Centers for Medicare & Medicaid Services
COVID-19 Lessons from the Front Lines
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Alina Czekai: Hello. Thank you for joining our CMS Lessons from the Front Lines on COVID-19 today, May 15th. We'd like to begin by thanking all of you for the work that you are doing day-in and day-out to care for patients and their families around the nation amidst COVID-19.

This is Alina Czekai, leading Stakeholder Engagement in the Office of CMS Administrator Seema Verma. And as I mentioned, today's call is part of our ongoing weekly 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 box which is covid-19@cms.hhs.gov. Here at CMS, we recognized 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, care for the patient in your local communities.

Around the nation, providers and local communities are innovating in response to COVID-19. At CMS, we hope to bring local innovators together to share best practices that can be scaled at the national level. And today's call, we'll focus on these expanded flexibilities and we will hear from providers who are seizing the opportunity to really innovate and transform to support their local communities.

Today, we will hear from providers who are in the midst of reopening the health care system and resuming care that might have been deferred during the pandemic. We'll also hear some best practices for post-acute care, long-term care and successful transitions of care, as well as solutions for provider resiliency and support during these challenging times.

And we do encourage you to direct your questions to our guest speakers today, and you're also welcome to share best practices or perspectives from your own community, and should you have more technical questions on CMS waivers and guidance, we do encourage you to join our CMS Office Hours which are held every Tuesday and Thursday at 5:00 p.m. Eastern.

This week we are joined by Dr. Satish Pillai, who is leading the Health Care Resilient – Resiliency Task Force for an update from the Office of the Assistant Secretary for Preparedness and Response, also known as ASPR. Dr. Pillai, over to you.

Satish Pillai: Thank you so much, Alina, for the opportunity and thank you for the participants for joining. Just as a brief reminder for those of you who have previously attended, the Healthcare Resilience Task Force in the National Response Coordination Center at FEMA have the objectives to ensure that providers and health care systems have what they need to effectively manage the health system surge from COVID-19 and to provide care to priority COVID and non-COVID-19 patient.

The task force is has been engaged on a variety of topics to deliver against our objectives. For example, we recently released guidance on Medical Operations Coordination Cells or MOCCs. This guidance recognizes that some hospitals have been overwhelmed with COVID-19 patients while other nearby hospitals have excess capacity.

The MOCCs are designed to facilitate the transfer of patients between facilities, future of patients will receive the highest possible level of care (inaudible) to better load balance demands across the health system. The MOCC guidance is currently available on ASPR TRACIE.

In addition, recognizing the risk and vulnerability among residents of nursing homes, the task force has been tracking and supporting works, including coordination with CDC and CMS on leveraging CDC's National Healthcare Safety Network to set up reporting modules for states. Of 15,000 nursing homes in the country, 12,000 are now registered and over 6,700 nursing homes have recorded data.

Also, the team is conducting a federally-supported nursing home techno pilot across multiple states in – multiple facilities across four states to better understand optimal ways to address the risk of COVID-19 infections in the nursing home setting.

Regarding another high-risk patient population, dialysis patients, we have partnered with ASPR to deploy dialysis resources to hotspot including 50 dialysis machines that have been deployed from the Strategic National Stockpile of New York and would help facilitate the import of dialysis solution.

Another area of increasing focus is rural health. Recognizing rural hospitals represent over half of all hospitals in the U.S. and provide access to inpatient, outpatient and emergency medical services to rural communities, it's important to note that they had unique challenges related to their geography and vulnerable populations.

And because of these unique challenges, the task force is working on a rural health surge proposal to prepare for a potential second wave of COVID-19 partnering with across the Health and Human Services Department, including groups from CMS, CDC, HRSA and the Federal Office of Rural Health Policy.

Another important area for our task force has been clinician's outreach working with ASPR staff and the University of New Mexico, we have leveraged project ECHO to facilitate peer-to-peer learning sessions from physicians to hear COVID-19 best practices in clinical diagnosis. Between March 24 and May 14th, we've had 23 sessions that have hosted 17,900 live participants engaging in peer-to-peer sessions on topics ranging from EMS, critical care, emergency department care and special topics, such as PPE preservation.

And through our CDC partnerships, there had been over 1,100 views during the agency's Clinician Outreach Communication Activity or COCA calls which provide a state-of-the-art on a variety of clinical COVD-19 topic, and

there have been over 1.5 million Web page hit on CDC recommendations on a variety of clinical guidance and clinical evaluation material.

Finally, we are currently in the process within the task force thinking about the need of the health care system in the coming months as the pandemic evolves of new plans to sustain ongoing federal operations, we are looking to continue a set of activities to put the health care system including remote delivery of health such as through telemedicine services providing vulnerable populations with optimal care services and ensuring critical care access to overall population.

With that, I'll stop and turn it back to the moderator. Thank you very much.

Alina Czekai: Thank you so much, Dr. Pillai, really appreciate hearing your perspective and update from the task force. Operator, let's open up the lines for some questions for Dr. Pillai. Thank you.

Operator: Certainly, and just to remind everyone, in order to ask a question, please press star one on your telephone keypad. Again, that's star one on your telephone keypad.

We have a question from Lydia Aguinaldo from Science Home Health Care. Your line is open.

Lydia Aguinaldo: Yes, doctor. I just want to know if when can an employee come back to work, a COVID positive?

Satish Pillai: So, my recommendations right now would be to refer back to the CDC Web site. There are updated guidances on optimal timing of return to work for health care providers, some employee (inaudible) strategy and some employee at home-based strategy, the optimal guidance for any particular agency would be based on their current staffing situation, guidance from the local health department and their human resources policy.

But the most up-to-date guidance for the health care providers can be found on CDC Health Care Provider health guide, over.

Lydia Aguinaldo: Thank you.

Alina Czekai: Thank you. We'll take our next question, please.

Operator: Again, if you would like to ask a question, please press star one on your telephone keypad.

Female: All right. Someone close, again.

Alina Czekai: Hi, there. We can hear you. What is your question, please?

Female: Everybody, thanks. (Inaudible).

Alina Czekai: Operator, we'll take our next, please?

Operator: We have no further questions at this moment, ma'am. You may continue.

Alina Czekai: Great. Thanks, again, Dr. Pillai, for joining us today. We'd now like to hear from physician leaders around the country about what they're facing in their local communities and strategies that are working for them as we address the pandemic.

And today, we are joined by physician leaders from around the country who have offered to share their insights and best practice. Our speakers today will discuss reopening the health care system specifically perspectives from oncology and primary care, long-term care, as well as resiliency support for providers during this time.

And also joining me from CMS are several of our physician leaders who will offer their expert perspectives throughout the conversation as well. Joining me today is Dr. Marion Couch, Senior Medical Adviser to Administrator Seema Verma; Dr. Shari Ling, Acting Chief Medical Officer at CMS; 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 Clinical Engagement.

And we'll start today's best practices session with a discussion on resuming deferred care and I'd like to introduce Dr. Steven Libutti, Director of the Rutgers Cancer Institute of New Jersey. Dr. Libutti, over to you.

Steven Libutti: Thanks, Alina, and thanks for inviting me to participate today. So, as Alina said, I serve as Director of the Rutgers Cancer Institute of New Jersey. We're New Jersey's only National Cancer Institute designated comprehensive Cancer Center, and as the designated cancer center by the NCI for the state, have done our best to play a role in helping the cancer programs throughout New Jersey to discuss and put in place best practices. We've engaged with 12 other a statewide cancer programs throughout New Jersey.

And we meet by WebEx once a week to discuss mutual challenges, ways that we are approaching things like personal protective equipment, scheduling patients for acute care needs, whether that's medical oncology, surgical oncology or radiation oncology needs and discussing ways in which we could be best prepared to handle the various waves or surges of the pandemic given the fact that cancer patients are particularly vulnerable population, both for their risk of contracting source SARS-CoV-2 and their morbidity if they develop COVID-19.

The cancer programs throughout New Jersey never stopped providing cancer care. We've been providing infusions to patients on active chemotherapy regimens, radiation therapy and urgent cancer surgery throughout the pandemic. However, we did significantly leverage telemedicine for certain less acute visits and this was incredibly important to maintain care and contact with our patients.

And so, we are grateful to CMS and others for allowing telemedicine to be implemented on a much larger scale, and we believe telemedicine is here to stay certainly for the management of cancer patients. However, now as we try to get back to a more in-person posture, we have established screening programs for our patients and our staff.

This involves contacting patients ahead of time to do symptom checks and to determine whether or not there may be a situation where a patient is

manifesting symptoms of COVID before an appointment. We do temperature and history screening at the door of the cancer center for patients and staff.

And we've now not only begun testing all symptomatic patients, but we are also testing asymptomatic patients that meet certain criteria, patients about to start chemotherapy, about to start radiation therapy or plan of surgical resections for their cancer. We're also opening up surgical oncology more broadly and cancer screening, screening modalities, such as mammography and endoscopy in order to catch up with what we believe have been deferred cancer screening by many patients.

We're also working with some of the payers in our region evaluating approaches to things like home chemotherapy infusion, so we can be best prepared for future waves of the pandemic if they present themselves. And so, that's been our approach to enhance communication among all the cancer programs throughout the state.

So, we're sharing experiences and best practices to provide a means of screening our patients and our providers, so we can maintain the best level of care possible. And now, we're on a posture where we're trying to open up more cancer screening, cancer surgery and in-person visits to get back on a more usual posture on – for the best care for our patients.

And so I'm happy to stop there for any questions.

Alina Czekai: Great. Thank you so much, Dr. Libutti. We'll now turn it over to Dr. James Rice of Annapolis Pediatrics and then we'll open up to questions after Dr. Rice's presentation. Dr. Rice, over to you.

James Rice: Great. Thanks. Thanks, Alina and thanks for the opportunity to present a perspective from Primary Care Pediatrics. My name is Jim Rice. I'm a pediatrician at Annapolis Pediatrics, which is an independent general pediatrics practice in Maryland, fairly large with 30 providers, five office locations.

We serve 37,000 patients and 6,000 of those patients are covered by Medicaid. I want to focus my comments as a pediatrician on vaccination. We

may not yet have a SARS-CoV-2 vaccine, but we do have safe effective vaccines against other deadly diseases. So, for my fellow pediatricians and for me, a terrible aftershock to this pandemic would be to the outbreaks of pertussis, measles or other vaccine-preventable diseases, such as infant meningitis.

So, unfortunately though pediatric vaccination rates have dropped substantially since March 13th, CDC data shows declines in ordering and administration of vaccines by 50 percent or more nationally. In my practice, our experience or vaccination rates for the month of April this year are down 40 percent overall from our baseline.

But throughout the pandemic following the American Academy of Pediatrics Guidance, we've focused on vaccinating the less than 2-year-old age group where timing of vaccines is the most critical. So, in that age group, we've kept rates in – at 85 to 90 percent of normal. On the other hand, adolescent vaccinations way down and really did not occur at all through April in the first half of May in our practice.

Like both practices around the country in primary care in mid-March, our overall in-person – in-person visit volume dropped to 20 percent of normal. We quickly mobilized telemedicine and it's great.

We appreciate the flexibility from CMS and from payers to use that. We've temporarily closed two of our five offices, and we designated one office as the single location to provide vaccines and well-baby care for symptom-free patients, accompanied by one parent wearing a mask.

Our staff wears PPE and then patients of any age who are symptomatic in any way, fever or otherwise, are screened with a telemedicine visit, and if appropriated and evaluated in-person in a different office, telemedicine, we've also used extensively for behavioral health, for other amenable medical conditions and for non-vaccine related well-child care within anticipatory guidance since it's been effective for that.

But as far as keeping the vaccine rates up in young kids, the separation of symptomatic versus well patient by office location has helped decrease

parental resistance to in-person care. However, we definitely still encounter some degree of a parental reluctance to come into the office with their infants, in particular for vaccines.

We are, as pediatricians, concerned about asymptomatic shedding in children of COVID-19, and we did have one of our physicians become ill with COVID-19 in mid-March prior to more universal use of PPE in the office in primary care. So, PPE is now critical. This physician is doing fine by the way.

So, we have not vaccinated the older children or adolescents during the period when Maryland limited nonessential care, and this will now be a priority of our efforts in reopening everything in the practice. Deferring adolescent vaccines for eight weeks is recoverable but the summer is when we really catch a lot of these adolescents, and so we really want to recover those rates for meningococcal, HPV and tetanus, pertussis vaccines.

Sustainability of our ability to continue to vaccine is a huge concern. Financial strain on pediatric practices, particularly independent ones that serves so many kids in our country is really considerable. Revenues down considerably and pediatric practices are – have normally run on a very high fixed overhead and very low margins.

So, it's – we don't have much reserve. It's been tough. So, we've furloughed staff, and to date, nationally, pediatricians have not been eligible for stimulus funds disbursed to Medicare providers. So, really haven't gotten that source of funding. Our practice, in particular, was fortunate to receive PPP loan funding which has allowed us to continue to function for the short term.

But beyond that as the independent practice and from hearing so many of my pediatric colleagues around the country, we depend upon day-to-day, week-to-week revenue to operate, it will be a challenge to continue to provide pediatric care and vaccines, especially as we reopen – efficiency will really be strained by new workflows, by use of PPE, by separating patients.

I think we'll want to try to continue to separate a healthy and symptomatic and so volume and revenue are not likely to rebound quickly. So, it can be

challenged. We're committed to remaining viable like for me, pediatricians around the country and try to continue back-thinning and we hope to be able to give the COVID-19 vaccines, totally, in our practice as well. I'll stop there. Thanks.

Alina Czekai: Thank you so much, Dr. Rice. Before we open it up to questions from the line, I'd like to invite my CMS colleagues to ask any questions or make any comments before we open it up to live Q&A. Thank you.

Barry Marx: Hi. This is Barry Marx from the Office of Clinician Engagement and wonderful presentations, and Dr. Rice, I have a question for you. You mentioned performing well-child visits virtually and you mentioned specifically anticipatory guidance.

So, I'm just wondering has there been experience with the new practice around the parents engagement with things like developmental screening and other risk assessments that are normally done as part of the scheduled routine well-infant, well-child and well-adolescent visits?

James Rice: Yes, thanks for that question. There has been engagement around that. We have, for years now, performed standardized developmental screening in the office using the Ages and Stages Questionnaire and the MCHAT.

We've done those on paper and then had to enter those into our EMR. Other practices have gotten the technology where they're – actually have an electronic portal to enter those, and I think those practices were in sort of better shape to be nimble with that by a telemed.

We quickly sort of posted those screens at our Web site and even had a couple of our – used some of our nurses and medical assistants to kind of go through to screen and verbally with parents and fill that out. I think the added value is as pediatricians, we realized we are actually with telemedicines getting to observe kids at home.

And sometimes in addition to the developmental screening, the standardized tools that additional observation of kids in the – in the environment they're

comfortable with has opened up some new windows for us into observing development and parent-child interaction that I think has been helpful.

Barry Marx: Thank you very much.

Michelle Schreiber: Hi, and this is Michelle Schreiber from the Quality Measures and Value-Based Incentives Group. First of all to both of our presenters, thank you for being here today and thank you for your innovations, and to all of you on the phone, thank you for being the heroes of the front lines fighting this pandemic.

I have a question for both of you. We hear from patients frequently that they're afraid to go into the office and they're afraid to restart care. What is it that you're doing in your practices to help reassure patients even having patients waiting in the car before they come in or any outreach that you're doing to make patients feel more comfortable?

Steven Libutti: So, I can start the answer. This is Steve Libutti and then let Dr. Rice gives his thoughts as well. So, one of the things we felt as important is for our patients to feel a sense of security that we are being vigilant on identifying infectious risk for them as best as we can. Obviously, cancer population is a particularly vulnerable population to the morbidity of COVID-19.

And so screening patients ahead of time, 24 hours before their visit minimizing – and the number of patients that are in a waiting area, so maximizing social distancing, we decreased the number of folks that can accompany patients to their visit, which as a cancer provider, and I'm sure this is true for Dr. Rice as a pediatrician, that was really counter to our culture.

We look to provide the best support network possible and that often involves friends and family coming with patients for visits or treatment, but we had to scale back on that quite a bit to maximize social distancing, and now our rigorous efforts to test patients, asymptomatic or symptomatic.

And we have special areas within the Cancer Institute, where if the patient is positive and does need to proceed with treatment, we are keeping patients who are positive and patients who are negative separated in order to decrease the

risk of spread. So, I think a lot of it is – and then, obviously, our staff uses PPE and our patients are all wearing masks when they're in the facility.

And so it's been the ability to communicate to patients that we are cleaning rooms, frequently. We are masking and using social distancing, and we're testing to try to minimize the chances of picking up an infection by coming into what is usually considered a safe place for them to receive their care.

James Rice: Great. Yes, I think our approach has been similar. We actually just today posted a video on our Web site for our patients, and we actually e-mailed that out to patients. If anyone want to take a look at Center Annapolis Pediatrics' Web site, and it shows the new process in the office to patients, and we thought just showing that directly by video might be helpful involving social distancing in the office.

We're really trying to get away from the waiting room. No one likes the waiting room anyway, but we are asking patients to call or text from the car and we'll sort of escort them into the office and really sort of in and out without the waiting room. I think that will be key to our – to our workflows. It does – yes, it would be the right thing to do medically I think from a viability standpoint.

It's concerning and that like I said we run really very high-volume operations. We've traditionally run a walk-in clinic to provide frictionless access for patients in all-day walk in service even. I don't think we'll be able to do that. We need to be able to plan and manage flow a little bit better. So, it will change something substantially in pediatrics.

Michelle Schreiber: Thank you, both.

Alina Czekai: Thank you so much. Operator, let's open up the line for questions from the phone. Thank you.

Operator: Certainly, ma'am. As a reminder to everyone, in order to ask a question, please press star one on your telephone keypad. Again, that is star one on your telephone keypad. Again, to ask a question or make a comment, please press star one on your telephone keypad.

We have a question from Lydia Aguinaldo of Science Home Health Care. Your line is open.

Moving on to the next question, we have from Keith Assad of IHP. Your line is open.

Keith Assad: Hi. Can you hear me?

Alina Czekai: Yes, hello.

Operator: We can.

Alina Czekai: What is your question?

Keith Assad: Yes. We had a question regarding whenever a practice applies to be in-network with the health insurance company. They say that they take – they have – they are allowed 120 days and sometimes it can take six months.

So, with the current situation, can there be anything in place such that we are able to see patients that are considered out-of-network or if there is a way to speed up the process for the in-network for a health insurance so that we can help patients that are requesting for help.

Alina Czekai: Thank you for your question. I don't think we have the right CMS technical experts on the phone to ask or excuse me to address that question, but I'm happy to take that one back as a follow-up. I've recorded your contact information from the operator queue, so to speak. So, I'm happy to follow up with you on that one.

Keith Assad: OK. Sorry, I didn't hear who's speaking?

Alina Czekai: Sure. This is Alina Czekai at CMS.

Keith Assad: OK. All right. Thank you.

Alina Czekai: Thank you. And we'll take our next question, please.

Operator: Again, for everyone, if you would like to ask a question, please press star one on your telephone keypad. There are no further questions, ma'am. You may continue.

Alina Czekai: Terrific. Thank you and thanks, again, to Dr. Libutti and Dr. Rice for joining us and sharing your perspective. Our next segment today, we'll discuss caring for post-acute patients and transitions of care during COVID-19. And today's speaker is Dr. Dheeraj Mahajan. He is the president and CEO at the Chicago Internal Medicine Practice and Research. Dr. Mahajan, over to you.

Dheeraj Mahajan: Thank you, Alina. Good morning and good afternoon, everybody, based on where you are. My name is Raj Mahajan. I'm here in Chicago. I'm an internist and geriatrician and I'm also the president and the CEO of CIMPAR which is a group practice of 15 physicians and eight advanced practice clinicians.

We do cover hospitals, but our specialty is transitional care and nursing home care and the niche we have developed here is several years ago, we moved away from the traditional fee-for-service in Madison to go directly to either payers or health systems and ACOs to give them their post-acute coverage on a performance and risk-based contract, and we are able to do that with providing them the performance not only on clinical, as well as on the resource use side.

First of all, I would like to thank Administrator Verma and her team for so quickly coming up with the things and plans to save us. It's a private practice that I own, and as you can say, we have 20 plus providers that get paid every two weeks, and during early piece part of April, I just didn't know how we were going make our payroll.

And like a lot of my other friends, the surprise we received on April 10th, so that Friday, woke up to the bank account having miraculously had enough funds to make the payroll the following Wednesday. I have not been that happy since my 11-year-old daughter was born back in June of 2008.

So, thank you so much for that. We were able to get our advance payment, also, as well as the payroll protection loan which has really helped us just be

able to have payroll for our employees. Imagine being on the front line and putting everything at risk and not be able to be paid and asked that's not – and so very thankful for that.

I personally – I'm a medical director at CCRC, the Continuing Care Retirement Communities, and personally, have spent a lot of time volunteering to advance the quality and reduce the disparity that we have within the post-acute space. I have been on several CMS and National Quality Forum Technical Expert Panels addressing the quality and other physician-related value-based programs.

And I worked with CDC, as well as – as well as local health department on the technical expert panels for post-acute-related matters. I definitely want to thank AMDA, the Society for Post-Acute and Long-Term Care Medicine that is the group where all of our practitioners come together.

They have worked tirelessly to give direction to all the common concerns we have from medication treatment, isolation guidelines physician practice. It's been very helpful, and so as the groups like Advancing Excellence in America's Nursing Homes as a loose group of quality UMA experts and stakeholders that come together.

I personally have worked on the infection control and interoperability and have been fighting for meaningful electronic health technology and post-long-term care which we all know has a lot of opportunity. I am amazed every day by the selfless and courageous attitude all my clinicians have shown during this worst crisis of our lifetime, and I know it's a cliché, but most of them have decided to run towards the fire instead of running away from.

Early on, we heard people really just not wanting to be around an outbreak facilities, but our practitioners on an average are spending 12 to 14 hours every day on site and that some is by design because these are advanced practitioners that we have put on site, and they've been the only practitioners in the facility.

Currently, all three facilities that I have as the medical director are at different stages of outbreak. The facility that had its first case is officially COVID-free

as of yesterday. I'm so proud to say that. The second facility is at the peak of its outbreak. It has 25 active cases and so far three deaths, and it's been fighting a lot of media negativity and that's a challenge as physicians and clinical leaders.

And then the third facility which for years I've probably bragged that a lot of national avenues as the best facility that has Infection Control Program throughout the country, if not the best, definitely among the best had just first two cases last week, and just this week, we found we have four more.

We're doing everything to do our infection control-related precautions and most of these facilities have assisted living or other independent living within the campus, and it is very, very difficult to control the flow of visitors and residents in that setting.

Very early on before we had our first nursing home case in Illinois, we were able to institute visitor restrictions, address of goals of care for all our residents, and thanks to AMDA, again, for giving that guidance and we did our daily PPE inventory.

We did a massive staff education on hand hygiene, social distancing, enhanced infection control practices. We definitely made sure we included all our nonclinical staff because nurses and CNAs a lot of time to get regular in-services on basics of hand hygiene and social distancing, et cetera. But we made sure we had our environmental services and nutritional services staff included on these educations.

We were lucky that most of our residents and families who were supportive of our visitor restriction, and in coming weeks, we did institute practitioner restrictions especially after the data from Kirkland Facility showed that a lot of these initial outbreaks are related to asymptomatic staff going in between different facilities.

So, we were very strict on our registry and agency staff as to places that we're going the screening were put in place very, very early on. And so – and as the – as the telehealth visits work through by CMS, and we were able to encourage our community practitioners.

Our specialty physicians – that's not me – physicians to perform virtual visits and we made sure that there were enough equipment available and, again, to thank everybody playing their role. We were able to actually get medical grade covering including tablet devices to some of the local charities that not only gave us that but also provided us with some PPE.

Thanks to that, and we are actually, to CMS' information, applying to get some of the CMP money-related audio-visual tablet devices to continue to allow our residents and practitioners to be able to see and talk to their loved ones remotely.

So, the way we are managing our outbreak is we have an APC that evaluates residents on our COVID units at least twice a day and then presents the update to our command team, the Incident Command Team that I lead as the medical director.

Our Incident Command Team consists of the medical director, myself, the executive director or the administrator, the director of nursing, the infection preventionist and also the in-house advanced practitioner.

Through the help of our State Department, we were the first facility that or the facilities that were able to test all our resident staff and to our surprise we did have around 8 percent of our staff that tested positive were asymptomatic and even approximately 3 percent of our residents who are asymptomatic when they tested positive.

We use our twice a day incident command call to address clinical operational HR regulatory staffing and PRN resident family concerns, and we make prompt interventions on clinical management, infection control testing strategy for its upcoming days, as well as staffing changes that might be needed and it's been an honor to be involved in the decision-making.

Medical directors a lot of time in nursing facilities don't get that involved, but I am amazed how much the team has come together and respected the medical directors in the buildings with not only clinical but also administrative

recommendations. And I'm proud to say that the first facility we were able to restrict our outbreak to just two residents with no deaths or hospital send outs.

One of our recovered patients is a hospice patient and I'm proud to announce as of yesterday that facility is COVID-free using the test-based strategy. We could not have done it without the unconditional support from our executive leadership, nursing staff, nonclinical and frontline staff, especially in the nutrition and environmental services.

The family member who did a drive-by on Mother's Day and held, "We Love You Mom" signs in the yard. We have pictures on her Web site. It's been – it's been very heartwarming to see the support that we have received from our practitioners and family members.

And last but not the least, I have to thank the State Health Department of the guidance and CMS for their proactive waivers and support in SNF setting, whether it was few-day stay – admission requirement or telehealth waivers, and we definitely thank the administrator for the recent letter to the nursing home staff and releasing the recent toolkit. We're still going through it, but it so far what I have seen is really good.

The NHS I'm reporting is definitely going to be helpful, and I conclude by saying this is the nasty and a sneaky bug but together as we build the plan we fly, we can do it. We are very, very thankful for the financial and the other technical support we received from CMS and the Proposed Nursing Home Commission and the CDC Nursing Home Task Force.

We – that we have found out in last few days are definitely going to be helpful, and I would definitely propose that the practicing physicians be involved in that process, and we work towards, probably, not having more regulation, but best practices disseminated and, again, thank you very much for CMS staff for recommending me to be on this call. It's truly an honor.

Alina Czekai: Thank you so much, Dr. Mahajan, really appreciate your perspective, and congratulations to you and your team on your COVID-free facility right now. I'd like to invite my CMS colleagues to ask any questions or share any comments before we open up the lines. Great. Operator …

Marion Couch: Alina, this is Marion Couch.

Alina Czekai: Oh, go ahead. That's great.

Marion Couch: I just – I just want to …

Alina Czekai: Go ahead, Marion.

Marion Couch: … thank them. They're just wonderful stories and it just means so much for us to hear back from you on what is working. So, thank you so much.

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

Operator: Certainly. As a reminder to everyone, if you would like to ask a question, just press star one on your telephone keypad.

You have a question from Sarisha Coppola from CMS. Your line is open.

Sarisha Coppola: Sarisha Coppola from University of New Mexico. I have a question more for the CMS leaders. We want to – we are looking for more guidance with the medical students that we teach.

We have received some information on the – how the residents can kind of document, see the patient, but if – we would really appreciate if you can provide more guidance on how we can involve the medical students in this audio-visual visit and also on the billing component of that. Thank you.

Alina Czekai: Thank you so much for your question. We certainly take that back on sort of technical and policy experts who are working on those issues.

Sarisha Coppola: And just to add, I want to thank for everything that you – in CMS have been doing and very timely in this critical time of pandemic and I would also want more clarity on the facility fee that we can infer for this audio-visual and telephone equipment. Thank you.

Alina Czekai: Terrific. Thank you so much. And I will direct you, we do have a number of technical resources on our Web site about telehealth. We also recently

released a video that kind of as a user guide to the agency's latest guidance on telehealth. So, if you haven't seen that yet, I do encourage you to take a look and, again, thank you for joining our call and for asking those questions.

Operator, we'll take our next question, please.

Sarisha Coppola: Thank you.

Operator: Thank you. We have a question from a participant. Please state your first and last name then ask your question. For the participants with phone number ending with 4156, your line is now open. Please state your first and last name.

Kimberly Gemaro: Thank you. Kimberly Gemaro. We are beginning to hear that CMS may be planning to amend the visitor restrictions for skilled nursing facilities. Could we have some insight on that, please?

Alina Czekai: Could you repeat your question, please? I heard you say skilled nursing facilities, but I didn't catch the rest.

Kimberly Gemaro: We are beginning to hear that CMS may be considering amending the visitor restrictions for skilled nursing centers. I'm wondering if you can provide some insight on that.

Christine Teague: Hi. This is Christine Teague from the Division of Nursing Homes. So, we, as always, are constantly reevaluating all of our guidance and all of our practices. We are looking at visitations and looking at providing guidance to states and facilities on how to best implement when they are restoring the resident visitations. So, as soon as we have information available, we will let all know.

Kimberly Gemaro: Thank you.

Alina Czekai: Thank you. We'll take our next question, please.

Operator: Thank you. Again, for everyone, if you would like to ask a question, please press star one on your telephone keypad.

We have a question from (Sherry Mitchell) from Health Care Council. Your line is open.

Sherry Mitchell: Hi. I just – based upon a CMS publication just about an hour ago, I just want to say, again, clarification that CMS is planning on publishing the COVID-19 reporting information that goes to the CDC on Nursing Home Compare and if that is the case is that going to happen at the end of May or was that referenced to the end of May simply information will be available – may not be available on Nursing Home Compare at that time? Thank you.

Alina Czekai: Christine, would you like to take that question or we can take this one back as well?

Christine Teague: Yes, I can take that question. We will be publishing on the Nursing Home Compare Web site, but I do not have the exact date yet.

Sherry Mitchell: OK. Thank you.

Alina Czekai: Thank you for your question and thanks, again, Dr. Mahajan, for joining us today and for sharing your perspective. And our final segment today is discussing provider resiliency, support, compassion, communications.

We note this is a challenging time for providers on the front lines and joining us today is Dr. Rana Awdish, and she's the Director of Pulmonary Hypertension Program and Medical Director of Care Experience at Henry Ford Health System. She's also the author of the book, "In Shock" which documents her own personal experiences as a patient in the health care system. So, I'm pleased to turn it over to her. Thank you.

Rana Awdish: Thank you so much, and thank you to Dr. Schreiber for inviting me to share my experiences today and experiences at Henry Ford Health System. Henry Ford Health System is an eight-hospital system with the largest flagship hospital being right in the City of Detroit, and as you all know, Detroit has been quite hard hit by the pandemic.

At our peak census, we had over 350 patients just in our hospital that we are treating for respiratory distress related to COVID and our ICU surge really to

double capacity. As the Medical Director of Care Experience for the System, I used to have a very unique perspective having been hospitalized near death in my own system.

I'm afraid it's becoming a little more common with this pandemic. We have been very focused on the unique challenges to the delivery of care not only for our patients but for our providers. There have been so many issues that arose that really in many ways created barriers for our providers to really give an optimal experience of care for their patients and increase their risk of moral injury. Early in the pandemic, we had the strict visitor restrictions.

There was this very critical need to preserve personal protective equipment and the patients were so isolated that there was really a unique stress of caring for large volumes of critically ill patients in isolation from family, and with a significant risk of contagion for the providers themselves, communication was made more difficult by those layers of personal protective equipment and yet it was more important than ever.

We found that not having family here meant that the patients were at risk really of depersonalization. We found that many of the patients had the same risk factors of diabetes and hypertension, obesity, and OSA, and because of that and the lack of any family nearby, and no personal artifacts in the room, it was easy for the patient to blur together to some extent for our nurses and our physicians and respiratory therapist.

And this really put them at risk of moral injury, and so we devised early on a leader rounding scheme to allow for regular in-person check-ins with the teams that were caring for COVID patients. We, initially, cohorted all of our patients in one medical ICU pot that quickly swelled from 16 beds to 150 ICU beds.

And it was important early on before we were able to have results quickly that the rounder was someone who was already caring for COVID patients. We didn't want to expose additional people to the risk. We felt that it was important that that person be expert in skilled communication and really oriented to the resources that were available.

There was so much that was put into place really early on and both from a behavioral health perspective, a wellness perspective, policy and procedure perspective, but much of that was remote. COVID created a unique situation for all of us and that many of the staff who normally on site were instead working remotely and that included our behavioral health colleagues, administrative leaders.

And so, we really had to make the people who were here able to provide psychological first aid in a way that was meaningful for the people providing the care, and unlike the sort of mental health interventions that are done by very trained professionals, providing psychological first aid is really something that many people can be trained to do because that comes down to being visible, available and validating and normalizing emotions during extreme time.

And also, recognizing when someone's response may fall outside of what is common or expected. So, the psychological first aid wellness rounds were really built to support the staff, and we set out a few goals for ourselves. So, the first one was to build connectivity, so simply by having leaders show up demonstrating support for the work that was being done and recognizing that it was really in a very complex and evolving situation.

So, the leaders who rounded were able to share best practice resources that were relevant for the moment at the beginning that was simply how do our nurses decontaminate themselves before going home to young children, and it evolved to ensuring that there was adequate PPE. There was a really clear need that people wanted to share their stories. They felt that what they were doing was really extraordinary work in many ways.

And we developed because it was really an ask from the teams that they themselves generated. We developed a site called Frontline Diaries where anyone in the system could submit photos, diary entries, videos describing events of their day, and there were questions that were post, that were appreciative inquiry, tell me a moment of compassion that you thought today.

As a means of really capturing for ourselves and our colleagues and our leaders who weren't necessarily able to be there with us who we were and what values we were demonstrating and it was a very generative process and it allowed people to have pride in their work and also to share some of the more difficult emotions so that others would feel less alone.

Another goal that we set was simply to identify and link to resources. So, we had a lot of providers tell the leaders that we're rounding that it was incredibly difficult to provide an accurate assessment of how sick families, loved ones had become. Oftentimes our families were dropping patients off at the ER.

And they were walking and talking with maybe a fever and some mild respiratory distress and then they would deteriorate and become ventilated and describing this became abstract in many ways. And so, we heard from the teams that they needed the ability to videoconference with families.

We helped get about 300 iPads for the units that were caring for these patients and we set it up with WebEx IT made that possible and that allowed not only for the teams to communicate with their families, but also for the families to be brought into the rooms and see their loved ones, and if they were able to communicate, to communicate and even when they weren't, we had families that would read prayers over the iPad.

We had wives that would read letters that they wrote to their husbands, and it was a means of communicating during a time when communication was difficult and people were feeling very isolated.

And although that was something that we were doing for the patients, I think the providers benefited an even greater measure because they were able to have contact visually with their families as they were describing what was very serious news and sometimes having end-of-life conversation.

We were also asked to help script a lot of those end-of-life conversations in a compassionate way. We utilized VitalTalk which is a national organization to help us to do that and that scripting was really very gratefully received, especially by our residents, who were often working in unfamiliar areas and

that brings me to another goal that we set for ourselves of restoring personal integrity.

There weren't just physicians who were working in unfamiliar fields and needed to develop a more fluid identity in that space, but there are also a lot of physicians who were sidelined in this crisis and that was difficult in a different way. We're used to being of use and so finding ways that those physicians could still find meaning and value and feel a part of this became very important.

This was scaled really by teaching-coaching behaviors. So, teaching leaders to ask reflective question with nonjudgmental curiosity, noticing if the people who they were speaking to needed more support and being really aware of what those resources were.

Our chief wellness officer, Lisa MacLean, put in a remarkable amount of work creating resources that were available and although remote was very accessible and sometimes it just took someone who is present rounding to identify that resource in a one-on-one way for our team members to be able to access them.

So, I'll stop there and take any questions that anyone might have.

Alina Czekai: Thank you.

Operator: As a reminder to everyone – as a reminder to everyone …

Female: So, Dr. Awdish …

Operator: … if you …

Alina Czekai: I believe we have a question from one of our colleagues first. Thank you, operator.

Operator: Thank you.

Alina Czekai: Michelle?

Michelle Schreiber: Thank you, Alina. And it's Michelle Schreiber. What a pleasure to have you on the phone and what you created within the system in terms of building compassion and reaching out to the providers in a very difficult time for providers, as well as patient has been remarkable.

I know that there were also some providers who had been in the intensive care unit and who had been very ill, was there any special approach towards them?

Rana Awdish: Yes. So, we've had a number of our own colleagues who have gotten very sick, and we've actually worked in a number of ways to support them. The most important probably is developing a post-ICU Multidisciplinary Clinic with behavioral health, physical therapy, pharmacy and our pulmonary colleagues that are able to provide really comprehensive assessment.

There is so much about post-ICU syndrome that we do not understand and especially for high functioning people to have the kind of cognitive decline and delirium that many of our patients suffer. It's a tremendous undertaking to rebuild from that and I've often wished that when I went through my critical illness, we have something similar. So, building that has been a real source of pride for us.

Michelle Schreiber: Thank you.

Rana Awdish: Thank you, Michelle.

Alina Czekai: Thank you. Other questions or comments from my CMS colleagues before we open it up. Great. Operator, let's take some questions from the phone. Thank you.

Operator: Certainly, everyone, if you would like to ask a question or make a comment, please press star one on your telephone keypad. Again, that is star one on your telephone keypad. We have a question from (Keith Assad) of IHP. Your line is open.

Keith Assad: Yes, can you hear me?

Alina Czekai: Yes, we can. Thank you.

Keith Assad: Oh, thank you, that was very motivating to hear. I just had two questions. One is do you have the contact for Dr. Mahajan just to follow up with him about something?

Alina Czekai: Sure. I will connect to – with our speakers at the end of this session to confirm if they'd like to give out any contact information, so you can expect follow up on that after this call. Thank you.

Keith Assad: OK. It could be an office contact or anything. OK. And the second follow-up was, again, thank you for having this. Regarding like the earlier physician also mentioned, could there be some program in place to help with that practices that see pediatric patients, and also that are seeing new patients – no more new patients right now. Could there be some type of assistance from CMS? Hello? This – hi.

Michelle Schreiber: So, this Michelle Schreiber. I think we would need to know exactly what you mean by that question and maybe clarify it a little bit more. Are you looking for financial assistance, telehealth assistance because I don't know that we have that right people on the phone, but if you can clarify your question that will be helpful for us?

Keith Assad: OK. Like with the current – like the, I think the earlier physician had mentioned like, with the – with the health care assistance coverage for Medicare, what – it's usually – it's the one that is there right now is for practices or hospitals that see Medicare patients which are usually (these) patients that over 65 years of age.

But for practices that see pediatric patients, we like – I guess that didn't include those. So, I was wondering if there is some type of assistance that could be especially for those of us that are seeing patients that are – that don't have insurance or their insurance doesn't cover certain visits. I was wondering if there could be some type of coverage for them.

Michelle Schreiber: I understand your question now, and thank you. So, there has been conversation about support for those patients who don't just take Medicare. Some of that will be coming through the states. I don't know how much of that has been finalized yet, but just so you know there are certainly active

conversations about that recognizing that there is some certain percentage of physicians who don't see Medicare.

Keith Assad: OK. So, would this be to the State Department of Health?

Michelle Schreiber: Alina, do you know where that would come from or we could post information on our Web site?

Alina Czekai: Yes. We can post information on that. I've taken down your question and we can certainly address it either in follow-up communication or we can also address at the top of our call next Friday. So, thank you so much for your question.

Keith Assad: OK. Appreciate it and I wanted to follow up with you here. Will you be able to send me an e-mail or follow up with you?

Alina Czekai: Sure. It's – I've taken down your phone number from the call service ending in 0033. So, I can send you a follow-up – give you a follow-up phone call at that number. So, thank you so much. We'll take our next question, please?

Operator: A reminder to everyone, if you would like to ask a question, just press star one on your telephone keypad.

Our next question comes from the line of Sarisha Coppola of CMS. Your line is open.

Sarisha Coppola: Hi. Thank you for taking my question. We would like to know like even for the audio-visual visit. We are still using our MAs and staff. It's kind of helped us set up those visits, and also to talk to the patients, get more information, as well as screening.

But we know, we don't know how much that kind of activity in the form of facility fee, we would get reimbursed. I would need some – I would request some kind of information from CMS about this. Thank you.

Alina Czekai: So, can you please clarify the type of reimbursement clarification you're looking for? I just want to make sure I'm understanding your question correctly.

Sarisha Coppola: Thank you. For the – right now, we don't know how much of the facility fee we are getting reimbursed for the work that MAs and the other clinical staff are doing because we are needing a lot more help from them compared to in-person visits because they are helping us set up the telephone with it for the providers, as well as the Zoom or the audio-visual visits we are doing from the clinics.

They call the patient, help us get initially before the visit, they actually screen the patient and then they help us with the social history, family history and all the components that we need to fill in. So, with all the help they are doing, we don't know how much of the reimbursement we are getting from the facility fee component.

Alina Czekai: Understood. Thank you for the clarification. I don't think we have our correct subject matter experts on the line to address that question. Unless any of my physician colleagues would like to take it; otherwise, we are happy to take that question back and address it either in a follow-up note to you or addressing it at the top of our call next week. So, would any of my colleagues like to take that one?

Thank you. So, we appreciate your question and, again, we will take that one back. Any other questions from folks on the phone today?

Sarisha Coppola: Thank you.

Operator: For everyone, if you would like to ask a question or make a comment, please press star one on your telephone keypad. There are no further questions.

I'm sorry, we have a question from Kimberly Gimko – Kimberly Gemaro of Bauman Health. Your line is open.

Kimberly Gemaro: Hi. Thank you. As some of that facilities begin to enter like the mid-range, the post-surge range, we are going to be looking at after-action

planning, especially knowing that the fall flu season will be practically right on the heels of this.

What types of opportunities do you foresee for centers across the country to do some after-action coordination with CMS regionally or nationally? So, these are like operational after-action plans versus political policy after-action plans.

Marion Couch: Alina, this is Marion Couch. Thank you for your question. I think we might take that offline and talk we – after-action plan isn't part of our vernacular, but we're in unprecedented time. So, I think it would be a wonderful conversation. So, within the guardrails of what we do at CMS, I – we would be happy to talk to you further about that.

Kimberly Gemaro: All right. Thank you.

Marion Couch: Thanks.

Alina Czekai: Thank you. And thanks, everyone, so much for joining our call today, and special thanks to our guest speakers who's always really motivating for us here at CMS to hear what providers on the front lines are doing both in terms of the innovation, the clinical strategies and just the approaches to these very difficult times.

So, in the meantime, if you have any questions or comments that you'd like to send to CMS, you can direct those to our COVID-19 e-mail box which is covid-19@cms.hhs.gov. And as always, we appreciate everything that you're doing for patients and their families around the country and hope everyone gets a restful weekend and take care. Thanks.

End