Commonwealth of Virginia

Allen, Rebekah <rebekah.allen@vdh.virginia.gov>

Bergman comments for RAP meeting 10/29

1 message

Christian Bergman <Carl.Bergman@vcuhealth.org> Tue, Oct 27, 2020 at 3:02 PM
To: "rebekah.allen@vdh.virginia.gov" <rebekah.allen@vdh.virginia.gov>
Cc: Matthew Kestenbaum <mkestenbaum@capitalcaring.org>

Rebekah,

I had a good discussion today with Dr. Matthew Kestenbaum. Here are my written comments and I will use my 2 minutes on Thursday to discuss these comments. I will keep my comments brief and hope the panel will take this under consideration. I can be reached at the contact information below.

Looking forward to the call on Thursday.

Christian

Carl J. "Christian" Bergman, MD, CMD

Assistant Professor

Division of Geriatric Medicine

Department of Internal Medicine | Virginia Commonwealth University

Clinical Section Lead

Nursing Facility Attending Service (NFAS) – Center for Advanced Health Management (CAHM)

2116 W. Laburnum Ave, Richmond VA, 23227

C: (804) 310-9344|**O**: (804) 254-3500|**F**: (804) 254-1616

Email: Carl.Bergman@vcuhealth.org

Bergman Comments to Regulatory Advisory Panel_10272020.docx
18K

Comments to Regulatory Advisory Panel – 12VAC5-371 and 12VAC5-391

Regulations for Licensure of Nursing Facilities

Carl J. “Christian” Bergman, MD, CMD

Assistant Professor

Division of Geriatric Medicine

Department of Internal Medicine | Virginia Commonwealth University

Clinical Section Lead

Nursing Facility Attending Service (NFAS) – Center for Advanced Health Management (CAHM)

2116 W. Laburnum Ave, Richmond VA, 23227

C: (804) 310-9344|**O**: (804) 254-3500|**F**: (804) 254-1616

Email: Carl.Bergman@vcuhealth.org

Overall Summary:

- How was the composition of this regulatory advisory panel decided? There is no SNF medical director present and no PA/LTC clinicians (PA, NP, or MD/DO) whose primary role is patient care. Glad there is representation from the LTC ombudsman program, nursing colleagues, and lawyers representing resident interests.

- On the frontlines right now in nursing home, there seems to be an abundance of caution being taken to keep visitors and families out even in facilities who are regularly doing testing and have had no new cases. We need to change this and we should advocate for this change and make regulatory changes that facilitate families and residents being able to return to in-person visits, inside, and with physical contact. Think progressively. Be bold.

- We know a lot about COVID-19 and with appropriate IPAC management and an appropriate screening and testing protocol, we can allow more in-person visits as stated in the CMS memo September 17, 2020.

- Reviewed PPT presentation from 10/14/2020, excellent examples of other state policies.

- What about compassionate visits?

- What about essential caregivers?

- Support person?

- Involvement of the medical director locally in these decisions?

- **Specific comments:**

- HB 5041 / SB 5042
- Va. Code § 32.1-127(B) to read: 28. During a public health emergency related to COVID-19, shall require each nursing home and certified nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid Services and the Board. Such protocol shall include provisions describing …
- (i) the conditions, including conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual;
    - What are the conditions? Can we specify them in regulatory changes?
    - Community prevalence rate? <10%, <5%
    - Phased approach, can we please make sure we abandon "phased" approach to reopening nursing homes. It was taken out of CMS memo.
    - If regular staff testing, screening and no new cases for 14 days, shouldn't visitors be allowed?

- (ii) the requirements with which in-person visitors will be required to comply to protect the health and safety of the patients and staff of the nursing home or certified nursing facility;
    - What are the requirements?
- (iii) the types of technology, including interactive audio or video technology, and the staff support necessary to ensure visits are provided as required by this subdivision; and
- (iv) the steps the nursing home or certified nursing facility will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subdivision…
- Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a requirement that each nursing home and certified nursing facility publish on its website or communicate to each patient or the patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing facility's plan for providing visits to patients as required by this subdivision
    - I would also add a provision that a SNF should have their visitor protocol be reviewed and approved by the local medical director.

CMS memo (QSO-20-39-NH – September 17, 2020) comments:

Outdoor Visitation

- While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred and can also be conducted in a manner that reduces the risk of transmission. Outdoor visits pose a lower risk of transmission due to increased space and airflow. Therefore, all visits should be held outdoors whenever

practicable THIS IS AN IMPORTANT CAVEAT. Aside from weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), an individual resident's health status (e.g., medical condition(s), COVID-19 status), or a facility's outbreak status, outdoor visitation should be facilitated routinely. Facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, facilities should have a process to limit the number and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining social distancing). We also recommend reasonable limits on the number of individuals visiting with any one resident at the same time.

- **Indoor Visitation** **These are good criteria that should be made more specific**
- Facilities should accommodate and support indoor visitation, including visits for reasons beyond compassionate care situations, based on the following guidelines:
- a) There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing;
- b) Visitors should be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;
- c) Facilities should limit the number of visitors per resident at one time and limit the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors; and
- d) Facilities should limit movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Visits for residents who share a room should not be conducted in the resident's room.
-
- NOTE: For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.

Visitor Testing

While not required, we encourage facilities in medium or high-positivity counties to test visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days) with proof of negative test results and date of test.

Required Visitation

We believe the guidance above represents reasonable ways a nursing home can facilitate in-person visitation. Except for on-going use of virtual visits, facilities may still restrict visitation due to the COVID-19 county positivity rate, the facility's COVID-19 status, a resident's COVID-19 status, visitor symptoms, lack of adherence to proper infection control practices, or other relevant factor related to the COVID-19 PHE. However, facilities may not restrict visitation without a reasonable

clinical or safety cause, consistent with §483.10(f)(4)(v). For example, if a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is low or medium, a nursing home **must** facilitate in-person visitation consistent with the 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 transmission-based precautions are no longer required per CDC guidelines, and other visits may be conducted as described above.

Commonwealth of Virginia

Allen, Rebekah <rebekah.allen@vdh.virginia.gov>

Nursing Home Visitation Recommendations RAP

Latimer, Joan <joani.latimer@dars.virginia.gov>
To: "Allen, Rebekah" <rebekah.allen@vdh.virginia.gov>

Thu, Oct 29, 2020 at 9:57 AM

Dear Ms. Allen and Members of the RAP,
There has been much good work done by our panel so far that has gotten us to where we are with the recommendations. I think Rebekah Allen has done an excellent job of capturing the thrust of our discussions so far (no easy feat). At the same time, as I reviewed what we have put together to date, I have felt that we are unintentionally missing some important element. What seems to be missing (and this may be something that a regulatory format may be ill-suited to capture) is the overarching message and vision of our intent to enable visitation as the critical support that it is to a resident's holistic well-being. All of us who serve on the panel are there because we understand, and dedicate our efforts to promoting community and connection that are so essential to quality of life for our long-term care residents. Of all people, we understand that quality of life is largely about relationship and connection. Our daily work is testimony to that understanding. So, why does what we have crafted to this point seem not to adequately reflect strong support for that vision, with a clear outline of steps in that direction?

I want to suggest that, if the regulatory format can accommodate it, we should frame the specific expectations/requirements under a stated goal that captures overall intent. CMS has actually been better able to accomplish that in providing its current recommendations within the frame of a preface of sorts, explaining the recognition of a need to rebalance infection risk management over and against the equally important need to ensure residents do not suffer harm and decline through social isolation resulting from our precautions.

CMS clearly underscores that visitation needs and preferences should be addressed through person-centered planning. While acknowledging the limits that serve as 'guardrails' (e.g., positivity rates, outbreaks), the thrust should be in the direction of safely supporting visitation rather than focusing on 'must not's'. A suggested overarching goal (from which our specific recommendations could flow) might be the following:

> Understanding and supporting each resident's individual visitation needs is vital to providing quality care that supports the holistic well-being and quality of life for the resident. Nursing homes should implement visitation policies that promote safety while supporting the individual resident's visitation needs and preferences. Through each resident's person-centered care plan, the nursing home should work with the resident to identify and support visitation that helps each resident attain or maintain the resident's highest practicable level of physical, mental, and psychosocial well-being. Opportunity to maintain vital social relationships and maintain a sense of community is critical to such well-being.

On the level of specific recommendations, we would suggest adding the following:

- Each nursing home must develo0p, as a part of each resident's person-centered plan of care, specific strategies and steps by which the resident's visitation needs and preferences are addressed. Such individualized visitation plans should:
  - Be included in the resident's care plan and revised as needed and no less frequently than at the individual's regularly scheduled care plan meeting.
  - Ensure that in-person visitation is supported and accommodated in accordance with the resident's preferences, except when there are specific, valid prohibitive conditions.
  - Holistically promote the resident's well-being, by addressing not only risk of infection exposure, but also risks/decline related to social isolation resulting from excessive visitation restrictions.
  - Be communicated to the resident (and legal represe4ntati e or family as appropriate) in a language and manner the resident/representative can understand.
  - Address visitation schedules, location of visits, and responsibilities of all parties.
  - Be reviewed frequently and adjusted to meet changing circumstances.

- Facility visitation policies must ensure that residents and families are free to question/challenge the facility's visitation policies in general, or any specific visitation restriction imposed on a resident/family without fear of retaliation.
- Residents and families with concerns about visitation policies should be advised of the option to raise concerns and to contact the Ombudsman Program as a resource in this regard.

- If a nursing facility utilizes schedule visitation slots, the schedule must accommodate at least ten 'open' slots per day to enable 'as needed' visits outside of pre-scheduled sign-ups. Availability of these slots should be clearly communicated as a part of the posting of updated visitation policies online and at the physical entrance of the facility.

- A nursing home must not deny, restrict, or prioritize visitation based on a resident's cognitive status, physical limitations, or inability to articulate a desire to have a visit or verbally express feelings of loneliness or depression.

- A facility's established visitation policies and procedures must be submitted in writing to the Office of Licensure and Certification (OLC), and the State Long Term Care Ombudsman Program (SLTCOP). Nursing homes must communicate their visitation policies in writing to residents and families and must promptly inform them of any changes and the reason for such changes. The policies should be posted (in a manner easily readable) at the primary visitor entrance as well as online. Facilities that utilize scheduled visitation should display at this location the schedule of visitation slots available for 'drop in' or 'as needed' visits not previously arranged.

- Nursing homes are required to report visitation activities weekly to OLC (copying the OSTLCO), using the weekly visitation activity template. The weekly report documents the nursing home's current practices for visitation, any current restrictions and the reason(s) for visitation restrictions, emergent obstacles to visitation (e.g., internet connection failure) and correction plans, and the number of residents who participated in a visit in the previous seven days.

- There must be public reporting of visitation status (e.g., VDH website) so that residents, their families and the public have a clear understanding of the status of visitation in a particular nursing home on any given day.

Thanks to all for consideration of these comments and thank you all for your earnest efforts in this important work.

Joani

--
Joani Latimer
State Long-Term Care Ombudsman
Virginia Department for Aging and Rehabilitative Services
8004 Franklin Farms Drive
Richmond, Virginia 23229
(804) 726-6624

Commonwealth of Virginia

Allen, Rebekah <rebekah.allen@vdh.virginia.gov>

Visitation Concern

Robert E. Walters <RWalters@vahs.com> Thu, Oct 29, 2020 at 12:25 PM
To: "Jamerson, June Carol" <carol.jamerson@vdh.virginia.gov>, "Rebekah.Allen@vdh.virginia.gov" <Rebekah.Allen@vdh.virginia.gov>

Rebekah, I appreciated your presentation during the LTC Task Force call today. By way of introduction, I am a Geriatric Medicine physician practicing with Mid Atlantic LTC and also the VP of Clinical Affairs for Virginia Health Services (VHS), a company operating multiple LTC facilities in Southeastern Virginia. I've been working with Carol and others on a particular concern that may also prove relevant to you from a regulatory standpoint. Some of the initial part of this email will be redundant for Carol, and the end (as identified later) may be less relevant to you.

In short, I'm concerned that Virginia may be implementing law and/or guidance inconsistent with federal law/guidance.

From the CMS visitation memo: "if a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is low or medium, a nursing home must facilitate in-person visitation consistent with the regulations… 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 transmission-based precautions are no longer required per CDC guidelines"

Note that the CDC guidelines referenced are regarding discontinuation of precautions are for individuals that have had confirmed or suspected COVID-19. Note also that the usual CDC definition of transmission-based precautions (TBP) applies to cases of known or suspected disease (https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html), and the CDC guidance pertaining to new admissions and readmissions with unknown COVID-19 status does NOT specify use of TBP (https://link.edgepilot.com/s/194d6ed8/hg4Hm3nzO0agvutqtPPrhQ?u=https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%253A%252F%252Fwww.cdc.gov%252Fcoronavirus%252F2019-ncov%252Fhealthcare-facilities%252Fprevent-spread-in-long-term-care-facilities.html).

Currently, VDH guidance does apply the TBP terminology to new admissions and readmissions and the department favors NOT allowing visitation during the specified 14-day quarantine. Do either of you know of a CMS source that could clarify the intentions at that level? OLC would have an interest in resolving this, as it seems that nursing facilities could presently find themselves cited either way (i.e., whether they do or don't allow (re)admissions to have in-person visits per the CMS memo).

This is the part more relevant to Carol.

I appreciate the desire to quarantine (re)admissions. Frankly, I'm rather dismayed that this concept isn't applied more broadly, i.e., to any resident that leaves the supervision of the facility for any reason. I'm especially concerned about resident's that will be signed out for Thanksgiving to eat with families. This is a TREMENDOUS threat to our facility residents, and it would help to have the backing of the State to enforce some corresponding precautions. The greatest clinical value of the quarantine comes from minimizing interactions between residents with unknown status and those that are presumed negative and staff taking care of residents in different cohorts. Meanwhile, since the fundamental goal is to protect the presumed negative residents, and these presumed negative residents are allowed in-person visitation with appropriate precautions, it's unlikely that we are significantly increasing exposure of the presumed negative residents by allowing (re)admissions the same privilege. There are further nuances that could be discussed, but this email is long enough already.

Thank you for your consideration. If either of you or your colleagues would like to talk to me directly, my personal cell is 757-592-1273.

Rob Walters, MD
Vice President of Clinical Affairs
Virginia Health Services, Inc.
240 Nat Turner Blvd.
Newport News, VA 23606
Phone: (757) 596-6268