Centers for Medicare & Medicaid Services
COVID-19 Call with Nurses
July 9, 2020
3:00 p.m. ET

Operator: This is Conference #: 9386539.

Alina Czekai: Good afternoon. Thank you for joining our July 9th CMS COVID-19 Call with Nurses. This is Alina Czekai leading stakeholder engagement on COVID-19 in the office of CMS Administrator, Seema Verma.

Today, we are joined by CMS leaders as well as providers in the field who have offered to share best practices with you all.

First, I'd like to turn it over to Jean Moody-Williams from the Center of Clinical Standards and Quality for an update from the agency. Jean, over to you.

Jean Moody-Williams: Great. Thanks, Alina, and thank you everybody for joining the call. We have a couple of updates we want to give you. But more importantly, we have a wonderful guest speaker that can give us some updates from the field.

I think it is important that we continue to come together to talk about what's happening in the field. I think as we look across the country we were getting variability in transmission of COVID-19. Some places are seeing things begin to flatten, others are seeing things peak.

And what we hope to do is if you happen to be from a place where you kind of have already been through this then you have some good experiences and what works for you that you can then begin to share those with – share with those who might just be starting to go through it. We've been holding a number of calls and we've been finding that to be the case.

So, one of the things that we want, and I know that this audience is particularly interested in, is being evidence-based and data driven. And we're

starting to get data now from a number of mechanisms that we put in place, including recently we started to collect data from nursing homes and COVID through NHSN data. As you know, that's being publicly recorded at this time.

But just recently – and I just wanted to make sure that you are aware of this because we will be updating this data – CMS released data from our claims. We've been collecting data related to COVID since the beginning, January 1st. However, about April, we had some specific codes that were specific to COVID-19. So, that's even enhanced our ability to track what's happening across the country.

You can access this data via our website and it really is a snapshot at any give time. And it's – most of the time when we release data, it is after all the claims have settled and that could take anywhere from six months to a year. People get to appeal, send in the different – they edit their claims. However, given the importance of this and the impact of this pandemic, we are releasing this data as soon as we feel that we can. So, there are some limitations to that and we do highlight that.

But I think that what we saw was that between January 1st and May 16th we issued data that breaks down the number of COVID-19 cases and hospitalizations from Medicare beneficiaries by state, by race, ethnicity, by age, by gender, whether they were dual eligible from Medicaid – Medicare or Medicaid, and that has definitely an impact on what we're seeing, urban, rural.

The new data showed that more than 325,000 Medicare beneficiaries had a diagnosis of COVID-19 between the time period I referenced. So, this is – this is equivalent to 518 COVID-19 per 100,000 Medicare beneficiaries. The data also indicates that nearly – over 100,000 Medicare beneficiaries were hospitalized for COVID-19 treatment.

And African-Americans were hospitalized at a rate nearly four times higher than white and the disparities presented in the snapshot go beyond race and ethnicity, it suggests the impact of some of the social determinants of health particularly as we think about socioeconomic status.

There are a number of other findings, such as with our end-stage renal disease patients had the highest rate of hospitalization among Medicare beneficiaries. I know some of you may in fact worked with end-stage renal disease population, the second highest beneficiaries enrolled in Medicare and Medicaid which we call a dually eligible. And then among racial and ethnic groups, African-Americans had the highest hospitalization rate as well and Hispanics followed that and Asian-Americans and whites followed that.

So, we saw that beneficiaries living in rural areas has fewer cases and were hospitalized at a lower rate than those living in the urban-suburban areas. So, that just gives you a really, like I said, a snapshot of the rich data that is now available. And many of you I know are even researchers. So, I encourage you to please take a look at that and much of our data too is publicly found.

So, that is just amazing …

Lee Fleisher: Jean?

Jean Moody-Williams: Yes?

Lee Fleisher: This is just Lee Fleisher. While I have two minutes, I wanted to say hello, I look forward to interacting with this group. I am actually making sure that I'm healthy before I start this job. I think people would understand that. So, I'm at my internist. But I really going forward – look forward to learning and hearing their concerns. So, thank you for the opportunity to say hello.

Jean Mood-Williams: Awesome, Lee. I didn't think you're going to make it on. Lee is the new Center Director of Center for Clinical Standards and Quality as well as the new Chief Medical Officer. And he is very much supportive of all clinicians. And so, we will be happy to have you on future calls.

Lee Fleisher: Thank you.

Jean Moody-Williams: All right. So, that's really where I wanted to bring you by way of data and to encourage you because I know there are a lot of researchers as well on this call that you take a deep dive into that.

The other thing that might – I want to mention because I know we have tons of nursing homes as well is that the staffing measure we are holding constant some of our data in nursing homes as far as the star rating system goes. However, for our Payroll Based Journal, we have ended that waiver and facilities must now submit data for calendar quarter – the second calendar quarter April through June. And so, please begin to know that your data are due by August 14th.

So, with those announcements, I now want to turn to our guest speaker. Colleen Hole is the vice president at Atrium Health in North Carolina. And thank you so much for joining us, Colleen, and I'm going to turn it to you for – to share some of your wisdom.

Colleen Hole: Thank you so much. Can everyone hear me OK?

Jean Moody-Williams: Yes. Just fine.

Colleen Hole: OK. Wonderful. I am privileged to be a part of a very large system, Atrium Health, down in Charlotte, North Carolina, that's where we're based, and really appreciate the opportunity to share just for a few minutes some of the work that was at the same time exhilarating and terrifying, but I believe we really made an impact through our COVID-19 virtual hospital.

As I mentioned, we are – we're a large healthy system with thousands of beds really in the Charlotte market, but we recognized the peak came as we anticipated. We could meet up to 100 percent additional hospital beds, and that was anticipated for about mid-April.

So, our objectives at creating a virtual COVID hospital were really to assure that we have that inpatient bed capacity, to actively monitor COVID patients in their homes to assure that we could escalate promptly because we were keeping an eye on them more closely, and then also, of course, to decrease community spread. So, part of it was educating about the importance of staying home, educating others in their home and making sure that patients weren't seeking care in traditional venues.

So, we established several – across our region, several mobile testing sites, literally tents in parking lots where patients could go to be tested and use a clinical similarity stratification to determine does the patient need to go to brick and mortar hospital or could they be admitted to the COVID-19 virtual hospital.

If they had moderate symptoms at that time of assessment, we admitted them to the COVID virtual hospital acute care units. And if the symptoms were mild or actually non-existent, they went to the observation care unit.

And we were intentional to establish a hospital language and construct as we knew it would be familiar to most of the folks across our health system and really even to the patients. So, using the language of a care unit or even we became to refer it to as the first and second floor. People understood transfers, admission, discharge, care escalation, et cetera.

So, a little bit about the observation floor of the virtual hospital. This was a nurse-driven model that patient received at least in every other day nurse assessment in addition to a very thorough intake or admission assessment.

We also had 24/7 physician coverage for call in case the patient needed care to be escalated. And we were able to deploy the GetWell Loop. I'm sure many of you are familiar with Get Well. We've used it for years on the inpatient side for patient education. But they quickly developed a patient engagement tool that appears to be really helpful in getting feedback from patients.

The acute care floor or sometimes referred to as the second floor is for patients with moderate symptoms. So, in addition to the RN telephonic assessment and monitoring, which happened at least daily, they also had a home monitoring kit that they received either at testing or on discharge from acute care. So, we were able to monitor blood pressure, temp and oxygen saturation where the patient mainly recorded those and reported to us.

We also – a key component was our community paramedecine and nurse home visit program. So, patients receive the daily in-home visit by community paramedicine and/or a nurse where they were able to receive

advance therapies, respiratory treatments. They could receive IV fluids, IV antibiotics, respiratory protocol, EKG monitoring. We could draw labs.

And at that same visit, we were able to connect the patient to a provider for a virtual visit. So, each day, there were virtual visits, in-home, CP or nurse home visits plus the ongoing monitor from the nurse as well as the GetWell Loop.

We had developed early on a nursing assessment that we quickly embedded in our EMR that followed, as you might expect, symptoms of shortness of breath, cough, lightheadedness, et cetera. And it auto-scores and enabled us to get a score in Cerner that was connected to a protocol that defined the escalation of care. So, if the patient was the same or better than yesterday, pretty much it continued. But as care escalated or symptoms became worse, we were able to identify another CP visit, transfer to the hospital, or just a conversation with the physician.

That's second floor because it did require in-home care. We developed some eligibility criteria around patient factors mostly can the patient comply with the devices, are they able to manage them, are they able to transfer an ambulate within the home. We had secondly social determinant factors to make sure that there were – living conditions that were safe and that they had support in the home and had food. And the of course, clinical factors like less than 4 liters of oxygen per nasal cannula and clinical stability.

So, so far, we've seen over 9,000 patients in the virtual hospital, essentially 97 percent of all those who have been tested positive, so a very small number admitted to the hospital as you might expect and we would hope for. Only 2 percent of our COVID virtual hospital patient have had to be transferred to brick and mortar hospital and we received many patients who did have to be transferred there back into the virtual hospital when their care has improved and they're safe for discharge.

Our current census is running around 2,200 in the virtual hospital. I will mention for a few weeks we closed the second floor because we were able to

flatten the curve and the hospital had capacity. But we did reopen again this past Monday and we are already with 30 patients.

So, the patients have really loved it. We get feedbacks from them. And a lot of the language is around, I felt like I wasn't alone, you alleviated my fear, I felt safe and appreciated that I was able to reach help when I needed it. So, we think of it really as a continuum of care all the way from virtual observation to virtual acute to inpatient medical, surgical nursing units to the ICU.

I'll speak just for a moment about what we believe this has prepared us for. We've been doing virtual technology here for a number of years, but COVID presented the platform to really apply that knowledge and experience and resources for a true crisis. And so, we were able to test and prove some of what we have really believed to be true but found to be absolutely true.

We also had challenges to our paradigms where we had kind of believed that older patients or underserved patients might struggle with the technology and found actually that wasn't true at all. They did wonderful and truly appreciated and felt that the care was very, very, very personal.

So, we don't know exactly the next iteration of our virtual hospital, but we're really thinking of two patient populations. One would be your complex chronic population who really needs more proactive ongoing management of care and reducing those inappropriate high dollar ED and inpatient stays.

The other group would probably be more condition specific, acute episodic patients, such as cellulitis, pyelonephritis, dehydration, or even some post surgical conditions that we could discharge the patient earlier than we traditionally do and care for the patient in their home, thereby, decreasing our hospital length of stay and improving our bed capacity.

So, that is essentially our story. I'd be happy to take some questions.

Alina Czekai: Great. Thank you so much.

Jean Moody-Williams: Thank you …

Alina Czekai: Go ahead, Jean.

Jean Moody-Williams: Oh, no. I was – I was about to say thank you as well. It's fascinating. But I'll turn it – I'll let you go from there, Alina.

Alina Czekai: Perfect. Thank you and thanks, Colleen, for sharing your perspective. Operator, do you mind giving the instructions for questions from the audience. And after you give the instructions, I'll turn it over while you're setting up the queue. I know Dr. Ellen-Marie Whelan has some questions for Colleen. So, over to you, operator.

Operator: Thank you, Alina. At this time, if you would like to ask a question, please press star then the number one on your telephone keypad. Again, that's star one on your telephone keypad. To withdraw your question, please press the pound key. Thank you.

Ellen –Marie Whelan: Thank you, operator. This is Ellen-Marie Whelan. I'm the chief population health officer over at CMS and Medicaid. And I also want to thank Colleen for the presentation and also for just all the work that you've done. It was an enormous amount of work that you so succinctly captured in a 10-minute presentation. So, we appreciate that.

And also, I know we spoke before and you'd be happy to answer questions for folks who might be going through some of this now. As Jean pointed out at the top of the call, there are states that are now starting to see increased numbers. And if other folks are looking to replicate or do something similar, I appreciate, Colleen, you offering to help people make that happen.

One question that is I had is we were listening to what you were doing and kind of all these creative, brand new ways of delivering care, was what if any of the flexibilities and waivers that CMS allowed during the public health emergency were – did you take advantage of or did you take advantage of any that were – that had to be in effect in order for you to be able to do what you were doing?

Colleen Hole: That's a great question. As I mentioned, we had been doing a fair amount of virtual care previously. We did virtual visits. We did e-visits, e-consults even. But several of these waivers were very instrumental in allowing us the flexibility to deliver care to more patients.

Two or three that come to mind specifically was being able to deliver telehealth services across state lines. So, many of you may know, Charlotte sits almost on the state line between North and South Carolina. So, we have a significant number of patients who lives in South Carolina just across the border.

So, we were able to more flexibly – more easily staff for providers who were not licensed and credentialed across the line. We were able to staff the South Carolina patients. And that made a tremendous difference and just again being able to deliver North Carolina based care across the line.

Another one that is obvious to a whole of us is the telehealth payment parity with face-to-face. We were able to care for patients that we traditionally would bring in to clinics. But as I'm certain you know most of our elective or non-urgent visits we stopped mid-March and patients were afraid to come in. So, that includes the Medicare annual wellness visits and many other visits, being able to assure payment parity with face-to-face really touched thousands more patients than I believe we would have otherwise.

And then I'll mention in a similar vein allowing telehealth payment for audio only. That was really, really important as we really haven't had time to assure that all of the parties have the technology to do videos. So, that's both our clinicians as well as patients. Not everyone was able to do beyond just the audio. So, we were able to deliver to E&M services, behavioral health services, annual wellness visit, all of these very important preventive even services, were able to be delivered. And without the waivers, that would not have been possible.

Ellen-Marie Whelan: That's really helpful. Thank you. And I think that's the kind of advise that I think if folks are thinking of needing to start one of these sites, being able to

look to see which flexibility you should take advantage of, it's going to be a big help.

Operator, do we have any questions on the line?

Operator: We have no questions from the line. And as a reminder, if you would like to ask a question, please press star then the number one on your telephone keypad.

Ellen-Marie Whelan: So, I'll take the prerogative of Ellen-Marie Whelan again asking another question. And just to comment first, one of the things I think was really remarkable hearing you talk about this was the fact that you were able to use so many different professionals and kind of expand what they were doing still to the top of their license and really a strong role for the RN. Lots of times people are thinking about this and looking at advance practice nurses, but you took that RN role and really looked to see what it is that they could do just to fully contribute to the new care delivery model. So, I really applaud you on that.

Since we're talking about folks that might be wanting to think about doing something similar across the country, is there anything that surprised you or that you thought was kind of an aha moment for you as you were moving forward, just to share some of those lessons or thoughts or insights to the other folks from the – on the call?

Colleen Hole: Sure. I think my first aha is how we were able to do all of this virtually. We lost the ability to meet in person as teammates and we were literally – I believe we had two initial in-person meetings, but that core team of planner and implementer people literally did the entire set up virtually, including recruitment of staff to work. It's remarkable how much you can actually do virtually and I think we are all in that mode of learning how to do that. But really for nearly four months now, we've almost not been together. So, that was an aha moment.

I was also amazed and really, really proud of how we were able to be flexible and agile. We are really large and spread out geographically over many counties. We're complex. And like most organizations, we have silos and we

tend to want to plan and – you've heard the term paralysis by analysis. We were really able to turn on a dime almost and bill in a manner of days.

I would say it was between seven and eight days from the time we said, we got to do this, to the time we saw our first patient. So, it was almost – that's why I said almost breathtaking even how quickly we were able to do it.

I was also proud of how title and position and department didn't matter at all. I've likened it to a code in an ICU. Even if there have been traditional turf wars between nursing and respiratory therapy and physical therapy and everyone, human nature, in a code, it's all hands on deck and everybody is contributing their very best to get it done and I saw that just from conception to implementation, everyone, all hands on deck.

And I guess my last surprise and all of this actually brings me great joy is that how wonderfully exciting and fun it is when no one cares who gets the credit. It was truly everyone coming from everywhere and I mean that literally, and that there was no staff for this. The staffs that we used were coming from ambulatory care, endoscopy, inpatient care, surgical centers, community health, case management. We pulled nurses and physicians from every corner of our organization, and we all collectively contributed to the care and felt really proud of it.

Ellen-Marie Whelan: That's such a great way to end the presentation. It is really remarkable that you cut all of that from kind of zero to 60 in only a week. It is – it's amazing and I feel proud of how health providers can pull together when need be. So, that is really a great story.

Operator, do we have any questions? We'll do one last call to the line to see if anyone has any questions.

Operator: We have a question on the line and it comes from Carol Bigford. Your line is open.

Carol Bigford: Could you share with me the information technology solution that you might have used to allow you to maintain clinical documentation, care coordination, and the use of clinical orders and so on?

Colleen Hole: Sure. So, we used our EMR for documentation just as we would. It was essentially an outpatient service. So, we didn't need to do some of the things like a discharge summary, some of those pieces, but we were able to do virtual visits, which were really important. So, we used our Cerner outpatient tools that everyone was pretty familiar with. We had to do some extra training for our inpatient folks, but that works well.

Another technology we used was Doxy.me for some of the patient encounters when we just wanted to quickly talk with the patient. And then I mentioned the GetWell Loop briefly. That was a wonderful tool, still is, to engage the patient. They would receive alerts – I'm sorry – they would receive prompts to get feedbacks on their symptoms. And based on their answers, we got feedbacks of yellow or red alerts and allowed the nurses to know the urgency of that feedback and to reach out proactively in between their daily calls.

So, mostly, we just leveraged tools that we already had and I would say as we move forward we're looking at other technologies to facilitate that even better, but it's working pretty well even as it is.

Oh, I forgot to mention. Vidyo was our audio-video technology for our virtual visits.

Alina Czekai: Thank you so much. Operator, any other questions?

Operator: No further question at this time.

Alina Czekai: Great. Well, thank you everyone for joining our call this afternoon. Special thanks to our terrific guest speaker. We hope that you'll join us next Tuesday for our CMS Office Hours. Again, that's next Tuesday, July 14th at 5:00 p.m. Eastern. And on that call, we'll have all of our CMS subject matter experts on the line to answer your more technical questions. And in the meantime, you can direct any questions through our COVID mailbox and that e-mail address is COVID-19@cms.hhs.gov.

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

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