Centers for Medicare & Medicaid Services
COVID-19 CMS CDC Nursing Home Outbreak Response Calls with States
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OPERATOR: This is Conference #6982631

Ashley Spence: Good afternoon all and thank you for joining the CMS CDC Nursing Home COVID-19 Outbreak Response Calls with States. My name is Ashley Spence. I'm with CMS and is moderating this call today.

To get started first, I would like to turn over the call to Dr. Lee Fleisher, Director of the Center for Clinical Standards and Quality of CMS. Dr. Fleisher?

Lee Fleisher: Yes, Ashley. Thank you so much. And it's a real pleasure to be joining (Arjun) and our CDC colleagues today on a call. And I want to thank the states, the Governor's office, the agencies, the public health component, for all you do every day, on the care of all individuals in your state, and in particular, the focus on the nursing home residents.

As I'm sure you're aware that the CDC and CMS have essentially spent the last nine months working together, ensuring that our guidances were coordinated. And now we're really coming to the next phase of the pandemic, where it is clearly surging again, and the need to become much more tactical, and strategic in the way we deploy our joint resources to ensure the safety of the nursing homes with regard to COVID-19.

So I'll be talking about that shortly. We'll be reviewing both the CMS approach the CDC, our joint approach, as well as hearing some best practices from the states. And with that, I'll turn it over to (Arjun).

(Arjun): Thanks so much, Lee. I'll just echo everything Lee said. We so appreciate everything that all of you are doing. We know this has been – already been a marathon. And you guys have been doing so much in working with the

nursing homes and the long-term care community to protect the residents. And we know it continues to be a challenge.

As Lee noted, cases are going up in nursing homes, deaths are going up in nursing homes, largely have a reflection of what's going on outside of nursing homes, which remains an ongoing and continuous challenge.

We already know that there is tremendous coordination happening in all of the states. We're going to hear a little bit about some of those best practices. We are eager to support your coordination efforts in any way that we can and support you in any way we can with additional help that you all might need.

We are standing ready to do that. And one of the other things that is obviously a big priority for us is to be able to have some little bit of information and insights into all of the different things that are going on in the states, where there's – follow what happening, so that we can help track here at the federal level, and provide whatever real federal resources are useful and can be brought to bear into that is one of our other priorities.

And I know that's something (Joe's) going to talk about and has been working on is trying to get that increased awareness from us without making that a truly burdensome process for all of you. So we thank you all for all that you're doing for all your help and support and for your patience with us, as we try to work through the process of enhancing this coordination. Over.

Lee Fleisher: Thank you so much, (Arjun). And I want to say we, we've seen a lot of articles, and (Arjun's) mentioned this, about the fact that what is happening in nursing homes. And it's important to recognize that, I think, without all the work that you're doing every day, that the CDC is doing, our guidances in our use of our survey or agencies with you, in collaboration, it is my opinion that the situation would be much, much worse, and that we'd be seeing a greater number of homes and a greater number of residents, who were having COVID and are dying from COVID.

And, in fact, I was not at the agency back at the beginning of the pandemic, but the nursing homes were the leading edge. And now, we're sort of seeing it

concordant with the community and really, the fact that even with the best of testing, a symptomatic spread is coming in.

And I think it's important to recognize something that we recently heard from (Inaudible), the association that we really are looking at three sort of buckets of nursing homes. Those who get understand what best purchase practices are, that they understand what they're supposed to do, but COVID still can get in because of the asymptomatic entry from staff. And that, in fact, once it comes in, the hope is that they really are quickly able to address the issues and limit the spread. And that's a lot of how we're thinking about this approach we're taking, that's much more tactical.

There's a second set of nursing homes that really want to do best practices that are really trying their best. They may have limitations, PPE, staffing, other issues. And if we provide them with additional education, being a frontline provider myself, I know how hard it is to maintain my N95 the whole day in proper position, that, in fact, we want to make sure that we provide whatever they need to get it under control.

And there's a third group who were not as convinced that their approach to control is optimal. And, therefore, we may need our survey, which you guys are doing, as well as much more oversight. So the approach we're taking that has just begun over the last several weeks is dividing the group up into three essential buckets.

Those that have, what we would call, the very hot spots, the 30 or more cases in a single nursing home in a week. Those in that 10 to 30, that we really, if we get in there, we can hopefully mitigate quickly, and ensure that they don't get to the 30 or more residents with COVID in a given week, and those one to nine that we want to watch. And we want to make sure we give them the resources.

And when you think about it, the resources are really threefold, or fourfold. We have survey, the CMS work. We have the guidances that are joined – CMS, CDC. We have the CDC work with the states with the AHI's, which we'll be talking about, as well as we now have Project Green Light, which is

coming out of HHS, which coordinates with the states and provide you with where they need additional PPE, additional staffing, and additional testing, which can come directly from HHS, with regard to the Binax cards or other things.

So for those 30 or more, our QIO organizations are making those phone calls. We're getting the list, we're asking them a series of questions. One of them – several of them being regarding resources, which I just discussed, and we're triaging those to the appropriate place within HHS, as well as asking them if they have the state agencies, the local resources already involved, whether it be strike teams or HAI teams from the states.

If they don't, and they feel they're not under control, we're at – we're actually working with the CDC to identify that. And to determine which resources whether it needs federal resources to come on site, as well as asking them, "Do they need more educational information?" And then sending in our QIO teams to do that education.

And in fact, we want to remind the state agencies, the HAI teams, that if you feel that a QIO can come in and help, you can coordinate directly with the QIOs, or work through our offices. And we will direct the QIOs to go to a nursing home that needs that additional assistance.

I'm very pleased in that middle group, the 10 to 30. We're asking those same basic questions about resources and control of the pandemic, and need for more education. And we are doing that to our Opal group, another part of CMS.

And that we are getting that information again, asking about the level of control, getting that information over to the CDC, who's working with the state agencies, using our QIOs for those places that need more resources.

And, finally, getting any kind of education also out to those who asked for the education. So this is great. really much more tactical. And then finally, we're do – looking at utilizing for the one to nine. We have Operation Green Light, which is at HHS, which is asking some of those questions. This is really the resource, it's sort of focused on the issue of resources. We're getting a lot of

information from the state, so they may not call everyone. They're calling those the states can get to. And again, deploying our appropriate resources to the appropriate location.

So I hope you can see we're trying really to get the nursing homes what they need, but most importantly, to not duplicate your efforts. And, in fact, one of the main reasons for this call today is to establish even a closer tie, not only the CDC-CMS coordination, but with the state. So because we've heard if too many of us go in there, that actually can cause harm. But there's certainly opportunities to coordinate.

And, lastly, we have the survey organizations, which we continue to say that they have one new case or three or more cases they can go in. But we're trying to deploy them, given the marked increased number of these homes that are showing things, not every week that we're seeing this.

But unless they have very high numbers, really deploying it strategically. And you – many of your state agencies have heard this, to use it strategically to survey those homes that, again, have very high levels that are in crisis 30 or more. But for some of the ones in the one to nine, if we surveyed them, and they're starting to turn the corner, we'd like them to just get the control themselves. So I hope you can see how we're thinking about this in the strategic manner.

And then – and I'll now turn it back to (Arjun) to talk about the CDC's approach and how we coordinate. (Arjun)?

(Arjun): Agreed, right. And we agree that all of that coordination is critical. And I'm going to turn it over to Joe Perz on our end, who's going to share some of the – some of the thoughts on the response, Joe?

Ashley Spence: Joe, if you're speaking, you're on mute, by the way.

Joe Perz: Shucks. OK, sorry. This is Joe Perz from CDC. And I was just thanking (Arjun) and Dr. Fleisher for their comments. And I'd like to pick up on some of those themes in terms of – and this is something that you've all been doing

since the early days of the pandemic, which is you're using data for action, and particularly in the long-term care space.

And when we think about the robust information systems that you've helped us build, we have all U.S. nursing homes reporting to CDC's National Healthcare Safety Network, or NHSN. And that does provide data for action.

We also recognize that, in many respects, the states have systems that are more real time, in terms of the information that you can receive. You're requiring, in many cases same-day reporting of new COVID cases in nursing homes, and you're acting on that data.

I know that, again, since the early days of the pandemic, most jurisdictions have taken a single staff or resident case, as a signal of a potential outbreak. And that you've applied what we would recognize as a containment approach to, again, in a very tactical manner, as Lee was describing, interact with the facility to understand where they are, what their needs are, and to make sure that they're following guidance that will help them limit the spread and limit harm to their residents and to their staff. We'll hear from our state guests in just a few moments. You'll hear more about how information is shared and managed to affect that kind of effective outbreak response.

I don't want to say too much more except to say that we are trying to model this kind of coordination and data for action at the federal level. CMS has organized outreach to facilities, based on the numbers of cases, as you heard.

We hope that that activity complements the work that you're already doing. And as noted, if the responses from facilities in terms of the conversations that they have with CMS staff are concerning we will relay that information. And in fact, we're building systems to make sure that information is relayed to those of you on the front lines at the state and local levels.

I think I'll pause there, and maybe invite my colleague, Dr. Nimalie Stone, to see if she'd like to offer a few comments. Many of you will recognize Nimalie as CDC's lead for long-term care, infection prevention and response. Nimalie, are you there?

Nimalie Stone: Thanks so much, Joe. And, and let me just start by expressing my gratitude. And that is our whole program supporting long-term care during the COVID response for the incredible, ongoing partnerships that we have with all of our state and local colleagues.

While this has been one of the most challenging experiences we've ever faced, I think something like a silver lining from this pandemic, is how we have expanded and strengthened the partnerships across federal, state, and local health departments with the long-term care provider community.

Many colleagues have expressed the value of the increased communication and coordination occurring between regulatory programs, communicable disease and HAI prevention programs, and quality improvement programs. Just as our federal programs at CDC and CMS are jointly planning and implementing prevention strategies, we are seeing similar robust efforts in place in state and local jurisdictions across the country.

We are also hearing from nursing home and assisted-living providers how helpful it is to participate in calls and webinars, where all the various stakeholders providing them with outbreak support are represented.

It reassures everyone that we're all working together to maintain consistent guidance and messaging. And we know it's not always easy to coordinate activities, especially during this really hectic time. But we are tremendously grateful for all of your efforts.

And with that, I just want to say how excited we are to learn from two of our state programs that are sharing their experiences and providing examples of strong cross program collaboration.

So let me turn it back to Lee to introduce them. Thanks so much.

Lee Fleisher: Thanks so much. And do we have (Erica) on the line?

Erica Baldry-Araos: Hi, this Erica. Can you hear me?

Lee Fleisher: Yes. So Erica is from Montana. And you can tell us more about yourself since I don't have the full details, but we look forward to hearing what you do in Montana. Thank you so much for joining us.

Erica Baldry-Araos: Sure. Perfect. Thank you for having me. So my name is Erica Baldry-Araos. And I am the Program Coordinator and Communicable Disease Epidemiologist here in Montana. The state of Montana encounters certain challenges in the delivery of health care and prevention of infectious diseases because it is a geographically large state with a small population.

We are a decentralized state, which adds another layer and players to the COVID-19 response. Due to this collaboration is a necessity. In Montana, we recognize the overlap of activities and requirements of different entities, including the QIN-QIO, state health department, and the state survey agency very early in the pandemic.

Facilities also made sure we knew about the duplication of efforts. As the HAI program coordinator, my primary role in the COVID response has been working with local partners to investigate outbreaks of COVID-19 in long-term care facilities and assisted-living facilities.

Additionally, I have been tasked with providing infection control expertise to facilities throughout the state. I have a team of four infection preventionists performing infection control assessments in our assisted-living facilities and long-term care facilities.

During an outbreak situation, all assisted-living facilities and long-term care facilities are offered an infection control assessment. We are actively recruiting all assisted-living facilities and long-term care facilities and offering this service to them.

Each Tuesday, I reach out to every single assisted-living facility and long-term care facility experiencing an outbreak, either directly or through the local public health department. Our local public health departments have continued communication with each facility to make sure they feel supportive throughout the entirety of their outbreak.

To improve communication and to decrease duplication of efforts, we have scheduled a bi-monthly or every other week meeting to discuss current activities between our QIN-QIO Mountain Pacific quality health, HAI program, which is located in the communicable disease epidemiology section, and the state survey agency.

During this call, we discuss what types of facilities we're working with, what issues we are having concerns that we have heard from facilities and ways that we can help. It has been very beneficial to have a structured, consistent way of working together.

In addition to our bi-monthly call, we host a weekly infection prevention webinar. Our QIN-QIO joins these calls. For the past two months, we have also asked the state survey agency to join infection prevention webinars and host an FAQ session once a month.

I am often asked regulatory questions. So having a relationship with the state survey agency has not only increased my knowledge about CMS requirements, but my relationship with facilities and our confidence in my knowledge base.

Every Wednesday, we post a summary of assisted-living facility and long-term care facility outbreaks in the state to our communicable disease COVID-19 webpage. A list of facilities experiencing outbreaks is shared with the state survey agency weekly.

It is very important to us that the state – that the state survey agency knows what they are walking into during an on-site survey. Something as simple as CC-ing one another on emails has really helped to streamline efforts and decrease the number of emails that facilities have to send or respond to.

The Montana HAI program also works closely with the Hospital Preparedness Program and Public Health Preparedness Program regarding NHSN data, PPE supply and staffing shortages, I can communicate problems identified in facilities experiencing outbreaks. This has been particularly helpful during times of surge to ensure facilities are receiving necessary supplies in a timely fashion.

The Montana HAI program has a strong relationship with the Montana Public Health Laboratory, which helps with testing efforts in the state. Our department has worked very hard at building our testing capacity by adding several laboratory partners.

Our governor recognized the importance of testing and our long-term care facilities and assisted-living facilities at the beginning of this pandemic. Having that support was vital to creating a process for testing in these facilities. We offer baseline testing in both settings, prior to (national) long-term care facility testing recommendations.

When these facilities started experiencing outbreaks, they had already been through the testing process, and many of the hiccups have been worked through. We still face challenges regarding testing and continue to improve this process. The increasing volume and external partners have led to increased turnaround time.

In a rural state, working with other entities is essential and a response to this magnitude. If we don't work together and agree on messaging, the facilities and residents are the ones that suffer. By working together we can improve the overall assistance that we're providing facilities.

This also helps to streamline efforts and create a unified front. At the end of the day, we want to do what's best for the facilities and be there for them during one of the hardest things that they have been through. Thank you.

Lee Fleisher: Thank you so much. And if now we can go to Thi Dang from Texas. Are you on the line?

Thi Dang: Hi, good morning or good afternoon.

Lee Fleisher: Great, thank you. You can tell us about yourself …

Thi Dang: And my name …

Lee Fleisher: … and what you're doing in Texas. Great.

Thi Dang: Sure. My name is Thi Dang. I am one of the Texas HAI epidemiologist, and I'm speaking on behalf of our HAI coordinator, (Dr. Maringua). Thank you for inviting us today and to share what we're doing in Texas to unify our approach here.

So just want to introduce that Texas has 254 counties and approximately 4,000 licensed nursing facilities, assisted-living facilities and group homes. And here in Texas, we have state regional and local health departments.

DSHS is the state health department and we, the HAI epidemiologists, work for DSHS. But we serve in a unique role at both the state and regional level, where we also are on the boots on the ground, as you can say.

So since the beginning of the Texas response, our regulatory – we actually been holding regulatory – regular meetings with HHSC, which is our state regulatory agency, DSHS and our state operations center. These joint meetings have actually allowed for more collaborative information sharing inconsistent information dissemination across all of our agencies for a more unified messaging.

And the data sharing has been going very well between our agencies throughout the response, and we believe that, really has led to more joint approach for outbreak and mitigation efforts. Our COVID-19 data has been reported daily by facilities to our regulatory partners, HHSC. And HSSC summarizes their data into spreadsheets, which they then send to us at DSHS. The data that they send includes a list of the facilities that have positive COVID-19 cases. And this helps us epidemiologist at both the regional and local health department levels, as it is real time data.

The epidemiologists are able to use this list to contact the facilities via phone. And then we identify the case burden, what processes they currently have in place, and identify any infection control gaps that would need to be addressed. And we make recommendations for mitigation.

As you heard me say we were quite a large state, and we do not have the manpower to really go on site to every facility in Texas that has COVID-19 cases. However, our epidemiology teams, both at the regional and local level,

have been implementing remote infection control assessments, as well as on-site infection control assessments.

The on-site infection control assessments are really being done as needed, or depends on the specific situation at the facility. And in some situations, our regulatory partners have actually asked for our assistance.

So our focus is always to assist facility to decrease the disease burden among the residents, staff and visitors. However, sometimes we do identify situations on the epidemiology side, as we're working with them, where a referral to our regulatory partner is needed.

One of the things that we're doing is actually the NHSN CDC data is being used by HHSC to create a call down list for the long-term care regulatory regional staff to conduct calls to facilities on a weekly basis. And these calls of staff are contacting the facilities regarding the information they reported on PPE shortage and staffing shortages in the NHSN database.

Results of these calls are then documented, and they're reviewed by our long-term care regional directors to determine if an on-site visit is needed. And then the outcomes of the visits are documented. And then if requested, the HAI epidemiology team is able to assist the facilities with an on-site ICAR.

HHSC, our DSHS, HAI team, our emergency management partners as well as some other entities here in Texas, have collaborated on joint response teams that we call the Rapid Assessment Quick Response Force. And this response team basically was formed to assist long-term care facilities with their needs during the pandemic.

So through our safe assistant request process, our facilities are able to request assistance on various things that include things, such as our HAI epidemiology or infection control assistance. This is done either mostly on-site, but we can also assist with these requests virtually. They also can put in requests for testing, staffing, facility disinfection, as well as the PPE or some supplies that they may need that we have as a resource.

The collaboration between our agencies has definitely been instrumental for our own situational awareness and each of the agencies. But it's also been very helpful for all of us to work together with the facilities to show more unified approach and to show them that we really are here to help them. Thank you.

Lee Fleisher: Thank you so much. And we now have time for questions and then open discussion. So, unless Nimalie, any other or Joe any comments first?

Nimalie Stone: Not for me, Lee. Thank you.

Lee Fleisher: OK. So, Ashley, you want to open up the questions.

Ashley Spence: Yes. Sure. Operator, if we can begin taking questions on the line, please?

Operator: Thank you. At this time, if you want to ask a question over the phone, please press star followed by 1. Again, that is star 1 to ask a question.

To ask a question over the phone, please press star 1.

Lee Fleisher: So as we're waiting for questions …

Operator: First question …

Lee Fleisher: Great. OK. Operator, please.

Operator: OK. First question comes from the line of the participant is has 4904 the last four digits of your phone number, please introduce yourself. Your line is now open.

Cristina Chaminade: Hi, my name is Cristina Chaminade epidemiologist with the local health department in Virginia, the Virginia Department of Health. My question is we've had challenges. We've done all the Tele-ICARs and the coach our facilities on what proper infection control needs to be done.

But we still have challenges that they say they're doing all the right thing, but we're still finding spreads within the building. And I was wondering how you

kind of address this, especially in Texas, you said you weren't able to go on site a lot of the time.

So what are some tricks that you've learned in communicating with your facilities to really find out what's really going on the ground. We found our in-person visits to be most valuable and finding some of these deficiencies when on the phone, everything seems to be OK. Thank you.

Thi Dang: Yes.

Lee Fleisher: Yes, please.

Thi Dang: Would love – would address – OK. OK. So this Thi. So yes, we've also found the in-person visits to be the most effective. And what we have done in Texas is we do the – we utilize the CDC's Tele-ICAR tool, where we go through all of the questions.

And then we do offer facilities to do a video ICAR as well, where we're able to actually have somebody in the facility holding some sort of device, whether it's a phone, or if it could – it could be a tablet of some sort that has a video conferencing application on there.

Mostly, we've been using FaceTime, but we use other applications as well. And we ask somebody to hold it and basically take us around the facility. That seems to be the most effective way to really see some of the processes.

Because we choose (the list) same way. As you just said, a lot of times when we're asking questions, and they're answering verbally, we're not really able to see what they're describing. And that's typically when we ask them to switch to the video portion.

We are not always successful 100 percent of the time to be able to switch to the video, as some facilities do not want to do that format. And so, we really try to encourage them to accept an on-site visit from us. Thank you.

Cristina Chaminade: Thank you.

Lee Fleisher: And as you probably are aware, the CDC and CMS also created the three-hour scenario-based training, which was based a lot on Nimalie's and other visits with the strike teams, which hopefully will further educate individuals. Nimalie, just double checking any other thoughts or advice from your experience on the ground?

Nimalie Stone: Only to echo the values that the time that you all are able to spend with providers and the troubleshooting that you can do some times more effectively when you're able to visit a center, just how important and how much that helps with the implementation of these principles and guidance.

It's often in the translation, taking a policy and putting into practice that are – can be the most difficult. And we also learn a tremendous amount from you, as you share what you're observing and what you're hearing from the provider community back to us. So it's a – it's certainly informed the changes and updates that we're able to make. And it's a critical sort of directional communication path. Thanks, Lee.

Lee Fleisher: Thank you. Operator, do we have another question?

Operator: Yes, sir. Next question comes to the line of Lyndsay Kensinger from the state of Nevada. Your line is now open.

Lyndsay Kensinger: Hi, thank you so much for the call and taking my question. I just wondered if there was a recommendation for long-term care facilities with the updated guidance around quarantines, moving to 10 days, and then seven days with a negative test?

Are you suggesting that facility residents start following this updated guidance? Or should residents still continue to follow the 14-day quarantine guidance, and then maybe only staff follow the 10-day or seven-day option? And I was also wondering if there's going to be any publicly posted guidance or recommendations for how we should put this into practice in our facilities in the future? Thank you.

Lee Fleisher: Sounds like a CDC question. (Arjun) or your team.

(Arjun): Joe and Nimalie …

Nimalie Stone: Hey, this …

(Arjun): Yes, go ahead, Nimalie.

Nimalie Stone: Sorry, (Arjun). Yes, this is Nimalie. I really appreciate the question. We have been receiving it from a lot of colleagues across the country. And we are in the midst of making some updates to guidance for nursing homes and long-term care facilities, based on some recent updates to the broader CDC guidance.

But we will continue to preferentially promote 14-day quarantine for residents and staff. It is the safest option. And we know that there will be some level of risk introduced, if people choose to shorten that period of quarantine, with or without testing.

And so, for health care, in particular, for settings that are really taking care of the most vulnerable, we will continue to sort of recommend the 14-days, acknowledging that sometimes circumstances are such that you need to make adjustments based on staff shortages, or bed shortages, which are realities that a lot of providers are facing. Thanks.

(Arjun): And, Nimalie, any timeline they're on when we might have something posted? I think that was the other question?

Nimalie Stone: I'm not sure I can give an accurate timeline, (Arjun). But I would say that it's a high priority. And we're doing our best to move it to our review process as quickly as we can.

Lee Fleisher: Great. Operator, we have time for one more question?

Operator: If anyone wants to ask a question, please press star 1.

Lee Fleisher: And, again, I think one …

Operator: And I'm seeing no further no questions, please continue.

Lee Fleisher: Great. Great. (Arjun), any final comments? And then I'll close the meeting.

(Arjun): Yes. Thanks, Lee. Just to thank everyone for their time, for their ongoing work that they're doing, again for their ongoing patience with us as we work to try to improve all of the things that we are doing. And we are all about continuous quality improvement. And so, we always want to hear from any of you who have ideas of ways that we can improve the processes and support on our side. Over.

Lee Fleisher: And, again, I really want to thank you continue learning from each other. We would be more than happy to rejoin you, again, for these calls and folk – and highlight other states of what they're doing, because we still have several months ahead of us.

Even if the nursing home residents are prioritized with COVID getting in and spreading. So – and most importantly, as was highlighted on one of the previous questions, it's not about the guidance, but it's what you see on the ground, and the implementation of that guidance, that's really critical.

So learning from each other about how to help the nursing home community would be the ideal situation. So thank you very much for all you do every day for the resonance of your states both the nursing home, the staff, and all the residents. And with that, I'll turn it over to Ashley to close it out.

Ashley Spence: Yes. Thank you so much, Lee, and thank you all for joining the call today. As always, you can submit any questions that you may think of post-call to our COVID-19 mailbox. And so that's COVID-19@cms.hhs.gov. So thank you all for all that you're doing, again, for patients and families during this public health emergency, and we look forward to chatting with you at another call soon. Thank you.

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