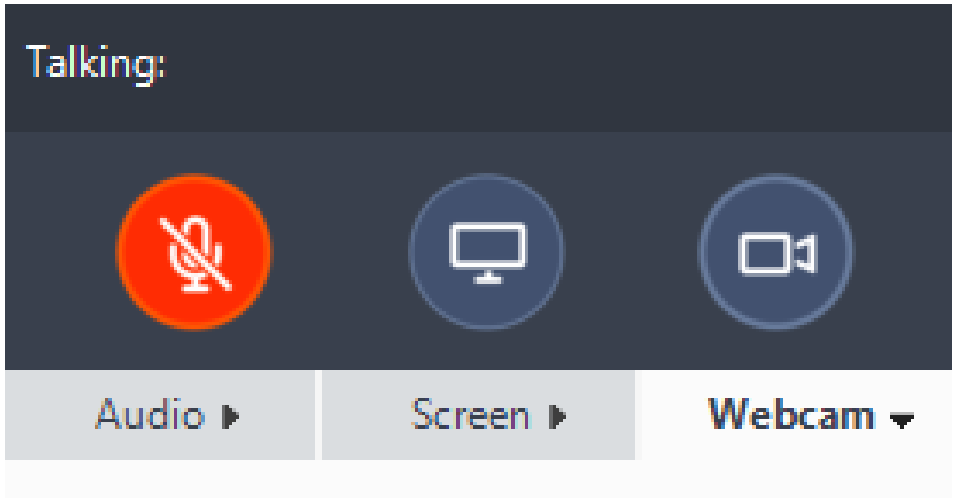
NEQCA COVID-19 Update and Patient Prioritization & Outreach Strategies

September 3, 2020

Please Mute



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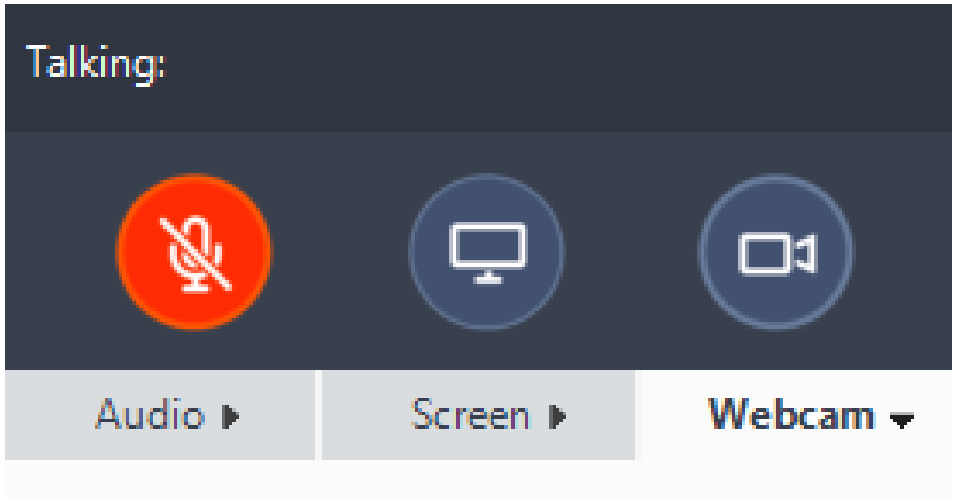
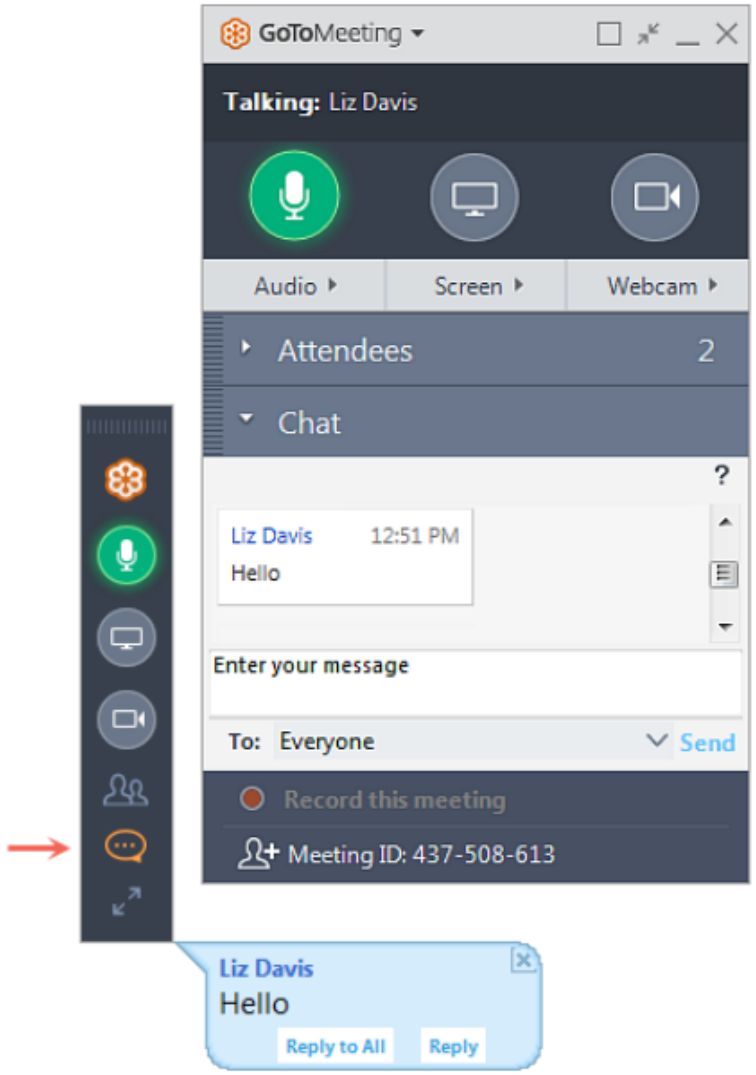


To Ask A Question

- Please use the “chat” feature to submit your question
- A moderator will then pose your question(s) to the presenters



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Opening Comments

Joseph Frolkis, MD, PhD

CEO and President

Agenda

- COVID-19 Update
- Patient Prioritization and Outreach
- Flu Vaccine Administration
- Helpful Resources

COVID-19 Update

Ben Kruskal, MD

Senior Medical Director

COVID-19 News of the Week(s)

News of the Week

Tufts Medicare Preferred (TMP) Telehealth Telephone-Only Visit coding clarification:

- Tufts Health Plan recently issued the following clarifying note on the Coronavirus Updates for Provider section of their website regarding Telephone-only telehealth visits: ***"For Medicare products, under CMS rules, special codes already exist for certain telephonic services and those codes will be paid at the CMS fee schedule."***
- TMP and other Medicare Advantage plans have stated that they are following Medicare guidelines for risk adjustment coding, and therefore, providers **should not use** E/M codes 99201-99215 for TMP telephone-only telehealth visits.
- The CMS approved codes for telephone-only visits (no video) are the CPT time-based codes in the range of 99441-99443 (CPT description*: Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment).*

Testing

- **Antigen testing**
  - Lower sensitivity than PCR but high specificity; + are helpful, Negs are not
  - Abbott's BinaxNOW antigen card test: 15 min, $5, standalone-no instrument required

- **Specimen type for PCR**
  - NP vs OP, MT, or self-collected anterior naris: NP higher sensitivity
  - NP vs saliva: about equal sensitivity
  - Yale SalivaDirect: NOT first saliva PCR test, but MUCH less onerous sample prep, easily adapted to many different vendors' existing testing platforms

CDC Changes Recommendations: Testing of Asymptomatic Contacts of Known Positives

- Last week, CDC removed the recommendation to test ALL contacts of known infected patients, regardless of symptoms
- No reason was given; no new evidence has emerged to suggest that this change is justified
- The Mass. Dept. of Public Health, by whose guidance we are bound, has NOT changes its policies regarding this
- Therefore, we continue to recommend testing ALL contacts of known positives, including asymptomatic contacts (as soon as known + in contact is reported)

Kids and COVID-19 Transmission: Still Murky

- Multiple studies show PCR viral loads in kids may be as high as adults which you would think would mean increased transmission

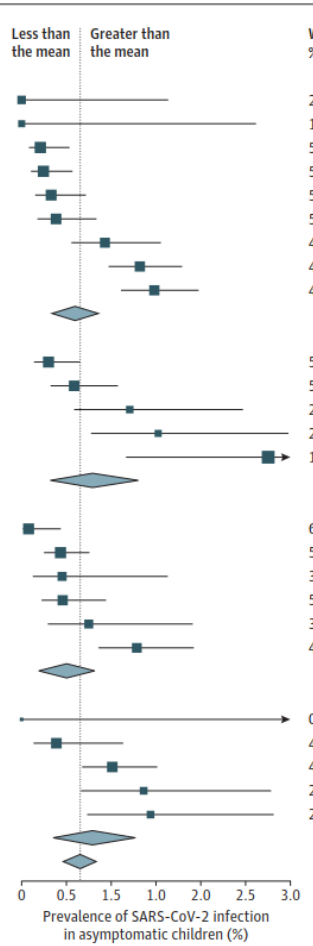
BUT

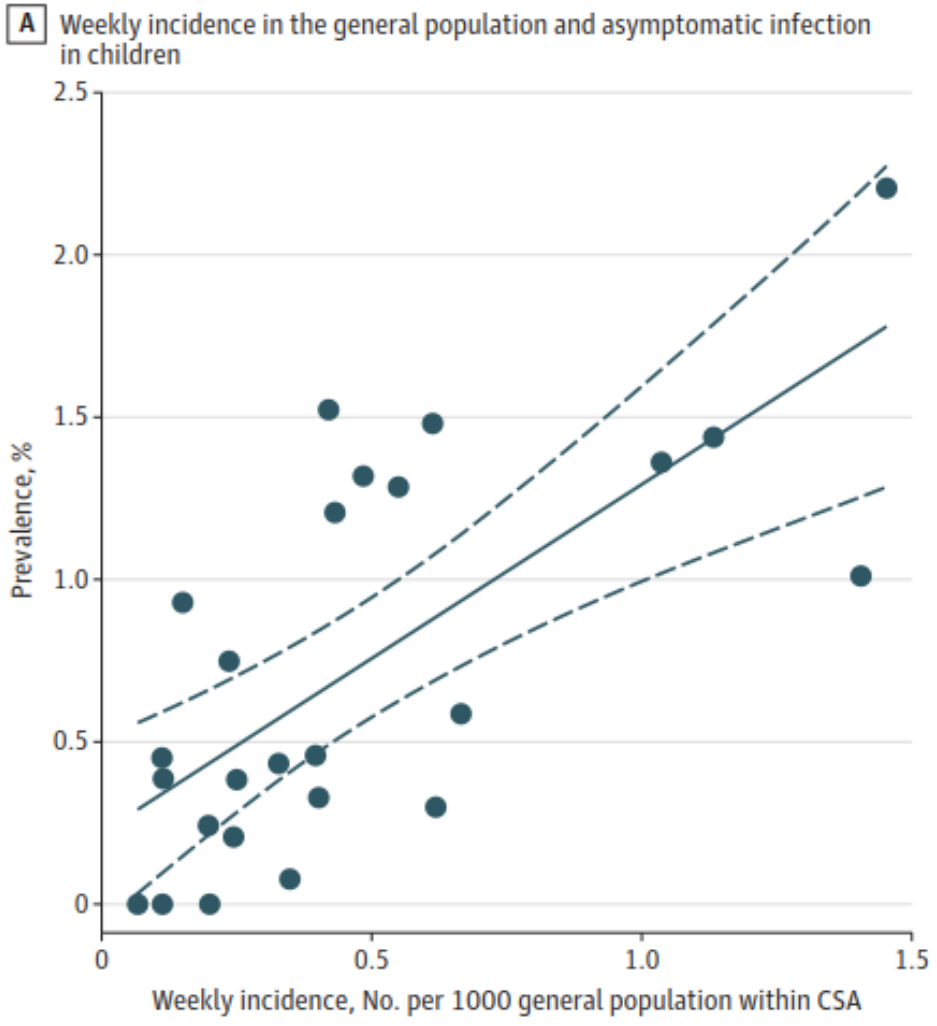
- Multiple studies in households, schools and small social groupings show kids are much less often index patients and transmitters than adults

Asymptomatic kids have prevalence of PCR+ ~ 0.5%

Figure 1. Prevalence of Asymptomatic Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Infection in Children

Region/ CSA	No./ total No.	Testing indication	Testing site	Calculation period	Prevalence, % (95% CI)	Weight, %
West						
1	0/231	Preop	NP	June 1-June 30	0.00 (0.00-1.64)	2.68
2	0/143	Preop OHNS	NP	June 1-June 23	0.00 (0.00-2.62)	1.39
3	4/1919	Preop	NP	May 29-June 30	0.21 (0.08-0.53)	5.98
4	5/2058	Preop/clinic	MT	NA	0.24 (0.10-0.57)	5.94
5	6/1821	Preop	NP	NA	0.33 (0.15-0.72)	5.69
6	6/1562	Preop/clinic	NP	June 5-June 22	0.38 (0.18-0.84)	5.45
7	14/1506	Preop	NP	May 29-July 8	0.93 (0.55-1.55)	4.40
8	40/3032	Preop	NP	May 29-July 9	1.32 (0.97-1.79)	4.86
9	45/3039	Preop	NP	NA	1.48 (1.11-1.98)	4.73
West (all) I^2 = 85.5% (P < .001)	120/15 311				0.59 (0.28-0.90)	
Midwest						
10	6/2000	Preop	NP	May 29-July 8	0.30 (0.14-0.65)	5.81
11	10/1704	Preop	NP	NA	0.59 (0.32-1.08)	5.12
12	7/580	Preop	NP	NA	1.21 (0.59-2.47)	2.50
13	8/525	All ASX	NP	NA	1.52 (0.77-2.98)	2.02
14	9/408	Preop OHNS	NP	NA	2.21 (1.16-4.14)	1.27
Midwest (all) I^2 = 72.4% (P = .006)	40/5217				0.87 (0.37-1.37)	
South						
15	1/1293	All asx	NP	June 4-July 7	0.08 (0.01-0.44)	6.19
16	12/2767	Preop	NP	NA	0.43 (0.25-0.76)	5.78
17	2/443	All ASX	NP	NA	0.45 (0.12-1.63)	3.63
18	7/1528	Preop	NP	NA	0.46 (0.22-0.94)	5.26
19	4/534	Preop	NP	NA	0.75 (0.29-1.91)	3.12
20	23/1789	All ASX	NP	NA	1.29 (0.86-1.92)	4.18
South (all) I^2 = 80.4% (P < .001)	49/8354				0.52 (0.20-0.84)	
Northeast						
21	0/42	Preop	NP/MT	NA	0.00 (0.00-8.38)	0.16
22	3/774	Preop	MT	June 1-June 23	0.39 (0.13-1.13)	4.68
23	23/2273	All ASX	OP	June 1-June 23	1.01 (0.68-1.51)	4.83
24	7/514	Preop	NP	NA	1.36 (0.66-2.78)	2.14
25	8/556	Preop	NP	May 29-June 29	1.44 (0.73-2.81)	2.18
Northeast (all) I^2 = 45.5% (P = .12)	41/4159				0.90 (0.45-1.35)	
Overall I^2 = 79.4% (P < .001)	250/33 041				0.65 (0.47-0.83)	





Health Care Workers: Multiple publications, Summer 2020

- Several studies, generally offered to all, uptake 50-75% of all staff at acute care hospitals

- Overall ~10-15% Ab+
  - Of those known to have been infected (PCR+ at any time), Ab+ in >90%
  - Known PCR neg or not done: ~10% Ab+
  - Working in ICU or COVID-19 floor NOT associated with Ab+ status when other covariates were corrected for
  - Inconsistent mask use WAS associated with clinical cases, PCR+ and Ab+

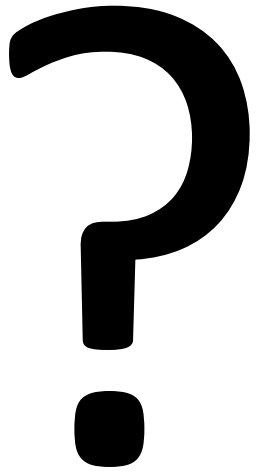
COVID-19 Situational Update

- State government is holding at Phase 3 of reopening
- Clinical testing methods:
  - Not becoming more sensitive
  - Saliva testing or self-swab (anterior naris) being approved
  - Antigen testing (low-tech, less expensive, less sensitive, but correlates better with infectious period)
- Extensive testing of large asymptomatic populations (e.g. college students) for early identification and disease control
- ?Use of antigen testing for frequent screening of low risk individuals (M. Mina, MD): likely to become available for individual use?
- Practicality and utility of more extensive contact tracing?

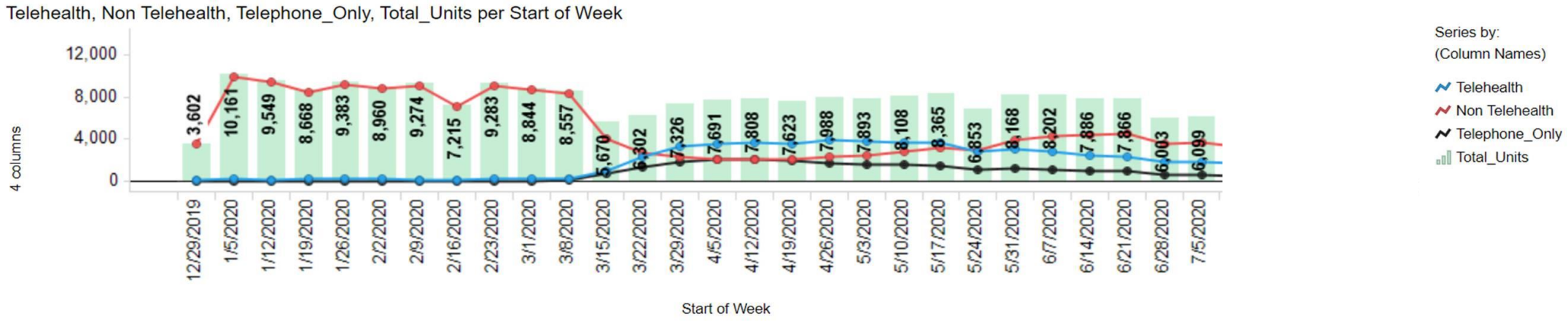
COVID-19: The Big Picture

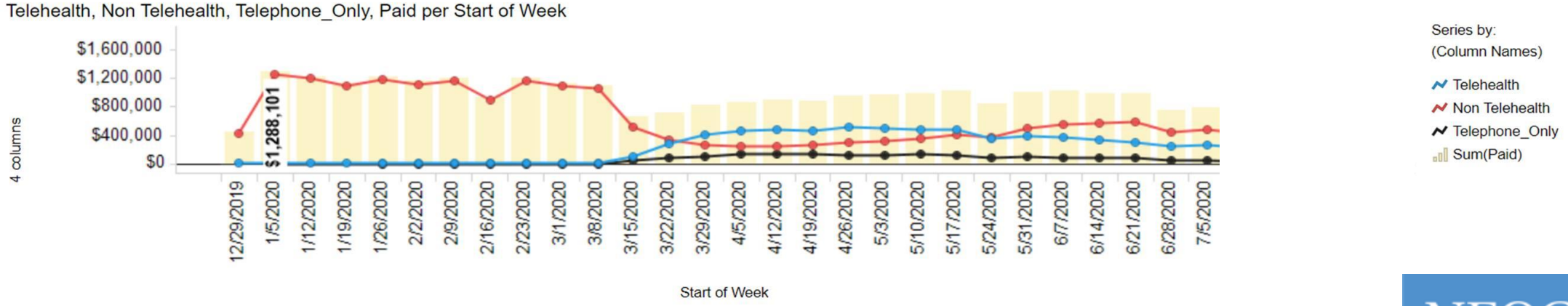
- Disease activity in Mass. is at a fairly low level due to ongoing mitigation measures
  - Distancing including limited commerce and limited gatherings
- Increased social exposure (in-person school and college re-openings, any loosening of commerce and gathering rules) will result in acceleration of disease spread
- Disease activity is high in many parts of the country; importation of infection from elsewhere remains a significant danger no matter how well we control it here
- In the best-case scenario (which is unlikely), a safe and effective vaccine will be approved by FDA Dec 2020-Jan 2021
  - Even in that best case, will take MANY months for significant number of doses to be available

Second Wave: When?



Office visit volume and revenue: NEQCA Network Totals





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Practice Preparedness Evaluation Tool

- Simple tool for evaluating one's own practice (or any practice)
- Focuses on issues most relevant to patient and staff safety, continuing to care for patients, and sustain practice revenue despite COVID-19
- Results will be available to LCO leadership for review, discussion, support
  - We urge LCO Medical Directors to review the results from their LCO's practices and reach out to colleagues as seems appropriate
- Results will also be available to NEQCA Central for aggregation and will be reported out in aggregated form—prelim version today!
- NEQCA Central Medical Directors and Practice Reactivation Team members will consult as requested by the practice or LCO leaders

Practice Preparedness Evaluation Tool

To be used to help practice identify areas of opportunity

**Copies will be sent to NEQCA central to be tabulated for analysis and a copy will also be shared with your LCO leadership

LCO *

Select

Practice Name *

Select

Completed by (Include position): *

DPH Attestation Guidelines

Has practice updated policies and procedures?

Select

Any additional notes related to Policy and Procedures

Does practice request assistance with Policies and Procedures?
This information will be shared with your LCO leadership for potential follow-up

Select

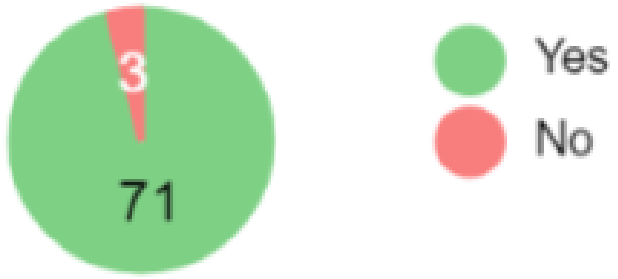
Infection Control and Personal Protective Equipment (PPE)

Practice Preparedness Evaluation Tool: Network results: DPH policies and procedures

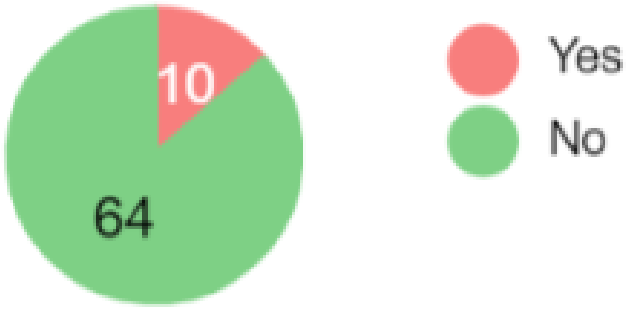
Practices Completed Survey Count**

74

DPH Policies and Procedures Updated

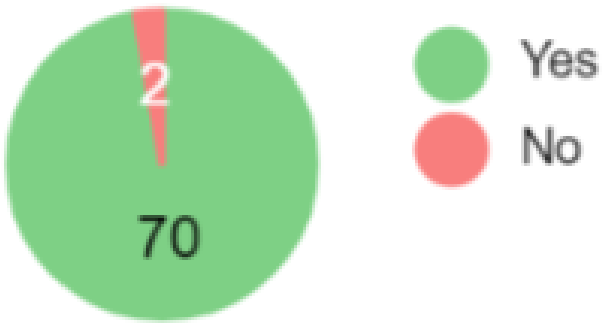


Practice Requests F/U

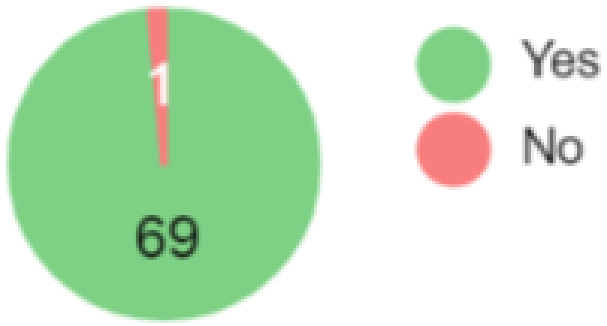


Practice Preparedness Evaluation Tool: Network results: Infection Control and PPE

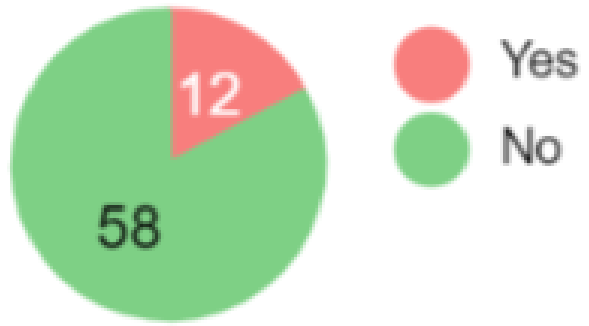
Gloves - 30 Day Supply



Masks - 30 Day Supply



Practice Requests F/U



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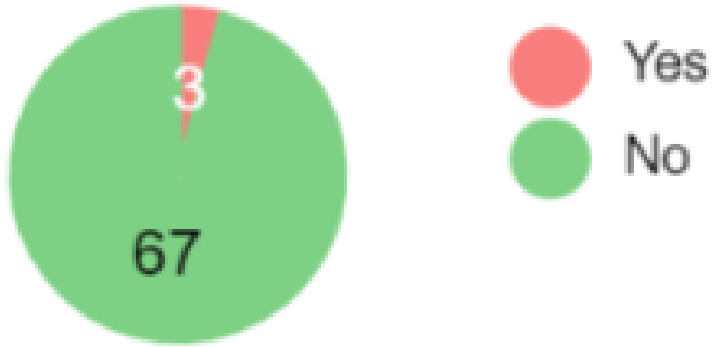
Practice Preparedness Evaluation Tool: Network result: Office configuration

Office Configuration Survey Questions

1. Waiting Room
2. Front/Back Office
3. Exam Rooms
4. Breakroom/Kitchen
5. Other Common Areas
6. Does practice have an elevator on site?
7. Does elevator have signage to ensure proper physical distancing?
8. Where does practice have patients wait for their visit?

Practice Requests F/U



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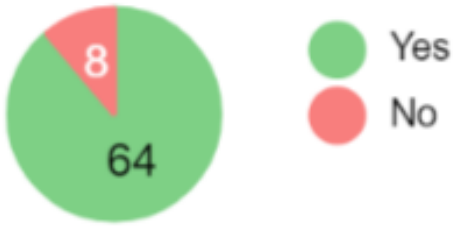
Practice Preparedness Evaluation Tool: Network results: Office workflows

Office Workflows - Survey Questions

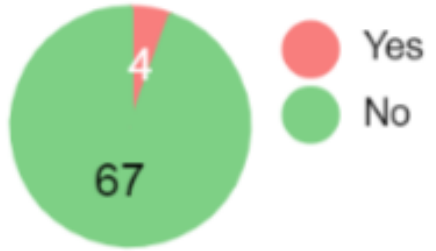
4. **Does practice have process for triaging patients for in-office vs. telehealth visits?**
5. **Does practice have a DAILY process for screening and documenting ALL office staff (including Providers) for COVID symptoms?**
6. If yes, How do you screen staff for COVID symptoms and how is it documented?
7. Has practice implemented contactless registration or co-pay processes?
8. How many patients does practice anticipate it can see

Triaging Patients for Telehealth vs. In-Office

Daily COVID Symptom Screening for Staff



Practice Requests F/U



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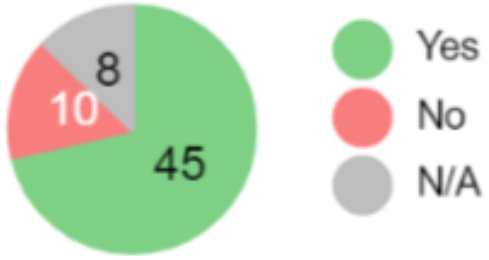
Practice Preparedness Evaluation Tool: Network result: Communicating safety changes to patients

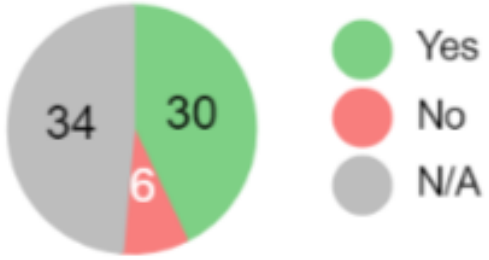
Communicating with Patients - Survey Questions

2. **Has practice sent message to patients since pandemic began?**
3. Does practice use a website?
4. **Has practice updated website with relevant pandemic information?**
5. Does practice use social media?
6. **Has practice updated social media with relevant pandemic information?**
7. Has practice reviewed Wellforce's "Safe with Us" materials?

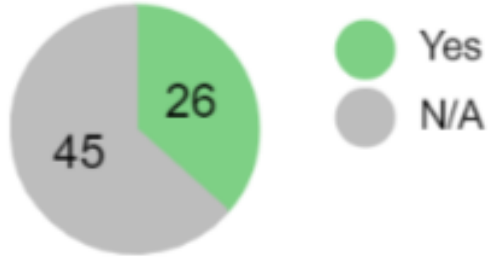
Patient Portal Updated



Website Updated



Social Media Updated



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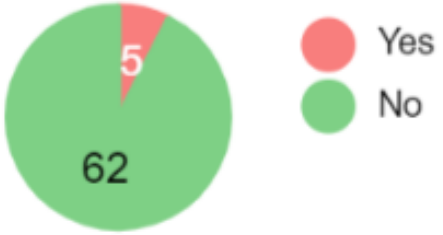
Practice Preparedness Evaluation Tool: Network results: Patient volume / Telehealth

Patient Volume and Telehealth - Survey Questions

1. **What platform is practice using for Telehealth?**
2. How many Telehealth video visits does practice do weekly?
3. How many In-office visits does practice do weekly?
4. How many telephone-only (no video) visits does practice do weekly?
5. Has practice proactively contacted patients for Telehealth visits?
6. Does practice conduct any pre-vist prep for Telehealth visits?

Practice has HIPAA Compliant Telehealth Solution

Practice Requests F/U



Practice Preparedness Evaluation Tool: Network level results--Summary

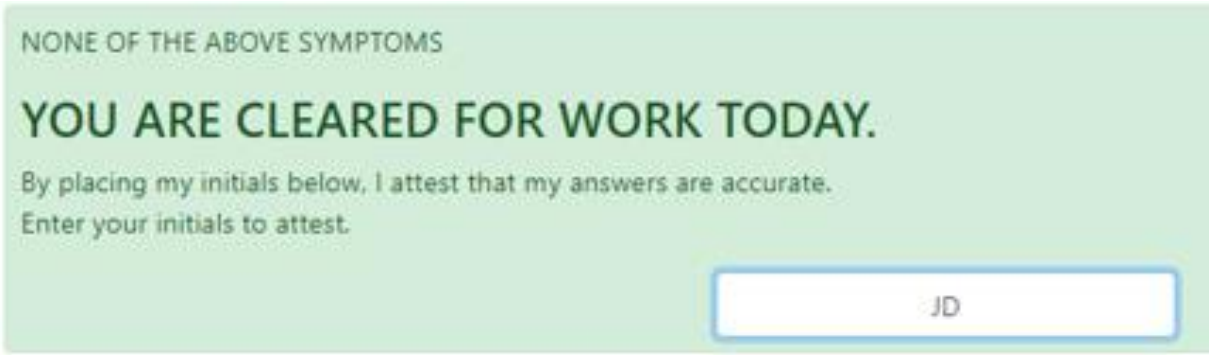
Recurring issues:

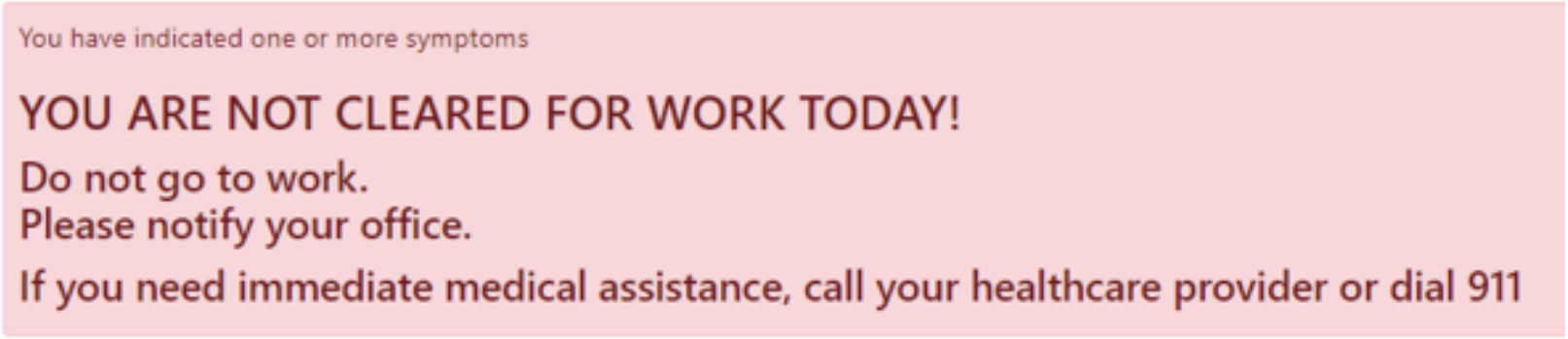
- No HIPAA-compliant Telehealth solution: 27.0%
- Not yet broadly communicated safety changes: 13.5%
- No process for screening staff for COVID symptoms: 12.5%

Symptom Screening for All Staff

- Important to explicitly have staff review the symptom list every day and attest to having none
- Recorded by any reasonable means: paper checklist, logbook, electronic checklist, Tufts Medical Center app
- Tufts Medical Center has adapted their app COVID Pass to make it usable by our practices

COVID Pass





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COVID-19 Update

Questions

Patient Prioritization & Outreach Aug-Dec 2020

Ben Kruskal, MD

Pratiksha Patel, MD

Senior Medical Directors

2020 is not like any other year*

(*as if you needed a reminder)

- Many fewer patients have been seen
  - Some of those missed visits are no longer necessary, but many are, generating a huge backlog of needed care
  - The patients calling to schedule may not be the ones who need visits the most.
  - Care is currently being provided by a mix of telehealth and in-office visits
  - In-office visit availability is limited by infection control considerations
    - Need for lower people density in the office
    - Delays due to PPE and cleaning/disinfection
  - There is limited time and energy available for the rest of the calendar (performance) year
  - The likelihood of a second surge of COVID-19 disease could further limit in-office appointment availability

How should we prioritize adult patients for care for the rest of the calendar (performance) year?

- The patient comes first: who has the greatest clinical need?
  - Patients with chronic diseases need management, especially multiple conditions
  - The very sickest patients (top 5% by cost) receive care from a specialty team/hospital
- What about population health?
  - Prevention is better than treatment and is more time efficient (more life-years saved per person-hours spent)
  - BUT clinical care is a higher priority: preventing DKA is more urgent than preventing diabetic retinopathy
  - Payers pay for quality metrics =population health: BUT payers acknowledge that 2020 is singular and are aligned with us around the concept that clinical needs trumps contractual requirements to satisfy quality metrics

Need panel list ranked in order of overall clinical need (complexity/severity)

- The HNHU (high needs, high utilization) patient list is an existing all-payer report that uses cost of care as a surrogate for complexity/severity/clinical need
  - Start with the 5-10%ile by cost as patients in the top 5% are so complex and severely ill that their care is managed by a specialty/hospital team
- We have created a modified version of the HNHU patient list intended as a tool for patient outreach for Aug-Dec of 2020
  - Starts with the 5-10%ile of patients by cost, ranked in order by cost (Medical costs $PMPM)
  - Because many patients do not have prescription coverage, we have removed the Rx column from the modified version of the HNHU list so we can compare “apples to apples”, i.e. medical costs NOT including prescription drugs across all patients.
  - NEQCA Central will generate and distribute lists for each LCO/practice which will include date of last PCP visit, and the most clinically important quality care gaps (related to DM and HTN)
  - The prior HNHU report will not be published during this period

How is the list used?

- PQAs will be completely dedicated to Patient Outreach for the remainder of 2020.
- PQAs will connect briefly with the Practice/PCP and review the list with them. The Practice/PCP will designate which patients need to be scheduled for a visit and within what time frame. Outreach calls will be made to schedule the visits. Information will be provided to the practice re care gaps, which may be added to the practice's existing pre-visit preparation process to ensure that gaps are closed at the scheduled visit.
- Many of the patients listed will also have coding opportunities. When seeing these patients, providers should be mindful of taking advantage of coding opportunities.
- If the practice finishes their initial list of patients, PQAs will continue to provide additional groups of patients in order of clinical priority (as indicated by Medical $PMPM) as long as needed.

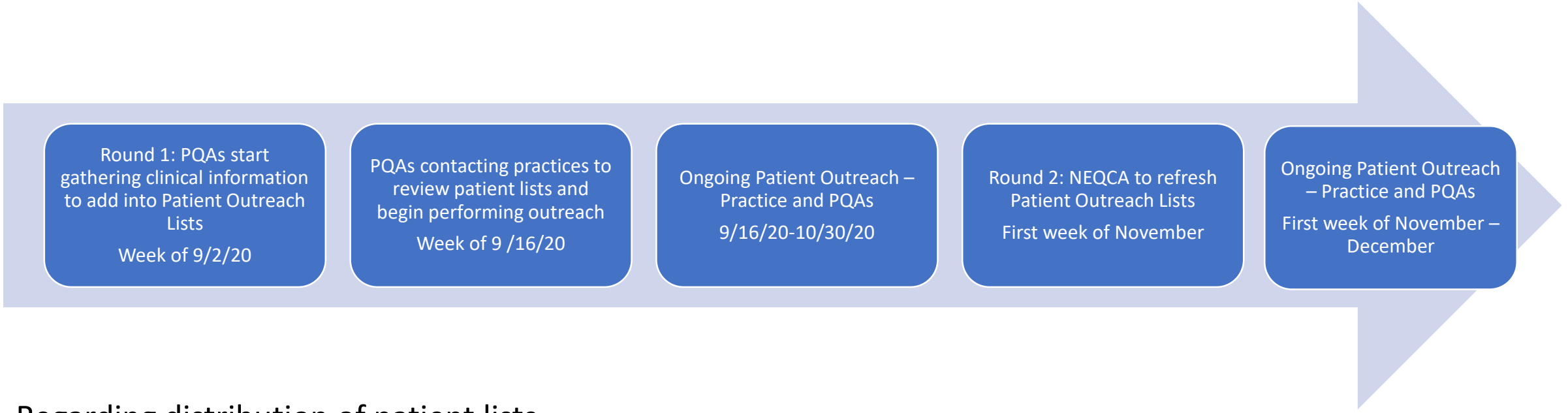
Adults: The big picture

- Clinically and ethically, prioritizing based on clinical need in a payer-blind fashion is the right thing to do.
  - This is a requirement of the DPH Reopening guidelines
- There are many lists available as always; however, for clarity and efficiency, we strongly recommend utilizing the new *patient outreach HNHU list* as the first and central focus for scheduling
  - Practices that have additional bandwidth may utilize practice staff to work additional lists to address quality, coding or other gaps as during a normal year
- De-emphasis of quality metrics by the payers allows practices to put quality metrics secondary to overall clinical care

Pediatrics – The big picture: A different approach

- Cost is not as helpful for prioritization in pediatrics as in adults
- A high proportion of the most important care is delivered at annual checkups (management of common chronic diseases, developmental assessment, immunization, lead screening, etc). It is of major concern that pediatric patients are attending fewer routine visits and immunizations since the onset of COVID-19.
- Thus, for this population, NEQCA Central staff will generate a annual checkup list for patient outreach, targeting routine immunization ages first.
- PQAs connect with the PCP and review the list with them
  The PCP will designate which patients need to be scheduled for a visit most urgently and within what time frame. Outreach calls will be made to schedule the visits.

Timeline and note on distribution of files:



Regarding distribution of patient lists

- NEQCA will be working with LCOs and practices to ensure a secure method of file distribution
- NEQCA will be keeping track of file distribution history and detail (to who, how it was sent, when it was sent, etc.)
- NEQCA recommends LCOs and Practices to minimize additional file distribution and to document some detail if there is additional distribution

Patient Prioritization & Outreach Aug-Dec 2020

Questions

Flu Vaccine Administration 2020

Ben Kruskal, MD

Senior Medical Director

Considerations not different in 2020

Supply

- Manufacturers and public health agencies have known for a sufficiently long time that there would be increased demand this year, so production has been ramped up.
- Vaccine typically arrives in batch from April to November.
- Remember that flu doesn’t usually start to increase till around the beginning of December. There are reasons why earlier administration may be easier this year, but DPH predicts there will be ample amounts of vaccine available.
- DPH continues to supply pediatric vaccines at no cost to any provider who administers vaccines to children

Considerations not different in 2020 (continued)

Immunization not in your practice

- Pharmacy chains will be administering vaccine as usual
- Employers, schools, public health clinics may be useful venues for some patients
- Home care/VNA agencies can do immunization sessions and bill insurance

Route

- The same administration routes are used for all of this season's flu vaccine—IM for injected inactivated influenza vaccine (IIV), intranasal for Live attenuated influenza vaccine, FluMist) LAIV.

Flu vaccine formulations in a nutshell

- Quadrivalent (99% of the supply) vs trivalent (1%)
- Thimerosal-free: 87% of the supply this year
- Egg content: 80% of the supply with, 20% without
  - Cell-based, recombinant
- Intranasal (non-injected, LAIV)
- High dose vaccine (for seniors)
- Adjuvanted vaccine (for seniors)

What is different in 2020?

- Administration in a manner that avoids or reduces exposure of both patients and health care workers to reduce possibility of COVID-19 transmission
  - PPE must be worn as usual in any encounter
    - Gloves are the only item that needs to be changed between patients. Hand hygiene must be performed before donning and after doffing gloves.
  - Outdoor clinics reduce likelihood of transmission if feasible.
  - Drive-up clinics likely reduce transmission even more

Flu vaccine administration 2020

Questions

Helpful Programs and Resources

Ben Kruskal, MD

Senior Medical Director

Mark Your Calendars

Upcoming Programs:

Thursday, September 3, 2020, 5-6 p.m.

Patient Prioritization and Outreach Strategies

Join here: https://global.gotomeeting.com/join/123026381

Wednesday, September 9, 2020, 5 - 6 p.m.

Wellforce Webinar: Practicing in a COVID-19 Era

Register here: https://wellforce.zoom.us/meeting/register/tJYkd-2trzgvHtQkKxE1XKFqUKo31xkVc0UP

Thursday, September 10, 2020, 7:30 - 8:30 a.m.

Risk Coding Lessons Learned from the Field

Join here: https://global.gotomeeting.com/join/420257117

Recent Programs:

Please scroll down to the description within each Webinar video, to easily fast-forward to different segments

- NEW: COVID-19 Update featuring Dr. Andrew Strand: Presentation and Webinar - August 12, 2020
- COVID-19 Update: Preparing for a Second Wave Presentation and Webinar - August 6, 2020
- COVID-19 Update Presentation - July 29, 2020
- COVID-19 Webinar: Dr. Ben Kruskal, Dr. Chris Perkins, Dr. Alice Connors-Kellgren - July 29, 2020
- Developmental Trauma and COVID-19 Presentation by Dr. Alice Connors-Kellgren, PhD, Clinical Psychologist, Tufts MC - July 29, 2020
- COVID-19 Update Presentation and Webinar featuring Michael Eaton, Senior VP BVK Advisory Services - July 22, 2020
- COVID-19 Update Presentation by Dr. Ben Kruskal - July 15, 2020
- COVID-19 Neurological Considerations Presentation by Dr. David Thaler, Neurologist-in-Chief, Tufts Medical Center - July 15, 2020

Unable to join us "live"?
Most sessions available "on demand"

NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

Please Tell Us How We Can Help

PRACTICE REACTIVATION GUIDELINES

NEQCA has developed guidelines to help our Network safely and effectively ramp-up practice operations. Please visit this section regularly for new and updated information.

If you have specific concerns that impact your ability to see patients in the office, please click here to tell us how we may assist you.

- UPDATED: NEQCA Medical Practice Reactivation Guide – June 8, 2020
- NEW: DPH Guidance Phase 2 Reopen Approach For Non-Acute Hospital Health Care Providers – June 8, 2020
- NEW: NEQCA Summary of DPH Guidance Phase 2 Reopening Approach – June 8, 2020
- NEW: DPH Phase 2 Reopen Attestation Form For Non-Acute Hospital Health Care Providers – June 8, 2020
- NEW: DPH Phase 2 Nonessential, Elective Invasive Procedures during the COVID-19 Outbreak – June 8, 2020
- NEW: Template Policies and Procedures in DPH Phase 2 of COVID-19 Era (MS Word Version)
- Template: Policies and Procedures in DPH Phase 1 of COVID-19 Era (MS Word version)