Centers for Medicare & Medicaid Services
COVID-19 Call: CMS Front Line Learning
Moderator: Alina Czekai
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4:00 p.m. EST

OPERATOR: This is Conference # 4647687

Ladies and gentlemen, thank you for standing by. And welcome to the Lessons from the Frontline COVID-19 Conference Call.

At this time, all participants are in a listen-only mode. After the speakers' presentation, there will be a question-and-answer session. To ask a question during the session you will need to press "star" "1" on your telephone. If you require any further assistance, please press "star" "0."

I would now like to hand the conference over to your speaker today, Ms. Alina Czekai. Please go ahead, madam.

Alina Czekai: Thank you, Operator.

And I will turn things over immediately to Administrator Seema Verma. I'd like to thank all of you for joining our call.

Administrator, I'll turn it over to you.

Seema Verma: Thank you, Alina. And thank you all for joining us this morning.

This is one of – it's our very first call, which is supposed to be a series of calls that we're calling CMS Frontline Learning on COVID-19.

We've spoken to many of you before on our other regular stakeholder calls, but this one is going to be a little bit different.

We're going to be, in some cases, giving you some updates. But the purpose of this call is really to offer a forum for providers around the nation to share

with leaders and with one another the innovation that's taking place at the local level around the COVID virus response.

I'm going to cut short my comments this morning because Dr. Birx is joining us, and I know she's going to get to another meeting. But she wanted to take a few minutes to address this group. And hopefully she'll be back with us on another day.

But Dr. Birx, I'll turn it over to you.

Deborah Birx: Thank you so much, Administrator.

I just want to really, again, thank you for setting up this Innovation Learning Call because I think it's really critical.

We have been getting reports from the frontlines but more of an anecdotal way. And we think that many of you have developed solutions that are key for our success.

And why is this particularly critical? I know all of you are watching New York very carefully. I just want to be very clear that the attack rate normalized per population in the Metro New Jersey, Metro New York City area, is about four to five times any other region in the country. Again, normalized per population.

So I know you know that they account for 60 percent of the new cases and 56 percent of all cases, but only right now currently, 31 percent of all the new deaths.

So if we can learn from you all that have been on the frontlines of the previous hotspot (which was out) in Washington State, and really make sure that we're carrying your messages as you continue to confront this in a clear way throughout the country, and really learning from you all.

I think Administrator Verma has been excellent in really staying in communication with you all. And we want to make sure that we're using our federal platform and voice to bring your learnings to scale.

So thank you very much. And I just, again, thank you for what you've done.

Seema Verma: Thank you, Dr. Birx.

And Dr. Birx had to run to another meeting. But I'm sure she'll join us on another call to be able to give you different information that's going on.

What our – what we want to be able to accomplish on this call, as she said, give you an opportunity to share best practices. We'll also give you updates as we are developing rules, regs, kind of the latest announcements, so that's also an opportunity to get information.

I'm also going to have my team on, the CMS team, because we're going to be – we want to hear the challenges that you're facing. And if there's anything that we can do from a regulatory standpoint, we will certainly be attuned to that in adjusting our policies and regulations.

I don't want to take up this call in terms of what CMS has planned. But I will tell you that we will have a very significant expansion in waivers and a new rule to give you a lot more flexibility. But that's in the works. It will probably come out later this week, and we can talk about that when it comes out.

The other person that we have on the – on the phone is Dr. Giroir. I'm not sure he's on the line yet. Dr. Giroir, are you with us yet?

Alina Czekai: Administrator, I believe he'll be in just two minutes or so.

Seema Verma: OK. That's fine. We'll just keep going.

So when Dr. Giroir joins us – Dr. Giroir is heading up all of our efforts on testing, to try to increase testing. We know that that's been a major concern, along with supplies. And he can talk a little bit about the supplies as well, but his focus is mostly on testing.

But again, today, we really want you to be able to have a forum to talk about best practices. And I think today we teed up a few topics. My guess is, we won't get through all of them. But patient triage, telehealth, workforce challenges, and then just other topics.

And we're really going to count on the group to identify the types of things that you want to spend time on. And also ask for volunteers. You may have come up with a great strategy that you want to share across the nation and don't have time to write a big journal article, or something like that. But this could be a forum for you to share with your peers across the nation some of your best practices.

So I think that Dr. Giroir just joined us. And I want to be mindful of this time. We will be rotating the taskforce members and some of our other leads in different areas to come in and address this group. And so we're very lucky that Dr. Giroir is able to take a few moments of his time to give you an update on the testing situation.

Brett Giroir: Thank you, Administrator Verma. And thanks for everyone being on the call.

As you all know, testing is a rapidly evolving process with new tests coming on the market literally every day, as well as laboratory-derived testing.

I would say that there are a couple of major issues that have just surfaced.

Number one – or opportunities is number one. The FDA yesterday, after a study we were working with, with the United Health Group and Gates Foundation, approved the use of foam swabs instead of all the fancy flocked swabs or in addition to them for nasal testing.

So that does not mean nasopharyngeal but a foam swab that could be self-administered nasal instead of the flocked provider. What that does is it opens up a whole another market of swabs, probably 6 or 7 million that are on the market now with generally unlimited supply, as well as the ability to do this without changing PPE because there really is no PPE recommended. I hope that will open up the front side of the equation.

On the back side of the equation, as you know, Roche, Abbott, Qiagen, Thermo Fisher, all have tests on the market, depending on what laboratory you have.

There is now a point-of-care test from Cepheid, of which 60,000 cartridges will come out. This is going to be very important to many of your hospitals. And we need to get input on who has machines, who needs machines.

But this is a 45-minute turnaround, relatively low throughput depending on the number of machines. But it's going to be critical as we think it for hospital testing, for infection control, and for diagnosis, as well as for nursing home.

But my team is ready to field questions or – and to answer questions as you need it. And I'll be on the call to understand what you need as we go on.

Thank you Seema. Thank you Seema.

Seema Verma: Dr. Giroir, why don't we open the line to ask a few questions? And in that way, we can move on to a different topic.

And I know you got a lot of pressing issues to deal with. So why don't we just open the line? And if people have specific questions for you, why don't we can go ahead and get those addressed?

Operator, would you please open the lines for Q&A?

Operator: Thank you.

Just a reminder, to ask a question, you will need to press "star" "1" on your telephone. Again, to ask a question, press "star" "1" on your telephone. To withdraw your question, press the "pound" key.

Please stand by while we compile the Q&A roster.

Brett Giroir: While we're waiting, I will also say that we formally put out in our communicating priorities for testing, and several of the major reference labs are acting on that. I need to get a daily update.

I know Lab Corp did it yesterday so that hospitalized patients will be given a separate code to have priority. What we don't want is the low-risk people who are getting tested from all over the country in a variety of situations to dilute

and to put back in line the people who are in the hospital or ICUs, if you're using the central services.

So I just want to make that while we're waiting for questions.

Seema Verma: Operator, do we have any questions?

Operator: Person on queue, please state your first and last name. Your line is open.

I'm sorry. That is Pamela Hoffman.

Pamela Hoffman: Hi. I have a question about telemedicine. So I can wait.

Thank you.

Seema Verma: Well – and bear with us. I think we have about 5000 people on the line today. So it's a lot to manage.

If people have particular questions on testing, if, Operator, you're able to open the line. Otherwise, we can move on with the rest of the agenda.

Operator: Thank you.

Next question comes from the line of Lori Wightman. Your line is open.

Philip Fracica: Hello. Can you hear me?

Seema Verma: Yes. We can hear you.

Philip Fracica: This is Dr. Philip – this is Dr. Philip Fracica.

We have been notified about the availability of a 15-minute turnaround IgM/IgG rapid test, that's an antibody rather than a nucleic acid testing. Is that something any of you are aware of and know if that is available for clinical use?

Brett Giroir: This is Brett Giroir. I am not aware of that. And the FDA, as of last night, is not aware of it.

But remember, in the milieu you have, some states have basically the regulatory authority of the FDA and thesetests could be out there if they're notified to the state. But according to the FDA, there is not a notification to them about this test in (Q4) and EUA. And there's not an EUA.

If you have any specifics about the test is and the manufacturer, can you send it to me? What is it? And I will track it down and get a general ...

Philip Fracica: What is your e-mail?

Brett Giroir: Well, everybody knows it, brett.giroir@hhs.gov. B-R-E-T-T-.-G-I-R-O-I-R at hhs dot gov.

Philip Fracica: All right. Thank you.

Brett Giroir: Let me also say that the FDA, it's on there. If you do FDA coronavirus FAQs, there's a 24/7 hotline that you can call them at any time to answer that kind of question. We set that up about a week-and-a-half ago.

And if they don't know, it goes right to Jeff Shuren. So we want to make that available for these types of things, as well as substitutable reagents, et cetera.

Operator: Next question comes from the line of (Amy Davis). Your line is open.

(Amy Davis): Hi. This is (Dr. Davis). Thanks for taking time to do this.

Do you know that there's a difference in specificity and sensitivity with the new swab?

Brett Giroir: We're based on very limited data, right? So this was – the data was supplied to the FDA. This was a study done on 600 suspected patients with four matched swabs - tongue, self-administered nasal, self-administered mid-turbinate, and a classic nasopharyngeal flocked swab.

And essentially, it was the mid-turbinate, the nasal self, and the nasopharyngeal. I have reviewed all the data. But according to the Jeff Shuren, were nearly identical. The tongue swab and oral is much less sensitive.

So based on that, the FDA put out that it's substitutable. So – and again, we're dealing with limited. That's a number of 600, with about, I think, it was 36 positives in that. But that's what we have. And so we're not seeing a loss in sensitivity.

Now based on the Seattle Flu Study, which is a Gates-Seattle Flu Study that they've been doing self-swabbing for 29 other viruses for the past few years. The self-swab nasal is really identical to the nasopharyngeal. We just didn't know it for COVID-19. And it was important because it has (pre-election) for the lower respiratory tract.

Let me also say that the CT number was taken, so the cycle number on the thermal cycler, to understand how many amplifications you need. And it was nearly identical for nasal, as well as nasopharyngeal. The oral/buccal was much higher and therefore it's still not recommended.

I hope that answers your question.

(Amy Davis): It does. Thank you very much.

Operator: Next question comes from the line of Bettina Riveros. Your line is open.

Bettina Riveros: Thank you. Bettina Riveros, Christiana Care in Delaware.

We've been working – you mentioned the Roche's and Cepheid's point-of-care test. Who's the best contact on that? We've been working to try to get reagents for our Roche 6800. Any further information on how we can connect on that? Or if there's an alternative that would work for us, it would be great to have a contact point, thanks.

Brett Giroir: I think the Roche reagents are really in short supply. This is their large high throughput system, right, the 6800? Is that right?

Bettina Riveros: Yes. I understand.

Brett Giroir: They only have 400,000 tests available. We are not directing them in any way, except they told us they were shipping to the biggest hotspot, until they

can up their production. Meaning, New York, Washington, and some of the reference laboratories. So I don't have a handle on that.

On the Cepheid, do you have – do you have the platform itself?

Bettina Riveros: We would have to confirm that.

Brett Giroir: OK.

Bettina Riveros: We have the Roche 6800 machine.

Brett Giroir: Yes. But they're totally different. I mean, the Cepheid machine, you're really only going to be doing – their highest throughput is 64 samples at a time. Most machines are 4 to 8. So this is a whole different con-ops.

But it could be very useful. Like in an ICU, if you need to know a diagnosis, or you're in a nursing home. So it's a whole different – a whole different platform.

So Roche, I don't have any answer because Roche has very limited supply. They're supposed to be ramping up their supply. But again, it's only at about 400,000 test level per week. And that is not enough to supply all the labs.

Bettina Riveros: OK. We actually – we do ...

Brett Giroir: We have not interfered in that – yes.

Bettina Riveros: We do have the Cepheid machine. So if we could get a contact for that, that would be really helpful.

Brett Giroir: OK. We can – OK. We can supply – so Cepheid is going to be doing their supply through their normal – this is sort of in real-time here – but through their normal channels. We are going to work with them to make sure that the US domestic market is supplied.

But we don't intend to – our intent right now is not to interfere with their supply chains but to let them answer the orders that they're getting from

throughout the United States, as long as the hotspots are covered. So it's from their normal Cepheid supply.

And again, they only have 60,000 tests this week. So that's not going to be enough to go around the country. But it should be used for those really priority patients where you need to know in 45 minutes. We certainly don't want people to use this on a worried-well or other people. It's really for actionable data that should need it in the first hour.

Bettina Riveros: I appreciate it. We've been trying through the supply chain. What they've told us is they shipped to Italy. So thanks.

Brett Giroir: That Cepheid ships to Italy?

Bettina Riveros: That's what our supply chain was told by them.

Brett Giroir: So our intent is to make sure that that doesn't happen.

And again, this is in real time. But with the Defense Production Act, we have the ability to assure that it gets domestically to high points. And by the end of the day, we will have that worked out.

We want to be fair to around the world. But this is our only point-of-care diagnostic. And it's the Administration's intention to keep that domestically until there are more supply.

Bettina Riveros: OK.

Operator: Next question comes from the line of (Mike Largo). Your line is open.

(John Ferrell): Good morning, Admiral Giroir. This is (John Ferrell) of HCA Healthcare.

First let me thank you so very much for your exceptional leadership and the hardwork in the important area of lab testing.

This may be more of a comment because it was alluded to between the times that the operator open the line. But I just want to emphasize the importance of prioritizing lab testing for the in-hospital patients.

It's not only important in terms of getting the answer. But we have 30 patients in some markets for every COVID-positive patients, or PUI. And very difficult to – provide disposition for it, because post-acute care won't take patient absent a negative COVID tests.

We can argue about the merits of that. But the most expeditious route for patients who have been languishing up to a week would be to accelerate and prioritize the testing.

The other point obvious to the team is that, those PUI patients burn the same amount of PPE as COVID-positive until they're ruled out.

So anything you can do to prioritize the testing in all means is much appreciated.

Thanks so much again.

Brett Giroir: So thanks, (John).

If you have any ideas – from my standpoint, obviously your in-hospital tests are going to prioritize who you prioritized. What I've asked the ACLA lab is to follow the prioritization that we put out as official guidance yesterday.

I know LabCorp is doing it now with a separate code for hospitalized patients as they go to the front of the line at their testing facilities. I will check with ACLA.

But if you have any other strategy, please let me know. We are certainly going to prioritize point-of-care test to hospital systems as opposed to drive-throughs for the worried-well.

If you have any other ideas, I can do it on the backside with ACLA. I assume you're doing it in your hospital. Just let me know and we'll do it.

(John): Will do. Thank you very much.

Operator: Next question comes from the line of (Derek Greenwald). Your line is open.

(Gerald Caden): Hi. My name is actually (Gerald Caden), in the laboratory.

I see a lot of concern about the NP swabs. To be honest with you, our biggest problem is the viral transport media. We run these molecular tests. And while we have the swab, you can't typically go from swab to instrument. They have to be pipe-headed. So we have to have some type of matrix.

So without that viral transport media, our respiratory pathogen panels, our COVID testing is still limited for big hospitals or small hospitals, both.

Brett Giroir: OK. So ...

(Gerald Caden): So we allocated five a week.

Brett Giroir: So please go to the FDA FAQs. The FDA has approved sterile saline as a transport media. So that should eliminate that problem. We just need to get that information out there. There are a couple of alternatives aside from VTM.

So that should – I can't – I don't know the data on that. The FDA says it's an acceptable alternative. So I would suggest ...

(Gerald Caden): It has to be validated right now. The only lab is LabCorp that accepts that. So Quest right now is not accepting saline, if you go through them. They may have changed but they still want to do their own validations.

So LabCorp has done them. We just got an e-mail this weekend that they're taking frozen saline. So – and that is helpful on the COVID.

Brett Giroir: OK. That's good information.

I know what the FDA had said is acceptable. I do not have the detail down to the reference lab of what they're taking. And I will take that as an action item to see if we can get some systematic work on that.

Thank you.

Seema Verma: Well thank you, Dr. Giroir. And I want to be mindful of your time.

We will be having these calls regularly. And so we can bring Dr. Giroir back. And we could also bring somebody from the FDA to answer questions as well.

I appreciate all the great information here, Dr. Giroir, and your time today.

Let's switch gears.

And I think one of the other topics that we thought we could focus on today, given all of the work and all of the flexibility that we're doing around telehealth, not just in Medicare but across the insurance industry; some of the flexibility that we provided around HIPAA to allow physicians to use Skype and Facetime, and things like that, I think hopefully has helped.

Also in Medicare, we're waiving copays. And I believe that a lot of the commercial insurance plans have done that as well.

And so what I thought would be helpful today is (the peer) from those on the frontlines.

I believe that we have Dr. Alison Haddock on the line. She is Assistant Professor of Emergency Medicine at Baylor College in Texas.

Dr. Haddock, are you on the line? Do you want to make a few comments about some of – how you've been using telehealth?

Alison Haddock: Yes, I am. Thank you so much for introducing me.

I'm a member of the Board of Directors at the American College of Emergency Physicians. And in that role, I'm hoping to support our members around the country who are involved in telehealth. And I can really say that we're seeing emergency departments around the country adopting telehealth that have never used it before.

On my shift last night, for example, I used an iPad to reassess a patient. And this is the first time that I've ever done that in my emergency department.

Doing that allowed me to preserve PPE while reducing staff exposure to the patient, but still allowed me to provide a high quality of care to him by visually reevaluating him and answering all of his questions.

That's a great example of something that your new regulations have allowed us to do.

Another place that we're seeing increased use of health with that point-of-entry in the emergency department. And we're developing an app that's almost ready to roll out to help triage our patients into the separate waiting rooms for patients with potential COVID symptoms versus those without those symptoms.

But our members around the country are still asking for a little bit more guidance around telehealth, particularly at the point-of-entry in order to know whether telehealth can be used to satisfy the MSC under EMTALA.

They also have some questions about the ability to use our usual emergency medicine, E&M codes, for care delivered by emergency physicians for an emergency complaint via telehealth. And adding those to the approved Medicare codes would better reflect the intensity of the services that we're providing.

We appreciate what's been done so far, including the guidance that was given during the Ebola outbreak. But we do need a little bit of additional guidance to help us expand the use of this modality in order to preserve PPE and preserve our healthcare workforce while still providing excellent care.

The College of Emergency Physicians is accepting stories from our members. And is really happy to continue this dialog with you, and share examples of how we're using telehealth. And I thank you again for the opportunity to join this call.

Seema Verma: Thank you. And you will be seeing more from CMS.

I think we recognize that there could be more done on telehealth. Also within Medicare, there's a lot of requirements, as you all know, about face-to-face requirements, which we are looking to address, as well as specifically giving more flexibility to emergency rooms to use more telehealth.

So we're in the process on that. And I appreciate your detailed comments.

I think we should – fingers crossed – we'll get something out in the next few days here. So I appreciate that.

Also, I think we have Dr. Peter Hollmann from Rhode Island, who is also a member of the AMA. Dr. Hollmann, do you want to talk about how you're using telehealth?

Peter Hollmann: Thank you very much for the opportunity.

And again, I'd like to also echo, so thanks for the site of service waiver and HIPAA requirements.

In Rhode Island, this has been the silver lining, if there is one, to this problem that we're all facing, if we're bringing telehealth to every practice. It's helped us take care of our patients and help keep the practices open and running.

There are several things that we're doing in Rhode Island, which may be different, and other states may be doing the same.

We have a Health Insurance Commissioner. And the commissioner was very concerned, as were many of the payers and the practices as well, about making sure we can get care to everybody who doesn't have access to the real-time audio/video type of format, and also to the deliverable primary care and mental health services.

So we have a regulation that took effect this past week that requires all services that can be delivered in-person, that if they can be appropriately be provided by real-time audio/video, or by audio alone, in other words, just the telephone call, those services must be covered by the payers and they must be

covered at the full amount that would be covered for our participating payer if they were done in person.

Some of the plans have also waived copays for those types of services. That's not uniform. That has been extremely helpful.

There are many questions when such a rule is implemented.

And so one of the things that is extremely helpful is to have consistency in policy. Things, such as which modifiers to use, what are some of the rules.

Questions have come to me, especially, as was already mentioned about the documentation guidelines, the CPT definitions, when for certain services there is a very limited exam component.

So we are writing that. The AMA is putting out coding guidance as well over COVID. And I'm trying to help both locally and with the AMA on that.

I think it's important to recognize the way Medicare sets a standard for everybody. And I think that once the leadership is shown there, which it has been, it helps everybody sort of fall in line to get consistency.

And it's very important that the Medicare Advantage plans follow all the requirements that CMS has set for the traditional Medicare fee-for-service.

As you heard from the emergency room physician, it's important that these services be available in all settings.

As a primary care geriatrician, I would not have necessarily been aware of this. But because of my role, and my multi-specialty group, which does hospital care and critical care, I realized that due to the shortage of personal protective equipment, we have people in the hospitals and in nursing homes that are also providing services by telemedicine.

That is the safest way that they can provide patient care both to their health but also to the health of the other patients in the facility.

And rules, such as requirements that skilled nursing facility can only have telehealth services once every 30 days, and cannot be used for the mandatory visits, are the type of detailed thing that does need to be looked at. And we know that CMS will be evaluating these types of issues as well.

So we're very thankful for this. We're looking forward to working through all the problems and getting the details resolved so that we are able to deliver this service to everybody. And I think the first most important step is to include telephone or audio-only services.

Seema Verma: Well, Dr. Hollmann, we hear you. I think both of those issues, the nursing home limitations – I think our first step was just to get the telehealth out there sort of more a part of the emergency declaration knowing that we needed something ASAP.

But we're in the process of kind of going through a lot of those, what I'll call additional barriers, in the Medicare program - 30 days, telephone calls - all of those things are being looked at. Unfortunately, those require us to go through rule-making.

But our team has been working around the clock. And you all should see something pretty shortly on that. But I appreciate you raising the issue.

I think we also have (Dr. Harmon), who is a family physician who's implementing telehealth. And again, if you can just tell us a little bit more about how you're approaching it in your office that maybe helpful for your peers. Thank you.

Do we have (Dr. Harmon) on the line?

OK. Well, maybe not. So maybe we'll try to hear from (Dr. Harmon).

Any other – just before we switch topics here, is there anybody else that would want to say a few words about telehealth? Any best practices or techniques that they're using that are useful that your peers may want to hear about?

Operator, can we please open the line to the audience? Thank you.

Operator: Again, to ask a question, press "star" "1" on your telephone.

First is Norton Elson. Your line is open.

Norton Elson: Hi. I'm from the Adventist Healthcare.

And we're concerned about our older healthcare workers. Is there any recommendation or guidelines regarding healthcare workers who are aged over 70, or have other conditions, which would predispose to COVID or COVID complications?

Seema Verma: Sure. I would refer you to the CDC website. I think what we're – this segment of the conversation is about telehealth. So if people have suggestions on telehealth, best practices, I think we'd want to focus on those questions. But my counsel to you would be to go to the CDC website.

Norton Elson: Thank you.

Seema Verma: Do we have any ...

(Alina Shakai): Go ahead.

Seema Verma: Operator, do we have any more comments on best practices around telehealth? Thank you.

Operator: There are no on the queue at this time.

Presenters, please continue.

Seema Verma: OK. The next area that we wanted to, at least, spend a little bit time on was workforce challenges.

I think the last question was sort of along those lines, is what workforce challenges are causing the most strain? What strategies have you been using to help address these challenges?

I think we've heard some facilities or hospitals establishing new or existing programs on child care, or meals, anything that people want to speak to, I think we can open the line on that.

And Dr. Mark Victor, who's a cardiologist from Philly, if you're on the line, I've heard you may have some suggestions.

Mark Victor: Yes. Thank you again for the opportunity, Administrator Verma.

Just to answer the last one, I did try to signal in but I couldn't about telehealth, because I think they really both go hand in glove.

So our practice is a cardiology practice, and I'm on this call on behalf of the American College of Cardiology.

We, on Monday, the 16th, our practice which is a fairly large practice throughout the five counties of Greater Philadelphia Metroplex, we went to a virtual telehealth relationship. We had all of our employees, all 450, non-provider employees working from home.

We initiated, as of Monday morning when we began, that each visit would be as parallel to a regular in-face office visit as we could. So we had our medical assistant and our front desk people call the patient, tell them that they're about to have their visit, why we shifted from offices after notifying virtually all of them by phone over the course of the weekend.

And then just as our workflow would have been in the office, the medical assistant will call the patient, go over their list of symptoms, go over their active medications, any new problems that have occurred, lab work if it was available scanned into the system. And then said that the physician will call them back within 5 to 10 minutes.

And indeed, when I would then call the patient, and my colleagues, we would entertain a full host of the same questions, the same areas of specificity of that particular patient's problems that we would have in the office. If they had a scale or a blood pressure cuff, we would have them take it at that time, review lab work, change medications if necessary. And that was our telehealth visit.

We found that the video component, especially in older patients and some of our inner-city patients became more of a confusing delay in care, and became sort of, in some cases, a circus. Patient is not wanting to be seen. They weren't dressed appropriately, embarrassed by their lack of aptitude. And we found that more of a hindrance than a help.

We also created six triage centers out of our 35 offices that were regional. We said that those offices would be properly staffed with physicians and staff that were protected. We would screen the patients before they enter the triage office with their temperature and questions.

And what we found was, expecting those triage offices to be quite brisk in volume, we found that the amount of patients that had actually be seen over these last eight days was surprisingly low for cardiology practice that typically see huge numbers of patients. Then we've shrunk those from six to three. And today, we only have one open seeing about a dozen patients.

As it relates to the employees, needless to say, we had it convert a lot of employees. About 75 of our employees were involved in advanced imaging. And since we've cancelled all advanced imaging, we preserved their incomes but shifted them to this type of called Triage Outreach Telehealth to prepare the patients both for the next visit and beyond.

How long we're going to be able to maintain that, of course, is questionable. But so far, we've made that commitment to our entire workforce. All of whom continued to work from home.

I hope that answers some questions. And I'll be happy to answer any further, if I can be of help.

Seema Verma: I'm just going to pause there for a second. That was a great overview.

Does anybody have any questions for Dr. Victor?

Operator, can we please open up the line for questions? Thank you.

Operator: As a reminder, to ask a question, press "star" "1" on your telephone.

Person on queue, please state your first and last name. Your line is open.

For the person who queued in for question, your line is open.

Stephanie Vanterpool: Hi. My name is Stephanie Vanterpool. Can you all hear me?

Seema Verma: Yes.

Mark Victor: Yes.

Stephanie Vanterpool: Hi. I'm at the University of Tennessee, a University Anesthesiologist, on Pain Medicine Practice.

And our challenge has been – I'm curious about converting non-medical assistant employees to be able to still help the practice produce revenue during this challenging time.

I'd like to hear more about your call tree, how you're repurposing some of your other employees? And what type of hours they're able to capture with the different types of phone calls? And what types of phone call questions they're asking the patients? So you can keep the practice running, generate revenue that appropriately compensate your employees for the value they're bringing.

Mark Victor: So we have not utilized anybody but our provider staff, which is physicians and APPs to actually be the forward-facing team to patient care. But we've used all of the non-provider workforce to prepare those patients for the calls to get all the reference data which used to be streams and streams of it by faxes to the office. And now we're doing it in an electronic care medium.

We do have some of our provider support staff working non-traditional hours because of the children at home. And so we have found that forward-reaching the patients for the visits tomorrow, the next day, the next day, many times, because they're also in a home environment, some are home-schooling, some are taking walks with their kids outside, they're not as available as traditionally they should or would have been.

So off-hours phone calls is actually then a key strategy to engaging a larger percentage of patients to be prepared for their next-day visit. So yes, we have definitely used non-traditional time. But we have not used any non-provider as an actual provider of telehealth care.

I hope that answers that question.

Stephanie Vanterpool: It does. Thank you very much.

Operator: Next question comes from the line of Gregory Esper. Your line is open.

Gregory Esper: Hello. My name is Dr. Gregory Esper. I'm the Associate Chief Medical Health Officer for Emory Healthcare.

And this is a question for the presenting physician. And I also have some best practices from telehealth from our perspective that we could share if there is time.

The question that I have for the presenter, especially cardiology, is, for your patients that are – that you are delivering care at home, and are – that are still requiring a cardiac exam, and that would potentially include new patients, have you deployed any technology to their home, or have advised them on any technology so that you could potentially examine the heart electronically, the heart and lungs, to be able to document the cardiovascular and pulmonary exam? That's the first question.

Mark Victor: Yes. Sure. I mean, crucial, clearly to our field – and each member on this call has their own fields where certainly key elements of their exam are crucial.

So for new patients, obviously, we've had people referred for new heart murmur, new rhythm, or palpitation disturbance. So those were exactly the kinds of patients that would be then re-referred from the screening telehealth cardiologist to one of these triage centers that I alluded to, where they would actually be seen in person by one of the team.

We've been working with a number of telehealth companies. And we actually have a project we're working with Philips to do exactly what you suggested.

But it is not yet online. And we don't have it as a part of this outreach. And we were in the early phases of rolling it out.

So it's sadly about – this crisis is a few months too early for our particular level of expertise. But many perhaps on this call have already deployed those physiologic tools to enable further outreach.

We do find, however, and I talked to one of my primary care colleagues the other day about this, sending a patient for new heart murmur. While really important, I still believe that the crucial elements of the decision tree of whether that patient's murmur is going to be relevant for an immediate care decision can mostly be handled by history.

Because even if their mitral regurgitation is moderate or severe by exam and echo, the crucial area of the decision tree is, are they symptomatic? Or are they shorter breath? Or are they having trouble laying flat? Or are they having palpitations? Do they have edema?

And so by going through those things, I believe we've still been able to give appropriate triage; while we still have to answer that question, is it moderate or severe MR? I think we can still outline a a care path for that patient at this moment.

Gregory Esper: Thank you. That's a very helpful answer.

May I ask some questions of the CMS team, while I have the time?

Seema Verma: Sure. Go ahead.

Gregory Esper: Specifically for the Critical Care Billing Code, the 99291 and the 99292, as well as the Emergency Medicine Billing Codes, are those being updated for use in telehealth?

Seema Verma: Yes. You're going to see some more guidance on the codes, probably later this week on that. In particular, we understand that there's been a lot of questions on that. So expect to see something just in the next few days here.

Gregory Esper: Thank you.

Has – we saw some – a potential need for physicians to update their site of service on their Medicare profile to add their home site as a site of service. Is that standard that we should be asking our physicians to do? And if so, can that be waived?

Seema Verma: OK. I will look into that. I agree, the timing is not great on that. So let me look into that. I appreciate you raising the issue.

Gregory Esper: The last question I have is, our APPs are – in the state of Georgia where Emory is, our APPs are required to update their supervision to reflect the fact that they can practice by telemedicine.

While that may be a state requirement, is there a federal requirement for them to do that? And if so, can that be waived so that we don't have to do a lot of paperwork with the thousand or so APPs that we have before they can deliver telehealth services?

Seema Verma: Yes. I can't control because I'm on the state level. But I couldn't agree with you more. The last thing we want to do right now is add more paperwork to what you already have on your plate. So I will look into that and ensure that there are no additional requirements on that at this time.

Gregory Esper: And we do have some practices that I could share for others, if we have time.

Seema Verma: Yes. Please do.

Gregory Esper: OK. We actually – because we had to roll out on telehealth to basically thousands of providers, including physicians and APPs, we actually developed a three-part health stream learning center module. After which we require a test and an attestation that would allow the providers to then be certified to produce telehealth visits under their privileging and credentialing that already exists.

So we'd be happy to share – so we'd be happy to share the module that we developed for that.

We've created also a GME policy and workflows for residents and scholars to participate in telemedicine services provided that the right staffing is in place for them to deliver those services for their learning as opposed to for a service perspective.

We'd be happy to share that policy for those of you that have residents and fellows.

We've created a hub-and-spoke model at our health system that allows – that allows the disparate parts of our organizations to have facilitators that directly aligned with our small central telehealth team, by which we update our standard work hourly and daily. And then we present that work to a SharePoint site that is available for all members of the provider community to look at.

And so they can actually see what are the best practices, not only for providers, but also what is patient education, to be able to deliver to patient how to get on a telehealth site or on a telehealth visit, as well as advice and standard work for schedulers to book those visits as well. And we are primarily using the Zoom platform.

We've created extensive education that we're happy to share with people that wish to have that.

We are deploying in-patient models for PPE preservation for audiovisual consultation for patients at end-of-life, which cannot be present in the ICU for consultation.

And we are actively involved in assessing digital strategies to – for testing – for testing and delivery of testing with some organizations.

We're happy to share information. And if you – and I can give my e-mail if people are interested in having that. And we can – if I'm allowed to do that from the CMS side.

Seema Verma: Please do. I think it's a great example, the types of learnings that we want to get out there. So yes, if you want to give your e-mail address, and we can also follow up and make sure it's posted somewhere, but go ahead. Thank you.

Gregory Esper: My name is Gregory Esper – E-S-P as in Peter-E-R. My e-mail address is G-E-S-P as in Peter-E-R at emory-E-M-O-R-Y dot edu. That's gesper@emory.edu. We'll be happy to sharing any information that we have to make it easier for other folks.

Thank you.

Seema Verma: Thank you. That was terrific.

And so I also want to switch gears and we didn't get a chance to talk about triage. We've heard that that's a major issue for providers that are on the frontlines.

And so I think today we have Dr. Jean Kutner from – the Chief Medical Officer at the University of Colorado to talk about triage for patients during COVID. Dr. Kutner?

(Alina Shakai): Dr. Kutner, do we have you on mute?

And if Dr. Kutner is not there, I think there's also Dr. Christine Carr.

Christine Carr: Hello. Can you hear me?

Seema Verma: Yes.

Christine Carr: Hi. Thank you for listening. I'm an Emergency Physician in South Carolina. I work at a large academic medical center. And we are doing a lot of the telehealth already.

We are moving to iPad. And specifically, we're trying to do triage prior to patients entering the emergency department. And I think I speak for a lot of EDs around the country.

EMTALA to date mandates that we do our medical screening exam. We would like to use telehealth or even iPads to use providers that may be in a different location, or could even be inside of the ED but do a medical screening exam and redirect patients if they don't have a medical emergency to alternative care sites, i.e. not the emergency department.

And we would like clarification on, is that OK to do a telehealth visit-only as a medical screening exam for ED?

Seema Verma: That's something that we've heard a lot about. And that's going to be part of the guidance that hopefully we'll be able to get out in the next few days on that. I think we agree that that would be a tool that we would want ERs to be able to use.

Christine Carr: Thank you.

Seema Verma: So any other – we just got a few minutes here. Are there any other – does anybody else want to comment on triage in hospital settings?

Gerry Harmon: Hey, Dr. Verma, this is – Administrator Verma, this is Gerry Harmon with AMA. I'm a physician, a family medicine specialist in South Carolina, in rural South Carolina.

We are triaging and keeping folks out of our emergency departments, and even out of our practices, by having folks call ahead rather than showing up in our family medicine offices.

And then we actually have outside tent set up with the adverse weather gear. We have PPE on our screener to actually screen the patients in the parking lot, before we let them into our facility. We've had an incredible impact on reducing the ER overcrowding here in South Carolina.

Seema Verma: That's terrific.

Gerry Harmon: Dr. Carr is – at the Medical University and Academic Medical Center down in Charleston, about an hour-and-a-half south, and with – in conjunction, as an affiliate with her institution, we're getting referrals to – or checking online and

giving their symptoms. And then if their qualifications are for appropriate screening where they're seeing them in the local area.

And we're doing it really at no charge to the patient. So I think the physician is stepping up incredibly there.

Seema Verma: That's great to hear. Thank you for sharing that.

I'm going to open up the line. Does anybody have any other questions for the speakers?

Operator: Again, to ask a question ...

Seema Verma: Operator, please open the line.

Operator: You may press "star" "1" on your telephone.

Our first question comes from the line of (Michelle Francis). Your line is open.

(Michelle Francis): Hi there. (Michelle Francis). I'm a family medicine resident in my third year with the Medical College of Wisconsin.

And my question is kind of surrounding capacity planning for some of the residents. As you may know, for example, our Board certification exams have been canceled in some cases. And also some of our rotations have been cancelled. I can give an example of myself, I was supposed to be in Infectious Disease next month.

But I'm just wondering – this is kind of an open question for everybody – where you see us fitting in? I know there's a shortage of protective equipment. But there's a number of new roles that I think we could participate in. I just want to hear from people where you see us best fitting in this time?

Janis Orlowski: Administrator Verma, this is Dr. Orlowski. I'd like to address the question.

Seema Verma: Sure, please.

Janis Orlowski: Sure. Hi. This is Dr. Janis Orlowski. I'm the Chief Healthcare Officer at the Association of American Medical Colleges. And we thank you very much for your comments.

We see residents as a critical part of the workforce here as we continue to plan. In regards to your own individual situation, we do know that some elective rotations had been cancelled. But we know that Academic Medical Centers are planning to utilize residents in specific capacities throughout their institution.

Also, if you take a look at the ACGME website, they are providing information to you regarding any issues regarding supervision, any issues regarding your concerns of whether you would graduate on time, and what the role of residents are.

We continue to work with the ACGME and the Academic Medical Centers to make all of our healthcare workers participate at the appropriate level.

And I'd be happy, if you had a specific issue, to give me an e-mail. My e-mail address is jorlowski-J-O-R-L-O-W-S-K-I at aamc dot org, jorlowski@aamc.org.

Thank you.

(Michelle Francis): Thank you so much.

Operator: The next question comes from the line of (Marcus Luz). Your line is open.

(Marcus Luz): Hi. I want to thank you for having this call.

And my name is (Marcus Luz). I apologize I – I'm the CEO of a small rural hospital and a rural health clinic in North Dakota.

And the telehealth, while we're very excited about it, there are certain rules on rural health clinic that are still restricting some of those options. And we're hoping that those will be relaxed to fill some of those needs.

And then also on the triage, I do want to – I do want to say that the Critical Access Hospital, we really appreciated the different and unique ideas, I guess through a rural lens on this, on completing those kind of triage. And we were able to do it. We just really would like to expand it to our clinic, and hopefully recapture some of those lost volumes in this uncertain time.

Seema Verma: And I'll just answer that one really quickly.

We have identified that there are some barriers for FQHCs and rural health clinics. I believe that there is legislation moving on that to address that. I think CMS had some restraints within our authority. But fingers crossed that this bill passes. But I do believe there is language in there to address that.

(Marcus Luz): Thank you so much. It really would make a huge difference to our population.

Seema Verma: Thank you.

And I want to make sure we're mindful of everybody's time today.

This is – these are trying times for all of us. And those of you that are on the frontlines really are the heroes of this fight, of this war.

And I can tell you from CMS' perspective, the entire federal agency, and from the President himself, we want to do everything that we can to support you. From CMS' perspective, we are trying to get all of these regulations out of the way that we know are interfering with your ability to provide care during this pandemic.

So you're going to see a lot more from us on this. These calls really are intended, again, to answer your questions. We just want to make sure that we're keeping the dialog going between us and you, but also between providers.

Just the conversation that we had today, you being able to share what you're doing, everybody is trying to figure out the same issues, solve the same

problems on the local level. And to the extent that we can work together and share best practices, I think it will help all of us.

So we're going to continue to have these calls. I will invite folks in. Give us your suggestions on what topics you'd like us to cover. And if you have something that you want to present, we're happy to give you some time to do that.

And again, let us know what your questions are. We can bring in additional speakers whether it's the FDA. I think Dr. Birx would like to come back as well. She can give you a little sense of the data that she's seeing and her analysis. And we can bring others as well.

So again, just thank you all for what you're doing. We know that you all are on the frontlines of this. And we're here to support you and just appreciate everything that you're doing, for all of America, for your patients, and for this fight. So thank you.

Male: Thank you.

Seema Verma: Thank you.

Male: Thanks, Administrator Verma. Honored to do it.

Female: Thank you very much, Administrator.

Seema Verma: Thank you. Have a good day.

Male: Thanks. Bye.

Operator: Ladies and gentlemen, this concludes today's conference call. Thank you for participating. You may now disconnect.

End