@missouri.edu
- Debbie Pool email: poold@missouri.edu
- Melody Schrock email: schrockm@missouri.edu
- Carol Siem email: siemc@health.Missouri.edu

Your QIPMO Nurses
CLOSING

Resources are available at:

- QIPMO
- MO DHSS
- MO DHSS Regional Emergency Contact Numbers
- MHCA
- CDC
- CDC LTCF COVID-19 Module
- World Health Organization