Centers for Medicare & Medicaid Services
COVID-19: Home Health and Hospice
Moderator: Alina Czekai
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OPERATOR: This is Conference #: 7844154.

Alina Czekai: Good afternoon, thank you for joining our May 5th CMS COVID-19 weekly call with Home Health Hospice and Palliative Care. We appreciate you taking time out of your busy schedules to join us today. 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 and providers in the field who have offered to share their best practices with you all.

I'd first like to turn it over to Jean Moody-Williams who is the Acting Director at the Center for Clinical Standards and Quality at CMS for 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 good afternoon everyone, thank you so much for joining. We've had a busy couple of weeks at CMS with as it relates to updates and guidances and I want to share a little bit of that with you. But first I would like to again thank you for your work and for your effort and I know that some, not all, but of you that are on this line are nurses as well so I want to recognize that it is the month of the nurses and actually it's the year of the nurses but we're celebrating in May, so congratulations to you all.

I thought it was quite timely their suggestions of what we should do each week during this month and during the first week it was suggested that we really take some time for mindful recognition and focus on some of the stressors and emotional challenges that we're having and this was written long before COVID came about I'm sure of what we should do during this week. But it is so fitting to take time for some self-recognition, to rejuvenate because

the work that you're doing is extremely challenging on the frontlines and we thank you for that.

Over the past couple of weeks we have released a number of waivers and flexibilities and this past Thursday we did the interim final rule with comment and through the recent changes we announced that delay and reporting requirements for home health agencies for the reporting of the transfer of health measures and certain standardized patient assessment data elements. This is also known as SPADE.

Initially providers were required to give reporting in January of 2021 but prior to the – prior to the delay but the delay will provide really maximum flexibility by reducing the burden and administrative effort associated with having to go through the training, training staff, the workload, working with vendors to incorporate the updates to the instrument so this really should allow you to focus your attention on the public health threat that we're currently facing and we will come back with additional details about how we will move forward after the delay.

We've also done a number of things, some of which I mentioned during our last call, but just for those just to reiterate, the 12-hour annual in-service training requirement for home health aides we modified that requirement so that home health agencies the requirement that you must ensure that each home health aide receives 12 hours of in-service training in 12 months, we're postponing that deadline for completing this requirement through COVID-19 public health emergency until the end of the first quarter the declaration of the PAG, so that will give you a little bit more time for that.

Also, some of the detail information sharing for discharge planning we have waived. Some of the clinical records requirements we're extending the deadline for completion the requirement at the home health agency to provide the patient a copy of their medical record at no cost during the next business or within four business days which is usually the case but we are extending that to ten business days instead of the four. For the (inaudible) performance improvement, what we're requesting is that you continue to do the quality activities but that they be focused on infection control and also but still

continuing to use the data driven quality assessment methodology and that you look at adverse events as well.

And for hospice as well, the modified annual assessment of skills and competency of individuals furnishing care, providing in-service training and education where required, so I encourage you to look at this particular waiver because there are still some requirements that selected hospice staff must complete as far as having a competency evaluated, but please take a look at the waiver to see which things that you will not have to do. So, there were – there were several other updates that we had that we put forward on our waiver site and you can go to the CMS COVID-19 flexibilities web page and see those.

I also encourage you to begin to look at some of the Opening of America documents which begins to talk about various gates and criteria that communities are using as they look to see either how they continue their mitigation strategies because of the numbers that they're seeing in their communities or they're using these gating strategies to look to see should they begin to relax certain things.

We ask you to take a look at that to be aware of what's of course happening in your communities and provide your input as to what you think should be happening in the various communities because you certainly have a great deal of knowledge in that area that I think will be helpful as some really tough decisions are being made across the country.

So that's basically our updates for today. And we want to spend time really hearing from the frontlines as was mentioned earlier and have been so appreciative of those who have volunteered their time to come and share because we often hear a lot of times about what's not working but we also know that there are a lot of things that are working and we want to promote that and celebrate that as well.

And so, with that I want to turn to Liz Fowler who's the president and CEO of Bluegrass Care Navigators and it's a Kentucky based provider of hospice,

palliative medicine and private duty nursing, adult day health care. So, Liz, I'll turn it to you now.

Liz Fowler: Yes, thank you very much, and first on behalf of all of us I want to express our appreciation to all of you at CMS Administrator Verma and the president, including hospice and palliative care and the CARES Act funding was really critical for us in alleviating the financial stressors related to the pandemic. You know, for many of us it was purchasing the additional PPE, rapidly deploying telehealth capabilities, and alleviating that financial stress has helped us to focus on patient care. So, I want to just say thank you to all of you.

And as I think of best practices now at this point in the pandemic, and was preparing to participate today I thought OK we need to begin to be forward-thinking and the things we've put in place for infection control for a long time we're going to need to continue them and to maintain superior infection control behaviors, home where many – most of our care is delivered can be safest place for a patient and will be for some time.

And we have to assure our community providers, our team members, our patients and families that we (inaudible) disease and we have to protect our team members for that. And when we're in this for the long haul, you know, PPE isn't comfortable to wear but it's going to be our new normal. So how do you make that normal among all of your team members and just what you do and especially, you know, we say to our team, you know, integrity is doing the right things when no-one's watching and when we have individuals in homes no-ones watching, how do you assure your folks are always wearing the right protective equipment?

And beyond infection control, we are also beginning to think about what our teams will – members will need for them on the frontlines with a post-trauma sort of support that Jean alluded to the emotional toll, the anxiety that the pandemic's taking on our care givers. It's taken a lot of resiliency. It's taken a lot of adrenaline and emotional demand and for those of you that have delivered care in other emergency situations, hurricanes in Florida, the Las Vegas shootings, you know that there's a psychological and physical sort of

drop-off when you go from being a hero as we are on the frontlines in an emergency situations to returning to normal.

And although we are all yearning for normalcy and getting back to the way we've done business in the past, it very likely will be a big letdown to a lot of our frontline heroes and, you know, we're still wondering what our best practice is going to be with that, I think number 1 is, having an awareness that although what we're doing right now is very stressful, it has a real feel-good feeling to it as well and many of us are doing extra services and supports for our frontline team members.

And when we begin to take those away what does that do to their mor, acknowledge that they'll have unsettled feelings, perhaps some depression that business as normal isn't as exciting any more.

And perhaps I should stop there and open it up for questions or other thoughts on those topics.

Jean Moody-Williams: So, thank you so much for raising issues for us to think about. So, operator, why don't we open up the line for people to ask questions or to offer some thoughts and best practices in this area.

Operator: Certainly. To ask a question via the telephone please press "star" and the number "1" on your telephone keypad. To withdraw your question press the "pound" key. We'll pause for just a moment to compile any questions. Again, if you would like to ask a question please press "star" then the number "1" on your telephone keypad. And there are no questions at this time, I turn the call back over to the presenters.

Liz Fowler: You know, another area …

Jean Moody-Williams: Thank you.

Liz Fowler: Would you like me to …

Jean Moody-Williams: OK.

Liz Fowler: Another area I thought of that we know our communities will have a lot of unmet bereavement needs, families that can't be together during this time because of visitor restrictions and the limitations that are placed on funerals and services people may be having or used to having, that we could very well see a surge in behavioral health needs as people begin to come together and what does that do with our – what can be offer with our bereavement counseling staff that many of us have or having community services or opportunities for people to do remembrances in new and different ways? I think the resiliency learned during this time will certainly need to carry on for quite a bit.

Jean Moody-Williams: Yes, this is – this is Jean, thank you for that. I'm curious are you – have you started to see this already, I'm hearing in some areas where there really is a heightened need for this kind of service, particularly as loved ones may not even be at the bedside when they see their loved one passed away, how are you working with this at handling it?

Liz Fowler: So in some facilities I know they're doing a tremendous amount of telehealth and teleconnection I should say with family members that are away, and we have also realized the – that our frontline care givers are also becoming (surrogate) family members for patients, and the bereavement grief that our frontline team members that are there with individuals as they're passing in lieu of family, offering support to them has been very, very important.

One thing we have also done to support family members that can't have services or they're away, we have been mailing them compassion bags that have three various rituals or activities they could participate in in remembrance of their loved one. Sometimes just a simple tool such as that can help them create their own meaningful remembrance of their loved one. Facilitating communication with our team members that are present or the family member that is present to – helping them to communicate with other family members and keep them informed of what's going on. It comes down to good communication and it's not a one size fits all.

Jean Moody-Williams: Yes, definitely I think that the unique needs must be considered and which, of course, is one of the characteristics of home health and hospice

is really that care planning that is specific given the situation that you're in sometimes in folk's homes or in their assisted living space which is their home. I want to just check to see if in fact there are any more questions and if not, I want to turn it to Alina to give us some information on our office hours. Any questions coming?

Operator: We did have one question come over the phone.

Jean Moody-Williams: OK.

Operator: Your first question comes from the line of a participant whose information was unable to be gathered. Caller, please state your first and last name and your organization. Your line is open.

(Freda Chestfore): I hope that – this is me, my name is (Freda Chestfore) and I'm calling from NorthBay Health at Home and Hospice in California, and this is to talk about the telehealth visits that we have been using a lot mainly due to patients sometimes not wanting a staff member to be in their home, so we've been doing telehealth with chaplains, skilled nurses, volunteers and MSWs and we're still wondering if at any time CMS would consider those for payment since they're interfering with our revenue and I don't know if you would understand the – the – the LUPA jargon and with our LUPA threshold, thank you?

(Kelly): Hi, thank you for (inaudible).

Jean Moody-Williams: Yes, I was just (inaudible).

(Kelly): OK, yes. For payment policy I'm assuming you're referring to home health since you mentioned the LUPA, the statute prohibits substitution for a telehealth visit for ones that are in person visit as stated on the plan of care so we're not able by law to separately pay for the telehealth visit.

However, we've tried to afford as much flexibility as possible to allow telehealth visits to occur along with any in person visit because, you know, we do believe that home health is primarily an in-person service and in fact the statute even quotes it out as such. So, we've tried to afford as much flexibility

as we possibly can for home health agencies to be able to make those in person visits without unnecessarily exposing patients or their staff.

(Freda Chestfore): Thank you. I have my director with me here, Jeanne, and she has a question, can she ask a question?

Jean Moody-Williams: Yes, go ahead, please.

Jeanne Dennis: This is Jeanne Dennis. Hi, Liz, nice to hear your voice.

Liz Fowler: Thank you.

Jeanne Dennis: One of the things that we're finding in our – in our practice is the reluctance of many family members to allow us to come into the home and more particularly our nursing homes in our area don't want outsiders, even outside care givers coming in. You've seen that in elsewhere and how are you managing that, what – nursing homes where we have patients inside those facilities will allow the nurse in but they're to allowing other team members, therapists, social workers, chaplains, all of that's being done by – all that intervention's being done by phone?

Jean Moody-Williams: Yes, this is Jean and we are hearing that this is occurring in nursing homes, in assisted living, even in hospitals and one of the things we note is that coordination of care, continuity of care in the best of times is an issue and I think is exacerbated during the time of situations such as this. We do have guidelines. We refer nursing homes, for example, to our guidelines how to screen and allow folks in and we do encourage that necessary care be provided.

It is up to their discretion to a great deal of extent when they feel that it is safe to allow providers in. What – as we move towards reopening as it were, I think it's going to be very important to have these crucial conversations with the people that you normally work with to - staff to kind of work through what's best for the patient. It could be – it could not be but in the event that we see something like this again we're hopeful that these things we're hearing about we can have better solutions.

But I do want to open up the line to see if maybe someone on the – on the line has experiences and what you've done to kind of help with the coordination of care.

Jeanne Dennis: Thank you.

Female: You're welcome.

Jean Moody-Williams: And, operator, are there any others on the line just yet?

Operator: Yes, your next question comes from the line of a participant whose information was unable to be gathered. Caller, please state your first and last name and your organization. Your line is open.

Female: Hi, and I don't want to divert from the question that was just asked (inaudible) about care coordination, my name is (inaudible) I work for the Colorado Division of Internists. We had a question from a provider here in Colorado that I was trying to relay some healthcare, it's not my forte so I apologize if I stumble here on any of the terms, but this is also in relation to the telehealth and I certainly understand the requirements (inaudible) but they can't replace an in person visit that was in our plan of care.

This is more around the face-to-face requirement for certification and recertification which is allowed under telehealth but an issue that we're running into here is that some patients aren't comfortable using video technology, they either don't have access for that or just aren't comfortable (inaudible) audio visual communication. So, the question was around is there any guidance about being able to do those visits with telephone only knowing that CMS has opened up some (inaudible) services, but the question was if I would be allowed for (inaudible) certification or recertification requirement?

Jean Moody-Williams: OK, thank you. Your question is telephone visits for recert and certification requirement, can someone on the line address that?

(Kelly): Yes, this is (Kelly) again. Congress was very explicit in using the term "face-to-face" and we really believe that that's not something that we could get

away from because of how explicit the language is in the statute, that it must be a face-to-face encounter.

You know, we do recognize that there may be those patients that are a little hesitant and that's why we've encouraged providers to, you know, potentially assist patients in obtaining more and explaining the need for face-to-face in order to get sufficient information to do the certification and recertification, but we really can't waiver from that just because of how explicit the statute says what the face-to-face is to be.

Female: Thank you.

Liz Fowler: This is Liz Fowler, I can add a best practice that we've added to facilitate the visual to virtual face-to-face visit. For families, we have because we were realizing families were having a hard time or hesitancy to connect or didn't know how to use technology, a non-clinical individual supports our clinician and establish the contact, teaching the family how to use the application we're using so that it's not reliant on our clinician to establish the visit.

And that administrative support in someone that's just excellent at teaching a family that's not familiar with technology has been really helpful in making the visits much more productive and gives a greater comfort level for the family.

Female: Liz, is this someone that's affiliated with the agency or this is more like an informal care-giver?

Liz Fowler: No, it's one of our team members on the administrative side.

Female: Hello …

Liz Fowler: We've selected a handful of individuals that can help take on this role during this – the pandemic.

(Kelly): Thank you for sharing that, I always like to take these nuggets myself back to – you know, to our leadership and share the different things that we're hearing so that's good to know, thank you.

Jean Moody-Williams: Thank you and can we have …

(Tom): (Inaudible).

Jean Moody-Williams: Yes, go ahead.

Male: (Inaudible) from (inaudible) I just had a comment on a couple of the other speakers.

Jean Moody-Williams: Yes.

(Tom): So specific as (Jeanne) has already mentioned, I know there's been – I oversee the hospice recert and cert program within (VCAB), but what I wanted to mention was that there has been recognition as (Jeanne) has said regarding the challenges with access for the staff of the hospice into the long-term facilities, and just adding again that there was some additional long-term care guidance published last week that tried to clarify that indeed essential staff would include a hospice staff member in, you know, some language around that.

And then subsequently to that it also talked to some of the other stakeholders around in those situations for various where again the attempt of the hospice is to provide those services, and if they're not able to do so that, you know, at this point we just have to document and make that effort of collaboration in those things to the best of their ability, you know, given the situation that I think is, you know, recognized not to be – there's no complete quick fixes to some of these things within this PHE currently.

And then subsequent to the first caller, I'm interested to learn more and I think the question about the post-bereavement I'm hearing a lot from, not only individuals, but providers and I actually have a couple of personal experiences with individuals that were not able to be with their loved one when they passed, I think that you alluded to – first let me applaud you for what you're trying to do with some of the special packets and support packets and things sending out to them, but I think it will be interesting going forward for the hospice providers and I wouldn't certainly say that it should be a (inaudible) component.

But looking at how in your post-bereavement year in-services looking and getting tracking, if you will, some of your experiences in terms of having to find ways to provide resolution in terms of bereavement in those kind of lessons learned and/or best practices again could be something that unfortunately may not serve us today in this particular pandemic, but, you know, maybe we can learn from that going forward and again try to enhance and improve on those services in the event that there another one or something of that type.

So again I just want to acknowledge that effort and also, you know, restate that we're continually looking with long-term care to help kind of clarify that language for those long-term care facilities that are at this point still not allowing for other to visit patient, or other staff from hospice staff to participate so thanks.

Jean Moody-Williams: Thanks for so much, (Tom), for jumping in. We are at time, but I really do appreciate this dialogue, I think it's been very interesting to hear the challenges but also how others are working some of this and, of course, you've got, as you know, your CMS folks on the line and we're taking note as well as we think through a number of issues. So, with that, I'll turn to Alina to close us up.

Alina Czekai: Thanks, Jean. Thanks everyone for joining our call today. We do hope that you can join us later today for our CMS COVID-19 office hours and that's at 5 p.m. eastern today.

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 continue to direct questions to our mailbox which 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 good rest of your day.

Operator: Ladies and gentlemen, this concludes today's conference call, you may now disconnect. End