Centers for Medicare & Medicaid Services
COVID-19 Call with Home Health and Hospice Facilities
Moderator: Alina Czekai
April 21, 2020
3:00 p.m. ET

OPERATOR: This is Conference #9895252

Alina Czekai: Good afternoon. Thank you for joining our April 21st CMS COVID-19 weekly call on home health and hospice. We really appreciate you taking time out of your busy schedules to join us today.

This is Alina Czekai, leading stakeholder engagement on COVID-19 in the office of CMS administrator Seema Verma. Today we are joined by CMS leadership and subject matter experts, as well as providers in the field who have offered to share their best practices with you all today.

I'd first like to turn it over to Jean Moody-Williams. Jean is the acting director of the Center for Clinical Standards and Quality at CMS. She'll be providing a brief update on the agency's latest guidance in response to COVID-19 before we hear from our external speakers. Jean, over to you.

Jean Moody-Williams: Great. Thank you so much, and welcome everybody. Great to have you on this call again this week. And I think that we are in for a great afternoon of presentations right from the front line. We also want to hear from you and your questions, and have you share whatever your experiences are as well.

Before I turn it over to our speakers, I just want to remind you to visit our COVID-19 Web site. We update it almost daily. But we have new opportunities and information included on that site.

Most recently, we have announced the – we have the announcement of the administration's recommendations for reopening health care systems in areas with low incidence of COVID-19. Please review that as your particular localities are considering what your next steps are.

We've also placed information – if you happen to be a clinician that bills Medicare part B, we've added some improvement opportunities there for our improvement activities if you're participating in the quality payment program, and then a number of other flexibilities.

And so that – again, please join – please take a look at the new information as we put it up. Now we will have a time for questions and answers, but I thought I would – we've been getting one question fairly frequently. So I thought I would just address that.

The question that we have received is, Can CMS include all hospice services to be provided virtually through telephone and telehealth modalities as determined by the hospice plan of care, including visits from all hospice disciplines, including nurses, social workers, spiritual services, bereavement and other counselling?

Are there any other types of services specified in the plan of care? So if that was your question that you sent in, I think we – we captured it all, but we've received variations of that question as well.

So the answer is that hospices may provide any services via telemedicine or audio only, as long as the patient is receiving the routine home care level, and those telemedicines or audio only services are capable of fully meeting the patient and caregiver's needs.

So you're really going to be the best judge of that. There – there are some things where, of course, they are going to require an in person visit to – to meet the needs, and some that can be done by telemedicine. But basically it is permissible to do that if – when it is – when it is advisable to have a telemedicine visit.

So again, we do have some subject matter experts on that will be able to answer questions, although I hope you're tuning in to our Office Hours that we're having on Tuesdays and Thursdays, that's really an opportunity to get your very technical billing questions and waiver questions answered at that time.

So I'd like to move right to our guest speakers for the afternoon. And first I'll introduce Maureen Hinkelman, the executive director of hospice services for Northwell Health. So Maureen, thank you so much for joining. And I'll turn it to you so you can share some of your experiences.

Maureen Hinkelman: Thank you. Thank you for giving us the opportunity to share those experiences. Just as a way of background, just to give you a sense of Northwell Health hospice services. We currently have three hospices, and we cover two counties in the city, as well as several surrounding counties around this city. We have a total census of over 700 patients a day that we care for.

So our experience with this pandemic has been we're getting a larger volume of referrals, but the referral patterns are different. We're getting most of our non COVID patients from physicians' practices, because they're trying to prevent the patient from being hospitalized. We are getting, from those practices as well, COVID patients. And then from the hospitals, we're primarily getting COVID patients.

And I'd just to just speak to – kind of start with our inpatient experience. We currently have inpatient beds in hospitals, nursing homes, but we also have our own free-standing facility.

And so I'd like to speak to that a bit. So when this pandemic started, we didn't really think we could do – care for the COVID patients in that facility, because it's free standing. It's not a part of a hospital setting.

But what happened is, one day, I got a call from the director of the facility saying that he had a patient on the way to our inpatient setting. And the reason they were coming was because the patient's wife tested positive, and was being hospitalized, and he had no caregiver.

So we knew we had a suspect COVID patient coming. So what we did is we immediately reached out to our infectious disease leadership and environmental safety leadership, so we could make sure that we were really following the necessary protocols to protect our staff, as well as the other

patients, and also to make sure we are, you know, sanitizing those rooms they way they needed to be – to be done.

So since we had this one patient, you know, we decided, "OK, well, we could take a couple of more patients." And so gradually – the inpatient setting has 18 individual rooms. So we started with two, and now we're up to 12 patients that are – 12 rooms that are COVID positive, and the remaining ones are for non COVID patients.

And I would say that our experience has been – I'd say very positive in the sense that the staff have handled the situation very well. And mainly because the director of the facility has really been wonderful in communicating and – and educating and really revising our policies and procedures, so that everybody is informed, and feels comfortable with what they're doing.

And we've had – you know, since we have quite a few hospitals in our system, there has been a great need for these beds to be available. And so that is why we've kind of expanded the number. We also have a contract for inpatient beds in one of our skilled nursing facilities.

And they just recently opened up a COVID positive unit. So we reached out to them to ask if we could have two more beds on that unit, and we did. And we reviewed with them what our experience has been with the inpatients that we had so far. And just to give you some background about those patients.

We have no piped in oxygen. But two thirds of the patients do have respiratory issues. So we've had to use liquid oxygen and 10 liter concentrators to help those patients be comfortable.

And then the other experiences that we've had in terms of those patients that are going home. So we – with the COVID positive patients, we primarily do telehealth admissions, and then we try to do telephonic and telehealth visits, but as you've mentioned before, certainly if the patient needed a visit, we would certainly do that. For our COVID patients, we provide them with PPE.

So we actually redeployed – we had a – we have a van that we've used for different purposes before this. And we redeployed that – our van driver

actually drops off the equipment at the patient's home, so the families will have that as well.

And then for the non COVID patients. Telehealth has come in really wonderfully, because of the fact that many of these referrals – they're really in acute needs. They're in pain, or some other issue that they really need to be seen pretty quickly. So we have to quickly get the consent. We want to quickly assess the situation, and we want to get those medications, or whatever they need, in the home as quickly as possible.

So one of – why it's also helped us is the fact that we've had several people – several of our staff – out, either COVID positive, or with symptoms of COVID. And so we've been short of staff.

So we've been able to, like, redeploy other staff. Like we have nurse liaisons in most of our hospitals to evaluate patients. Well we pulled them out a few weeks ago, and they're working remotely. But we've been able to have them trained in telehealth. And so they're able to help us to process new admissions, and even to process visits.

So the telehealth has been really great. And as you said, you know, we adjust the plan of care to reflect those telehealth visits. We assess whether that's adequate to meet the patient's needs. But it has been really a great help to us to meet the needs of our patients and families.

And so that is really primarily our experience with caring for patients in our area. It's certainly been a time of, I think – that hospices had to really kind of step up and respond, and help the patients and the families in our community. So that's kind of what our experience has been so far.

Jean Moody-Williams: Thank you. Thank you so much for sharing that. And certainly I know it's kind been a learning experience for us all, if we find different ways to meet the needs of the patient during – during this crisis using different modalities. But certainly none – none more important than the services that you're providing through hospice. So we really appreciate you sharing that information.

And with that I'd like to move to Dan Savitt, who's the chief financial officer of the Visiting Nurse Service of New York. Dan.

Dan Savitt: Great. Thank you for having me today, and your interest in hearing our experiences as we continue to be on the front line of this pandemic. Thought I would provide a quick overview of who we are. Talk about the framework we have used to respond. And then walk through some lessons learned.

Just as a quick background. Visiting Nurse Service of New York has been serving New Yorkers for 127 years now, operating primarily in New York City and surrounding suburban counties. We have multiple businesses, both provider and health plan.

On the provider side, that includes certified home health, with a patient census of about 9,000, hospice care with an average census of 1,300 or more, home care where we employ 9,000 home health aides and 7,000 patients on service on any given day. In addition, we have a community mental health program, where we serve about 14,000 clients annually.

And I mention those numbers because each one of those businesses has been highly impacted with what's going on in New York. And as you're all likely aware, the pace of spread of COVID in New York, and specifically New York City, has been over whelming. And, you know, only 45 days ago, New York City had its first positive case. Today, of course, that count is well over 100,000.

So from a disaster planning perspective, the crisis escalated much faster than – than we could have ever imagined. And so in dealing with COVID-19, you know, the first thing as we move to – to framework that we would suggest, the first thing I would do, or we would do, or we did, is establish your guiding principles and plans for a COVID response up front to help prioritize.

And so our guidelines were really three. First, protect our patients and staff, and all who they come in contact with. Second, we adjust New York City's pressing public health needs by support decompression of local inpatient facilities. This was a critical role for home care to play, and has been playing

in the fight against COVID-19 in the city. And finally, mitigate the impact to the organization wherever possible.

So with that then, that sort of guiding principle, we took a three phased approach – not that we had much choice, the way that it spread – but essentially the first phase began in February on surveillance and preparation. And really our prioritization there was staff and patient screening, beginning to monitor the travel as well of our staff, and then emergency planning.

And then, a few weeks – the first few weeks of March we moved into phase two, which was mobilization, where we continued to protect patients and staff as best we can – as best we could. And then securing PPE, of course, and then moving to telework.

And then since later March into the present, you know, it's all about the emergency response, which is what I would call phase three, where we continue to protect patients and staff, and all who come in contact with them.

Continue to work with hospitals to decompress their beds, and get people moved out when appropriate. We're caring for COVID positive patients, and spending a lot of time on our PPE pipeline. And then we're managing our staffing shortages, as our staff has fallen ill as well.

And so I'd like to essentially highlight four buckets of lessons learned as a part of our response. And the first bucket really is addressing office based staff. So we had to move over 3,000 staff from the office to home in a week. I would say we scrambled quite a bit – laptops, phone equipment and related – and so, you know, we really learned a lot about being more prepared for this kind of mass move to the home.

And second is the moving to virtual visits, which we hear a lot about. And deciding what care can be done virtually, and begin to train staff on how to do this, because this was not a part of our normal business.

So replacing in person contacts with virtual care is an important tool to help protect patients and staff, and reduce community spread. And so virtual visits also preserve PPE – continues to be in short supply.

And so we had to make sure that we had the right physician orders and clinical protocols to provide telehealth safety – safely and effectively. And then we had to understand the impact on (inaudible) and reimbursement, as it would further help us to protect our patients and staff if tele-visits were reimbursed as part of the payment model.

And so the third bucket – and then I'll wrap up – the third bucket was securing PPE. And many of us are struggling with that, and it's been an acute issue for us from the onset. And so the main thing is we had to become essentially a supply chain organization.

So we had to – we had to procure it, test it, get it – train on it, get it in the hands of the staff, and repeat. And have inventory and all these things that we weren't used to doing. And so we had to quickly become a modern supply chain organization.

And finally on the communication front – I can't stress this enough – commuting through multiple – communicating through multiple channels, very broadly, to the staff. We used video and audio messages, COVID specific intranet site, conference calls and e-mails. And then you had to create a mechanism for two way communication, so staff are heard.

This is absolutely critical. And finally there's a need to communicate clinical information that is complex and evolving. And so the important part here is communicate supportive, empathetic information. Because what we know is that staff are anxious, and need some level of assurance and reassurance.

And so – just to wrap up. For more information on all our up to date protocols and policies, you can visit our Web site at vnsny.org. If you click the yellow COVID banner at the top, and then Professional Resources in the blue rectangle on the left, we've posted our protocols and policies, and continue to keep those updated to share with the rest of our colleagues. And so with that, I wrap it up.

Jean Moody-Williams: Thanks so much, Dan. And definitely a report from the front line there. I'm a very mission kind of driven person, so the fact that you started off

with principles, and then always pointing to those, I think that really does help the cohesiveness and organization.

So thanks for sharing that, and for posting your protocols so others can take a look at that. So we are going to now move to Bob Parker, who's the chief clinical officer and chief compliance officer for Intrepid USA. Bob.

Bob Parker: Hi. Thank you. Yes, I would echo what Maureen and Dan have said. A lot of those aspects are incredibly important to be thinking about. So I want to give a – give a little other different information, so that we're not always sounding the same. But I think a lot of the things that we're all doing are very similar.

When we started the COVID-19 thought process – I'll give you a little bit of background on us. We are a national organization – home health, hospice, private duty, as well as palliative care.

We provide care to about 7,000 patients a day, and in multiple states. So we – we started right off the bat, because we take care of patients in Washington State. So that initial sort of foothold that happened for the United States moved us towards this path probably quicker than maybe some of the other locations because of our national footprint.

So that immediately prompted us to start our emergency preparedness plan, and putting that into place. And what did it look like? What did it need to look like? We made that a very much – a living, breathing document.

We – we – I put one person in charge of really owning that process, so that we could ensure that she was looking across all of our state – so local, state and federal guidance that was coming out, to ensure that what we were putting into the – to the emergency preparedness plan was correct and accurate, based on the information that we were – available to us. Each state has been a little different, so the – the congruency of all of that has not been the most easy to navigate.

From that, we – we did daily, weekly, however – whatever (inaudible) was needed to be – communication with our entire company on the latest and greatest, where we – where we needed to be.

Process change, procedure change, and things like that. When we started that process, we also started a town hall daily call. So every day I host a call with the entire organization, and I call it, you know, the COVID-19 Town Hall, but it's also rumor control.

So what we wanted to do there was make sure that we were providing a consistent message, that we were dealing with any of the rumors that were being created out of fear and anxiety.

And there were many, many of those in the earliest days. And then making sure that everyone felt connected to each other as an organization. And certainly that senior leadership was very visible and engaged within the – within this process. Part of it helping – how do we take barriers down? All of those things that would go into a leadership aspect.

We developed COVID-19 teams, because we are taking care of patients in their homes, and we were running up against a lot of issues with access to care in nursing homes or, you know, physician offices.

Patients weren't going to see their physician. We're trying to keep people out of hospitals. All those things were happening. So we – we developed COVID-19 teams for every one of our locations, so that they were the ones that were going to be tapped when we were going to start getting those COVID-19 patients.

Just like Dan talked about, PPE is – is, and will continue to be, an issue. We are doing the same types of things. It's a daily sourcing, a daily activity of, What do we have? So we immediately took inventory of our – of all of our PPE across the country, just so we knew who had what.

Fortunately we were going through ACHC process for accreditation on the home health side, so we had fortunately already prepared for some of these things. We wanted to make sure we had enough PPE in place for that process.

Some of the other things that we did were – logistics around how do you screen your employees, and how do you screen your patients, to know whether they are exhibiting signs and symptoms that we need to do something with. So we initially put in a very manual process that we had all the staff doing.

We then – every day, before we would go visit a patient, we were making phone calls to the patient to kind of screen them. You can imagine they were getting a little annoyed with that process.

We were in the middle of doing a pilot for a technology that we were going to implement. We made the decision to just full go out and implement that. So that gave us the telehealth capability.

It also gave us the ability to do these screenings through an application process that aggregates all that information for us. So it's very easily seen on a dashboard. We can immediately go to those people that we need to validate whether their symptoms are truly warranted, or for further action or not.

I think that are the things – besides what Maureen and Dan said – I think those were the things mostly on my list that I wanted to bring up. But overall, you know, we have patients obviously on service that are COVID-19. Those COVID-19 team are taking care of those folks.

We have had staff who are also – become positive with COVID-19. So the daily – the daily anxiety around all of that is – is palpable. And being able to manage your staff and your workforce in a way that keeps the anxiety low through a lot of communication I think is probably the biggest lesson learned from my perspective. So with that, I'll turn it back over.

Jean Moody-Williams: Great. Thanks so much, Bob. I want to make sure that we have a few minutes for questions. So, Operator, could you please open the line to see if there are any questions for our presenters or CMS?

Operator: Ladies and gentlemen, as a reminder, for the participants over the phone, if you would like to ask a question, please press "star", then the number "1" on your telephone key pad.

Again, to ask a question, please press "star", then the number "1" on your telephone key pad. We'll pause for just a moment to compile the Q. Once again, to ask a question, please press "star", then the number "1" on your telephone key pad. One moment please for your first question.

Again, participants, if you would like to ask questions, please press "star", then the number "1" on your telephone key pad. Your first question comes from the line of Liz Vote(ph). Your line is now open. You may ask your question.

(Liz Vote): Hi. Thank you. I was wondering about consent, both on the hospice side and the home health side. So maybe a question for CMS – if there have been any flexibilities regarding obtaining patients consent, specifically, you know, with a signature. And a question for the presenters on how you guys are handling that. Thank you.

Jean Moody-Williams: Rob? Karen? Do you want to speak to that maybe?

Karen Tritz: Yes. I think – so this is Karen Tritz from the Quality Safety Oversight Group. We did – we have talked about that, in terms of the – of requiring the signature.

It – I do not believe there's anything in the conditions of participation for that, but there may be a payment related issue there, in terms of that signature. I don't know if anybody from the payment end is on.

(Hilary Leffler): Sure. Hey, this is Hilary Leffler, division of home health and hospice, on the payment side. So right now we're still requiring the signature for the beneficiary to elect the hospice benefit. You know, it's very important, because the patient is agreeing to forgo their right to have Medicare payment made on their behalf to any other provider except the hospice.

So it's important that the patient be fully informed of this. And we still believe that the written signature is appropriate in this instance. But I'm interested in the – in the speakers, and if they're encountering any challenges with that from their perspective.

Bob Parker: Hi. This is Bob Parker. We are not experiencing any challenges with getting physical signatures on our paperwork.

Maureen Hinkelman: This is Maureen Hinkelman. We do everything we can. We fax, we e-mail, we have somebody drop them off at the patient's home. So pretty much we are able to accomplish that.

Jean Moody-Williams: OK, great. Thank you. And actually we are over time. But as a reminder – why don't I turn it to Alina, and she can tell you about the Office Hours.

Alina Czekai: Great. Thanks Jean, and thanks to all of our speakers today. As Jean mentioned, we have Office Hours, both today and Thursday of this week at 5pm Eastern. And we hope that you will consider joining us to hear some more question and answers with our CMS (inaudible).

And until then, if you have any questions, you're always welcome to direct them to our COVID-19 inbox, and that is covid-19@cms.hhs.gov. Thanks again, everyone. Have a great rest of your day.

Operator: Thank you. And that concludes today's conference. Thank you all for joining. You may now disconnect.

End