COVID-19 Skilling Infection Control Testing Requirements

11.19.20

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COVID-19

Skilling Infection Control Testing Requirements

11.19.20

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Harmony Healthcare International (HHI) a Nationally recognized, premier Healthcare Consulting firm specializing in C.A.R.E.S.
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COVID-19
Learning Outcomes

1. Identify the **difference** between skilling COVID-19 Medicare Part A patients during **isolation vs. quarantine**
2. Identify the **8 elements** of **COVID-19 Infection Control**
3. Identify **COVID-19 staff and resident testing requirements** necessary to support compliance

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COVID-19
Skilling
Isolation versus Quarantine

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COVID-19
Skilling Isolation and Quarantine

- According to the CDC, isolation is for people who are ill, while quarantine applies to people who have been in the presence of a disease but have not necessarily become sick themselves. Per the CDC,

"Isolation separates sick people with a contagious disease from people who are not sick."

- Isolation is for patients with symptoms and or positive tests
- Quarantine is for patients exposed but exhibits no symptoms

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COVID-19
Skilling Isolation

- **Isolation** (Z29.0) and **COVID-19** (UO7.1)
- **Coding isolation** for a patient with an active infectious disease places them into an ES1 nursing category under both Medicare Part A and certain Medicaid Case Mix states.

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COVID-19
Skilling Isolation

To properly code isolation on the MDS, the patient requires:

- Isolation for a minimum of one day
- MD Orders for isolation
- Active Infectious disease ICD-10 coded:
  - On the UB-04 and
  - On the MDS (Section O. and I.)
- All treatments rendered in the patient's room with documentation to support said services are provided at bedside
  - Isolation cannot be coded if the patient is being "co-horted", meaning rooming with another patient

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COVID-19
Daily Skilled Documentation

- **Skilled (Medicare Part A) Observation and Assessment** is Indicated when there is a reasonable probability or possibility for complications or the potential for further acute episodes
- This references conditions where there is a **"reasonable probability or possibility"** for:
  - Complications
  - Potential for further acute episodes
  - Need to identify and evaluate the need for modification of treatment
  - Evaluation of initiation of additional medical procedures

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COVID-19
Daily Skilled Documentation

- Daily observations and assessments include but are not limited to, fever, dehydration, septicemia, pneumonia, nutritional risk, weight loss, blood sugar control, impaired cognition, mood, and behavior conditions
- Example of Daily Skilled Documentation
  - "This patient requires daily skilled nursing observation and assessment of signs and symptoms related to exacerbation of COVID-19, pneumonia, and related medical conditions."
- Skilled observation is required until the treatment regimen is essentially stabilized, and the patient is no longer at risk for medical complications

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COVID-19
Quarantine and Skilled Care

- Although a quarantined patient may not have symptoms, the mere fact the patient was **potentially exposed to COVID-19** warrants daily skilled nursing to observe and assess for signs and symptoms of COVID-19
- **Observation and Assessment** references conditions where there is a "reasonable probability or possibility" for the nurse to:
  - Evaluate the patient's condition i.e., observe and assess for fever, body aches, loss of appetite,
  - Identify acute episodes, and
  - Identify the need for treatment (modifications)
  - Initiate treatment changes

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COVID-19
Quarantine and Skilled Care

- In addition, the nurse may provide observation and assessment of signs and symptoms related to:
  - Dehydration,
  - Septicemia,
  - Pneumonia,
  - Nutritional risk,
  - Weight loss,
  - Blood sugar control,
  - Impaired cognition and
  - Mood and behavior conditions

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COVID-19
Quarantine and Skilled Care

- Nurses need to document the defined assessment **on a daily basis**
- This may include neurological, respiratory, cardiac, circulatory, pain/sensation, nutritional, gastrointestinal, genitourinary, musculoskeletal, and skin assessments
- In these situations, the Nurse may write:
  - **"This patient requires daily skilled nursing observation and assessment of signs and symptoms related to COVID-19."**
- Skilled observation is required until the **treatment regimen is essentially stabilized**

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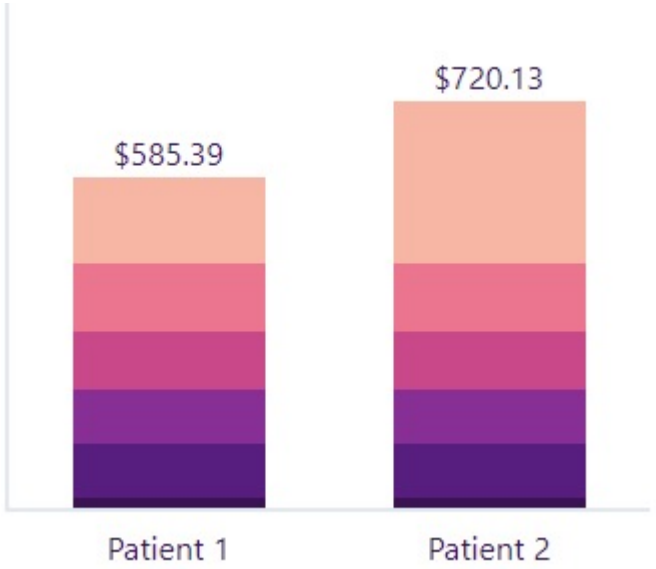
COVID-19
Reimbursement Medicare Part A Skilled Care

- The difference in reimbursement for accurately coding **isolation** for a patient with **active infectious disease** in rural Vermont

Patient 1	Patient 2
Avg Daily Rate	Avg Daily Rate
$585.39	$720.13
30 days	30 days
PT/OT: TK	PT/OT: TK
SLP: SA	SLP: SA
Nursing: CBC2	Nursing: ES1
NTA: ND	NTA: ND
HIPPS: KAND1	HIPPS: KACD1
Vermont	Vermont
Duplicate / Delete	Duplicate / Delete

$ Impact Isolation COVID-19 (VT) =

$720.13 - $585.39 =
$134.74 per day
x 100 days =
$13,474



*Courtesy of Hopforce PDPM Calculator: https://pdpm-calc.com/

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COVID-19
Reimbursement Medicare Part A Skilled Care

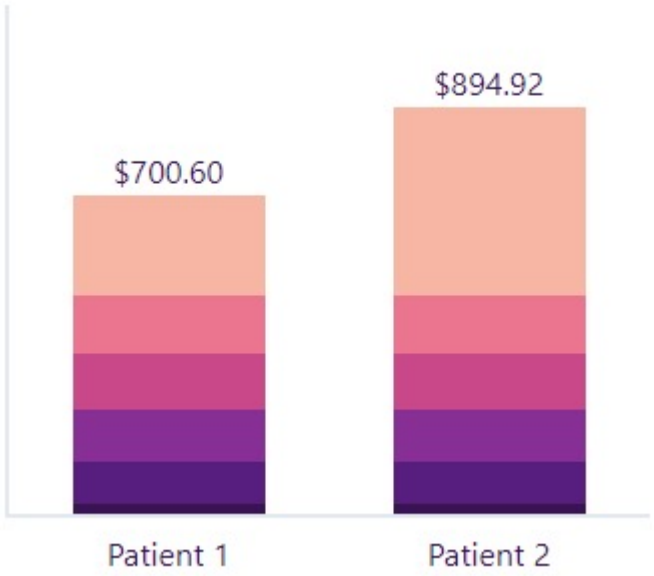
- The difference in reimbursement for accurately coding **isolation** for a patient with **active infectious disease** in urban New York

Patient 1	
Avg Daily Rate	$700.60
	30 days
PT/OT	TK
SLP	SA
Nursing	CBC2
NTA	ND
HIPPS	KAND1
	New York County, New York
Duplicate / Delete	

Patient 2	
Avg Daily Rate	$894.92
	30 days
PT/OT	TK
SLP	SA
Nursing	ES1
NTA	ND
HIPPS	KACD1
	New York County, New York
Duplicate / Delete	

$ Impact Isolation COVID-19 (NY) =

$894.92 - $700.60 =
$194.32 per day
x 100 days =
$19,432



*Courtesy of Hopforce PDPM Calculator: https://pdpm-calc.com/

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COVID-19
Reimbursement Medicaid Case Mix – D.C.

- In D.C., the coding of isolation also impacts the Medicaid Case Mix Index An ES1 Level for Isolation yields 2.22 CMI
- Conservatively, the CMI Impact Isolation

  COVID-19 = ES1 versus CB2 = 2.22 - .95 = 1.27

- When identifying patients who are isolated and quarantined, it is imperative to assess if the condition warrants skilled care
- Currently, each state uses its own Medicaid reimbursement system
- Multiple states are collecting data in preparation for applying the PDPM model

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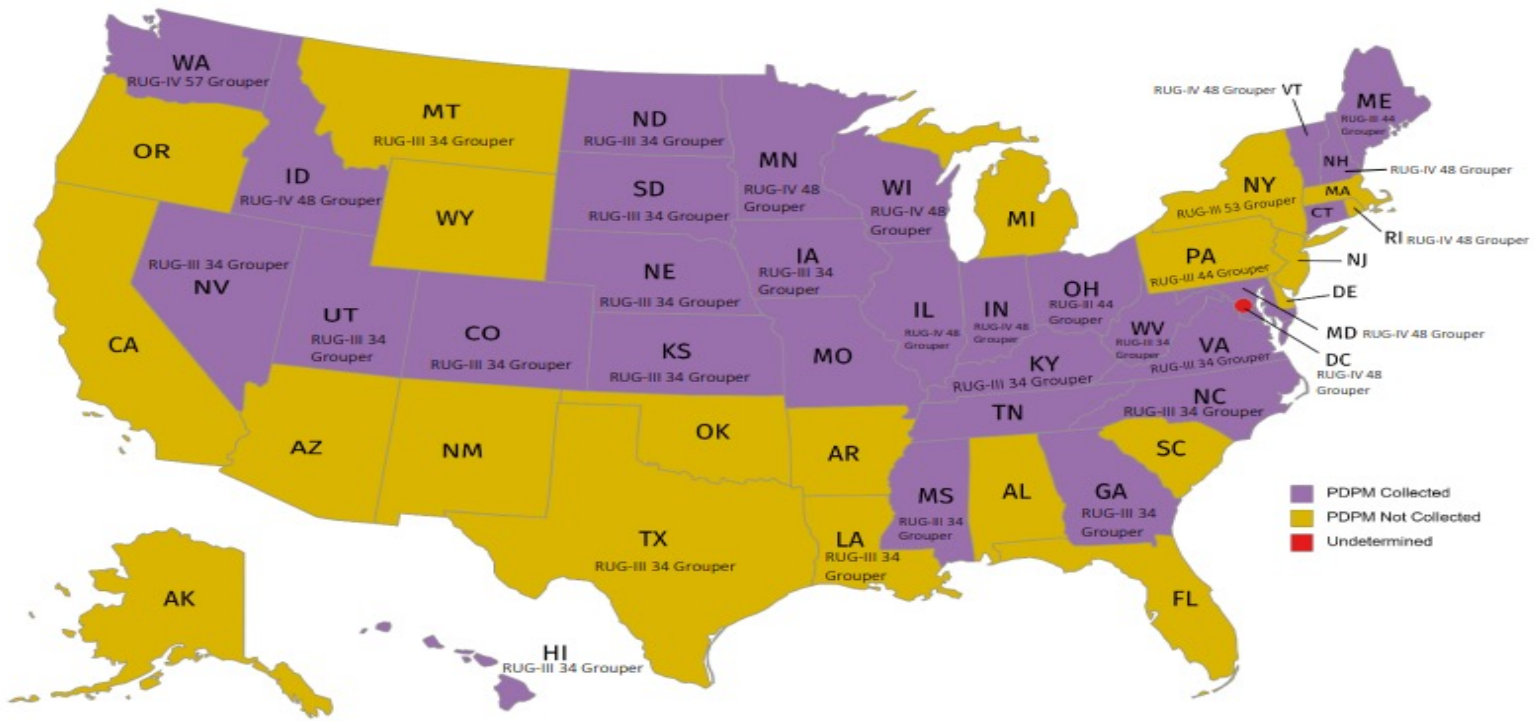
PDPM Conversion MDS Collection OBRA Assessments



COVID-19
ICD-10 Active Infectious Disease

- The ICD-10-CM Diagnosis Code is U07.1, Virus Identified
  - U07.1 is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes
  - ICD-10-CM U07.1 is a new 2021 ICD-10-CM code that became effective on October 1, 2020
  - This is the American ICD-10-CM version of U07.1 - other international versions of ICD-10 U07.1 may differ

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COVID-19
ICD-10 Active Infectious Disease

- ICD-10-CM U07.1 is grouped within Diagnostic Related Group(s) (MS-DRG v38.0):
  - 177 Respiratory infections and inflammations with mcc
  - 178 Respiratory infections and inflammations with cc
  - 179 Respiratory infections and inflammations without cc/mcc
  - 791 Prematurity with major problems
  - 793 Full term neonate with major problems
  - 974 HIV with major related condition with mcc
  - 975 HIV with major related condition with cc
  - 976 HIV with major related condition without cc/mcc

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COVID-19
ICD-10 Active Infectious Disease

- The ICD-10-CM Diagnosis Code is U07.2, Virus NOT Identified
  - Clinically-epidemiologically diagnosed
  - Probable COVID-19
  - Suspected COVID-19
- https://www.who.int/classifications/icd/icd10updates/en/
- 9.29.2020 ICD-10 Update COVID-19
- A set of additional categories has been agreed to be able to document or flag conditions that occur in the context of COVID-19
- Both, 3 character and 4-character codes have been defined to respond to the different levels of coding depth that is in place in different countries

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COVID-19
ICD-10 Active Infectious Disease

Personal history of COVID-19

- **U08.9 Personal history of COVID-19, unspecified**
- This optional code is used to record an earlier episode of COVID-19, confirmed or probable that influences the person's health status, and the person no longer suffers from COVID-19. This code should not be used for primary mortality tabulation

Post COVID-19 condition

- **U09.9 Post COVID-19 condition, unspecified**
- This optional code serves to allow the establishment of a link with COVID-19 This code is not to be used in cases that still are presenting COVID-19

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COVID-19
ICD-10 Active Infectious Disease

Multisystem inflammatory syndrome associated with COVID-19

- **U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified** (Temporarily associated with COVID-19)
- Cytokine storm
- Kawasaki-like syndrome
- Pediatric Inflammatory Multisystem Syndrome (PIMS)
- Multisystem Inflammatory Syndrome in Children (MIS-C)
- **Excludes**
  - Mucocutaneous lymph node syndrome {Kawasaki} (M30.3)

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COVID-19
HHI Recommendations

- Educate staff on Skilled Coverage Criteria
- Educate staff on ICD-10 Coding
- Educate staff on Isolation versus Quarantine
- Perform ongoing and retroactive Medical Record Reviews
- All patients should be reviewed immediately
- It may not be possible to retroactively correcting any errors

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COVID-19
Infection Control

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COVID-19
Infection Control

- Per the NSVH, the demographics of the age and mortality show that 78.23 % of deaths thus far are 65 years old or older!
  - 65-74 years old 22.02%
  - 75-84 years old 27.92%
  - 85 and older years old 28.29%

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Infection Control

The 4 top causes of infection today:

- Visitation
- New Admissions
- Employee
- Resident Outside Appointments

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Infection Control

The biggest obstacles today:

- **PPE** (Change gowns in between patients, even if not infected)
- **COVID-19 Testing** (Need widespread testing immediately)
- **Staff Shortages** (Much more labor intensive, it takes more staff, during outbreak and pandemic. Nursing Homes had shortages before pandemic.)
- **Training** ("Nursing Homes not designated to deal with level of crisis."- Dr. Avula, NY Times 4.17.20)

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COVID-19
Infection Control

- Coronavirus is a member of larger **"family of viruses"** called Coronaviruses (which includes the common cold).
- The name is derived from the shape of the virus at the molecular level, it looks like a **"crown"** with projections. Those **spikes** on the virus allow it to stick to human cells and proceed to **take over the normal cellular** structure and then **replicate itself.**
- This family of viruses has been around **over 50 years.**
- **COVID-19 (SARS-CoV-2)** is the **7th coronavirus known** to effect humans.

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COVID-19
Infection Control

COVID-19 Deaths and % Deaths by Age Reference: National Vital Statistics System (NVSS)		
Age	COVID-19 Deaths	COVID-19 % Deaths
Under 1 year	0	0.00%
1 - 4 years	1	0.02%
5 - 14 years	0	0.00%
15 - 24 years	4	0.10%
25 - 34 years	38	0.93%
35 - 44 years	102	2.51%
45 - 54 years	236	5.81%
55 - 64 years	504	12.40%
65 - 74 years	895	22.02%
75 - 84 years	1,135	27.92%
85 years plus	1,150	28.29%
Total	4,065	100.00%

As of 4.8.20, per the CDC, the U.S. has **399,752** cases of COVID-19 totaling **12,827 deaths and** a 3.2% mortality.

The key takeaway here is that **our nation's seniors (those age 65 and older)** are the most at risk to this disease. Furthermore, the residents of nursing homes have the greatest risk due to their **comorbidities** and **pre-existing medical conditions.**

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COVID-19
Infection Control

1. Minimize Exposure
2. Adhere to Precautions
3. Manage Visitor Access and Movement within Facility
4. Implement Engineering Controls
5. Monitor and Manage Ill and Exposed Staff
6. Train and Educate Staff
7. Implement Environmental Infection Control
8. Establish Reporting within Facility to Public Health

Harmony Healthcare INTERNATIONAL

COVID-19
Infection Control

1. Minimize Exposure
    - Visitation

      Move swiftly upon first identified case if not sooner.
    - New Admissions

      Work closely with hospitals, quarantine upon admission
    - Employee (Screening)

      Temperatures, Symptoms, Staff go to grocery stores and return. Live at facility.
    - Resident Outside Appointments

      Limit for only essential appointments (Dialysis)

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COVID-19
Infection Control

2. Adhere to Precautions
   - Contact Precautions
     - Staff don gloves and isolation gown before contact with the resident and/or his/her environment
   - Droplet Precautions
     - Staff don a facemask within six feet of a resident
   - Airborne Precautions
     - Staff don an N95 or higher-level respirator prior to room entry of a resident

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COVID-19
Infection Control

2. Adhere to Precautions

– Undiagnosed Respiratory Infection

- Staff follow **Standard, Contact, and Droplet Precautions** (i.e., facemask, gloves, isolation gown) with eye protection when caring for a resident unless the suspected diagnosis requires Airborne Precautions (e.g., tuberculosis)

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COVID-19
Infection Control

2. Adhere to Precautions

– Known or Suspected COVID-19

- Staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available
- A facemask is an acceptable alternative if a respirator is not available.
- Additionally, if there are COVID-19 cases in the facility or sustained community transmission, staff implement universal use of facemasks while in the facility (based on availability)

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COVID-19
Infection Control

2. Adhere to Precautions

– Known or Suspected COVID-19

- When COVID-19 is identified in the facility, staff wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability)

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COVID-19
Infection Control

2. Adhere to Precautions
   - Patient Placement
     - Isolate patient in private room
     - Co-horting (2 sick patients in same room) is being readdressed by CDC and CMS.
     - Do not cohort unless you have no other option. Isolate.
     - 50% of infected patients have NO SYMPTOMS!

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COVID-19
Infection Control

2. Adhere to Precautions
   - Patient Placement
     - AIIRS are single patient rooms at negative pressure related to surrounding areas and a minimum of 6 air changes per hour exhausted directly to the outside.
     - HEPA High Efficiency Particulate Air
     - Facemask on patient
     - PPE on Staff
     - Only essential staff enter room
     - Designated equipment

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COVID-19
Infection Control

2. Adhere to Precautions
   - Patient Placement
     - Keep log of staff who care for or enter room
     - Dedicated noncritical patient care items (Blood Pressure Cuffs)
     - If cannot dedicate items, clean and disinfect before and after usage

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COVID-19
Infection Control

2. Adhere to Precautions
   - Hand Hygiene
     - **Before and After** patient all contact
     - **Contact** with potentially infectious material
     - **Before** putting and removal PPE

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COVID-19
Infection Control

2. Adhere to Precautions
   - PPE Personal Protective Equipment
   - Training and Staff Demonstrate an Understanding
     - Gloves
       - Wash hands before and after donning
       - Replace Gloves if tear or become contaminates
     - Gowns
       - On upon entering. Change if becomes soiled.

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COVID-19
Infection Control

2. Adhere to Precautions
   - PPE Personal Protective Equipment
   - Training and Staff Demonstrate an Understanding
     - Respiratory Protection
     - Isolation
     - Diagnostic Respiratory Specimen

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COVID-19
Infection Control

2. Adhere to Precautions
   - PPE Personal Protective Equipment
   - Training and Staff Demonstrate an Understanding
     - Eye Protection
       - Goggles, Disposable face shield
       - Remove before leaving room
       - N95 filtering facepiece

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COVID-19
Infection Control

3. Manage Visitor Access and Movement within Facility
   - Procedures for Mentoring, Managing and Training Visitors
   - Restrict Visitors
   - Screen Visitors
   - Limit Movement within facility
   - Not present during aerosol-generating procedures
   - Follow respiratory hygiene and cough etiquette

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COVID-19
Infection Control

3. Manage Staff Movement within and without Facility
   - Staff Assignments to Specific Units
   - Staff with Secondary Positions
   - Showers and Locker Rooms (Supplied by DPH)
   - COVID Unit with Separate Entrance
   - Staffing COVID Units with COVID positive staff as long as no fever
   - COVID positive staff no need to wear masks but need to wear gloves and gowns
   - Staff residing at facility

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COVID-19
Infection Control

4. Implement Engineering Controls
   - Physical Barriers
   - Air Handling Systems
   - Private Rooms
   - Curtains

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COVID-19
Infection Control

5. Monitor and Manage Ill Patients and Exposed Staff

– Public Health Authorities

CMS Memo 4.19.20: Notify State or Local health department residents and staff with suspected or confirmed COVID-19 resulting in hospitalization or death, or 3 or more residents or staff with new-onset respiratory symptoms within 72 hours of each other.

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COVID-19
Infection Control

5. Monitor and Manage Ill Patients and Exposed Staff
   - Testing (broader and faster)
   - Implement Sick Leave Policies
   - Tracking Sheet
     - Room, Name, Age, Date of Onset Symptoms or Quarantine, Date of Testing, Results of Testing, Code Status, Hospitalization Status, Individuals in Contact, Family Contacted, Date of Deaths

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COVID-19
Infection Control

6. Train and Educate Staff
   - Medically Cleared, Trained and Fit Tested for Respiratory Device Use
   - Comfort Care Staff Education

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COVID-19
Infection Control

7. Implement Environmental Infection Control
   - Dedicated medical equipment for patient care
   - Disinfect
   - Routine Cleaning
   - Laundry, Food Service Utensils and Medical Waste

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COVID-19
Infection Control

7. Implement Environmental Infection Control
   - Cleaning and Disinfecting Facility (CDC attachment)
     - Disposable gowns
     - Clean surfaces soap and water
     - High Touch Surfaces
     - Soft Touch Surfaces
     - Electronics
     - Laundry
     - Building
     - Additional Considerations

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COVID-19
Infection Control

8. Establish Reporting within Facility to Public Health

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COVID-19
Infection Control

- S.P.I.C.E
  - Surveillance
  - Protection
  - Isolate
  - Communicate
  - Evaluate

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COVID-19 Data

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COVID-19 Seniors at Risk
Infection Control

More recently, in 2002, SARS (Severe Acute Respiratory Syndrome), in 2012, MERS (Middle East Respiratory Syndrome), and in 2017 SADS (Swine Acute Diarrhea Syndrome) resulted in the below Death Rates.

Virus	Year	Death Rate	Pathogens
SARS	2002	1%	Bats
MERS	2012	1 in 3	
SADS	2017	No humans infected but 25,000 piglets	
COVID-19	2020	3.2%	

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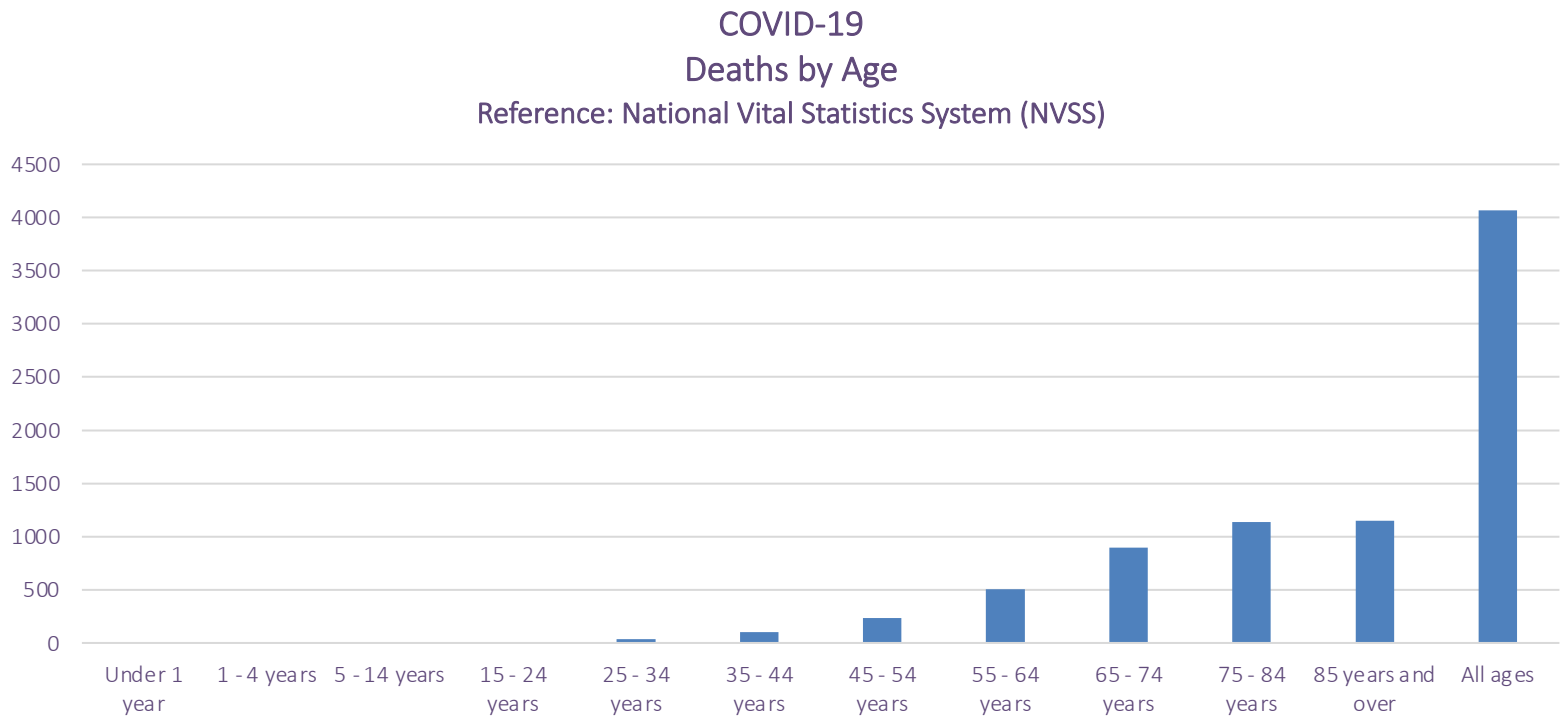
COVID-19 Data

- The below data (from the CDC and NVSS) aids to visualize the **risk of death by age** and **% death by age** for **seniors in the U.S.**



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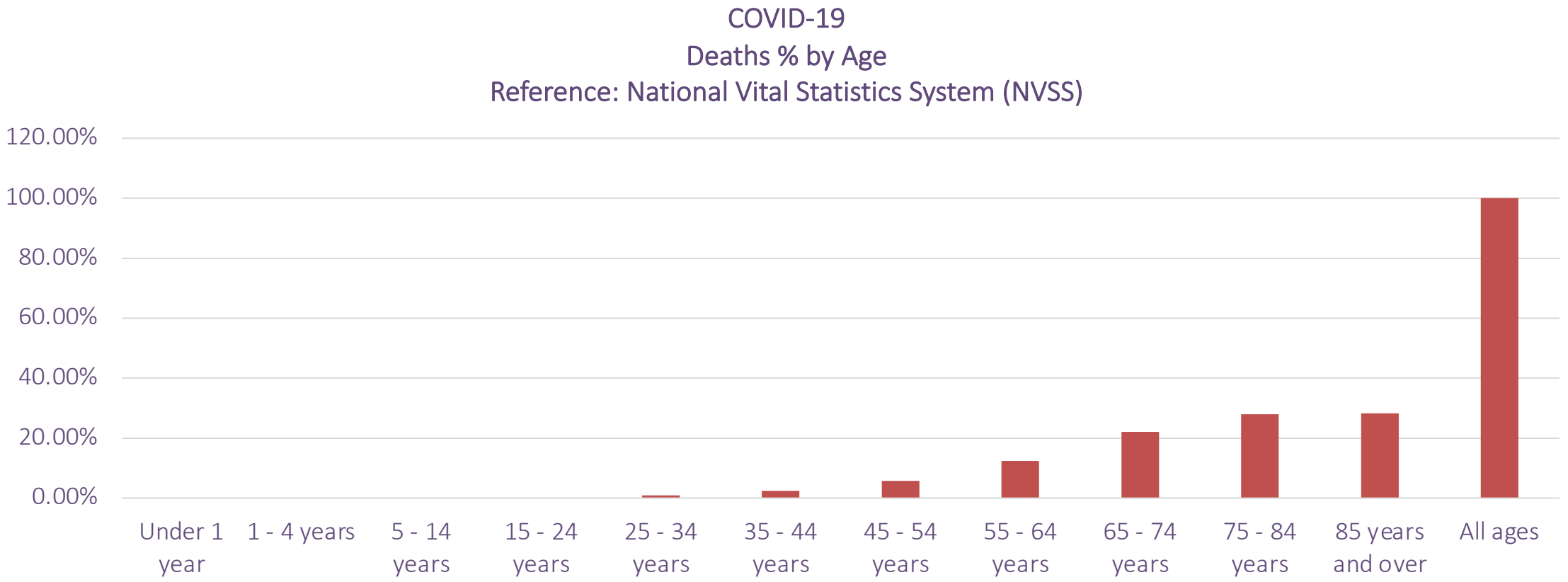
COVID-19 Data



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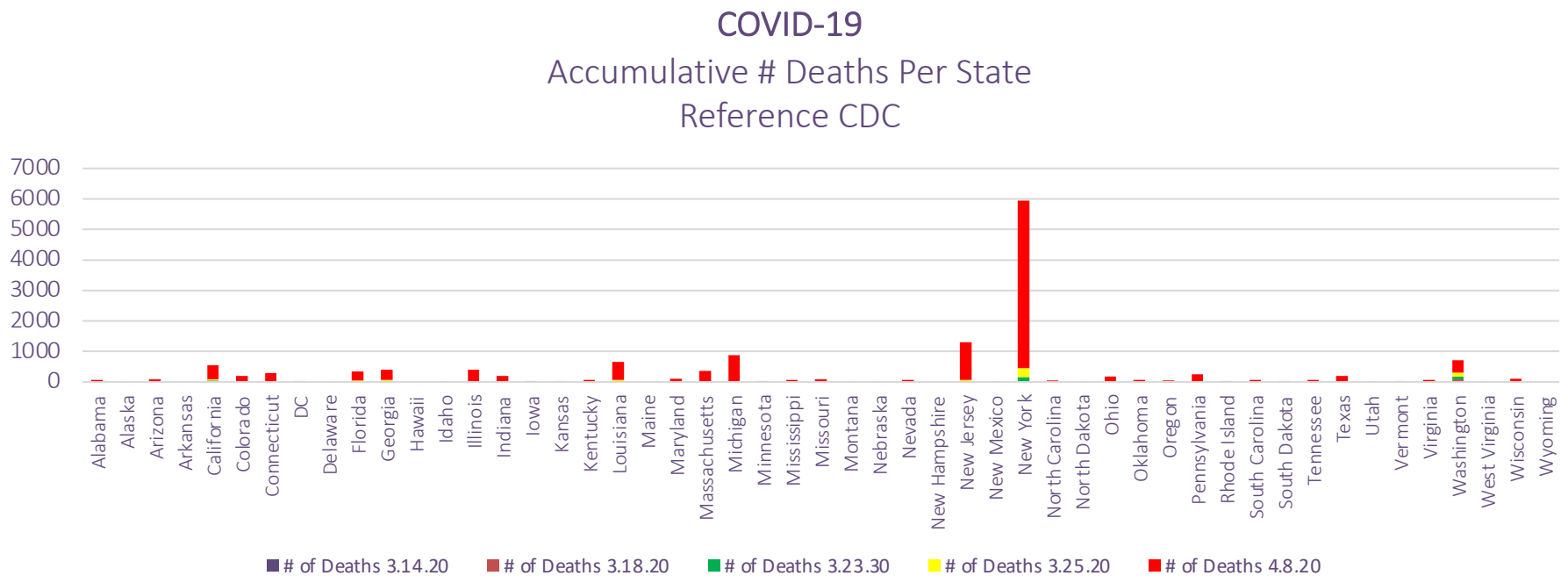
COVID-19 Data

- The below data (from the CDC) aids to visualize the **increase and number # of deaths from 3.14.20 to 4.8.20 by state.**



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COVID-19 Data

COVID-19 % of Deaths by State (Highest to Lowest) Reference: CDC			
State	# of Cases 4.8.20	# of Deaths	Death %
Kentucky	1149	65	5.657%
Washington	8682	403	4.642%
Oklahoma	1472	67	4.552%
Michigan	18970	845	4.454%
Vermont	575	23	4.000%
New York	142384	5,489	3.855%
Georgia	9156	348	3.801%
Louisiana	16284	582	3.574%
Wisconsin	2578	92	3.569%
Connecticut	7781	277	3.560%
Ohio	4782	167	3.492%

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COVID-19 Data

COVID-19 % of Deaths by State (Highest to Lowest) Reference: CDC			
State	# of Cases 4.8.20	# of Deaths	Death %
Kansas	912	31	3.399%
Colorado	5429	179	3.297%
Minnesota	1069	34	3.181%
Indiana	5507	173	3.141%
Mississippi	1915	59	3.081%
Alabama	2197	64	2.913%
Arizona	2575	73	2.835%
Alaska	213	6	2.817%
Illinois	13549	380	2.805%
Oregon	1181	33	2.794%
Nevada	2087	58	2.779%

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COVID-19 Data

COVID-19 % of Deaths by State (Highest to Lowest) Reference: CDC			
State	# of Cases 4.8.20	# of Deaths	Death %
New Jersey	44416	1232	2.774%
California	17620	450	2.554%
Iowa	1049	26	2.479%
Rhode Island	1229	30	2.441%
Maryland	4371	103	2.356%
Massachusetts	15202	356	2.342%
Maine	519	12	2.312%
Missouri	3037	70	2.305%
South Carolina	2417	51	2.110%
Nebraska	478	10	2.092%
Florida	14747	296	2.007%

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COVID-19 Data

COVID-19 % of Deaths by State (Highest to Lowest) Reference: CDC			
State	# of Cases 4.8.20	# of Deaths	Death %
DC	1211	24	1.982%
Virginia	3333	63	1.890%
Montana	319	6	1.881%
South Dakota	320	6	1.875%
Texas	8939	167	1.868%
Arkansas	997	18	1.805%
New Hampshire	747	13	1.740%
Tennessee	4138	72	1.740%
Delaware	928	16	1.724%
North Dakota	237	4	1.688%
Pennsylvania	14945	250	1.673%

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COVID-19 Data

COVID-19 % of Deaths by State (Highest to Lowest) Reference: CDC			
State	# of Cases 4.8.20	# of Deaths	Death %
New Mexico	794	13	1.637%
North Carolina	3321	54	1.626%
Idaho	1210	15	1.240%
Hawaii	410	5	1.220%
West Virginia	412	4	0.971%
Utah	1738	13	0.748%
Wyoming	221	0	0.000%
National Totals	399,752	12827	3.209%

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COVID-19 Data

COVID-19 # of Cases by State 3.14.20-4.8.20 Reference: CDC					
State	# of Cases 3.14.20	# of Cases 3.18.20	# of Cases 3.23.20	# of Cases 3.25.20	# of Cases 4.8.20
Alabama	5	46	157	242	2197
Alaska	1	6	32	42	213
Arizona	9	27	152	326	2575
Arkansas	9	33	165	230	997
California	314	751	1802	2511	17620
Colorado	77	184	591	921	5429
Connecticut	12	68	327	618	7781
DC	10	31	116	183	1211
Delaware	4	19	56	104	928
Florida	71	314	1007	1682	14747

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COVID-19 Data

COVID-19 # of Cases by State 3.14.20-4.8.20 Reference: CDC					
State	# of Cases 3.14.20	# of Cases 3.18.20	# of Cases 3.23.20	# of Cases 3.25.20	# of Cases 4.8.20
Georgia	42	199	620	1026	9156
Hawaii	2	14	56	90	410
Idaho	1	9	47	71	1210
Illinois	46	162	1049	1535	13549
Indiana	12	29	259	477	5507
Iowa	17	29	90	124	1049
Kansas	11	18	64	98	912
Kentucky	11	27	104	163	1149
Louisiana	36	257	837	1388	16284
Maine	3	42	89	118	519

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COVID-19 Data

COVID-19 # of Cases by State 3.14.20-4.8.20 Reference: CDC					
State	# of Cases 3.14.20	# of Cases 3.18.20	# of Cases 3.23.20	# of Cases 3.25.20	# of Cases 4.8.20
Maryland	14	85	244	349	4371
Massachusetts	138	218	646	1159	15202
Michigan	25	83	1035	1791	18970
Minnesota	14	77	169	287	1069
Mississippi	4	34	207	377	1915
Missouri	5	18	128	255	3037
Montana	4	11	34	48	319
Nebraska	28	24	42	53	478
Nevada	19	55	190	278	2087
New Hampshire	7	26	78	108	747

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COVID-19 Data

COVID-19 # of Cases by State 3.14.20-4.8.20 Reference: CDC					
State	# of Cases 3.14.20	# of Cases 3.18.20	# of Cases 3.23.20	# of Cases 3.25.20	# of Cases 4.8.20
New Jersey	50	267	1914	3675	44416
New Mexico	10	23	65	100	794
New York	420	2495	16900	26358	142384
North Carolina	23	70	297	504	3321
North Dakota	1	6	30	37	237
Ohio	13	86	351	564	4782
Oklahoma	4	19	67	106	1472
Oregon	29	68	161	209	1181
Pennsylvania	42	152	479	851	14945
Rhode Island	14	33	83	123	1229

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COVID-19 Data

COVID-19 # of Cases by State 3.14.20-4.8.20 Reference: CDC					
State	# of Cases 3.14.20	# of Cases 3.18.20	# of Cases 3.23.20	# of Cases 3.25.20	# of Cases 4.8.20
Wyoming	2	15	24	30	221
National Totals	2,271	7,690	35,045	54,714	399,752

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COVID-19 Data

COVID-19 # of Cases by State (Highest to Lowest) Reference: CDC			
State	# of Cases	# of Deaths	Death %
New York	142384	5,489	3.855%
New Jersey	44416	1,232	2.774%
Michigan	18970	845	4.454%
California	17620	450	2.554%
Louisiana	16284	582	3.574%
Massachusetts	15202	356	2.342%
Pennsylvania	14945	250	1.673%
Florida	14747	296	2.007%
Illinois	13549	380	2.805%
Georgia	9156	348	3.801%

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COVID-19 Data

COVID-19 # of Cases by State (Highest to Lowest) Reference: CDC			
State	# of Cases	# of Deaths	Death %
Texas	8939	167	1.868%
Washington	8682	403	4.642%
Connecticut	7781	277	3.560%
Indiana	5507	173	3.141%
Colorado	5429	179	3.297%
Ohio	4782	167	3.492%
Maryland	4371	103	2.356%
Tennessee	4138	72	1.740%
Virginia	3333	63	1.890%
North Carolina	3321	54	1.626%

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COVID-19 Data

COVID-19 # of Cases by State (Highest to Lowest) Reference: CDC			
State	# of Cases	# of Deaths	Death %
Missouri	3037	70	2.305%
Wisconsin	2578	92	3.569%
Arizona	2575	73	2.835%
South Carolina	2417	51	2.110%
Alabama	2197	64	2.913%
Nevada	2087	58	2.779%
Mississippi	1915	59	3.081%
Utah	1738	13	0.748%
Oklahoma	1472	67	4.552%
Rhode Island	1229	30	2.441%

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COVID-19 Data

COVID-19 # of Cases by State (Highest to Lowest) Reference: CDC			
State	# of Cases	# of Deaths	Death %
DC	1211	24	1.982%
Idaho	1210	15	1.240%
Oregon	1181	33	2.794%
Kentucky	1149	65	5.657%
Minnesota	1069	34	3.181%
Iowa	1049	26	2.479%
Arkansas	997	18	1.805%
Delaware	928	16	1.724%
Kansas	912	31	3.399%
New Mexico	794	13	1.637%

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COVID-19 Seniors at Risk Data

COVID-19 # of Cases by State (Highest to Lowest) Reference: CDC			
State	# of Cases	# of Deaths	Death %
New Hampshire	747	13	1.740%
Vermont	575	23	4.000%
Maine	519	12	2.312%
Nebraska	478	10	2.092%
West Virginia	412	4	0.971%
Hawaii	410	5	1.220%
South Dakota	320	6	1.875%
Montana	319	6	1.881%
North Dakota	237	4	1.688%
Wyoming	221	0	0.000%

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COVID-19 Data

COVID-19 # of Cases by State (Highest to Lowest) Reference: CDC			
State	# of Cases	# of Deaths	Death %
Alaska	213	6	2.817%
National Totals	399,752	12827	3.209%

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COVID-19
Infection Control
Policies and Procedures

Refinement COVID-19

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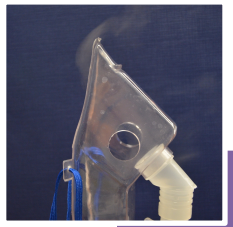
COVID-19
Infection Control
Clinical Policies CPR Revised Guidance

CPR

- Additional Precautions recommended during Pandemic
- Check AMDA, CDC plus your Medical Director for guidance

Masks

- N 95 mask policy
- Additional flexibility with PPE practices to conserve supply?



Aerosol Procedures

- Changes with Nebulizer treatments, BiPAP, CPAP?
- Consider reassessing these orders?

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COVID-19
Infection Control
Staff Policies

Staff leaving work d/t symptoms, returning after Quarantine

- Are your policies clear and understood by all staff?
- Ensure documentation

Decreasing staff cross contamination if COVID is present or suspected

- Avenues of entry/exit that are separate to prevent cross contamination between shifts
- Sharing of breakroom? Bathroom? Locker room?

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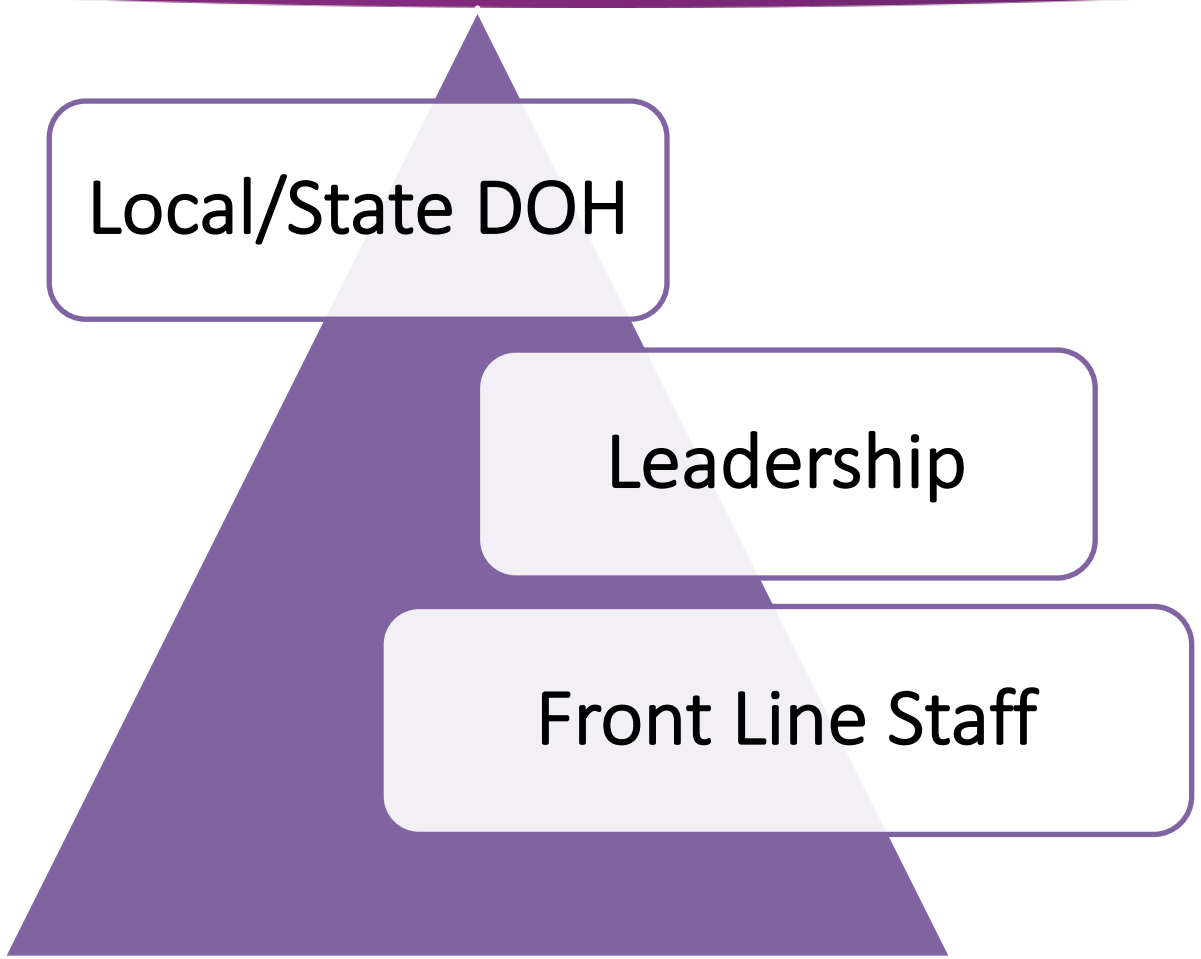
COVID-19 Infection Control Communication Policies
Process for Suspected/Confirmed COVID-19 +



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COVID-19
Infection Control
Education and Monitoring

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COVID-19
Infection Control
Education and Monitoring of Staff

Education IPCP	• Ensure training w/competency validation: Hand washing, donning and duffing of PPE, appropriate use of PPE, standard & transmission-based precautions, conservation measures…
Peer Monitoring	• Monitor each other for adherence to policies • Empower residents and any staff to speak up & remind others when seeing an incorrect practice
Observe Staff	• Round and ensure proper practices are being used! • Communicate with all staff about practices that can be improved

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COVID-19
Infection Control
Identifying Acute Changes and Conditions

Quality Care

Detect changes early! Remind staff to be **alert and observing** for acute changes

Communicate these to the nurse for assessment

Crucial in **recognizing early symptoms** of COVID-19 to mitigate it's spread

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COVID-19
Infection Control
Identifying Acute Changes and Conditions

Acute Changes

Cognition, physical function, vital signs, new symptoms

Meticulous attention to the details and the resident who just seems different

Loss of smell or taste, muscle aches, loss of appetite, red shadows around the outside of eyes, loose stools have been precursors to those testing + for COVID-19

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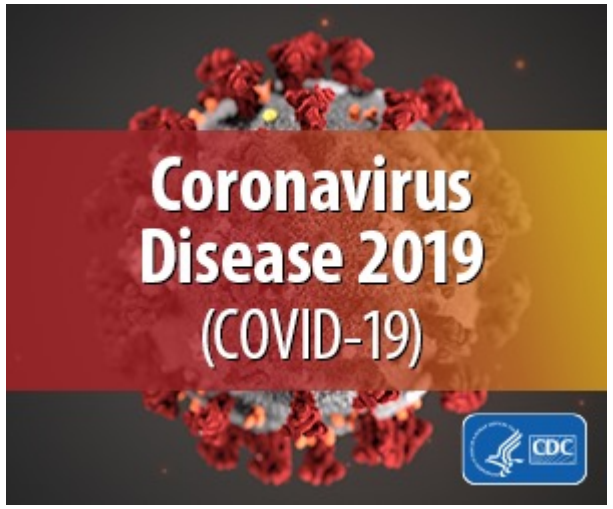
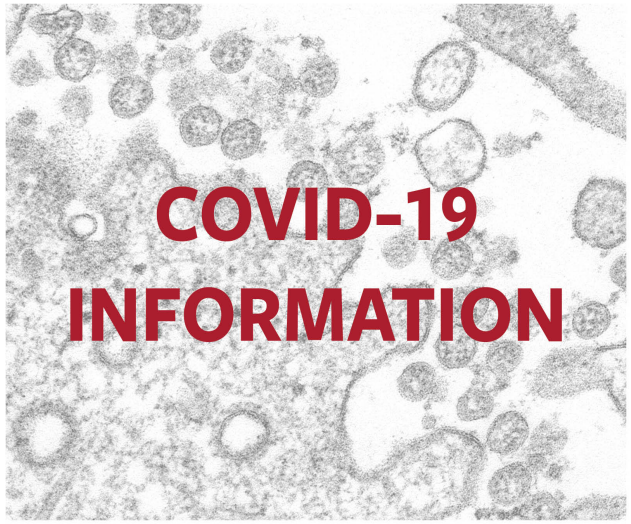
COVID-19
Infection Control
Educate All Staff, Families, Any Visitors





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COVID-19 Infection Control Social Distancing

Meetings	• Explore alternative virtual communication • Rearrange furniture when physically meeting
At Entrances/Staff Dining/Nursing Station	• Mark 6 feet on the floor to separate those in line for screening at the start of a shift • Monitor areas where staff congregate, brainstorm on how to facilitate social distancing

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COVID-19
Infection Control
Acquiring, Conserving and Preserving

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COVID-19
Infection Control
Acquiring, Conserving and Preserving

- N95 Masks
- Isolation Carts
- Isolation Trash Cans
- Gowns
- Gloves
- Bleach Wipes
- Thermometers
- Hand Sanitizer

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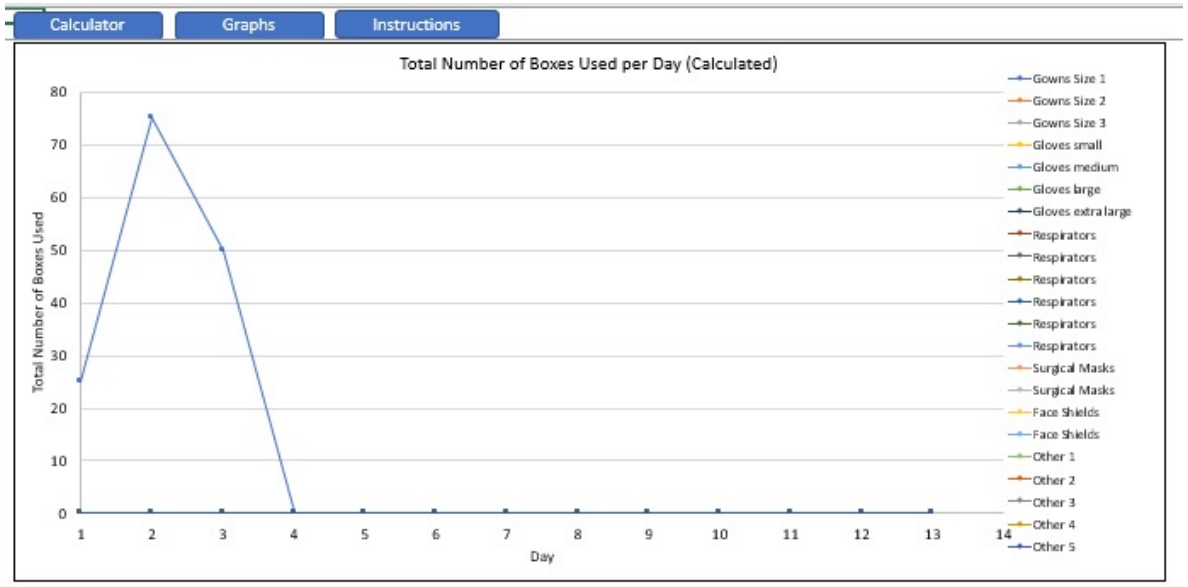
COVID-19
Infection Control
Acquiring

- Burn Rate Calculator
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html



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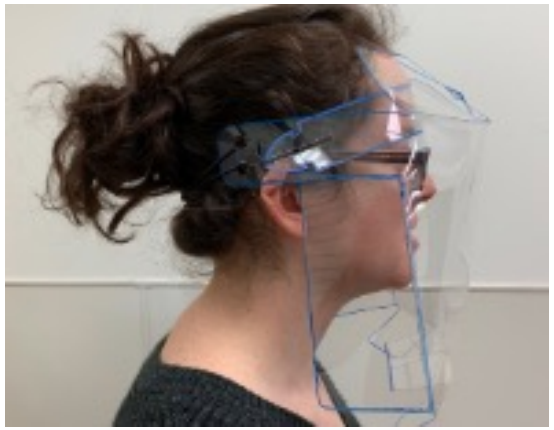
COVID-19
Infection Control
Preserving

- **Beware of scams** when working with vendors offering PPE supplies
- Face Shields
  - Face shields do not replace the need for face masks, such as N95s
  - Offer splash protection
  - Can extend the useful life of N95 respirators and surgical masks



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COVID-19
Infection Control
Acquiring, Conserving and Preserving

What is your stock of			
Isolation Carts	Isolation Trash Cans, Bags	Bleach Wipes	Other Sanitizers or Wipes

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COVID-19
Infection Control
Acquiring, Conserving and Preserving

Is a face mask readily available if a resident complains of cough and a fever?

Where are supplies?

Where is the hand sanitizer located?

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COVID-19
Infection Control
Environmental

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COVID-19
Infection Control
Environmental

- How often?
- What are your surfaces made of?

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COVID-19 Infection Control
Air Flow

Do you want to consider options to manage airflow in COVID-19 resident rooms?

- Reduces the potential spread of infectious airborne droplets

Ensure that any steps taken to modify rooms are in compliance with the Life Safety Code/State Regulations

5 steps to modify patient rooms to negative pressure for removing airborne respiratory droplets approximately 3x faster that the standard room are listed in a recent journal article*

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COVID-19
Infection Control
Focused Infection Control Survey

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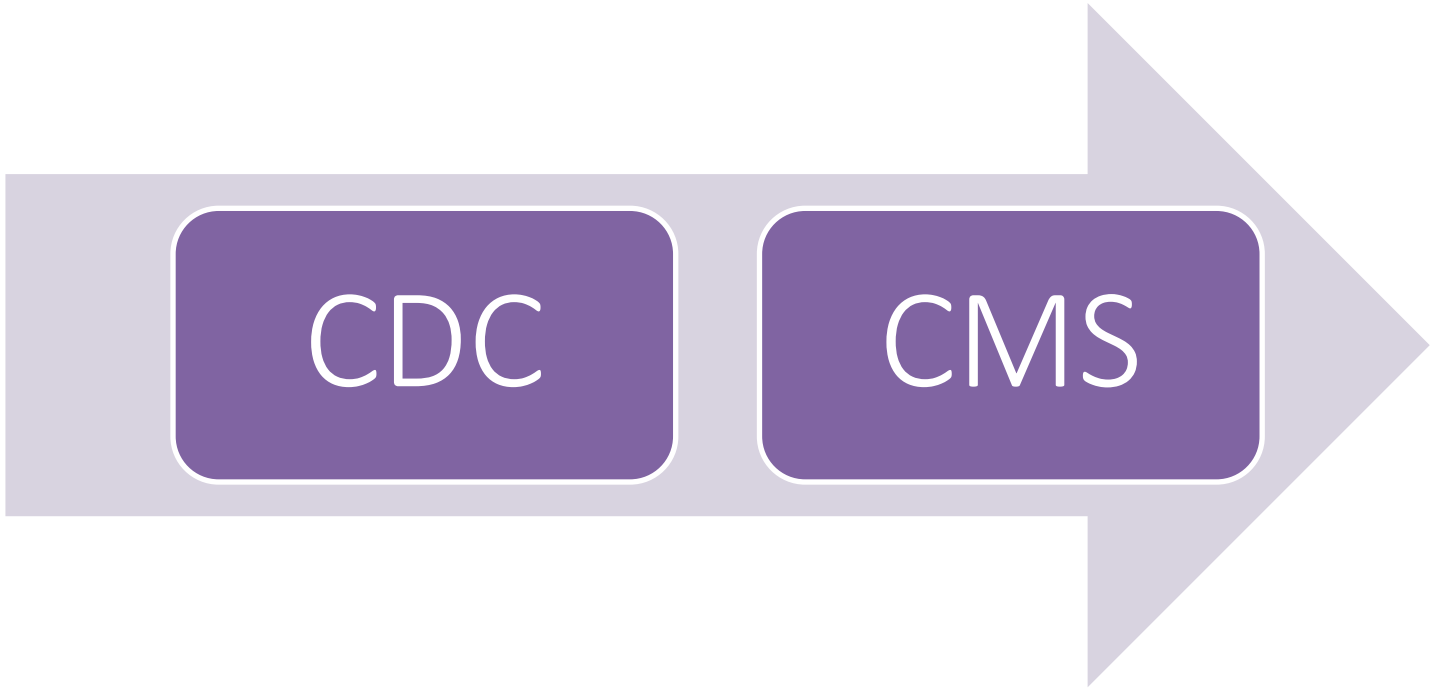
COVID-19 Infection Control Resources



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COVID-19
Testing Requirements

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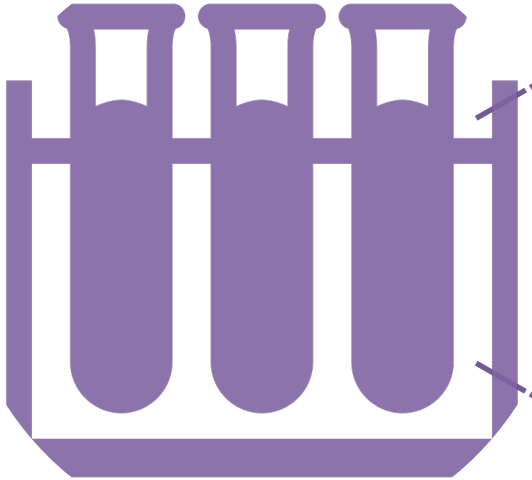
COVID-19 Testing Requirements
Effective September 2, 2020
New Federal Testing Requirements



All staff

- Employees
- Contractors
- Consultants
- Volunteers

All residents

- Symptomatic testing on anyone with signs or symptoms of COVID-19
- When an outbreak occurs

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COVID-19 Testing Requirements
Types of Testing

Viral Test

- Determines **current infection**
- **PCR** testing detects virus' **genetic material**
- **Antigen** testing detects **specific proteins** on the surface of the virus

Antibody Test

- Determines **past infection**
- Serology test that looks for antibodies against COVID-19 in a **blood sample** to determine past infection

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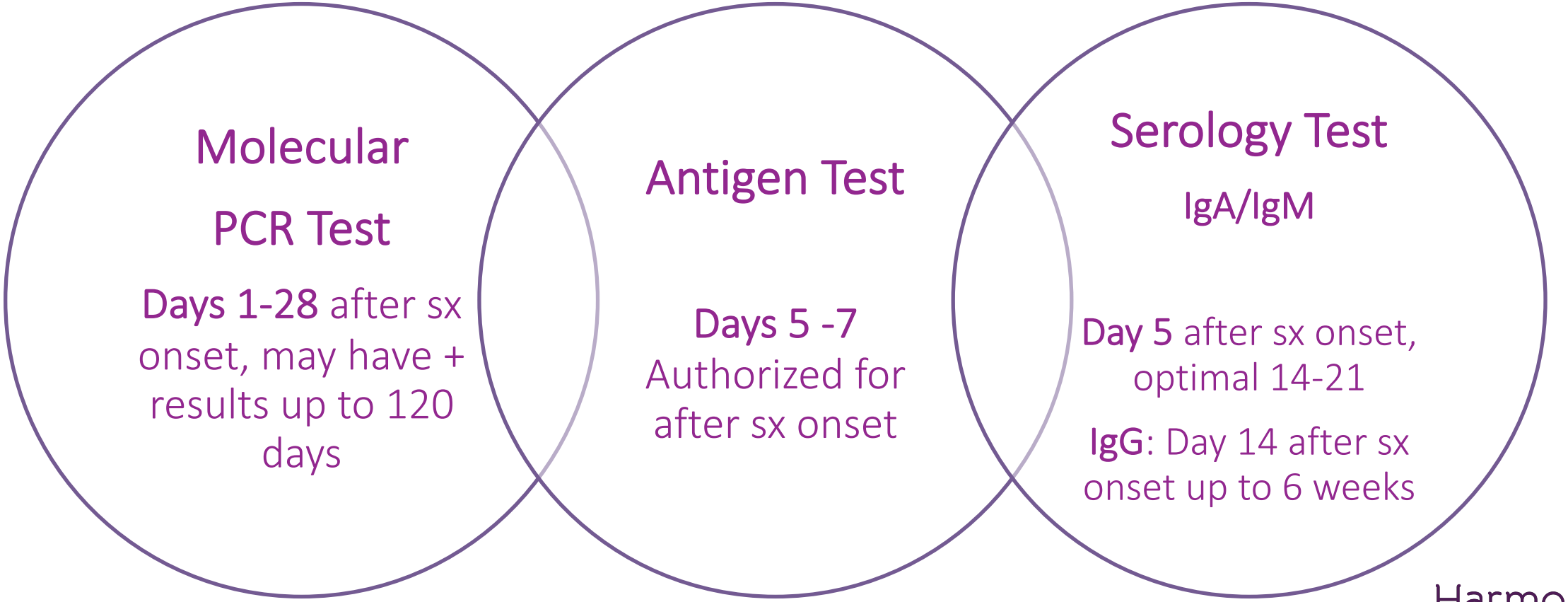
COVID-19 Testing Requirements
Testing Window



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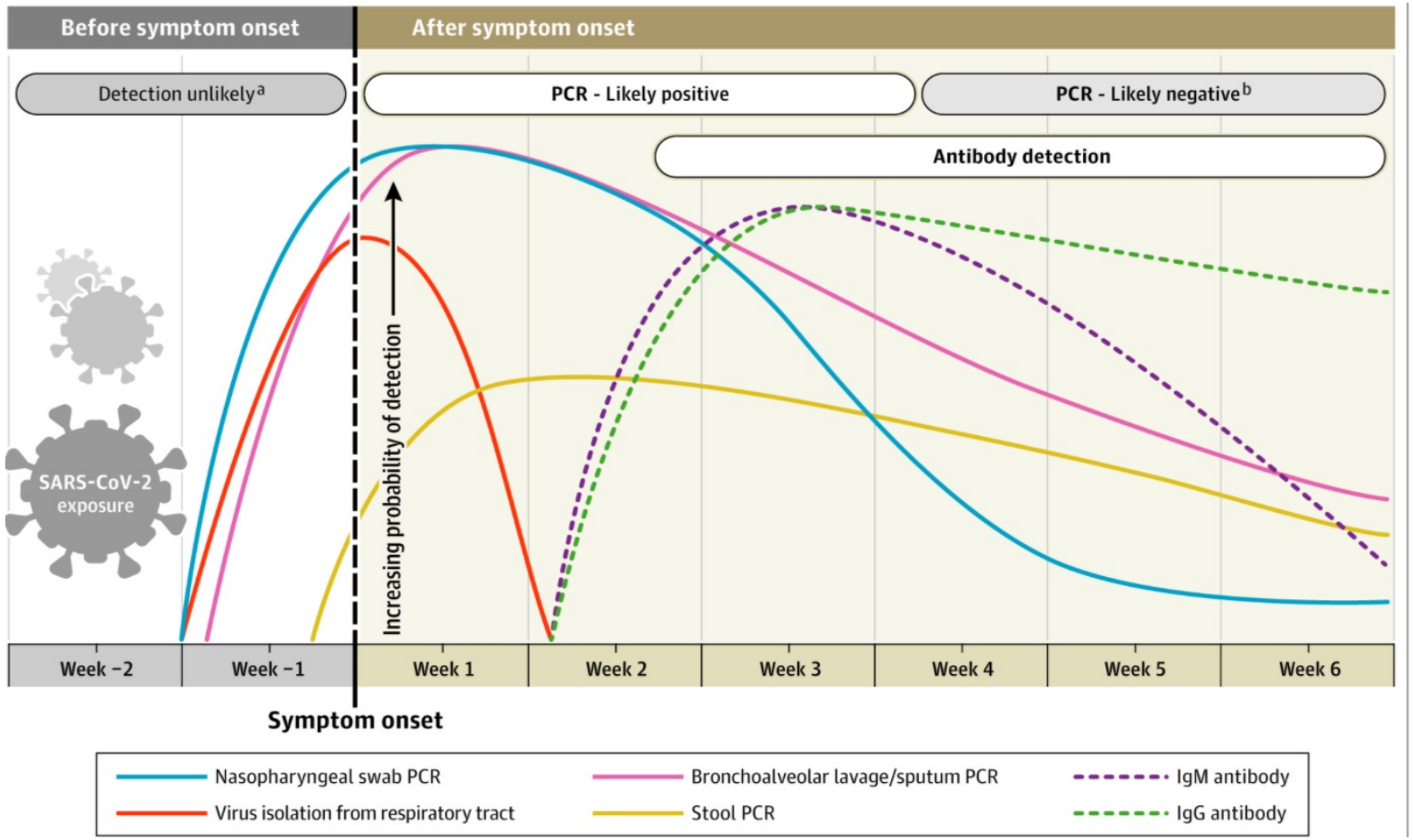
COVID-19 Testing Requirements
Infection Timeline & Testing



Sethuraman N et al. JAMA May 2020
DOI: 10.1001/jama.2020.8259

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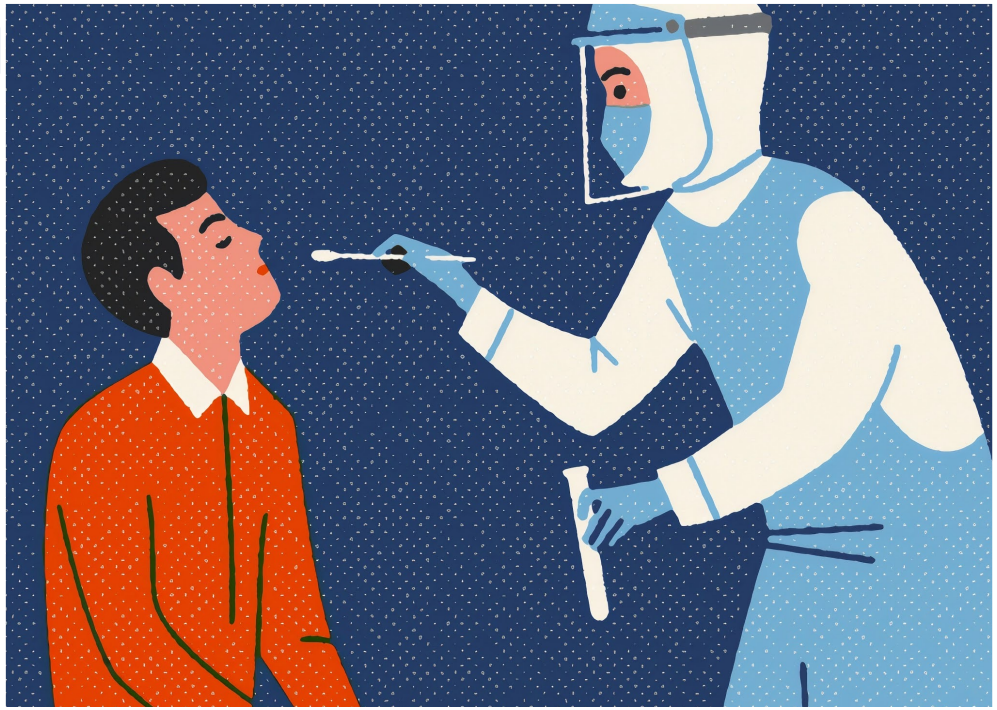
COVID-19 Testing Requirements
Routine Testing of Staff and Contractors



PCR/Molecular or Antigen Tests

Test **all staff** based on the extent of the virus in the community using **CMS' county positivity rate**

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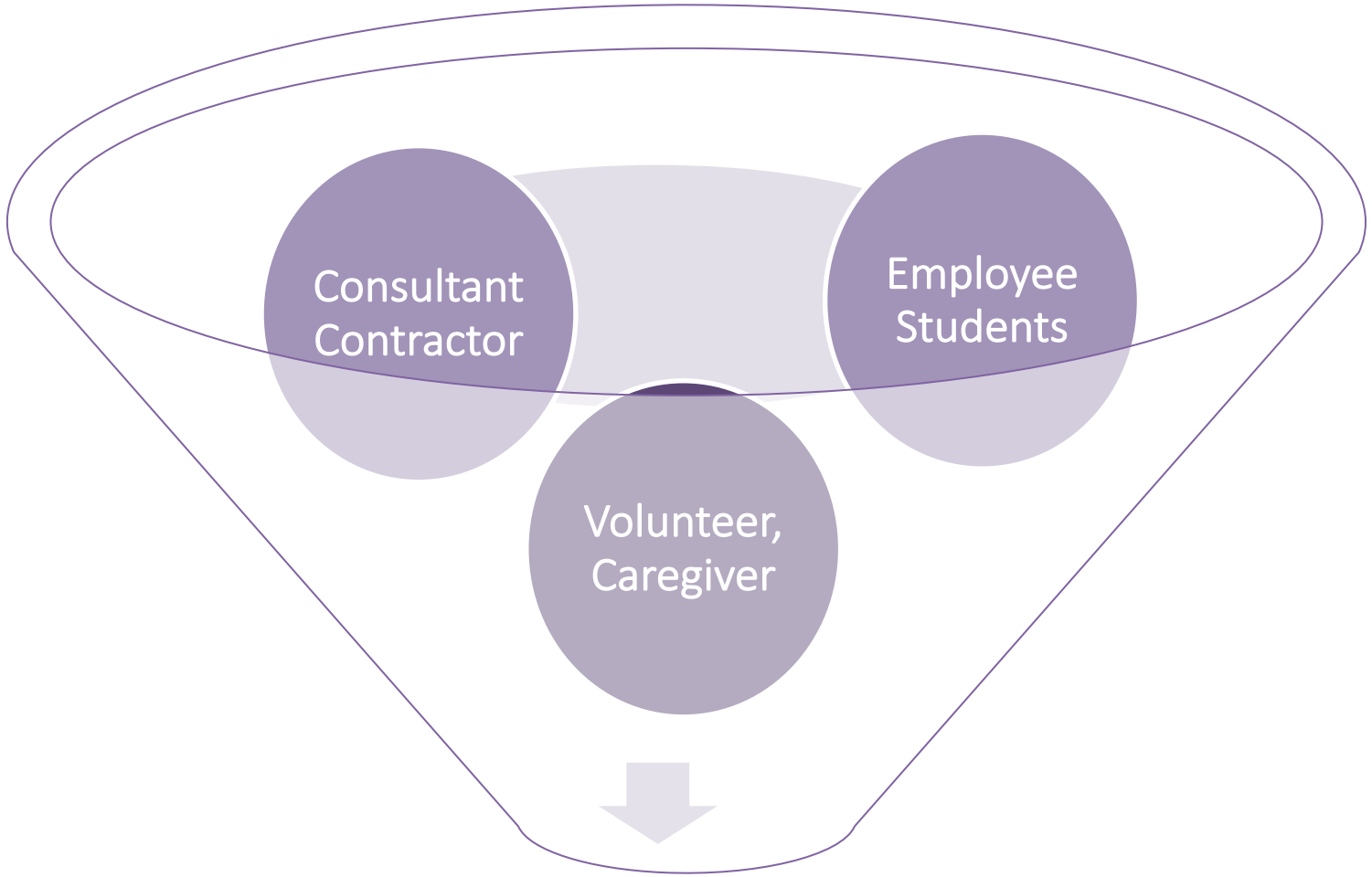
COVID-19 Testing Requirements
Facility Staff



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COVID-19 Testing Requirements
County Prevalence Rate

County-Level Positivity Rates

- Published by CMS every week
- https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg

Adjust Testing Frequency Based on Changes in the Positivity Rate

- Check rates on the same day of the week every week
- Rate increases → immediately adjust testing frequency
- Rate decreases → continue testing staff at higher frequency until rate remains at lower level for at least 2 weeks

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COVID-19 Testing Requirements
Routine Testing of Staff and Contractors
Testing Frequency: County Positivity

GREEN

- Low = <5% or with less than 20 tests in 14 days
- Test once a month

YELLOW

- Medium = 5% - 10% OR with <500 tests & <2,000tests/100k & >10% positivity over 14 days
- Test once a week

RED

- High = >10% and not meeting criteria for Green or Yellow
- Test twice a week

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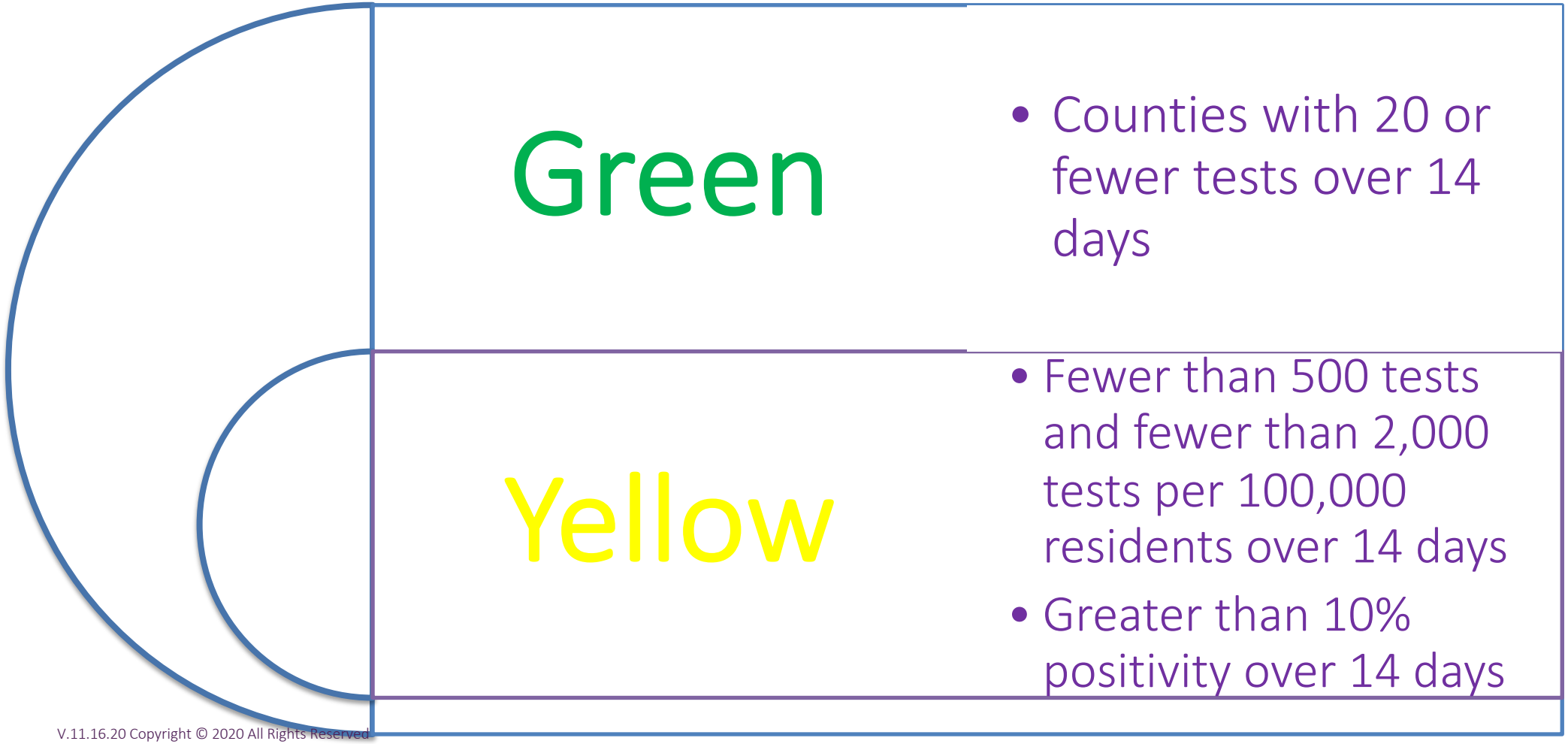
COVID-19 Testing Requirements
Testing Methodology
September 29th Update Addressed Rural Counties



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COVID-19 Testing Requirements
Routine Testing of Staff and Contractors

Individuals who have been COVID positive do not need repeat testing for 90 days.

Staff can be tested elsewhere in the correct timeframe with a documented result.

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COVID-19 Testing Requirements
More Testing Triggers

Staff and Residents

Symptomatic Testing

Anyone with signs or symptoms of COVID

Outbreak Testing

All staff and residents when an outbreak* occurs

Continue to test those who tested negative every 3-7 days until there are no new cases for at least 14 days since the most recent positive result

*** Outbreak** = Any single new infection in staff or a resident who tests positive **after** admission.

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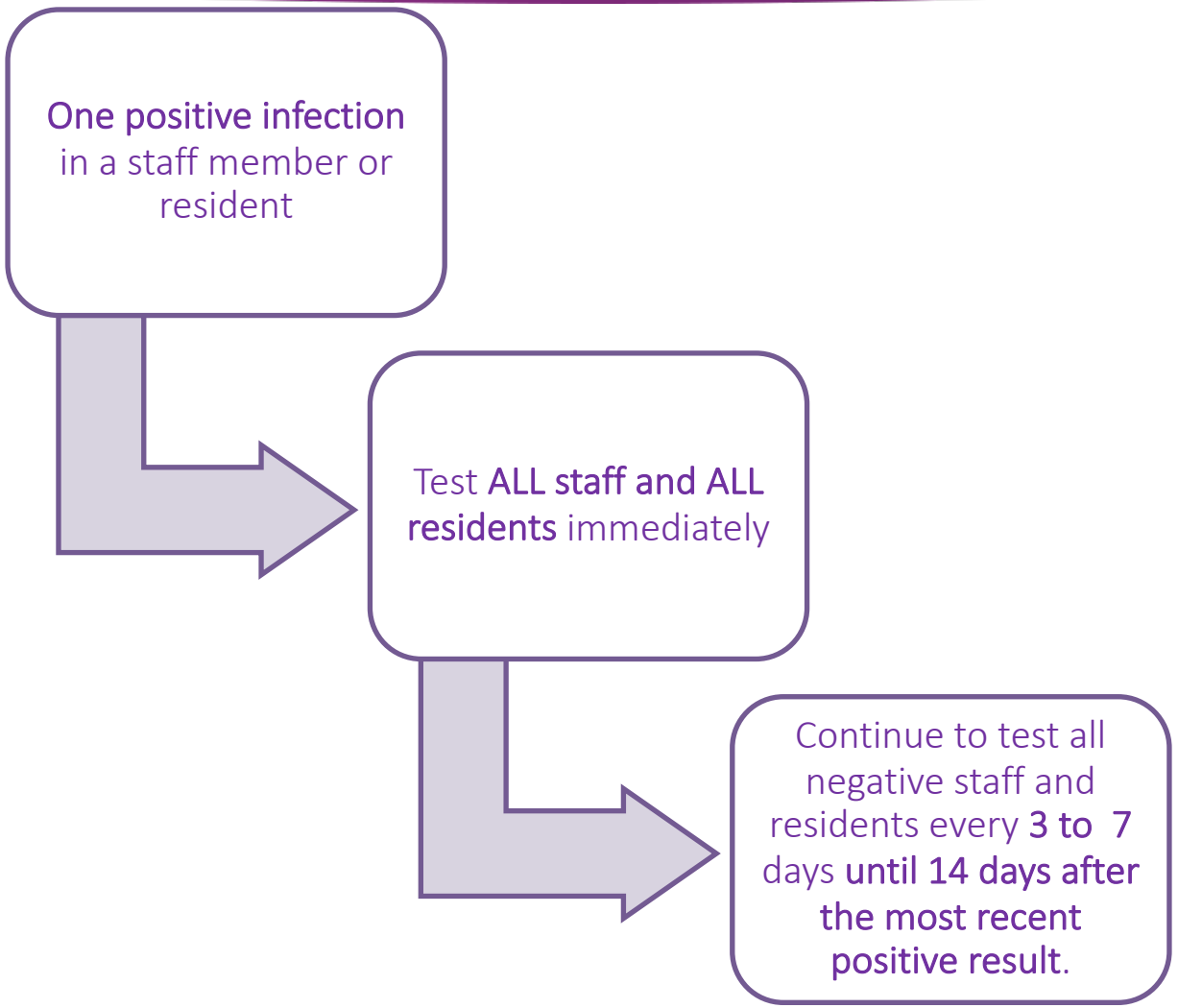
COVID-19 Testing Requirements
Outbreak Testing Frequency



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COVID-19 Testing Requirements
Testing Asymptomatic Residents: Non-Outbreak

Should asymptomatic residents in be tested regularly in a non-outbreak setting?

COVID is usually introduced into the NH by staff or visitors.

Testing asymptomatic residents can be reserved for a resident who experienced close contact with someone confirmed as COVID +.

Regular testing can result in false positive results and then additional unnecessary testing.

Consider testing symptomatic residents who go out of the facility often for medical treatment when **testing capacity allows.**

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COVID-19 Testing Requirements Documentation is Required

Where?

- In Medical or Employee Record
- Separate file for contractors and volunteers
- Results of tests must be in a secure manner consistent with standards for PHI, requirements in 483.80(h)(3)

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COVID-19 Testing Requirements Documentation is Required

What?

- **Symptomatic:** Date and Time of identification of signs or symptoms, date of test and date of result, results and action taken
- **Outbreak:** Date first case identified, date and results of initial testing and retesting for all residents & staff
- **Routine (Staff Testing):** County positivity rate and required testing frequency, date positivity rate was checked on CMS website

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COVID-19 Testing Requirements Documentation is Required

Refusals

- Facility policy for addressing residents and staff that refuse testing or are unable to be tested
- Document any staff or residents that refuse or are unable to be tested and how the facility addressed those cases

Supply Shortages, Late Test Results

- Document that the facility contacted state and local health departments when 48-hour turn-around time is not met

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COVID-19 Testing Requirements
Test Refusal

Staff Refusal

Outbreak Testing: Restricted from building until procedures for outbreak testing completed

Routine Testing: Follow occupational health & local jurisdiction policies

Resident Refusal

Residents with signs or symptoms of COVID who refuse are placed on TBP until criteria for discontinuing precautions met.

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COVID-19 Testing Requirements
Policies and Procedures
Facility Assessment

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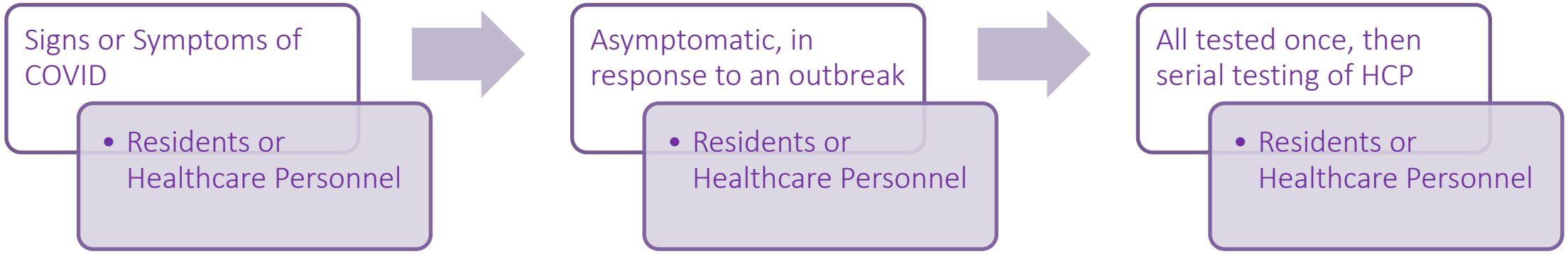
COVID-19 Testing Requirements
Priorities with Limited Testing Resources



Document your plan on how to prioritize testing when testing resources are limited.

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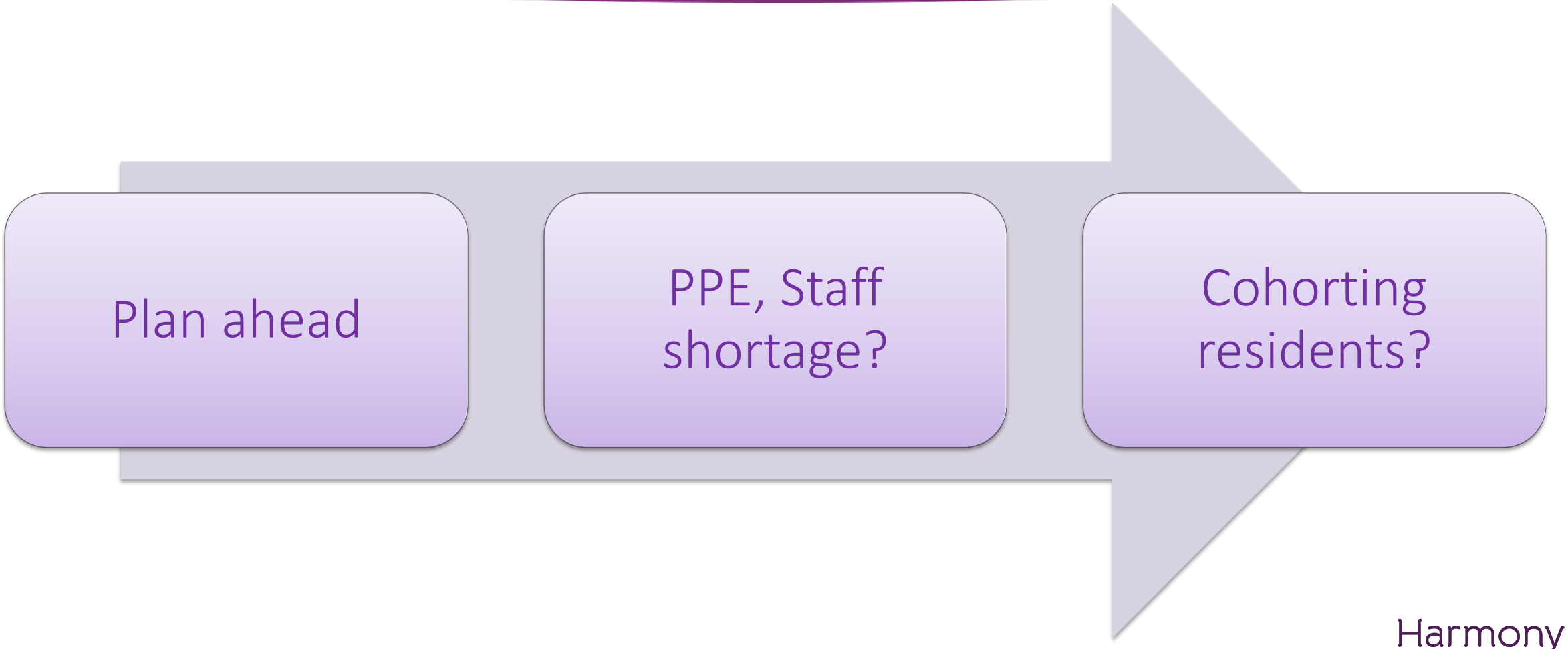
COVID-19 Testing Requirements
Plan for Test Results



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COVID-19 Testing Requirements
Testing Requirements

- Testing requires physician order for residents and staff
- Follow CDC guidelines on testing and specimen collection
- POC Testing: Need CLIA certificate and must report all results to public health agency

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COVID-19 Testing Requirements
Rapid Antigen Point of Care (POC) Tests

- Quidel Sophia 2

- BD Veritor System

- Abbott BinaxNOW

Email LabExcellence@cms.hhs.gov

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COVID-19 Testing Requirements Molecular (PCR) vs Antigen Tests

Sensitivity: Accuracy of detecting positive patient with infection

Specificity: Accuracy of detecting negative patients without infection

https://qioprogram.org/sites/default/files/CMS-CDC%20Fundamentals%20of%20COVID-19%20Testing_10-08-2020_FNL_508.pdf

Table 2. Summary of Some Differences between RT-PCR Tests and Antigen Tests

	RT-PCR Tests	Antigen Tests
Intended Use	Detect current infection	Detect current infection
Analyte Detected	Viral RNA	Viral Antigens
Specimen Type(s)	Nasal Swab, Sputum, Saliva	Nasal Swab
Sensitivity	High	Moderate
Specificity	High	High
Test Complexity	Varies	Relatively easy to use
Authorized for Use at the Point-of-Care	Most devices are not, some devices are	Yes
Turnaround Time	Ranges from 15 minutes to >2 days	Approximately 15 minutes
Cost/Test	Moderate	Low

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COVID-19 Testing Requirements
POC Antigen Testing

POC Antigen Testing

Authorized for use on symptomatic patients.

Use on asymptomatic patients is “off-label” but allowed.

CDC, FDA, HHS have issued guidance allowing off-label use and HHS guidance allows this guidance to override state restrictions.

Test results need to be confirmed in some situations.

CDC has published an algorithm/decision tree for interpreting antigen test results in the nursing home.

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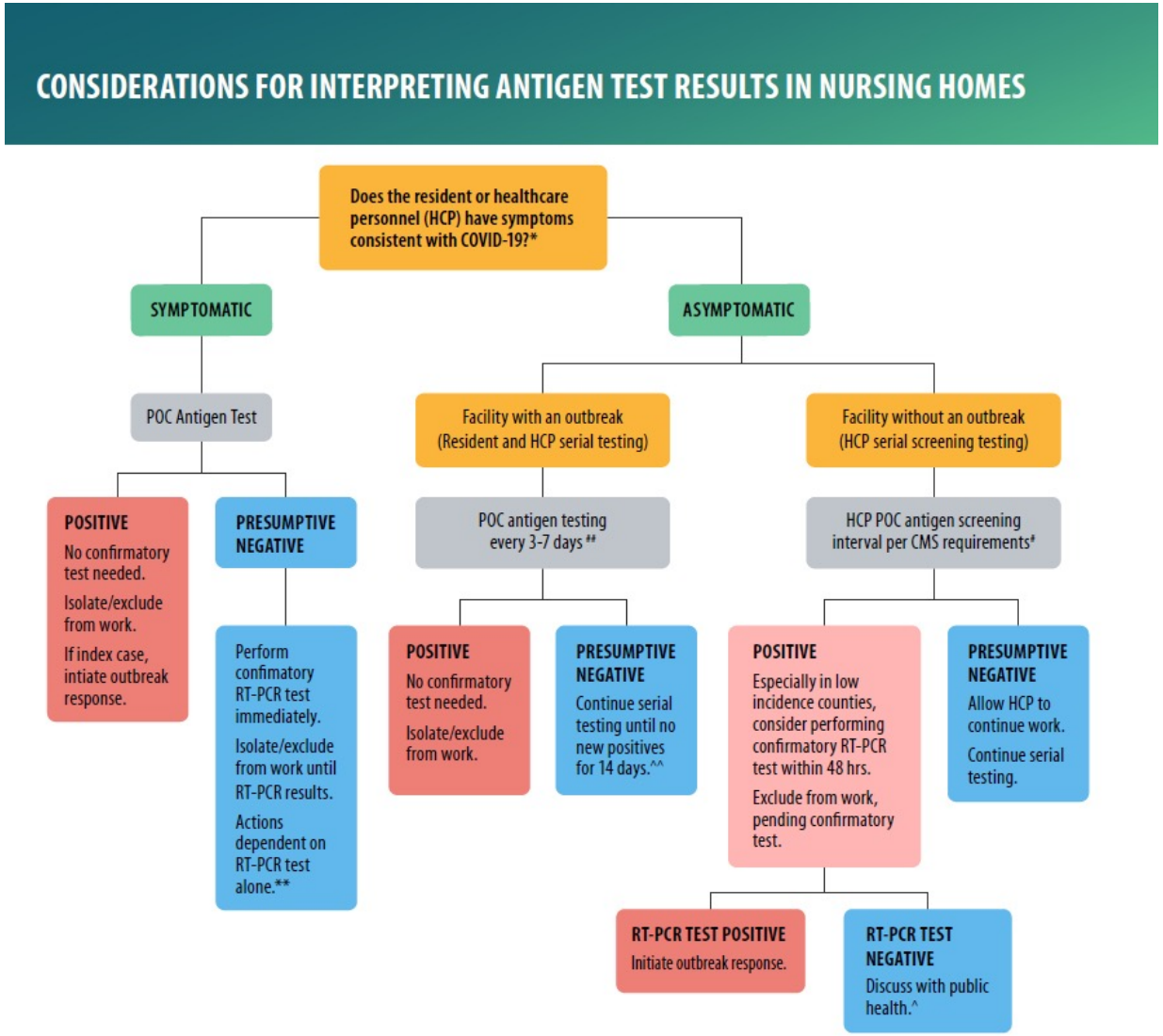
COVID-19 Testing Requirements POC Antigen Test Results Decision Tree

Available from CDC:

https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/nursing-home-testing-algorithm-508.pdf



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COVID-19 Testing Requirements Performing Antigen POC Testing

POC Antigen Testing

Training and proficiency in testing is needed for CLIA regulations. States may have further regulations

Some states may require that the provider add the POC testing device to CLIA certificate

There is no federal restriction on who can be tested under the CLIA waiver.

Visitors are not required to be tested but it could be used for them depending on state regulations

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COVID-19 Testing Requirements
Factors That Can Impact Test Results

- Quality of the specimen collection
- Proper use of the testing platform
- Clinical presentation at the time of the test
- Prevalence of COVID-19 in the area

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COVID-19 Testing Requirements
False Positive Antigen Test?

Inconsistent with the Clinical Picture

- Asymptomatic patient
- No risk factors
- County with low prevalence

Gather Review Information

- Review instructions for POC test for correct use
- Ensure accuracy of test machine – procedural quality control tests
- Compare % positivity for day/week to previous day/week to rule out operator error or test supply issue

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COVID-19 Testing Requirements While Confirming Potential False Positive Antigen Test

IPC Measures Pending Confirmation of Potential False Positive Test Result	Exclude HCP from work pending confirmatory testing
	Place asymptomatic resident in Transmission-Based Precautions and in single room when possible (otherwise stay in current room).
	Do not transfer resident to COVID unit or place in a different shared room with a new roommate.
Asymptomatic Patient	Delay additional testing of asymptomatic residents or close contacts

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COVID-19 Testing Requirements
Discordant Test Results

Conflicting tests such as a PCR and POC Antigen that have samples collected within 2 days = discordant test results

Suspected false positive antigen test result (patient asymptomatic) - ensure proper specimen collection and handling - then confirm with a PCR test.

Perform the test to confirm the result within 2 days of the initial test.

Explain false negative/false positive test results and your plan such as continued symptom screening.

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COVID-19 Testing Requirements
Positive Antigen Test, Symptomatic Patient

Confirming + Antigen Test with a symptomatic patient or patient in close contact with someone + is NOT recommended by CDC	However, if PCR testing was performed and is negative, then the facility still bases their plan on the positive antigen result
	Exclude from work if HCP or place resident on COVID unit with transmission-based precautions
	Expanded viral outbreak testing of residents and HCP indicated.

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COVID-19 Testing Requirements
How to Report Test Data

Directly to state or local public health departments

- According to state/local law or policy

Through a centralized platform

- Such as the Association of Public Health Laboratories' AIMS platform

Through a state or regional Health Information Exchange

- HIE then to CDC as directed by the state

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COVID-19 Testing Requirements
48-Hour Turnaround Time

Does the 48-hour turnaround time start at the time of specimen collection or when the lab receives the results?

HHI recommends **starting at the time the specimen is collected**. Facilities must document all efforts to meet the time frame.

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COVID-19 Testing Requirements
Time Between Testing

- What is the required timeframe between tests when testing twice weekly?

- **Answer:** CMS has not specified a timeframe, HHI recommends 2 -3 days.

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COVID-19 Testing Requirements
Testing Approach

- What is the timeframe and approach to testing when our county is in the low or green, testing category with testing required once a month?

- **Answer:** A great question that CMS has not specified. Provider could test a % of staff each week or test all the staff at the same time. Plan to test staff at the same time each month.

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COVID-19 Testing Requirements
Outbreak Testing

- When I have one staff member test positive within 14 days of being in the building during routine testing, do I then test everyone in the building or just on the unit?

- **Answer:** This is an outbreak, and you must test everyone in the building.

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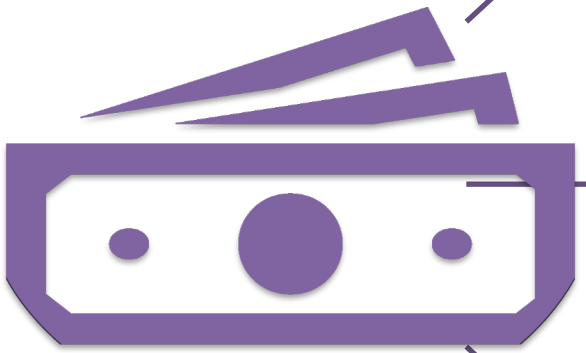
COVID-19 Testing Requirements
Funding for Testing



2.5 billion from Provider Relief Fund

- Approximately $1,500 per bed, more if allocated Incentive Payment Program funds

State may cover cost

Staff health insurance

- Diagnostic only

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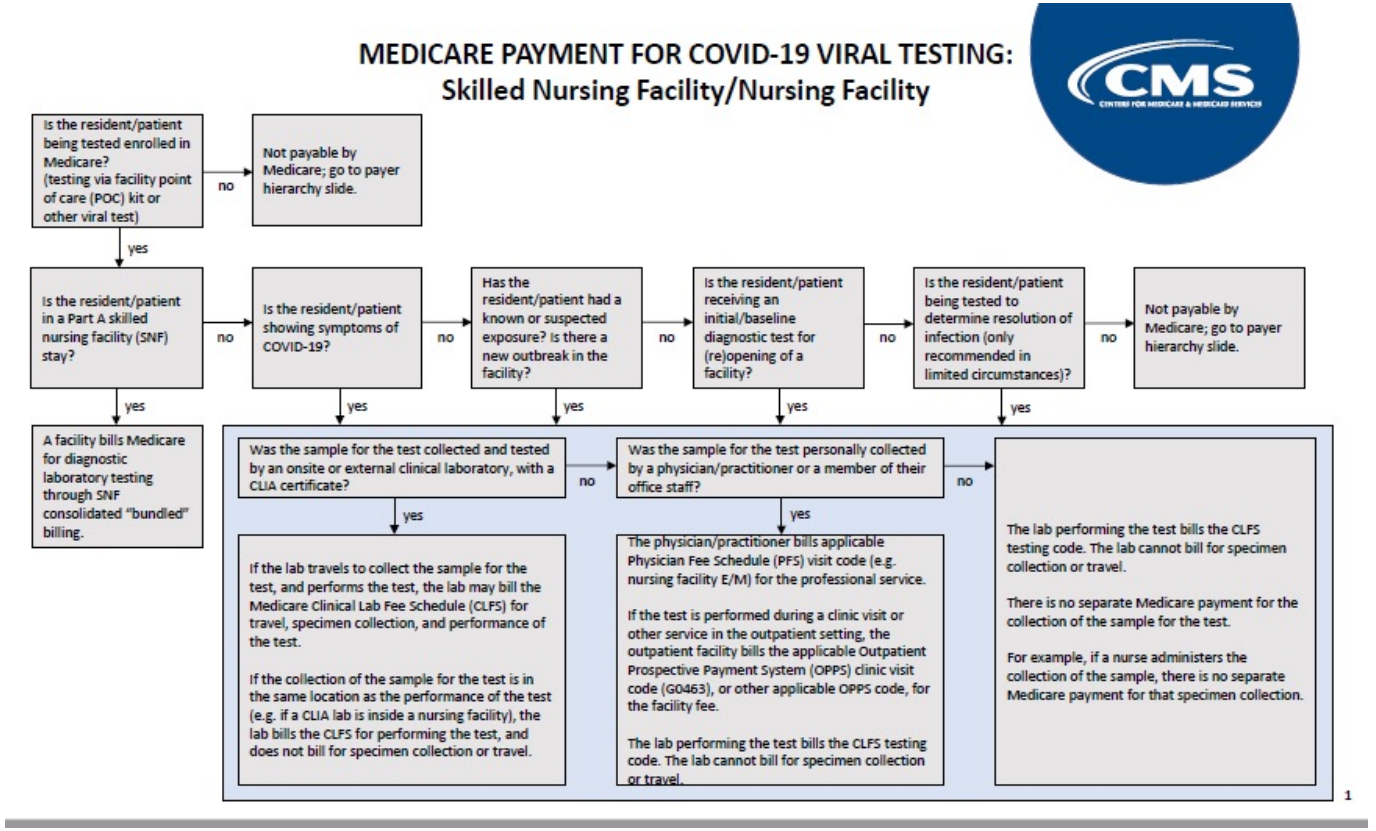
COVID-19 Testing Requirements Medicare Payment for Testing

CMS Flowchart and Payer Hierarchy Information

Available at:

https://www.cms.gov/files/document/covid-medicare-payment-covid-19-viral-testing-flow-chart.pdf



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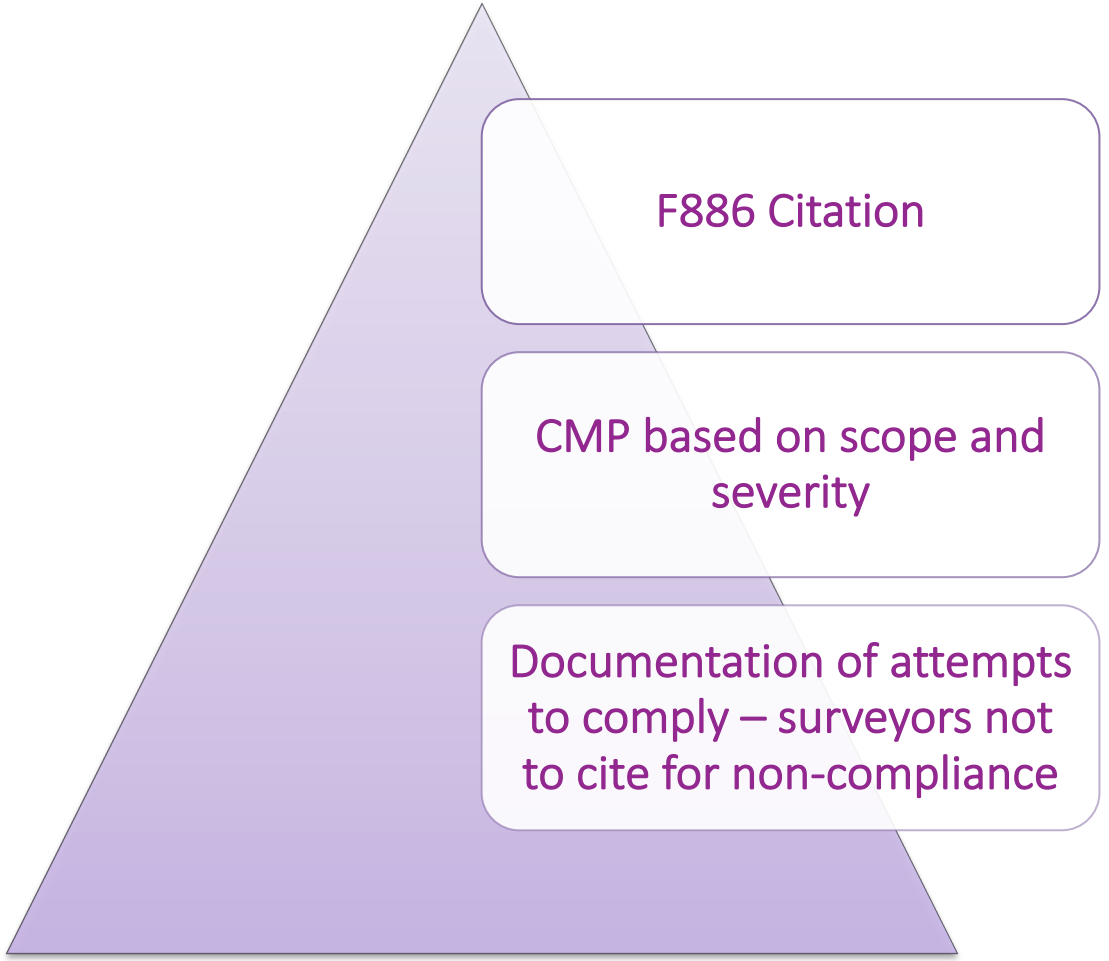
COVID-19 Testing Requirements Penalties



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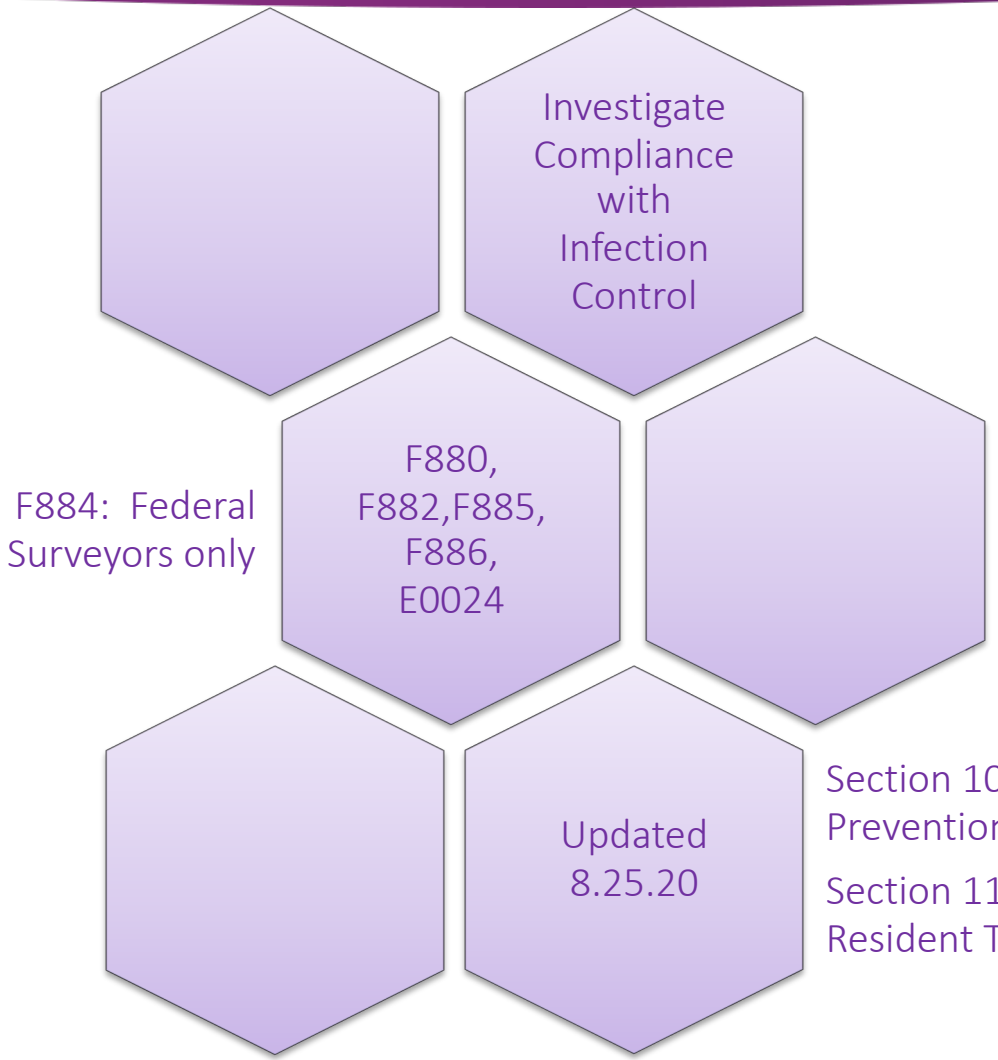
COVID-19 Testing Requirements
Focused Survey for Nursing Homes



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COVID-19 Testing Requirements
Updates to Infection Control Survey

Added 2 Critical Elements

- #10 CE Infection Preventionist
- #11 CE Staff and Resident Testing

Instructions and Updates on Reopening Guidance and CDC Recommendations

- Selecting a sample of residents
- Guidance on tag F886
- Questions related to hand hygiene, eye protection, ICP when moving between rooms & units, visitors, plans for cohorting, group activities, communal dining

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COVID-19 Testing Requirements
Focused Survey CE 10

Infection Preventionist (IP)

- During interview with facility administration and Infection Preventionist(s), determine the following
  - Did the facility designate one or more individual(s) as the infection preventionist(s) who are responsible for the facility's IPCP?
  - Does the Infection Preventionist(s) work at least part-time at the facility?
  - Has the Infection Preventionists(s) completed specialized training in infection prevention and control?
  - Does the Infection Preventionist(s) participate in the quality assessment and assurance committee? The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.
  - If "no" to any of the questions above, consider citing F882.
- Is the facility in compliance with requirements set forth at 483.80(b)? ☐ Yes ☐ No F882

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COVID-19 Testing Requirements
Focused Survey CE 11

Staff and Resident Testing

- Review the facility's testing documentation (e.g., logs of county level positivity rate, testing schedules, staff and resident records, other documentation). If possible, observe how the facility conducts testing, including the use of PPE and specimen collection. IF such observation is not possible, interview and individual responsible for testing and inquire how testing is conducted (e.g., "What are the steps taken to conduct each test?").
  - Did the facility conduct testing of staff based on the county level positivity rate according to the recommended frequency?
  - Based on observation or interview, did the facility conduct testing and specimen collection in a manner that is consistent with current standards of practice for conducting COVID-19 tests?
  - Did the facility's documentation demonstrate the facility conducted testing of residents or staff with signs of symptoms of COVID-19 in a manner that is consistent with current standards of practice for conducting COVID-19 tests?
  - Did the facility's documentation demonstrate the facility conducted testing of residents and staff based on the identification of an individual diagnosed with COVID-19 in the facility in a manner that is consistent with current standards of practice for conducting COVID-19 tests?

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COVID-19 Testing Requirements
Focused Survey CE 11

- Staff and Resident Testing
  - Did the facility take actions to prevent the transmission of COVID-19 upon the identification of an individual with symptoms consistent with or who tested positive for COVID-19?
  - Did the facility have procedures for addressing residents and staff that refuse testing or are unable to be tested?
  - If there was an issue related to testing supplies or processing tests, did the facility contact the state and local health departments for assistance?
  - If “no” to any of the questions above, consider citing F886.
- Is the facility in compliance with requirements set forth at 483.80(b)? ☐ Yes ☐ No F886

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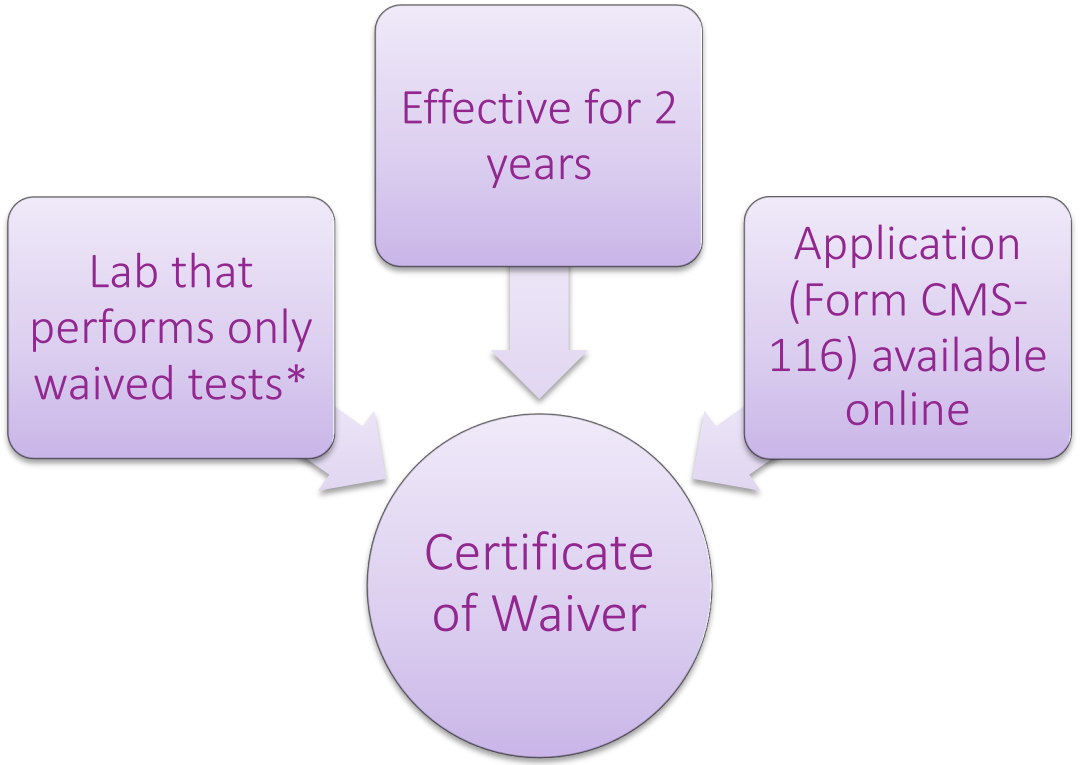
COVID-19 Testing Requirements
CLIA Certificate of Waiver



*Waived tests are listed on the FDA website, defined as “simple laboratory examinations & procedures that have an insignificant risk of erroneous result”

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COVID-19 Testing Requirements Enforcing Lab Reporting

CLIA certified labs will be identified as not reporting via survey and complaints

- CMS is assessing automated methods to gather data for determining compliance

CLIA will be surveying 5% of Certificate of Waiver labs over 3 years

- Failure to report will **result in CMP of $1,000 for the first day** of non-compliance and **$500 for each additional day** of non-compliance

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COVID-19 Testing Requirements
Emotional Impact of Repeated Testing

PTSD, other conditions exacerbated

Increased anxiety

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COVID-19 Testing Requirements
Testing Recommendations from Providers

Antigen Machine Calibration

- Look at # of tests
- Facilities performing 1x/week instead of 1x/month due to frequent use

Testing Team

- Clinical & Clerical for efficiency
- Nurse to swab, clinical to record

Be Organized

- Tracking state and federal requirements
- Communicate & educate staff, residents, families

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COVID-19 Testing Requirements
Choosing a Lab

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COVID-19 Testing Requirements
Testing Strategy Tailored to the Clinical Situation

Testing alone is not enough!

Clinical Assessment

Transmission Prevention

Environmental Cleaning

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Questions ?

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CAHCF Session Code

- CEU Session Code

melv

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Further Information?

- CMS Memorandum QSO-20-38-NH https://www.cms.gov/files/document/qso-20-38-nh.pdf
- CMS Memorandum QSO-20-37-CLIA, NH https://www.cms.gov/files/document/qso-20-37-clianh.pdf
- CDC Testing in Nursing Homes FAQs https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Testing-in-Nursing-Homes
- CDC Guidance on Antigen Tests https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html
- FDA Information on COVID-19 Antigen Tests https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/vitro-diagnostics-euas and https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/faqs-testing-sars-cov-2
- Funding for Testing: https://www.cms.gov/files/document/se20011.pdf (MLN Matters Number SE20011)
- CMS Press Release on Testing Methodology for Nursing Homes https://www.cms.gov/newsroom/press-releases/cms-updates-covid-19-testing-methodology-nursing-homes

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Our Process

- Prescribed medical record review process that encompasses HHI's core business
- HHI Regional HealthCARE Specialists provide expertise through teaching and training and an extensive chart audit process in order to ensure:
  - MDS Accuracy
  - MDS Supporting Documentation
  - Billing Accuracy
  - Nursing Documentation
  - Therapy Documentation
  - Clinically Appropriate Care

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HHI
Services and Plans

Gold C.A.R.E.
2 Year Service Plan

Platinum C.A.R.E.
3 Year Service Plan

List of HHI Services

PDPM Training and Audits | Medicare | Compliance | Rehab Program Development | Seminars | MMQ Audits | Mock RAC Audits | Rehab Certification | Mock Health Inspection Survey | MDS Competency | Talent Management | Denials Management | Compliance Certification | Clinically Appropriate Stay | QAPI | QIS | Medicare Part B Program | MDSC Mentor Program | Case Mix Consulting | Professional Development | Leadership Trainings | Regulatory and Survey Assistance | Five Star | PBJ | Quality Measures | Analysis | Staff Training | Infection Control and More!

Silver C.A.R.E.
1 Year Service Plan

A La C.A.R.E.
Customized Service Plan

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Our Senior HHI Specialists

- Founded in 2001
- Privately owned and operated
- Ranked among Inc. Magazine's top 5,000 fastest growing private companies in America three years in a row
- Active monthly contracts in 24 states
- Over 1,000 Skilled Nursing Facilities serviced
- Over 3,000 Clinicians Certified on the MDS

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https://www.harmony-healthcare.com/harmonyhelp

Live Support Available
8:00 a.m. – 5:00 p.m. EST

HarmonyHelp

With **HarmonyHelp**, Harmony Healthcare International (HHI) provides an invaluable resource for the entire interdisciplinary team. Imagine having questions answered by a Harmony HealthCARE Specialist within minutes of the inquiry. Fill out the form on the right to learn more about HarmonyHelp and our various Service Plans.

The **Knowledge Center** is loaded with **information** that will assist with your daily responsibilities at your facility. This self-help site is broken up into **5 Sections:**

Manuals I Tools I C.A.R.E. Community I Hot Topics I FAQ (Frequently Asked Questions)

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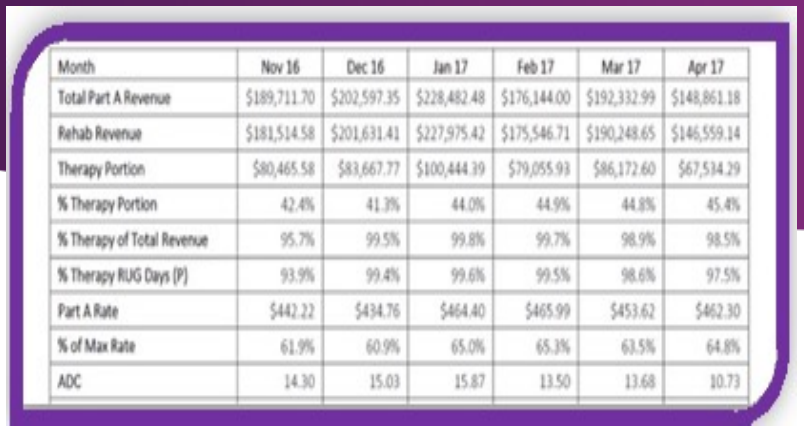
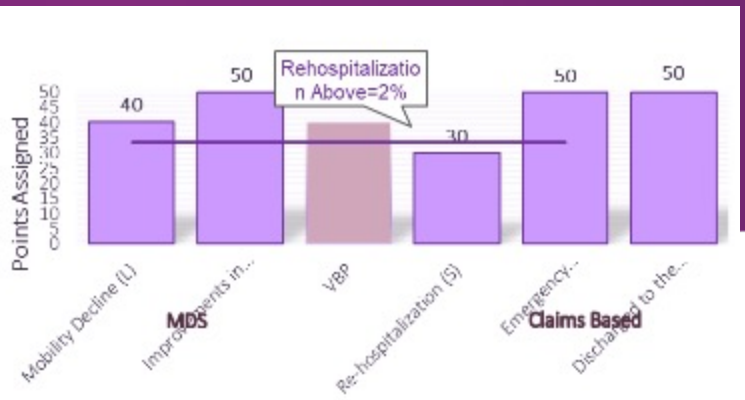
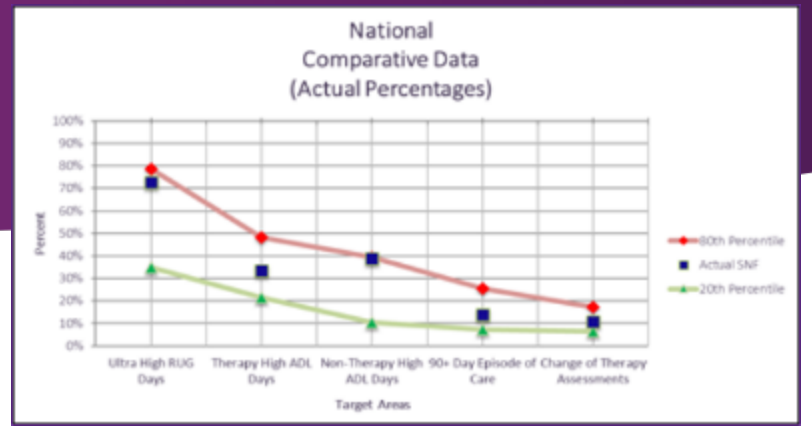


Month	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Total Part A Revenue	$189,711.70	$202,597.35	$228,482.48	$176,144.00	$192,332.99	$148,861.18
Rehab Revenue	$181,514.58	$201,631.41	$227,975.42	$175,546.71	$190,248.65	$146,559.14
Therapy Portion	$80,465.58	$83,667.77	$100,444.39	$79,055.93	$86,172.60	$67,534.29
% Therapy Portion	42.4%	41.3%	44.0%	44.9%	44.8%	45.4%
% Therapy of Total Revenue	95.7%	99.5%	99.8%	99.7%	98.9%	98.5%
% Therapy RUG Days (P)	93.9%	99.4%	99.6%	99.5%	98.6%	97.5%
Part A Rate	$442.22	$434.76	$464.40	$465.99	$453.62	$462.30
% of Max Rate	61.9%	60.9%	65.0%	65.3%	63.5%	64.8%
ADC	14.30	15.03	15.87	13.50	13.68	10.73





Complimentary HHI Offerings

- PDPM Revenue and Risk Analysis
- Medicare Part A Revenue and Risk Analysis
- Five-Star Quality Measure Points Analysis
- PEPPER Analysis

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