Centers for Medicare & Medicaid Services
COVID-19 Call with Nurses
Moderator: Alina Czekai
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OPERATOR: This is Conference #: 5058949

Alina Czekai: Good afternoon. Thank you for joining our April 16th CMS COVID-19 weekly call with nurses. We really appreciate you taking time out of your busy schedules to join us today. This is Alina Czekai, leading stakeholder engagement on COVID-19, here at CMS. And today we are joined by CMS leadership and subject matter experts, as well as providers in the field who have offered to share best practices with you all today.

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

Jean Moody-Williams: Thank you so much, and hello everyone. Thank you for joining this call. These calls have – I learn as much, and hopefully I can provide information to you as well.

I do have just a few updates, or highlights, that I want to make sure we go over before we get to our wonderful guest speakers. And just a reminder that we have issued a number of blanket waivers, obviously going back several weeks ago. But we have – we are – have a constant flow of waivers that come out. Last Thursday we issued some new waivers.

So just a reminder to please continue to check our emergency Web site to see if new – when new information comes out. We do expect to continue to have additional waivers over the course of the next several weeks.

For those of you who have been joining in on the calls, you are aware that we have a number of waivers as they relate to hospital and critical access hospital, particularly as it relates to the nurses' role in care planning and discharge planning. We have waived a number of the provisions that really get into the detail of what must be done.

However, we have not waived that it doesn't have to be done, because obviously during this time we want to make sure that we get the patients to the right place at the right time. And sometimes that might involve an alternative location, a non traditional location, and I know that the nurses play a great deal – play a great role in that, working along with the team.

Also in the area of home help agencies, we've expanded the roles for nurses there. And in hospice as well, we've expanded the roles. And we also waived some of the onsite visits to evaluate the aids that are working there. One of the things that we've done for hospice is to eliminate the need for training and certification for aids to be done on – on a live patient in the home. And those skills and competencies can be assessed using pseudo patients, as it were, in the lab, with observation of the nurses. And then we've also eliminated some of the need to do onsite visits for the certifications and assessments.

We also – I want to just highlight – this isn't new, but the deadline is coming up. So I want to call to your attention – for those of you who bill Medicare part B, and you are eligible for the (inaudible) payment program – as you are probably aware, we implemented multiple flexibilities in the merit based incentive program. That's to provide relief to clinicians, including nurse practitioners and CRNAs, and others who are responsible – and who are working in the COVID-19.

We did extend 2019 data submission deadline to April 30th. So that is fast approaching. And so if you are intending to submit data, please know that that deadline has been extended. But we have also identified the pandemic as a trigger event (inaudible) Automatic Extreme and Uncontrollable Circumstances policy.

So that any clinician that doesn't submit 2019 data by the deadline will automatically receive a neutral payment adjustment for 2020, which – so you don't really have to do anything, you don't have to apply for anything. If we don't receive data from you, then we will assume that you would like to be under the Automatic Extreme and Uncontrollable Circumstances policy. So you will automatically receive a neutral payment adjustment, meaning no downward or upward adjustment.

We opened the 2019 Extreme and Uncontrollable Circumstances application to individuals, groups and virtual groups as well. So please keep that in mind. And these changes will, of course ensure that as you are busy right now, taking care of your patients, that is the most important thing that you would have for you to worry about.

Just to mention a couple of things that we did in the long term care setting for those of you that work within that setting. We did put out some more waivers. Please take a look at that. We put some clarification out about transfer, and what facilities have to do if they are using alternative sites. For example, if you have an alternative site that's under the control of that nursing facility, then you continue to operate as normal, even though you have a different site that you are seeing patients in.

If you are opening up a non-certified site though, you still must work with your state agencies. And we've also waived many of the requirements that prevent a physician from delegating tasks, when regulations specify that a physician must perform something personally. So this will allow physician assistants, nurse practitioners, the clinical nurse specialists who meet the applicable licensing and scope of practice laws in the state to delegate – to be able to receive delegated task to use – be used to work as a – extend the workforce in long term care facilities.

Obviously we – though we are temporarily modifying this regulation, where supervision is required, that still must happen. But it can now – the work itself can be delegated. And many things can now be done by telehealth as well. So I invite you to see – look at the telehealth waivers.

I have had the opportunity to talk to some of you outside of this – this large meeting, and I do understand that, while the federal government has waived many of the barriers that might exist for you to do things by telehealth, there are still some states that have not. And so we continue to encourage governors to look at the – the waivers, and the flexibilities that they may be able to provide, so that you can practice at the top of your license.

So with that – I think those were the main things that I wanted to point out to you. We are continuing to work on some flexibilities. We are – gotten questions from you – from many of you – saying, "OK, what happens when we do get to the point where we are going back to "– I won't say normal – but to "the way we will practice health care in the future? And will everything be rolled back?"

And I will just say that we continue to look to see what – which of the things that we have been able to waive during this pandemic are things that we should think about on a permanent basis. And what are the things that we need to say, "You know, this is only really applicable in a pandemic, and we need to return back to the way we were doing it"?

I can assure you though, we are taking a close look at that. And I really applaud your efforts as you have stepped up to the plate to do what the country needs. And I think that speaks volumes to all of those that may even have concerns about scope of practice. So kudos to all of you. Very proud to be a member of the nursing profession myself.

So before we jump to specific questions – and I do want to mention as well to tune into our Office Hours that we have on Tuesdays and Thursdays, where we really get into those more technical questions. Because – particularly like your billing issues, and those kinds of things – we have the subject matter experts join those calls. Again, Tuesday, Thursday. We'll give you some more information about that before we hang up this call.

But today I am just so extremely pleased to be able to introduce Dr. David Bailey, the chief nursing officer at UCLA in Santa Monica, who will share

some of the best practices and experiences that he's seeing. So Dr. Bailey, I'll just turn to you.

David Bailey: Great, Jean. Thank you so much, and everyone. I appreciate the opportunity to spend some time with you today. You know, when I think we all started this year knowing that we were rolling into the year of the nurse, I don't think any of us ever envisioned, or completely imagined, what this year would turn out to be.

So first, I want to applaud you for the great efforts that you all are carrying on across our nation to make sure that our patients get the care that they need, while you're also protecting your communities and your families. But so – thank you so much for all of the hard work that you are doing on the front lines of this pandemic. None of us – you know, in our lifetimes have ever seen this, and I hope you are in agreement that I hope we don't see something like this again in our lifetimes, because this has been quite the extraordinary event. So I just want to say thank you.

But, you know, as Jean and the other – Alina have reached out to ask me to share some of the best practices that we've learned at UCLA, a lot of is how do we streamline things moving forward. Because we have obviously had – been forced to streamline some of our processes during this event, and we want to continue that.

As we've already started discussions now – how do we learn from what we have been through? How do we streamline what we will "as we do our refresh – restart"? And that's what we're going to call our program. Because we've already started meetings now to look at – you know, sort of as Jean discussed – what will our new way be? What will our new norm be? And I don't know if any of us know that at this point. We remain on safer at home guidelines for another month.

You know, we obviously have diminished volumes at this point. Because our surge is sort of now, and we have not been hit – in the area where I live, we have not been hit like some of our colleagues in New York, and the north east, and Detroit, and New Orleans. We have not experienced that. And for you all

that are going through that, thank you so much. And I'm thankful that we're just in a different situation.

But you know, a couple of things that – just to give you an example of doing things differently. And just to give you an example for the – you know, when we have a code blue or resuscitation need. You know, years ago – or, I'll rephrase that, months ago now – 20 people were in academic settings. 20 plus people would run into the room. We have stopped all that. It is five people in the room now. One to do CPR, two physicians to really guide and lead that. We do not record in the room anymore, in the sense of – you know, the recorder being in there. The recorder we put on the phone. And then we put a "person" at the door. "No, you can't go in."

And so anytime that we're doing this, we really have modified our entire approach. And so we have the five people in the room. They can relieve each other. There's obviously a medication administration person. And then obviously the physician leader of that event.

And so we really have done a lot of crowd control. I would encourage (you) to look at what are you learning now, and what can you do in the future? Because some of these things I hope we all have the opportunity to learn from.

The other thing is we have moved really every meeting that we've had to have to a Zoom process. And that has really been beneficial. We were on a call with a group of staff nurses early this morning. They said, "Can we stay? Can we continue to do this, and not go back to the old way, where we're all having to drive in, you know?" And Los Angeles traffic is always an opportunity.

So people said, "I can just jump on a Zoom call. I don't have to spend an hour plus getting, you know, to the campus," and things like that. So, you know, we're hopeful to re-look at what (May) meetings look like after that. And do we really need to have as many as we currently do?

The other thing that I want to share is when you do roll something out, make sure a nurse is involved. I know I've had to insert myself a few times, a few – where groups had good intentions, but did not have that clinical insight or

background to – they wanted to start processes. And, you know, I would sort of hear something on the side, and I would step in and say, "Guys, you've got to have a clinician's voice here. What – that's not going to work." And so, you know, they would sit there and scratch their heads. And it's like, "Just let me walk you through what you need to add and tweak."

But, you know, my big message to you is when you roll something out, make sure that clinician's voice is involved, especially – and I'll give you an example – the screening process. You know, this started – and there were mostly non clinicians, and I stepped in and inserted myself, and I said, "Guys, that doesn't make sense. You've got to ask these questions, because you're just, like, screening chimps."

And, you know, we had one person that walked through the building – one of my unit directors, in fact. He got by the screening process with a temperature of 89. Well, you know, to a non-clinician, that's a number. And so I said, "Well, no, no, no. We have to back up." So I really want to make sure that we – you agitate people. And when you roll out processes, that it's well thought out, and you don't do it in pieces.

You know, unfortunately, we've learned on our own. We have had to roll some things out in pieces. As you all know, this has been such a fast evolving process. So I really want to make sure that you – you have well thought out plans when you put into place that make sense. And the bottom line is that you communicate it out.

The chief medical and quality officer with the health system, and the chief health exec for the health system – they both send out – or together, they send out a message every night. And it's anything that's changed during that day, or if we've put a new guideline in place. Like we just recently went to universal masking. We've also moved to testing everybody that comes through the ED, or any (directed med), and all of our – the few procedures that we're doing now – all of them have to be tested.

And so just, you know, that messaging was very clear in those letters that came out each night between 6 and 8 o'clock. And that way, in the link to the

evidence – if there was a county change, you know, the safer at home, when that was put out – all those links are embedded in that note, so that people can easily go out and see, "Oh, this came from CDC," "This came from the World Health Organization,", or, "This came from our local county." Or that it was a guideline that we created internally. That – that link is there.

So those are some of things I want to – that I wanted to hit on. And I certainly look forward to your questions. I do want to save time for our colleagues. Because one of the things I believe they're going to talk about is really the psychological safety that our teams are faced. And I just – I don't want to over step my boundaries with that individual. But I'd look forward to talking about that.

The last thing I want to talk about is really helping your teams practice social distancing. What has been unfortunate on a – and one of my areas – where a team that's very, very close knit – most of them have worked together for many, many years – and unfortunately one individual had a community acquired situation – a COVID, of course. And not knowing it – you know, he's very social in the unit – and just that social distancing that you need to maintain on the unit

So we've had to put safety monitors into place on the units where we're providing care to the COVID positive patients, or the COVID (rollouts). And it's really – how do you do that, and how do you keep apart, and how do you make sure those teams are doing that physical and social distancing? So I'm going to close there and let my colleagues jump in on the line. And then I look forward to your questions near the end. Thank you.

June Moody-Williams: Thank you so much. That was a wealth of information there. And I want to move right to Dr. Judy Davidson, who is the nurse scientist at UC San Diego Health Sciences. Judy?

Judy Davidson: Yes. Well thank you for having me today. I'm also the coach here of the American Nurses Association Strength and Resiliency Taskforce. We were originally designed to come together on a different purpose – to collate all different resources to help identify nurses at risk of suicide, and suicide

prevention techniques. But when the pandemic hit, we had to swiftly shift gears to gathering resources for nurses on how to cope through the pandemic.

So coincidentally, many of these resources fit both objectives – how to prevent suicide, and how to cope adequately through the pandemic. So we had all the right people at the table.

We do know from the experience in China that the pandemic will cause panic disorder, anxiety and depression, and we anticipate post-traumatic stress. It's just too early to have that documented at this time. So how do we keep ourselves healthy? How do we keep the workforce healthy? I'd like to address this quickly on three levels – national, organizational and individual.

At a national level, we're organizing resources for you through Healthy Nurse, Healthy Nations – through our task force. And you can find them on the Web site, the ANA HNHN web site. You don't have to be a member of ANA to get access to that information. But once you navigate to Healthy Nurse, Healthy Nation, you do have to register as a person interested in keeping healthy. And then you'll have access to everything your individual or organization might need. And we have a blog that we've posted immediate COVID specific related resources there for mental health for nurses.

Organizationally, it might be the time – if you haven't done it already – to start a caregivers' support program, or a peer to peer support program, like was started by Susan Scott at the University of Missouri many years ago. They're very helpful. And we had a fledgling one at UCSD, and we're now bringing it up to full speed with the pandemic.

In one week, we have trained over 120 nurses and doctors on skills to provide emotional support to people who are not handling the situation well. So how to support each other. This should not be a time of "buck up and take it". This is not a war. We're in a pandemic. And none of us lined up for war. We want to serve and help the public. So people are going to have issues emotionally. We need to recognize that, and be prepared to help them through it out the other side – minimize the traumatic events that will occur later.

So at UCSD we also have a volunteer – voluntary screening to detect those at risk using an anonymous encrypted system that we developed in partnership with the American Foundation of Suicide Prevention. And it works – a simple screening – you get an e-mail saying, "Please take this screening."

And as people take the screening, they – we are able to find clinicians through encryption who are in need of mental health treatment, and refer – successfully refer them to treatment, while providing bridge therapy through internal therapists until they get out the other side for mental health treatment.

And if any organization wants to start a program like that, ours has been in place for nurses for three years, and our physicians for – actually four years, and 11 years for the doctors. We've published many papers about it. Just contact the American Foundation of Suicide Prevention. They'll help set something up for you. And it really does work. Last year, before COVID, we identified 40 nurses in one organization who needed help, and got them there.

So individually – there is a lot that every person can do individually, moving to the individual level. And I'm going to give you two techniques for stress reduction that I just find priceless, that you can teach your staff, or use yourself. The first one – my friend, (Ken Mendoza) from Behavioral Health – she taught me how to do this. And I call it, "Tap out and take a lap".

So tap out and take a lap. So you won't really tap out, because we're keeping our social distance. But you see somebody at work whose anxiety level is rising. You figuratively tap them out, and invite them to take a lap of the unit with you. A lap of the unit usually takes – any department – takes about one minute. And that's all it takes to do this stress reduction technique.

You coach them, while walking, through a little breath work. If they're really panicked, just do four in and four out. I'm going to breathe in for four, breathe out for four. And doing that for five cycles will add up to a minute, and that's all it takes to break the stress response that the person is under, and ground them again so that they can get back into the game.

If they're not totally panicked, they may be able to tolerate a more complex breathing pattern – four, seven eight. Breathe in for four, hold for seven, and

breathe out for eight. Four or five repetitions of that will give you a minute. You've walked around the unit. Now both you and your colleague are feeling better. So I recommend anybody to do that to – for helping out in the moment stress. Even as administrators, (take them out) for yourself before you hit the deck and do rounds. Might really be helpful.

The next is for when you leave work. "Scanning for normalcy" is what it's called. And I've heard this on several different broadcasts this week, and I just want to keep it snowballing forward, because it really does work. So it's – when you're fearful, you reflexively scan your environment for threats. It's a basic human instinct. All of us do it. We look for the threats in the environment. So we're going to break the fear response by turning that on its head. When you leave work, and you want to leave it behind you, do this exercise.

Turn your head all the way to the left. And that's important, the turning, because turning your head is going to activate the vagus nerve to help calm you down. Now once you've got your head all the way to the left, you slowly turn your head, and notice everything beautiful and normal that you can see. There's a bird in the tree. There's a leaf on the ground. That flower is just opening. There's a dog on the front porch. Right? And by the time you get to the other side, you've gone away from the stress response, from the flight versus flight, and you've brought yourself back into recognizing what's normal in your environment.

Do that when you leave work, for sure, and then as you're walking – any time you're walking outside for a little bit of exercise during this experience. And it will bring you back into normal moments. Because you can't be in a fear based mode 24 seven. It would be like doing bicep curls all day long at the gym. So as the old adage goes, stop and smell the roses. I'll stop there, and turn it back to our host.

June Moody-Williams: Thank you so much. Now I've picked up two things here. One is to refresh and restart, and the other one is to tap out and take a lap. So I'm going to post – put that on posters, and remember that, because I think that has wide application for all the work that we're doing.

Operator, I think we have time for at least one call. Can we check – question. Can we see if there's a question?

Operator: Yes, ma'am. At this time, if you would like to ask a question, please press "star" and the number "1" on your telephone key pad. And at this time, we will be announcing participants by the last four of their telephone number. And we do have our first question, coming from the line of 0717.

Mary Crotty: Yes. This is Mary Crotty from Massachusetts. I didn't hear Dr. Bailey offer any suggestions on social distancing. I also was concerned that he described nurses who might be COVID infected as "having a community acquired infection". The community is the hospital. Nurses are being turned down for worker's comp by hospitals, saying that it was acquired in the community, which is clearly not – not the case. And I just wanted to make that comment. But I'm also asking how you social distance in a setting. He – he didn't offer description. Thank you.

David Bailey: Thank you so much for seeking clarification. The one event that I was describing specifically about one of our employees. He picked that up outside of the hospital. He had been to a large event before people really started canceling large scale events. And so it is known that he picked it up there, and unfortunately there were some colleagues that also picked it up after that. So that – so when I said "community", I literally did mean in the community, not within the hospital. So thank you for seeking clarification.

The other thing about social distancing – when we – because of our surgical volume has been so low, what we did – we redeployed our surgical team members to the units where COVID positive, or COVID rollout patients are. And they really – this group of people – this is a 24 seven operation, and I have them stretched out across four units in the emergency room, the ICU, and then two of our adult units. And these people really are serving as safety monitors. And part of their role is the donning and doffing of PPE.

The second part of their role is to really watch for are people doing appropriate hand washing? Are they staying six feet apart, or beyond? Because what we picked up on when our infection prevention colleagues were

also out rounding – they noticed that – and because we're all social beings – they noticed a lot of the groups – and this is before we moved to universal masking – that they – the groups were just all huddled up really close to each other, like we would normally be prior to the pandemic.

So the safety monitors – we've asked them to really step in and say, "Guys, you're not – you don't have your distance that you should be." So what we've done – we've taken computers on (inaudible). And we've stretched them out in the halls. Normally we have one in every room, but we just put a few additional ones out in the halls.

Instead of – because we have computers at also each of the – the nursing stations. So – and those are really, really close together. And so what we did – we put additional computers out in the halls, just, you know, where people could move those, and move them to a cubby somewhere, so that they can really – can just have some private time.

We've also changed the way we do bedside reports. You know, obviously – you know, ideally, it was always done in the past in the patient's room. We've interrupted that process currently. And they now do it via phone. So there's just different things like that. And each unit has sort of taking a little nuance to that. But those are some of the things that we don't let people – you know, like, congregate together like that.

We've also – there's enough computers on every unit out of the nursing stations, so people have started placing their names on – you know, "OK, this is my computer for today," instead of everybody just sitting down to that one computer. So those are some of the things that we've tried to really keep people socially distanced.

But the safety monitor is based on that unit 24 seven, and we ask him to constantly move around the unit to look for – how do we make sure that we're, you know, maintaining our appropriate distance just to keep ourselves safe. And so those are a few of the things that we're doing. Does that help?

Mary Crotty: Yes. Thank you. That would be good to have that posted somehow. I was not able to get this up on my computer, so I'm just getting audio on. If there is a way to share that somehow, that would be helpful. Thank you.

David Bailey: Of course.

June Moody-Williams: Great. Thank you so much. And I know we're – we're at time. Really do appreciate everybody dialing in, and for our guests today. And look forward to – to talking to you next week, where we will have another great line up. So thank you very much. Alina?

Alina Czekai: Thank you Jean. And thank you to our external speakers today, and everyone for joining. We hope that you'll consider joining our CMS COVID-19 Office Hours later today at 5pm Eastern. There we'll have technical Q&A with our CMS subject matter experts.

And in the meantime, please continue to direct questions to covid-19@cms.hhs.gov. That's our COVID-19 mail box. And again, we really appreciate all that you're doing for patients and their families around the country as we address COVID-19 as a nation. This concludes today's call. Have a nice afternoon.

David Bailey: Thank you.

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