Centers for Medicare & Medicaid Services
COVID-19 Call with Home Health, Hospice & Palliative Care
Moderator: Alina Czekai
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Operator: This is conference #: 4666966.

Alina Czekai: Good afternoon. Thank you for joining our May 26th COVID-19 call with Home Health Hospice and Palliative Care. This is Alina Czekai leading stakeholder engagement on COVID-19 in the office of CMS Administrator, Seema Verma.

Today, we are joined by CMS leaders as well as providers in the field who have offered to share their best practices with you all. I'd first like to turn it over to Jean Moody-Williams, Acting Director at the Center for Clinical Standards and Quality, for an update on the agency's latest guidance in response to COVID-19. Jean, over to you.

Jean Moody-Williams: Great. Thank you so much. Good afternoon everyone and thank you very much for joining the call. I wanted to just note that I don't have a number of new updates for you today. But I did want to make sure to call your attention to continually go back for our – to our website, in which we – you may have noticed but we will post nearly every week everything that's happened that week as a well as a recap of our prior guidance.

And I always find that as a useful tool because we do issue – so many guidances and updates and waivers throughout the course of the week that it can be difficult sometime to keep up with that. So, I encourage you please to take a look at the website. Also, there are number of toolkits up there that you may find of interest.

And during the question and answer period, if in fact there are some toolkits that you might find helpful or additional resources that you might find helpful, please let us know and we can see how we might be able to work on those.

I'm pleased really to introduce to you our guest speaker for today, Ms. Carla Davis, who is the CEO of Heart of Hospice, which provides care in Arkansas, Louisiana, Mississippi, Oklahoma and South Carolina, so a very broad reach. And as the leader of Heart of Hospice, she makes headlines by partnering with hospitals in New Orleans to launch a temporary inpatient unit for Coronavirus positive patients, so really some innovative approaches that we're looking forward to hearing about. And I will turn it to Carla at this time.

Carla Davis: Thanks, Jean. I'm grateful for the opportunity to share some of our best practices, both in our home hospice as well as the temporary inpatient unit that you just discussed. So, as you've said, I'm the CEO of Heart of Hospice. We are a hospice and palliative care organization.

Today, we're serving approximately 1,700 patients from 16 different locations across those five states. Also, in five states, Louisiana has definitely been the hardest hit with COVID. And we are the largest hospice provider based in Louisiana serving about a thousand patients today.

So, just before I get into the inpatient unit, I thought it'd be helpful to share some of the things that we did generally to address COVID and some of the best practices. So, right from the beginning, the first week of March, we developed a COVID Task Force. We began meeting daily because as everyone knows things were changing, what we were learning, how we were going to approach it so that we could pivot really quickly, and I think being nimble was key to our success to be able to navigate through.

But from the beginning, the most important thing that the COVID Task Force really had focused on, was to prioritize the safety of our employees, and thereby, the safety of our patients and their families.

I would also say that from the very beginning there was no question that we were going to care for COVID-19 patients. We strive to serve all terminally ill patients. And so, this was no exception and we felt that this is the fulfillment of our mission.

But in order to do that, we had to be very aggressive with sourcing PPE, and we have to think about PPE in a way that we had never thought of it.

Honestly, it was something that I think I took for granted in our organization. And so, we didn't necessarily have the infrastructure around PPE that we needed to be able to handle this.

So, we did everything from appointing PPE Czar, a PPE Task Force. We developed heat maps and tracking mechanism. Then we went down multiple lanes to be able to source PPE from multiple different sources. People's jobs who – it wasn't PPE – it wasn't in any of category of their job took on the responsibility to be able to find PPE so we could make sure that we're able to keep our folks safe.

And of course, not knowing where the breakouts were going to happen or what the spread was going to look like, we had to have PPE in all our locations. So, we also tried to have some centrally located so that we can deploy it and move it around accordingly.

The only thing that I think we did well was we developed three levels of stratifications to be able to make market by market decisions based off of the risk in that market and based off of some correlations to the government's declarations. And we were able to move our agencies up and stratification or down in stratification as things began to change.

And that stratification determines what was our PPE utilization going to be, what was our utilization of televisits going to be, what was our frequency of in-person visits, how much staff we were going to reduce in the office, how we were going to have remote IDD, all of those kinds of things so people were able to know as we moved up or down, how their behaviors should change always, of course, individualizing the care for each individual patient.

I had a mentor – I have a mentor, David Ring, who told me that in the absence of truth, people will design their own, and that was a very good advice. And so, I think one of the things that we did immediately was begin company-wide town halls. That's not something we had ever done. And so, we invited all employees to participate in the team's call so they could see us, hear from their leadership, we could communicate decisions that we were making, provide

education, answer questions, provide support. And I think that's one of the practices that will continue after we are – we are on the other side of this.

We also asked each of our agencies to hold daily calls with their employees. We disseminated – just as CMS does update their toolkits and their documents on a weekly basis. We do the same so that we can make sure that people have the information that they need to be both mentally and physically safe. We built educational tools for our patients and families and referral sources. We even started a moment of joy where we share something to bring joy to our employees' life every single day.

I just wanted to say how grateful I am for NHPCO's advocacy of the CARES Act and the Administration's support for the CARES Act because allowing the regulatory release and the funds to cover our financial loses gave us the confidence that we would be able to care for people facing this virus.

So, now, I'm going to kind of transition to the inpatient unit itself. So, towards the end of March, that's when we started to see a major uptick in COVID-19 cases, particularly around the greater New Orleans' market. Now, of course, looking back on it, we know that the virus was rightfully there during Mardi Gras, and that was the reason for such a widespread penetration of that market.

So, the hospitals in the New Orleans area were invaded with COVID patients. We are starting to see the ERs and the ICU beds full. People were in hallways. They were allotting 2,000 beds in the convention center and had tents in the park setup. And so, things were starting to get pretty severe. And of course, we have seen all of it has been going on in New York City and we were starting to see a smaller version of that in New Orleans.

And the worst part about that to us is that patients and families and loved ones were being separated and not able to be with the people that they love, which caused I think trauma on both sides, certainly the patient's side being isolated during this time and sick and certainly from the family side not being able to be with the people that they love and say goodbye. And that's something that I think that they're going to carry with them for the rest of their lives.

So, our COVID task force is talking about all of this and thinking that there had to be something more that we could do. And so, Dr. Sonali Wilborn, our Chief Medical Officer, floated this crazy idea to open an inpatient unit for COVID patients so that they could get the care they need, great pain and symptom management but also be with their families. And in doing so, they would be freeing up the hospital resources to be focused on patients that had a chance of recovery.

So, it was a crazy idea for anybody who's out there who's run an inpatient unit or opened an inpatient unit, normally opening an inpatient unit takes a year, sometimes two years to be able to get everything in place. So, to try to do this overnight is a little insane. But we are a crazy hospice so we decided that we would try.

And so, I kind of group what – so what has to happen for us to open an inpatient unit and let's just run the lanes, let's not think literally. Let's think of all the things that have to happen and let's just start doing them and see if we can make it happen.

And so, I kind of group those things into four buckets. One is you have to have space, right? You have to have a location. You have to have the physical space that meets the regulatory requirements. You have to have regulatory support for licensure and Medicare approval because if this was going to take six months then obviously the need of now. So, we wanted to make it happen as fast as possible.

You have to have staff. You have to have nurses and aides and doctors and social workers and chaplains and you have to have people to be able to serve the people. So, that's certainly a big hurdle to get through. And then you have to have equipment, beds, suction machines, and you have to have the medical supplies and certainly medications and the PPE to make that possible.

And so, our Senior Leadership Team started running the lanes. And again, it wasn't really defined by what our job title was. For example, Dr. Wilborn was actually negotiating the lease for the space. I asked our Fort Smith, Arkansas Inpatient Unit Director, Melissa Moody, to consider coming to Louisiana.

This is before the state has even approved the concept. So, we're just like again taking actions so that if it is possible for us all to come together we'll have all of the things that we need.

And I picked up the phone and called her Friday night and she immediately committed to coming to Louisiana, leaving her home in Arkansas, and helping us start the inpatient unit if that was going to be a possibility to have happened. I then asked our entire employee-base to consider volunteering to work the unit if this – if this dream was to become a reality and over 75 employees to date have raised their hand.

And that's one of the most powerful things to me personally that so many people from across all of Heart of Hospice be willing to leave their families, leave their patients, leave their community and put their personal selves at risk to help the people of New Orleans die a death with dignity, and I'm very grateful for them.

The state of Louisiana got on the phone with us within minutes of reaching out to them, listened to our idea and our proposal that was just an idea at that point, and they approved the concept on April 4th.

We had Palmetto GBA approved our A55 within 48 hours, which is so super fast and again made this completely possible. We were able to secure a lease from LTAC that had recently closed it's doors . And so, that worked itself out. We started working with our pharmacy partner in Clara and DME Express to make sure that we had the things that we needed. We were surveyed and licensed eight days after receiving approval for the idea, eight days.

We accepted our first patient on April 14th. So, it's been less than six weeks since we began our inpatient unit. And to date, we've had over 60 Heart of Hospice employees serve a total of 69 patients in the unit in less than six weeks. In all of Heart of Hospice, we have served 133 patients in the home setting. wherever they call home, making that 202 total COVID patients served most all of those patients were in Louisiana.

And if you do the math on the total deaths in Louisiana, Heart of Hospice had served almost 8 percent of the total COVID deaths in Louisiana, either in the

home setting or wherever they call home or the inpatient unit. And I'm very, very proud to say that we made a difference. And I think that really the most rewarding part of it has been connecting loved ones with their family and especially after such months of apart.

Many of these people were nursing facility residents. And of course, the nursing homes were lockdown pretty much by the beginning of March. And so, it may have been already two months since they had seen their families than they were in the hospital for however long they were in the hospital. And so, for many of these people, they didn't know that they would ever see their loved one again. And so, to be able to hear the joy and see the tears and just the relief that people have experienced by being reconnected with their loved ones and having a chance to say goodbye.

So, we do feel like we've made a difference, but we still feel like there is much more to do. We still have people dying in hospitals and skilled nursing facilities without hospice, without pain and symptom management, without the emotional and spiritual support that they need and that the staff needs. Many of our facility partners are dealing with this pandemic and the grief that comes with it without the bereavement support that hospice provides and people are still dying alone, separated from the people that they love.

So, I just want to tell you how grateful we are for the guidance that CMS and the Administration has provided, particularly to the nursing facilities and hospital providers, acknowledging that hospice can be allowed to visit patients at the end of life.

My personal wish would be that CMS would more declaratively define hospice workers as essential medical care and not just for the actively dying, which is how some of the nursing facilities are interpreting that. And I wish that CMS could even require the nursing facilities and hospitals allow hospice in the facilities to care for the patients.

And obviously, the practice and the interpretation is – varied facility by facility. It's not even a market by market, thus, decision we care for patients and some nursing facilities and have the whole entire time with full PPE and

they have kept everyone safe and then some facilities have chosen to not allow hospice in or only very, very limited hospice.

And so, that's the part that hurts my heart now is that many of the sickest of the sick are dying without the care that they – that they need. And hospice wants to be a good partner to the nursing facilities in particular, not only to care for the patients and make sure that they have good pain and symptom management but also to provide support to the staff.

So, I don't know if CMS could issue any guidance to the facilities about sort of how hospice can safely provide care in the nursing facility or what does it look like to introduce hospice back into the facilities, like what would you recommend from the PPE testing, et cetera, perspective but any guidance would be appreciated on that.

And then, of course, one of the barriers to help with eligible patients getting the benefits in the skilled facility is the fact that the patients that are COVID positive are being skilled. And of course, you can't have hospice and skilled care at the same time. So, any waiver to allow concurrent care for this reason I think would help a lot more people that are terminally ill and COVID positive to get the care that they need.

And I just wanted to share because I find this incredibly reassuring that we've had over 60 employees working the unit that I've mentioned earlier caring for the 69 patients that we've had and not one – I'm knocking – of those employees have contracted the virus. And I think that proves that PPE works when you have it and when you use it correctly.

So again, I'm just grateful for the opportunity to share some of our best practices. I've learned a lot from my peers out there and I'm grateful for their sharing their story too. And I'm thankful for the support that CMS and the Administration have made, particularly the regularity release and our ability to use televisits to augment our care. We have seen some improved outcomes with utilization of the televisits because, ironically, it has allowed us to be more present than we would have even with our in-person visits. Then hopefully, we'll get a chance to share t some of those in the future.

I have learned so much from this experience. I've seen that the impossible can be possible if we work together and if we believe that it can. And I know that at Heart of Hospice we're stronger because of the diversity that we faced. I think that's true of our nation. And I hope that we do not go back to pre-COVID ways allowing barriers to impede access to care. So, thank you very much.

Jean Moody-Williams: Thank you. That was – it's really remarkable, the coordination that was required and that you all undertook to bring this about so quickly and amazing to get loved ones connected at such an important time and at such a broad scale.

And also, the consideration of staff and certainly did take note of the difficulties that I guess continues to exist with hospice being able to enter into certain facilities as well took note of the concurrent skilled and hospice care.

So again, thank you and operator, I'd like to open it up for questions please.

Operator: Thank you. To ask a question you will need to press star and then one on your telephone. To withdraw your question, press the pound or hash key. Please standby while we compile the Q&A roster.

Again, if you would like to ask a question, please press star and the number one on your telephone's keypad.

Your first question comes from a caller whose information was unable to be gathered. Caller, if you're queued up for question, please state your first and last name and organization. Your line is open.

Sheila: Hi. My name is Sheila, and I'm with the California Hospice and Palliative Care Association. And congratulations on what you're doing it's – opening that COVID inpatient unit. Was it – my question for you is, was it licensed as a hospice unit or how was it licensed?

Carla Davis: Yes. And again, I give huge credit to the state of Louisiana for being so responsive and so helpful and obviously base all the needs at this time. I didn't mention, it was only licensed as a temporary unit. So we were – we are

only licensed until the end of June, which obviously presents it's own set of dilemma's because you're not hiring people for a temporary unit that you're going to have to terminate at the end of June.

But yes, we had a hospice in serving patients in the home, about 200 patients (around), because we already – we're a hospice that was licensed and we're already a Medicare provider. We did not have an inpatient license. And so, we did receive an inpatient license and they did receive service. So, we did have to go through the regulatory approval process. They did a virtual survey.

So, barely walking around with the iPads and showing them things as well as they did review employee records, certainly fire marshal, some of those things that we could e-mail them our policy and procedure, all of those things they did remotely and then the way that they surveyed the unit was through camera, FaceTime.

It was a licensed LTAC prior to us sub-leasing it. So, I think that also probably gave them some assurance that we've met the regulatory requirements for the facility itself. And it was – it is inside the walls of the hospital.

Sheila: OK. Well, I applaud you for doing that. That's outstanding. Thank you very much.

Carla Davis: Thank you, Sheila.

Jean Moody-Williams: Thank you. I think we have time for one more question. Do we have another?

Operator: Again, if you would like to ask a question, please press star and the number one on your telephone keypad. And there are no further questions at this time. I turn the call back over to the presenter.

Jean Moody-Williams: Great. Thank you. I'll turn it to Alina and thank you all again for joining. Alina?

Alina Czekai: Thanks, Jean. Thanks everyone for joining our call today. We hope that you will join us later today for office hours at 5:00 p.m. Eastern. When we'll have all of our CMS subject matter experts on the line to address to your more technical questions. And in the meantime, you can continue to direct your questions to our e-mail box which is covid-19@cms.hhs.gov.

Again, we appreciate all that you are doing for patients and their families as we address COVID-19 as a nation. This concludes today's call. Have a great rest of your day.

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