Centers for Medicare & Medicaid Services
COVID-19: Lessons from the Front Lines
Moderator: Alina Czekai
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OPERATOR: This is Conference #: 5096006.

Alina Czekai: Thank you for joining our CMS Lessons from the Front Lines on COVID-19. We'd like to begin by thanking all of you for the work you are doing day in and day out to care for patients around the nation amidst COVID-19.

This is Alina Czekai, I'm leading stakeholder engagement in the office of CMS administrator Seema Verma. And today's call is part of our ongoing series, Lessons from the Front Lines.

And while members of the press are always welcome to attend these calls, we do ask that they please refrain from asking questions. All press and media questions can be submitted using our media inquiries form which can be found online at cms.gov/newsroom/media-inquiries. And any non-media COVID-19 related questions for CMS can be directed to COVID-19@cms.hhs.gov .

Here at CMS, we recognize the government's role during COVID-19 is to offer maximum flexibility and regulatory relief to allow you all to do what you do best, which is care for patients in your local communities.

A lot around the nation providers and local communities are innovating in response to COVID-19. And here at CMS, we hope to bring local innovators together to share best practices that can be scaled at the national level.

Today's call will focus on these expanded flexibilities and we will hear from providers who are seizing the opportunity to innovate and transform to support their local communities.

Today we will hear from primary care providers about the strategies they are employing a telehealth expert on recommended best practices and rural

hospital CEOs to learn about the strategies they are employing to address COVID-19 in rural communities.

And we encourage you to direct your questions to our guest speakers on the line. Should you have more technical questions on CMS waivers and guidance, we do encourage you to join our CMS office hours, which are held every Tuesday and Thursday at 5 p.m. Eastern.

And I'd first like to begin with a brief update from the agency. Earlier this week as part of the President's Opening Up America recommendations, CMS issued new recommendations for phase one to reopen the healthcare system. These are recommendations and every state and local official will of course need to assess the situation on the ground to determine the best course forward.

This week we also launched a new toolkit to help states navigate COVID-19 health workforce challenges, which includes a full suite of available resources, such as information on funding flexibilities, liability protections, and workforce training to maximize responsiveness based on state and local needs.

Additionally, the agency also announced a new nursing home transparency effort. Patients and families deserve to have the information they need. And CMS will require nursing homes to inform all residents and their families when there are cases of coronavirus in the nursing home. This requirement is unprecedented in its transparency. And we also will require nursing homes to directly report cases to the CDC.

As we gradually reopen our country, this nationwide reporting system will form a crucial element of the surveillance and monitoring system and communities so that we can quickly identify outbreaks, conduct contact tracing, and stem outbreaks at the community level. And as part of this effort, the CDC will provide a reporting tool that will support federal efforts to collect nationwide data.

And today we are joined by leadership from the Centers for Disease Control and Prevention to provide additional detail on this announcement and other important updates from the CDC.

And today, I'm pleased to now turn it over to Dr. Arjun Srinivasan, associate director for healthcare-associated infection prevention programs in the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention to share an update, turning it over to you.

Arjun Srinivasan: Great, thank you so much. And really, as always appreciate the opportunity to join this call and want to reiterate our continued ongoing thanks. We are quite frankly in awe of what you all are doing on the frontlines each and every day to care for people in the midst of this unprecedented pandemic. You are doing amazing work day in and day out. We are honored to be working with you and are eager to help you in any way that we can. And so you know, thank you so much for all that you're doing. We know it is not easy, and we greatly appreciate it.

A couple of things, I wanted to highlight as you just heard we will be launching a mechanism for nursing homes to report information not only on COVID status in nursing homes but also on their availability and access to testing PPE and staffing shortages. As you all have probably seen in the many, many reports.

The nursing homes have been heavily impacted by COVID significant morbidity and mortality in those populations and tremendous challenges in controlling outbreaks in nursing homes. And we hope that this new information will allow us to collaborate even more closely with nursing homes and help with allocating resources to the nursing homes that need the most. So we really look forward to bringing that online and to working continuing our efforts to help nursing homes and their efforts to control COVID. A lot going on in that space. A lot of materials are available on the web to encourage folks to take a look at all of the resources available for nursing homes on both the CDC and CMS websites.

The only other thing that I will mention for this group is the recommendation which is not exactly new. It came out about a week ago, but that is for the source control for everyone entering any healthcare facility and working in any healthcare facility. And this is an effort to try and reduce the transmission

from asymptomatic and minimally symptomatic individuals. We have learned a lot about the potential risks of transmission from people who have no or even mild symptoms of COVID. So our recommendation is that everybody who is coming into a healthcare facility wear some sort of the face covering. For visitors and patients we specify that they can wear cloth, face coverings, cloth face coverings are not personal protective equipment. They do not protect the wearer, but they will protect other people from the wearer. There are good studies that show that these cloth face coverings can reduce the spread of – reduce excretion of viral particles from the noses of mouth of the wearers. And so, visitors, patients who are coming into facility as they are able to tolerate them should be given a cloth face covering.

And the reason we're expressing a preference for the cloth face coverings for the non-healthcare staff is of course because we want the true surgical masks which are personal protective equipment to be reserved for healthcare workers. So we do recommend that healthcare workers in facilities should wear surgical masks as a source control measure. And the reason that we're doing that is that for healthcare workers, they will obviously be in situations where they will be needing source control clearly when they're interacting with their colleagues, but they may also or patients who don't have COVID but they may also need personal protective equipment.

And when they are interacting with patients with respiratory symptoms or who do you have COVID and so therefore, we are recommending that rather than having a healthcare worker wearing a cloth mask and have to shift back and forth between the cloth face covering and actual PPE with a surgical mask, we just suggest that they use the surgical mask.

Now obviously, in some situations they will need to remove the surgical mask to put on N-95 respirator if they have a need for a respirator. And so they will need to continue to be alert to those types of changes. But that is a newish recommendation that I really wanted to flag the recommendation for source control. There's lots of information on the CDC website about this recommendation and the use of these cloth face covering. So I would encourage folks to take a look at that.

And the other thing I will just mention very briefly is that, you know, there is certainly a need for ongoing vigilance with infection control, with compliance to precautions, the basic stuff, right remembering to wear PPE, put it on, take it off correctly. We do have resources there for folks who want refreshers, putting on and taking off personal protective equipment. There are some new videos that have been posted online if you want a refresher on how to do that. And also to remind folks about the need for active screening. You know, the best way to prevent outbreaks of COVID in healthcare facilities is to ensure that it doesn't enter the facility in an unrecognized patient or visitor. So really score staff members. So active screening of everybody coming into healthcare facilities to make sure that people don't enter who may have minimally symptomatic cases of COVID or frankly even symptomatic, so that you can make sure that you don't have unrecognized importation.

And those were the main updates I wanted to provide. So I will stop there and turn it back over to the folks at CMS. Thank you.

Alina Czekai: Great, thank you so much for providing an important update from CDC.

Operator, let's open up the mind to take a couple of questions from our call participants. Thank you.

Operator: To ask a question via the telephone, please press star one. Again, please press star one to ask a question. And if you would like to withdraw your question, please press the pound key.

We have no questions over the phone. Please continue.

Alina Czekai: Sounds great. Thank you.

Now we'd like to turn it to hear from some physician leaders around the country to learn about what they're facing in their local communities, and some strategies that are working well for them as we address the pandemic.

And today we are joined by physician leaders who have offered to share their insights and best practices. And today we'll focus on primary care, telehealth and rural health innovation.

And joining me from CMS are several of our physician leaders, who will also offer their expert perspective throughout the conversation as well. And joining me today is Dr. Marion Couch, Senior Medical Advisor to administrator Seema Verma, Dr. Shari Ling, Acting Chief Medical Officer at CMS, Dr. Michelle Schreiber, Director of the Quality Measurement and Value Based Incentives Group at the Center for Clinical Standards and Quality. And Dr. Barry Marx, Director of the Office of Clinical Engagement.

And let's start with our primary care speakers. Our first speaker today is Dr. Bill Fox. Dr. Fox is a primary care physician in Charlottesville, Virginia. Dr. Fox turning it over to you.

Bill Fox: Thank you, Alina, and thanks for the opportunity to speak today. To put things in perspective, I have a small independent three physician practice located in Charlottesville, Virginia. And I think one of the biggest lessons I've learned is to quickly pivot over to telehealth. So I am really pleased that Medicare and most payers at least in my area, are reimbursing for telehealth at the same rate as in person visits. And I hope that this policy will continue beyond the emergency period as my sense is that it will be necessary.

We also do telephone only visits but only as a last resort if the patient has no access to video communication, as the telephone visits require about the same amount of mental effort and time, but they're reimbursed at a much lower rate.

But I still feel a telephone visit is better than no visit at all. But still, and since Medicare is on the phone listening, I do hope that they and other payers recognize that we do need to reimburse for telephone visits at the same rate as in person visits.

If your practice is like mine, your volume is down significantly, we are seeing about 50 to 60 percent of the patients that we normally see. And of those, the majority, about 80 to 90 percent are being seen virtually and only about 10 to 20 percent are being seen in person.

It's important to do a physician staff huddle with a one to two day look ahead in the schedule to see who can be seen virtually and who needs to come into the office.

Now, if you're like me, no one ever taught us how to do this. The way I approach it is if you feel the bulk of what you need to know can be obtained through history, the most patients are a good candidate for virtual visits. And also, don't be scared to convert a virtual visit to an in person visit if you find that that's necessary.

We are seeing patients who report symptoms of fever, cough, shortness of breath or other symptoms that could be consistent with COVID. But we're seeing most patients outside car side. And we the physicians are wearing full personal protective equipment including an N-95 while we have those supplies.

I think it's interesting to note that the FDA recently approved nasal self-swab for patients. So instead of the healthcare worker collecting the swab, and we have adopted this practice in my office. We hope that that cuts down on coughing by the patient and aerosolization of respiratory droplets. And we think it might be more comfortable for the patient.

In the office, all the staff are wearing surgical masks if they are working in an area within six feet of one another. When we are evaluating the non-COVID patients in the office, we wear a surgical mask and the patient also wears a mask. And you heard a little bit about this from, I guess from Dr. Srinivasan.

There's this CDC guidance statements on risks to health care workers and criteria for return to work. If there's a potential exposure to an asymptomatic patient in the office who later becomes positive. So according to the CDC, the risk of transmission is considered low. And employees are not required to leave the workplace, as long as both the patient and the healthcare worker are wearing a mask. Otherwise, the employee may need to stay out of work in quarantine for 14 days, which would be very disruptive. So we've adopted that practice. The staff checks their temperatures in the morning to make sure they're not febrile.

The staff is wiping down all surfaces in an exam room after every patient which is not many patients who come in, but we're doing that with a Clorox wipe or some other similar disinfectant after each patient.

And finally, I'll just say that this is a stressful time and I think it might go on for a while. So try to keep a sense of humor and be kind to your staff because they're feeling the stress as well. So thank you, Alina.

Alina Czekai: Thank you, Dr. Fox, really appreciate your insight, especially the emphasis on sense of humor and maintaining positivity.

Next, we'll turn it over to Dr. Yul Ejnes, an Internist in Cranston, Rhode Island. Dr. Ejnes, over to you.

Yul Ejnes: Thank you very much. And I also thank you for the opportunity to share some experiences with the rest of the physician community. My practice is a little different from Bill's, I'm in a five position to (PA1), NP office. That's part of a practice that's got over 100 clinicians, mostly physicians and advanced practitioners spread out over the state of Rhode Island in about 20 locations.

And like the rest of you, we had to transform the practice in days to one that did the primarily and in some cases exclusively virtual visits. And looking back at when we became a medical home, we spent months doing that and here we did things and days and that included learning to use telehealth as well as new ways of triage and patients.

In terms of best practices and perhaps some of this will be covered in the next section. One thing we learned early that we've refined as we've gone along is unlike a ramping up of telehealth, when it was planned where you have months to get patients up to speed and staff up to speed here, you're basically plunging into it and having to create tech support people out of your staff and out of yourselves, because you're trying to connect with people in ways that they haven't connected before and that everything works out fine.

So one thing that we found very helpful was to actually have multiple ways of connecting with people using telehealth. The default is the system available through our EHR that has some functionalities that make it advantageous. But

there are services that work outside the EHR that are sometimes easier to use, where you just send a text to the patient and they click on the link and go from there. So being nimble in terms of what modality we use has been very helpful.

The other piece of this is that typically in an office visit, you have a patient being roomed in by the medical assistants, who takes the vitals who does a med reconciliation, who may do some screenings, like a PHQ-9, and in the telehealth motif oftentimes the patient initiates the contact or the physician does and the medical assistant doesn't get to do her work. And that means one of two things, either the work doesn't get done or done as well or the physician has to do it adding to the burdens of the visit. So one thing that we've started doing is having the medical assistant make a pre call, a phone call usually, to go over the med list to do the screens that would be appropriate for risk, et cetera. So that when the physician initiates the visit, even if it may not be for an hour later in the in the day, that a lot of the pre work that would have been done by the medical assistance has been done, even though we're doing the visits remotely.

And like Bill, we've been really pushing to have these visits, the two-way audio/video, partly because I think you get more information that way and you can evaluate all sorts of interesting things like rashes. And secondly, certainly there are some advantages in terms of payment especially with Medicare patients, since there's a big difference in reimbursement for phone call versus telehealth.

And ironically, that's the group that's most challenged with the technology though some of these easier to use telehealth platforms where if you can text and have a smartphone you can do telehealth have helped out with that.

Another handicap that we encountered of using telehealth or remote visits to try to continue the chronic care management, despite the pandemic is not having lab data available, which oftentimes if you're treating a diabetic patient, for example, you want to know what A1C was.

And what's one thing that we've done in that respect is to really secure our lab in a way that is very safe for patients to come in and get their routine lab work to make the remote visit much more effective. One person in at a time. Anyone else waits in their car until they get a text message or a phone message to come in. Everything's wiped down. Everybody is in PPE.

And another phenomenon that we've figured out a way around is the issue of what happens when someone does need an in person visit. Being a larger group, we've been able to centralize in person visits into respiratory and non-respiratory sick clinics so that instead of having all 20 plus offices needing to have PPE and having clinicians and staff at risk, we actually have a couple of offices that are focusing on taking care of those patients, using scribes to minimize the touches of the treating clinicians to limit the risk of contamination and infection. And all of those visits are performed following a telehealth visit so we can screen people to make sure that they're going to the appropriate place since you don't want someone who calls in complaining of belly pain but also happens to have a cough ending up in the non-respiratory clinic.

So, I mean, being nimble has been very important here. And sometimes we'll switch the workflows, you know, from one week to the next until we figure out how to do this.

The last thing is the issue of volume. And, you know, Bill alluded to this. Patient volumes are lower. Partly, I think, because people have other things on their minds, or some don't like the notion of a remote visiting would rather wait until we're back in regular office visits. I think a lot of it also is – A lot of patients don't think we're still open and seeing patients and how to get the word out that we're still available, still seeing patients, still there for our patients is a challenge. If you're a large organization that has a website or a patient portal that can send emails out that can be helpful, but you know, the assumption that offices are closed, the lights are out. Therefore you're on your own unless you're real sick is something that, I think we should try to dispel because we don't want to end up with a second wave after all of this of chronic illness that was on attended.

And again, I thank you for the opportunity to share these thoughts.

Alina Czekai: Thank you, Dr. Ejnes. I appreciate your perspective.

Well, next turn it over to Dr. Mike Malone, a geriatrician at Aurora Health Care in Milwaukee, Wisconsin, Dr. Malone over to you.

Mike Malone: Thank you very much. So I very much respect and appreciate the input from the two prior presenters, and concur. What I'm going to do is to tell you briefly about the context of our work, the challenges that we're facing, just some brief comments about the themes and lessons learned. So the context is that we work in a large not for profit health care system, in the Chicago land area and Eastern Wisconsin. Our primary care practice of geriatric medicine is located in the inner city of Milwaukee in its primary care and consultation of geriatrics with care that extends into each of the communities, mostly in Wisconsin, but also now into Chicago land area as well.

The challenges that we're facing come mostly from my colleagues that report to us on a regular basis we meet similar to the work we're doing today, but in a smaller group within our health system.

And I'll indicate number one, we're concerned that older adults who have multiple comorbid illnesses really haven't come to the doctor into our clinic to see their providers over a period of time, as alluded to by our two prior speakers. And they're – we would say, rather vulnerable in that many of their needs haven't been addressed. And so that's a challenge for us to make sure that we're engaging with them to make sure that their healthcare needs are properly monitored over time.

Second point would be that we see that there are people with Alzheimer's disease who are in their homes with their family caregivers, and that the family caregivers, in fact, need respite and kind of a break from their responsibilities now that they're not perhaps receiving care at local, either daytime sites and such. So again, in short, the strain on family caregivers is important.

Next, families also described to us their concern about folks from home care agencies coming into their homes. So when we practice it's often in collaboration with home care agencies and that many are rather hesitant to receive such services.

And turning to those older adults in regards to who in fact, need emergency services. Some families are hesitant to actually bring their family members to the emergency department because they fear that they'll not be able to be with their older adult. And hence, folks from our practice, stay at home without services and some at the end of their life.

Also, we see those with Alzheimer's disease and we attend to in assisted livings where they're perhaps in their rooms, alone instead of with staff and left at times perhaps without adequate supervision, with some vulnerable older adults becoming dehydrated, and then hence needing additional care.

Lastly, in regards to challenges, we see that those who, from our practice who require hospital care for non-COVID-19 related health needs that they're hesitant to, in fact receive care subsequently in sub-acute facilities for fear of COVID-19 and hence families are stepping forward and overall, receiving the patients their family members back home.

So the key themes are those of our older adults who have vulnerabilities at their baseline and now they're faced with the challenges in the context of COVID-19, and the health care system, and communities in which they're receiving such care.

So, our efforts to improve care focus around this same practice that we're doing today. We huddle regularly. We compare notes with each other, we promote, like real time learning. And we do that with humility and with support for each other.

After that, we also, or in the context that we support our health professionals in what they're doing because they're stressed and at times, anxious. And then finally, we collaborate with our community. Namely, the Alzheimer's Association is doing a fabulous job that we make sure we integrate better with

them, as well with home care agencies that are, you know, in collaboration to serve our patients.

Those are my comments.

Alina Czekai: Terrific. Thank you, Dr. Malone, really appreciate that especially interested to hear about the community collaborations and how groups across your local community are working together in partnership with physicians.

Today, our final primary care physician speaker is Dr. Beverly Jordan, a Family Medicine Physician from Enterprise, Alabama, Dr. Jordan, over to you.

Beverly Jordan: Hi, I'm Beverly Jordan. And I really appreciate the opportunity to share with you today, the challenges that we have seen and the ways we've tried to approach those challenges head on.

So I'm in a rural private practice. So there are five physicians in my practice and I'm the managing partner. So not only have we had to worry about the medicine of this but as an employer of 55 employees. We've had to worry about our employees and their health, their financial well-being and really continue to put them first, which is something that most of us in private practice do a lot. But it really has brought to the forefront when we were decision making. We really had to think about how do we take care of our patients? And then how do we take care of our employees.

And so it has added some unique challenges. And this really has been hard. And I think that in medicine, a lot of times we are trained to not acknowledge the difficulty that we face with what we do. And I do think that our training in medicine has been really helpful in addressing these situations.

And someone asked me yesterday how I felt like, how I was doing personally. And I said, well, you know, for those first two weeks, I felt like I was running up heel 24/7, and then you kind of settle in and I do feel like I'm on the third year of medical school rotation where those first two weeks I was trying to find the bathroom and we get something to eat and not get screamed at but we finally settled into the part where we may not be doing everything

perfect, but at the very least we have a plan. And I think that's really important.

And I really feel like family medicine was really made for a time like this. I feel like we have an advantage because we have been trained to take care of patients from womb to tomb, but also with the importance of the community and family setting in mind. And I think those community collaborations have been critical in our ability to work through these problems.

And I really think problem solving and the ability to be flexible has been key. You know, we've been willing to, one, make a decision. And two, change when your decision didn't work out. And when you make a decision, it can either be great or it cannot be the right thing to do and being flexible enough to say we're going to do this and then if this doesn't work, we're willing to do something else has really been beneficial for our practice as we've tried to make these changes.

And that's something we've kind of done, I guess, all of our careers and we just don't always think of it that way. So our first and obvious and instant challenge was that overnight, our patient visits went down 75 percent. And so as a business owner, we knew that this was not sustainable. And we would have to let some of our employees go and the thought of letting our employees who are like our family go during such a crisis was just not tolerable.

And so we decided we had to do something in order to maintain their employment. And so the first thing we did was transition to telehealth in one day. And we had no telehealth before this, so we did choose a free platform to use because we didn't have any money to purchase telehealth infrastructure. And then we found some challenges with telehealth. You know, we are in rural Alabama. The vast majority of our patients do not have access to adequate high speed internet to do prolong telehealth visits. And so we've had to make some changes. So we're – we recognize that maybe a family member needs to get into the home or that a patient needs to go to the family member's home in order to talk to us. We may need to do part of the visit via telephone and then crucial parts of the visit via video when necessary.

We really kind of learned on the fly and figured out what we were doing. First thing we figured out besides the fact that many of our vulnerable and poor patients don't have access to the video components was that we were missing those pre-visit work things that our medical assistants do . So just like the first speaker mentioned, we quickly figured out that the medical system needed to call the patient first over the telephone and work through all the pre-visit planning that we typically have them do in our office. So that has been a critical change that has really helped.

So the other thing we've done from that standpoint in the office, so we're seeing well patients in the morning and sick patients in the afternoon. We are not big enough to divide up any more distinctly than that. And so, you know, we do have lift physical patients in the clinic.

So two things we're doing is we're having our MA go ahead and call all of the telehealth patients for the whole day, the first thing in the morning so that when we get to them, we can get to them and grab them and go. And so we're letting our telehealth patients know, you know, we could call you anytime during the day. And that has really been well received by our patients.

But the other thing we're doing is we're taking this opportunity to train our medical assistants to scribe. So while we have fewer patients in the clinic, and we were intentionally facing appointment to limit potential exposure to other patients. We have a little bit of extra time on our hands where we can teach our medical assistants to be scribes in the rooms for our visits. And that's really gone over really well.

So, you know, I really anticipate that we're going to keep the telehealth. And I'm not going to focus on that, because then there's a whole section about that. But, you know, I think we need to remember as we do that, that our rural communities are really at a disadvantage with access to telehealth, purely based on lack of access to adequate seeds of internet and access to appropriate devices.

So other things we've used to kind of help our access problem is our patients that have had home health. We use our home health nurses to assist us in the

telehealth visit. We're doing the same thing inside our nursing home to limit our exposures. The nurses are using their own phones to log in to our telehealth platform and assist us in doing video enabled visits with our patients. And that's been really very helpful.

We are doing our COVID testing outside of our clinic. We call it curbside testing. And we're also having curbside waiting. So we're having all of our patients wait in the car, call us when they pull into the parking lot to check in. And then we get them, we call them when we want them to come up, so that there's never anybody in the lobby all together that's been really helpful and well received, been a huge change for our telephone staff. So we've had to really be patient and graceful with them about changing how they do their job all together.

We run our own lab, x-ray, ultrasound, we're a rural practice, we do it all. And so, you know, we really had a lot of people that had to change what they were doing and being kind has been very helpful to do that.

So a couple of other things we've done, so social media has been really huge for us. So we really didn't have a whole lot of social media presence. We threw up some funny names and some cute infographics occasionally. But we realized really quickly that there was a lot of misinformation out and about in the public about this illness. And I serve on our state's committee of public health. And so I felt like I had a little better access to good information than even the average physician, much less our average community member. And so we started doing Facebook live events where we took questions. We answered every question that was asked. We offer a basic medical information. And also basic mental health information.

So I was really inspired by the members of our community who chose to do a quarantine diary or coronavirus diary and search for something positive to post every day. And so, we've really encouraged our patients to try to find something positive, to think about to do something positive with their community. And to really do some activity. We live in a rural community, get outside, walk around, you can – There are lots of activities you can do that

aren't probably what you were doing before, but it can clearly be done in a very safe and effective way.

We've also encouraged our patients to limit their 24/7 viewing of social media or the internet or television news because too much of this stimulus of negativity has been really difficult for our patients. And, you know, we understand that unfortunately 25 percent of Americans don't have a primary care doctor. And, you know, primary care physicians really at this point have been the linchpin to this entire situation to coordinate care and get people where they need to be. And Family docs and primary care docs are really the front lines. We've tested more people in our office than we have tested in our hospitals.

In our community, we actually opened up our testing to every physician in our community. We coordinated with them, set up a little order sheet for them to use. And just let them know, we would be willing to test their patients so that we could throughout the community conserve PPE. And that has been really, really well received by both our other primary care colleagues. So there's only one from your care clinic and sound testing and that's us, but also by our specialty colleagues who really didn't know what they were supposed to do with their patients. And that team has been really well received.

Another thing that's truly been a success for us is that we use our relationships. Our relationships with community members, you know, we really had lots of people calling and wanting to know what they could do for us. And our relationships with our home health and hospice nurses, and then our chronic care management staff. And we coordinated food drives and have taken food to our suddenly huge homebound population.

So, family docs, we have patients of all ages. And we noticed that a lot of our patients we're begging them to stay at home, how are they supposed to get access to basic things they need like food? And we have patients who have really big transportation issues in a rural community. Many times, patients drive into town once a month to pick up supplies. And if you go to your local store to pick up supplies, and there's a shortage, you can't just come back tomorrow. So that outreach has been really amazing for our community. And

we're not only serving our patients that just serving members of our community.

We live near a military base and so we have had a big spread of that where people from other states have called in, or messaged in on Facebook and said, you know, my mom lives in your community and she's not your patient, but she can't get to the store, can also use drop a food basket off at her home. And that's really been very, very impactful for us.

We also use our relationships to kind of reach out and look for other sources. So obviously, our testing is limited and our PPE is limited at this point still. And my dad actually saw on the news where in those first few weeks when I was drowning, where the (EMA) had access to PPE. So I contacted my local (EMA) director, I've never met through our legislator and talked to him about how we could work together. And he had no idea that all physician practices were not owned by hospitals. And so he thought when he had communicated with our local hospital CEO. We only have one hospital in the county, that he had done everything he needed to do to distribute PPE to health care workers.

And so we have developed a wonderful relationship over the past six weeks so that we all now get access to supplies. And that's been really helpful.

We are short on face shields and the State University, which is three hours away created a program to use a 3D printer and create face shields and our local high school happens to have a 3D printer. So our ad shop at our local high school, reached out to our college and they got materials and the template for printing 3D masks. And there we go. We now all have access to face shields.

We couldn't get up with hand sanitizer. And a lot of our local distilleries began to produce hand sanitizer and that's been a real helpful thing for us. We've accepted hands on mask from anybody who would like to give them on nurses has been the hands on mask queen of making masks and that thing great, some friends of ours are making hooks to keep your mask off your ears which have been helpful.

But the other thing that we found really helpful to do is that we have made a lot of how to videos. How to access our telehealth platform? How to get an appointment? How to put on mask. How to wear gloves, and when not to wear gloves? Just basic health information that we've been able to give out and promote through our social media platforms. And those things have been very, very helpful for us.

So, you know, we too are really concerned about our patients that are not getting the health care we need. We know that if our visits are down 50 percent we weren't making a visit for entertainment. So we recognize that half of our patients aren't getting the health care we need.

My very own cousin died during this pandemic from a heart attack because he was too scared to go to the emergency room and stayed home and unfortunately collapsed in front of his children and died. So we've really also started a big social media campaign to make sure that our patients know that we're still available, what our opportunities are for them to seek care. And that we're doing anything they need to allow them to access to care, because certainly their health care is essential. And so we've really enjoyed using these community relationships and our new graphs of social media to try to solve a lot of the problems that have really approached us.

So we've also connected with our other family physicians, trying to figure out the billing process that this is because it's very difficult when everybody bills in a different way, but we're certainly working on that. And that has been a very helpful outreach as well. So once again, thank you very much for allowing me the opportunity to share with you and I hope you all learn something you can take back to your practice and do as well.

Alina Czekai: Thank you, Dr. Jordan. Really appreciate it.

And before we open it up to questions from our college attendees, I'd first like to invite my CMS colleagues to share any reactions or questions with our primary care speakers.

Shari Ling: Hello, so this is Shari Ling, Acting Chief Medical Officer with CMS. I'm a geriatrician and dementia care provider in usual times. But first, I just want to

say really, thank you for continuing to provide care to our beneficiaries. Amazing innovation and ingenuity that we've heard today. And do share one common theme with you is that, you know, we do worry about how do we enable care to continue for those beneficiaries, those patients with chronic conditions who have deferred treatment and management and creating that connection. So I'm curious, and maybe we can get further into this as the conversation goes on. But, you know, what would make that connectivity – What could facilitate that connectivity?

We've heard some ideas today through the community and social media and things. But, you know, really, I do believe that is an important opportunity that's ahead of us that is based on patient needs. So I'll close with saying thank you and then turn it back to Alina.

Alina Czekai: Thank you, Dr. Ling.

Operator, we'd like to open up the line to take a few questions from the phone. Thank you.

Operator: Once again, if you wish to ask a question, please press star one on your telephone and we wait for your name to be announced.

Still, no questions over the phone. Please continue.

Alina Czekai: Thank you. Well now shift gears to a little bit of a deeper dive on telehealth knowing it's an important topic just about to everyone on the phone.

Joining us today is Dr. Sylvia Romm, Chief Innovation Officer at the Atlantic Health System. Dr. Romm over to you.

Sylvia Romm: Alina, thank you so much. And again, I want to echo the thank you to all of the primary care providers that have already spoken today.

The work that you're doing is just so crucial. And I know that many of you are forced to change the way that you are practicing medicine and maybe have been practicing medicine for years in order to accommodate new circumstances. And every single primary care provider I've spoken to, has

just been so dedicated to their patients and so dedicated to providing good care even in times of uncertainty that is truly inspiring to continue to be helping all of the primary care physicians out and all of the physicians who are responding and all the other providers who are responding in this crisis. So thank you very, very much.

So, to take a little bit of a step back, many of the questions that have already been raised on the call are the types of questions that I think about with digital healthcare delivery and telemedicine, not only from a provider, individual provider standpoint, but from a health system standpoint. And it's very interesting for somebody like me that has been practicing with telemedicine and has been organizing departments around telemedicine to see the types of shifts that have happened over the last few weeks, and how that's really changed my role.

For many years, a lot of my role was talking about what it is like to be practicing with telemedicine and really have that clinician perspective and helping people work through workflows and understanding what types of technologies you can use and how you can use them.

And then all of a sudden, there are hundreds of thousands of physicians who now have this experience under their belt. And so I really found that my role as less about introducing telehealth and what it's like, and now it's more about consolidating and understanding what best practices people have found throughout the years and throughout the country, and trying to organize that. So people that have made the switch can start to not only be providing care in the necessary way that they have been, but also in a more longitudinal way and perhaps more standardizes as we move into eventually the post immediate pandemic world.

So when I think about that as somebody who's at the health system level, my first thought is how do we get good information out to all of the providers who are in our health system? Because information is changing so rapidly. And if you rely on for example, a Google search to look up around billing questions or maybe regulatory questions, you will find information that's not

very old, but it's outdated because it's changed so quickly over the last few weeks.

And so as a health system, we've really taken it upon ourselves to consolidate sources of truth and this includes CMS websites or American Hospital Association websites or the American Medical Association website, as well as our own specific information that can that physicians know and for other providers know that they can go to as a source of truth for understanding questions that they have. And so we've consolidated all of this into one website that that can be accessed by everyone in our health system that they know they can go to, to ask questions or to have their questions answered.

And anytime questions come up and we find a pattern in the question. We'll update the website with that information. And so one of the best practices that I found as a health system level is really consolidating that information so people have a place they can trust to go to.

And so, if you look at the types of information that we've pulled together, some of it is simply the basics around what does it mean to practice with telehealth? What is telehealth? And understanding how the regulatory and reimbursement landscape has changed over the last few weeks with highlighting specific areas that the regulatory and reimbursement qualifications have loosened. And highlighting those with the understanding that this is the current environment, people should be taking care of whomever they need to in this way. These reimbursement and regulatory issues were loosened in order to be able to treat patients effectively. But also just have an eye for what has happened before because we know that things will likely change after the pandemic. And so, you know, for example, we have a recommended list of technologies that is going to come from CMS and from other areas that we talked about are available during the pandemic.

And we highlight ones that have always been available and have always been secure as ones that, you know, may be safe or best to start building their practices on right now. Because then we'll be – They will be much more likely to be continued in the future as people move back to the – in a different cadence of their practice.

And so really highlighting those differences and trying to give guidance not only for the present situation, but how we think it is going to roll out in the future.

And I know that one of the physicians earlier made a request to CMS around some reimbursement areas. I think that one of the areas where we're always trying to offer guidance, and anytime we can get clarity on what the future is going to look like, it's incredibly helpful because many of our providers are really changing the way they practice not just for now, but for the future. And they really want as best as possible to be able to change it in a way that's sustainable, that they can continue to build standard operating protocols and be able to build up the practice in a sustainable way as they move forward.

And we are as best as possible, helping our providers around how to actually practice with telehealth. I think that in the first few weeks, we had a lot of the same questions how to do a physical exam? How do you understand which of our patients are amenable to telehealth? And what's interesting to me as well as I found that the extreme increase in volume made those questions actually go away fairly quickly. Because all of a sudden, it wasn't someone trying to do one video visit a week. People were doing 10 video visits a day. And so they were very quickly able to develop their own tips and tricks.

And I echo, again, one of the other physicians earlier said today, being gentle with others, but also being gentle with yourself. I think is important when you're developing this new process. If you are unsure, if you have enough information to be able to complete the visit, you can always appropriately escalate to in person care.

And also, if you find that you do a visit with somebody, and there's maybe a question you forgot to ask, maybe your habits aren't as established. One of the advantages of using technology is that it's – there's a lower barrier for connecting. And so being a little bit gentle with yourself in that one visit and understanding that you can set up another visit and maybe you can hone your skills or get additional information is OK. It's fine to do. And most of the

patients that are being seen are also understanding. And I think it's important to take advantage of that as well.

When we think about the types of people that are coming to us, another best practice is taking advantage again of loosening, for example of the licensor needs is very important as you're taking care of people who really need a different level of care or a different types of care right now.

And also understand that we don't know exactly what's going to happen with the licensure, relationship regulations as we move forward. And so obviously, you need to take care of the patient populations that need care right now. We're also recommending for people to have in the back of their minds, if they're establishing a patient population, that they are not – They don't have the outside of the pandemic licensure for, keeping the back of their minds that at some point, these regulations are probably going to change again. And they should have a sort of re-entry plan as they are thinking about how they're going to manage these populations in the future.

Finally, one of the other areas that I think everyone is getting used to not just in practicing with telemedicine but also as many of us have found other areas of our life moving to video. We have a concept in telemedicine that we called website manner for years. Honestly, it's a similar concept that you probably have seen floating around on the internet.

If you're in any video meeting, there are ways to make you and your environment more friendly to being on video. And so we've really been encouraging providers who are using telemedicine and who are likely be using telemedicine in the future to try to establish these website manner best practices now. Because it's a way to set up a comfortable practice for yourself and your patients even moving forward.

And so as best as possible and understanding that there are a lot of people who are working from home and maybe right now, their home environments aren't as conducive as they otherwise might be. But as best as possible, really try to have an environment where your background is clean. Certainly in all cases, you need to make sure that you're in a secure place, so that, you know, there

aren't other people that could potentially be listening to information that is private.

Again, as best as possible, ensure that you have front lighting so that the person on the other end of the line can see your face. And that you will have a camera distance and angle that is friendly to the other person. So make sure that you're far enough away that they can see almost what is considered like a passport photo, a picture of yourself with your shoulder and your face. And that your camera angle and set up so that it's eye level, so you don't look like – so you're looking down or looking up at the patient.

When you establish these sort of ground rules and you get sort of good hygiene and how you think about using technology to see your patients, you're better able to build rapport. And again, that concept of your patients being gentle with you and you being gentle with yourself extends even further when you have that rapport and when you're able to really continue the relationship in that way. And so those are very high level best practices that are good for you to think about as you're starting out your practice.

Alina Czekai: Thank you so much Dr. Romm. Really appreciate your perspective. Especially appreciated hearing some of your advice on how to really leverage the technology to build rapport.

Before we open up the lines for questions from the phone, do any of my CMS colleagues or our physicians have any comments or questions for Dr. Romm?

Michelle Schreiber: Hi, Alina. Thank you. This is Michelle Schreiber. I am the Director of the Quality Measurement and Value-Based Incentives Group. So to Dr. Romm, I think the explosion of telehealth has been really exciting. And I have a question because the challenge of doing the physical exam at home is one that we get a lot of questions about. Do you see other devices that might be used in the future for this? Or how can people get it some of the physical exam requirements that are needed to see patients?

Sylvia Romm: Yes. No, that's a fantastic question. And certainly there are devices that are out on the market that help with the physical exam. There are several consumer level devices that allow for example, to see the tympanic membrane

or to see the oropharynx or to allow a digital recording or digital transmission of lung sounds and heart sounds. And they have improved so much over the last five years. I can tell you as someone who's been working in telemedicine for a while, there's really a world of difference in quality even in the last five years. That said, I think that the restriction there continues to be the ability for patients to afford and have access to those devices.

And so it – though the technology is improved a lot, and though I certainly know that there are more people out there that have them, I don't think that we're at the point yet where we can truly rely on other devices to be able to do that.

And so for most clinicians, from physicians, they really are having to rely on their ability to one have the patient, help them with the physical exam, and to understand different ways to do a physical exam to get at similar outcomes. And so, you know, for example, I was just talking with somebody yesterday, who's a neurologist in our health system. And we were talking about, you know, ways to do a physical exam through video to look at muscle fatigue. And he mentioned how, you know, one of the ways he's trying out is to have the patient stand up and sit down and for, you know, for him to observe that and to – for him to look at the muscle fatigue.

I think this is all developing over time. And, and it's something now that there are so many, you know, again, tens, hundreds of thousands of more visits being done, that there's just such a substantial amount of data being collected on that right now, as we consolidate again after the sort of emergency pandemic period. I think that we are going to learn a lot as a medical community about different ways to be able to collect this type of information through medium like a video visit.

Alina Czekai: Thank you. Do we have any questions from folks on the phone?

Operator: Yes, ma'am. We do have from Peggy Wheeler. Your line is now open.

Peggy Wheeler: Thank you. Hi. This is Peggy Wheeler with the California Hospital Association. Not really a question, but a strong statement. I just want to add to the course of thank yous.

You know, I've always known, I've been working in rural health for many, many years now. And I've always known and felt strongly that rural is the seat of innovation and the presentation by the physicians this morning just confirms that for me. I'm so proud to be working in the rural space. Thank you very much for what you all are doing every day. It's so appreciated.

Alina Czekai: Thank you, Peggy. We really appreciate hearing that. And we'll have a couple more speakers in just a bit really focusing on rural health innovation. So glad you're finding these presentations so helpful.

We'll take our next question, please.

Operator: Yes, ma'am. From the line of Fran Bell. Your line is now open.

Fran Bell: Hello. I appreciate all the information that you all are giving. It's excellent. I'm with Big Bend Hospice in Tallahassee, and I'm wondering, Dr. Romm, is there a website that you would recommend that other types of healthcare could get to that website and see how to consolidate the information and the website manners, best practices and things such as that?

Sylvia Romm: Yes, there are a few different websites. But if I were to give one at this point, the American Medical Association created a telehealth implementation playbook. Now it was started before the COVID-19 pandemic. And so some of the beginning about it is all about planning, which I feel like many of us skipped right in our state and just started. But nonetheless, there's a lot of great information on implementation and actual practice as well.

Fran Bell: All right, thank you.

Operator: Once again, if you wish to ask a question, please press star one.

Your next question is from the line of (Philip Polikoff). Your line is now open.

(Philip Polikoff): Thank you. I'd like to continue with the compliments. It's been a fantastic presentation. I'm a professor of medicine at Stanford dealing with rural health for throughout America. And there's so much knowledge you presented, is

there a way to get the comments in place for him so I can use the bullets in promoting it nationally. I just think you've done a phenomenal job. It's an unusual experience to hear so many clear voices from different perspectives. So somehow, is there a way to get what was said today, from all the different parties, because they really did tell a story that really is not been shared. So clearly, as was presented today.

Alina Czekai: Thank you, Philip. We really appreciate that. So all of our calls are actually recorded. And so the recording for this call and others will be posted, hopefully by Monday or Tuesday of next week, on our website. And I'll make sure that we send this link out. But it is cms.gov/outreach-and-education. And you'll find all of our recordings and transcripts so you can have accessible to the great information that we've heard from all of our speakers today. Thanks again.

Operator: Your next question is from the line of Stacey Brennan. Your line is now open.

Stacey Brennan: Thank you. I am a family physician and a big shout out of gratitude to all the primary care physicians and practitioners on this call.

I work as a DME MAC contractor, medical director and I actually participate in writing durable medical equipment policies. And I wanted to bring to you Dr. Romm. Two issues have been brought to my attention mostly from suppliers who are getting giving our beneficiaries and supplying them with the needed devices to keep them going at home.

First of all, is it necessary for the physician to acquire a patient consent prior to telehealth visit? And secondly, could you comment on the art of documenting a telehealth visit versus that of an in person visit? Thank you.

Sylvia Romm: Yes, happy to comment. So, yes, you do need a consent. It can be a verbal consent. And so you just need to document it. For our health system, we actually have part of our consent to treat for the entire health system, has the telehealth component consented in it. And so, that was one way that we were able to streamline that and it's one of the recommendations that we have for organizations. It's just to build that in to the consent, for the consent to treat.

I'm forgetting a second part of your question.

Stacey Brennan: I'm just talking about, is there a different way to document a telehealth visit in general compared to one that you would have for an inpatient – I mean, in person visits?

Sylvia Romm: Yes. So, yes. In that, I think most people learn how to do physical exams in person. And so they almost have the same templates that they've used for ages for thinking about how to do a physical exam. And it is a little bit different when you do a telemedicine visit.

I often share example templates with providers who asked me, but it does rely on more visual cues and having the patient help you out for example, with – I said, you know, maybe doing exercises that highlight some sort of physical exam portion that you're trying to look for. Sometimes it's, you know, if you're looking for musculoskeletal, you know, maybe that you'll have, you'll demonstrate how to do an exam to looking for where tenderness is. Things like that, that are a little bit different, but there are stands – there – which has been done often enough so that you have these sort of normalized templates for telemedicine out there.

Stacey Brennan: Thank you.

Alina Czekai: Thank you. We'll take our final question in this segment, please.

Operator: Yes, ma'am. Next question is from the line of (Sandra Nordsell). Your line is now open.

(Sandra Nordsell): I am (Sandra) and I work for a doctor. And this has been so just wonderful information. I did miss the website that you said that we can go to that kind of, you know, puts it all in one nutshell. So I don't have to go all over the place to try and get all the information. Can you just re restate that website for me? I'd really appreciate it.

Alina Czekai: Sure, absolutely. It is cms.gov/outreach-and-education-outreach-opendoorforums/podcasts and transcripts. And again, we'll include this in our

invitations for our next calls and call recap. But it also might be helpful to just go to Google and you can type in CMS podcasts and transcripts and that page should also pop up for you there.

Sandra Nordsell: Perfect, thank you.

Alina Czekai: Thank you.

And so now to wrap up this call. I'm now excited to introduce our next segment, which is addressing COVID-19 in rural communities. As we've heard from many of our speakers and guests on the phone, we know that our rural neighbors have been very used to innovating under unique circumstances, especially related to access and other challenges. So knowing that these best practices and their insights will not only be applicable to rural providers, rural hospitals, but urban providers as well.

So really pleased to introduce first, Dennis Shelby. Dennis is the Chief Executive Officer at Wilson Medical Center in Kansas. Mr. Shelby, over to you.

Dennis Shelby: Thank you, Alina.

First, I want to thank CMS for holding these lessons from the front lines.

Yes, I am the CEO, Wilson Medical Center. We're a 15 bed critical access hospital in Neodesha, Kansas, in a town of 2400 people, and in a county of little over 8000.

We have three rural health clinics serving both Wilson and Montgomery County in southeast Kansas.

What I want to share today is how we have responded to this pandemic. How we have been able to serve our communities in this time.

It involved the utilization of telehealth and curbside visits to treat and serve our patients.

Between the middle of March and April 1, we saw a drop in our clinic visits by 70 percent.

People didn't want to leave their homes. They didn't want – They were afraid to get out of their homes. And that they might catch something in our hospital or clinics.

Our COVID-19 Task Force quickly sprung to action. By the end of March all of our clinics were providing telehealth. And by April 6, all of our clinics were providing curbside clinic visits and curbside lab.

Telehealth, we're providing this in two ways. If a patient has the technology to do Skype or FaceTime, our providers in the clinic conduct the session.

If they do not have equipment or technology, a medical assistant from our clinic goes to the home and provides an iPad so that the telehealth visit can be performed.

We are so grateful to CMS and the President for quick moving quickly to allow rural health clinics to perform this service. It has been well received and the service we trust we'll be able to continue after the pandemic. It greatly improves the access to care, particularly in a rural setting.

Curbside lab and curbside visits. This has been extremely well received. Patients drive up to our clinics and there's signage, directing them to the area to be seen. At our hospital we have a staff person at the entrance to our campus that directs them where to go, and then notifies another staff member via walkie talkie. What they are here for either lab or clinic visits.

At our two offsite clinics, the patient calls the clinic number when they arrive, and the nurses and providers are ready to see them.

Nursing staff greet the patient, take their vitals, assess their situation and then the metal provider comes out to the car and treats the patient. The labs staff do the same. They come out to the car and perform the blood draw.

After info implementing the services, that telehealth and the curbside visit, we have seen our volumes that had dropped 70 percent increase back to 70 to 80 percent of our pre-COVID-19 volumes.

The key success factors are number one, medical providers must endorse and support this way to see and treat patients. We have medical providers from the age of 32 to 81. And they have embraced this way of care.

Flexibility, be willing to make adjustments daily tweaking and improving the processes.

Number three, weather, heat, hot, cold, rain, you need to have a way to provide coverage so that these visits can take place.

On the hospital campus, we've even had to move locations to deal with inclement weather.

And the last thing is teamwork. It takes clinicians and support staff working together to make this work.

If you want additional information, we have put together a packet on how to set up these programs.

It is my hope that CMS will allow us to continue telemedicine services in our rural health clinics after the pandemic. It would also be helpful to receive a payment that is equal to the current encounter rate.

In closing, I would like to say I believe the new normal is going to require these new ways of treating patients.

Thank you again for allowing us to speak today. I find it an honor and a privilege to be able to work in a rural setting.

Alina Czekai: Thank you so much Dennis. Really appreciate hearing your perspective and your insights.

And lastly, I'd like to turn it over to Mr. Lee McCall. Lee is the Chief Executive Officer at Neshoba County General Hospital in Philadelphia, Mississippi. Lee, turning it over to you.

Lee McCall: OK, thank you for the opportunity to be with everyone today. I'd like to start off with just telling you a little bit about Neshoba General. With me today I have Jennifer Phillips who's a family nurse practitioner and Kyle James, who's our I.T. Director. They've really streamlined and been champions of our change that we had in our organization. So towards the end when we have questions and answers they'll be likely more apt to answer those as they come about.

Neshoba General is in a rural part of east central Mississippi. We do have an Indian Reservation that is right next to us. The City of Philadelphia is 7000 give or take mechanics 30,000. We are accounting governmental hospital. So community we've got 160 bed nursing home, we do offer inpatient psych unit. We are a part of an ACO. We have two rural health clinics, two fee for service clinics and a school clinic which Jennifer also manages for us.

We offer your host rural at a Family Care Services, pediatrics, Family Medicine, internal medicine, urgent care, surgery and a host of other things.

Annually, we end up seeing around 55,000 or so annual clinic visits. That's about 150 a day. On around March 16, we dropped 50 percent, then about 75 a day and all of our clinics.

In response to what was going on with COVID-19, we saw as a health system, the need to really preserve PPE, really protect staff, patients we serve and try to come up with some streamlined processes to route patients and keep those patients out of the facilities where they didn't need to be if they could stay out of the facilities.

We launched a tele-COVID screening service manned by Jennifer, essentially patients would call in if they were symptomatic or the worried. Well, they would go through the screening process by Jennifer and her team and if they met the mark to be tested, we would send them to our mobile testing site.

If they maybe had something else going on and needed to be saying we routed those patients to our Urgent Care Clinic or their family care provider. Saying after we launched there and it was very successful, we were keeping people that weren't symptomatic from coming into clinic could be tested and we were, again preserving PPE so that we could manage the way that we saw coming.

Soon after that test, Kyle was really getting us a telehealth initiative rolling. We'd never utilize telehealth here except for in limited circumstances with distant site providers. Kyle and Jennifer worked on this and we selected a program, MEND, M-E-N-D as our telehealth platform. And we got contract signed and quickly were able to launch telehealth on April 1 with existing patients. Jennifer was able to see the first patient on that day. Again, she was spearheading this for us.

And the next coming days, we started seeing all existing patients and all of our provider sites. We're able to get up to in this month alone, right at 300 telehealth visits. We were down 50, 60 percent of what we've normally seen in any given period of time. We're now right at about 65 to 75 percent. So we are catching people that otherwise needed to be seen. They were staying out of out of our settings. The same time we were keeping those folks. They were not needing to come to the ER, out of the ER. Our ER volume we usually see 60 patients a day. It's down to about 30. But we're seeing the true emergencies and people aren't scared, I guess you'd say, to come to the hospital because we've taken all these proactive measures to route people to their favorite locations.

I'll tell you that telehealth expansion is a major strategy of ours right now. We are looking at ways that we can deploy that in different ways. As I mentioned, Jennifer manned a school clinic. And it's been very successful. We also have other schools in our community that we'd like to start providing those services to but quite honestly, it's been difficult to justify nurse practitioners in those locations. So with telehealth we believe we can start leveraging that technology to begin seeing those students and those teachers or administrators in those various school settings, keep students helping well in school and keep the sick out.

I want to also say that we work with a lot of businesses in our communities on wellness type works activities. So we're looking at ways that we can deploy telehealth in those workplace settings. Again, to keep employees safely working at work when they need to be or being able to see a provider without having to go to the waiting room is truly transformed the way we look in approach medicine at this point in this lifecycle. Anyway, and, and we've really had great adoption by providers. I mean, it's truly been a great team effort. I can't thank our providers enough. Kyle and Jennifer, they're on the phone with us here. We've been able to do some amazing things in a short period of time.

I want to say thank you to all of you at CMS, and all of our legislative folks that are in Washington or in our local states and those regulatory bodies that have freed us up and allowed us to be flexible and really innovate with technology. This is absolutely being a permanent way that we can continue to be viable and sustainable in our own rural communities. And thank you for that. I want to ask for, you know, continued effort to make this a permanent fix for us and not just a short term waiver as we go through this pandemic.

With that being said, the last comment I'll make is we've done similar education. We've posted on our Facebook, we've done live video feeds, educating the public on various things. We've done a video of the telehealth program and from the user standpoint, how you use technology and things like that. So, with those comments, I'll get back to you. And we'll be ready here to answer if anyone might have. Again, thank you for the opportunity.

Alina Czekai: Thank you. We really appreciate it. Operator, do we have any questions from folks on the phone?

Operator: Again if you wish to ask a question, please press star one.
We have a question, please state your first and last name. And your line is now open.

Excuse me, please state your first and last name. And your line is now open.

(Tracy Frets): Hello, this is Tracy Frets isn't my line?

Alina Czekai: It is. Hi, (Tracy).

(Tracy Frets): Hey, good morning, from Portland, Oregon. My company provides rehabilitation services in about 90 nursing homes across the country. Nearly all the speakers today have really eloquently mentioned the benefits of telehealth during this pandemic and beyond. However, the benefit has not yet been extended to Medicare beneficiaries who need physical, occupational or speech language pathology services. And so I'm wondering why the Department of Health and Human Services hasn't used their authority granted by Congress under the Cares Act to expand telehealth services to rehabilitation professionals.

Emily Yoder: Hi, this is Emily. Emily Yoder, I'm an analyst in the Division of Practitioner Services in CM, and I work on telehealth. We are currently looking into how best to utilize the Cares Act waivers which you do point out, give us the authority to waive a number of the restrictions on Medicare telehealth that are in the statute. So we're definitely working on that. We really appreciate the comments.

(Tracy Frets): Thank you.

Alina Czekai: Thank you. Any other questions?

Operator: No further questions at this time. Please continue.

Alina Czekai: Well, that concludes today's presentations. I'd really like to thank all of our speakers today for sharing your insights, best practices and just allowing us all to come together to learn from one another.

And in the meantime, if you have any questions or comments for CMS, you can continue to direct them to our COVID-19 email box, which is covid-19@cms.hhs.gov . And as always, please don't hesitate to contact us with any questions. We look forward to our continued collaboration and just appreciate all that you are doing for patients and their families around the country. Have a nice rest of your day. This concludes today's call.

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