Centers for Medicare & Medicaid Services
COVID-19 Call with Home Health, Hospice & Palliative Care
Moderator: Alina Czekai
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OPERATOR: This is Conference #: 6477704.

Alina Czekai: Good afternoon. Thank you for joining our May 19th CMS COVID-19 Weekly Call with Home Health, Hospice and Palliative Care. We appreciate you taking time out of your busy schedules to join us today. This is Alina Czekai, leading stakeholder engagement on COVID-19 in the Office of CMS Administrator Seema Verma.

Today, we are joined by CMS leaders, as well as providers in the field who have offered to share their best practices with you all. I'd first like to turn it over to Jean Moody-Williams, acting director at the Center for Clinical Standards and Quality for an update on the agency's latest guidance in response to COVID-19.

Jean, over to you.

Jean Moody-Williams: Great. Thanks so much and hello, everybody. Good afternoon. I want to thank you for joining the call and excited to get to our guest speakers that will share some best practices from the field.

I did want to spend just a few minutes letting you know about some very important guidance that we issued yesterday related to nursing home reopening, and I know that this is the home health and hospice call, but I think it's of importance to all of America and in particular I know that our hospice professionals also provide care in our long-term care facilities as well. And so, I just want to make sure that that information is available to you all.

So, as you – as you probably may know, we've issued quite a bit of guidance particularly in the nursing home area over the last several months that more than 11 different guidances working closely with the Center for Disease Control and Prevention. And one of the guidances that we issued in March

relayed – really the very difficult decision to restrict nonessential visitors from nursing homes.

And at the time when we did that, we fully appreciated how painful that separation would be for residents and for those – and for their loved ones and really had to make a decision based on the safety of, of course, with the residents that impacted some of you on this call as well.

I know we kind of got off to somewhat of a rocky start in which there were discussions of whether we should be admitted or let into the facilities to provide your services or not. And I think we're trying though those issues have resolved themselves, and hopefully, we'll continue even with this new guidance should not cause a wrinkle in that, but I'm sure you'll let me know if it does.

So, we worked very closely with CDC in the Coronavirus Task Force – in providing states and localities with the new recommendations that really proposes a phase-in approach to reuniting nursing home residents with their loved ones and, as well as loosening some other restrictions.

So, given the vulnerabilities of nursing home residents, though I think this has been very important even as you have the opportunity to speak with those in your – in the home, and getting a home care who may have these questions is that we are using extreme caution and – in our approach to moving forth with reopening and making sure that it's methodical and data-driven.

So, there isn't – this is not like some of the businesses that are reopening. We know that there are risks involved, and so we want to be extremely cautious. Our focus continues, as I said, to be on safety and it aligns with the president's Opening of America Again Guidelines that can be found on the White House Web site.

There are three phases in that document and we have aligned with those three phases as well. And these decisions were being made and because the pandemic is affecting communities in different ways, several factors have to be considered, such as the case status in the community. How many cases are

in the community? What's happening in hospitalizations? What's happening as far as the number of deaths?

What's the capacity in home health and dialysis and other areas? Also, the case status in nursing homes that we're looking at the absence of new cases of onset in COVID-19 which the staffing in nursing homes and the training and testing – for testing, supplies and PPE.

So, the guidance, it (caused) for screening entrance into facilities, using PPE, restricting nonessential medical staff, it gives guidance on when and where that will be loosened up, as well as other activities that must occur.

So, at the high level, CMS is recommending that nursing homes avoid relaxing restrictions and advancing through reopening phase until they have baseline data about all residents and staff. So, that would make testing the residents and the staff first to get that baseline data.

Again, in addition to the baseline test, we're recommending that nursing homes screen all staff daily, and anyone else that enters related to fever symptoms and the like and looking at potential exposures in other areas. So, facilities may also need to continue testing their residents if symptoms persist.

We're encouraging state and local leaders to use data to help adjust in any of the requirements that we're putting out. Obviously, I'm not going into much of the detail here on this call, but the guidance is on our Web site if you are interested in the details.

But another important factor about reopening really depends as I shared under the declining case count and the state of the community in which the nursing home resides and also I know one of the main questions that people will have including those that you come in contact is when will visitation be allowed, again?

And this is important question to family members and we will, obviously, continue to allow compassionate care and those – in hospice that are providing those services through Phase I of the guidance and Phase II of that guidance. But general visitation will be allowed, again, in Phase III which is when we

anticipate there has been sustained decrease in COVID cases, in particular within that nursing home.

And when the time does come to allow visitation, it will be important to mention – it's important to mention that even with the reopening, visitors will be screened and will wear across face coverings or face coverings at all times in order to limit the potential exposure and still continue to protect the residents.

So, these – while we've issued these recommendations on yesterday, I know that states and we actually – we spoke with the governors on yesterday. So, they have already begun to start thinking about how they're going to implement this because at the end of the day, the decision does rest with the state and local leaders who are really most familiar with the needs in their community.

We were encouraging them to collaborate, obviously, with the nursing home but the others in the community that have a stake in and what's going on in that particular region. So, I will end with that and note that, again, we're really committed to working with everyone to ensure that we do things in the right manner to continue to ensure decrease transmission and ensure safety.

So – and that – those are the main highlights that I wanted to bring to you today, and I will take questions at the end, but at this time, I would really like to get to our guest speakers and I'm really – we're really fortunate to have Dr. Carl Wenzel who's a board certified internist, who served as the medical director for Abington, now Jefferson Health System Hospice, and it is one of the largest health systems in Southeastern, Pennsylvania.

And we also have Marie Sheedy who's the nurse practitioner at Jefferson Health Home Care and Hospice. So, I'm going to turn it over to Marie and Dr. Wenzel.

Carl Wenzel: Hi, guys.

Jean Moody-Williams: Thank you.

Carl Wenzel: How you're doing? Thank you very much. It's a great pleasure to be able to speak with you guys today. Marie and I have been working together for a few years up in – at the Abington Hospice Program, and I've been involved with it for well over 12 or 13 years now.

So, Marie and I today we're going to talk about what the best practices we seemed to have worked our way into the systems of many other of our colleagues – over the last – for 10 weeks or so, to try to do the best we can in the phase of the epidemic that we're involved with. So, we're going to talk about six major points today. Each of us are going to do three points.

So, I'm going to begin and Marie will follow up and then we'll just go back and forth like that. So, the best practices for hospices in the COVID-19 world is what we're asked to talk about today and one of the things that Marie and I do every day is that when we have patients that passed away we always notify the physician, updated patient who died, and we also call the family to let them know we're thinking of them.

So, about eight or nine weeks ago, I spoke to a physician about after one of his patients died and he left a message and then he called back and he apologized and he said, "Oh, I'm so sorry. I always gowned up seeing a patient who was ill." And he said, "You know what, I'm learning about this virus is that I need to respect it, but I can't fear it."

So, that really struck home with me that it is a very scary time, but if we do what's right, we should be OK. So, one of the things we've implemented in our Home Care Hospice Program, as well as our Inpatient Hospice Unit is that we know that hand-washing is of immense importance. We do that constantly. A lot of us are getting rashes on our hands I think from washing so much.

We wear PPE for everybody who's a COVID suspect patient where it had to do this itself and all of our nurses would be very thoughtful in this about our nursing administrators have been wearing N95 mask for all of our patients visit, then we do the same in our inpatient unit. So, if we have anybody that

we are caring for, the nurse will be wearing an N95 mask, and if the patient is a COVID suspect patient or a COVID-positive patient, full PPE will be worn.

And we've been very blessed that none of our nursing staff has been infected by this virus to this very day. We've been very, very fortunate and we believe it's due to the fact that we've been wearing N95 masks from the get go.

So, I'm going to turn it over now to Marie, and I'll be back in a little bit.

Marie Sheedy: Thank you. So, Dr. Wenzel mentioned about respecting the virus don't fear it. One of the things that we've been hearing about is people who are almost paralyzed caring for patients were donning and doffing garb.

So, one of the things that we've had – some of our nurses who actually kind of dove right in, we were very – you know we've been lucky enough to have, the PPE to take care of our COVID patients, and like Dr. Wenzel said, the N95 at home. So, we're – one of the things that really helped our nurses if somebody feels like they have this down path, they have actually taken other colleagues kind of under their wing. This is what's worked for me.

This is how I've done this and I'm also going to say that the education and the security of having somebody else comment when your technique. There are fabulous videos that the CDC has on their site about donning and doffing PPE, and it just goes to that feeling more comfortable about putting on the personal protective equipment.

There was a survey that was mentioned by Dr. Wenzel that we had – I spoke to – do I feel supported? Is there something that I need regarding the COVID-19 pandemic? And do I feel like I have what I need to take care of patients safely? And all those things I had to say yes.

And there was box that said, "When – is there any time when you don't …." and I wrote in foraging for food because for me, going to the grocery store has been more stressful and watching people in how they're using gloves or mask in the grocery store than it is for me to be in my home or also taking care of patients.

I feel very comfortable and I'm so appreciative of comments that other people page me as in, you're touching your mask or you want to make sure that you are washing your hand before and after you're taking your mask on and off. The front of your mask is considered dirty so that you want to make sure that you're very careful removing your mask.

We have been provided with some paper bags and we take our mask off and put them in a paper bag, so they're not sitting around. So, the coaching I would say – coaching the other staff, providing opportunity for people to see what you're doing and to assist with your technique.

One of the other things as far as to your interpretation is we have colleagues now in the hospital who are taking care of our general inpatient, hospice patients who are not comfortable or haven't been really – this is something new for them. So, we're spending time coaching them as well.

Yes, you can put a Foley into a patient who is on hospice that may provide them some extra comfort, and even as far as how they're medicating patients, we can coach our nurses through using opiates for dyspnea where we are ordering the medication we'll hear – well, I didn't recognize that they were in pain.

So, we'll talk about pain and the discomfort of having a high respiratory rate and just giving them some general coaching and some education so that they feel more comfortable taking care of a cohorted patient that they're not as familiar with.

So, Dr. Wenzel, I think that I'm going to turn this back over to you. So, we can talk about …

Carl Wenzel: OK.

Marie Sheedy: … our best practices in the IPU.

Carl Wenzel: So, we've had a General Inpatient Unit, as a freestanding hospice units since 2009. Our census there is we have 14 beds that are for adult and three beds

for pediatric. I get their obvious census has usually run about 10 or 11. So, we have a designated COVID wing for our hospice patient.

They stay more on the east side of the hospital that we were into it – they're building that we're in and all of our staff that are caring for the patient are doing full PPE with N95 respirators. We have followed the recommendation to try to reduce airborne secretions to our very best of our ability.

So, we really have tried not to use any nebulizer therapy. We have tried not to use BT along with any nasogastric tube. We consistently try to get Foleys in folks after. So, they are not incontinent, don't need to have more interactions with being changed some things like that.

Usually, we schedule medicine if there have been some sense of need for symptoms of distress whether that'd be pain, anxiety, shortness of breath, nausea, vomiting. We try to schedule medicine so that the patients are comfortable, so that the nurses they don't have to run in and out of the room many, many times.

And I must say through this entire pandemic, if without a doubt that the nursing force in this country are the major heroes in our – in caring for these folks every single day. They are incredibly selfless people and that should be – they're amazing.

We tend to use drips after than we may have in the past just try to get somebody as comfortable as possible. We have baby monitors, watching patient in the room so that we can see that they're comfortable and interact with them or help them if they are not.

Marie Sheedy: Dr. Wenzel?

Carl Wenzel: Yes.

Marie Sheedy: It's Marie. I'm just going to comment, so – on hospice especially in the freestanding hospice, we aren't monitoring patients. We – they are not on telemetry. They're not on monitors. So, the baby monitors for us have just

been a brilliant idea. The nurses have brought them in and we can actually see at the nurse station. And you can hear – so you can hear if somebody is having troubles with secretions or if they tachypneic or if they are short of breath. So, it's been a wonderful addition as enable – to enable us to see what's going on the room. Thank you.

Carl Wenzel: Thank you. We provide a lot of emotional support for each other. We're always making sure we're getting through the day OK supporting each other whether it'd be the nursing staff, the chaplain staff, the social worker, the note administrator. So, everyone is always looking after each other to make sure that we're staying as mentally comfortable as with that we can.

I want to share a story with you. One of the – we have two visitors that we allowed to come in to the patient. We'd like to restrict them to the same two people that are coming in to visit their loved one, and so we're just trying to reduce the web effect of the immense virus that so many people seem to touch.

So, about – I guess about 11 or 12 weeks ago, we needed a patient who had a defibrillator deactivated who would go in one-half, but – and I called Boston Scientific to ask them to deactivate the defibrillator and they told me that they couldn't do that, so I asked, "Why?" And they ask just to put a magnet on a patient which in my opinion can be somewhat uncomfortable for people as time goes on.

And then lady was very nice, and I've known it for a long time and she told me that there was only nine people in the area Southeastern, Pennsylvania where the Philadelphia area that we worked up that work for Boston Scientific that program pacemakers and defibrillator and the lady told me that at the beginning of the pandemic, i.e. technician was helping a physician program a pacemaker.

The – well, either the physician or the patient had COVID. The Boston Scientific person subsequently got infected, went back to her office and just didn't feel unwell and then eight of the nine people that worked together became ill with the virus and they could not help anyone. So, the reason we

built that with a good practice with the amount of visitation worked at we could reduce the web effect of us getting infected and not being able to provide any end-of-life care.

So, with that, I'm going to turn it over, again, to Marie about our community interaction that has been so wonderful as we've been going through this pandemic.

Marie Sheedy: This is – this is so true and it's so uplifting. So, our community hospice runs on volunteers – and our volunteers have always been wonderful but they're not present right now. So, one of the things that our volunteers have been doing has been making masks and hats and they're rock stars.

So, they're still out there crocheting for us in doing other things but people have been just pitching in all different ways and has a massive – just been taking care of us. People have been providing meals, treats, snacks and also we've – they've been providing signs and even the enterprise has fabulous videos about how much they appreciate what's going on.

At some point, we opened our front doors to the inpatient unit and someone we are – I think we're still trying to figure out who exactly it was but was covered with cutout butterflies. So, it was just a nod to people any appreciation for what we're doing in a hospice since the day, but it was just covered with beautiful cutout butterflies and all different kinds of paper.

So, that is really – we are so appreciative of the way that everybody is appreciating us. And Dr. Wenzel, I turn it back to you for your other – your number five bullet point.

Carl Wenzel: So, one of the things that I had asked for early in the pandemic was to – I spoke with the medical director of the Jefferson Primary Care Practices where the physicians were restricted and our practitioners were restricted with seeing patients other than doing it visually through telemedicine at the beginning of the pandemic and many of them were still doing the same.

So, we were – I had asked the physician, the medical director if – maybe this would be a good time – that it's always a good time, but maybe they had more

time to speak to the patient and their families about what their goals, the care we are going through this crisis. Do you want to go the hospital if you have bad lungs and – from COPD and bad heart failure or you have a malignancy?

Do you want to be on ventilator? Do you want CPR? So, what happened was – having like that many of the physicians took that information and started having more discussions with their patients and their family about end-of-life thing that they would or wouldn't want, and that was something that we thought was very, very important and it seemed to work well.

We were getting more patients that seemed to be starting on hospice sooner than later because that's something that we're always trying to accomplish the length of stay. Sometimes it's way too short hospice as you all know means that you are supposed to live less six months or less not six hours.

So, it will – that was a real good feeling that the physician would take in that role on that actually have a heart-to-heart discussion with the patient and their families about what they really want because that's truly what they want to talk about, and then lastly, I'm going to turn it over to Marie about our bereavement service that has been so instrumental in helping family during this amazingly difficult time.

Marie Sheedy: Exactly, and you know, I think it was acknowledged at the beginning of this that many folks are dying alone, their family is limited, unable to visit and that the COVID pandemic has created a novel grief experience that families are – for us we allowed two people to come and families will leave it to them to figure that out sometimes.

There's an opportunity where little lingering in the parking lot where – when big ambulance come. There has been a little bit of pushback, but we do go into – that the web effect as Dr. Wenzel described. We also try to use the phone for FaceTime. We're doing Zoom meetings with our Team meetings and I'm – privy to hear conversations with our chaplain having conversations on the phone and praying with our hospice patients over the phone.

This has been described as such a strange experience not being able to be with a loved one and many times we have patients who they perhaps have not seen

their family in six weeks, hospitalization perhaps that we have recovery back to the hospital.

So, one of the – one of the terms that I've heard is a Disenfranchised Grief also. Patients who are kind of caught in the wake of the COVID epidemic where they're not able to see their family members who may not be COVID positive, but they are – if – sometimes even feeling that their grief isn't as warranted because they're not part of this pandemic, but they still have loved ones who are dying. It is a traumatic loss.

It's frequently – we'll hear from families where we thought that had another year and hear with something that's like being hit by a truck. So, that they're – that they're definitely so rapid. Dr. Wenzel, is there anything else that you would like to add?

Carl Wenzel: Yes, the one thing, we kind of – but we …

Marie Sheedy: I think …

Carl Wenzel: … have very – we have a really wonderful bereave – we have a wonderful social work team and nursing team and we are – we have a social worker Carmella who'd kind of taken the lead to be the COVID person and reaching out to family. So, she's been doing a lot of Zoom meetings than she's really been conversing with the patient earlier in the course of the bereavement than she may have in the past.

And she recommended that the Hospice Foundation of America has a webinar on the Disenfranchised Grief and COVID-19, and she thought it was a wonderful thing to – that she viewed and to share that with you. So, I think that what Marie and I wanted to talk about and I guess if you have any questions, we do our very best to try to answer them.

Jean Moody-Williams: So, thank you and I know we are right at time, but that was so much great information and I think, too, our people are appreciating what you're appreciate – what you're doing because I can hear in your voice that – the compassion. But I do – so obligated to take at least one question because that was such great information. So, I'm going to ask the operator for those

that can hang on for just a minute if we could open up the line to get a question. Operator?

Alina Czekai: Joanna, take our questions. Oh, great. Thank you.

Female: Hello?

Carl Wenzel: Oh, hi.

Marie Sheedy: Yes.

Alina Czekai: Hi, operator. Do we have any question on the phone?

Jean Moody-Williams: OK. Well, I think I will just take this time to thank our presenters so much and for all you do and for presenting today and I will now …

Marie Sheedy: Thank you.

Jean Moody-Williams: … turn it back to Alina.

Marie Sheedy: Thank you for …

Alina Czekai: Great. Thanks, everyone, for joining our call today. We hope that you'll join us later today for our CMS COVID-19 Office Hours. That will take place at 5:00 p.m. Eastern, and on that call, we'll have all of our CMS subject matter experts on the line to answer your more technical questions.

And please continue to direct your questions to our COVID mailbox which is covid-19@cms.hhs.gov. Again, we appreciate all that you're doing for patients and their families around the country as we address COVID-19 as a nation. This concludes today's call. Have a great rest of your day.

Operator: This concludes today's conference call. You may now disconnect.

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