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FOCUS POINT NEWSLETTER -- April 28, 2021

. **CMS and CDC Update Guidance on Visitation, Activities, and Testing in Response to COVID-19 Vaccination --** On April 27, 2021, CMS and CDC updated guidance for long term care facilities in response to COVID-19 vaccination. The following key changes have been made:

- Updated SARS-CoV-2 testing recommendations
- Updated visitation guidance to include recommendations for post-acute care facilities and to describe circumstances when source control and physical distancing are not required during visitation
- Added guidance for communal activities and dining in healthcare settings

Details of these changes may be found at the following sites; be sure that you are looking at the revised/updated QSO 20-38 and QSO 20-39 dated 4/27/2021. The tables below offer a summary of changes and other reminders

- *CDC Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination*
- *QSO-20-39-NH - Memo on Nursing Home Visitation*
- *QSO-20-38-NH - Memo on Testing*

Updated SARS-CoV-2 testing recommendations	
CDC	**Revised QSO – 20-39**
• Anyone with symptoms of COVID-19, **regardless of vaccination status**, should receive a viral test immediately. • Asymptomatic HCP with a higher-risk exposure and patients or residents with prolonged close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately and 5–7 days after exposure. o People with SARS-CoV-2 infection in the last 90 days do not need to be tested if they remain asymptomatic, including those with a known contact. • In healthcare facilities with an outbreak of SARS-CoV-2, recommendations for viral testing HCP, residents, and patients (**regardless of vaccination status**) remain unchanged. o In nursing homes with an outbreak of SARS-CoV-2, HCP, and residents, **regardless of vaccination status**, should have a viral test every 3-7 days until no new cases are identified for 14 days. o Hospitals and dialysis facilities with an outbreak of SARS-CoV-2 should follow current recommendations for viral testing potentially exposed HCP and patients, **regardless of vaccination status**.	DEFINITIONS ▪ "Fully vaccinated" refers to a person who is ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine. ▪ "Unvaccinated" refers to a person who does not fit the definition of "fully vaccinated," including people whose vaccination status is not known, for the purposes of this guidance. For **outbreak testing**, all staff and residents should be tested, regardless of vaccination status, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. For more information, please review the section below titled, "Testing of Staff and Residents in Response to an Outbreak." Residents who have signs or symptoms of COVID-19, vaccinated, or not vaccinated, must be tested immediately Testing of Staff and Residents with an Exposure For information on testing staff and resident who may have been exposed to COVID-19, see the CDC's Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination.

• Expanded screening testing of asymptomatic HCP should be as follows: ○ Fully vaccinated HCP may be exempt from expanded screening testing. However, per recommendations above, vaccinated HCP should have a viral test if the HCP is symptomatic, has a higher-risk exposure or is working in a facility experiencing an outbreak. ○ In nursing homes, unvaccinated HCP should continue expanded screening testing as previously recommended.	**Routine Testing** of Staff Routine testing of unvaccinated staff should be based on the extent of the virus in the community. Fully vaccinated staff do not have to be routinely tested. Facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency. Reports of COVID-19 county-level positivity rates are available on the following website (see section titled, "COVID19 Testing"): https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg See Table 1 and Table 2 below

Table 1: Testing Summary

Testing Trigger	Staff	Residents
Symptomatic individual identified	Staff, *vaccinated and unvaccinated,* with signs and symptoms must be tested	Residents, *vaccinated and unvaccinated,* with signs and symptoms must be tested
Outbreak (Any new case arises in facility)	Test all staff, *vaccinated and unvaccinated,* that previouslytested negative until no new cases are identified*	Test all residents, *vaccinated and unvaccinated,* that previously tested negative until no new casesare identified*
Routine testing	According to Table 2 below	Not recommended unless theresident leaves the facility routinely.

Table 2: Routine Testing Intervals Vary by Community COVID-19 Activity Level

Community COVID-19Activity	County Positivity Rate in the past week	Minimum Testing Frequency *of Unvaccinated Staff*[+]
Low	<5%	Once a month
Medium	5% - 10%	Once a week*
High	>10%	Twice a week*

[+]***Vaccinated staff do not need be routinely tested.***

*This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-sitetesting turnaround time is <48 hours.

Updated visitation guidance to include recommendations for post-acute care facilities and to describe circumstances when source control and physical distancing are not required during visitation	
CDC	**Revised QSO – 20-39**
Post-acute care facilities, including nursing homes ▪ Indoor visitation could be permitted for all residents except as noted below: ○ Indoor visitation for unvaccinated residents should be limited solely to compassionate care situations if the COVID-19 county positivity rate is >10% and <70% of residents in the facility are fully vaccinated. ▪ Indoor visitation should be limited solely to compassionate care situations, for:	**The original guidance from QSO-20 - 39 remains intact; guidance was updated to be consistent with CDC guidance. Other key reminders include:** ▪ CMS and CDC continue to recommend facilities, residents, and families adhere to the **core principles of COVID-19 infection,** ▪ Visitors should physically distance from other residents and staff in the facility. **Visitation During Outbreak** – the guidance has not changed and remains consistent as outlined in QSO-20-39. NOTE: In all cases, visitors should be notified about the potential for COVID-

○ Vaccinated and unvaccinated residents with SARS-CoV-2 infection until they have met criteria to discontinue Transmission-Based Precautions. ○ Vaccinated and unvaccinated residents in quarantine until they have met criteria for release from quarantine. ▪ Facilities in outbreak status should follow guidance from state and local health authorities and CMS on when visitation should be paused. ○ Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility if they are permitted to visit. **Other recommendations**: ▪ Visitors, regardless of their vaccination status, should wear a well-fitting cloth mask, facemask, or respirator (N95 or a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators) for source control, except as described in the scenarios below. ▪ Hand hygiene should be performed by the patient/resident and the visitors before and after contact ▪ Facilities should have a plan to manage visitation and visitor flow. Visitors, regardless of their vaccination status, should physically distance (maintaining at least 6 feet between people) from other patients/residents, visitors that are not part of their group, and HCP in the facility ▪ Location of visitation if occurring indoors: ▪ If the patient/resident is in a single-person room, visitation could occur in their room. ▪ Visits for patients/residents who share a room should ideally not be conducted in the patient/resident's room. ▪ If in-room visitation must occur (e.g., patient/resident is unable to leave the room), an unvaccinated roommate should not be present during the visit. If neither patient/ resident is able to leave the room, facilities should attempt to enable in-room visitation while maintaining recommended infection prevention and control practices external icon, including physical distancing and source control. ▪ If visitation is occurring in a designated area in the facility, facilities could consider scheduling visits so that multiple visits are not occurring simultaneously, to the extent possible. If simultaneous visits do occur, everyone in the designated area should wear source control and physical distancing should be maintained between different visitation groups regardless of vaccination status	19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of **Required Visitation**: Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR § 483.10(f) (4) (v). A nursing home must facilitate in-person visitation consistent with the applicable CMS regulations, which can be done by applying the guidance stated above. **Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR § 483.10(f) (4), and the facility would be subject to citation and enforcement actions.** Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through windows, or in-person for compassionate care situations, with adherence to transmission-based precautions. However, this restriction should be lifted once transmissionbased precautions are no longer required per CDC guidelines, and other visits may be conducted as described above

Added guidance for communal activities and dining in healthcare settings	
CDC	**Revised QSO – 20-39**
Who should not participate in communal activities? ▪ Vaccinated and unvaccinated patients/residents with SARS-CoV-2 infection, or in isolation because of suspected COVID-19, until they have met criteria to discontinue Transmission-Based Precautions. ▪ Vaccinated and unvaccinated patients/residents in quarantine until they have met criteria for release from quarantine. **What infection prevention and control practices are recommended when planning for and allowing communal activities?** ▪ Determining the vaccination status of patients/residents/HCP at the time of the activity might be challenging and might be subject to local regulations. ▪ When determining vaccination status, the privacy of the patient/resident/HCP should be maintained (e.g., not asked in front of other patients/residents/HCP). For example, when planning for group activities or communal dining, facilities might consider having patients/residents sign up in advance so their vaccination status can be confirmed, and seating assigned. ▪ If vaccination status cannot be determined, the safest practice is for all participants to follow all recommended infection prevention and control practices including maintaining physical distancing and wearing source control. **Patients/Residents** **Group activities:** ▪ If **all** patients/residents participating in the activity are **fully vaccinated**, then they may choose to have close contact and to not wear source control during the activity. ▪ **If unvaccinated patients/residents are present, then all participants in the group activity should wear source control and unvaccinated patients/residents should physically distance from others.** **Communal dining:** ▪ Fully vaccinated patients/residents can participate in communal dining without use of source control or physical distancing. ▪ **If unvaccinated patients/residents are dining in a communal area (e.g., dining room) all patients/residents should use source control when not eating and unvaccinated patients/residents should continue to remain at least 6 feet from others.** ▪ Patients/residents taking social excursions outside the facility should be educated about potential risks of public settings, particularly if they have not been fully vaccinated, and reminded to avoid crowds and poorly ventilated spaces. They should be encouraged and	**Communal Activities and Dining** While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. The CDC has provided additional guidance on activities and dining based on resident vaccination status. For example, residents who are fully vaccinated may dine and participate in activities without face coverings or social distancing if all participating residents are fully vaccinated; if unvaccinated residents are present during communal dining or activities, then all residents should use face coverings when not eating and unvaccinated residents should physically distance from others. See the CDC guidance Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination for information on communal dining and activities.

	assisted with adherence to all recommended infection prevention and control measures, including source control, physical distancing, and hand hygiene. If they are visiting friends or family in their homes, they should follow the source control and physical distancing recommendations for visiting with others in private settings as described in the Interim Public Health Recommendations for Fully Vaccinated People.	

- ***CHC Note***: How does your direct care staff know which residents / staff have been fully vaccinated or not? You want to ensure the privacy of the resident and while vaccination is encouraged for all, those that choose to not be vaccinated should not be made to feel self-conscious about their decision. Consider options such as "colored bracelets" or other means of quick and easy identification to facilitate compliance with social distancing and use of masks. Do you have a system of maintaining an accurate and up-to-date list of residents/staff who have been fully vaccinated?

Confused About What PPE to Wear???? – One of the most critical components of minimizing spread of COVID is the consistent use of PPE; yet this is also one of the most challenging for many reasons. It is confusing any way that you look at it. The CDC provides lots of guidance, but that website is also difficult to navigate and to know what is current. We found the following summary from AHCANCAL and it appears to a clear and concise summary.

The CDC outlines expectations for personal protective equipment (PPE) use in its interim infection prevention and control *recommendations* to prevent COVID-19 spread in nursing homes. Given that PPE is now largely available for purchase, facilities are expected to be using PPE with these conventional strategies. Per CDC guidance, this includes:

- **Communities with minimal to no community transmission:** adhere to *Standard* and *Transmission-Based Precautions* based on anticipated exposures and suspected or confirmed diagnoses. This might include use of eye protection, an N95 or equivalent or higher-level respirator, as well as other PPE. In addition, universal use of a well-fitting facemask for source control is recommended for health care personnel (HCP) if not otherwise wearing a respirator.
- **Communities with moderate to substantial community transmission:**
  - Follow *Standard Precautions* (and *Transmission-Based Precautions* if required) based on the suspected diagnosis which includes using an N95 respirator or equivalent and face protection for applicable situations with increased risk of pathogen transmission.
  - With respect to COVID-19 transmission prevention precautions, HCP should use PPE as described below:
  - N95 respirators or equivalent or higher-level respirators should be used for all aerosol generating procedures (refer to these *FAQs* for information on which procedures are considered aerosol generating procedures in healthcare settings)
  - One of the following should be worn by HCP while in the facility and for protection during resident care encounters:
    - A NIOSH-approved *N95 respirator* OR
    - *A respirator approved under standards used in other countries* that are similar to NIOSH-approved N95 filtering facepiece respirators OR
    - A well-fitting facemask (e.g., selection of a facemask with a nose wire to help the facemask conform to the face; selection of a facemask with ties rather than ear loops; use of a mask fitter; tying the facemask's ear loops and tucking in the side pleats; fastening the facemask's ear loops behind the wearer's head; use of a cloth mask over the facemask to help it conform to the wearer's face).
  - Additional information about strategies to improve fit and filtration are available in the *resource*, *Improve the Fit and Increase the Filtration of Your Mask to Reduce the Spread of COVID-19*.

- If implementing new strategies or equipment to improve fit, HCP should receive training on how to safely put on and remove their facemask and the facility protocol for cleaning and disinfecting any reusable equipment (e.g., fitter). They should also ensure that any new strategies do not impede their vision or ability to breathe.
- Eye protection should be worn during patient care encounters to ensure the eyes are also protected from exposure to respiratory secretions.

Note: While the CDC does not clearly define what metrics to use to determine moderate to substantial community transmission, providers may be able to use CMS' color-coding methodology to determine community transmission levels.

In addition, the CDC outlines the following expectations for PPE in specific situations, including:

- **In an outbreak:** The CDC recommends that during an outbreak, providers should care for all residents using an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. This includes anywhere direct care is provided, including dining rooms, therapy, etc. An outbreak is defined as a single new case of COVID-19 in a staff person or a nursing home onset infection in a resident.
- **When managing residents with close contact:** HCP should wear an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.

Note: AHCA/NCAL recognizes that staff may have unanticipated encounters with residents outside of their room, which may result in them interacting with residents without full PPE or an N95. We encourage providers to develop policies and procedures to adhere to this CDC guidance, recognizing that there may be circumstances where full PPE or an N95 is not worn during a patient encounter. Providers should be prepared to share the policies and procedures with surveys and show they are making good faith efforts to meet this guidance. Providers should train and empower staff to monitor each other to support consistent and appropriate PPE use.

- **If PPE shortages exist,** providers should follow the CDC's *Optimization Strategies*. However, when this occurs, facilities need to document that:
  - the PPE shortage exists;
  - all their efforts to obtain PPE; and
  - they reached out to their state health departments to notify them of the shortage and seek assistance in gaining additional PPE.

Providers are strongly encouraged to read the CDC's interim infection prevention and control *recommendations* to prevent COVID-19 spread in nursing homes for additional guidance not included here. Finally, providers should also follow any local or state health guidance in place.

MDS Certification Training – Sponsored by AANAC and taught by Judy Wilhide Brandt

RAC-CTA - Advanced Certification -- Dates Mon, May 17, 2021 thru Thu, May 20, 2021;
Virtual class, 12 to 6pm Eastern Time Zone. For the RAC-CT professionals looking to take their experience to a higher le vel, AANAC introduces the Resident Assessment Coordinator - Certified Advanced (RAC-CTA) education program and certification.
The RAC-CTA program provides advanced principles of clinical reimbursement, Medicare program compliance and integrity, RAI/MDS program integrity, leadership, ethical practice, managing medical review, accurate ICD-10 diagnosis coding, advanced strategies for payment oversight, and improving a facility's quality measurement in all CMS quality programs.

Is RAC-CTA right for you? -- Whether you are a clinical reimbursement specialist in a regional, state, or national consultant, or are a professional in any aspect of MDS and Medicare compliance and oversight, this program will help you excel as a reimbursement leader. You must hold a current RAC-CT to qualify to take the RAC-CTA exam. Criteria to maintain RAC-CTA certification: These are separate certifications as they each have a Body of Knowledge. RAC-CT must be maintained as well as RAC-CTA. Link: https://www.aanac.org/Events/Live-Workshops/Workshop-Details?MeetingID=%7BDFB584EA-BA64-EB11-80EB-000D3A0EE4ED%7D

RAC-CT -- **Date Tue, Jun 22, 2021 thru Fri, Jun 25, 2021**; Online Virtual class, 12-6pm Eastern time
The Resident Assessment Coordinator—Certified (RAC-CT) education and certification program has long set the national standard for skilled nursing facility PPS and MDS 3.0 education. The course is constantly reviewed and updated by a team of experts, the RAC-CT program ensures your knowledge of clinical assessment and care planning, completion of the MDS, and the regulatory body surrounding the RAI/MDS process.

- Navigate tough coding dilemmas with the most current coding and regulatory knowledge *Recover reimbursement and avoid overpayment by knowing where to find important MDS data
- Proactively solve quality pitfalls by recognizing the clues reflected in your Quality Measure and Five Star reports *Uncover unique solutions that honor resident preference by synthesizing MDS, CAA, and care plan data into individualized interventions
- Earn respect in your facility by proving that you are dedicated, capable, and knowledgeable
- Gain confidence that will enable you to take a leadership role in resident care

Link: https://www.aanac.org/Events/Live-Workshops/Workshop-Details?MeetingID=%7BBDA90A9D-3660-EB11-80EB-000D3A0EE4ED%7D

MDS Training – Free on YouTube from CMS -- SNF Resident Mood Interview Video

Don't underestimate the importance of accurate coding of Section D [Mood] on the MDS. Watch the 30 minutes Resident Mood Interview (PHQ-9©) for the Skilled Nursing Facility (SNF) Setting video to learn how to:

- Properly code D0200 and D0300
- Improve your interviews
- Complete the Total Severity Score

PEPPER REPORTS are AVAILABLE for SNFs

Fourth quarter fiscal year 2020 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for Long-Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs), Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs), hospices, and Skilled Nursing Facilities (SNFs). **These reports summarize provider-specific data for Medicare services that may be at risk for improper payments. Use your data to support internal auditing and monitoring activities.** PEPPER provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER can support a facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments. More Information:

- Visit the Distribution webpage for guidance accessing your report
- Visit the PEPPER Resources website for user's guides, recorded training sessions, FAQs, and examples of how other providers are using the report
- Contact the Help Desk if you have questions or need help getting your report

Boost Your Team's Optimism

Leaders, even during these trying times, are setting the tone to empower employees to do their best work. When times a tough and in general people feel down, you can still steer your team towards optimism. Here are four suggestions:

1. **Create fun times for employees.** Allow a time and space to unleash your team's imagination, creativity, and laughter.
2. **Encourage problem solving** with autonomy in fixing problems and piloting new ideas. Driving a project, you are passionate about creates an optimistic mindset.
3. **Help employees connect.** Human connections keep employees upbeat and motivated.
4. **Share and celebrate good news.** Highlight accomplishments and positive developments. Show gratitude and positivity at your next team meeting.