Centers for Medicare & Medicaid Services
COVID-19 Call: Lessons from the Front Lines
July 17, 2020
12:30 p.m. ET

OPERATOR: This is Conference #: 3096434.

Alina Czekai: Hello, and thank you for joining our CMS Lessons from the Frontlines on COVID-19 call today, July 17. We'd like to begin by thanking all of you for the work that you were doing day in and day out to care for patients around the nation amidst COVID-19.

This is Alina Czekai leading stakeholder engagement in the Office of CMS Administrator Seema Verma. Today's call is part of our ongoing series, Lessons from the Frontlines. And while members of the press are always welcome to attend these calls, we do ask that they please refrain from asking questions.

All press and media questions can be submitted using our media inquiry form which can be found online at cms.gov/newsroom. Any non-media COVID-1-related questions for CMS can be directed to COVID-19@cms.hhs.gov.

And I'd like to begin today's call with a brief update on the agency's latest activity. At the federal level, CMS has boosted payments to labs for testing inside nursing homes in order to increase the number that are administered.

This week, in conjunction with Admiral Giroir and his team, we began the process of procuring thousands of point-of-care testing machines. These will eventually be distributed to every nursing home around the country, but we're starting with a very special priority to those in hotspots.

These testing machines return results in as little as 15 minutes and that makes them especially useful for nursing homes looking to keep the virus at bay and protect their residents. It also gives nursing homes a powerful tool when it is appropriate to reopen their nursing homes to visitors and reunite visitors with their families.

As we all know, it's important to appreciate that coronavirus isn't simply a threat to the lives of nursing home residents. It's also been a long drawn out nightmare with respect to their quality of life. It's kept them apart from their loved ones and hold them up in their homes with diminished group activities to boot. It's a heartbreaking predicament and one that we also want to resolve as soon as possible. And we really think this distribution is going to do exactly that.

Specifically, these tests can be used to conduct the regular testing of staff and residents called for in CMS' recommended reopening strategy for nursing homes. Regulatory oversight of nursing homes is a shared responsibility between states and the federal government.

CMS is responsible for setting health and safety standards that nursing homes must meet in order to receive federal reimbursement. States, in turn, are responsible for conducting inspections of nursing homes and licensing them to operate. In addition, CMS has released the initial result of an unprecedented transparency effort that requires nursing homes to report new cases directly to the CDC.

Families and residents have had this information for months, but this nationwide reporting has allowed for a standardized nationwide picture and is forming the backbone of a nationwide virus surveillance system.

In conjunction with our state partners, we are in the process of completing over 10,000 surveys focused exclusively on infection control and compliance with our longstanding guidance. And we are working to encourage even more to take place by tying inspection funding appropriated in the CARES Act to state performance in this area.

The results of our focused ongoing inspection and the self-reported nursing home data are helping to inform new and aggressive policies. First, we are ratcheting up our financial penalties with more severe repercussions for facilities with a failure of infection control.

But our approach is not merely punitive. We are also proactively working with nursing homes to help bring them into compliance with our standard – by working with them directly. As always, CMS will continue to fight tirelessly for nursing home residents and all patients at every turn.

So, that is our CMS update for you all today. And today, we are also joined by Erin Fowler from the Health Resources and Services Administration also known as HRSA. Erin is the deputy of the Healthcare Resiliency Workgroup and she has offered to provide from the workgroup for you all today. Erin, over to you.

Erin Fowler: Thanks, Alina. I just wanted to talk a little bit about our priorities, to begin with. The Healthcare Resiliency Workgroup priorities include supporting CRAFT assessments and follow-up technical assistance.

For folks that aren't familiar with CRAFT, it's the COVID Response Assessment Field Team. This is regional folks that will go out to hotspots to meet with state and local health authorities to talk about issues and challenges that they may be having and try to figure out how we can help them. Other priorities include supporting long-term care facilities and nursing homes, integrating EMS issues into response planning and strengthening workforce resilience.

So, I want to talk a little bit about some of the key initiatives that our group is working on right now to contribute to our current priorities. So, as I mentioned, supporting the CRAFT, examples for some of the guidance and the technical assistance that we have been responding to, we've been giving out information on meta-collaboration and coordination to look at patient load balancing; training, upscaling, and rescaling and health care workforce on COVID-19 prevention and treatment, including PPE preservation; establishing and operationalizing alternative care sites including guidance in the recent third edition of the toolkit which is all of the guidance that I'm talking about can be found on ASPR TRACIE.

And we're also developing a PPE survey for CRAFT teams to use during assessment dates to determine the need for supply preservation strategy. There is also an operational plan for protecting long-term care residents.

In the long-term care space they recently develop this plan specifically to your hotspot communities. The initiative has the support of ASPR leadership and we continue to move forward in collaboration with other components of COVID-19 response.

This plan really focuses on building out infection prevention and control portion of the response plan and working closely with CDC and CMS. We are also developing a nursing home training series, collaborating with CDC and CMS to launch a remote training series designed to help nursing homes effective prepare for and response to COVID-19 transmission.

We're also looking at supporting health care supply preservation. There's a number of PPE preservation things that we're doing including developing resources on an ongoing basis. The recent highlights include respirators for health care during COVID-19 and a fact sheet on elastomeric half-mask respirators or EHMRs.

We're also looking at strengthening EMS information systems. One example of that is behavioral health intervention for working on the CMS and 911 on our webinar series. We're also currently working to establish a platform for the series to begin in August. The first session is titled Stress and Finding Your Calm which I am sure we all could use about now.

We're also looking at expanding telemedicine implementation. This is something that Dr. David Long is working on and we're launching – it's called Telemedicine Hack. It's a 10-week learning community to accelerate telemedicine implementation for ambulatory providers.

The goal of the collaborative is to accelerate telemedicine implementation during the fall through COVID coverage – or surge, sorry. Specifically, we're aiming for 75 percent of all participants to begin implementing telemedicine by September 2020.

So, the first session is scheduled for 7/22 and we have confirmed a physician executive who oversees multiple rural clinics in Tennessee and other executives overseeing FQHCs in Baltimore, Maryland to participate.

And the last thing I wanted to talk about was vaccine optimization. Our ambulatory folks are working with the Department of Housing and Urban Development in coordination with HRSA's federally-qualified health centers to target lower-income areas with racial and ethnic minorities. And we're using that data to understand how we can build capacity and communications for vaccinations for public housing.

Authorities that receive HUD grants, we like to determine how to set up vaccine clinics in public housing and provide tailored messaging around vaccines. So, we already have pilot projects for two housing areas, one in Baltimore and Los Angeles to check this out.

So, those are a few of the priorities that I just wanted to mention. And I'm available, obviously, for any questions. I can also, Alina, send out – we have the telemedicine pack flyer that lets folks know when it – the information for when it starts and what the topics will be. If you want, I can send it to you and you can send it out to the group.

Alina Czekai: Terrific. Thanks, Erin. And Absolutely, I'm happy to share that with our Listservs with all of the terrific providers who join our calls. And thank you, again, for sharing your updates and just the partnership generally.

Operator, let's open up and take a couple of questions from the audience, either questions for me or questions for Erin. Thank you.

Operator: As a reminder, you may press "star," "1" to ask a question over the phone. Your first question comes from the line of Ginny Boyd. Your line is open.

Ginny Boyd: Yes, thank you. And thanks for these briefings. We understand that worldwide and in this country that men are at much higher risk of death from COVID-19 than the ladies are. I understand that we all are in danger and nothing against the other side of the equation here.

There was – and particularly of interest there is the Native American population. As part of the ACA there was passed an authorization of the Office of Indian's Men's Health at the Indian Health Service.

The Obama administration never set that office up. Even though there is an existing office of women's health, it would be a great focus point to reach out to that segment of the Native American population to make sure that we can do the best for them and actually reach them in the language that they understand.

Is there any possibility that the Trump administration would set up that office? And also, an office of men's health at HHS would be fantastic, again, to meet out – to reach out to the special population with messages that resonate with men and boys.

The Office of Women's Health has done fantastic work over there. I'm with the men's health network and we do a lot of partnerships with them. They do great work. But we do need an office of men's health too. I will be quiet.

Alina Czekai: Thank you so much for sharing that perspective. I've taken note of that and I'll be glad to share it back with my other colleagues at CMS. And thank you for all that you're doing to help get excellent health care to men and boys around the country. And we'll take our next question is.

Operator: Your next question comes from the line of Cathy Lapier. Your line is open.

Cathy Lapier: Good morning. I have a question, hopefully, that you can delve with. Our enterprise requires COVID testing for all preop surgeries that we'll be having. And this comes from a research department and wants to find out if we should be billing the COVID test to the insurance company as a standard of care or routine care or should that be considered part of the research procedure. Since we do it for all days, we weren't quite sure how that should be handled.

Alina Czekai: Thank you for your question. Do we have any of our CMS billing experts on the line? I don't think we have the right folks on our today, Cathy, but we have discussed this exact question a couple of times on our COVID-19 Office Hours call. That's our call that we have every Tuesday with all of our billing

and coding subject matter experts. But I've taken down your phone number and your question. I can see that on the backend here and I'm happy to connect with my colleagues and follow up with a phone call to you with a response to that today.

Cathy Lapier: Great. Thank you so much.

Alina Czekai: Great. Thank you.

Operator: Once again, to ask a question, please press "star," "1" on your telephone keypad. We have another question from a participant whose last four number is 0194. Your line is open. Please state your name.

Rabi Yanini: Rabi Yanini from (inaudible).

Alina Czekai: Hi, there. What is your question, please? Operator, we'll take our next question, please.

Operator: Our next question is from a participant whose last four number is 1671. Please state your name. Your line is open.

Dr. Elisa Graph: Yes, hi. This is Dr. Elisa Graph. The question regarding – is regarding the nursing home wanting to know what sort of testing will be done out of concern that the rapid – the rapid testing will result in false positives and false negatives at point of screening. Thank you.

Alina Czekai: And sure, do we have any of our nursing home colleagues on the phone? Otherwise, I'm happy to point you to our latest guidance that could be found on our…

Dr. Elisa Graph: No, I'm not looking – sorry, no, I'm not looking for the latest guidance. I have your latest guidance. The question is in response to our call today in which we are told that the priority is going to be to offer point-of-care testing in nursing homes across the country. So, I am – my question is regarding this new development.

Christine King: Hi. This is Christine King from the Division of Nursing Homes. We should expect that there will be additional guidance that will come with these products and will be posted by CMS.

Dr. Elisa Graph: OK. Thank you. I'm just registering the concern as a clinician regarding false positives/false negatives if you're not doing a PCR test and you're doing a rapid point-of-care test. In my …

Christine King: Correct. And we…

Dr. Elisa Graph: … facility – yes.

Christine King: Yes, we understand you.

Dr. Elisa Graph: Thank you. OK.

Christine King: Absolutely.

Dr. Elisa Graph: Thanks. All right. Have a great day. Bye.

Alina Czekai: Thank you. You too. Well, thank you, everyone, for your questions. And we will now transition to our next part, probably the most popular part of this call and that is hearing from providers in the field about their experiences and listening to their best practices from what they're seeing in their local communities.

Here at CMS we recognize that government's role during COVID-19 is to offer maximum flexibility and regulatory relief to allow you all to do what you do best, which is care for the patients in your local communities.

Around the nation, providers and local communities are innovating in response to COVID-19 and, at CMS, we hope to bring local innovators together to share best practices that can be scaled at the national level.

And today, we are joined by physician leaders from around the country who have offered to share best practices and insights with you all and many of you have joined this series since the beginning of the public health emergency, so you might recognize some of the names today.

All of today's speakers presented on calls back in April, and given the influx of cases around the country particularly in the south, we invited these physicians back to share their best practices on telehealth, primary care and ambulatory care knowing that their experiences and perspectives had evolved over the past several months.

Our first topic today is ambulatory care and primary care and first speaker is Dr. Ted Long. Dr. Long is the vice president of ambulatory care at New York City Health and Hospital and he is also the executive director of the Test & Trace Corps, which is New York City's operational response to suppressing COVID-19. Dr. Long, welcome. Over to you.

Dr. Ted Long: Thank you for having me. Just to make sure, can you hear me?

Alina Czekai: Yes, we can. Thank you.

Dr. Ted Long: OK. Great. So, last I was here was April and we, in New York City, at that time, were the epicenter. At that time, were hitting our own surge. So, it was a very stressful time and we've learned a lot since then. So, I want to share three things in terms of what we've learned that I hope will help others since April when things were the worst for us in New York.

The first is that it's critical to keep people out of the emergency department and, of course, to give them the care that they need from a primary care and ambulatory care perspective. But before I get to telehealth, the first point I want to make is that we learned that people really needed to have a way to engage with New York City when they were worried on an instantaneous basis.

Otherwise, they were going to the emergency department oftentimes for things like low-risk exposures that, honestly, being in the emergency department was a higher risk exposure than the reason they came in there in the first place.

So, what we did which works very, very well is we set up a COVID hotline where it was an easy-to-remember number. We could access it through our

311 system or through those – it is 844-NYC4-NYC and you get paired up with a clinician who talks through your concerns, questions and talks through your symptoms as well. That really met New Yorkers where they were.

I remember when we went live on that in April on day one we got I think four days; day two I think even double, eight calls. And by day, I think, it was around 10 or so, 4,000. So, it exponentially went off the – off the chart in terms of the need we are moving here.

This is one of the ways that we keep and press our emergency departments. Before this, there was a long line outside of our emergency departments like Elmhurst Hospital and this really served a critical role in being able to give New Yorkers what they need to be able to stay home which was the right answer for them especially in the time of surge.

Our hotline now has taken more than 100,000 phone calls from New Yorkers, always pairing them up with a clinician almost instantaneously. So, we're proud of that and we think it – think that that's made a big difference.

The next thing – the second thing I want to talk about is – and this is something that our hotline could connect people to as well – is how can we take care of people's health in a different way than in-person visits moving forward.

I know we talk a lot about telehealth, but some of the things that we learned which we're eternally thankful to CMS for supporting is having different modalities for telehealth that meet people where they are.

I'm a primary care doctor and, actually, soon as I hang up this phone call, I'm going to have my Televisits for the afternoon with my patients. In my case, I know my patients well, so most of my patients are revisits. But it works well for new patients and revisits and patients that come in for return visits.

One of the key things though is that not everybody wants to have video visits and that's OK. A lot of my patients tell me and we saw this across our system, that some people just want to talk by phone.

A lot of people had trouble logging on to the video visits, so if you didn't give them the option of immediately diverting into a telephone-based telemedicine encounter, then you lose them or it would slow down your clinic.

So, we left those options open with CMS' support which, again, made a huge difference for us. And we've now done – before COVID, we did only a handful of Televisits. We've done hundreds of thousands of Televisits in the last couple of months alone. So, we've really gone from zero to 100 miles an hour almost overnight here.

But I think one of the most important things we learned is, again, like with the hotline, the importance of meeting people where they are so that you can deliver to them the care that you need – that they need.

In concert with setting up our different modalities for TeleVisits, we also created an in-person fast track. So, if one of patients this afternoon needs, let's say, a lab and/or a USPSTF screening exam like a mammogram, what we do is we schedule those in clinic, in person. But when you get to the clinic, you get in and out very, very fast to minimize exposure for yourself and others and it's a regimented process. So, we linked together this sort of fast-track in-person visits with different modalities and telehealth and I think that's what made us successful there.

The final thing that I'll say, number three, is not to undervalue the importance of testing. Testing is how you get out of this. So, it's hard when you're in a time of surge especially with limited reagents and limited lab capacity which we're seeing across the country now. But it's important to do as much testing as you can.

If you're in a phase of community spread, testing will help you so that, when people hit the hospital, there could be immediate cohorting. It can help – obviously help with diagnostics. But it also – as you get out of rampant community spread into local transmission or we are in New York City, we're at the stage of suppression. Testing powers your tracing, your contact tracing.

So, what we're doing in New York City now that we're past our initial surge is we're doing more than 30,000 tests a day. Then, all of those positive tests,

regardless of where they're done, we do it in more than 200 locations across the city. It has been a big effort for us.

All of this test results go into our Test & Trace Corps Program. We call all new cases or people newly-diagnosed with coronavirus. We figure out who their close contacts have been, who they've been in touch with.

We call the close contacts that have been exposed, bring them in for testing. And it's such of a process that's enabled us to actually maintain viral levels that are, right now, only a couple of hundred new cases a day. I mean, this is compared to the thousands upon thousands of cases every day where we're having with the even more limited testing we had at the time of our peak. So, this is – this strategy of building up testing and powering tracing has made an enormous difference for us.

And I'll leave you with one example of why that makes a difference too is that, as we've been doing the tracing, which is where, again, for all new cases we call them. We get through to 97 percent that have a phone which we're also proud of and through people that they identify as contact, they've exposed up through last week – or we had a group of more than 13,000 of these contacts that by the time we called them told that they were actively symptomatic.

Meaning this is a group of people in New York City that we're presumed and we're fairly sure they're really at high risk for having COVID that we're able to intervene on, get them to isolate or quarantine, give them resources on that same phone call like food delivery or even a free hotel stay.

And if we didn't do the testing and tracing, if the – our program didn't exist across New York City now, if you're using averages, they would have gone out and infected up to three more New Yorkers a piece, 1,300 people times three is about 4,000 cases of – or potential cases of COVID.

But through our testing and tracing operation, which is our aggressive offensive approach to suppressing the virus, we've been able to potentially prevent since we started to do the testing and tracing in early June.

So, I'll pause there. I'm very happy to answer any questions both now or offline. And, most importantly, this is a hard time for everybody across the country. We, in New York, have been through it and we're here to help in any way that we can.

Alina Czekai: Thank you so much, Dr. Long, for sharing your perspective. Operator, let's open up the lines to take any questions for Dr. Long. Thank you.

Operator: Once again, to ask a question over the phone, please press "star," "1" on your telephone keypad. We'll pause for a moment to compile the Q&A roster. Once again, you may press "star," "1" to ask a question.

We have a question from the line of Julie Stanson. Your line is open.

Julie Stanson: Hi, Dr. Long. Thanks for taking our calls. I work for a home health agency and our local hospitals are asking us to accept COVID-positive patients. We do not have enough PPE and we do have some clinicians that are very hesitant to treat COVID-positive patients once they're at the hospital setting.

My question is, in New York, how are you doing post-acute care of those patients that are medically stable and coming out of the hospital and how are those home health agencies managing those patients?

We are seeing some success in our other agency in El Paso, Texas with telemedicine visits for these COVID-positive patients. But that might not be the best practice, and so, I was curious of what you're all doing in New York.

Dr. Ted Long: Yes. That's a fantastic question. So, we're doing three things. And I think in different places there may be different relative effectiveness of each of the three. But one is we do send patients from our hospitals directly to the post-acute care – to our post-acute care facilities.

That's an option that, obviously, has always existed. But we've been building that up to now including with one of our post-acute care facilities actually building on a new sort of wing, if you will, that's a lower-level acuity hospital.

Number two is a little bit more creative and innovative that what we've done is we actually have set-up hotels that are dedicated to COVID patients. And you either could come from the community or from a hospital, and then, get a room at the hotel free of charge. And at the hotel we have medical monitoring, we have telehealth options, and we even give you free pajamas when you come in.

But that's the way of sort of getting people where they are because one of the challenges we have in New York is, if you're stable enough to potentially go home, you may live with a multitude of other people that share a room or share a bathroom. So, we needed to have an option that wasn't as high level …

Julie Stanson: Right.

Theodore Long: … as opposed to acute facility, but wasn't – but as you couldn't go home if the hotel provided us with what we thought was a good reasonable alternative there. We also do send patients home if they can go home and then pair them up with telehealth at home, which is an effective strategy as well.

Anybody that goes to any of our – either the hotel or to directly home also can call our COVID hotline around the clock as well, which is helpful because that also gives people sort of a valve in case there's something that's building up they need help with acutely.

Julie Stanson: OK. And I have one more question if that's OK. I – you had said that you're doing telehealth visits and sometimes your patients are technically inclined to do the video and the – and the video and audio at the same time, like you give them a choice.

What our challenge has been is that our provider is arguing giving that option. However, when they need to refer to home health agencies, we're required by CMS to have both video and telephone or audio in order to have that as an encounter note to support home health services.

I don't know if CMS is working on that to allow us just to have the telephone visits. It would be nice if home health – home health across the nation could

just use whatever access that the providers have to allow us to get into the home health patients and prevent them from having to go into acute services because they're not being supporting in the home setting.

The second part is CMS, from what I understand and the research I have done, is not supporting telehealth visits under home health services. I don't know if that's going to change in the future, if that's going to be discussed since it's being accelerated. That's the way of the future is to do telehealth visits. But, currently, right now, we will not be reimbursed for telehealth visits under home health. Do you have anything to add to that?

Dr. Ted Long: As – I left CMS two and a half years ago, but I still miss everybody, of course. I'm probably not the best person to comment on that.

Julie Stanson: OK.

Dr. Lee Fleisher: So, this is actually Lee Fleisher the brand-new Chief Medical Officer from CMS and thank you for your comments. We are evaluating issues of telehealth and what should be continued and what should not. Some of which will require congressional action. So, we'll certainly take that back – your comments back to the team as part of the evaluation process of what happens after the public health emergency and the waivers are discontinued.

Julie Stanson: That would be wonderful.

Dr. Lee Fleisher: So, thank you.

Julie Stanson: Thank you so much, yes. Thank you, sir. Thank you both.

Dr. Ted Long: Thank you.

Alina Czekai: Thank you. And thank you, again, Dr. Long, for joining us today. Our next speaker is Dr. Michael Malone, a geriatrician with Aurora Health Care in Milwaukee, Wisconsin. Dr. Malone, welcome. Over to you.

Dr. Michael Malone: Thank you, Alina. And can you hear me OK?

Alina Czekai: Yes, we can. Thank you.

Dr. Michael Malone: OK. So, thanks a lot. What I'd like to do is to share some lessons learned from the frontlines. And what I'm going to do is to kind of walk you through the context of our geriatrics practice and our clinical programs.

I'm going to describe some of the challenges that we have faced and our innovations and response to many of those challenges. We'll kind of look at some continued unmet needs or difficulties that our patients are telling us about. And then, we'll comment on some themes to help better position our practices and our organizations moving forward.

So, the context of our practice, so we have a geriatrics primary care program in downtown Milwaukee where we see primary care patients who are over age 65, along with consultative practice at the same site. It's an academic practice where we teach and learn continuously and we're part of what's called Advocate Aurora Health.

This health system is a not-for-profit health system with 26 hospitals, 500 locations, and 74,000 employees serving over three million individuals in the Chicagoland and Wisconsin area. So, we're, like, a part of a big organization.

At our primary care practice is four geriatricians, a nurse practitioner, two nurses who are wonderful, two medical assistants, a social worker and our front-desk staff and supervisor, all actually now working very well as a team.

In addition, kind of like in support further, there's 10 additional geriatricians seeing patients in our – mostly in our cities in Milwaukee more than in Chicago. We have five wonderful senior resource nurses and 10 team members who work in senior services really who help to prepare our large workforce and disseminate programs towards making our health system age-friendly. So, in short, it's a small primary academic practice, but it is built to have a big impact.

That primary care site now is back up to about 75 percent of our capacity. This is like a programmed build up that follows the organization's lead. Virtual visits continue. They're not at the level that Dr. Ted Long had described, but, in part, our patients really want to come back to see their

providers. The – we've found that it's important to build rapport with each of our patients with each contact and each interaction to support them during this, I would say, stressful time.

In regards to workforce resilience and comments by our HRSA leader, Erin Fowler, I'm pleased to report from the frontline that our nurses and team members are highly engaged really so much so better even than before this COVID-19 pandemic.

Turning to our memory clinics, our memory clinics have resumed. We now, at every point, make sure to connect our patients with the Alzheimer's Association in our community. Instead of at the end of their evaluation, we make sure that there's contact at each time of our interactions and we guide our patients.

Initially, we had trouble with the uptake of the televisits that Dr. Ted Long talked about. We struggled a bit. And that's mostly because our patients would not answer their telephone. They – when they did, they were overwhelmed with the technology. So, I concur with Dr. Long's approach to being able to convert to telephone type of visits.

Our – we set up weekly times to really work at improving those processes and those processes have turned into a regular study group on Alzheimer's disease to review our practices and to improve our skills and our care.

And that's even layered on top of the recent launch of our health system-wide plan to improve care for older adults with Alzheimer's disease which was kind of all along going to happen, but now we're now going full force with that, engaging as well patient's family, caregivers and the Alzheimer's organization into that planning process.

So, in short, from the frontline, in primary care, I would say that you've got a lot of people working really together with community. In regards to community, turning to the next point, I think would be that we've now learned to engage the Department on Aging much better than even before in our efforts to develop during this last three months a Falls Prevention Coalition through the Department on Aging.

So, this was in response to our needs of caring for older adults who had fallen and where we saw a variation in practice among the different cities within our county. So, now, within the Department on Aging, multiple health systems in our community join with AARP, home health agencies, physicians, nurses, to implement best practice for falls prevention throughout our county and all of that has occurred in the context of the COVID-19 pandemic. So, we can work together with community. That's what we've learned.

In the context of coordination of care in our – for our patients in our acute care settings, we've had hospital elder life delirium prevention programs in our hospitals for, like, perhaps the last maybe eight years.

But, on April 1, we converted those programs to a remote nurse-led hospital elder life programs at five of our hospitals. So, the nurses working from remote locations use the health IT tools to identify vulnerable older adults. They review the charts, they connect with the nurses in our hospitals through secure electronic medical record messages, and help to guide the nurses with delirium prevention strategies in the context of COVID-19 for over 250 patients per month. So, the nurses are working hard with – in collaboration with the hospital nurses to support their practice.

And briefly, one of our nurse practitioners had always received a nursing receipt each day of those patients in the hospital who required a bedside companion or sitter. And, of recent, she's developed a strategy to review those cases and send secure chat to engage the bedside nurses and improve the care for those patients that have behavioral problems and symptoms during their hospitalization. So, in short, the innovation is to engage using electronic health record and tools to help to support those who may be at risk for delirium or who may have already developed such problem.

And last few points, one of them is our efforts over the years in regards to improving care in our clinics and in our hospitals have led us to also improve care in our emergency department. So, I was – I took note of Dr. Ted Long's point of keep people out of the emergency department.

So, while folks are – our employees are working in the emergency departments, like they're currently working to improve their care for older adults when they do, in fact, need to come in to our emergency department, so that they're prepared for the needs of older adults and our health system has supported our effort to disseminate this geriatric emergency department over the last three months in the midst of this pandemic to five additional sites while sustaining 10 sites and moving one of those rural sites to a higher level, level two, of certification.

So, all of this has been through innovative virtual platforms for learning and coming together such as Zoom or Teams. And it's been in the midst of the – this time where the emergency physicians and nurses are – have been under stress and duress, but also with – at the same time sometimes with time on their hands.

Also, I'm pleased to report from the frontlines that we've had fabulous work to convert many of our quality measures to automated reports. So, we've got not just that we're working harder; we're working smarter. And these areas have – so, we're – got good news to report in that regard.

And then, a few points where we've come across our greatest challenges in the midst of older adults who are acutely ill or injured, we write about those with writing groups for a new journal called The Journal of Geriatric Emergency Medicine.

There's challenges that remain. Those were described early by Alina where she talked about social isolation and loneliness of older adults in the setting of the visitor restrictions and such. That continues to be a, I'll say, compelling need and issue for our patients and for our community.

We've also heard of just, I'll say, efforts and needs that are really, really unmet in regards to underlying – addressing the worsening of underlying behavioral health needs in the context of COVID-19 where it's difficult to access services to support the patient's behavioral health needs.

And lastly, I would concur with our colleagues, I believe perhaps from Texas, who asked a question about the post-hospital care of those with COVID-19

and we're hearing of the needs of these individuals where they generally feel so weak, perhaps poor appetite, perhaps poor ability to adhere to their medications and at times with no one to assist them.

So, the last point would be the themes. So, our culture has always been, but continues to be to support each other in these times, to identify our patients' needs and to try to innovate in response to those challenges.

We've become more efficient. We've learned how to kind of identify those things that are most challenging and to try to take scholarly approaches to those efforts. We've become more connected to our community as a practice and we've learned to share where our challenges are with each other – with other each and to ask for help. So, Alina, that's the report from kind of our practice in Wisconsin and Chicagoland.

Alina Czekai: Terrific. Thank you so much, Dr. Malone. We always appreciate hearing your insights, and I'm really happy to hear about the partnership taking place at the local level and also the innovative and technology-enabled coordination among your providers. I think that piece is really paramount as the workforce generally continues to address COVID-19, not just the health care workforce.

I'd say the lesson for us too here from the federal workforce, we're all leveraging platforms like Zoom and new innovations to stay connected and collaborate. So, appreciate hearing that perspective. Before we open it up to questions from the audience, I'd like to invite any of my CMS colleagues to share any questions or comments with Dr. Malone before we open it up.

Dr. Barry Marx: Hi. This is Barry Marx. I'm the director of the Office of Clinician Engagement for CMS. And first of all, I'd like to thank both of our presenters really doing remarkable work. A question for Dr. Malone.

It sounds like you are doing extraordinary work with an extraordinary group of people and several points along the way in your presentation you actually spoke about finding yourselves and finding the care in a situation that was even more than before the pandemic. I think you spoke about nurses and team members being more engaged and, in several other instances, actually having results that seemed even better than the state before the pandemic took place.

Obviously, you have extraordinary people or extraordinary commitment to their mission. I'm wondering, from a leadership standpoint, is there a particular approach that really helps that to happen – helps people to really realize their best efforts?

Michael Malone: OK. So, it – a couple of things come to mind. I'll summarize – I'll try to summarize them. Number one, I think that we've learned to be humble. There are so many things in regards to this current situation that are so much bigger than us that we need a group of people who can, like, share their experiences into – so that we can support each other, so the, let's say, more experienced providers with perhaps those who are – who are newer in their career.

Number two, we meet more often to kind of like – and we check in across multiple different settings to try to understand at most every meeting the needs of our patients. And then, what we try to do is, at the next session, we try to develop strategies or kind of responses to improve that care.

And then, number three, we reach outside of ourselves like you would expect in a – kind of like a learning health care system, where we, like, reach out to colleagues in Los Angeles or New York City or in other parts of the country at University of Alabama Birmingham. We reach out and we try to ask for them to talk to us about what they're seeing, and then, we learn from each other. So, those would be parts to the – that I – that come to mind. And we're trying our best to – it's a – I'd say it's a remarkable time.

Dr. Barry Marx: Thank you.

Alina Czekai: Thank you. Operator, do we have any questions from the audience?

Operator: Once again, to ask a question, you may press "star," "1" on your telephone keypad. We have a question from the line of Dr. Rebecca Parker. Your line is open.

Alina Czekai: Hello, Dr. Parker. What is your question?

Dr. Rebecca Parker: My question relates to the upcoming influenza season and preparation by groups and hospitals for – relate to influenza and COVID.

Dr. Michael Malone: It's Mike. I'll ask our colleagues at CMS to – I'd – let's say I'm all ears as well.

Alina Czekai: Thank you. And I'll invite either Dr. Barry Marx or Dr. Lee Fleisher, I will say from my perspective with our communications and our stakeholder engagement efforts, we have already begun thinking about the upcoming flu season and engaging providers and other clinicians to best prepare for vaccinations for the flu. But I'll turn it to my clinician leaders to share any additional insights.

Dr. Lee Fleisher: And I would – this is Lee Fleisher again. I would defer to the CDC. We usually take their guidance on how best to practice particularly so on – I – we meet with them daily right now regarding nursing homes, so we'll have an opportunity to talk with them and get their recommendations and make sure they get that disseminated once published.

Alina Czekai: Thank you for your question. And our next topic for today is telehealth. As you all are well aware, telehealth has really transformed the practice of medicine throughout the public health emergency. And we're discussed telehealth on nearly every CMS Lessons from the Frontlines call since there are many best practices and insights we can share with one another.

Our first telehealth expert today is Dr. Scott Shipman. Dr. Shipman is the director of clinical innovations and also the director of primary care initiatives at the Association of American Medical Colleges also known as the AAMC.

Dr. Shipman, welcome. Over to you.

Dr. Scott Shipman: Thank you so much. It's a pleasure to join today's conversation for a bit of a repeat performance. I will be talking today briefly about work my team and others have conducted to implement a new tool and clinical practice called an E-Consult.

For anyone who may have joined the frontlines call a few months ago where I spoke of this, some of this may sound familiar. But happy to take any questions from the audience when I'm done.

Whether you're a primary care provider or a subspecialist or whether you're looking at the subject of care from a patient's perspective, at one time or another, you've undoubtedly experienced fragmented communication or poor coordination of care between a PCP and a specialist. Fragmented care creates inefficiencies at best and negatively impacts patients and their care at worst. Access to specialty care is often challenging even in the best of times, let alone during a pandemic.

In much of the country, patient wait times for specialty visits are often measured in weeks, if not, months. Beyond the long wait time, many patients live a significant distance from the nearest specialist, a further impediment to accessing immediate care.

Sometimes doctors will resort to curbside consult as a workaround to get clinical advice. This is typically done by catching a colleague at a hallway or a stairwell or calling them up, sending an e-mail etcetera.

As a mechanism for consultation, curbsides often lack important clinical information. Timing of the curbside is often inconvenient for one or both providers. They're not typically documented in the medical record and there's no reimbursement for the time or clinical advice that's provided.

So, a new clinical tool, for the focus of this presentation called the E-Consult, has emerged in the past few years that can overcome each of those limitations. An E-Consult, just for definitional purposes, is an asynchronous or a store-and-forward exchange between two clinicians most typically from a PCP to a specialist.

There are a variety of different approaches to using E-Consult, but the one I find most useful is when a tool is built into the EMR where a clinician can order an E-Consult in a way similar to how they place a referral.

Unlike a referral, an E-Consult avoids the need for the patient to be seen by or established a relationship with specialists. Instead, an E-Consult creates a reliable standardized and documented exchange between providers that allows the patient to be managed by their trusted personal physician with timely access to specialist advice and guidance when needed.

At the AAMC or the Association of American Medical College where I work, we work with health care systems across the country to establish an E-Consult program that we call Project CORE, which stands for Coordinating Optimal Referral Experiences.

Today, that's been implemented across more than 30 large health systems and 20 states. Much like Dr. Malone's comments in the previous session, we've used this network of health systems to create a learning community across all these sites where sites can learn from one another about best practices and as new innovations in each of E-Consult emerge, those can scale more rapidly across the country by virtue of this learning community, which we think is really helpful.

In project CORE, we find about 80 percent of the PCPs across our health systems use E-Consult on a regular basis. Most specialties, excuse me, participate in the model. And in the CORE model, both the PCP and the specialist are credited or reimbursed for the work they do when they complete an E-Consult. I'm happy to talk more about that if people have questions.

We like to say the E-Consults create what is the win-win, win-win for patients, providers, health system and payers. And I'll focus briefly on two of these – the patient perspective and the provider perspective.

So, on average, we've calculated that a patient will save more than $100 in out-of-pocket and opportunity costs for every specialty visit that can be averted by an E-Consult. No need for them to take time off work or travel somewhere new for care.

Yet they still get the input from a specialist who's personally reviewing their case at providing personalized advice to their PCP. And rather than waiting a

month for a visit to see the specialist, E-Consults are typically answered in roughly a day, in most cases.

PCPs and specialists benefit from this tool from a reliable structure for effective communication with standard expectations for each provider. PCPs get timely access to specialty guidance when they need it, allowing them to provide more comprehensive care for their patients, one of the tenets of primary care as most know. And specialists, conversely, are able to serve more patients more efficiently and they get reimbursed for it unlike the curbside consults which many are familiar with.

CMS, in 2019, created two new CPT codes for what are called interprofessional electronic consultations. What I'm referencing as E-Consults here. Those codes are 99451 and 99452, for those who are interested, that enabled both the PCP and the specialist to be reimbursed by Medicare for an E-Consult. Commercial payers are now starting to follow suit.

We found that during the COVID crisis E-Consults have been playing an especially important role by reducing unnecessary exposure for patients and providers. In addition to avoiding the unnecessary specialty visits in the ambulatory setting as I've been talking about, a number of health systems have adapted their E-Consult programs in the E-Consult tool to meet the needs for a subset of their inpatient consultations as well. When a physical exam, for instance, isn't needed by the specialist and they can consult on the case remotely, the E-Consult tool and the reimbursement mechanism therein has been useful.

I do want to call out that AAMC's appreciation for CMS' flexibility that's been added by waiving some of the regulatory restrictions during the COVID crisis. These restrictions can otherwise restrict some of the utility of E-Consults as well as other telehealth services, of course.

And they've been very helpful to have that liberty during the COVID pandemic and we look forward to continuing to work closely with CMS on

these matters going forward as we get beyond the crisis and look for moving some of the temporary waivers to more permanent status. Thanks very much.

Alina Czekai: Terrific. Thank you so much, Dr. Shipman, for joining us again. Our next speaker today is Dr. Karen Rubin. Dr. Rubin is the medical director of the Office of Telemedicine at the University of Virginia. Dr. Rubin, welcome, and over to you.

Karen Rubin: Thank you. Just checking, can you hear me?

Alina Czekai: Yes, we can. Thank you.

Karen Rubin: Perfect. OK. Well, good afternoon and thank you for the opportunity to join you again today to share a number of models of telehealth responses to the COVID-19 public health emergency.

As background, the University of Virginia is home to a longstanding telemedicine program through which we support synchronous video based clinical consultations and follow-up visits, tele-ICU care, remote patient monitoring, asynchronous store and forward services, E-Consults in partnership with the AAMC, and virtual education to patients and providers.

Our 161-site partner network in Virginia includes community and critical access hospitals, skilled nursing and long-term care facilities, federally-qualified health centers, free clinics, medical practices, correctional facilities, schools and EMS providers.

We offer telemedicine services spanning more than 60 different – 6-0 – different clinical specialties. In addition, as a state-designated special pathogens hospital, following the Ebola outbreak in 2015, we developed a model we refer to as iSOCOMS or Isolation and Communications Management System in which we configured all rooms within our then only five bed special pathogen unit with video conferencing to reduce provider exposure, improve the patient experience, and conserve PPE.

Last year, heartened by the relevant provisions of the 2019 Medicare physician fee schedule and by clear messages from our patients seeking new

models of care, we underwent a multi-stakeholder strategic planning process designed to further expand our virtual care offerings. And the COVID-19 public health emergency catapulted us into action to scale all elements of that strategic plan.

We are grateful for and with the waiver authority granted by the secretary of Health and Human Services that resulted in COVID-19 Medicare interim final rule and other waivers, we and others have rapidly scaled telehealth services.

The elimination of geographic and other originating site restrictions, in particular, enabling the home as an eligible originating site, the expansion of eligible providers and CPT codes, and waivers of enforcement discretion of HIPAA and stark regulations have been transformational. This is nationwide. This is not just UVA.

Importantly, and as we heard from Drs. Long and Malone, the activation of telephone codes has allowed us to ensure continuity of care for vulnerable patients, especially those without broadband connectivity, smartphones, or computers.

And even for patients who have them, it doesn't always work each time. Our state Medicaid program, thankfully, has taken similar action. So, UVA, our ambulatory clinics rapidly transform to replace in-person visits with virtual visits provided to the home or any other location or our patients, particularly important when 90 percent of our outpatient visits and all elective surgeries were canceled.

Within our hospital and emergency department, we configured more than 100 isolation rooms with our iSOCOMS 's carts far beyond the five beds special pathogens unit. And this enables our clinicians to provide video-based consultations to conserve PPE, reduce provider exposure, and communicate virtually face-to-face with our patients – COVID-19 patients, in particular.

The model also enables those patients to visit with their own loved ones. We heard – we hear constantly about the tragic isolation of patients who don't get to see family members. Likewise, when we accelerated by several months the opening of a brand-new bed tower to accommodate COVID-19 patients, we

configured all of our critical care and isolation rooms with the iSOCOMS's technologies.

We also launched a new on-demand direct-to-consumer urgent care service connecting patients to our emergency physicians, in particular, with great gratitude to a number of health systems across the country that have done so and have provided support to us as we've stood that up and all of us are willing to help others doing the same and we heard about that from Dr. Long.

We also expanded remote patient monitoring programs not only for vulnerably high-risk patients with chronic illness who we don't want to see exposed to COVID-19, but also for COVID-19 positive patients.

Those latter patients as appropriate are monitored by advanced practice nurses – providers – every four hours using video conferencing and biometric devices. Through this program, as needed care has been escaladed and patients are also monitored post-hospital discharge. We haven't yet needed to do hotels, but certainly, monitored in a number of different settings.

In some cases, we're also monitoring patients with multi-functional remote examination tools, stethoscopes, otoscopes and other tools. We've greatly expanded our external-facing relationships with long-term care facilities, the focus of a number of questions and comments today, where a significant number of outbreaks in Virginia and across the nation have occurred.

As an example, in early April, following a request from one of our long-term facilities in our region, at which 90 percent of the patients and staff members tested positive, we delivered a telemedicine cart and executed an agreement that same day enabling our clinicians to make daily rounds, offer consultative support, and escalate care as needed.

We've since expanded that model to an additional 11 skilled nursing and long-term care facilities in our region where outbreaks continue to be a serious problem. We've ramped up our ambulatory E-Consult program, as Scott mentioned, to also provide inpatient E-Consults that increase efficiency and further improve access to specialty. We've implemented a COVID-19 Project

Echo state-wide educational program in addition to another Project Echo focused on COVID-19 care in congregate care settings.

These transformations have required an all-hands-on-deck approach referenced to leadership we heard, I guess, from Dr. Malone, supported at the top by UVA senior leadership and across our clinical enterprise working in partnership with telemedicine, health IT, billing and compliance, patient registration staff, contracting, our analytics group, and of course our clinicians and our patients.

We're also very grateful for a recent award by the FCC COVID-19 telehealth program that has helped support our telehealth outreach, and all of these efforts have resulted in a greater than 9,000 percent increase in the utilization of telehealth at UVA.

At the HRSA-designated telehealth resource center, we, like the other TRCs have seen our request for technical assistance to training increase more than a thousand-fold. Our web site is matrc.org. All of the TRCs are incredibly active right now and continue to offer support. And I guess in the hack – the telemedicine hack will be involved in that as well.

So, whether because of convenience, concern for contracting COVID-19, reduced clinic appointment availability, or a combination of all of the above, national patient satisfaction data are clear that consumers wish to continue to engage with their providers where they are and not always in bricks and mortar health care facilities.

So, in summary, to build on these important actions taken during the continuing COVID-19 public health emergency, and to prepare us for any future public health emergency, and ensure that our patients and providers do not lose access to telehealth-supported care, we implore our colleagues at CMS and in Congress to ensure that these digital health reforms and investments scaled in response to this public health emergency endure.

So, we are very grateful for all of these collaborations and particularly to CMS and to the secretary and we're happy to answer any questions. Thank you.

Alina Czekai: Terrific. Thank you so much, Dr. Rubin. Your presentation and Dr. Shipman's presentation complement one another really nicely. So, glad to have you both on today.

Before we open it up to questions from the audience, I'd like to invite any of my CMS colleagues to share any questions or comments with Dr. Shipman and Dr. Rubin.

Dr. Barry Marx: Hi. This is Barry Marx. So, again, I'd like to thank both of our presenters in this session on telehealth both for the work that they're doing and for their willingness to give us their time and share with us today.

I have a question for Dr. Shipman. Around the Project CORE and, more broadly, the use of virtual care, through the AAMC, are there any specific efforts or initiatives to bring training in use of virtual care across the whole range of platforms into medical education, at the medical student level and at the residency and fellowship level?

Dr. Scott Shipman: Dr. Marx, I appreciation the question. It's a great set up. I promise to everyone on the line that this wasn't planned ahead of time. So, in fact, yes, separate from the work that we do at Project CORE, although – since Project CORE is implemented at academic health systems, trainees are very much involved in the use of E-Consults and learning that as they're going through residency, for instance.

Separate from that, we have assembled a telehealth advisory committee that's been working for over a year now, well before the COVID pandemic, on establishing a set of competencies in telehealth that can serve as a – we hope a consensus tool across the full continuum from medical school to residency to practice.

Dr. Rubin is on our advisory committee and can also speak to this. We anticipate – we've moved up the pace of publishing these in light of the pandemic as much as is possible without sacrificing the process. We anticipate that by the end of August those will be published and we will be working hard to disseminate those.

In addition, we've begun curating from across the country exemplary telehealth training curricula and programs that already exist to help those that see and recognize the need that you're calling out which is that if we want to have a workforce that's ready to provide care via these modalities, we have to introduce it as early as possible in training.

Dr. Barry Marx: Thank you very much.

Alina Czekai: Thank you. Operator, do we have any questions from folks on the phone?

Operator: Again, to ask a question, please press "star," "1" on your telephone keypad. Your first question comes from the line of Barbara Kabuchi. Your line is open.

Barbara Kabuchi: Hi. Thank you very much for this information. I got to say telehealth is really welcomed by many practices small and large. The University of Virginia is a really large organization and I've worked with small organizations as well.

But I want CMS to know that I do a lot of training and education for practices and there is an awful lot of confusion because practices like just the first press release that came out on March 31 goes, "ENMs can be done by telephone."

And, like, didn't then read the IFC and see that it's not ENMs; it's 994412443 and there – you know, people who were billing it out as place of service 02 instead of 11 and losing money. And it's – it has taken – it takes a lot of attention and work to stay on top of all of the changing rules.

And I understand why it's happening because CMS is trying to roll this out as quickly as possible to us. And as they roll it out quickly, some things are, yes, that's really good and some things are, "We should have made it that way and we need to change it." And I – and that's why it's happening.

The FAQ that came out on, I think, June 19 was really wonderful in clarifying things. But please keep in mind that practices may be making mistakes because the just misunderstood it or they ran with the early guidance, and then, didn't look back when the audits are being done.

Alina Czekai: Thank you, Barbara, really appreciate you sharing that perspective and your feedback and glad to hear your appreciation for how quickly we are rolling things out and know that sometimes things can be a little clumsy.

And hope that you do recognize that we're trying to make ourselves as available as possible to providers both in this forum, our weekly office hours where providers and others can dial in and ask questions about billing and things like that.

But we do continue to update our FAQs, particularly as it relates to telehealth and other modes of practice for providers. So, as always, we continue to welcome your feedback and feel free to send us an e-mail to our COVID mailbox. But again, appreciate you sharing that today.

Barbara Kabuchi: Yes. And a lot of the changes I really appreciate it because it came from feedback that people who work in the field have given to – given to CMS during the Office Hours calls and, you know, that CMS is listening to the people who are – who are living it. And I really do appreciate that all of that has happened.

Alina Czekai: Terrific. Thank you so much, Barbara. And we'll take our next question, please.

Operator: Next question is from the line of Grant Edelstein. Your line is open.

Grant Edelstein: Yes. I don't know if you're still taking questions back on the testing and skilled nursing. May I ask one about that?

Alina Czekai: Sure. We might not have the right folks still on the phone, but please ask your question.

Grant Edelstein: Well, my question was – and thank you for these calls. We've been directed here in California by the Department of Public Health that the test we do have to be viral tests, that they're not going to accept antibody test. So, I'm wondering what will be the direction if we get these kits because we've been told basically we can't do those tests when we've been doing the viral test.

And my other maybe suggestion back on the flu is, you know, maybe having flu test kits when it comes flu season would be helpful for skilled nursing to avoid readmissions and having to transfer out residents just to see whether they have the flu. And if we could diagnose something like that in-house, that might avoid some transfers or get them faster treatment. Just a thought thinking about flu season coming up. Thank you.

Alina Czekai: Terrific. Thank you, Grant, for your suggestion regarding flu kits. Do we have any of our nursing home colleagues on the line to address the testing question that Mr. Edelstein has?

Christine Teig: Hi. This is Christine Teig from the Division of Nursing Homes. So, I'm trying to seek a little clarity to understand your question there. You said some states are not accepting the rapid test. And what do you mean they're not accepting?

Grant Edelstein: Well, in other words, so, we've had all facilities letters from the California Department of Public Health about testing that says we have to do a viral test. It specifically distinguishes viral and antibody and says the testing and the mitigation plan we submit have to talk about how we're going to do viral testing and that's what we've been doing. There's – and there's been no mention of even considering antigen, you know, antibody tests. So, we would – we would kind of have to be told, yes, start also doing these tests.

Christine Teig: OK. So, I will take that back to our team and see what we need to do to get some additional guidance out regarding those. Thank you very much. Appreciate that input.

Grant Edelstein: OK. Sure. And if I could just give you one compliment. I've been an administrator about 30 years or so and I've really never seen a government work the way you're working in the spirit of collaboration and really trying to work together for the benefit of our residents. So, I've been very appreciative and it's definitely a sea change for the good.

Christine Teig: Great. Thank you very much. We appreciate that. We are trying our best to do what's right for our residents.

Alina Czekai: Thank you so much. Operator, do we have any final questions today?

Operator: Yes, we do from the line of Dr. Rebecca Parker. Your line is open.

Dr. Rebecca Parker: Great. Thanks so much. And I echo the high value of this conversation. Thank you so much. I'm an emergency physician in Arizona and a past president of ASAP. My question revolves a little bit more going on to influenza again.

You know, in the hospitals, we don't have or we've been trying to increase our reverse isolation beds to be able to accommodate high (inaudible) with COVID patients and sort of the infrastructure of the hospitals going forward.

And looking forward to influenza and COVID together in the next few months, I believe that there will be a challenge with number of ventilators needed and, frankly, being able to use high-flow and non-invasive options for patients that get admitted. But that takes infrastructure changes the hospitals where that negative flow rooms needed to be dramatically increased.

So, any comments or thoughts on that and then also how CMS or congress could help hospitals get that infrastructure they need coming into this season?

Alina Czekai: Thank you, Dr. Parker. Really appreciate your question. Do we have any of our CMS clinicians still on the line to respond to Dr. Parker? If not, Dr. Parker, I'm glad to take this one down and share it with our leadership here at the agency.

Barry Marx: Yes. This is Barry Marx. I think this deserves a more robust answer than I can provide on this call. I really think this – we should take this back.

Alina Czekai: Absolutely. Dr. Parker, we'll take this one back and either we can address this topic on one of our next Lessons from the Frontlines calls. I think we had two or three questions regarding influenza season, so that might be a great idea for another topic of discussion and updates from CDC and CMS. So, we will take this one back.

And again, we really appreciate everyone's time today joining our conversation, asking questions. And again, it was terrific to hear from these terrific best practices speakers again. I hope everyone has a restful weekend and thank you again for all that you're doing for patients and their families around the country as we continue to address COVID-19 as a nation.

This concludes today's call. Thanks again.

End