U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

August 19, 2020

The Honorable Robert P. Casey
United States Senate
Washington, DC 20510

Dear Senator Casey:

Thank you for your letter to Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma and me regarding the Coronavirus Disease 2019 (COVID-19) pandemic and nursing home resident and worker demographics. I am responding on behalf of the Centers for Disease Control and Prevention (CDC); CMS will respond separately.

We share your concerns regarding the disproportionate outcomes associated with COVID-19 among racial and ethnic minority groups and the contributing systemic social, economic, and health inequities. Inequities in the social determinants of health, such as poverty and healthcare access, affecting these groups are interrelated and influence a wide range of health and quality-of-life outcomes and risks.

These inequities may be further compounded in nursing home settings, given their congregate nature and resident population served. The elderly and people with serious underlying chronic medical conditions, such as chronic lung disease, a serious heart condition, or a weakened immune system may be at higher risk of severe illness from COVID-19.

CDC is working with CMS to leverage existing data systems and reporting requirements to improve COVID-19 surveillance. These data help inform decision making and the public health response across the healthcare spectrum, including in nursing homes. Clear and accurate demographic data will help to inform strategies to ensure that all groups have equitable access to testing and healthcare and allow accurate determination of the burden of infection and illness severity on populations who are at high risk for COVID-19. We have provided responses to your questions in an enclosure.

As you are aware, CDC has released multiple monthly reports to Congress that include data on demographic characteristics as mandated by the *Paycheck Protection Program and Health Care Enhancement Act* (Public Law 116-139). These reports outline the progress made by reporting entities toward providing more complete racial and ethnic data to increase our collective understanding of the impact of COVID-19 and to ensure key data are available to identify those most affected by this pandemic.

To accelerate progress toward reducing COVID-19 disparities and achieving health equity, CDC established a Chief Health Equity Officer Unit within the COVID-19 Incident Management Structure, which focuses on ensuring an all-of-response approach to identifying and addressing COVID-19 disparities. CDC has developed a COVID-19 Health Equity Strategy

(www.cdc.gov/coronavirus/2019-ncov/downloads/community/CDC-Strategy.pdf) aimed at ensuring that key data are available and that high impact programs and initiatives—that are culturally and linguistically responsive and tailored to address the unique circumstances of groups at increased risk for COVID-19—are being implemented.

CDC regularly updates public guidance as we learn more about COVID-19. Interim guidelines and resources for healthcare facilities, including those specific to nursing homes and other long-term care facilities, are available on CDC's website (www.cdc.gov/coronavirus/2019-ncov/index.html).

Thank you, again, for the work you do to protect the American people and for your interest in this ongoing response. We appreciate your support, and that of Congress, as we all work together to fight COVID-19. CDC remains committed to protecting the American public in the face of this pandemic. Please contact Anstice Brand Kenefick in our CDC Washington Office at (202) 245-0600 or abrand@cdc.gov if you have further questions. A copy of this response has been sent to the co-signers of your letter.

Sincerely,

Robert R. Redfield MD

Robert R. Redfield, MD
Director, CDC

Enclosure

Centers for Disease Control and Prevention (CDC) answers to questions about steps Centers for Medicare & Medicaid Services (CMS) and CDC have taken to collect demographic data of nursing home residents and workers who test positive with Coronavirus Disease 2019 (COVID-19)

1. **What specific steps have CMS and CDC taken to collect demographic data from residents living in nursing homes who test positive for COVID-19?**

   Data collected throughout the COVID-19 public health emergency serve a key surveillance function at the national level and CDC relies on timely public health surveillance data to guide public health action and inform the nationwide response. CDC guidance specifies that a healthcare facility or provider should notify state or local health departments about residents or staff with suspected or confirmed COVID-19.

   U.S. surveillance for COVID-19 cases is routinely conducted using a case report form (CRF) (www.cdc.gov/coronavirus/2019-ncov/php/reporting-pui.html) that is standardized nationally to ensure the same demographic, clinical, and risk factor information is captured. The CRF is aligned with the Council of State and Territorial Epidemiologists interim position statement (https://cdn.ymaws.com/www.cste.org/resource/resmgr/2020ps/Interim-20-ID-01COVID-19.pdf), which outlines the case definition criteria for COVID-19 and makes COVID-19 a nationally notifiable disease. The CRF includes variables for age, race, ethnicity, sex, and disability status, as well as entries to indicate whether the patient is a resident of a nursing home/assisted living facility. The CRF also provides a field to indicate whether the person who is ill with COVID-19 is a healthcare worker and includes fields for indicating whether they work at a nursing home/assisted living facility, long-term care facility (LTC), hospital, rehabilitation facility, or other facility type. The data collected from the case report forms improve the understanding of the epidemiology of COVID-19, thus informing public health action on the local, state, territorial and national level.

   In addition to using case report data, laboratory data is also important information to support decision-making related to public health emergencies. On June 4, 2020, HHS announced new guidance for laboratories that specifies additional data that must be reported with COVID-19 test results, including demographic data, such as sex, race, and ethnicity. The guidance, *COVID-19 Pandemic Response, Laboratory Data Reporting: CARES Act Section 18115*, (www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf), which took effect August 1, 2020, standardizes reporting to help ensure that public health officials have access to comprehensive data to inform decision making in their response to COVID-19.

2. **What specific steps have CMS and CDC taken to collect demographic data and other information pertaining to COVID-19 cases and deaths in other congregate settings, including intermediate care facilities and psychiatric hospitals?**

   The answer to Question 1 is broadly applicable to this question. CRF guidance and laboratory reporting guidance do not differ for intermediate-care facilities or psychiatric

hospitals. CDC's CRF includes fields to indicate whether the person under investigation is a resident of a LTC facility, rehabilitation facility, group home, or acute care inpatient facility, and has a free text entry field if the type of residence is not included in the available options.

3. **In what way have CMS and CDC coordinated with state and local health departments to improve data collection of COVID-19 cases, particularly concerning the collection of demographic information, including race, ethnicity, sex, age and disability status?**

CDC continues to work with each state and jurisdiction to develop long-term sustainable systems to enable complete and timely reporting that will be used for COVID-19 and will be adaptable to any specific public health issue.

In conjunction with CMS announcing upcoming new regulatory requirements for nursing homes (www.cms.gov/files/document/qso-20-26-nh.pdf) on April 19, 2020, CDC released a new standardized reporting tool, the *Long Term Care Facility COVID-19 Module* (www.cdc.gov/nhsn/ltc/covid19/ index.html), that allows nursing homes to provide data to CDC's National Healthcare Safety Network (NHSN). The key indicators collected provide a better understanding of the burden of disease in nursing homes at the local, state, and national levels and enhances the nation's ability to combat COVID-19 in this high-risk healthcare setting. NHSN data provided the first national lens into the burden of disease in nursing homes.

State health departments have immediate access to data submitted by facilities in their jurisdictions, and CDC provides analytic reports to state health departments twice weekly. CDC also uses NHSN to monitor and analyze the capacity of LTC facilities weekly, including nursing homes, allowing federal, state, and local officials to adjust their response and mitigation efforts as needed.

CDC is working with state and local health departments and public health partners to enroll facilities in NHSN and support reporting. CMS requires all Medicare and Medicaid-certified nursing homes to report specific COVID-19-related data into NHSN; however, its use is voluntary in other LTC facility types. As of August 13, 2020, NHSN has received reports from over 99 percent of the nation's Medicare and Medicaid-certified nursing homes (more than 15,000). In addition, NHSN has received reports from approximately 1,000 assisted living facilities and facilities for persons with developmental disabilities.

4. **What plans have been developed to perform reliable retroactive reporting of COVID-19 data to the beginning of the public health emergency on January 31, 2020 including demographic variables such as race, ethnicity, sex, age, primary language, and disability status, in nursing homes and other settings?**

   CDC has provided instructions for nursing homes and other LTC facilities on how to submit retrospective data in the NHSN. In addition, CDC has worked with health departments, LTC organizations, and other public health partners to promote reporting of COVID-19 data from the beginning of the public health emergency period. Facilities can enter this data any time during the response. CDC continues to provide technical support to those LTC facilities who are reporting retrospective data to NHSN. The purpose of the CDC collecting retrospective data is to gain a comprehensive understanding about the impact of COVID-19 on nursing homes using a systematic reporting mechanism and standard data definitions. Standard data definitions enable more fair comparisons across facilities and states. CDC plans to review these data to perform facility-level trend analysis to better track the burden of COVID-19 cases.

5. **In what way have CMS and CDC utilized COVID-19 data to inform treatment and prevention strategies in nursing homes and other congregate settings?**

   CDC and CMS collaborate to monitor nursing home facility enrollment and data reporting to NHSN, including confirming facility identity verification to use NHSN and data security within NHSN. CDC and CMS monitor staffing shortages by type (e.g., clinician, aide, nurse); supply shortages related to personal protective equipment, hand hygiene and ventilators; COVID-19 cases and mortality for LTC facility residents and staff; and percentage of ventilators in use. CDC and CMS are also working on additional ways to promote accurate and consistent reporting. For example, CDC provides funding for healthcare-associated infection and antimicrobial resistance (HAI-AR) programs in each state and in most territories to improve infection prevention and control (IPC) practices and implement prevention strategies to effectively respond to COVID-19 cases in nursing homes and other congregate care settings.

   CDC's emergency operations infrastructure includes dedicated teams to support nursing home facilities and other vulnerable healthcare facilities in detecting, responding to, and preparing for COVID-19 outbreaks. CDC works closely with state and local health departments to assist these facilities by providing on-the-ground support to more than 30 jurisdictions. As of mid-July, CDC has deployed 57 teams to LTC facilities and has completed 1,926 deployments to state, tribal, local and territorial health agencies to assist on the frontlines with acute outbreaks among special populations (such as meat packing plants, correctional facilities and LTC facilities) as well as enhance capacity and support a coordinated response to COVID-19. CDC staff are simultaneously providing extensive remote technical assistance from infection control experts to almost every state through a novel CDC approach called Tele-Infection Prevention and Control Assessment (ICAR). Tele-ICAR broadens the reach of public health IPC expertise via remote assessment of nursing home preparedness by quickly identifying and addressing IPC gaps. CDC has trained health departments on this novel approach and has been assisting state and local health departments in conducting at least 781 nursing home Tele-ICAR assessments across 20 jurisdictions as of mid-August.

CDC and CMS are working together to align COVID-19 guidance for healthcare facilities to protect patients and healthcare personnel (HCP), encourage safe practices, improve health outcomes, and save lives across the continuum of care. For example, CMS-issued guidance for state and local officials on the recommended phased reopening of Medicare and Medicaid-certified nursing homes based on CDC's guidelines for determining when nursing homes could relax restrictions on visitation and group activities and when such restrictions should be reimplemented. CDC also developed specific toolkits for state health departments, HCP, and nursing homes to improve IPC and preparedness and response capabilities. CDC and CMS continue to collaborate with these partners and other healthcare facilities to improve the implementation of CMS and CDC-recommended guidance.

6. **In what ways have CMS, CDC, Federal Emergency Management Agency, or other agencies utilized COVID-19 data to direct resources such as funding and personal protective equipment to the facilities most in need?**

   CDC shared hospital-level personal protective equipment (PPE) shortage data with FEMA and testing supply data with the White House Coronavirus Task Force to assist in their response efforts when these data were collected through the NHSN. As of July 15, 2020, hospitals are no longer reporting COVID-19 capacity, staffing, and supply-related data to CDC's NHSN. Hospital data can be accessed from HHS Protect (https://protect-public.hhs.gov/).

   CDC continues to provide guidance and recommendations to healthcare personnel on proper usage of PPE. To address PPE shortages due to the COVID-19 pandemic and help healthcare facilities optimize the use of PPE and other equipment during this time, CDC has developed tools and guidance documents, such as a PPE Burn Rate Calculator, to help prioritize and conserve PPE supplies along the continuum of care. These tools can be found on CDC's website (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html).

7. **When will CMS and CDC collect and publicly release COVID-19 demographic information aggregated at the state and federal level for residents in nursing homes and other congregate settings?**

   CDC reports on race and ethnicity data by posting the available data received through case-based reporting from public health departments on the CDC website. This information can be viewed on our *CDC COVID-19 Data Tracker* page (www.cdc.gov/covid-data-tracker/index.html#demographics).

   While CDC does not release facility-level nursing home data due to the NHSN Assurance of Confidentiality (www.cdc.gov/os/integrity/confidentiality/index.htm), CDC provides CMS, state and local health departments, and HHS these data. On June 4, 2020, CMS began publicly publishing NHSN data reported by nursing homes pursuant to Medicare requirements on their website (https://data.cms.gov/Covid19-nursing-home-data). CDC does not currently collect resident-level data from nursing homes; however, CDC is in

communication with CMS to understand how other CMS data sources can also be used to collect this data.

8. **To what extent can Medicare claims be used to analyze the demographics and other characteristics of COVID-19 patients in nursing homes and other congregate settings?**

   CDC defers to CMS to provide an answer to this question.