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Public Health Emergency

COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

<https://www.cms.gov/files/document/long-term-care-facilities-cms-flexibilities-fight-covid-19.pdf>

<https://www.cms.gov/coronavirus-waivers>

Long Term Care Facilities (Skilled Nursing Facilities) and/or Nursing Facilities: CMS Flexibilities to Fight COVID-19

As the beginning of the COVID-19 public health emergency, CMS issued emergency blanket waivers and other flexibilities to address the unique challenges that long-term care facilities (LTCFs) face in responding to COVID-19. CMS is also providing a one-stop resource for a complete list of flexibilities available to LTCFs to help them respond to the public health emergency and other federal and program requirements at the onset and end of the COVID-19 public health emergency.

This CMS one-stop resource aims to make sure that covered CMS waiver services and flexibilities are easier to find and use for operators after the PHE. The waivers being issued are:

1. CMS is waiving the need for submitting certain health care based on the public phase of the PHE. In the beginning of the PHE, CMS has the unique operational challenges and access to needed information. CMS is waiving the impact on communities, including unmet needs, and the impact on the health care system. The flexibilities are:
2. CMS is waiving certain flexibilities that may be used in a Public PHE, such as initial and final review and other emergency, to ensure a rapid response to future emergencies. CMS is waiving the requirement to submit the impact on communities, including unmet needs, and the impact on the health care system.
3. CMS is continuing to collaborate with federal partners and the health care industry to ensure that the health care system is prepared for addressing future emergencies.

As CMS identifies flexibilities and opportunities for operators, the goal is to help operators and operators respond with confidence and safety. CMS will continue to work with operators and other stakeholders to ensure that the health care system is prepared for addressing future emergencies.

COVID-19 Waivers:

On October 26, 2020, CMS issued an Interim Final Rule with comment period (IFR) regarding the COVID-19 public health emergency. The IFR includes the following:

- Waiver of the requirement to submit the impact on communities, including unmet needs, and the impact on the health care system.
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- Waiver of the requirement to submit the impact on communities, including unmet needs, and the impact on the health care system.

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Occupational Therapy Skilled Intervention Re-Imagined

Past

What did skilled interventions look like pre-COVID?

Present

What does current skilled interventions look like?

Future

What can skilled occupational therapy interventions look like?

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Interdisciplinary Team Collaboration-Inclusiveness

- Patient
- Patient family/caregivers
- Physician
- Pharmacist
- Case manager
- Nursing

- Occupational therapy practitioners
- Physical therapy practitioners
- Speech therapy practitioners
- Respiratory therapist
- Home health aide
- Restorative aide
- Wellness coordinator

- Admissions
- Administrator/executive director
- Dietician
- Social services
- Psychologist
- Housekeeper
- Maintenance

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Interdisciplinary Team Collaboration- COVID-19 Barriers

Patient:

- Change in daily schedule/routine
- Change in visitation/outings/communication
- Change in caregivers/therapists
- Change in roommates
- Change in behavior/mood
- Change in function
- Change in medical condition


Interdisciplinary Team:

- Change in staffing/schedules
- Change in behavior
- Change in how activities are delivered
- Change in how IDT communicates with patients/family
- Change in how therapy is delivered
- Change in how caregiver training is completed
- Change in how discharge planning is completed



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What Other COVID-19 Barriers Have You Experienced?



WORK LIFE

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Omnibus Budget Reconciliation Act (OBRA)

*“Each resident must receive and the facility must provide the necessary care and services to **attain** and **maintain** the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care”*

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Interdisciplinary Team Collaboration-Solutions

- We learned that we are all focused on our patients/residents and that our patients/residents need us
- We learned that we are resilient and adaptable
- What else did we learn?
- What are some best practices?

IDT Solutions/Best Practices:

- Re-evaluate/re-establish meetings and meeting agendas
- Walking rounds
- Education/review of critical element pathways
- New admission review
- Change of condition/risk review and meetings
- Review of quality measures (i.e. CASPER)
- Review of patient/resident concerns

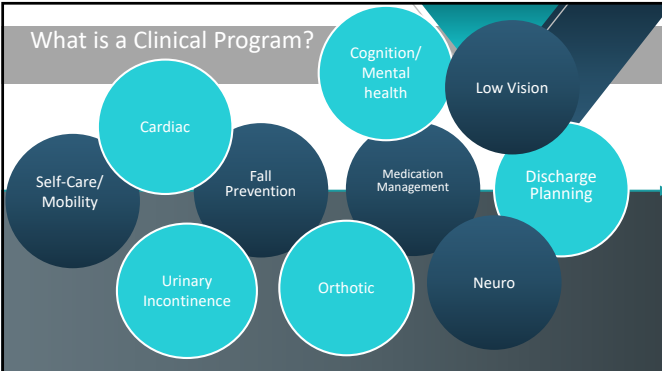
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What Other Solutions/Best Practices?



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What is a Clinical Program?



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Comprehensive Plans of Care-
Going Beyond the Reason for Referral.....

- Observe the patient/resident
- Listen to the patient/resident/family/caregivers
- Review medical record
- Assess the patient/resident....go beyond the reason for referral
- Utilize standardize tests and measures
- Expand the tools in our tool boxes
- Demonstrate the distinct value of OT



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Comprehensive Plans of Care-
Going Beyond the Reason for Referral.....



Occupational Therapy
If it matters to you,
it matters to me



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Comprehensive Plans of Care-
Going Beyond the Reason for Referral.....

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code / geography	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination Stress	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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Comprehensive Plans of Care

Figure 1. 4Ms Framework of an Age-Friendly Health System

What Matters
Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication
If medications necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.

http://www.hi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/HIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf

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Occupational therapy evaluations include the following components

Occupational Profile and Client History

Assessment of Occupational Performance

Clinical Decision Making

Development of Plan of Care

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Definitions

The level of the occupational therapy evaluation performed is determined by patient condition, complexity of clinical decision making, and the scope and nature of the patient's performance deficits relating to physical, cognitive, or psychosocial skills to be assessed. The patient's plan of treatment should reflect assessment of each of the identified performance deficits.

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Assessments

- Pain Assessments (i.e. Wong Baker Faces)
- Katz ADL Index
- Modified Barthel ADL Index
- Timed Up and Go (TUG)
- Berg Balance Scale
- The St. Louis University Mental Status Exam (SLUMS)
- The Routine Task Inventory (RTI)
- Geriatric Depression Scale
- Generalized Anxiety Disorder (GAD-7)
- Global Deterioration Scale
- Allen Cognitive Level (ACL)
- Perceived Stress Scale (PSS-10)
- The Delirium Rating Scale (DRS)3
- Brief Trauma Questionnaire
- Trauma Checklist
- Trauma Screening Questionnaire (TSQ)
- Occupational Profile of Sleep
- Medi-Cog

*not an inclusive list

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Brief Interview for Mental Status-BIMS

BIMS score	Interpretation
0-7	Severe cognitive impact
8-12	Moderate impairment
13-15	Intact cognitive response

<https://www.youtube.com/watch?v=qv-RhrFQoWE>

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Staff Assessment of Mental Status

<https://www.youtube.com/watch?v=qv-RhrFQoWE>

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MDS Section GG: Self-Care & Mobility




06. Independent
Resident completes the activity by him/herself with no assistance from a helper.

05. Setup or clean-up assistance
Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.

04. Supervision or Touching Assistance
Helper provides VERBAL CUES or TOUCHING/STEADYING/CGA assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.

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MDS Section GG: Self-Care & Mobility



03. Partial/moderate assistance
Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

02. Substantial/maximal assistance
Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01. Dependent OR Helper does ALL of the effort
Resident does none of the effort to complete the activity, OR the assistance of 2 or more helpers is required for the resident to complete the activity.

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Activity Not Attempted

07 Refused

09 Not Applicable- The resident did not perform this activity prior to current illness, exacerbation, or injury

10 Not attempted due to environmental limitations- e.g. lack of equipment, weather constraints

88 Not attempted due to Medical or Safety Concern

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GG0130: Self Care Items

Eating

The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is presented on a table/tray, includes modified food consistency. Eating involves bringing food and liquids to the mouth and swallowing food. The administration of tube feedings and parenteral nutrition is not considered when coding this activity. If the resident does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or total parenteral nutrition (TPN) because of a new (recent-onset) medical condition, code GG0130A is 88, not attempted due to medical condition or safety concerns. Assistance with tube feedings or TPN is not considered when coding Eating.

Oral Hygiene

The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

Toileting Hygiene

The ability to maintain personal hygiene, adjust clothes before and after voiding or having a bowel movement, if managing an ostomy, include wiping the opening but not managing equipment.

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GG0130: Self Care Items

Shower/bathe self

The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.

Upper Body Dressing

The ability to dress and undress above the waist, including fasteners, if applicable.

Lower Body Dressing

The ability to dress and undress below the waist, including fasteners, does not include footwear.

Putting On/Taking off Footwear

The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility, including fasteners, if applicable.

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GG0170: Mobility Items

Roll Left and Right

The ability to roll from lying on back to left and right side, and return to lying on back on the bed.

Sit to Lying

The ability to move from sitting on side of bed to lying flat on the bed.

Lying to Sitting on Side of Bed

The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

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GG0170: Mobility Items

- Sit to Stand** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
- Chair/Bed to Chair Transfer** The ability to safely transfer to and from a bed to a chair (or wheelchair).
- Toilet Transfer** The ability to safely get on and off a toilet or commode.

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GG0170: Mobility Items

- Car Transfer** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
- Walk 10 Feet** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 Skip to GG0170M, 1 step (curb).
- Walk 50 feet with two turns** Once standing, the ability to walk at least 50 feet and make two turns.




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GG0170: Mobility Items

- Walk 150 Feet** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
- Walking 10 feet on uneven surface** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
- 1 Step (Curb)** The ability to go up and down a curb and/or up and down one step. (skip pattern per CMS)

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GG0170: Mobility Items



- 4 Steps** The ability to go up and down four steps with or without a rail.
- 12 Steps** The ability to go up and down 12 steps with or without a rail.
- Picking up object** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

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MDS Section GG: Self-Care & Mobility

Does the resident use a wheelchair/scooter?

- 0.No -Skip to H0100, Appliances
- 1.Yes - Continue to GG0170R, Wheel 50 feet with two turns

Wheel 50 feet with two turns


Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

Wheel 150 feet

Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

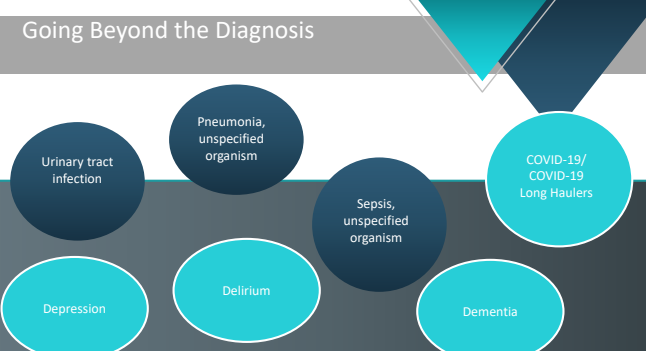
Indicate the type of wheelchair or scooter used:

- 1.Manual
- 2.Motorized



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Going Beyond the Diagnosis



- Urinary tract infection
- Pneumonia, unspecified organism
- COVID-19/ COVID-19 Long Haulers
- Sepsis, unspecified organism
- Depression
- Delirium
- Dementia

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Comprehensive Interventions

Patient Centered Care

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Comprehensive Interventions

- Self-Feeding
 - Loss of appetite?
 - Loss of interest in eating?
 - Loss of interest in eating in dining room with others?
 - Change of preference to eating alone in room vs. eating in dining room with others?
 - Is there a walk to dine program?
- Morning ADLs/Evening ADLs
 - Adjusting work schedule to assist with morning ADLs/morning routines or evening ADLs/evening routines
 - Do you know your resident's shower schedule?
 - Are you offering showers if clinically indicated?

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Comprehensive Interventions

- Oral Care
 - Compliant with regular brushing?
 - Is there pocking of food?
 - Do they have dry mouth?
 - Can they care for their dentures?
- Toilet Hygiene
 - Regular toileting schedule?
 - Benefit from bedside commode?
 - Independent with toileting?
 - Able to wear underwear vs. adult brief/diaper?

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Comprehensive Interventions


- Sleep
 - Address preference for clothing (i.e. pajamas)
 - Address lighting /noise
 - Establish routines
 - Address positioning/bedding (i.e. extra blankets, pillows)
- Behaviors/Cognitive Impairments/Delirium/Depression/Dementia
 - Cognitive staging
 - Establish routines based upon preferences/hobbies
 - Environmental modifications
 - Stress management/relaxation techniques



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Comprehensive Interventions

- Discharge Planning
 - Home assessment/home evaluation
 - Health journal
 - Medication management
 - Adaptive equipment
 - Community re-integration
 - Home exercise program
 - Home health/outpatient therapy



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OT/OTA Collaboration



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