Chiles Healthcare Consulting LLC
1908 Maple Shade Lane, Richmond, Virginia 23227
mary@chileshealthcare.com 804-690-5824

FOCUS POINT NEWSLETTER
FOCUS POINT COVID-19 ALERT 5-11-2020

CMS Updates to 1135 Waivers – 5/11/2020

HOSPITALS: Expanded Ability for Hospitals to Offer Long-term Care Services ("Swing-Beds") for Patients Who Do Not Require Acute Care but Do Meet the Skilled Nursing Facility (SNF) Level of Care Criteria as Set Forth at 42 CFR 409.31. ***(New since 4/30 Release)*** Under section 1135(b)(1) of the Act, CMS is waiving the requirements at 42 CFR 482.58, "*Special Requirements for hospital providers of long-term care services ("swing-beds")*" subsections (a)(1)-(4) *"Eligibility"*, to allow hospitals to establish SNF swing beds payable under the SNF prospective payment system (PPS) to provide additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF. In order to qualify for this waiver, hospitals must:

- Not use SNF swing beds for acute level care.
- Comply with all other hospital conditions of participation and those SNF provisions set out at 42 CFR 482.58(b) to the extent not waived.
- Be consistent with the state's emergency preparedness or pandemic plan.
- Hospitals must call the CMS Medicare Administrative Contractor (MAC) enrollment hotline to add swing bed services. The hospital must attest to CMS that:
    - They have made a good faith effort to exhaust all other options;
    - There are no skilled nursing facilities within the hospital's catchment area that under normal circumstances would have accepted SNF transfers, but are currently not willing to accept or able to take patients because of the COVID-19 public health emergency (PHE);
    - The hospital meets all waiver eligibility requirements; and
    - They have a plan to discharge patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.
- This waiver applies to all Medicare enrolled hospitals, except psychiatric and long term care hospitals that need to provide post-hospital SNF level swing-bed services for non-acute care patients in hospitals, so long as the waiver is not inconsistent with the state's emergency preparedness or pandemic plan. The hospital shall not bill for SNF PPS payment using swing beds when patients require acute level care or continued acute care at any time while this waiver is in effect. This waiver is permissible for swing bed admissions during the COVID-19 PHE with an understanding that the hospital must have a plan to discharge swing bed patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.

LONG TERM CARE FACILITIES: Paid Feeding Assistants. **(New since 4/30 Release)**

- CMS is modifying the requirements at 42 CFR §§ 483.60(h)(1)(i) and 483.160(a) regarding required training of paid feeding assistants. Specifically, CMS is modifying the minimum timeframe requirements in these sections, which require this training to be a minimum of 8 hours. CMS is modifying to allow that the training can be a minimum of 1 hour in length. CMS is not waiving any other requirements under 42 CFR §483.60(h) related to paid feeding assistants or the required training content at 42 CFR §483.160(a)(1)-(8), which contains infection control training and other elements. Additionally, CMS is also not waiving or modifying the requirements at 42 CFR §483.60(h)(2)(i), which requires that a feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

LIFE SAFETY CODE: Specific Life Safety Code (LSC) for Multiple Providers - Waiver Information: ***(New since 4/30 Release)***

- CMS is waiving and modifying particular waivers under 42 CFR §482.41(b) for hospitals; §485.623(c) for CAHs; §418.110(d) for inpatient hospice; §483.470(j) for ICF/IIDs and §483.90(a) for SNF/NFs. Specifically, CMS is modifying these requirements as follows:

- **Alcohol-based Hand-Rub (ABHR) Dispensers:** We are waiving the prescriptive requirements for the placement of alcohol based hand rub (ABHR) dispensers for use by staff and others due to the need for the increased use of ABHR in infection control. However, ABHRs contain ethyl alcohol, which is considered a flammable liquid, and there are restrictions on the storage and location of the containers. This includes restricting access by certain patient/resident population to prevent accidental ingestion. Due to the increased fire risk for bulk containers (over five gallons) those will still need to be stored in a protected hazardous materials area. Refer to: 2012 LSC, sections 18/19.3.2.6. In addition, facilities should continue to protect ABHR dispensers against inappropriate use as required by 42 CFR §482.41(b)(7) for hospitals; §485.623(c)(5) for CAHs; §418.110(d)(4) for inpatient hospice; §483.470(j)(5)(ii) for ICF/IIDs and §483.90(a)(4) for SNF/NFs.
- **Fire Drills:** Due to the inadvisability of quarterly fire drills that move and mass staff together, we will instead permit a documented orientation training program related to the current fire plan, which considers current facility conditions. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. Refer to: 2012 LSC, sections 18/19.7.1.6.
- **Temporary Construction:** CMS is waiving requirements that would otherwise not permit temporary walls and barriers between patients. Refer to: 2012 LSC, sections 18/19.3.3.2.

Telehealth Video

CMS updated a video that answers common questions about the expanded Medicare telehealth services benefit during the COVID-19 public health emergency. **New** information includes how CMS adds services to the list of telehealth services, additional practitioners that can provide telehealth services, and the distant site services that Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can provide. Further, the video includes information about audio-only telehealth services, telehealth services that hospitals, nursing homes and home health agencies can provide, along with how to correctly bill for telehealth services. Video may be found at: https://www.youtube.com/watch?v=Bsp5tIFnYHk&feature=youtu.be

VDH Point Prevalence Survey Guidance for Long-Term Care Facilities

The PPS is being offered as a collaboration between the Virginia Department of Health (VDH), the Division of Consolidated Laboratory Services (DCLS), private laboratories, and the tertiary medical centers of Virginia, the University of Virginia (UVA) and the Virginia Commonwealth University (VCU) Health Systems. The Virginia National Guard (VANG) is also a partner to assist facilities with testing kit delivery, specimen collection, and specimen delivery to the lab. The use of the VANG reduces the burden on facility staff, allowing them to focus on the care of its patients. In order to meet demand for high-risk settings while recognizing limitations in testing capacity, VDH is prioritizing PPS by setting as outlined below. This prioritization is based on the Commonwealth's data regarding the number of settings experiencing COVID-19 outbreaks. As laboratory testing capacity and supplies to support testing increase across the Commonwealth, the Virginia Department of Health (VDH) will revise this guidance.

- Priority #1: Skilled nursing facilities/nursing homes, assisted living facilities
- Priority #2: Targeted units of state correctional facilities and local jails
- Priority #3: Other congregate living facilities (e.g., homeless shelter, group home, rehabilitation facility, or residential behavioral health facility)

Expectations of Facility

- The local health department or the VANG would deliver specimen collection supplies to the facility.
- The facility would identify staff to collect, label, and package the specimens (nasopharyngeal swab). The facility would supply the necessary personal protective equipment (PPE) for those who collect specimens (gloves, goggles, facemask).
- VANG is a resource the facility could use to collect the specimens. VANG provides its own PPE.
- The goal is to collect specimens on all residents (or those on a particular wing/floor) and staff on one day. If there are more residents than lab testing/collection capacity for a specific day, specimen collection may be split over more than one day.
- Specimens would be packaged and transported to the laboratory by DCLS courier, commercial courier (e.g., FedEx) or VANG transport.
- The facility **would be responsible for obtaining consent from residents or families for the testing.**

- Facility staff would be responsible for collecting data on each resident tested, including name, date of birth, location within the facility, temperature, signs or symptoms of illness, and other data elements identified in advance by the local health department.

Considerations for Facility

- The results will inform facility administrators about the extent and distribution of infection with the virus that causes COVID-19 in the facility on the day(s) of testing.
- The results could necessitate changes to resident care recommendations for those who test positive and their roommates. These changes could impact staffing and use of PPE.
- Repeat testing could be recommended to determine if persons who were negative on the day of the survey became infected afterward.
- The documentation of positivity could cause concerns among staff and residents.
- A plan needs to be in place for managing staff with positive or negative test results, which may include furloughing staff who test positive.
- The facility **would need to have a plan for communicating results to residents, staff, and families.**

Frequently Asked Questions regarding Point Prevalence Surveys in Long-Term Care Facilities

Q: *What is a Point Prevalence Survey (PPS)?*

A: A point prevalence study involves testing staff and residents for the presence of SARS-CoV-2, the virus that causes COVID-19. The results from a PPS can describe the scope and magnitude of COVID-19 in a facility and can sometimes help inform additional prevention and control efforts designed to further limit transmission.

Q: Who will be tested?

A: VDH recommends testing all residents and staff in facilities with two or more laboratory-confirmed cases of COVID-19.

Q: What is the purpose of testing all residents?

A: Early experience from long-term care facilities with COVID-19 cases suggests that when residents with COVID-19 are identified, there are often asymptomatic residents with SARS-CoV-2 present as well. Conducting a PPS of all residents in the facility can identify infected residents who can be cohorted on a pre-specified unit or transferred to a COVID-specific facility.

Q: What is the purpose of testing all staff?

A: Early experience suggests that, despite healthcare personnel (HCP) symptom screening, when COVID-19 cases are identified in a long-term care facility, there are often HCP with asymptomatic SARS-CoV-2 infection present as well. HCP likely contribute to the introduction and further spread of SARS-CoV-2 within long-term care facilities.

Q: How should my facility prepare?

A: Facility leadership should be prepared for the potential to identify multiple asymptomatic residents and staff. CDC guidance on responding to COVID-19 in long-term care facilities should be reviewed by the appropriate infection prevention staff in your facility.

Q: How do I schedule a PPS?

A: A coordinator from VDH will reach out to the facility to schedule. VDH is prioritizing facilities with at least two laboratory-confirmed cases of COVID-19.

Q: How will I get the results?

A: VDH or the testing laboratory will inform you of the results. The results will be reported back to the facility within 24 hours of the testing laboratory receiving the specimens. General guidance about what to do with the results will be communicated with the facility point of contact.

Q: What changes might happen based on the results?

A: Results from a PPS will lead to infection prevention and control actions such as: 1. Cohorting residents to separate those with SARS-CoV-2 infection from those without detectable SARS-CoV-2 infection at the time of testing to reduce the opportunity for further transmission. 2. Identifying HCP with SARS-CoV-2 infection for work exclusion. 3. Determining the SARS-CoV-2 burden across different units or facilities and allocating resources/training.

Q: Is a PPS required?

A: No, a facility can opt out of a PPS.