Centers for Medicare & Medicaid Services
COVID-19 Call with Nurses
June 25, 2020
3:00 p.m. ET

OPERATOR: This is Conference #: 9496814.

Alina Czekai: Good afternoon. Thank you for joining our June 25th CMS COVID-19 call with Nurses. We appreciate you taking time out of your busy schedules to join us today. This is Alina Czekai leading stakeholder engagement 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. I'd first like to turn it over to my colleague, Dr. Ellen-Marie Whelan. She's a chief population health officer at the Center for Medicaid and CHIP Services. Dr. Whelan, over to you.

Ellen-Marie Whelan: Thank you so much, Alina. We're really excited for today's call. We have so enjoyed being able to speak to nurses across the country over the past number of months and share some best practices.

Today, we're going to hear from a nurse anesthetist, which is someone who's not heard from on these calls. I will introduce her in just a minute. I just want to make a couple brief announcements of some of the work that we've done over the past week or so and some upcoming work.

Tomorrow, we are going – CMS is going to post a frequently asked questions document about the emergency page that provides an extra clarification on the reopening recommendations for nursing homes during the COVID public health emergency.

We also are pleased to announce the membership of this independent Coronavirus Commission on Safety and Quality in nursing homes. Last Friday, we announce the members of this commission and we're looking

forward to seeing what work they will accomplish over the next short period of time.

And last, just want to note that there will be some staffing change information on the quality measures that will be on our Nursing Home Compare and the 5-Star Quality Rating System. We'll be posting a memo, I think, just later today that will talk about what those staffing changes are as it relates to the 5-star rating period – the 5-star nursing home plan that will go into effect for data submitted the fourth quarter of calendar year 2019.

So, just again a couple of announcements but I'm really excited to day to introduce Tracy Castleman. Tracy is a certified registered nurse anesthetist and is working now at, in Central New Jersey at the Albany Medical. I don't think that's right.

Actually, I think that you're working elsewhere to another health system. But we're thrilled to have Tracy come and talk today, first of all, because Tracy was there in the thick of it as New Jersey was one of our first hot spots, was very instrumental in helping her health system established the best plan of care for patients.

And she's going to talk a little bit about what that was like and a little bit about the way that their health system moved forward helping to address COVID-19 crisis. So, Tracy, why don't I turn it over to you?

Tracy Castleman: Hi. Thank you so much, Ellen-Marie. I went to – I received my masters at Albany Medical College Program. I now work in Central New Jersey. So, but for all of you, I'm going to briefly kind of take you through what we experienced in New Jersey as the pandemic came knocking on our doors.

So, we had a little bit more time about a week or two to prepare for what was coming because New York, obviously, had it first. And as the virus evolved in New Jersey, it went from North Jersey down to Central Jersey. So, we all experienced it just after, we all experienced it a little bit differently. But where I practice, we did have the luxury of a little bit of advanced knowledge.

Our senior leadership had conversations early on what did we need to do to prepare our hospital and our providers to be able to give the best possible care to patients that we knew were coming. And I was fortunate enough to be able to listen in and participate on some of these conversations.

So, the first thing we needed to really do is how do we ready ourselves and what resources do we have to be prepared? We were asked from the state and federal level to increase our ICUs capabilities. We currently use about 10 ICU beds at my hospital, which is roughly 450-bed hospital. So, we were able to double that capacity pretty quickly by opening up the unused section of the ICU, but it was obvious that we needed to get more – to create more beds to be available.

We emptied out our pediatric units. We are fortunate to be part of a larger healthcare system, so we moved our children who were in the hospital either to home or up to the other pediatric hospital as the mother facility. And the same with our oncology unit, we sent either patients to the home-home and we move the rest up to our main campus oncology unit. And we – under order of the governor and the federal government, we stopped all elective surgeries to start conserving PPEs. We're able to empty out our surgical floors.

We needed nurses to care for patients in these units. And so, the decision was made to quickly train up those med-surg nurses, the oncology nurses and the OR nurses to be able to manage critical care patients. We had a couple of extra days to do that and they mobilized technicians and nurses aids into roles of spotters and runners in order to be able to support the care that was needed and the providers who needed to give care whether they were in the rooms in full PPE or as they were coming in and out of the room to make sure they were protected.

And we had to adapt their physical plan to what – our hospital to be prepare to manage these patients. Our pediatric unit, which with the pediatric unit is filled with children size equipment, had to be turns into an adult size unit. We have to put windows or change out doors. If patients were being discharged, we have to change the doors of the rooms from solid wood to doors with large windows so the nurses could see the patients. We had to move where the bed

was able – was positioned so that nurses could be able to see the patient through the door fully.

And we had to drill holes in the wall to be able to, as you many people have probably seen, bring IV lines out so we could put the monitors outside the doors. We could put the ventilator control system outside the door in order to decrease of the amount of time nurses were exposed inside the room to care for patients and the use of PPE.

So, at the same time we were doing that, we have to look at how we are going to manage on a higher level the quality of care being provided in these ICUs. In my hospital, that were no longer just on one floor, but now there was instead of one or two ICUs we had three or four ventilator type ICUs on different floors. And then we have step down units, so to speak, that were taking care of patients who were either just on eight or nine liters of basic oxygen or who are moving all the way up to high flow oxygen to maintain saturations above 86 percent.

We needed to have far more capability on those units for higher level providers to be able to interpret labs and assist nurses to be making that high-level decision-making in order to provide the best care for the patient, and that's where the role of the advanced practice nurses and especially the nurse anesthetist.

So, as the operating room came to a close more or less, you – we realized we have this large resource available of certified registered nurse anesthetist. We are ICU-trained nurses prior to going back to school to receive either masters or now a doctorate in anesthesia and critical care. And so, we quickly were able to adapt our knowledge to meet the needs – the new needs of the hospital to provide care.

We clearly needed to keep some anesthesia providers available on the – in the operating room because people were still falling and breaking a hip or an arm, people still have appendicitis or GI bleeds. So, we have to keep a small skeleton crew of anesthesia providers around-the-clock ready to provide emergency care in the operating room.

We were still providing necessary anesthesia in the labor and delivery unit because babies were still being born in spite of the pandemic. We were still providing labor epidurals and anesthesia care for C-section. And so, our world then grew from there. We staffed "the dirty" – and I say that with quotation mark – the dirty intubation team.

We were able to provide that highest level intubation knowledge and skill to be able to come in and quickly intubate patients in the ICU who needed to be quickly put on the ventilator, you wanted to have the most skilled and most knowledgeable person in the room providing that intervention in order to decrease the exposure and optimize patient care.

So, we (staffed) that around-the-clock in our hospital and in our sister hospital that we worked in as well as providing information and being the resource for the ICU nurses who are managing patients who honestly were becoming sicker by the minute often, their care fluctuated, they would be hypotensive, and five minutes, later hypertensive and I'm talking about extreme. The pendulum swung from 60/40 of a blood pressure to 200/100 with very little intervention in just some time.

And so, the APN – the APN nurses and nurse anesthetist will often the only ones in the ICU standing with several of these ICU nurses truly titrating medication, reading labs and making adjustments on ventilators and medications and basic care for these patients moment to moment.

Oh, and in addition we're manning the positioning teams. We were managing the airways in helping to coordinate patients who are being proned from supinated in the effort to improve ventilation. That was quite a feat and it took a lot of conversations in the beginning to determine the best way to manage that, what the best practices were, and it was a constantly evolving role based on patient age, like the time they were intubated and their overall general care.

So, it became very evident that APN and nurse anesthetist were able to apply this diverse knowledge and capabilities to the frontline managing many different roles. We came out of the operating room to provide that high-level

critical care for the ICUs, helping to convert anesthesia machines to ICU ventilators.

As I said, our pediatric unit became an ICU. But because it was so far detached from the rest of the hospital, we put our anesthesia machines in there in order – in order to kind of keep them together in one small area and the different members in the anesthesia department became that resource both with the respiratory therapist managing those ventilators and for the ICU. And we managed to provide anesthesia care and caring for all those critically care – critically ill patients as well.

And in that way, we were able to help our hospital really kind of ride the wave that came in instead of being overwhelmed by the wave that came in. I know in North Jersey, many systems became overwhelmed and it was the ability of APN coming in – being able to come into the ICUs and working as intensivist that helps stabilize those systems to provide care.

Ellen-Marie Whelan: Thank you, Tracy. If feels like a natural pause. The work that you're doing I think really highlights the variability and the versatility of nurses being able to kind of jump in and address that crisis almost where need be. We'll open – ask the operator to open the line for questions. And in the meantime, I'll take the moderator's prerogative to ask the first question.

One of the things that we were thrilled to have you come and talk about your experience in New Jersey is because, again, like I said before, you guys are at the forefront. And we're hoping that there's some nurses on the phone in other areas across the country where maybe seeing a little bit more of an uptick to be able learn from some of the lessons that you're providing.

One thing that we did at CMS was we provided certain flexibility, some waivers and a number of things that we did early on to try to maximize the workforce to be able to have states and health systems and hospitals be able to address the work in front of them in the best way that they could, not really sure what needed to happen, but we try to look for some flexibilities.

So, the first question I'll ask is were you aware of some of these waivers and flexibilities that CMS allowed for providers and for health systems? And if

so, did that have an effect on your ability to do the work that you just described?

Tracy Castleman: You know that's a terrific question and thank you. As the pandemic evolved, it was very clear that facilities in New Jersey, I'll say in all the states in the initial wave and continue to date, absolutely needed every available resource to meet the demands of this urgent and intense patient care.

CMS with their emergency waiver lifting the restriction and the barriers in place to prevent that popped advanced practice nurses from being to provide care at the highest level of their licensure. By lifting that barrier, we were able in New Jersey to have conversations with our governor about how advanced practice nurses, if they could be untethered from the joined protocol, which was another barrier for us to practice through our full scope, how we could be part of the solution to increase the amount of high-quality providers, accountable healthcare providers able to meet the needs.

And the lifting of that waiver absolutely made the difference in New Jersey. It allowed us through our healthcare systems, our staffing companies to reach out into the states that were has – that were not yet affected and bring in that valuable advanced practice nursing resource and these APN came in, these CRNAs, as an APNs came in and immediately went to work in ICUs, especially in the vulnerable populations in hospitals that were very stressed and did not have adequate resources, yet we're seeing an enormous volume of patients from in the door.

Those advanced practice nurses were critical to providing that high-quality care in maintaining semblance of care in the units and coordination of efforts and increasing outlines of communication. And without that waiver, we might not have been able to have the conversation with our governor. And it might have looked a lot different in New Jersey.

Ellen-Marie Whelan: That's great. Thank you so much. And I realized I forgot to allow the operator to announce how folks could key up a question. Can I turn that over to our operator?

Operator: Yes, ma'am. To ask a question via the telephone please press “star,” “1”. If you would like to withdraw your question, please press the “pound” key.

Ellen-Marie Whelan: And do we have any questions keyed up?

Operator: No questions over the phone presenters. Please continue.

Ellen-Marie Whelan: OK. So, again, sorry for not announcing that earlier. We'll go ahead and see if anybody has any questions for how Tracy and her health system were providing care. Tracy, one of the thing that we spoke a little bit about which I think is really important especially as states are either just coming out of the surgery and perhaps preparing for a bit of an uptick in their health systems, one of the things I really appreciated you talked about is your paying attention to the mental health of how difficult this was for nurses.

It was an incredible scene providing care that haven't been provided before, lots of unknowns and I appreciated the fact that you were paying close attention to what your nurses were going through. And maybe you can talk a little bit about what some of – some of what you did to try to get on top of that and help support the nurses as they address the needs of their COVID patients.

Tracy Castleman: Thank you. That became a passion of mine almost in this crisis, as I was feeling panic within myself. And I was seeing it and hearing it and many of the nurses who are being moved into the ICU world, especially the OR nurses who are coming out of a role of really not direct to patient care at all and being put into what they felt was the belly of the beast and in the line of fire.

I heard a lot of angst and anger and projection and fear. And I think for all of us, who are used to taking care of patients that generally get better and go home, the fact that we were walking into a fire of unknown with tremendous fear of this we were bringing home virus to our family. If we are exposed, we're going to get sick and also seeing some of the sickest patients we've ever seen – I've ever seen in my over a 30-year career, and knowing that they were alone in the room and feeling their fear and for us, the nurse anesthetists going in in full popper which completely disassociated ourselves from the patient, they couldn't hear as well.

We were covered from head to toes so you didn't have that human contact knowing that they were hanging up the phone with their family members saying goodbye and putting breathing tubes in or intubating – I apologize on the terminology for group of people, putting – intubating them and putting them on ventilators knowing that they might not or very well were not coming off of those ventilators. That they were going to pass away alone or spend a very long time alone in a very frightening scenario.

The emotional toll I could hear and feel was great and I was very concerned about what our current healthcare population or healthcare providers were going to look like after work, especially our new nurses and our new nurse anesthetist who had not have find to assimilate and grow that little bit of power that we need to do our jobs so well.

And so, I started on the state level. I became the lead of the taskforce for our state association sending out ensuring that the nurse anesthetist had some of the best up-to-date information on how to care for these patients but along with that as many different wellness initiatives, opportunities, help lines that I could find to send out to them to ensure that our providers knew that somebody have their backs and that there were many different avenues for them to seek help if they need it.

And I still have concerns on many levels for what the long-term effect will look like for this. And if I could take the liberty also to step outside of that mental health piece to say that we also – in looking at the long-term, I really don't believe we've realized yet what the long-term impact that this COVID crisis is going to have on our highly vulnerable populations that were already experiencing a healthcare access problem.

And I think we're really obligated to look back on what the healthcare system did right in this crisis and how does waiver or the federal waiver enable states to provide very high level care by allowing advancing practice nurses and nurse anesthetists to work to their – to their full skills. I think it really shows that advanced practice nurses and nursing itself is very capable and ready and educated to pivot to all of these high-level roles that are required to provide high quality care.

And I think these vulnerable populations are going to be a great of a risk as we go forward as this – until we contain this disease and we're really obligated to make sure that they have the resources needed to access all the care that will be needed going forward.

Ellen-Marie Whelan: Thank you, Tracy. And I will also slide, Alina, mentioned in the beginning of the call that these calls are recorded. And about a month or so ago we had another great call from folks from the American Nurses Association. We talked about some of the mental health resources that they had available. And we had a good discussion about that. So, I'll just slide that for folks who are listening who might want some additional resources there.

Let me turn to the operator and see if we have any questions on the line.

Operator: Yes, ma'am. We do have from the line of Deborah Graham. Your line is now open.

Deborah Graham: Thank you so much. Tracy, thank you for your dedication and sharing of your story. I'm really, I'm an informaticist in East Tennessee, working in behind-the-scenes not frontline with a long line of education. And I'm really curious to know and I still appreciate the use of the word pivot, so what did you from training from adjustment time at the elbow where there are computer-based learning, how did you learn to use automated drug delivery on the charting, and just participate in the care that was not the anesthesia's role.

So, help us with what works, what didn't and what we can do in the future to help pivot – people pivot so quickly.

Tracy Castleman: That's an interesting question. When I'm – in my main hospital, I already accessed our – we use Cerna for that platform. So, I was already within the platform as an advanced practice nurse. I have ordering capabilities and charting capabilities. As far as working as a bedside nurse that – I did not use that type of charting because that was not necessarily my role.

Our nurses, again they were we had that luxury of a few days and our chief nursing officer was right on top of ensuring that as the operating room close

down and as they were closing down those units, they were quickly moving our med-surg nurses and our operating room nurses into all day educational forms where they put them on into those platforms, put in services, put all the equipment in front of them and did a lot of intensive quick training with the nurses to get them to at least baseline knowledge in order to perform duties at the bedside.

And then, as my main hospital, we were fortunate to have layers of care providers. So, you had ICU nurses who are backing up the floor nurses in that capacity. And then you have the advanced practice nurses over that next level who were working with laboratory work that was coming in the ventilator settings the information the nurses were giving us.

So, in that situation, my role to pivot was not necessarily a big pivot as far as an informatic. The nurses were trained very quickly in the laboratory setting. We have a steam lab and they quickly brought them into the stem lab to teach them. When I worked at our sister hospital, they used a different platform, and so we relied upon the nurses who were already in the hospital to do that type of bedside charting. We again use our APN rule and work through the chart as an advanced practice nurse.

And in both hospitals, I use all of our Ivaxon or the so-called (IVAX-R). We use all the electronic ID system and the ventilators and stuff in the operating room so it was the same system we use throughout the hospital. Does that answer your question?

(Deborah Graham): Yes, thank you. Thank you very much.

Tracy Castleman: I think the key was really being ahead of the curve and having a couple of days to get people into the stem lab and get their hands on the equipment in very small intense group, so that they have personal training, and they also made sure that there were a lot of available resources in the hospital at all times on all units to shore up the – to shore everybody up in the first few weeks.

Ellen-Marie Whelan: Thank you so much, Tracy. We might have time for one more quick call if there's anyone queued up?

Operator, any other call? Any other question?

Operator: No questions, ma'am.

Ellen-Marie Whelan: OK. Well, again I want to thank you, timing worked out. Thank you, Tracy so much not only for the work you're doing and kind of following the path forward through New Jersey's initial response to COVID, but also for sharing your story with us and highlighting the role of the nurse anesthetist and the flexability of you being able to jump into the (fray).

So, our next call will be two weeks from now. We're going to have – two weeks from now we'll have some nurses talk about setting up the alternate care sites and have it be a nurse run center trying to best address the influx of COVID patients. So, that'll be – I think it'll be really interesting to hear their story and that'll be two weeks from today.

So, thank you everyone for joining. Everyone have a happy and healthy July 4th, holiday and look forward to "seeing everyone two weeks from now". Alina, I'll turn it over to you.

Alina Czekai: Great. Thanks Dr. Whelan, and thank you everyone for joining our call today. We look forward to having you join us on this call in two weeks. And, in the meantime, we do have our CMS Office Hours next Tuesday, June 30th at 5:00 p.m. Eastern, where will have all of our CMS subject matter experts on the line to answer your more technical question.

We hope that you all continue to stay safe and thank you again for all that you were 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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