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THE ADELMAN ADVANTAGE

by Rebecca Adelman

Nursing Homes Need Shortages Prioritized – Not More Revised Guidance, More Surveys and More Fines

I've rewritten this month's article three times in the past two weeks (thanks to the publisher for eternal patience) because it's hard to keep up and keep track of the many punitive actions that CMS has taken during the past two weeks.

As I write this version, "CMS is taking unprecedented action to ensure that nursing homes are doubling down on efforts to prevent the spread of the virus," by offering an infection control training webinar program for staff and management. Threatening fines and funding cut-offs, CMS also announced that it will require facilities to test staff regularly. Last week, CMS announced the resumption of certain routine surveys and inspections of healthcare providers and suppliers, including on-site complaint investigations, surveys and revisits/revalidations, *once sufficient staff and necessary personal protective equipment are available*. All the while, CMS touting $15M in fines and tripling of Immediate Jeopardy citations against nursing homes during this pandemic. From August 4 to August 14, CMS cited more than 3,300 deficiencies and imposed more than $5.5M in Civil Monetary Penalties (CMP) to the less than 1% of nursing homes that had failed to report required COVID-19-related data to the CDC or had lapsed in reporting.

Recommendations from the Select Subcommittee on the Coronavirus Crisis focused on nursing homes is expected September 1 and I'll be writing about those recommendations next month. Concerned about the government's response to the needs of nursing homes including providing resources for staffing and PPE and childcare and testing, I remain cautiously optimistic that recommendations will be proactive and supportive to counter-balance the punishments meted out by CMS.

What Nursing Homes Need Is Help Not Threats

As we hear and read every day in the media, nearly half of all COVID-19 deaths in the United States have occurred among nursing home residents, whose age, chronic medical conditions, and congregate living quarters place them and their caregivers at high risk of contracting the disease.

And yet, six months into the pandemic, more than 20 percent of nursing homes in the United States continue to report severe shortages of staff and PPE. A study last week[1] is among the first to report results from a new CMS COVID-19 Nursing Home Database. The database includes responses from more than 15,000 nursing homes and other long-term care facilities—or 98 percent of the US total—regarding the impact of COVID-19 on staff and residents. Nonetheless, based on nursing home responses submitted for the database from May 18 to June 14, and from June 24 to July 19, the researchers determined that:

-Rates of both staff and PPE shortages did not meaningfully improve from May to July.

-The facilities most likely to report shortages were those with COVID-19 cases among residents and staff, those serving a high proportion of Medicaid recipients, and those that score lower on a five-star quality rating system used by CMS.

The report summarized the lack of the government's adequate response to the needs of nursing homes. The CDC suggests that nursing homes must "provide supplies necessary to adhere to recommended infection prevention and control practices." Adequate access to PPE includes supplies like masks, gowns, goggles, gloves, and hand sanitizer. Many nursing homes have reported shortages of PPE, which has led to the use of lower-grade equipment or reuse of equipment across COVID and non-COVID patients. In response to this shortage, the federal government promised to provide two weeks' supply of PPE to all United States nursing homes back in May. However, many nursing homes reported that they did not receive adequate PPE through this initiative.

The CDC has also called for nursing homes to "develop (or review existing) plans to mitigate staffing shortages from illness or absenteeism." Many nursing homes struggled with staffing prior to COVID-19, and shortages have reportedly been magnified because many staff are unable or unwilling to work in these conditions.

Providing detailed data, the research suggests specific policy implications.

First, too many nursing homes lack a minimally sufficient supply of PPE to adequately protect themselves from COVID-19. This shortage has now persisted over a period of almost two months. Given that nearly half of all deaths from COVID-19 in the US come from nursing home residents, this mustbe a policy priority if policymakers intend to save as many lives as possible.

Second, as in most crises, the most vulnerable nursing homes are at the highest risk for shortages that put the health of their residents and staff at risk. Although there is no quick fix for the complex problems faced by nursing homes with more disadvantaged populations, additional targeted financial support

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for direct patient care and supplies, coupled with appropriate oversight to ensure that funds are used for intended purposes, as a part of future stimulus packages could help prevent COVID-19 from being both a financial as well as clinical crisis for these facilities.

Third, there is clearly substantial geographic heterogeneity in the shortages faced by nursing homes. Some states need to prioritize their nursing homes' resilience for outbreaks more than others, particularly as the geographic distribution of COVID-19 hot spots continues to evolve.

Fourth, these data are extremely valuable and CMS should continue its commitment to gathering information on nursing homes' available resources and disseminating it publicly. However, as facilities improve their data reporting capacity, CMS should also update their survey questions to reflect the current realities of the pandemic. The current set of questions reflects an extreme of scarcity that may not apply for long and misses other important factors like the degree of staff shortages or testing turnaround time.

Surveys Resume and More Fines – Not Helpful

Since March 4, CMS and state survey agencies have completed upgraded infection control surveys in more than 15,200 (99.2%) of nursing homes, the federal agency said. They have netted 180 Immediate Jeopardy findings for infection control — triple the rate found in 2019, according to CMS. As of August 3, more than 99% of facilities had reported COVID-19 reporting data to the CDC. The rest, however, had not reported data or had lapsed their regular reporting, leading to the $5.5 million in fines.

On August 17, CMS reiterated that it "is committed to taking critical steps to ensure America's health care facilities continue to be prepared in response to the threat of the 2019 Coronavirus Disease (COVID-19)." What are those critical steps?

•CMS is revising guidance on the expansion of survey activities to authorize onsite revisits and other survey types.

• **CMS is providing guidance to State Survey Agencies (SAs) on resolving enforcement cases**: CMS is providing guidance on resolving enforcement cases that were previously directed to be held, and providing guidance on Civil Money Penalty (CMP) collection.

• **Expanded Desk Review Authority**: CMS is temporarily expanding the desk review policy to include review of continuing noncompliance following removal of Immediate Jeopardy (IJ), which would otherwise have required an onsite revisit from March 23, 2020, through May 31, 2020.

• **CMS is also issuing updated guidance for the re-prioritization** of routine SA Clinical Laboratory Improvement Amendments (CLIA) survey activities, subject to the SA's discretion, in addition to lifting the restriction on processing CLIA enforcement actions, and issuing the Statement of Deficiencies and Plan of Correction (Form CMS-2567).

Where are the critical steps of prosing resources for staffing, PPE and childcare? More training webinars? How about resources for strike teams and on-the-ground-support?

Some Hope and Support

We are seeing strike teams apply an emergency response model traditionally used in natural disasters like hurricanes and wildfires to combating outbreaks in long-term care facilities. Composed of about eight to 10 members from local emergency management departments, health departments, nonprofit organizations, private businesses — and at times, the National Guard — the teams are designed to bring more resources and personnel to a disaster scene. Seven states have sent strike teams to long-term care facilities with outbreaks, including Florida, Texas, Massachusetts, New Jersey, Ohio, Wisconsin and Tennessee. Other states have proposed but not yet adopted them.

A bill in the House, introduced by members of both parties, would allow the secretary of the Department of Health and Human Services to allocate federal funds to the states specifically for the creation of strike teams to manage Covid-19 outbreaks in nursing homes. We'll be tracking this progress.

In my birth stte and in the county where I was Raised, Doctors Without Borders/Médecins Sans Frontières has provided technical support to nursing homes. According to interviews with MSF's leadership, the United States response to the disaster in long-term care facilities focused too heavily on punitive measures at the expense of on-the-ground support for beleaguered nursing home staff.

MSF proposes developing long-term partnerships between local institution such as schools of nursing and public health and nursing homes is integral to improving elder care, "forming a bedrock of in-person expertise that fines and webinars cannot create alone."

People on the ground is what nursing homes need not more guidance or webinars. One executive for MSF has stated " They're drowning in webinars and guidelines, and they have no help to implement, to operationalize those guidelines completely. And if they can't do it per the specs, per the protocols, they don't have anybody to turn to to say: "Well, okay, you don't have this, but we can do it like that."

In its effort to prevent and mitigate the consequences of COVID-19 in skilled nursing facilities further, MSF proposed the following recommendations to health departments and policy-makers:

• Provide direct, hands-on on-site support for skilled nursing facilities. This includes one-on-one coaching, targeted refresher courses and practical training sessions on infection control for all staff.

• Develop a more collaborative oversight process with on-site training and support that is constructive and non-judgmental. Regulation plays an important role but cannot be the primary tactic to affect true behavior change and improve health outcomes for residents and staff.

• Increase support for staff wellness and improve access to mental health resources. Staff faces a dual burden: stress, anxiety, grief, and fear in their day-to-day reality, having lost colleagues and residents, while simultaneously suffering stigma in their sector.

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Health Affairs, *Severe Staffing And Personal Protective Equipment Shortages Faced By Nursing Homes During The COVID-19 Pandemic*, Brian E. McGarry, Ph.D., Assistant Professor of Geriatrics/Aging and Public Health Sciences at the University of Rochester Medical Center (URMC) in collaboration with David C. Grabowski, Ph.D., Professor of Health Care Policy at Harvard Medical School, and Michael L. Barnett, M.D., M.S. Assistant Professor of Health Policy and Management at Harvard's T.H. Chan School of Public Health, August 20, 2020

Getting on the Same Page by Paige Hector, LMSW

Ready, Set, Go

On June 5th, the Bighorn fire broke out in the Santa Catalina Mountains, a beautiful mountain range in Tucson, AZ. My family lives at the base of that mountain; we could see the flames devouring the landscape, the billows of smoke stifling the hot desert day.

From my backyard, I could see the helicopters flying overhead, back-and-forth as they filled and emptied enormous containers of water. The thwop-thwop-thwop of the helicoppter blades a constant, omninous sound that had us on edge, a constant reminder of the raging inferno so close to our home.

Very quickly, we learned about the all-hazard evacuation steps, Ready-Set-Go, and the 5 P's, the supplies one should gather for an emergency "go kit": people and pet supplies, prescriptions, papers, personal needs and priceless items. Our neighborhood began in the 'Ready' zone, and on June 11th switched to 'Set' which meant that the danger in the area is significant and we had to be prepared to evacuate immediately. We filled suitcases with a few days of clothes and personal items. We gathered pet supplies and I grabbed projects from my desk that I just couldn't bear to leave behind. Fully anticipating having to leave my home and carrying the weight that I may never see it again, I viewed every shelf, closet and room in a completely different light, the memories swirling around in my mind, squeezing my heart. My hand reached for the tchotchkes lovingly bestowed on me by my son. And then, pulled back as my logical mind knew that I had to focus on the absolute necessities. Do I take the dozens of photo albums chronicling our family life before we transitioned into digital albums? The gifts from my husband? A set of sheets? Shampoo? Given that we are living during a pandemic, I grabbed loads of cleaning supplies, lysol wipes and spray bottles of alcohol. Significantly adding to the distress on this day was the 105

degree weather and our air conditioner stopped working. And, the next day was the one-year anniversary of my mom's death.

According to the Substance Abuse and Menthal Health Services Administration (SAMHSA), "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." What might be traumatic to one person may have zero affect on another.

As my family managed the traumas of the fire, the exquisite discomfort of extreme heat and no air conditioning, the anniversary of my mom's death and a pandemic, I recall thinking whether my husband, son or I would experience long-term truama. I acutely remember the helicopter noise, the way it started in the distance and progressively became louder and more frightneing as it passed over my home. The multi-sensory experience of this dread, felt in my stomach, my muscles and my mind, quickly became associated with the blade noise which now translated into danger and fear. Today, the fire is no longer a threat (deepest gratitdue to the emergency workers!) and I have not yet had the experience of hearing helicopter noise, but I wonder if that sound will still trigger a sense of dread, fear and impending loss. Time will tell. Perhaps I will eventually come to associate that sound with rescue and safety.

Just like the sound of the helicopter blades may be a trigger for me - a reminder of the emotions and cognitions related to the fire and the possibility of leaving and losing my home – there may be any number of triggers associated with the pandemic: heightened infection control protocols and the knowledge that COVID-19 is a deadly disease easily transmitted from perseon-to-person, the disturbing affect of interacting with people garbed in PPE, the isolation from human interaction and touch, the discomfort of testing, the changes in routines, and the pervasive fear that permeates every venue, especially the nursing home.

Whether a fire or a pandemic, the reality is that these are shared traumatic experiences. While there are similiarities, there exist a multitude of differences, unique to each individual, their perceptions and life experiences. Trauma-informed care has quickly taken a front seat of importance; trauma screenings and follow-up should be a routine part of resident care. Staff are doing an incredible job of mitigating the effects of prolonged isolation, connecting residents and families in creative ways and demonstrating enormous flexibility as they ride each wave of discomfort and challenge. Regardless of the fact that CMS requires trauma-informed care (although guidance is still pending), screening, assessing and providing trauma-informed care is the right thing to do. I also believe that trauma screenings and follow-up care should be part of employee wellness.

As staff accommodate the delicate balance of COVID-19 positive diagnoses and strict isolation protocols, residents are displaced from their rooms, sometimes multiple times, and have likely experienced a profound loss of choice and being in charge of their lives. They've had to trust that their belongings would be tended to and not become lost in the complicated jumble of room changes and transfers.

When I was making those heart-wrenching choices of what I would take if our status changed to 'Go' and we had to evacuate, I couldn't help but wonder if people living in nursing homes would relate to that sense of sadness and despair as they selected their belongings and evacuated their homes for, perhaps, forever.

As we navigate a path through this collective traumatic expereince, I am hopeful that we will continue to do so with compassion, patience, and kindness, showered upon residents, their families and the staff.

Contact Paige at 520-955-3387 or at paige@paigeahead.com
Discover more about her at www.paigeahead.com

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This is on top of an increased workload due to the closure of the facilities to family who previously helped provide companionship and care.

• Provide clear guidance for re-opening facilities to visitors. Staff regularly report serious concerns about the cognitive decline of their residents. Loneliness and isolation also pose a great threat to their health.

• Conduct in-service training for non-clinical staff. Environmental services staff are the least likely to have received adequate training on infection control in their critical position, or on the proper use of PPE.

• Ensure more supportive leadership from corporate, administration, and directors of nursing. This, perhaps above all, is the key indicator of success for crucial infection control measures to be implemented to best protect residents and staff alike.

• Promptly disseminate testing results to facilities and conduct regular health education for both staff and residents regarding the rationale and importance of regular testing. Timely testing is essential for monitoring of infections and organization of care.

We know what the challenges are for nursing homes and assisted living facilities in the United States. Let's focus on the solutions and not create more problems with the punitive position of regulators and policy-makers.

We are here to bring you peace of mind so let me hear from you and STAY SAFE.

Rebecca Adelman is an entrepreneur, influencer, thought leader and founder of Adelman Law Firm, a Women's Business Enterprise National Council (WBENC) certified Women Business Enterprise (WBE) established in 2001. For nearly 30 years, Rebecca has concentrated her practice in insurance defense and business litigation. The firm's practice extends through the Tri-States of Arkansas, Mississippi and Tennessee. Rebecca's insurance defense practice includes representation of insurance companies and long-term care providers and their insurers, both regionally and nationally. She also provides consulting services and educational programming to healthcare professionals and business associates. She has active practices in the areas of general liability, professional liability, premises, and employment law. She is a listed mediator serving all areas of business and healthcare litigation. Contact Rebecca at rebecca@adelmanfirm.com and visit www.adelmanfirm.com and www.rebeccaadelman.com.