PUBLICATION

CMS and CDC Guidance for Addressing Coronavirus Risk in Long Term Care: Practical Considerations for Implementation

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As new confirmed COVID-19 cases emerge daily in the United States and countries around the world, the various federal agencies tasked with overseeing health care have issued a steady stream of guidance that aims to assist health care providers in managing risks related to the outbreak. Increasingly, the available evidence shows that the elderly are among those most likely to be affected by severe forms of the disease. Thus, providers that serve this vulnerable population – including, most particularly, nursing facilities, but also including assisted living facilities and home-based providers – are well-advised to ensure that they are taking all necessary and appropriate steps to protect their residents and patients.

On March 4, 2020, the Quality, Safety, and Oversight Group at CMS issued its first provider-specific guidance memoranda to State Survey Agency directors that address the ongoing response to coronavirus in health care facilities. The first memorandum, QSO-20-12-ALL, directs State Survey Agencies to suspend most survey and certification activities, with certain exceptions focused specifically on infection control issues. The second, QSO-20-14-NH, updated on March 9, is directed to nursing homes and provides guidance on how to handle specific issues that may arise in handling the ongoing coronavirus outbreak. In addition to this guidance, CMS has also issued memoranda to hospitals, hospices, home health agencies, and dialysis clinics. There is also guidance addressing the use of personal protective equipment (PPE) in health care facilities and reviewing Emergency Medical Treatment and Labor Act (EMTALA) requirements. These memoranda support, and make reference to, the guidance to health care facilities offered by the Centers for Disease Control, which is updated on an ongoing basis.

As providers seek to prepare for, and respond to, COVID-19, the primary focus and concern is, of course, the safety of patients, residents, and staff. But it is also important for providers to ensure, to the extent possible, that their efforts to prevent and mitigate the risk of transmission are well-documented, supported by and in accord with their policies and procedures, and coordinated with state and local health authorities.

Key Takeaways

While news will undoubtedly continue to flow fast and furious as more information becomes available and more cases of COVID-19 are identified, several key points emerge from the guidance that is currently available to providers.

- **Communicate Effectively**. Effective communication is a critical part of an effective emergency preparedness strategy. As the situation changes, facilities should monitor the CDC COVID-19 website and remain in close contact with local and state health authorities to stay up to date on emerging cases, ensure awareness of local management strategies, and report suspected or potential cases of COVID-19 as appropriate. Facilities should also ensure that their emergency preparedness contact information is complete and up to date and that steps are taken to communicate important information accurately and effectively to residents, families, and staff.
- **Implement Good Infection Control Practices**. Infection control practices directed at preventing the potential transmission of COVID-19 to residents and staff and identifying individuals who may be displaying signs of illness are critical. Key areas of focus include appropriate use, and staff

knowledge, of proper transmission precautions, hand hygiene, and PPE, as well as appropriate infection surveillance. The CDC has provided basic preparedness checklists and preparation guidelines for health care facilities and will continually update the relevant clinical criteria and guidance for triage of suspected cases. It is also important that staff are trained on infection prevention and control policies and procedures.

- **Limit Visitors to Vital Situations.** CMS will soon issue "guidance directing nursing home operators to temporarily restrict all visitors and non-essential personnel, with few exceptions, such as end-of-life situations," according to CMS administrator Seema Verma's comments during the President's news conference on March 13. While suppliers or vendors may still need to deliver goods and equipment to the facility, such deliveries should be made outside the facility. If a volunteer, vendor, supplier, or transportation provider must enter the facility for a necessary purpose, the facility should provide such individuals with PPE for their safety and the safety of residents and staff.
- **Update and Implement Your Emergency Preparedness Plan**. While CMS has not issued any COVID-specific updates specifically addressing emergency preparedness requirements, these are set forth in detail in Appendix Z of the State Operations Manual. All health care facilities, including nursing homes, are required to have an all-hazards emergency preparedness program in place that includes a risk assessment, a communications plan, and an emergency plan that is implemented through appropriate policies and procedures. The plan should address issues such as ensuring adequate supplies, staffing during emergencies, and coordination with state and local authorities during a period of emergency. Facilities should ensure they have plans in place that are adequate and appropriate to managing and mitigating an outbreak, should one occur.

Specific Information

Suspension of Survey Activities

Until further notice, CMS has directed state survey agencies to suspend normal survey activities in favor of a focus on infection control-related issues. Survey activity will still prioritize investigation of potential immediate jeopardy-level complaints, but surveys required by statute (e.g., initial certifications and annual recertification surveys) and revisits to resolve any currently-open survey cycles are subordinated in priority to investigations of complaints related to infection control concerns, potential COVID-19 cases, and other respiratory illnesses. All other non-emergency survey activity is suspended, with the exception of surveys in hospitals and nursing facilities that have been cited for an immediate jeopardy-level deficiency related to infection control in the past three years and hospitals, nursing facilities, and dialysis centers with any history of lower-level infection control deficiencies.

Review of Infection Prevention and Control Programs

As part of its directive to state survey agencies, CMS identified focus areas for surveys evaluating infection prevention and control. These instructions to surveyors also provide guideposts for facilities as they seek to ensure their infection prevention and control programs are appropriately addressing areas of concern. These focus areas are detailed in an attachment to the guidance, which also includes a surveyor checklist that facilities can utilize to evaluate their own efforts. Items on the checklist include, among other things, coordination of all aspects of the infection control program across the facility; use of good hand hygiene, PPE, and transmission-based precautions by staff and others; and appropriate infection triage, surveillance, and reporting to applicable health authorities. For facilities reporting potential infections, the surveyors are directed to focus on concerns related to improper transmission precautions, including:

- Lack of staff knowledge of transmission precautions or improper procedures
- Improper use of PPE
- Inadequate hand hygiene

- High-risk, significant environmental cleaning issues (e.g., use of ineffective disinfectant cleaners)
- Improper or ineffective laundering of linens
- Issues with infection surveillance

In addition to the guidance provided to surveyors and the COVID-specific guidance highlighted above, guidance to facilities on general infection control measures are also available. As part of its implementation of the updated Requirements of Participation related to infection control, CMS and the CDC have provided training materials on various infection control topics, and Appendix PP of the State Operations Manual also contains crucial information under F-tag F880. For individuals with confirmed or suspected COVID-19, the CDC has established guidelines that include recommendations for the use of personal protective equipment.

Within facilities, CMS recommends creating COVID-specific units and designating specific staff to care for residents with confirmed or suspected COVID-19 infection in order to minimize the possibility of transmission within a facility. Sharing of work areas should be minimized, and workplace areas and supplies should be disinfected frequently.

In both its guidance to nursing homes and its March 10 guidance on the use of PPE, CMS appears to acknowledge that supply of facemasks capable of protecting health care workers from COVID-19 exposure may be insufficient to meet demand and advises surveyors that, in determining whether facilities are complying with infection prevention protocols, "based on local and regional situational analysis of PPE supplies," it may be appropriate for facilities to utilize face masks rather than fitted N95 respirators in some circumstances. CMS directs surveyors not to cite facilities that do not have sufficient supplies of items such as PPE and alcohol-based hand sanitizer "for reasons outside of their control," but expects facilities to put mitigating strategies in place and use existing supplies in a manner consistent with CDC optimization guidelines. PPE shortages should be communicated to state and local health authorities.

Guidance to Nursing Homes

Restriction of Visitors

First and foremost, CMS recommends restricting and limiting visitors to nursing homes, who may unknowingly introduce COVID-19 to vulnerable resident populations. Generally, federal long term care regulations require that residents have free access to visitors of their choosing. This right can be limited for "reasonable clinical and safety reasons," including "restrictions placed to prevent community-associated infection or communicable disease transmission to the resident." In its initial guidance, CMS strongly recommended outreach to family members and friends of residents to discourage them from visiting, limiting visitation to emergency situations (such as a significant change in condition), and screening visitors for potential exposure to the virus. On March 9, CMS strengthened its recommendations, stating that facilities should "actively screen and restrict visitation" by people meeting the following criteria:

1. Show signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat
2. In the last 14 days, have had contact with someone with a confirmed diagnosis of COVID-19, or are under investigation for COVID-19, or are ill with respiratory illness
3. Have traveled internationally within the last 14 days to countries with sustained community transmission.
4. Reside in a community where community-based spread of COVID-19 is occurring

CMS also recommends restricting visitors who are not able to demonstrate proper use of infection control techniques (such as hand hygiene, limiting surfaces touched, and use of PPE). At the time of publication, the

CDC's tracking of cases did not identify areas with confirmed community spread of COVID-19, making it difficult for facilities to identify whether a particular individual resides in an area where community transmission is occurring. While state and local health authorities may be able to provide such information, low testing rates also hamper effective identification of community spread. CMS also recommends that facilities "in counties, or adjacent to other counties" where a COVID-19 case has occurred (regardless of origin) should limit visitation, meaning that visitors should not be allowed "except for certain situations, such as end-of-life situations or when a visitor is essential for the resident's emotional well-being and care." Some states have also issued directives regarding, or in excess of, CMS requirements.

Given the complexity of these requirements and the magnitude of risks involved, facilities may consider simply restricting visitation entirely in order to minimize the risk of resident exposure. While the March 9 CMS guidance stops short of directly authorizing such a step, there are multiple considerations that could influence a facility toward doing so. Factors for consideration include a high volume of local cases; the particular vulnerabilities of the patient population at a facility; or concern about supply of PPE in the facility. Such a step may be appropriate, but facilities that intend to do so should clearly document the rationale for doing so and consult closely with local and state health authorities about the steps they intend to take.

In lieu of in-person visitation, facilities should identify other means to allow residents and their families and friends to remain in contact as well as remaining in direct communication with families about visitation.

For those facilities that continue to allow limited visitation, in addition to active screening for exclusion criteria, CMS recommends posting visible signage at all facility entrances and exits that directs visitors to consider visiting at another time, increasing the availability of alcohol-based hand sanitizer, and limiting the movement of visitors to the room of the resident they are visiting. Visitors should also be directed to wash or sanitize their hands on entry to the facility and to notify the facility if they experience any symptoms of respiratory illness within 14 days of the visit. After the visit, facilities should fully disinfect any resident rooms that visitors enter.

Facilities that continue to allow visitors should document their screening of any visitors that are allowed to visit the facility, as well as any education provided to visitors regarding transmission precautions and completion of post-visit disinfection, and other measures.

Screening Employees

CMS also has recommendations for screening employees for COVID-19 infection and exposure. Read our more in-depth exploration of employment issues here. In large part, these recommendations mirror those for visitors: employees displaying signs or symptoms of respiratory infection should not report to work, and those who have been in contact with individuals infected with COVID-19 without appropriate PPE should self-isolate for 14 days after exposure and continue to be monitored in accordance with CDC guidance. Employees who develop symptoms of a respiratory illness during a shift should don PPE, self-isolate, and report the symptoms to the facility's infection preventionist and the local health authorities for contact monitoring and testing. The facility should also ensure that it documents the locations, equipment, and individuals that the staff member came into contact with and the measures taken to prevent potential transmission (e.g., disinfection of rooms and equipment with an EPA-approved cleaner and use of PPE in accordance with CDC guidelines).

Due to the necessity of self-isolation to prevent transmission to residents, facilities with asymptomatic staff who have been exposed to COVID-19 may experience a shortage of staff available to provide resident care. Facilities should do their best to anticipate the effects and put contingency plans in place. Communication with state and local health authorities regarding staffing concerns is appropriate to ensure that all available resources to supplement staffing where necessary are brought to bear.

Outside Vendors

Vendors, outside providers, and delivery workers should not be overlooked as a potential source of transmission. CMS recommends having deliveries made without allowing vendors to enter the building – i.e., by leaving supplies at a loading dock. CMS also recommends that facilities "review and revise" how they interact with outside personnel, including agency staff, EMS workers, and transportation providers and "take any necessary action to prevent potential transmission." While CMS's guidance in these cases is far less specific, these interactions represent a key area for implementation of transmission-based precautions (e.g., good hand hygiene and use of PPE) and active screening that facilities should not overlook. Again, facilities should implement policies and procedures to minimize the risk posed by these interactions, ensure staff and outside vendors are aware of such policies and procedures, and document their implementation.