Centers for Medicare & Medicaid Services
COVID-19: Lessons from Front Line Nurses
Moderator: Alina Czekai
April 9, 2020
3:00 p.m. ET

OPERATOR: This is Conference # 6785957.

(Alina Czekai): Good afternoon. Thank you for joining our call today focusing on COVID-19 as it applies to the nursing profession and some of the challenges that you all are addressing during this pandemic.

Today, we are joined by Jean Moody-Williams. Jean is the acting director at the Center for Clinical Standards and Quality here at CMS. We also have several experts from the field who have agreed to share their best practices with your all.

Today we'll be focusing a little bit less on Q&A since we recently launched a new call series which we're calling CMS Office Hours and those calls are every Tuesday and Thursday at 5:00 p.m. Eastern, and those calls have all of our relevant CMS subject matter experts and agency leaders on the line and they'll all be available to answer your questions.

So, really hope that you all can join us either this afternoon or in upcoming calls on Tuesdays and Thursdays. And I'd like to now turn things over to Jean Moody-Williams for some updates from CMS. Thanks, Jean.

Jean Moody-Williams: Thank you so much (Alina), and thank you all for joining in. I really have come to look forward to talking with you each week to provide a brief update on some of the things that we are doing here at CMS primarily based on a lot of your feedback.

But then, again, more importantly to hear about what's going on in the field and to have the opportunity to share some of the best practices that we will do today. Just a couple of updates from CMS and you've probably been on some

other calls which you've heard some of these things as we talk about the blanket waivers that we released on April 3rd.

And I believe I went through some of those with a group that give – I wanted to just give you an example of some of the waivers that we released specific to nurses so that you can indeed, again, go and visit the main site that we have for COVID-19 Emergency Web site to see all of the waivers – the blanket waivers that we have released because they do – I think impact your work.

But for example, we waived the requirements that Medicare patients be under the care of the physician allowing practitioners that this physician assistants, nurse practitioners and others clinical nurse specialists to care for the patients to the fullest extent possible.

We waived some of the supervision requirements where they were required by federal law such that where supervision is required that it can be done remotely through telemedicine in many cases except – where that is required.

Obviously, what we are waiving the federal requirements so the state is – we always defer to state law in many cases, and I have – and I understand that in many instances the state are waiving a number of things in their state law and then I also understand that some are not and we can encourage that we cannot require, but we will continue to encourage.

As far as anesthesia services, we are waiving the requirements that certified registered nurse anesthetist be under the supervision of the physician. CRNA's supervision will be at the discretion of the hospital or the ambulatory surgery or state law, and so this would applied to hospitals, Critical Access Hospitals, Ambulatory Surgery Centers, et cetera, so that CRNAs can function at the top of their license.

And another example would be for Critical Access Hospital personnel qualifications clinical specialists, nurse practitioners and physician's assistants will have to meet certain state requirements for licensure scope of practice but not the additional federal requirements for Critical Access Hospitals so that there can be some coverage of the more remote facilities that are really in need of additional help during this time.

So, again, I just wanted to throw out a few examples because I've not gone through the laundry list with you before but please visit that for those who have not been able to join this call so that you can see the flexibilities that are available to you. Now, this week, we did release the number of infection control guidance documents and those documents can also be found on our site.

They really are, I call them more practical documents, because they kind of walk you through what the guidelines are, the latest guidelines from CDC. We'll give you the link, the latest guidelines from CMS and it walks through a number of infection control guidances and the like and we issued them – we already issued some for hospitals and nursing homes.

But we actually went through for all of our facilities, so for Critical Access Hospitals, Psychiatric Hospitals, Ambulatory Surgery Centers, Community Mental Health Centers, Comprehensive Outpatient Rehab Facilities, Outpatient Physical Therapy or Speech Therapy Services.

Rural Health Clinics, those Federally-Qualified Health Centers, Intermediate Care Facilities and for Individuals with Intellectual Disabilities and Psychiatric Residential Treatment Facilities. So, you can see I think we've got almost all.

There may be one or two that we haven't put some guidance out that was for example hospitals, psychiatric hospitals and CAHs, the revised guidelines provides expanded recommendations on screening and visitation restrictions, discharge to subsequent locations and recommendations related to staff screening and testing and return to work.

So, obviously, that's an important element as the guidelines are coming out about how the staff can return to work. Similarly, we've got the guidance on the Emergency Medical Labor and Treatment Act, EMTALA, and this includes the detailed discussion of patient triage, corporate medical screening and treatment, the use of alternatives testing sites, telehealth and the appropriate medical screening – examinations that can be performed with these alternative sites.

For outpatient clinical setting such as the ASCs and FQHCs and other guidance discussed recommendations for mitigation of transmission including screening, restricting visitors, some information of cleaning and disinfectant – disinfecting and it does address some of the supplies scarcity and FDA recommendation.

And for the Intermediate Care Facilities and the IIDs and Residential Treatment Facilities, we included practices related to screening there but also outside health care services and community activities just because of the nature of those settings, those things are extremely important there.

So, the other area that we updated was in home dialysis training and support services and this was really to help some dialysis patients stay at home during this challenging times. We did get a number of request for that and the establishment of special purpose renal dialysis facilities which would allow some facilities to isolate vulnerable patients to have the nursing staff or other staff to be able to treat those patients in that facility.

As in – have the non-COVID – the COVID-negative facilities in a separate location and we're working through issues related to transportation and disinfecting and all of that. So, I do encourage you to take a look at those particular guidances that were released for this week. But it's actually released on the (3rd) that we are highlighting them and now on our web site.

So, with that, I want to go and shift to hearing from you and providing opportunity to share some best practices in (field). We really were fortunate this afternoon to hear from experts, I would say in the field and, of course, it's Dr. Kimberly Glassman, a clinical professor and associate dean of Partnership Innovation at NYU Rory Meyers College of Nursing. So, Dr. Glassman, we'll start with you.

Kimberly Glassman: Great. Thank you so much for having me today and I'm happy to share some notes from the warzone which is what we call New York City these days. I'm going to talk about two perspectives. One is an academic perspective and the other is a little bit of what we're seeing on the clinical side.

But I'll start by first thanking CMS for all of the waivers that you have put through. They have been immeasurably helpful. The first thing, of course, which everybody knows, that I can't emphasize it enough is reducing population density. This is the number one thing that is the best practice if you're in areas of the country where this hasn't happened. You have to make it happened.

We don't have enough testing. We don't have a vaccine. Anybody testing is in its early days. So, until we get to that point, the only way we're going to beat this is for those who can stay home should stay home so that the essential workers can travel to and from their jobs.

On the academic side, particularly in New York City, we saw a sudden shift to remote teaching and learning that sent entire universities home and this was to reduce population density. So, the academic side wanted to do their part to make sure that we could get as many people out of New York City or into their homes as possible.

With our students, now doing a remote learning and our faculty doing remote teachings, that emptied out dorms to be repurposed for housing, for first responders and health care workers, this makes it easier for those people who have long commute to have reduced their commuting time and reduced their time on public transportation.

Finally, maintaining academic progression so our students can graduate and get to work on time has been critically important. There were lots of request as hospitals and nursing homes began to get very stressful staffing for nursing students to come in and either work as unlicensed personnel or to volunteer.

And many of us have not done that because we do not want to delay our student's education. We want them to graduate on time, which for some of us will just be in a few weeks. We want to get them out into the workforce so that they can practice.

We're happy to see that NCLEX testing sites are reopening in New York, and although there are reduced seats to maintain physical distancing, New York

does have a liberal limited permit policy for graduate nurses. So, we are hopeful that those nurses who are graduating in the field in 2020 will be out and hired soon.

On the clinical side in New York City, the governor reported today, Governor Cuomo, that we are seeing some very slight and I emphasized very slight slowing of new patients in hospitals. Deaths are likely to rise for existing hospital patients as we expected but at least in the New York City area, we seemed to be seeing a slight flattening of what was a very steep curve. Long Island, however, is increasing and we are starting to see COVID patients in the more remote areas of Upstate New York.

Telehealth has been a best practice, thank you CMS, because virtual urgent care has been key to reducing patients needing to go to emergency rooms, particularly for the worried well and also for primary care has been very helpful for some patient to avoid traveling on public transportations, and we have been able to do very good care in identifying people who may be positive, but could stay at home.

Of course, the downside of that is the testing issue but since we are still limited in not being able to test the entire population then it is better to keep people home who can be at home. Use of any or all adjacent or nearby spaces has been critically important to hand the large influx of patients that we have been seeing in our hospitals. So, tents for triage of patients where then they can be sent home after being seen in a triage setting next to an emergency room.

They're being used for testing sites and even in some cases for hospital beds. We have been grateful for the number of field hospitals that have been set up to help deal with the overload of hospital patients and that includes the patients that are being transferred from hospitals over to the Javits Center that is being staffed by the United States Public Health Service Commissioned Corps Department of Nursing and all of their different divisions, as well as many others.

There's been two schools of thought, I just mention on managing the acute pulmonary problems that COVID patients are seeing. One school of thought is to intubate early, rest the lungs, sedate and make a closed system to reduce viral shedding, but a more recent school of thought that we're seeing is actually to delay intubation, using high-flow nasal cannula sometimes under a mask to reduce viral shedding.

But we're seeing that – and this was reported in the news yesterday that many of the COVID patients with respiratory problems are actually tolerating much lower oxygen levels than we have seen in other types of viral illnesses.

So, the recommendation has been to delay intubation, look at the patient, which is always a strong nursing principle, and if the patient is not in distress, if they don't have increased work of breathing even if their oxygen levels are low, but they seem comfortable then do not rush to intubate because many of these patients can recover on their own.

So, I will stop here and let the next speaker go.

Jean Moody-Williams: Oh, thank you so much for that valuable information, and as you said, it is coming directly from the field. I want to go ahead and let Dr. Carolyn Hayes speak, chief nursing officer at Rutgers Cancer Institute of New Jersey and then we will take questions. So, Dr. Hayes?

Carolyn Hayes: Thank you very much, everybody. Good afternoon and I'd like to join in the thank you for the CMS waivers. So, I'm going to cover as we had prepared a little bit ahead of time some of the implications that ambulatory nursing practice and the leadership activities that are going on.

I will say that the leadership activities feel like they go from the sublime to the ridiculous. There's some very practical things that have worked that I will share and at the same time doing some real-time planning for the future. Like many of you I'm sure I'm part of a multihospital system. I'm the chief nurse for the Oncology Service line for what is a 12-hospital system. So, we are working in tandem ambulatory and inpatient.

The leadership activities is we're all working on our worst-case scenario planning, and I encourage you to think through that when that goes something like at what point do we stop what activities based on availability of supplies, drugs, beds and staff?

We have daily command center updates where we make decisions, sometimes multiple command centers because of the multiple systems, hospitals, communication to staff, patients, the community and our web sites is a fair amount of the day and activity. And, of course, all meetings by WebEx as Dr. Glassman outlined the most important thing we believe we can do right now is social distancing.

And we're following the shifting sands of all the data, the trends, the two schools of thought and the regulations. We're trying to secure test and PPE for staff to maintain the largest workforce we possibly can recognizing in a very real powerful way. There's no way we can stay in full force. The virus is too contagious.

We're preparing for the recovery period. Right now, we have reduced our surgeries to only those that are urgently needed, and we have shifted our clinic volume by delaying surveillance patients as their case history allows and moving towards telemedicine. So, what happens when we go back to full care and how are we going to manage that, what I hope is this summer return to normalcy.

And I want to put a plug into here for the care of the caretaker. This is going on for protracted period of time. It's not the snowstorm that nurses are all used to kind of rallying around. This is actually months of some ethical challenges, physical challenges, and certainly, emotional challenges.

So, we do things like every day at 2 o'clock for 10 minutes. We have a "break and breathe" where everybody can call in to line and be led through a guided meditation 10 minutes, and Fridays, we have "yoga at your desk". So, I encouraged leaders to think about the long-term ramifications of those, we're all kind of going through this trauma together.

As I said, things have worked well. We have reduced – significantly reduced our clinic volume, and since PPE is considered potentially scarce resource and every person can be asymptomatic and contagious at the same time, therefore, every person is considered a potential source of infection, we've quickly moved to maximizing social distancing.

And although that has the most utility, it's also a difficult thing to do in the public spaces that we all occupy. So, we have invoked both some policies and physical changes. We closed each building to one entrance only to control coming and going. We've instituted a zero visitor policy. Of course, there are exceptions to that based on age or capacity for the patient to consent to the treatment.

And there are consequences to those decisions things that loved ones usually do are now falling to the clinical staff. With an expedited DOH waiver, we closed one of our clinics since we decreased the volume and converted into a treatment area, and in doing so, we're able to spread out the distance between infusion chairs and in the waiting areas and also created more private rooms for infusion because the clinics or rooms is not open space.

And that's where we're treating our recovering COVID-19 patients because we're at a point now where some patients are on the other side of the virus and are high suspicion. We marked outside which we took this from grocery stores. It was taped areas where patients are queuing up to be screened when they come in to give them a visual cue to stay separate.

And similarly, on the inside, we put tape on floors so where the employee screening is happening. Every patient is getting screened before they come into the building. We call them the day before.

Now all those telecommuting staff that are not on-site are making calls to the patient and doing symptom screening, asking them if they have a fever, asking them who they've been with and then as the patient arrived the next day, we rescreen them, same questions and take an infrared temperature where – and give them a mask.

Every patient is wearing a mask, surgical or procedural. We're obviously preserving the N95 and every staff member whose patient facing is also wearing a mask. The masks are not to protect you but to stop you from spreading the virus and we're very honest and realistic about that. The good news is the community has been incredible and they've been donating PPE and coming with meals.

There've also been some practice changes. In general, the regulatory support for increased flexibility for APNs has been enormously helpful. Compact State Agreements and now even more flexibility around licensure is helping us get workforce in to the state. We have implemented buddy systems, which have been very effective.

Again, APNs are in a buddy system with their collaborating MD with – so that they are not exposed to the same patients or personnel because they share the same caseload and expertise. So, the waivers have been very helpful that they don't have to be on site. Our governor, Governor Murphy, seems to be taking the said advice for which I'm grateful.

So, one is off-site, while the other one is here and the – therefore, we think we've decreased the odds of both of them being infected and, therefore, unavailable to care for the patients. Similarly, we have nurse clinicians who don't cross paths and the inpatient teams are doing three days on, two days off in different cycles. So, we're very grateful for the telehealth …

Female: That's why – but the updates haven't been made, so that's (why) we went over on the call today. You need to (hold) for now.

Carolyn Hayes: I'm not – is somebody asking me a question?

Jean Moody-Williams: I think somebody may not be on mute.

Carolyn Hayes: OK.

Jean Moody-Williams: Sorry.

Carolyn Hayes: We've been very grateful – that's OK, for the telehealth flexibilities that have been made available. That's the safest thing for our patients in particular not to come in. I'm happy to share with anybody the challenges, particularly of keeping clean pods, if you will, I hate to use it versus COVID pod and the staff and cross-contamination efforts.

Given the fact that the data is coming in that 6 percent of the nurses who worked on the COVID units are themselves becoming infected with the virus and some of the oncology patients have a 50 percent mortality rate if they in fact contracted, so happy to share those details.

And as stated at the beginning, more broadly, than oncology, when – we need to think about what situations do we let staff back. When do we let patients back and where and when do we treat positive patient in the ambulatory settings. Radiation oncology working out the highest level of detail right now.

The communication burden of the changing information is obvious and some of the restrictions on nurses as employees are a little bit different than physicians who are not employee-based model. In fact, as much as how we can move the puzzle parts around even though we have a 12-hospital system to leverage.

So, I will leave it at that since I have run into a time crunch. So, happy to answer any questions.

Jean Moody-Williams: Yes, such valuable information. We could probably go on for quite a while, appreciate that. Operator, do we have a question?

Operator: To ask a question via the telephone, please press star one. If you would like to withdraw your question, press the pound key. Again, to ask a question, please press star one.

There are no questions over the phone. Please continue.

Jean Moody-Williams: OK. Well, that's great. I think it was a very thorough presentation. I really – I do appreciate you taking the time out from – I could tell from your

presentation was very – a very busy time for all of us. I'm going to turn it back to Alina to close us out.

Alina Czekai: Great. Thank you, Jean. Thank you to our speakers and everyone on our phone call today. This concludes today's call. Should you have any questions or comments, feel free to direct them to our CMS COVID-19 e-mail address, and that is covid-19@cms.hhs.gov and again we have our CMS COVID-19 office hours this afternoon at 5:00 p.m. Eastern and hope some of you hopefully going to join us there as well.

Have a great rest of your week. Take care.

End