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IN THIS ISSUE

EDUCATIONAL EVENTS

August 27, 2020
The Impact of COVID-19 on Workers' Compensation
Webinar

September 15, 2020
Pandemic Considerations for Health Facility Design
Webinar

September 24, 2020
Opioid Epidemic Case Study – Meeting the Increasing Challenges of the Opioid Epidemic in America
Webinar

Rural Physician Leaders Roundtable Grapples with Common COVID-19 Challenges

Issues include lab testing, clinical care, masking and preparing for influenza and school re-openings

WHA's Rural Physician Leaders Roundtable held its third set of meetings in 2020 on August 6. The roundtable is a forum for physician leaders in rural communities to connect, discuss common challenges and to share best practices. The Rural Wisconsin Health Cooperative is a key partner of WHA for the roundtable. The latest roundtable meetings focused on the following key issues:

Lab testing
Many rural hospitals lack a consistent supply of testing materials, particularly reagents. Testing turn-around times can be up to 8-10 days for commercial labs. Those hospitals that have access to in-house testing are prioritizing those tests for patients needing care. Almost all hospitals do not have enough kits to test asymptomatic patients who are not a direct contact of a person infected with COVID-19. Many physician leaders are concerned about the additional stress that re-opening schools will place on lab testing ability as the viral respiratory season advances this fall.

Clinical care in rural communities
Roundtable members were generally satisfied with their ability to provide a variety of therapeutic modalities to their patients hospitalized with COVID-19, especially Remdesivir, dexamethasone and even convalescent antibody serum. Several physician leaders noted the pandemic has facilitated greater coordination and communication within their hospitals, their health systems and even across health systems in their

(continued on page 5)

WHA Continues Pushing for Hospital Relief as Congress Leaves for August Recess

WHA is continuing to advocate for health care priorities to be included in the next COVID relief package as federal lawmakers have returned back to their home districts.

While the U.S. House of Representatives passed a $3 trillion spending package known as the Heroes Act in May, the U.S. Senate waited until the end of July to introduce a much smaller $1 trillion package. Despite both houses mentioning a desire to reach an agreement that bridges the wide gap in these packages prior to the scheduled August recess, no agreement was reached and lawmakers were allowed to return to their home districts with the expectation that they could come back to Washington for votes at any time if an agreement is reached.

WHA has been advocating for Wisconsin health care priorities to be included in a compromise package, and activated its grassroots HEAT network shortly after the

(continued on page 2)

(WHA Continues Pushing for Hospital Relief as Congress Leaves for August Recess . . . continued from page 1)

Senate package was released in late July. Since then, WHA has been hosting virtual roundtables with federal lawmakers on both sides of the aisle. These virtual roundtables have been a great avenue for WHA members to connect directly with their own federal lawmakers and provide insight into how hospitals are dealing with COVID on the ground. It has also allowed lawmakers to hear directly from their hospital leader constituents about challenges that continue to persist, such as testing supply shortages, revenue losses, and rising caseloads.

During an August 4 virtual roundtable with Congressman Tom Tiffany (WI-07), hospital leaders discussed their concerns with dwindling testing supplies that make it difficult to test all patients and health care workers in need of testing. Hospital participants stressed that adequate supplies are necessary to maintain a healthy and available workforce that can keep up with the demand for planned patient procedures.

During an August 5 virtual roundtable with Congresswoman Gwen Moore (WI-04), hospital leaders expressed support for an increase in the federal Medicaid matching rate (FMAP) to keep up with the influx of 97,000 new BadgerCare patients since the start of the pandemic, and an estimated 230,000 projected to join BadgerCare by next summer. Hospital members described the continued need for more financial relief for Wisconsin hospitals, noting that distributions from the federal Provider Relief Fund designed to go to safety-net hospitals missed most safety-net hospitals in Wisconsin.

WHA also hosted virtual roundtables with Congressman Mark Pocan (WI-02) and Congressman Glenn Grothman (WI-06) on August 11. While coming from separate sides of the political aisle, both lawmakers lamented the lack of progress on negotiations between party leaders in the House and Senate. Both lawmakers were also happy to voice their support when hospital leaders discussed the need to permanently extend the Medicare telehealth flexibilities granted under COVID.

With President Donald Trump issuing executive orders on August 7 that would allow the federal government to fund a boost in unemployment insurance benefits and defer student loan interest, along with discouraging evictions and deferring certain payroll taxes, it is expected this could relieve pressure for Congress to reach an agreement in the short term. However, a number of federal provisions expire on September 30, which could create pressure for Congress to agree on a COVID package as it looks to pass another continuing resolution to fund the federal government. WHA will continue advocating with federal lawmakers to include Wisconsin health care priorities as COVID relief discussions continue.

CMS Issues Proposed Physician Fee Schedule Rule for Calendar Year 2021

The federal Centers for Medicare & Medicaid Services (CMS) on August 3 issued the proposed Physician Fee Schedule for 2021. The rule proposes a $3.83 reduction in the Physician Fee Schedule conversion factor for CY 2021. Additionally, the rule proposes several changes to Medicare telehealth coverage. Category 1 services, which are similar to existing services, are updated in the rule.

Importantly, CMS proposes to create a third temporary category of criteria for adding services to the list of Medicare telehealth services. Category 3 describes services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic that will remain on the list through the calendar year in which the PHE ends. These include services like home visits for the evaluation and management (E/M) of an established patient with problems of higher severity than those allowed under Category 1, as well as emergency department E/M visits for a patient.

CMS is not proposing to continue to recognize audio-only payment codes under the PFS in the absence of the PHE for the COVID-19 pandemic; however, it acknowledges that the need for audio-only interactions could remain as beneficiaries continue to try to avoid sources of potential infection. Therefore, CMS is seeking comments on whether CMS should develop coding and payment for a service similar to the virtual check-in but for a longer unit of time and subsequently with a higher value. CMS is also seeking comments on whether this should be a provisional policy to remain in effect until a year after the end of the PHE for the COVID-19 pandemic or if it should be a permanent PFS payment policy. The Remote Patient Monitoring (RPM) services that were added during the COVID-19 pandemic are modified in the proposed rule. CMS is proposing to return to the requirement that an established patient-physician relationship exist for RPM services to be furnished. Several other RPM clarifications are also proposed in the rule.

For purposes of limiting exposure during the duration of the PHE for COVID-19, CMS adopted an interim final policy revising the definition of "direct supervision" to include virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology. CMS is proposing to continue this policy through December 31, 2021 and is seeking comments on whether there should be additional guardrails for the policy during this time, as well as comments on whether the policy should be continued beyond 2021.

(continued on page 3)

(CMS Issues Proposed Physician Fee Schedule Rule for Calendar Year 2021 . . . continued from page 2)

Payment for outpatient E/M visits, as finalized in the CY 2020 PFS final rule, will largely be aligned with rule changes laid out by the CPT Editorial Panel for office/outpatient E/M visits, beginning January 1, 2021.

The proposed rule contains several proposals regarding professional scope of practice, including making permanent a COVID-19 policy that allowed nurse practitioners, clinical nurse specialists, physician assistants and certified nurse-midwives (CNMs) to supervise the performance of diagnostic tests in addition to physicians. The rule also proposes to allow physical and occupational therapists to use the same discretion to delegate maintenance therapy services to PT and OT assistants that they utilize for rehabilitative services.

The rule also contains provisions to implement year five of the Quality Payment Program (QPP) created under MACRA.

WHA will seek input on the rule from WHA members before submitting comments to CMS, which are due October 5. For more information contact WHA Vice President of Policy Development Laura Rose.

President Trump Releases Executive Order on Improving Rural Health Care and Telehealth

President Donald Trump issued an executive order August 3 on Improving Rural Health Care and Telehealth.

The order contains four main areas:

1. **Telehealth** – HHS is directed to issue a regulation within 60 days extending certain Medicare telehealth flexibilities beyond the public health emergency declared for the COVID-19 pandemic.
2. **New Rural Hospital Financing Models** – HHS is directed to announce a new payment model within 30 days that would allow rural areas to deliver innovative, high-quality, value-based care.
3. **Physical and Communications Infrastructure** – Federal agencies are directed to improve rural health care's physical and communications infrastructure.
4. **Rural Policy Initiatives** – HHS is directed to release a report within 30 days to improve rural health care by reducing regulations, developing initiatives to improve health outcomes, reducing maternal mortality and morbidity, and improving mental health.

WHA has been strongly advocating for permanently extending the telehealth flexibilities granted during the COVID-19 pandemic, and this is a further signal that the Trump administration intends to use its executive authority to extend flexibilities that are within its power to do so. At the same time, WHA has been pressing the Wisconsin congressional delegation to push for making these flexibilities permanent in the COVID relief package that is currently being negotiated in Congress.

While the details on additional rural initiatives under this order are scarce at this time, WHA will continue to follow new developments and will share additional details as they are available.

Member Quality Spotlight: SSM Health St. Mary's Hospital, Madison

Reducing opioids given to infants of mothers with opioid use disorder using Eat Sleep Console

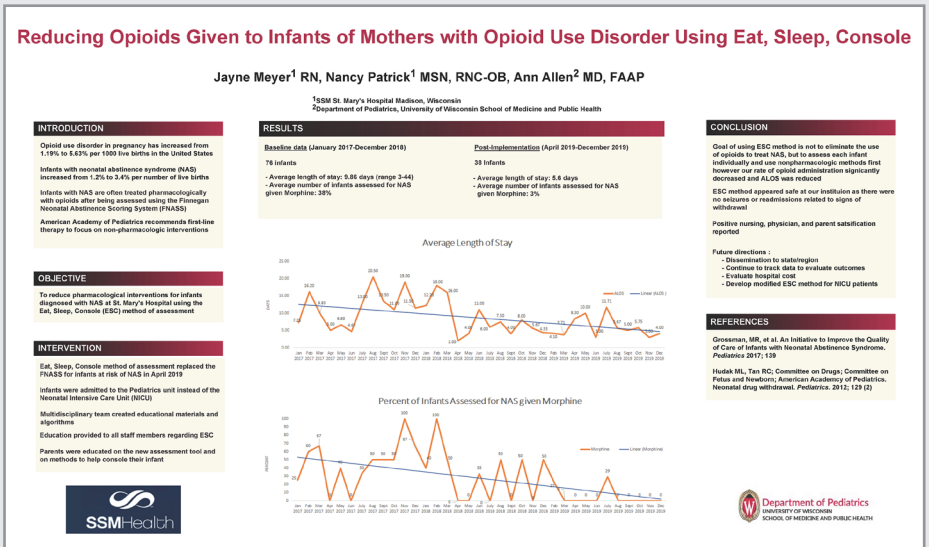
Special Note: Many WHA members proud of their quality improvement efforts had prepared special poster presentations that were to be displayed in the Capitol Rotunda during WHA's Advocacy Day 2020, which was cancelled due to the COVID-19 pandemic. WHA is pleased to highlight these efforts in today's and future editions of The Valued Voice.

Opioid use in pregnancy has escalated dramatically in recent years, paralleling the epidemic observed in the general population. Since 2000, opioid use disorder in pregnant women has increased from 1.19% to 5.63% per 1,000 live births in the United States.[1] Consequently, infants with Neonatal Abstinence Syndrome (NAS), which results from intrauterine opioid exposure, has increased 5-fold in the past 15 years. Infants born to mothers with opioid use disorder traditionally have been treated pharmacologically with additional opioids after being assessed for withdrawal symptoms using the Finnegan Neonatal Abstinence Scoring System (FNASS).[2] However, this scoring tool has never been validated and lacks internal consistency and interrater reliability. Monitoring and treatment of NAS results in prolonged hospitalizations, disrupts infant-parent bonding and leads to a substantial health care burden.

(continued on page 4)

(Member Quality Spotlight: SSM Health St. Mary's Hospital, Madison . . . continued from page 3)

The health care team at SSM St. Mary's Hospital in Madison wanted to reduce pharmacological interventions and average length of stay in infants diagnosed with NAS. The team wanted a model that focused on non-pharmacologic therapies and a simplified evidence-based, family-centered approach to assessment for infants exposed to opioids prenatally. The supportive care included increased skin-to-skin contact with mothers and babies, feeding on demand, calming techniques and maintaining a quiet environment. Focus was on the mother as the treatment for her baby and how she could provide the supportive care her baby needed. The model of care and assessment implemented is called Eat Sleep Console (ESC). This strategy shifted the goal from reducing withdrawal symptoms by exposing an infant to additional opioids to an approach prioritizing the overall functional well-being of the infant. The ESC model of care, developed by the New England Perinatal Quality Improvement Network, led to significant decreases in average length of stay and opioid administration at Yale New Haven Children's Hospital.[2]



Click on image to enlarge this poster presentation

ESC replaced FNASS as the method of assessment for infants at risk for NAS at SSM St. Mary's Madison. Their multidisciplinary team created an algorithm and provided education and training to all members of the health care team. Families and caregivers were educated on the new assessment tool and on methods to help console their infants. Educational materials were distributed in the clinic before birth to help the mothers prepare for what would happen in the hospital. Suggestions on how to calm a baby are shared on a poster in the hospital room and mothers are encouraged to be with their babies continuously to help calm and soothe them.

From January 2017 to December 2018, 76 infants were identified at risk for NAS with length of stays ranging from three to 44 days, with the average length of stay being 9.86 days. The average doses of morphine given per month was 40 with a low of 15.5 doses to a high of 132 doses. The percentage of infants who received morphine was 38%.

Since implementation of the ESC method in April 2019, there have been 38 infants identified to be at risk for NAS through December 2019, and the average length of stay decreased to 5.6 days. The percentage of infants receiving morphine decreased to 3%, and no infants were readmitted for signs of withdrawal and no adverse events were reported.

The goal of using the Eat Sleep Console method is not to eliminate the use of opioids to treat NAS, but to assess each infant individually and use other methods of non-pharmacologic treatment before pharmacologic intervention.

Members of the health care team appreciate the new scoring method, as the interrater reliability improved, and the infant does not have to be disturbed to do the assessment. Many families have also noticed the difference. One example is a mother who was on opioid replacement therapy during pregnancy had her second baby scored with ESC while her first was scored with FNASS. She reported that she was "happy to see that her baby was disturbed less, and she was able to help with the assessment and treatment this time."

References

[1]American College of Obstetricians and Gynecologists (ACOG) 2017. Opioid use and opioid use disorder in pregnancy. Committee opinion 711. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy.

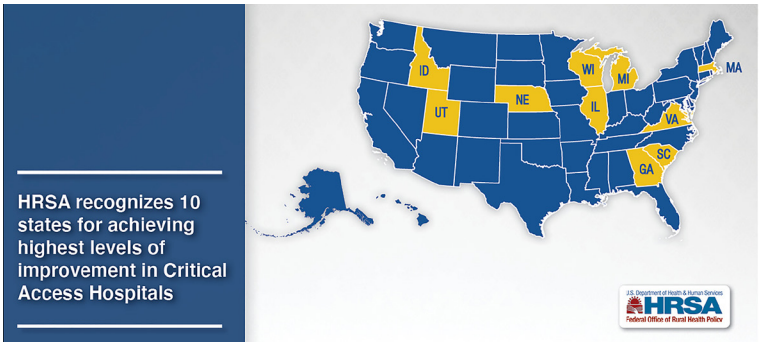
[2]Grossman MR, Berkwitt AK, Osborn RR, et al. An initiative to improve the quality of care of infants with neonatal abstinence syndrome. Pediatrics. 2017;139(6):e20163360.

Feds Give WI's Critical Access Hospitals Top Marks for Quality Excellence

Wisconsin's Critical Access Hospitals (CAHs) are national standouts for health care quality and performance, according to the federal Health Resources & Services Administration (HRSA). The agency recently ranked Wisconsin's CAHs third in the nation for the quality measures over the last 12-month period. Only Virginia and South Carolina were ranked higher.

HRSA's measures are from its Medicare Beneficiary Quality Improvement Project (MBQIP), which involves more than 1,350 hospitals across 45 states, including Wisconsin's 58 CAHs. You can read HRSA's announcement and more about MBQIP here.

"Our Critical Access Hospitals have been national leaders in voluntarily reporting quality data," WHA Chief Quality Officer Beth Dibbert said. "Wisconsin's CAHs outperform state and national scores in important areas like patient satisfaction and infection rates. And by voluntarily reporting public and transparent measures, these hospitals proactively drive quality initiatives that ultimately benefit patient safety."



MBQIP gives hospitals the opportunity to compare their data with that of other hospitals in the state and form partnerships to create strategies that can improve care in four measured areas: patient safety/inpatient, outpatient care, patient engagement and care transitions.

"This ranking confirms again why we're so proud of health care in this state, and WHA is privileged to be their voice," WHA President and CEO Eric Borgerding said. "No matter where you live in Wisconsin, patients get some of the best health care in the country right in their own community.

"These accomplishments aren't just by chance," Borgerding said. "WHA is committed to helping our members achieve such strong results for their patients through our nationally-recognized quality improvement programming and effective advocacy in the state's and nation's capitals."

WHA's CheckPoint is one example of Wisconsin hospitals' commitment to sharing information about the quality and safety of health care services delivered in their communities. The hospitals reporting to CheckPoint provide care to more than 99% of the state's patient population.

(Rural Physician Leaders Roundtable Grapples with Common COVID-19 Challenges . . . continued from page 1)

communities. Roundtable members consistently described robust system support including ease of transfer when patients need higher levels of care, particularly respiratory support. Some rural hospitals continue to experience challenges transferring patients with COVID-19 to long-term care facilities when those patients are medically ready for transfer.

Masking

Rural physician leaders noted that masking was often a contentious issue in their communities with lots of misinformation that made masking a challenging topic of conversation with patients. Most patients and visitors are complying with hospitals' mandatory masking policies. But in many rural communities, compliance with Governor Tony Evers' public health emergency masking mandate is inconsistent. Many patients are making appointments with providers to obtain a written note documenting a masking exemption even though that is not necessary under the most recent public health emergency declaration.

Preparations for fall and winter

Rural hospitals and physicians are proactively working with local school systems to develop testing protocols. One health system is applying for an EUA (emergency use authorization) to perform test pooling in order to conserve supplies. Another hospital is converting its drive-up COVID testing site to a drive-up influenza vaccination site since traditional influenza vaccination clinics are not compatible with the physical distancing appropriate for COVID-19. Roundtable discussions reflected how closely rural providers are working with schools, businesses and local government to lessen the adverse impact of COVID-19 on their communities. In addition to public schools, there was concern shared about testing supply volume in the case of college students returning to campus and being required to test prior to arrival. Outstanding questions include where students will be tested and how testing will be paid for.

The Rural Physician Leaders Roundtable meets quarterly via videoconference. Physicians interested in learning more or who would like to join the roundtable should contact WHA Chief Medical Officer Mark Kaufman, M.D.

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