Centers for Medicare & Medicaid Services
COVID-19 Lessons from the Front Lines
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OPERATOR: This is Conference #: 2258722.

Alina Czekai: Good afternoon. Thank you for joining our CMS Lessons from the Front Lines on COVID-19 today, June 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, 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 online media inquiries form which can be found at CMS.gov/newsroom. Any non-media COVID-19 related questions for CMS can be directed to our e-mail which is covid-19@cms.hhs.gov.

And again, I'll ask everyone to please mute their line if they are not speaking at this point. And we would like to begin today's call with the update from the Centers for Disease Control and Prevention. Joining us today is Dr. Doug Trout, co-lead of the CDC's Health Care System and Worker Safety Taskforce. Dr. Trout, over to you.

Douglas Trout: Great. Thanks very much. I'm really happy to give you the short update this afternoon. I hope everyone is staying well. So, I have I think five brief updates. The first one is related to updated guidance.

And, so I'll just back up. So, I am what's called a co-lead of a taskforce within the CDC Emergency Operations Center Incident Management Team. And so, our – I'm going to focus on some of the activities and things that our staff which are – who are working very hard and doing quite a lot of work are directly participating in. But by no means am I going to give you an overview

of all the work that's going on within the CDC or within – even within our taskforce.

So, with that disclaimer, there are some updated guidance that has been updated in the last week and, actually, as we speak, more updates and improvements are underway. So, the first type of guidance is related to testing.

Of course, we know this is critical. There is now an overview – what we call an overview testing guidance document on the CDC web site. This document summarizes the CDC recommendations for testing in a variety of settings.

You may know that there already had been, prior to this overview document, some guidance on nursing home testing guidance and that – other guidance is also a bit updated and still actually further updates are planned in collaboration with partners and stakeholders.

Probably – and then, I – it's hard to say on timeframe, but the CDC, various groups within the CDC are working on specific testing guidelines that will hone down on some – different categories of workplace and/or community settings. So, be on the look out for those in the next week or so.

Secondly, in terms of guidance, there is an updated general infection control and prevention guidance which is currently in clearance. So, that probably will be out in the next week or so. This document will not present any major changes in current CDC recommendations, but will incorporate within the guidance many of the frequently asked questions and it will be reorganized slightly.

And last, in terms of updated guidance, CDC telehealth guidance was also recently posted. It complements information on the telehealth.hhs.gov web site and describes some uses, limitations and considerations for implementing telehealth services.

So, secondly in terms of my updates, just wanted to mention that NHSN and COVID-specific reporting is currently occurring from about 3,000 to 4,000 hospitals every day and 1,500 nursing homes. And the NHSN data is being

used daily really with CDC updates to the CDC and even I think HHS leadership levels to identify hotspots where COVID is increasing and to proactively deploy teams to support state and local public health departments.

Thirdly, the CDC has conducted more than 670 Tele-ICAR remote preparedness assessments in nursing homes and is now piloting this Tele-ICAR process for hospitals in outpatient clinics.

And last, the CDC did a clinical outreach and action COCA call on the updated recommendations for clinicians for preventing SARS-CoV-2 transmission in nursing homes on the 16th of June. It had more than 7,000 attendees and the recording is available on the CDC COCA web site.

So, that's my update. I hope that's helpful and if this is the time for questions, I'd be happy to answer any that I can or take them and try to get back to you if I don't have the answer.

Alina Czekai: Great. Thanks very much, Dr. Trout. Operator, let's open up the lines for some questions for Dr. Trout. Thank you.

Operator: At this time, if anyone would like to ask a question, simply press "star," "1" on your telephone keypad. Again, to ask a question, press "star," "1" on your telephone keypad. At this time, ma'am, there are no questions on the phone.

Alina Czekai: Great. Thank you. And thanks again, Dr. Trout, for joining us today to share updates from the CDC.

Douglas Trout: Thank you.

Alina Czekai: Next, we'll move on to our segment of the call where we are hearing from providers in the field. Here at CMS we recognize that 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 the patients in your local communities.

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

And today, we are joined by physician leaders who have offered to share insights and best practices from the field with you all. Today's topic is Best Practices for Oncology Care During the Public Health Emergency. And also joining me from CMS are several of our physician leaders who will offer their expert perspective throughout the conversation as well.

Joining me today is Dr. Marion Couch, senior medical adviser to Administrator Seema Verma; Dr. Michelle Schreiber, director of the Quality Measurement and Value-Based Incentives Group at the Center for Clinical Standards and Quality at CMS; and Dr. Barry Marx, director of the Office of Clinician Engagement.

And first, it's my pleasure to introduce our first guest speaker, Dr. Jennifer Elston Lafata, professor in the UNC Eshelman School of Pharmacy and she also co-leads the UNC Cancer Care Quality Initiative. Dr. Elston Lafata, over to you.

Jennifer Elston Lafata: Thank you. Good afternoon and thanks for the opportunity to speak with you today. And thanks to CMS for inviting us to speak and for creating this important venue to learn from each other during this pandemic.

As Alina said, I'm Jennifer Elston Lafata and I work with the Quality Improvement Team in Oncology Services at UNC Health, a non-profit medical system owned by the state of North Carolina and I'm here with my colleagues today representing a large team of clinicians and other practitioners who deliver and support oncology services at our large academic medical center here at Chapel Hill and at nine other facilities across the state.

And our facilities are really located across the state, everywhere from rural communities, on the mountainside and the coastal sides of state to the cities that are in the central parts of the state. And as the state's medical system, we deliver care to everyone regardless of their ability to pay or need and we pride

ourselves on the fact that our patient population mirrors our state's population demographically, economically and otherwise.

And those of us who are with you today are all affiliated with the medical center here in Chapel Hill and at this facility alone over 1.2 million professional businesses are delivered annually; 200,000 of which are in oncology services. And as everybody on the call knows, the need for cancer care did not stop with the pandemic.

The oncology patients that we care for represent some of the most vulnerable patients, not only because of their cancer and immunosuppression, but because of the social, economic and other challenges that the pandemic has highlighted.

And since the onset of the COVID-19 pandemic, our patient volumes in oncology have continued to remain relatively high. We did see an initial drop in the month of March to about 50 percent. But, since then, oncology volumes have consistently picked up. We're now operating at about 83 percent of what our volumes were pre-COVID.

But that overall specific doesn't really tell the full story and there have been two dramatic shifts in the care that we are providing. The first pertains to how we deliver care and the second pertains to who we are delivering that care to. And let me tell you about the latter one first.

While we're now delivering care at volumes close to 80 percent of our pre-COVID period, our new patient volumes have steadily dropped in the past 12 weeks and are now reduced by about 43 percent.

To put another way, while we were able to work quite hard and able to continue to treat – continue to treat patients who are under our care when the pandemic struck, new patients are not accessing our services during the pandemic. We've reached out to referral networks to let them know that we're open and seeing cancer patients.

But as most of you know, primary care practices, including our own, have stopped delivering screening for cancer for the most part and we know, on top

of that, that patients, even when they are symptomatic, are choosing to delay care because they are afraid of contracting COVID-19.

With this as the backdrop, we're not expecting our new patient volumes to return for some time and, obviously, this confirms on multiple fronts and requires that we plan for multiple contingencies including the possibility that we may be seeing more late-stage disease when screening resumes and symptoms cannot be ignored or patients become more comfortable seeking care.

The second shift has been on how we deliver care. Since March 22, almost half of our completed visits have been virtual. Sixty percent of those have been via telephone and 40 percent via video. That means that since March, in oncology services, we've delivered over 8,000 virtual visits. But again, the summary data do not tell the whole story.

While the overwhelming majority of patients that have been seen in UNC's (inaudible) and multidisciplinary clinics at the medical center have been virtually – have been deliver virtually, those shifts have not been as dramatic in other clinics as the medical center.

In large part, that's due to the type of services those clinics provide. But even so, we have been able to convert 43 percent of our surgical oncology visits to virtual and 16 percent of our radiation oncology visits to virtual.

So, the shift hasn't been consistent from clinic to clinic, but it hasn't been consistent from facility to facility either. And some of that variability has been driven by the geographic variability and the intensity of the pandemic, meaning there's been less need for shifting to virtual in some of our communities that we serve where the onset of the pandemic was slowed. But it's also been an artifact of the resources that are needed to adapt our workflow to accommodate virtual visits.

Implementing the processes to conduct virtual visits and altering staff workloads while continuing to deliver high volume and high-quality care has been challenging. At UNC, we were fortunate in that we had a platform for virtual visits pre-COVID, but nobody in oncology had used that platform and

since the onset of the pandemic, we've actually completely shifted away from the platform that we had because of the challenges we encountered.

That meant that we have had to train all of the oncology providers to deliver virtual visits sometimes twice as we shifted our platform. And then, we've also had to train clinic and administrative staff to completely alter how they do all their functions to support those visits, so that all the things that needs to happen before and after a visit, all the registrations, all the scheduling, all the pre-appointment charting and all the follow-ups needed completely new processes and we've worked to be able to put those in place.

This has all been made even more challenging because much of our staff is working remotely. And then, that further challenges the communication between and among staff and providers. And we've recently conducted an internal study that was done by the quality team in oncology and found that virtual visits take 1.4 times longer in staff time to prep for and execute as in-person visits did during pre-COVID.

We've been fortunate an UNC in that our analytics team was able to rapidly build a dashboard for virtual visits so that our volume can be tracked. That means we were able to celebrate our – we were celebrate our successes and come and talk to you all about things like the fact that we've delivered over 8,000 virtual visits in oncology services.

And while we've been able to use those visits to minimize care disruptions while mitigating the risk to those we're treating, those same recording tools have highlighted challenges. So, we know, for example, that we've been less successful engaging our Spanish-speaking patients virtually and we know that pulling interpretive services into virtual visits is challenging.

Similarly, and for reasons that we don't yet understand, our African-American patients seem to be disproportionately underrepresented among those who have a completed virtual visit. And we're just beginning to engage our African-American, Hispanics and other patients to understand the barriers and facilitators that they have been facing to virtual visits during this pandemic.

We think that these are really important considerations and one that we want to understand now, so as not to build disparity into the virtual care process. And we think it's particularly important in a state like North Carolina where we're anticipating seeing increases in the number of COVID-19 cases well into the fall – into September and October and, thus, anticipate the need for continued use of virtual visits for some time to come. So, with that as background, I'd like to give the physicians who've joined us their time to share their perspective.

Bill Wood: Thank you – thank you, Dr. Lafata. Good afternoon, everybody. I'm Dr. Bill Wood. I'm a hematologist and oncologist at the School of Medicine at the University of North Carolina and it's a pleasure to speak with all of you today to share my own experiences.

I'll talk further about what I've learned over this time and the perspective of virtual care and we'll also be sharing some experiences provided to me by one of my colleagues in surgical oncology, Dr. Angie Smith, who was, unfortunately, unable to join us today.

So, I think it goes without saying that the COVID-19 pandemic has required us all to re-envision clinical care for our patients with cancer in many different ways. And as we've heard from Jennifer, the rapid implementation of virtual visits was needed so that we could continue what we do all the time and that's time-sensitive treatment for our vulnerable patients with cancer. But we need to do this in a way where we minimize the exposure for this group, often high risk and immune suppressed, to COVID-19.

So, after several months of doing this and providing virtual care, it's clear that there are lots of different clinical care considerations that have become evident and some common themes that have woven throughout this process that we wanted to share with you today.

So, first, virtual care has definitely required all of us, myself included, to reconsider the utility of the physical exam. And so, video visits offer the opportunity for basic elements of the exam and we're learning which of those elements we can continue to incorporate into virtual visits that are important

for ourselves as medical oncologists and also our surgical and radiation oncology colleagues.

So, by virtual video visits, we can evaluate incisions; we can have a basic understanding and appreciation of body habitus. We might be able to look at respiratory rate or accessory muscle use. We can, with assistance sometimes from patients, look at evidence of peripheral edema or unmistakable rash, but at the same time, there are some technological limitations that prohibit us from using the full potential of these visits and the physical exams.

So, we find – we found that poor Wi-Fi sometimes leads to pixelated images. Parts of the exam then become either less relevant or useful. So, for example, as somebody who spends time seeing patients, following allogeneic hematopoietic cell transplantation, I find that oropharyngeal or skin exams can be quite challenging in the context of virtual video visits.

Sometimes our patients have a hard time moving far enough away from the camera, so we can appreciate their overall clinical condition, body habitus or musculoskeletal function as we would should they be in person.

At the same time though, we can also find that we can find creative ways so that patients can get up out of a chair, for example, when they're at home; walk across their room; do other kinds of things in their home environment that actually add additional insight to what we'd otherwise get in clinic.

My colleague, Dr. Smith talked about recently operating on a patient who she evaluated through a video visit. She scheduled that patient for surgery and, on the day of surgery, was surprised by the patient's body habitus in ways that she wasn't quite prepared for from the perspective of that particular procedure that was planned. And she might, in retrospect, have recommended a slightly different approach, but she was able to adjust for on the fly.

So, as providers were finding new ways to better look at functional status of our patients by video visit as before we can look at gait and function perhaps in new ways and there are best practices that we are sharing informally and then could potentially be shared in a more formal manner for not only our colleagues at UNC, but at large as well.

And I think we'll find new ways as we do this to optimize that virtual physical exam. But in the absence of tools that replicate elements of that exam that can only be performed in person and the absence of other onsite examiners, we might be able to lay hands on a swollen joint or visually inspected incision for subtle signs of infection, we will continue to experience challenges despite our best efforts.

With that said, with new innovations and technology and creativity and the way that augmented or assisted virtual visits can be conducted and reimbursed, we're optimistic that these challenges can be met.

A common misconception is that virtual care requires less time. But for us, and I think as Jennifer mentioned earlier, that's not been the case. We find that, as our workflow has been disrupted, responsibilities such as medication reconciliation and rooming have been shifted from medical assistance, nurses and other personnel to the provider.

We might find that we have less time to discuss important parts of treatment like benefits and risk if we're spending part of our energy just working on technical audio/video issues or (pinning) and reconciling medication list, for example.

And so, we're looking for new ways to operationalize staff to simulate an in-person workflow and free up time for providers so that providers can spend the time that they need to deliver in cancer care.

Some of our colleagues have found new ways to bring trainees into virtual encounters and that can be done asynchronously or synchronously with three- or four-way virtual video conferencing. And these actually have opened up new and interesting learning opportunities.

So, some of our trainees are finding that the flexibility of virtual visits scheduling overcome some of the barriers that they're previously experienced when they were trying to learn in the clinic at traditional bricks and mortar facilities.

So, virtual care also presents opportunities to augment our clinical care. There are a few different ways in which we can look at new innovations in cancer clinical care delivery that are especially relevant in the virtual care era. One of these is in, for example, the use of patient-reported outcomes.

Some of our patients are signing up for the electronic health record. This is often a vehicle. They get into the video visit and doing so, looking through that patient portal, they can actually have specific questionnaires (to learn) before the visit and then sent to the provider for review.

And that allows all of us to focus on the most relevant and concerning symptoms that patients have and there's now a cluster of evidence that these data are quite informative for cancer care and it can improve cancer outcomes.

These also address non-symptomatic areas like physical and cognitive functional, quality of life, social needs, mitigation adherence and nutritional concerns. Because we have this now expanded scheduling and care delivery workflow, we think there may be new opportunity to use PROs in ways that streamline and improve care.

However, we also know that because of the issues around disparities that we're recognizing, we don't want to worsen inadvertently disparities by building into our processes new workflows that require a certain level of technological sophistication or ones that come up against language barriers.

We also find that virtual care to be augmented through remote monitoring. So, we now know that there are fit-for-purpose connected sensors that are available that allow us to obtain vital signs like heart rate, blood pressure, pulse oximetry or temperature remotely, or that might allow us to track physical activity and function.

So, for many of our cancer patients this is particularly relevant. A patient might be undergoing systemic chemotherapy and objective sensor data could complement patient-reported symptomatic toxicities and what we're learning from the patient at the time of the exam.

Somebody who's recently discharged from the hospital for surgery might find that a passive activity tracking helps the provider ascertain information about symptoms and functions a bit better.

And tracking specific vital signs or activity can help us figure out which of our patients who are out in the community may need closer observation and allow us to deliver just-in-time interventions to prevent acute care utilization and other adverse outcomes that impact quality of life and function.

So, we know that virtual visits are not for everyone. Some of our patients live in areas where internet bandwidth is suboptimal leading to poor or missed connections and this is something that I think is incumbent upon all of us to figure out ways to improve.

We know that virtual care materials and web sites must be translated into other languages so that the benefits of these services can be felt equitably throughout the communities of our patients and their different backgrounds.

For some patients, they may have psychological or cultural barriers with participating in visits virtually. Anecdotally, I have seen myself and some of my colleagues have told me that some of their patients prefer not to connect by video.

They might have concerns about privacy and security, some are worried about showing their home environment to health care providers, some are worried about their appearance on video camera and we've heard all of these different concerns expressed.

We don't know a whole lot about the barriers in facilitators of virtual care delivery yet for patients from vulnerable, high risk or unrepresented social demographic groups and, with this, a potential for virtual care to worsen pre-existing health disparities. We do think that this is a critical area for future research. With dedicated study, we could better understand these issues and hopefully develop approaches that could be tested rigorously from implementation science perspective to mitigate these issues.

I'd like to thank everybody on this call for the opportunity to provide my own perspective as a hematologist and oncologist providing virtual care for patients during the COVID pandemic. I'd be delighted to answer questions as they come up or to engage with others who are interested in working with me and my colleagues to make virtual care delivery better and more accessible to our patients with cancer.

So, at this point, I'll turn things over to my colleague from radiation oncology, Dr. Trevor Royce, who will be speaking about opportunities to re-envision clinical trials and research in oncology through the lens of virtual care. Dr. Royce?

Trevor Royce: Thank you, Dr. Wood. And thanks to the organizers for not only ensuring our patients have had access during this time, but also inviting us to share our stories at the bedside.

My name is Trevor Royce. I'm a radiation oncologist here at UNC Chapel Hill, North Carolina. And improving the outcomes of patients with cancer is really a fundamental goal of the oncology community.

A foundational strategy for that goal is obviously through research. Oncologists take tremendous pride in an evidence-based approach to patient care and, as such, research is really a core part of our identity. Indeed, this has resulted in improved outcomes with patients with cancer over the decades.

Out of necessity, the pandemic has really fundamentally altered the oncology community's approach to research. For example, the clinical trial and essential component of cancer research has traditionally required frequent in-person visits for objective assessments such as patient-reported outcomes, physical exams, laboratory tests, imaging, endoscopy and so on.

Physical distancing has really introduced major hurdles for clinical trials and their frequent requirements for these in-person visits. In fact, early survey results from the American Society of Clinical Oncology show that the pandemic has significantly disrupted conducting clinical trials along the lines of enrollment, protocol adherence, patient provider support of staff, services engagement.

To illustrate these challenges, I can share my personal experience as junior faculty and investigator at a major academic medical center. Certainly, an incredible amount of time and energy goes into the preparation and execution of clinical trials. Indeed, careers are devoted to and build upon this.

I'm a radiation oncologist, as I mentioned, and I focus on genitourinary cancers like prostate cancer. Just before the pandemic hit, we opened a trial investigating a promising and novel imaging technique to better detect metastatic prostate cancer.

Of course, this requires substantial resources including a major allotment of professional time and committed institutional support on the order of hundreds of thousands of dollars. And clearing the final regulatory hurdles, our trial opened just before the pandemic hit.

As the country shut down, so did research at our medical center. Our imaging center still has yet to reopen and this research remains on hold today. We have not enrolled a single patient despite being open for nearly four months and many of our expensive reagents have expired and subsequently needed to be discarded.

But, of course, most importantly, it's deprived patients of a novel diagnostic with a significant chance at improving their outcomes and nationwide researchers and patients have experienced similar disappointment.

Interestingly, telehealth has really emerged as an essential facilitator in keeping many clinical trials operational and it may provide an opportunity, ultimately, to improve our clinical trial system, for example, by allowing fewer in-person visits and the burden associated with that.

As investigators adapt to the pandemic environment, it's plausible we shift our focus to more pragmatic or streamlined trial designs, fewer clinical trial related patient visits, minimizing sponsor visits to trial programs and so on.

As a specific example, patient-reported outcomes, which you've heard a little bit about earlier, the health outcome directly reported by the patient who

experienced it are really a core component of modern oncology clinical trial reporting and, in fact, in clinical care their integration has been shown to improve the survival of patients.

So, patient-reported outcomes are important and, traditionally, have been collected via in-office questionnaires. But much of this patient reporting has shifted to being collected in the virtual space, for example, for telehealth. But this too must be done with care and purposely in ways that engages participation by traditionally hard-to-reach populations especially participation, for example of racial minorities.

At our current cancer center, the Lineberger Comprehensive Cancer Center, we really have worked hard to ensure that patients who participate in clinical trials have representation equivalent to the population of our state and that our goal of incorporating virtual visits into the clinical trial process is to further expand the population able to participate without jeopardizing a lot of the success we've experienced in reaching some of these populations.

More specifically, roughly 25 percent of patients with cancer seen at our cancer center are racial minorities and roughly 25 percent of our trial accrual are racial minorities. And so, there is an opportunity in this crisis, you know, this unprecedented support for telehealth may allow us to minimize the burden of clinical research and perhaps ultimately reduce disparities by reaching some of these populations that have traditionally been really underrepresented in clinical trials and research more broadly.

So, I'll end on that. I'd just like to thank you for the opportunity to provide my perspective as a radiation oncologist and as a clinician and as a researcher providing virtual care for patients during this pandemic. I'll turn things over to my colleague, Brendan Fitzpatrick.

Brendan Fitzpatrick: Thank you, Trevor. I'm going to talk about the fiscal realities. Good afternoon. My name is Brendan Fitzpatrick. I'm the associate vice president for cancer services at UNC Health.

I appreciate the opportunity to speak with you today. I'm proud to be here with this team. I've been with UNC for about three years now and can tell

you that it's the dedication and talent of the members of our clinical team, such as those that you've heard from today, who make me proud to be a Tar Heel. I wanted to end our time with you by talking about the reality of the finances behind the care that these physicians are delivering.

When the pandemic struck, we were about 2 percent ahead of our budget, but all of that has changed. Our revenue has been off by almost 20 percent for the last two months. And as others have mentioned, our new patient visits across the board have dropped between 30 percent and 40 percent ensuring that we'll likely to remain behind budget for the next six months to eight months with much less care being delivered.

So, while I'm concerned about the health of the communities we serve, I'm also concerned for the health of our organization. This concern comes at a time when, as others have indicated, we are working harder than ever and delivering services which – for which we are not currently being fully reimbursed in part because of the lack of encounter facilities to use for virtual visits and hospital-based clinics.

But, as you've heard today, there are – there are costs associated with virtual visits that extend beyond what the professional fee is reimbursed. Our internal study, as you heard from Jennifer, takes about 40 percent more time than virtual visits in comparison to in-person office visits.

And as you've heard our physicians say, they're working harder than ever and, honestly, today, my team is not able to provide them the support we all want to. As we gain experience with virtual visits, we no doubt will identify ways to reduce wait and enhance efficiencies, but the cost of supporting virtual care will never be zero.

As you can imagine, it's the uncertainties that present physical and other challenges that we cannot plan for nor staff for for what we do not know. In North Carolina, where our COVID-19 cases continue to rise, we have been in a constant state of readiness since mid-March. Our state's latest projections now forecast an in-patient admissions to peak in September, months from now.

In oncology, a big unknown is what a case will look like then. We anticipate screening opening back up and perhaps symptomatic cancers that have gone undetected due to delays in care delivery will start presenting themselves.

Whether this might mean a surge in new cancer cases or a surge in relatively later-stage cancer cases or something completely different is known, these scenarios are all things that we must be preparing for as we alter the way that we deliver high-quality care safely to immunosuppressed patients during the pandemic.

I've no doubt that our people are up to the challenge, but part of my job is to make sure that we can afford that challenge. Thank you, again, for listening. On behalf of all of us at the UNC oncology program, let me reiterate how much we appreciate the opportunity to tell you about our frontline experiences.

Alina Czekai: Thank you so much to UNC for joining our call today and sharing a terrific perspective. Before we open it up to questions from the audience, I'd like to invite my CMS colleagues to ask any questions or share any comments based on today's presentation.

Michelle Schreiber: So, Alina, thank you so much. This is Michelle Schreiber from the Quality Measures and Value-Based Incentives Group. And to all of you at UNC, thank you for participating in this call and for your leadership in oncology.

I have a couple of questions that came to mind as you were speaking. The first is you mentioned disparities for your Hispanic population and your African-American population in doing televisits. What about an age difference because we frequently, you know, have these preconceived notions that the elderly aren't comfortable with doing this? I wonder if you've noticed any age difference in the use of telehealth.

Bill Wood: Thanks. This is Bill Wood. I can start and I invite my colleagues to provide additional information as well. So, I'll just – I'll say first that I don't have empiric data to tell you more about potential age-related disparities and

perhaps Jennifer or others do who are on the call. So, I'll speak from just my own personal experience anecdotally.

Where I've seen this becoming a potential issue is around the interface that's used to access virtual video visits. To the extent that that interface is clean and easy, actually virtual video visits can be quite accessible regardless of age.

Some systems, for example, will allow an individual on a smartphone to receive a text message that then opens up the link that goes to a secured video chat room and that's an example of a workflow that's quite intuitive. And so, for an older individual who has a smartphone and familiarity with using it can make these visits quite accessible.

I think on the other end of the spectrum is an example where one needs to develop a specific account on the portal, download an app and do other kinds of things and that require additional technological sophistication that I found, at least again in my personal anecdotal experience, to present some barriers from an age-related perspective.

So, I see the – I do see the – I do see barriers here. But I do think that with intelligent design of the systems and particular attention to those with varying degrees of technological and health literacy that these barriers can be mitigated significantly with appropriate design. But I'm happy to let my other colleagues comment on that issue as well.

Trevor Royce: Thanks, Bill. This is Trevor Royce, again radiation oncologist and clinician. I would just emphasize what Bill said and, you know, it's really kind of three major groups that I've seen that have had difficulty accessing virtual care, one being a lot of the rural patients we treat in North Carolina does have a large rural population and many of these groups don't have great connectivity such as Wi-Fi or good cellular access.

The other are lower socioeconomic groups which we have mentioned and then, certainly, the elderly population. Not only is the elderly population at greater risk for cancer, but they also have – can have trouble with some of the technological barriers involved with telehealth. And in the setting of the

COVID pandemic, they're an at-risk population, number one, for their age, but number two, for their associated cancer diagnosis.

So, there certainly have been challenges with them accessing telehealth and often they'll rely on family members, you know, to help them with doctor visits and that sort of thing. But if you're physically distant, I've noticed personally the touching scene of a family member being in their older relative's home, but that younger family member having a mask on or personal protective equipment while helping them with the virtual visit and that certainly is not available to all of our elderly patients.

Jennifer Elston Lafata: And this is Jennifer. I don't have data – quantitative data to add, but I would just add that, on the flip side, what we've been hearing anecdotally is that sometimes with the virtual visits, it enables adult children who are not physically located with their patients to actually dial in separately, so the two can keep family members – it's more – it's easier to keep those family members informed and part of the care process with the virtual visits. But we can look into the age question that you asked more systematically too.

Bill Wood: And I just had one more point, again, to what Jennifer has just said. And I do agree that there are some potential silver linings here. The same types of issues that are potential barriers with virtual visits are also barriers of traditional visits too.

And I think that, in some ways, as long the technological issues can be solved for many of our older patients, it actually has been quite convenient for them to be able to remain in their home environment and not necessarily having to work on transportation back and forth to the medical center and all the other logistical complexities that would require. And so, I think that's actually been well received in many cases. So, we are definitely seeing some benefits from this as well, ways in which we can better reach our older patient population.

Michelle Schreiber: Thank you all for your answer. I have one more question because it's something that we've been thinking about at CMS and discussing amongst ourselves and with the CDC and that's the issue of visitation within the hospital.

Certainly, for cancer patients, I would think in particular, this is a very stressful time. They're undergoing chemotherapy and there's difficult decisions to be made and it's really hard to do that in social isolation without their families. What have you done around visitation?

Brendan Fitzpatrick: Actually, this is Brendan Fitzpatrick. I might take the first stab at answering that. Surprisingly, this has been an incredibly reviewed topic at the medical center. We've gone across the entire spectrum.

But what we've found is that, in many of our ambulatory clinics, we can get away with not allowing visitors or companions to the appointment. But what we've found out pretty much early on is that, in cancer care, that we really had to allow our patients to bring a companion, but we are still discouraging it. But we've realized that many of our patients can't navigate to their appointments or navigate through their appointments without some assistance.

And then, on the in-patient side, we've had to basically eliminate all visitors for about two months now. But we've realized that have a tremendous impact especially to our BMT program. Some of our patients who could postpone their transplant have done so because they didn't want to go through the long period of time that they'd be hospitalized without a family member or loved one with them.

It has been a hot topic and we are just at a point where we are actually going to be able to open up our visitation policy to allow one visitor with our inpatients. But we've decided to keep our outpatient policy the same so that only in cancer clinics will we allow our ambulatory patients to have a visitor or companion with them.

Bill Wood: I would agree. It's Bill once more and I'll just speak to that inpatient issue. As a bone marrow transplant and cell therapy physician, this has been an issue that I have been acutely aware of particularly on the inpatient side and with another two-weekend patient rotation upcoming, I can recall some particularly poignant comments that I've heard in the exam room before my patients have come in for their transplants noting that they've been married for 30, 40, 50 years and they've never spent more than two or three nights away from their

spouse and now about to undergo a pretty intensive procedure in isolation for a three-week hospitalization and the potential psychological impact that that has. And so, it truly has been a challenge.

And I do have to say that, in this case, video technology has really been quite helpful. And we have incorporated – we have incorporated with the caregivers and other family members into our with-patient permission bedside rounds and other experiences so that we can do our best, albeit imperfectly, to maintain that very important social connection for hospitalized patients.

Michelle Schreiber: Thank you.

Alina Czekai: Thank you, Dr. Schreiber. Operator, let's take some questions from the phone. Thank you.

Operator: Once again, to ask a question, please press "star," "1" on your telephone. We have a question from Ronald Hertz. Your line is open.

Ronald Hertz: Hey, thank you. Actually, I have two questions. The first is, the scant data that's available suggest that patients who are getting chemotherapy and are either asymptomatic or pre-symptomatic with COVID do very poorly.

So, I'm wondering what the screening protocols you have in place for patients coming in for outpatient chemo and, even more, what about their family members when they go home and have, you know, people in their household that they're being exposed to that could potentially spread it to them?

And my second question is do you think that there's a silver lining to this in that the lack of all the routine screening will also eliminate a lot of low-value care like routine PSA testing or thyroid cancer screens that are still taking place despite lack of good data? Thank you.

Bill Wood: Brendan, do you want to start with the screening question?

Brendan Fitzpatrick: Yes. So, we've done extensive screening in the days leading up to the outpatient visits to make sure that we're, as much as possible, eliminating the possibility of someone that would be COVID positive or highly susceptible

for being positive, so that we could catch them before they were walking around our clinics or our cancer hospital.

But this has taken a lot of time. It's an extra telephone call. And what we've found is, for every patient that we need to screen, it's basically taking two phone calls to reach them to go through our screening process and set of questions.

And then, what we're doing, again, is we're screening at the front door on the day of the appointment. And then, once they get to the clinic, we're making sure that each patient we can be sure as possible that they are healthy and that we are delivering care in a safe environment.

Part of the reason we are putting so much emphasis on the days leading up to the appointment and especially the day before is because we do have a respiratory diagnostic clinic right on campus that is a drive through facility so that we can actually test patients the day before.

Now, keep in mind we've got COVID-positive patient workflows that we can bring our patients into, but we want to make sure that we're doing this appropriately and for the right patients because we want to make sure that all of our patients feel safe as well as our staff. And I don't know if either one of our oncologists wanted to address the second piece of the question.

Trevor Royce: Thanks, Brandon. I'll just add a quick comment on the first question about screening, this is Trevor Royce, radiation oncologist – I do a fair number of procedures and they involve general anesthesia and a very important component of our workflow that has been added in the setting is ensuring a COVID test prior to any general anesthesia or intervention 48 hours ahead of time and a lot of these procedures are on Mondays, for example.

So, patients are coming in on Saturdays to get that clearance with that COVID test and that's been an important way to keep our other patients safe as well as providers given the higher risk nature of sterilization with intubation. And I'll pass it on to Dr. Bill Wood to answer the other question.

Bill Wood: I think the flow value question is a very interesting one and I do think that there is so much to be learned and anything I could say on this topic, quite honestly, at this level would be speculative because I think we recognize that there is likely a lot of needed care that is being delayed or not received despite our best efforts to go out into the community virtually and deliver that.

And clearly, there's a worry that we'll see an increase in preventable ED visits, hospitalizations. We'll see patients present with more advanced stage of the disease and forgoing potentially previously curative opportunities. But that remains a worry and we need rigorous health services studies and data to evaluate that.

And the other side of that as you say is perhaps there are examples where there is either low value or redundant care delivery that can be streamlined in this era and I think that will be a particularly interesting question to evaluate as well. But I don't have any data to tell you about at this point and I know that the study I'm sure are in process at the moment.

Jennifer Elston Lafata: And just to quickly add to that, this is Jennifer, I think on the – in the – in the more primary care team, there are discussions that are being had now about how to open screening back up and whether you open that up in one file group or you do that by risk and by, one would hope, yield of those tests as well for health benefits.

Ronald Hertz: Thank you, all.

Operator: Again, if anyone would like to ask a question, simply press "star," "1" on your telephone keypad. Ma'am, we have another question from Elizabeth Sullivan. Your line is open.

Elizabeth Sullivan: Thank you. I have two questions. I'm responding to something that one of the doctors discussed about the reduction in new patients. And I am – you know, of course, when you give that report, you're not just talking about Medicare and Medicaid patients underneath the CMS jurisdiction, but surely across population.

And along those lines I wonder if you've considered or if anything is being done in a CMS partnering kind of situation addressing perhaps not technology, but portability of health insurance. And so, as an example, suppose another person had a finding in a mammogram that maybe was not obviously malignant, but warranted follow up with an oncologist.

And in light of COVID, either her employer's insurance is going to expire in 90 days or 60 days or maybe she's already on a COBRA plan that's going to expire shortly. And maybe that patient would not – is worried about, you know, do I want to be diagnosed when my coverage is about to end?

So, I realize that's not normally a CMS responsibility, but one would think that maybe there is something being done to address that. And then, the second part of that is that, being an HIM professional and having studied the history of insurance in America, I understand that the legislation with HIPAA originally included the idea that a person could take their insurance with them. But in today's environment, COVID doesn't – your insurance doesn't go with you forever. COBRA ends in 18 months and then you're left in a lake without a paddle. So, if you could speak to those things, I'd be most grateful.

Marion Couch: Hi. This is Marion Couch from CMS and I thank you for that. Again, I think that that's one of those issues that seems straight forward and reasonable, but there's a lot of statutory limitations and a lot that goes into it. I think, for the purpose of this call, I want you to know that we heard you and will take that back with us. Thanks.

Alina Czekai: Thank you. Operator, any other question for today's call?

Operator: At this time, ma'am, I'm not seeing any questions on queue.

Alina Czekai: Great. Thank you. And thank you, again, to our terrific presenters from UNC. Really appreciated hearing all that you are doing for oncology care and cancer patients in your community. And thank you, everyone, for joining our call.

You can continue to direct any questions or comments to CMS via our COVID-19 e-mail box, which is covid-19@cms.hhs.gov. As always, we

appreciate everything that you are doing for patients and their families around the country as we address COVID-19 as a nation.

This concludes today's call. Have a great weekend.

End