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McKnight's LONG-TERM CARE NEWS

CMS 'Deeply Concerned': COVID-19 Cases in Nursing Homes Have Escalated Nationally

With COVID cases on the rise in nursing homes, CMS has cause for concern when it comes to the health of seniors nationwide. Since the senior population is the most susceptible to the virus, nursing home staff have to be extremely cautious about their plans moving forward.

Written by: Danielle Brown

8/14/2020

Top officials with the Centers for Medicare & Medicaid Services are uneasy following a recent uptick in coronavirus cases at nursing homes over the last few weeks.

"We are deeply concerned about the situation that we are seeing in nursing homes," CMS Administrator Seema Verma said during a call with nursing homes Thursday afternoon. "The situation nationally has escalated."

Nursing homes were reporting 11,000 new cases per week when they first started submitting data through the Centers for Disease Control and Prevention's National Healthcare Safety Network in late April, which was a peak at the time. New weekly cases reached a low of about 6,300 by the end June but as of the end of July, nursing homes have reported about 12,000 new cases per week.

She added that the rise is tied to the increased general community spread in many areas of the country. The agency is eyeing facilities with just a few cases because the disease's ability to rapidly expand and cause an even bigger crisis, she noted.

"Even if you have one to two cases, I cannot emphasize enough that that situation can turn into very very quickly," she said. "In a matter of hours, you can go from having two or three cases to having half of your nursing home impacted, which is what we've seen in some areas. Those nursing homes that don't have any cases I would not be complacent in that."

Verma also explained that the Federal Emergency Management Agency is also on high alert regarding the

tracking and shipping of supplies for providers. The agency is also working closely with manufacturers and lab companies to ensure point-of-care tests and results for nursing homes are being prioritized.decrease) between March and July, its higher margin skilled occupancy increased by 571 basis points (or a 37% increase) over the same period.

Emphasis on infection control

Verma noted that the recent rise in cases is “not just a testing issue or a supply issue.”

“Our deep concern is that even in nursing homes that are doing testing on a regular basis that we’re still seeing significant spread,” she said. Verma explained that federal strike teams and Quality Improvement Organizations (QIOs) are seeing “significant deficiencies in infection control practices.”

Lee Fleisher, CMS’s chief medical officer and director of the Center for Clinical Standards and Quality, and Shari Ling, deputy CMS chief medical officer, were also on the call Thursday and laid out several infection-control recommendations and best practices for providers. They emphasized wearing personal protective equipment properly, hand-hygiene and following social distancing guidelines.

“We are here to help you and support you. This isn’t a time of fines and being punitive,” Verma concluded. “It is a time — as [Ling] said — to be problem solvers. I want you to know that whatever you need, we are here to help you on any level, whether it’s staffing, supplies, testing, technical assistance, we’re here to get you whatever you need.”

McKnight’s
LONG-TERM CARE NEWS

Parkinson: Recent Jump in COVID-19 Cases at Nursing Homes ‘Incredibly Frustrating’

Mark Parkinson, President and CEO of AHCA, has been a leading voice amid all of the confusion around the COVID outbreak. Here, he gives his thoughts on why we are seeing another spike in infection rates and how we can take action to flatten the curve in the coming months.

Written by: Danielle Brown

8/13/2020

The leader of the nation’s largest nursing home association expressed disappointment with the recent spike in COVID-19 cases at long-term care facilities after months of improvement.

“It’s incredibly frustrating,” Mark Parkinson, president and CEO of the American Health Care Association/National Center for Assisted Living, said Wednesday during an interview with CNN Newsroom.

“We had made tremendous progress in reducing the cases in long-term care facilities from the highs in March and April. We cut the number of cases per week in almost half and we cut the death rate over 70 percent,” he added.

Pressure on PPE, testing

Case numbers began to rise in June as states reopened and fewer people practiced social distancing, he said. The growth in cases then put stress on the demand for personal protective equipment and testing, he said.

“In over 60 percent of the facilities today, you can test a resident or a staff member but you don’t get the results back for three or four days. In 25 percent of the cases, you don’t get it back for over five days,” he explained.

“What we really need to happen is we need the case rates in the states that have had the spike to drop down, so that we can get the testing and get the equipment that we need in long-term care facilities.”

Parkinson called on all citizens to wear masks and socially distance to reduce case rates and for public officials to refocus their efforts on long-term care facilities.

“When people are making a conscious decision to not wear a mask, they are making a decision that is killing old people in nursing homes. We need to take responsibility and change that,” Parkinson said.

“Every governor needs to make a priority, particularly in these states with an exploding number of cases, to make sure that every long-term care facility has the N95 masks and the testing that they need. It’s the only way that we can bring these case counts down,” he added.

Prioritizing elderly

Elderly citizens around the world have not been prioritized throughout the entirety of the pandemic, according to Parkinson. He added that it’s been “really despicable” to see what’s happened in long-term care facilities worldwide.

A recent New York Times analysis found that many governments around the world failed to include nursing homes in emergency preparation plans during the beginning of the pandemic — creating deadly results for long-term care facilities.

“We just made some major policy mistakes that we need to make sure never happen again,” he said.

Skilled Nursing News

Isolating COVID-19 Patients Critical for Nursing Home Safety — But PDPM Hasn’t Caught Up

The COVID-19 virus is notoriously slow to start showing symptoms once an individual has been infected. Isolation is one of the most effective ways to prevent further spread of infection, but the PDPM system still has gaps when it comes to the care for seniors in skilled facilities.

Written by: Maggie Flynn

8/14/2020

The infectious nature of COVID-19 makes it imperative that skilled nursing facilities take extra precautions around any new admissions that they bring in, as well as any residents that are returning from a hospital stay.

According to the Centers for Disease Control and Prevention (CDC), the procedure for SNFs is straightforward: Keep any COVID-19-positive patients separate from the rest of the resident population — comprised primarily of elderly people with multiple co-morbidities that make them uniquely vulnerable to the illness.

There are different forms that this can take for SNFs, depending on the scenario they're facing, according to Bill Goulding, lead consultant at the post-acute firm PACS Consulting — an arm of the Frisco, Texas-based therapy company Aegis Therapies.

A patient could come to a SNF with a positive COVID-19 test and symptoms of COVID-19, or with a positive test without symptoms. SNFs are also taking in patients that are either untested or waiting on test results while having COVID-19 symptoms, or patients without symptoms who have come from an environment where COVID-19 was present.

PACS, which launched January of this year, does an array of consulting work for post-acute facilities, including analyses of the Minimum Data Set (MDS), and it was in studying this information that the consulting firm began to notice one of the many financial challenges COVID-19 has caused for nursing homes: Whether or not they can code a patient as requiring "isolation" under the Patient-Driven Payment Model (PDPM), the reimbursement system for Medicare that took effect in October of last year.

The financial implications of this can be significant. Coding a patient as "infectious isolation" puts the patient in the Extensive Services 1 (ES1) case mix group, one of the highest-paying ones under PDPM, Goulding said. The nursing base rate is essentially $100 per day, and is multiplied by 2.93 because the patient falls under the "infectious isolation" category, roughly translating to about $290 a day for that patient's nursing care.

"It's CMS's [Centers for Medicare and Medicaid Services] way of saying: We understand that single isolation is extremely expensive," Goulding told Skilled Nursing News on July 31. "It's one of the most expensive things you can do in a nursing facility."

PACS has seen a sharp increase in SNFs using the ES1 code ever since the COVID-19 pandemic took hold in the U.S. According to 95,000 MDS assessments by the consulting firm, before COVID-19, SNF providers coded residents for isolation 1% of the time. After the onset of COVID-19, that rose to 8%, according to a July 27 email from Aegis Therapies.

A breakdown by state sent to SNN by Goulding on August 1 shows even steeper increases.

State	10/1/19-2/29/20	4/1/20-7/15/20
CA	2%	10%
MN	0.4%	4%
MA	0.04%	9%
FL	1%	1%
IL	2%	14%
VA	0.5%	2%
WA	1%	10%
WI	1.4%	9%
IN	0.3%	3%
GA	1.4%	12%

Percentage of MDS Assessments that used the ES1 (Isolation) code
Source: PACS Consulting

"What strikes me is that ALL States except Florida has seen a noticeable increase in usage of the Isolation code, but there is still quite a bit of variability that could be caused partially by the confusion as to how such patients should be coded, as well as the relative incidence of COVID in each area," Goulding noted in that August 1 e-mail.

The confusion stems from the definition of "isolation," which is restrictive in a way that puts SNF at risk for a denial of services if they use it, Goulding said on July 31. One of the key components of the definition is that a resident "has to have an an active infection with highly transmissible or significant pathogens that have been acquired by physical contact or airborne or droplet transmission, in other words, confirmed active infection," Goulding told SNN.

This isn't an issue for a patient that has a confirmed COVID-19 diagnosis, even if they aren't showing symptoms, Michael Sciacca, partner and chief operating officer at the Morganville, N.J.-based reimbursement consulting firm Zimmet Healthcare Services Group, told SNN on August 4. Such a patient is a straightforward case of isolation under PDPM.

"Where you get into the issues, and you get into a very unclear situation, is when you don't have a positive test, but residents may have been exposed to the hospital that has COVID patients," he said. "So if a hospital had a fair amount of COVID — which is very common when it really surges in a particular area and in a particular locale — the questions that we're getting are specific to what to do with residents that do not have a positive test but have possibly been exposed to the virus."

The CDC is quite clear on the need to keep these patients separate from the general population, he said. But based on the guidelines in the Resident Assessment Instrument (RAI), there would be no active diagnosis that would lead a SNF to believe that resident is infectious, simply an active exposure, Sciacca explained.

COVID-19 complicates the picture by taking a long time to lead to symptoms in an infected person; the window can be as long as 14 days, though five to seven days seems to be more typical.

Zimmet Healthcare Services Group is taking a conservative approach to this issue, and following the RAI guidelines, Sciacca told SNN. In other words, possible exposure to COVID-19 does not constitute an active diagnosis of infection that would warrant isolation coding on the MDS, regardless of whether a facility is keeping such patients in single rooms until they receive a negative COVID-19 test.

Where this creates a challenge for SNFs is the potential for delays in getting test results back for those possibly exposed patients, Mat Robie, vice president of PACS Consulting, told SNN on July 31.

"In some cases, facilities have to wait days upon days to get those results back," he said. "And so during that timeframe while you're waiting, what do you do?"

But he also echoed Sciacca's concern about the need for facilities to be aware of how they code these patients, as the guidelines "are very, very strict."

In fact, PACS saw several SNFs in the early stages of the pandemic use isolation-related coding and had to tell them to change their practices — and Robie's concern is that others will do the same. Ultimately, if CMS receives isolation claims coded without positive COVID-19 tests appearing later, the question is whether the agency will try to recoup dollars from the facilities that used these measures.

Goulding stressed that because of the gap in the regulations, facilities have to create some criteria — and ideally set it in writing— on how they will make decisions related to cohorting and coding, whether it pertains to flagging

certain symptoms or settings.

Then this has to be noted in documentation, so any decisions related to the patient's care and the coding of it has backup, he explained.

That makes it all the more important for SNFs to be aware of every risk: medical, legal, and reimbursement-related.

"To meet that hard definition [of isolation] right now, you must have that active infection, and you must be able to prove that in the clinical notes," Robie stressed. "Otherwise if somebody were to come in and audit a payment related to isolation and you don't meet the burden of proof, you're at risk for in essence, potentially upcoding that claim inappropriately."

Skilled Nursing News

Why Even a COVID-19 Vaccine May Not Be a Silver Bullet for Nursing Home Residents, Staff

With the development of a working vaccine for the COVID virus under way, there seems to be hope for a return to normal life, but there are even more hurdles to face after the successful tests become a reality. Nursing home residents will still need to be cared for and kept under a keen watch to prevent further outbreaks and more difficult news to bear in the coming months and into next year.

Written by: Alex Spanko

8/7/2020

The prospect of a COVID-19 vaccine sits at the center for the public's hope of any return to pre-pandemic normalcy: With no effective treatments and outbreaks rising alongside relaxed lockdown rules, it's difficult to imagine any real change without a proven vaccine.

But in a twist of dark irony, the population most susceptible to COVID-19 — elderly people, with multiple comorbidities, living in congregate settings — may not necessarily benefit from the discovery and distribution of a coronavirus vaccine.

For the Chicago-based skilled nursing operator Symphony Care Network, which has already dealt with a high-profile outbreak at one of its facilities, the knowledge that a vaccine won't be a silver bullet was the primary motivation to participate in a clinical trial for a preventative drug under development at pharmaceutical giant Eli Lilly and Company (NYSE: LLY).

"The advanced elderly population doesn't do particularly well with vaccines — and therefore, depending on a vaccine to stop this epidemic, and to stop this excess death rate in skilled nursing facilities, was unlikely to be an effective long-term strategy," Dr. Alexander Stemer, co-chair of the COVID-19 task force at Symphony Care Network, told SNN last week.

Stemer joined Symphony in an advisory role in the wake of an outbreak at a facility in Joliet, Ill., and through a colleague at the National Institutes of Health (NIH) became involved with the Lilly study.

Under a pending phase-three trial announced last week, the drugmaker plans to enroll up to 2,400 residents of nursing facilities with recent COVID-19 cases to test the efficacy of LY-CoV555, an antigen that the company believes could both treat and prevent coronavirus infections.

So far, 101 facilities in California, Florida, Georgia, Illinois, Louisiana, North Carolina, Ohio, Pennsylvania, and Texas have signed up to participate, according to the federal government's public clinical trial data; in addition to Symphony, list includes skilled nursing and assisted living properties operated by HCR ManorCare, Belmont Village, and Sunrise, among others.

The intravenous drug is based on antibodies from people who have recovered from COVID-19 infections, Stemer said. A given person's immune system can take upwards of two weeks to develop a response to new invaders such as the novel coronavirus, but the LY-CoV555 antigen could help speed up that process.

"Now what we can do — on day one of dealing with a patient who has proven COVID-19 infection — is not have to wait two weeks for what may be a strong or weak antibody response, but immediately give them the antibody that will allow their immune system to attack this virus," Stemer said.

This avenue of attack against COVID-19 is especially important to explore among long-term care residents because of known weaknesses in how vaccines behave among the elderly, according to Stemer.

He gave the example of the more familiar flu vaccine: Seniors over the age of 65 generally receive a high-dosage version with four times the normal amount of antigen material — and even then, it's not an automatic option for preventing flu cases among the elderly.

"While it's helpful in ameliorating influenza, it is not a cure-all or end-all for influenza, and that is a well-known feature of this population," Stemer said.

But as with the use of vaccines, conducting clinical trials with older, vulnerable nursing home residents presents challenges unique to the population.

"The consensus was that nothing like this had ever been done in a skilled nursing facility before, so we needed to really start from the ground zero to understand how we were going to implement this, and what was going to be necessary to make this happen," Stemer said.

Targeting the post-acute and long-term care population had been a top priority for Lilly researchers, according to vice president of new therapeutic modalities and COVID-19 research Andrew Adams, but there were serious concerns about the lack of a precedent for conducting clinical trials in SNFs.

"It's hard, because the nursing home is not a space that's typically used to being the host for clinical trials," Adams said. "We don't really have the type of infrastructure that we have at a research hospital or a clinical trial site, or even in an academic setting. They're just not built to do these kinds of studies."

So Lilly and other nursing home leaders devised a plan that will bring the necessary infrastructure to the nursing homes. The drugmaker has retrofitted a fleet of recreational vehicles to serve as mobile pharmacies where pharmacists can compound and store the experimental medication on site.

Because the drug must be administered intravenously, separate rented trucks will deliver chairs and IV poles for staff to set up temporary infusion clinics. Long dormant due to restrictions on group activities, dining areas can easily be repurposed to handle the infusion portion of the trial, Stemer noted.

“We want to follow the strictest ethical guidelines as we go into a vulnerable patient population like this,” Adams said. “We’re kind of balancing that need to go into this population — where it might be more challenging to enroll if you stick rigorously to those rules — with the fact that this is a population that has a huge unmet need.”

Further complicating the timeframe is the unpredictable nature of COVID-19 outbreaks: Because the study focuses on whether the antigen can prevent or slow the spread of infections and serious complications within the LTC setting, the teams must wait for “index cases” to pop up among participating facilities.

“There’s going to be some variability around how quickly we find out from a site that they have a positive case, how long that case has been present at the facility, and then how quickly can we dispatch the convoy to that facility to start the trial,” Adams said. “I think we’re going to learn as we go.”

In terms of results, the researchers will be looking for evidence that the residents who received the experimental treatment never developed COVID-19 in the first place, as well as improved outcomes for those who do contract the virus — for instance, residents who did not require oxygen or develop complications such as dehydration and acute kidney injury.

While Stemer expressed optimism that the antigen treatment will eventually show positive results, he emphasized that even just the prospect of a treatment can provide precious hope for residents, families, and staff during a difficult time.

“Most facilities recognize that giving patients hope, giving patients’ family hope, that there is intervention — that we have a high likelihood of being able to prevent illness and death — is a huge positive for each facility and for each company and for the industry,” Stemer said. “Because at this point, who would want their their loved one in a skilled nursing facility where the infection is transmitted, and so many people have died?”