Centers for Medicare & Medicaid Services
COVID-19 Call with Home Health, Hospice & Palliative Care Providers
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OPERATOR: This is Conference # 6782346

Alina Czekai: Good afternoon. Thank you for joining our August 25th CMS COVID-9 call with home health, hospice and palliative care providers. 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 best practices with you all. First, I'd like to turn it over to Dr. Shari Ling, deputy chief medical officer at CMS, for an update from the agency.

Dr. Ling, over to you?

Shari Ling: Hi. Good day, all. This is Shari Ling, deputy chief medical officer here at CMS. I would like to express my thanks to all of you for joining the call today. And we continue to make progress in providing care and services amidst this unprecedented public health emergency and, also, while doing so, continue our regular work.

I did want you to note that given our speakers today, we actually were able to post the hospice quality reporting quarterly updates for the second and third quarters of 2020 and provide some highlights for the second and third quarters as well. So, I just wanted to mention that briefly.

We also have a great deal of work including providing updates on new programs and new efforts to enable point of care in our long-term care facilities and nursing homes. But you'll be hearing more about that over the coming days and weeks.

I did want to also provide direct thanks to our speakers today. Beth Rubio, who is the chief clinical officer for Aveanna and Aveanna Health Care, she

oversees all aspects of the company clinical services and patient care efforts, and Brian Bertram, who is co-founder and executive VP of Infinity Hospice Care, providing care and services across Arizona and Nevada broadly. It is a non-profit palliative care foundation or organization and really has been dedicated to providing high-quality care, education and also leadership.

In these two veins, which really are about the care and services – high-quality care and services needed by our beneficiaries, I do want to say thank you for those of you who provide services to our beneficiaries where they live through home health care and also regarding hospice and palliative care, really bringing comfort to the people who we serve and at a part of their lives where comfort and quality of life really, really matters.

So, with that said, Alina, shall I turn this back to you or shall – would you like Beth to start with her remarks?

Alina Czekai: It would be great to hear from Beth. Thanks so much.

Beth Rubio: Thank you, everyone. Glad to be here and glad to share some of our stories. I think from our perspective, we are a pediatric primarily home care agency across 22 states with about 30,000 caregivers and about 25,000 to 26,000 patients receiving private-duty nursing primarily and therapy services.

I think one of our early challenges – we started monitoring things in February and in late February started to reach out to vendors related to PPE. Most vendors were starting to feel the pinch. Our's quickly began to put limits on our account and had allocations for each office that we had across the organization.

So, we had to go to market ourselves with no real experience in this process, so to speak. We had to start networking and learn how to become our own buyer. We had to set up systems for tracking what PPE was available in our branches, what the utilization was, what the burn was on that PPE minus COVID because since we all know we still have to use PPE for our patients in the home.

So, we had to kind of calculate that utilization. And, then, as COVID became more prevalent, we had to think about the full PPE related to those patients and those situations that we encounter. And we had to develop tracking systems in order to monitor and measure where we were. And, then, as we put the two buckets of PPE together related to COVID and the normal patient care, we had to calculate our burn rate utilization.

As an organization, internally I had to learn how to stay close with our internal partners as well as our branches. We had to work with many different vendors across the country and across the globe. We had to work very closely with our internal partners here, with finance and payables to ensure we have the cash flow to purchase PPE.

As many of you probably have encountered, most vendors – because PPE became so scarce, you had to pay for it ahead of receipt. And then, based on the research that you did on the company and the product that you believe that it's a good product, that actually good product does come.

And we have been very fortunate and we have not encountered any really bad situations with the vendors we have been dealing with. So, all of that was great learning. And we continue to do so and continue to stay close with vendors and try to stay ahead 90 to 120 days on utilization for PPE.

Secondly, I think one of the other big best practice things we did is develop region response teams. So, it became obvious early on that the incoming amount of enquiries that we had could not be managed just simply from corporate support. So, within our business lines, we developed region response teams comprised of HR, finance, clinical – all our business partners in each region.

And, then, we would meet two times a week to talk about all the different situations. The amount of patients we had – or nurses we had, we did contact tracing. We would work on education, policy, exposures. We created a centralized COVID toolkit that contained all of our documents that our business lines and our branches would need.

We also then had regular company leadership calls on a weekly basis. I think it's been very advantageous that we kept everybody close and continued to discuss and talk about things as COVID changed over time, regulations changed, mandates changed, recommendations from CDC changed.

We all worked together to make sure that everybody was informed. Communication was paramount. And we believe it was very successful as a result of staying tight with each other. So, I think those are the two biggest things that I can share related to how we have been able to weather COVID in our industry.

Alina Czekai: Terrific. Thank you so much, Beth. I really appreciate hearing your insight from your perspective. And we will now turn it over to our other guest speaker, Brian Bertram, the co-founder and executive vice president of Infinity Hospice Care. Brian, over to you.

Brian Bertram: Thank you so much, Alina. Thank you first off, Beth, having three small kids at home, my wife and I appreciate all that you do for the palliative care and pediatric patients and home health care. And thank you for the introduction, Dr. Ling. I'm very happy for being invited here to share some insights to our fellow leaders and stakeholders on the call today.

I'd also like to thank CMS and the National Hospice and Palliative Care Organization for this opportunity. I want to thank CMS for distributing valuable insight and information to help providers navigate this pandemic. I would also like to thank Administrator Verma for leadership and the regulatory flexibilities that CMS has granted through waivers and rulemaking.

I am honored to be here today describing our organizational transformation that took place under COVID-19. My role as the founding partner of both Infinity Hospice Care and Nevada Care Connect is to design our serious illness platform and develop partnerships across the care continuum. But, my most important role is that of mentor and coach to our leadership and staff.

Our family-owned organization, Infinity Hospice Care, operates three licensed hospice agencies. We started in Phoenix, Arizona in 2005 and serve eight

counties in Nevada. In any given day, we care for about 400 hospice patients across the organization.

In addition to hospice, our medical group managed by Nevada Care Connect provides hospital palliative medicine, transitional care management, chronic care management and community-based palliative care services to more than 3,000 seriously ill individuals throughout Nevada.

From an operational standpoint, three days after the President declared a national emergency, our management team began daily virtual meetings to conference and discuss information coming in from all sources such as CMS, CDC, NHPCO and state and local health departments. Agendas included the acquisition of PPE, policies regarding acceptance of COVID-19-positive patients, protocols and duties.

As founders in the organization, by brother Darren Bertram, our CEO, and I began weekly staff video updates distributed to Paycom meant to inform, unite and calm our staff. We discussed why access to the office was strictly limited. We distributed equipment to work remotely and masks and social distancing protocols, which we demonstrated and enforced.

We provided enhanced cleaning protocols, distributed products and set the stage for virtual in-service operations to all our locations. Our senior leadership team coined the motto "Care is usual but protected" as a rallying cry for teamwork towards alleviating suffering, especially in those testing positive for the virus.

Since the March declaration, our hospice agencies have cared for nearly 100 COVID-positive patients. In Las Vegas alone, we have cared for 32 positive patients in contracted hospitals, 26 in our inpatient unit, 13 in the facility and home setting and not to mention six additional added to our service just today.

Nearly half of the COVID-positive patients accepted to our inpatient unit were previously cared for in a skilled nursing or rehab facility. We test patients and staff exhibiting symptoms when in unprotected contact or they have household exposure. Testing remains a tremendous administrative challenge.

In some areas, tests return in one and a half days. In others, it may take up to 14 days.

We have not found a lab that offers consistent, dependable and timely results. We are fortunate to have a lab and CLIA waiver in our inpatient unit in Las Vegas and have recently executed a contract for rapid testing capabilities. We are solely bearing the burden of this capital expense and would welcome support or coverage for those tests.

We have had several staff who tested positive for COVID-19 and have traced the vector in nearly all cases to household spread. In areas we operate, the virus is out in the community and we continue to stress precaution. So long as we continue to have access to PPE, our trained staff will be protected in this unpredictable environment.

One of the most critically important waivers provided under Administrator Verma's leadership has been the permission on telehealth flexibilities for both the hospice operations and the medical group. For hospice, our most pressing challenge was caring for patients whose families were deemed non-essential in the care of their loved ones.

As our hospice agencies quickly adopted virtual whenever necessary and appropriate, we were able to enter nursing facilities and homes where our staff were previously restricted. The virtual flexibilities afforded to hospice have allowed our agency to partner with skilled nursing and assisted living facilities willing to raise the standard of care under this pandemic.

Even so, skilled nursing facility restrictions in Nevada require two negative tests before accepting a patient. And very few, if any, facilities in Phoenix, Arizona will accept a hospital patient on respite care regardless of their testing status.

We have experienced numerous cases where families too worried or concerned for small children at home have refused to accept the COVID-positive hospice patient back into the home setting. We are fortunate to own and operate our own inpatient unit where these COVID custodial patients remain on routine home care until their viral status resolves.

I would like to advocate for the need for extended respite flexibilities provided to hospice so that our SNF partners would be more willing to accept and collaborate in the management of hospice respite patients. Since our hospice inpatient unit in Las Vegas is licensed as a hospital in the state of Nevada, we were permitted to join the Nevada Hospital Association in 2014.

This affiliation became critically important in the onset of COVID-19. We were given access to daily hospital census numbers and able access to the PPP under – PPE, rather, under FEMA – the FEMA allotment to Nevada. Unfortunately, for most agencies in Nevada, this was not the standard protocol across the board. It left our Phoenix and Reno agencies struggling to compete in the marketplace like so many have said before us. Had hospice been given tier-one status under the disaster guidelines, I believe agencies would have been able to do more to assist in the nursing home crisis in its early stages.

In order to bring families together in the face of a virus quarantine, we launched a program called We Are Essential. These are virtual celebrations of life with patients, families, friends and neighbors where scripted hosts help people say "Thank you," express gratitude, love and joy. In many ways, when families are supported, communities come together and heal.

I would like to take this opportunity to discuss how the telehealth flexibilities have supported our ability to care for our medical group patients through our community palliative care efforts. We estimate that nearly one in three patients would not have received a visit from a provider or nurse practitioner if it were not via telehealth.

Often, when a scheduling reminder call is placed, we hear from patients who are too fatigued, stressed or anxious to get out of bed. The ability to perform a virtual visit immediately and address symptoms has been invaluable. One additional area of support we need in community-based palliative care is for more support for remote monitoring technology.

And, finally, I will be remiss if I did not take this opportunity to thank our staff for their dedication, perseverance and empathy during this pandemic. What it took for us to successfully navigate this crisis was an intentional

organizational shift to online and virtual operations wherever possible, not simply directed towards patient care but as leadership, managers and staff communicating with patients and families and getting comfortable with technology in order to provide compassionate, person-centered, interdisciplinary care.

I want to sincerely thank you for having me today, and I will take any questions.

Alina Czekai: Terrific. Thank you so much, Brian. Operator, let's open up the line to see if we have any questions from the audience either for CMS or for our guest speakers today. Thank you.

Operator: That is noted. And ladies and gentlemen, we are about to start the question-and-answer session. To ask a question, you will need to press "star" "1" on your telephone. To withdraw your question, press the "pound" key. If your line is not transcribed yet, I will identify you with the last four digits of your phone number. Please stand by while we compile the Q&A roster.

Once again, ladies and gentlemen, if you would like to ask a question, press "star" then the number "1" on your telephone keypad. We have our line on queue for question with the last four digits of 0959. Please state your first and last name and your organization name. Your line is now open.

Carrie Vandon-Hamill: Hi. This is Carrie Vandon-Hamill from The Good Samaritan Society, and I have a question. How did you address the well-being of your employees during that initial time, and just moving forward, what are best practices that you have found to be effective?

Beth Rubio: So, this is Beth Rubio. I will answer that from our perspective. So, we have implemented self-screening and self-temperature checks in many areas. We also have fully outfitted our employees that are seeing patients with several sets of full PPE so that should they walk into a situation, they are prepared and ready. A lot of states have mandated that households be screened. And, so, where that is mandated, we have also implemented those strategies.

Carrie Vandon-Hamill: What have you done for the staff as far as addressing their well-being for emotional support, for example?

Beth Rubio: So, we have employee assistance programs that we offer and have continued to reinforce that. We've had special counseling (inaudible) in certain cities and areas based on what's happening in the community. We have supported time off. We have supported pay when someone had to stay out as needed. Just whatever has been determined to be a need, we have been able to grant it for the employees.

Carrie Vandon-Hamill: I love that. Thank you so much for addressing that and being an advocate for staff as well. Thank you.

Operator: Again, ladies and gentlemen, if you would like to ask a question, please press "star" then the number "1" on your telephone keypad. We don't have any more questions on the queue. I will the call back to you, presenters.

Alina Czekai: Great. Thanks, Ryan. And thanks, everyone, for joining our call today. We hope that you will join us later today at 5:00 p.m. Eastern for our CMS COVID-19 Office Hours. And that's our call where we have all of our CMS subject matter experts on the line to answer any of your more technical questions.

And we also have a special national stakeholder call today at 4:30 p.m. Eastern with Administrator Verma, Admiral Dr. Brett Giroir and a few other administration officials regarding the third interim final rule that was announced earlier this afternoon. So, we hope that you can join us for that conversation as well.

In the meantime, please continue to direct your questions to our COVID mailbox, which is covid-19@cms.hhs.gov. Again, we really appreciate all that you are doing for patients and their families around the country as we continue to address COVID-19 as a nation. This concludes today's call. Have a great rest of your day.

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