Centers for Medicare & Medicaid Services
COVID-19 Call with Nurses
Moderator: Alina Czekai
April 30, 2020
3:00 p.m. ET

OPERATOR: This is Conference #: 4268398.

Alina Czekai: Good afternoon. Thank you for joining our April 30 CMS COVID-19 Weekly Call with Nurses. We appreciate you taking time out of your busy scheduled 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 and providers in the field who have offered to share best practices with you all.

I'd first like to turn it over to Jean Moody-Williams, the Acting Director at the Center for Clinical Standards and Quality at CMS, for a brief update on the agency's latest guidance in response to COVID-19. Jean, over to you.

Jean Moody-Williams: Great. Thank you. Good afternoon, everyone. Thank you so much for joining. We are looking forward to a great half an hour here with you. And before I turn it over to our guest speaker, I have just a couple of updates that I'd like to provide.

First, I'd like to acknowledge and thank you, as I always do, for your service and acknowledge the Year of the Nurse and Midwife celebration. The American Nurses Association has expanded National Nurses Week, which we know is traditionally celebrated from May 6 to May 12, to a month-long celebration in May, and really to expand the opportunities to elevate and celebrate nurses that are on the frontlines or behind the scenes or working on policy or working in all kinds of areas.

Our clinical nurses, nurse managers and leaders all deserve this recognition. We want to take this time to thank you and acknowledge the Month of the Nurse, which sounds really good to me.

I am also happy to announce that today CMS, just coming hot off the press before this call, released regulatory waivers and rules designed to expand the care to our nation's seniors and providing flexibility to the health care system. As you know, we have already released quite a few waivers. But, today we were able to put forth an interim final rule. And these actions were informed by requests from health care providers such as yourself as well as the CARES Act.

Just to highlight a couple of things, it's quite a few. Please go to our website and take a look, because I will not have time today to go through them all. But, I wanted to just highlight some of the goals, which were expanding the health care workforce by removing some of the barriers for physicians, nurses and other clinicians to be readily available to continue the work that you are doing.

For example, since beneficiaries may need in-home services during the COVID-19 pandemic, nurse practitioners, clinical nurse specialists and physician assistants can now provide home health services as mandated by the CARES Act, and they can now order home health services, establish and periodically review a plan of care for home health patients, certify and recertify that the patient is eligible for home health services.

Previously, Medicare and Medicaid home health benefits c only be received from home health services with the certification of physicians. And I just got a question about this today from an area where they were having difficulty. It was, kind of, a remote area. The physician's office was closed and they weren't able to get recertification. So, this change, I'm sure, will be welcome.

We made some changes in student documentation. We had made changes in the Physician Fee Schedule Rule to simplify medical record documentation requirements for physicians and certain other clinicians to allow the billing clinician to review, verify rather than redocument information added to the medical record by any member of the health care team.

During a public health emergency, this principle applies across the spectrum of Medicare-covered services and was also applied to therapists so that they

can review and verify rather than redocument notes added to the medical record by therapy and other students.

And we wanted to continue to ensure that hospitals and health systems have the capacity to handle COVID-19 patients through temporary expansion sites. So, we have expanded to additional remote locations that can be built under the hospitals banner such as hotels or community centers provided that appropriate services can be provided in those locations.

We have increased access to telehealth for Medicare patients so that they can get care from additional clinicians and therapists. We have expanded some of the at-home and community-based testing to make it more convenient for Medicare and Medicaid beneficiaries to be tested. And we are also looking at some of the temporary relief from many of the reporting and audit requirements. So, you can take a look at that as well. We have some provider-specific fact sheets and a number of different types of information.

So, with that, I'd like to now move on and introduce our guest speaker who will share some experiences from the field. And we will have the opportunity to ask questions of her. We do have a few subject matter experts on from CMS. However, we are trying to reserve the more technical billing, coding kinds of questions for our Office Hours, which we have on Tuesdays and Thursdays.

So, with that, I will introduce Dr. Gretchen Schumacher, who will give us some information. She is a board-certified nurse practitioner, both family and gerontology. So, Dr. Schumacher?

Gretchen Schumacher: Yes. I'm here. Thanks for this. I was really excited to get the call. In fact, they asked me last week, but things are so crazy in my practice right now I said, "There is no way I can make this happen." And, then, it all fell into place today. I'm really excited to share with you what's happening for us.

COVID-19 has really opened a door for the true return of the medical house call. At my service – I'm a home-based primary care program – we provide care for those high-risk, medically complex patients. And, in fact, the United

States has about 2 million of these patients that are in-home, and only about 15 percent are really, truly, being seen at home.

It's interesting that with home-based primary care, we are proven to be saving the system money and improving care for older folks over the long term. But now, suddenly, everybody being at home and the need to get service at home, has really shined a light on why home-based primary care is such a game changer.

So, despite the fact that COVID-19 has driven us home, the home-based primary care model in the U.S. really has not taken off over the past 15 to 20 years. And most of that is because of the limitations of fee for service, because home-based primary care and this kind of patients – we are very high value and very low volume.

But, we are crucial in the COVID-19 circumstance to avoid the hospital setting because these patients are already sick with lung disease, chronic disease and they don't want to go to the hospital. So, we have to innovate. It's just like we've got to innovate. And this is why I love to be with nurses, because nurses – we innovate. That's what we do.

So, in my particular practice, Elder Care of West Michigan, which is eldercarewestmichigan.org – we are NP, nurse practitioner driven and owned in West Michigan and we are growing and serving. We take all insurance. We bring all the services of primary care into the home – lab, X-ray, case management, rapid assessment, chronic disease, advanced care planning et cetera onsite.

And in our practice, about 60 percent are in assisted living. So, we have about 15 different assisted livings that we have patients that reside in and about 40 percent, 35 to 40, are in traditional homes like rural America and some in suburban areas outside of Grand Rapids.

So, what have we discovered? Some things I want to just share with you is home-based primary care, we have discovered, does not always have to be in person. Telemedicine for us is working. And it is working well. I don't think there is necessarily 100 percent long-term – not 100 percent of cases. But,

telemedicine and home-based primary care, thanks to the circumstances we've been in, have definitely found a place for it.

And to give you some examples of why I am so passionate that this telemedicine opportunity has transformed some of the care we are able to do is we have noticed we've been able to get some folks to hospice sooner. We have particularly with advanced directives.

Removing that face-to-face requirement for advanced directive discussions, we have been able to move the needle on advanced directives for many of our patients partly because we can now connect with their families, which many of these older patients or their DPOAs, the individuals who are their stakeholders for making decisions about advanced care planning, when they don't want to go to the hospital right now if they were to fall or have an issue, the telemedicine has made that possible and solidified the ability for us to have those conversations.

In fact, when I am done with this phone call, I have a telemedicine phone call on a patient, a complicated DPOA situation with one son in California, one daughter in Texas and another son in Colorado and the patient is here. So, we are using the telemedicine platform to meet and solidify, review the documents so they all know what's happening. And that's something we were not doing before. We are very grateful for telemedicine.

Advanced directives – we've been able to review documents through screen share and have conversations, particularly with our frail elders who are fearful of going to the hospital. And some have changed their decisions.

So, the family meetings. Another thing that happened for us that I just wasn't using the codes or doing it, but, because the platform was there, we started doing more picture visits. I used to get a phone call from the assisted living that would say, "I think so and so has cellulitis." That may or may not be a trained individual. And I say, "OK. What does it look like?"

Now, to have that picture sent, I can see wounds, I am seeing things. And that particular service was certainly available to practices prior, but we were never

using it. And now, we have found a place for that because of the telemedicine technologies that are forcing all of us to communicate in a non-face-to-face and a social distancing kind of way.

Some of the suggestions I would have for CMS long term besides, "Please don't take it away," "Please don't it away; it's working," is expand it. The thing about telemedicine is tricky. And in my population, because they are not young folks – the average age of our patients is 84, I think, 85 – it takes a little bit of front leg work to get these visits set up. So, we have to restructure our days and how we are seeing patients.

In an assisted living where I have 10, 12 individuals and an RN onsite, I need to work with that RN as to what her schedule looks like, how to see certain patients. So, it's taking some front-end work from my office where we are saying, "Can you fax us the med list? Can you fax us?" And we are holding the video visits kind of together and then doing documentation later.

But, what my point of this is nurses especially – we are willing to innovate. We will change. We will mold and mold our structure and our processes to accommodate telemedicine in our home-based primary care. It's a win, and we would do it.

I think something that would be helpful. would be to think about payment for some vital signs technology. And this is particularly for the home-based patients that are in their own homes. It's not hard for someone to have a pulse ox now.

Today, I had two telemedicine visits prior to this call. One was at home. One was at a facility. The patient who was at home already had a pulse ox. I said, "Put it on your finger." She showed me what the pulse is. And a blood pressure cuff somebody could put their arm in. If there was a way to bundle some payments to help folks at home to be able to take their own vitals inexpensively, that would enhance some of the data in these calls.

Another thing that we have discovered with our home-based primary care nurse practitioner-driven practice is that this has really solidified our partnership with the home health care companies. Home health care and

home-based primary care, we have common goals. And our goals are to keep the patients safe and at home.

I applaud the legislature, CMS. The NP signature is a monster positive tool for us now. In fact, I can't believe this happened today right before this call. I was finishing this call before I came on this one. I have a patient, 92 years old, absolute respiratory case, a COPD exacerbation, a wife was very ill. They live at home. I needed a home health care nurse now to get out there. I ordered a nebulizer and I need someone to get there and train them and show them how to use it. We do not want this gentleman going to the hospital.

And because of the most recent signature changes, I was able to make that happen within hours today where I don't know that I could have filtered that as quickly. It may have taken 24, even 48, hours if I pursue a physician signature from the medical director of my practice. This was a win. So, I really want CMS to know there is a lived experienced every day – and I just had one – as to why this is working.

We need to think about expanding that signature to hospice certification – nurses, nurse practitioners, especially. We are capable of identifying folks who meet criteria for hospice. And I think that can lead to a delay.

One of the things I shared with some folks on the NP board staff that I serve with, the community circumstance that we are in in West Michigan with testing and particularly the assisted living, that they are concerned about their staff. Because I am a Quest lab, we have now set up clinics where I am able to come in to the assisted living and do the antibody testing for the staff where they are really concerned to know "Does somebody have immunity?"

Certainly, we recognize the long-term interpretation of the meaning of this testing. It's still preliminary. However, this is information people want. So, next week, I will be able to assist in the facility I'm visiting and be able to offer antibody testing to the employees so they can have any idea if maybe they have had an exposure and didn't know.

My only biggest concern that I am falling into – all these good things are happening. But, I have no access to PPE. And it's tragic. It's difficult. And

I have accounts at McKesson, different places. I reached out to the ACO yesterday. I need to be back out seeing patients in their home. But, to – access to a gown – I can't find it. I can't find it anywhere. And, so, that would be my plea. It's the PPE access. I don't even have one N95 for my team.

So, because I am not part of a hospital system, I am an independent practice serving a vulnerable population, I think we've just got to look at the strategies to get the PPE out there in other ways. And if someone has suggestions, I am open.

Jean Moody-Williams: Great. Thank you very much for sharing your experience. And we certainly have heard that telemedicine is really making a difference in how folks are practicing. And we get the message and continue to look to see how we can be flexible. Operator, I'd like to open up the call for questions, please.

Operator: Ladies and gentlemen, at this time, as a reminder, if you would like to ask a question, please press "star" then the number "1" on your telephone keypad. Again, to ask a question, please press "star" then the number "1" on your telephone keypad. For the participant who pressed "star," "1," please state your first and last name. You may now ask your question.

Jean Moody-Williams: And while we are waiting for the first question, maybe I'll ask one. We also do home health and hospice calls. And it was noted that some of the home health and hospice nurses are having difficulty sometimes gaining access to patients in assisted living or even long-term care facilities when face to face is necessary. Are you experiencing any of that in your practice?

Gretchen Schumacher: Yes. I personally in my practice am not. We made the decision to do 100 percent telemedicine during the lockdown in the state of Michigan, and we are managing. But I am heading back out officially on Saturday to see some patients at home that are low risk.

But, what we find happening here is that essential personnel include the physicians, nurse practitioners, PAs, most of the time nursing but the exclusion of PT and OT. And I am seeing that as being concerning because many of my patients now who have gone one or two or three months without

PT or OT – we are seeing a lot of falls – a lot more falls in patients we didn't see before. Certainly, there's other variables affecting that. But, the assisted living has direct instructions from Governor Whitmer that they are following. So, this time, it's really up to them as whether or not they are permitting folks in.

We don't do any skills environment. We only do assisted living. So, we don't fall under any federal regs for entrance. Rather, it's private business in the state of Michigan for assisted living.

Jean Moody-Williams: OK. Great. Thank you. Operator, are there any questions?

Operator: Yes. For the participant who pressed "star," "1," you may now state your first and last name. Your line is now open.

Donna Hertzler: Donna Hertzler.

Jean Moody-Williams: Hi. We can hear you.

Gretchen Schumacher: Hi, Donna.

Donna Hertzler: OK. I have a question. I work at an ambulatory surgery center. And I was wondering whether CMS has made any changes to the HMP being within 30 minutes. Our state just allowed for elective surgery. So, I just don't know how we are going to accomplish all that.

Jean Moody-Williams: OK. Let's see. Do we have anyone from our conditions of participation team on the line?

Alina Czekai: Jean, I don't think we have those folks on the phone. But, we can take your question back. Absolutely.

Jean Moody-Williams: OK.

Donna Hertzler: All right. Thank you.

Jean Moody-Williams: So, yes, that is a point. I think we talked last week that areas are moving back to doing procedures in recognition of the gateway that have been set up. Operator, we will take another call, please.

Operator: All right. Once again, participants, if you would like to ask a question, please press "star" then the number "1" on your telephone keypad. Again, to ask a question, please press "star" then the number "1" on your telephone keypad. For the participant who pressed "star," "1," please state your first and last name. Your line is now open.

Tyler Shirk: I am at an ASSC in the state of Arizona. And I have a question concerning what does robust testing look like for the ASSCs in Arizona? We've been kind of unclear on what we need to do to test our patients and staff that are considered high risk.

Jean Moody-Williams: So, I actually had a call for ASCs on freestanding emergency departments a little bit earlier today, and that question came up. And I know our clinical staff is looking at that. There were guidelines that were put out. But, that's all they are. There are no requirements from what we could say as "You must do this, this and that."

But, we do refer you to the CDC guidelines in which they have begun to put out information as far as what you should consider before you do certain procedures or move to another level of care. So, I would refer you to those guidelines. We do not have any specific at this point.

Tyler Shirk: OK. Thank you.

Jean Moody-Williams: OK. And I think we have time for one more question.

Operator: Once again, to ask a question, please press "star" then the number "1" on your telephone keypad. Again, to ask a question, please press "star" then the number "1" on your telephone keypad. Presenters, we don't have any further question at this time. You may continue.

Jean Moody-Williams: OK. Great. Thank you so much. I am going to turn it to Alina to give any additional information and close us up.

Alina Czekai: Great. Thanks, Jean. And thanks, everyone, for joining our call this afternoon. We hope you will join us for our next CMS COVID-19 Office Hours. And the next Office Hours will take place next Tuesday, May 5, at 5:00 p.m. Eastern. And as Jean mentioned, on that call we will have all of our CMS subject matter experts on the line to answer your more technical questions.

And in the meantime, please continue to direct your questions to our COVID mailbox, which is COVID-19@cms.hhs.gov. And, again, we really appreciate all that you are 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: Thank you, presenters. And thank you, ladies and gentlemen, for joining us today. That concludes today's call. You may now disconnect.

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