# Covid-19 Home Care & Hospice Town Hall Series

Visiting Nurse Service Of New York
COVID-19 Response

April 15, 2020 | 1 PM EDT

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<td>Dan Lowenstein, VP Government Affairs</td>
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<td>Dr. Jay Dobkin, Chief Medical Officer, VNSNY CHOICE</td>
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**VNSNY at a Glance**

We are the one of the nation’s largest not-for-profit home and community-based health care organizations, serving New Yorkers for 127 years.

**Our Mission**
To improve the health and well-being of people through high-quality, cost effective healthcare in the home and community.

**Our Vision**
To be the leading payer and provider of integrated, cost effective home and community-based healthcare.

**Powerful Dualities of Capabilities**

**As a Provider**
We bring 127 years of clinical expertise and experience.

**As a Health Plan**
With deep understanding of managing and financing care for complex conditions.

**VNSNY by the Numbers**

| **13,000** | Employees, including: 1,500 nurses, 400 rehab therapists, 400 social workers, and 8,500 home health aids |
| **44,000** | Patient lives touched every day |
| **50** | Languages spoken by our staff members |
| **$2+ BN** | Annual revenues |
| **$39M** | Provided in 2019 in charitable care and community benefit programs to under and un-insured individuals |

**Where We Operate**

VNSNY serves New York City, as well as the surrounding suburban counties in the NYC metro area.

VNSNY also services some upstate counties through its Medicaid Managed Long Term Care (*nursing home without walls*) program.
VNSNY Services Most Heavily Impacted by COVID-19

<table>
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<tr>
<th>Service Line</th>
<th>Core Services</th>
<th>Typical Active Daily Patient Census</th>
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<tr>
<td>CHHA and Care Management Organization</td>
<td>Traditional Home Care, including telehealth and virtual care management.</td>
<td>~9,000 patients</td>
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<td>Hospice</td>
<td>End-of-life and palliative care</td>
<td>~1,400 patients</td>
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<tr>
<td>Personal Care (Home Health Aide) Services</td>
<td>In-home support with activities of daily living for patients and members across VNSNY</td>
<td>~9,000 personal care workers</td>
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<td>Medicaid Managed Long Term Care Program</td>
<td>A ‘nursing home without walls’ program serving individuals with ongoing in-home long-term care support needs, including personal care (home health aide) services</td>
<td>23,000 members</td>
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<td>Cared for by ~35,000 personal care workers (9,000 employed by VNSNY)</td>
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<td>Community Mental Health</td>
<td>Behavioral health support and linkages for vulnerable individuals</td>
<td>Annually, 14,000 clients served</td>
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VNSNY COVID-19 Response: Overview
New York City has been hit hard by COVID-19

The pace of spread has been breathtaking
- Only 45 days ago, NY State had its first positive case, and today, the count is well over 100,000

The death toll has been high
- Over 7,000 fatalities in New York City and over 10,000 statewide

NYC's healthcare systems are overwhelmed but rising to the challenge
- Hospitals have mobilized to expand bed capacity by 50%, with the local convention center, auditoriums, and parks being converted into temporary field hospitals
- All elective care suspended, or being conducted virtually

Fortunately, social distancing measures seem to be having an impact
- All non-essential businesses and all schools have been closed for three weeks
- Promising indicators that we are ‘flattening the curve’
- Number of new hospitalizations, new ICU admissions, and new intubations are all declining

From a disaster planning perspective, the crisis escalated much faster than we ever could have imagined

VNSNY’s COVID-19 Response Planning Framework

- Guiding principles for VNSNY’s COVID-19 emergency response:
  1. Protect our patients and staff
  2. Address NYC’s pressing public health need by supporting decompression of local inpatient facilities
  3. Mitigate impact to the organization where possible
- These principles have guided our response in 7 key areas:
  A. Shift of office-based staff to remote-work
  B. Employee communication
  C. HR Policies and Employee Support
  D. Supplies and PPE Procurement and Management
  E. Volume Impact and Financial Tracking
  F. Clinical Response and Service Delivery (CHHA, Hospice, Personal Care Services)
     A. Transition to Virtual Care
     B. Home Care Criteria
     C. Hospice-specific Considerations
     D. PPE Protocols
  G. Regulatory Considerations and Advocacy Priorities
The VNSNY COVID-19 Response Timeline: 3 Phases

# NYT Confirmed Cases

<table>
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<tr>
<th>Phase I: Surveillance and Prep</th>
<th>Phase II: Mobilization</th>
<th>Phase III: Emergency Response</th>
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<td>Priorities:</td>
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<td>• Staff/patient screening, beginning with travel monitoring</td>
<td>• Protect Patients/Staff</td>
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<td>• Emergency planning</td>
<td>• Secure PPE</td>
<td>• Decompress overwhelmed hospital systems</td>
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<td></td>
<td>• Move to Tele-Work</td>
<td>• Care for COVID19-positive patients</td>
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VNSNY’s COVID-19 Response Governance Structure

VNSNY Executive Team
(7 leaders- daily 8:30am COVID-19 virtual-huddles)

Emergency Response Planning Team
(45 leaders- daily 9am calls)

Clinical/Infection Control Leadership Team (daily 10am calls)

Clinical Emergency Response Hotline Team (CERT): available 7 days/week

Supplies & PPE Procurement and Management
2x/week calls

Workforce and Human Resources
Daily calls

Regulatory Affairs and Compliance
Daily calls/updates

Financial Tracking and Metrics
Several new dashboards developed

Communications (Internal & External)
Key Features of VNSNY COVID-19 Response Thus-far

- Large groups of office-based staff had never routinely tele-worked in the past
- Had to quickly secure and deploy 300+ laptops and equipment to staff with desktop machines
- Set-up ‘soft-phones’ for call-handing staff
- Enabled remote VPN access for all staff
- Disseminated training on existing meeting collaboration software (Webex, Microsoft Teams, Skype)
- Planned a remote working ‘test-day’ with select departments to stress-test infrastructure

Lesson learned:
- Had to transition to tele-work much faster than anticipated; remote working went from an organizational-wide test on Friday March 13th to 95% implemented on Monday March 16th
- Helpful to already have the IT infrastructure housed in the cloud
- Quality of personal home internet wifi connections is a key dependency
- User guides were created and proved useful in addressing many initial challenges using video-collaboration software (user, technical stability, bandwidth)
- IT service desk increased operating hours to 10 hours daily, six days a week

Shift of Office-based Staff to Remote-work

Operationalized the technical infrastructure to enable ~3,000 office-based (non-field-based) staff to work remotely:

- Large groups of office-based staff had never routinely tele-worked in the past
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Communications

- Initially, centralization of messaging critical to ensuring accuracy
- Move to more department-specific comms over time
- Use multiple channels to expand reach

(a) Conveying of information
- Used “branded” template for all email; placed content on COVID-19 Intranet Hub; texts, videos, conf calls, audio messages
  - Primary information categories:
    - FAQs, Clinical Advisories, Business Advisories, Clinical Protocols
  - Weekly email updates to Board of Directors

(b) Engaging staff through other channels
- Daily inspirational audio messages sent by the CEO to all staff
- Weekly all-staff conference calls with the CEO + video message
- Weekly all-staff conference calls by business unit
- Heroic field staff stories; staff pictures/videos working remotely

Lesson learned:
- Create a mechanism for two-way communication so staff are heard
- Need to communicate clinical information and that is complex and evolving, while also communicating supportive, empathetic information. Staff may well be anxious and need some level of reassurance.

HR Policies and Employee Support
- At the outset, developed and clarified PTO policies in cases where employee is sick, exposed, or quarantined
- Prepared-for and have experienced significant staffing shortages - averaging 30%+ in many clinical service lines – these numbers balloon quickly
- Implemented daily employee screenings in Workday (HR system)
- Created a Clinical Emergency Response Team (CERT) Hotline to address real-time questions and concerns of clinicians in the field, providing guidance developed by central clinical team
- Identified local COVID-19 testing sites, advocating for prioritization of VNSNY health care workers
- Identified and communicated Employee Assistance resources to assist employees with to manage any physical, mental and emotional well-being mental issues that may arise during this pandemic
Supplies and PPE Procurement and Management

• At the outset of the crisis, in early/mid-March:
  – VNSNY had critically low supply of surgical masks and hand sanitizer
  – We had virtually no supply of isolation gowns, face shields, N95 respirators, and other PPE required to care for COVID19-positive patients

• Steps taken to address PPE needs:
  – Vocal governmental lobbying to raise awareness re: critical role of home care in decompressing inpatient beds
  – Identified sources for supplies and centralized lead-vetting process:
    • New vendors including overseas suppliers, in addition to current vendors
    • Governmental lobbying
  – Developed a supplies and PPE usage projection model
  – Prepared and distributed COVID-19 PPE kits for clinical staff to pick up in local offices
  – Distribution channels: procuring PPE is one thing, but getting into the hands of staff is another
    • We have become a supply chain organization (including security to protect inventory)
    • e.g., Mailed 100,000 surgical masks directly to the homes of 6,000+ personal care workers (home health aides)

Financial Tracking and Volume Impact

• VNSNY has experienced significant volume erosion as local hospitals have suspended elective procedures and in-person home care contacts have been reduced
• We are tracking the various expenses and investments being made to ensure continued operations and support to the community through the crisis
• VNSNY is reviewing all potential opportunities for funding and relief to support these incremental investments.

VNSNY Framework for COVID-19 related financial tracking

- Technology Investments
- Revenue and Margin Erosion
- Operations
  - Labor: Re-deployment
  - Non-Labor: Supply Expenses
VNSNY COVID-19 Response:
Clinical Service Delivery

Clinical Response and Service Delivery:

Disclaimer on Clinical Guidance Presented Here

This presentation contains guidance as of April 14, 2020, and is subject to change.

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Clinical Response and Service Delivery:

Virtual Care

We transitioned CHHA and Hospice to virtual care where possible
- Developed new patient triage methodology to identify which visits could be replaced with virtual encounters, in order to minimize in-person exposures
- Updated admission criteria to effectively triage patients during intake
- Created virtual visit guidelines and workflows for clinicians to collaborate with ordering physicians, document updates to plans of care as appropriate
- Allowed for temporary use of various available virtual visit technologies, consistent with CMS guidance (including FaceTime, WhatsApp, etc.)
- Tightened Interdisciplinary process to ensure no duplication of service across disciplines

Clinical Response and Service Delivery:

Home Care Admission Criteria

Given acute staffing shortages, we adapted our service delivery criteria to ensure we prioritized:

1) Protection of patients and clinical staff from COVID-19 exposure
2) VNSNY’s role in supporting local hospitals to decompress inpatient beds, including admission of COVID-19 positive patients
3) Preservation of scarce PPE

These criteria prioritized admissions considered essential, i.e. admissions that:

A. Are absolutely required to prevent significant medical decline, or prevent a hospital admission
B. Enable patients (especially COVID19-positive) to be discharged from a hospital to free-up beds, or prevent an admission to the hospital

Note on timing of COVID19-positive admissions: given acute lack of sufficient PPE until mid-March, VNSNY began admitting COVID19-positive patients into our CHHA and Hospice only after receiving an initial emergency supply from the NYC Office of Emergency Management
Clinical Response and Service Delivery:  
*Additional Home Care Admission Criteria*

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<tr>
<th>Critical Care Equipment Requirements</th>
<th>Caregiver in place</th>
<th>Medication Access</th>
<th>Physician Outreach</th>
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<tr>
<td>• All equipment and supplies should be in the home on day of discharge</td>
<td>• Patients must have a caregiver, unless they are independent and can care for themselves, able to get medications, etc.</td>
<td>• Ensure that patients have a means of receiving their medications (either by picking it up themselves, having a caregiver deliver to them, or whether a pharmacy will deliver to them)</td>
<td>• Patients must have a physician who is available to coordinate care during this time.</td>
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<td>• Verify whether pulse oximeter is being sent home with patient</td>
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<td>• If a patient's physician is not available during this time, there must be an alternate physician, PA (Physician Assistant), or NP (Nurse Practitioner) available to provide and sign orders to the field clinicians.</td>
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<tr>
<td>• Verify whether there are any aerosol treatments involved (and if available, whether patient is independent or not with aerosol treatments)</td>
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Clinical Response and Service Delivery:  
*Hospice-specific Considerations and Challenges*

VNSNY Hospice Care Core Values of Empathy, Agility and Integrity guided our response to COVID–19 pandemic

Hospice-specific Challenges
- VNSNY’s Hospice program experienced the organization’s *first admissions* of confirmed COVID19-positive patients (initially GIP)
- *High-risk end-of-life procedures* for COVID19-positive patients, requiring highest-levels of PPE for staff (including N95 respirators)
- *IDG Team Members* played a critical role to provide service delivery to our patients
- *Hospice Physicians* played a key role in ePrescribing medications to our patients and also in certifying deaths
- Online *Social Work* support provided to the entire VNSNY enterprise
- *Critical staffing* shortages at the Epicenter required utilizing triage skills of our *After Hours* staff to assist
- *Body removal. Due to the* high numbers of deaths in NYC, local funeral homes have begun to refuse or delay body removal, requiring VNSNY to partner with City Medical Examiner’s office for alternative solutions to remove bodies from homes
- *Bereavement Services* – grief and the impact of COVID-19
We created four patient protocols to guide clinicians on PPE usage:

### PPE Protocols: Protocols A and B

**Protocol A Patient**
(positive, lower-risk, less PPE)

- At least 7 days since onset of symptoms AND
- At least 48-72 hours since fever is resolved without the use of fever-reducing medications and improvement AND
- Overall improvement in illness (e.g. improving cough, shortness of breath)

**Protocol A**
Clinicians must follow Contact and Droplet Precautions:
- Surgical mask
- Gown
- Gloves
- Shoe Cover When Available
- Head Cover When Available

**Protocol B Patient**
(positive, higher-risk, more PPE)

- Evaluated/diagnosed/treated as COVID-19 in the Emergency Room or Clinic, Hospital and released home (Treat and Release)
- Patients report symptoms on Pre-visit Screening (positive Pre-visit screen)
- Diagnosed with COVID-19 while on service

**Protocol B**
Initial home care and hospice visits, clinicians use Contact, Droplet, and N95:
- N95 Respirator
- Cover N95 Respirator with Surgical mask OR Face shield to prevent droplet contamination of the N95 (discard surgical mask after the visit, face shield may be discarded if unable to clean between patients)
- Gown
- Gloves
- Eye protection (face shield or goggles)
- Shoe Cover When Available
- Head Cover When Available

### PPE Protocols: Protocols C and D

**Protocol C Patient**
(negative, but household member positive)

- Patients who may be NEGATIVE but have household member/family/home care companion living in the same home with lab-confirmed COVID-19 OR COVID-19 symptoms (fever, cough/shortness of breath).
- Clinicians should ask symptomatic household member to stay in a separate room or maintain distance of >6 feet during the visit duration

**Protocol C**
Initial home care and hospice visits, clinicians should follow Droplet and Contact Precautions
- Surgical mask
- Gown
- Gloves
- Shoe Cover When Available
- Head Cover When Available

For subsequent visits, screen the patient for COVID-19 symptoms. If the screening is positive, follow protocol B.

**Protocol D Patient**
(negative, lower-risk, less PPE)

- COVID19-negative patient

**Protocol D**
Initial home care and hospice visits, clinicians should follow wear:
- Surgical mask
- Gloves
- Gown When Available

For subsequent visits, screen the patient for COVID-19 symptoms. If the screening is positive, follow protocol B.
PPE Protocols: COVID-19 Kit Contents

**COVID-19 Positive Start of Care Kit: for CHHA Starts of Care Only**
- N95 Respirator (for Protocol B only)
- Surgical face masks
- Gowns
- Face shields
- Head cover
- Paper bag for mask re-use
- Shoe covers
- Plastic bags for disposal of PPE
- Alcohol Wipes
- Thermometer
- Blood Pressure Cuff
- Stethoscope

**COVID-19-Positive Standard Kit (CHHA Follow-up Visits, Hospice, Personal Care Workers)**
- N95 Respirator (for Protocol B only)
- Surgical face masks
- Gowns
- Face shields
- Head cover
- Paper bag for mask re-use
- Shoe covers
- Plastic bags for disposal of PPE
- Alcohol Wipes

*Note: For all staff, including personal care workers (home health aides), we have limited the length of visits requiring COVID-19 PPE to a maximum of 2 hours.*

Regulatory Considerations and Advocacy Priorities
Regulatory Considerations

Leadership, Compliance, Legal and Government Affairs teams took considerable care to align emergency processes with state and federal regulations by:

1. Digesting new rules and working with Operational teams to quickly update workflows and P&Ps based on guidance and best practice advice

2. Tracking key issues and logging all decisions: highlight clinical and quality rationale, especially infection control and patient safety concerns

3. Focus on standardized documentation and training, which allows us to more effectively monitor/audit:
   - Patient and employee screenings for COVID-19
   - Updates to plans of care, including missed visits and patients refusals
   - Obtaining patient and MD approval for incorporating telehealth interventions
   - Flexibility with telehealth platforms, given relaxation of HIPAA enforcement
   - Payor configurations for telehealth services (mostly not billable)
   - Coordinating with referral partners, who are inundated during the crisis:
     - Documenting virtual face-to-face encounters
     - Continued attempts to obtain signed documentation
     - MD/NP orders and clinical protocols for COVID-19 positive patients

VNSNY COVID-19 Advocacy Priorities

VNSNY is collaborating with our associations and hospital partners to advocate for regulatory relief in several key areas:

1. CMS and Congress:
   - Telehealth reimbursement
   - Documented verbal orders/certifications
   - Enhanced Medicare revenue and access to funding pools

2. NY State:
   - PPE
   - Flexibility in staffing in-home care (especially long-term care)

3. NY City:
   - PPE
   - Parking permits
Q & A