In this Industry Update you will discover:

1. *"Providers Seek Extension of 2% Medicare Sequester Cut Relief Through 2021"*
   - McKNIGHT'S LONG TERM CARE NEWS, 10/23/2020; pg. 1
2. *"Moving Nursing Homes Forward: The Future is Now"*
   - McKNIGHT'S LONG TERM CARE NEWS, 10/26/2020; pg. 2
3. *"'Completely Predictable' Link Emerges Between College COVID-19 Outbreaks, Nursing Home Deaths"*
   - SKILLED NURSING NEWS, 10/22/2020; pg. 4
4. *"Century Rehab's New CEO on the Pitfalls of Telehealth in Nursing Homes — and Demand for Therapists Amid COVID"*
   - SKILLED NURSING NEWS, 10/25/2020; pg. 6

McKnight's LONG-TERM CARE NEWS

Providers Seek Extension of 2% Medicare Sequester Cut Relief Through 2021

With a tough financial crisis looming, providers are looking for help from Congress in order to keep the doors open for many facilities struggling to find other alternatives. The healthcare industry has to find a way to prevent losses while giving the best care possible and many leaders are counting on the Federal Government to provide the assistance needed.

Written by: Danielle Brown

10/23/2020

Four of the nation's top provider groups representing long-term care, home health and hospitals are calling on Congress to extend a moratorium on the 2% Medicare sequester cuts into 2021 and for the duration of the coronavirus pandemic.

"Clearly the cost of providing care to patients continues to increase. Without future sequestration relief, America's healthcare safety net could be at further risk of collapse," the American Health Care, American Hospital and American Medical associations, and the National Association for Home Care & Hospice, wrote in a letter Wednesday to Congressional leaders.

The relief for providers was approved through the end of 2020 thanks to Congress passing the Coronavirus Aid, Relief, and Economic Security (CARES) Act in May. The groups argued that the relief from the cuts has been "critical" for all providers given the dire financial outlook they've been faced with.

"Given that the [public health emergency] is certain to continue into 2021, it is a safe assumption that America's health care providers will continue to face the overwhelming financial challenges and pressures associated with higher overhead costs due to personal protective equipment and other safeguards, lost revenue due to delayed elective procedures and/or forgone routine visits, and hazard pay to staff," they wrote.

They added without future sequestration relief "America's healthcare safety net could be at further risk of collapse."

“Physicians, nurses, hospitals, health systems, long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, home health agencies, and hospices have been hit hard by the pandemic, incurring significant expenses to treat the sick, but experiencing historic financial losses due to the decrease in inpatient and outpatient services,” the groups wrote.

“As such, we respectfully ask that Congress pass legislation this year that further postpones the application of this harmful 2% cut for the duration of the PHE in 2021,” they concluded.

The 2% sequestration reduction to Medicare payments have been in place since 2013. A 2013 analysis found that it would reduce payments to skilled nursing facilities by $9 billion over 10 years when the sequestration cuts first took effect.

In other news, AHCA President and CEO Mark Parkinson also issued a plea calling on public health officials and lawmakers that legal action and monetary penalties against long-term care providers for COVID-19 outcomes won’t improve care quality.

“Instead, these actions oftentimes fail to account for the entirety of what unfolded in a particular facility. Furthermore, they tie the hands of essential personnel and redirect critical resources away from where they are needed most,” Parkinson wrote in an op-ed for Morning Consult.

“Instead of pointing fingers, let’s acknowledge our challenges and begin to fortify areas such as workforce recruitment, training and retention, as well as Medicaid reimbursement policies which leave facilities under-resourced hurting both residents and caregivers,” he added.

McKnight’s
LONG-TERM CARE NEWS

Moving Nursing Homes Forward: The Future is Now

The former CEO of Rockport Healthcare Services urges fellow Skilled Nursing leaders to look forward and advance their infection prevention practices in order to keep their facilities afloat. Using improved tactics to fight the spread of COVID will also improve the lives of the staff and seniors in your care.

Written by: Michael Wasserman

10/26/2020

On March 11, I wrote about the COVID-19 storm rapidly approaching our nursing homes, and particularly the risk of nursing home staff transmitting the virus to residents.

On March 15, I pointed out the need for an infection prevention general in every nursing home.

This wasn’t a topic that came to me out of the blue. Nearly three years ago, as CEO of a company overseeing a 74-facility California chain of nursing homes, I convened leadership to discuss key areas of concern. One of the topics we brainstormed on was how to help infection preventionists do their jobs. It was clear that the IP’s in our facilities were being pulled in multiple directions and didn’t have enough time to perform their duties.

When COVID-19 struck the United States in late February, it was obvious that this issue would be at the heart of every nursing home's ability to respond. On March 9, the California Association of Long Term Care Medicine put on our first webinar, where we recommended that every nursing home assure its IP had the ability to devote a full-time effort to their job.

Last month, California Gov. Gavin Newsom signed a law requiring all nursing homes in California have the equivalent of a full-time infection preventionist. The battle against COVID-19 is now fully joined. Why was this legislation needed? It's simple: Without a requirement that the IP be full-time, they will invariably be pulled in multiple directions. This is actually symbolic of the types of issues that occur in nursing homes around the country on a daily basis.

Give IPs more time

I was previously the Director of Nursing Homes for the QIN-QIO, a quality improvement organization in California, where I regularly faced nursing home resistance to quality improvement efforts. The typical excuse for their inability to engage in such efforts was that they were constantly "putting out fires." I was always bothered by this excuse, as it didn't allow for facilities to actually implement proactive, actionable change efforts.

There is a simple reason to *require* every nursing home to allow their IP the ability to spend a full-time effort doing their job. The work of the IP is a necessity, and never more so than during a pandemic. However, even before COVID-19, and well after, it is imperative that the IP be allowed to focus on all aspects of their work, including assuring that the facility is adhering to its antibiotic stewardship standards.

There's a very important lesson in this that can and should be translated to everyone working in a nursing home: We are delivering medical care to a very complex and frail population. Many of today's nursing home residents would have been in a hospital 15 years ago. That level of complexity requires attention to detail and a focus on delivering that care.

For too long, nursing homes have had a primary focus on filling beds, the veritable "heads in beds" phenomenon, which is anathema to delivering truly person-centered care.

Engage the medical director

There is a natural step forward beyond requiring full-time IPs. Nursing homes must fully engage their medical directors. The medical director is supposed to be the clinical leader of a nursing home, required under the federal regulations to be responsible for "implementation of resident care policies" and "coordination of medical care in the facility," a tall order.

Medical directors can't fulfill that role unless they actually possess the tools and the knowledge base to do so. AMDA, The Society for Post-Acute and Long-Term Care Medicine, offers a medical director certification that provides tools that the medical director needs, including the complex regulatory framework for nursing facilities and general concepts of geriatric medicine and person-centered care — which sadly, many current medical directors lack.

The full engagement of the medical director must be allowed and embraced by each facility's management, including the administrator and the director of nursing, who under our current system often make virtually all of the important financial and clinical decisions in the facility. Ultimately, the willingness to accept the medical director as an active and integral member of the facility leadership team must come from the C-suites of corporations that operate large nursing home chains. Until that time, the historical inertia that exists in the industry will provide an ongoing impediment to this necessary evolution.

Embrace quality improvement

As we look at the future of nursing homes, we have to ask ourselves a key question: Do we want to assure that residents of nursing homes receive quality care? As the healthcare industry has pushed to make nursing homes increasingly responsible for the care of a highly complex, seriously ill population, that question must be answered. COVID-19 has demonstrated that our nursing home industry was not prepared. The medical literature has already demonstrated the association between registered nurse staffing and COVID-19 outbreaks and deaths.

Nursing homes desperately need strong medical leadership in an engaged and competent medical director, actively involved director of nursing, 24/7 RN coverage and a full-time infection preventionist. If we are to effectively battle the scourge that is COVID-19, we can't put this off any longer; the future is now. And surely our nursing home residents and staff are worth the efforts.

Skilled Nursing News

'Completely Predictable' Link Emerges Between College COVID-19 Outbreaks, Nursing Home Deaths

University of Wisconsin professor Paraic Kenny and his colleagues have pointed out that there is a staggering link between positive COVID cases among young adults and subsequent outbreaks in nearby nursing homes. Taking the examples from the state of Wisconsin, researchers can also predict what will ultimately happen in other parts of the nation.

Written by: Alex Spanko

10/22/2020

A preliminary study has found evidence of a link between COVID-19 cases at colleges and eventual outbreaks at nearby nursing homes, adding to mounting research showing the direct impact that community spread can have on vulnerable populations.

Researchers tracked two specific strains of the novel coronavirus as they spread through the town of La Crosse, Wisc., the home of a University of Wisconsin campus among other institutions.

"Although the majority of cases were among college-age individuals, from a total of 111 genomes sequenced we identified rapid transmission of the virus into more vulnerable populations," the researchers concluded in the study, which is still awaiting formal peer review. "Eight sampled genomes represented two independent transmission events into two skilled nursing facilities, resulting in two fatalities."

The paper, written by University of Wisconsin professor Paraic Kenny among others, included a warning for university officials across the country as they weigh the risks and benefits of holding classes on campus this fall.

"Our study highlights the very significant risks imposed by college administrator reopening decisions, not just on college-associated populations, but on vulnerable individuals in surrounding communities," the researchers wrote.

Other scientists cautioned that more research would be necessary to fully prove the connection between college and nursing home outbreaks, the Washington Post reported in a wider story about the COVID-19 situation in La Crosse, a city located roughly between Madison, Wisc. and Minneapolis on the Wisconsin-Minnesota border.

But Thomas Friedrich, a University of Wisconsin-Madison professor who has researched the COVID-19 genome, told the Post that high rates of coronavirus infection among students is like a major fire that can throw off sparks and create new, separate fires.

“High levels of transmission among students in La Crosse absolutely increased the risk of outbreaks in skilled nursing facilities,” Friedirch told the paper. “[Kenny’s] data are totally consistent with this scenario, but they do not prove beyond a shadow of a doubt that specific viruses traveled from students to nursing home residents.”

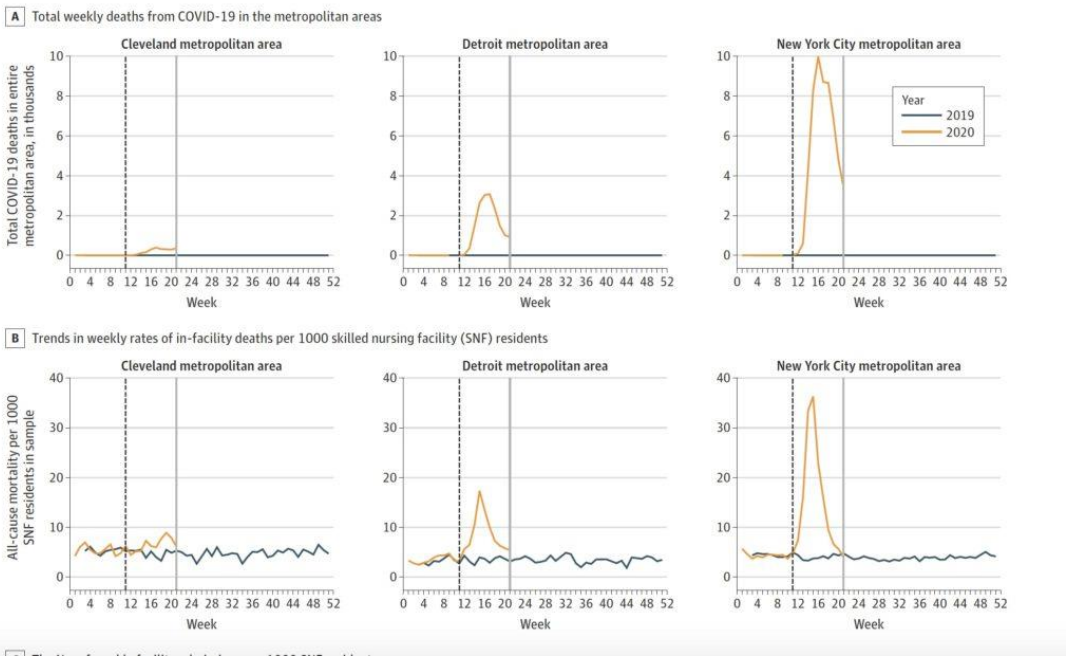
Nursing homes in La Crosse had been spared by COVID-19 until recent weeks, the Post reported, with most of the 19 recorded deaths this fall occurring at long-term care facilities — and all of them representing people over the age of 60.

Kenny was blunt in his assessment of the situation in his comments to the Post.

“Completely, completely, completely predictable,” he told the publication. “Everything we’ve known about this virus since January, everything we’ve known about 20-year-olds for the last 3,000 years — it’s predictable.”

Multiple studies have determined that high rates of overall COVID-19 infections increase the risk for outbreaks at long-term care facilities. Between March and May, for instance, coronavirus death spikes at nursing homes in New York City and Detroit almost exactly mirrored the toll among the general population, while Cleveland — which had significantly less community spread — saw significantly fewer COVID-19 deaths in nursing homes.

The two charts below, originally published in the Journal of the American Medical Association, illustrate the effect clearly. The top row shows overall deaths on a weekly basis, while the bottom displays skilled nursing facility mortality. The yellow lines are data for 2020, while the blue shows 2019 death rates for comparison.



Community spread is not the only factor, as researchers have also determined that facilities with more robust staffing hours are better at preventing and containing outbreaks than those with spottier coverage.

As with the general population, COVID-19 has also disproportionately affected nursing homes in communities of color, with high percentages of Black residents a reliable indicator of outbreak risk.

Skilled Nursing News

Century Rehab's New CEO on the Pitfalls of Telehealth in Nursing Homes — and Demand for Therapists Amid COVID

In the following interview, Tammy Tuminaro – newly appointed CEO of Century Rehab – shares her thoughts on the recent trend of telehealth the skilled sector. While the technology has become an essential part of the business, there are things that it cannot accomplish and the healthcare workers have to be diligent with everyday useage.

Written by: Maggie Flynn

10/25/2020

The world of third-party rehabilitation was braced for a change in the skilled nursing setting when the Patient-Driven Payment Model, the Medicare reimbursement overhaul that took effect last year, effectively removed therapy as the driver of payment.

A few months into that new landscape, the world itself was upended by a global pandemic — one that had a unique effect on the operations of SNFs, adding another twist to the path third-party rehab providers must navigate.

For Tammy Tuminaro, the recently appointed CEO of the Baton Rouge, La.-based Century Rehabilitation, the changes are the latest in a long line of upheavals to rehab in the SNF setting, and she's charting the course for Century accordingly after serving with the company in a variety of roles for 17 years.

Tuminaro joined Rethink last month to talk about the evolving role of third-party rehabilitation in SNFs, and how Century is getting ready to forge ahead in a health care landscape driven by outcomes and shaped by a pandemic.

Excerpts from that conversation, edited for length and clarity, are below. Rethink can be found on iTunes or SoundCloud — and if you like what you hear, be sure to subscribe.

When COVID-19 hit, what did Century Rehabilitation see in terms of changes, and how did you respond in working with your SNF partners?

With COVID-19, what we're finding as a company is that we are constantly having to re-evaluate our service delivery model. Overall, our goals have not changed: Our residents still need care, we are committed to providing quality care with the best outcomes. However, our approach has had to change slightly.

With the implementation of telehealth, that was really — I don't want to say necessary evil, but while it's not the ideal mode of delivery, in our opinion, it's definitely needed. We've lost some of our efficiencies as well. But like I said, the residents still need care and even more so now, what we're finding is that [for] some of our residents, the needs have changed. We're seeing because of a lack of socialization, maybe more cognitive deficits, more depression issues.

The other thing that we're really finding, and it's just now starting to emerge, is what are the long-term effects of COVID-19 on patients in skilled nursing settings, some of the respiratory issues that we're starting to see.

And then [there's] what's yet to be seen, but I think, primarily our focus has not changed. We're still looking at the best way to give quality care with the best outcomes and to work with our partners. Infection control, of course, has been a big topic, and we've had to reevaluate how we go about our day-to-day with our therapists. That has never really been an area where therapy was really concerned with PPE [personal protective equipment] and those types of things.

We are re-evaluating it every day, but our goals never change. We are committed to giving the best quality care and the best outcomes for the residents.

Can you talk a bit about some of the challenges you ran into with telehealth? Overall, there's a lot of optimism about what it means for care in the SNF setting, but with therapy, it sounds like it might not necessarily be the most optimal mode of delivery?

Telehealth for therapy developed out of a need, a necessity, and I do think it has a place and it's a great option when there is no other option. We definitely believe face-to-face interaction is best.

But ultimately our patients need care, and we have to become creative and resourceful to ensure that care and the outcomes. The biggest challenge has probably been just re-educating therapists on when and where this is applicable, as well as having hands-on resources in the facilities from the technology side. So sometimes it's a challenge because of just manpower; while we can remotely have a physical therapist or an occupational therapist dialing in, we still have to have someone on the ground, in the facility with the resident.

And from a technology standpoint, sometimes the population that we're dealing with is not as technologically savvy as some other populations. So that's been one of the biggest challenges, just re-educating to use the technology and having the boots on the ground in the facility to be able to facilitate the telehealth.

How has Century handled that element of needing boots on the ground in facility, and how do you foresee handling it, given that the current situation is likely to be around for a while?

We have a presence in every facility, first and foremost. We have gone out and we have beefed up our staff.

In the past, we may have had a physical therapist that did evaluations in two, maybe even three facilities, if they were near each other and with smaller census. Now, we can't have those folks present in all three of those different facilities. So we're doing telehealth from that aspect. But we have not taken our assistants, or maybe rehab tech [out of the facilities] — somebody is still in that facility.

In many cases, it meant we had to go out there and hire more staff, which I think for in this environment is a really good thing. We saw so many therapists get furloughed, or clinics just had to shut down for some time. But in the skilled nursing setting, we couldn't shut down; we had to be there, and rather than cutting our staff, we started adding to our staff and trying to become more efficient.

We also have worked very closely with our partners in the facility. So the operators in the facility — in some nstances where it may have been a little bit more difficult for us to have somebody in the facility for six to eight hours a day readily available — we have partnered with the operators to determine: Do they have staff, perhaps, that could help us in this situation, Whether it be may be a restorative aide or a CNA [certified nursing assistant]? We've been very successful in that area as well.

Again, our goals are the same; our goals are aligning. The residents still need the care, and we've still got to work toward those outcomes.

That point about is something I wanted to ask about: How have you seen the relationship between SNFs and rehab providers change over time, and where do you see that going as more and more providers zero in on outcomes?

I almost want to say: "What has not changed?" rather than what has changed over the years. But I think for Century, what has not changed is that we have always been in the business of building really strong partnerships — not just being a vendor, but going out there and really building a partnership with our operators to ensure that quality care and excellent outcomes.

In the past, rehab or therapy was more of a department within a nursing facility, and now we are much more integrated. In the past therapy came in, we may have told the facility what we were doing, maybe gave an update on progress with the resident, but pretty much just came in and told them what we were doing and moved on.

Now it's a true collaboration with the entire interdisciplinary team. We are constantly re-evaluating what we're doing, and how it fits in with our clients' goals. I think for the future, flexibility will be the key. Historically, contract therapy providers in the long-term care setting have had a certain way that they set up their program. I think going forward, we will have to have flexibility with our service models, whether that's having value-adds, new service lines, maybe different models of care delivery.

Whatever it is, we've got to do whatever we need to do to achieve those outcomes, and align our goals with those of the facility.

So what does that look like for Century, and how are you thinking about it as you go into this new role?

We have always focused on outcomes. So what we think that looks like going forward: We are implementing some different strategies from some of our auditing tools where we're looking at outcomes versus maybe documentation strengths.

In other words, we're trying to correlate: Residents with really good outcomes, does that correlate to therapists who have very good, strong documentation skills? And what we're finding is that there is often a correlation there.

So we start with looking at the competencies of our therapists — and when I say competencies, it's not to go out there and find who's not doing something the right way, but more identifying trends and opportunities — and using that to educate and give our folks the resources that they need to do their job, whether it be better clinical pathways, decision trees, whatever we can give our folks to make them more efficient and focus their care on treating the resident.

Also with outcomes, there's so much data out there, and we have a lot of unused data. We're actually working with some outside partners to take some of the data we already have — because we collect it, CMS is collecting it — and really be able to tap into that through some of the data analytics tools out there, to really be able to extrapolate and show our partners what we truly are doing and what our combined efforts are accomplishing.

We recognize that we're going to have to partner with some folks outside of our expertise to really get down to that, and be able to to show our partners — as well as to show the entire industry — that what therapy does within the nursing facility really does have value, at the end of the day.