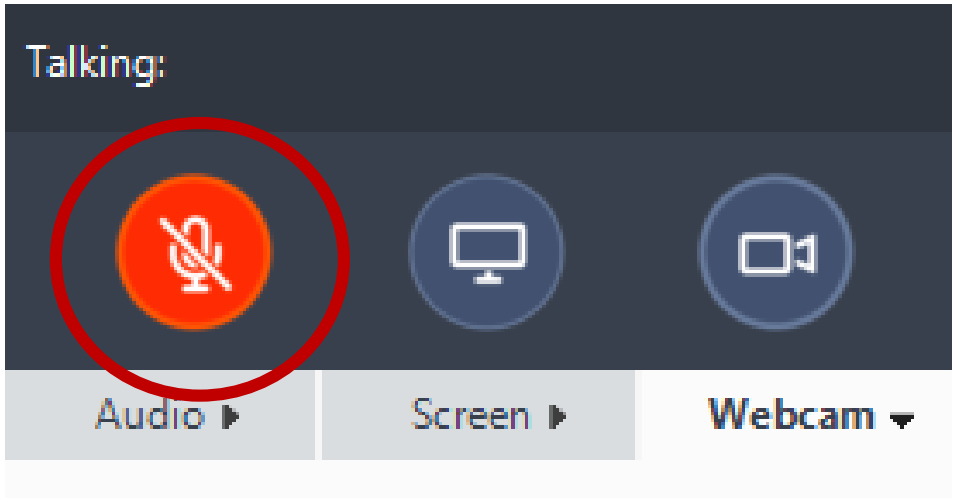
# NEQCA COVID-19 Update

**June 24, 2020**

# Please Mute




# No Webcam

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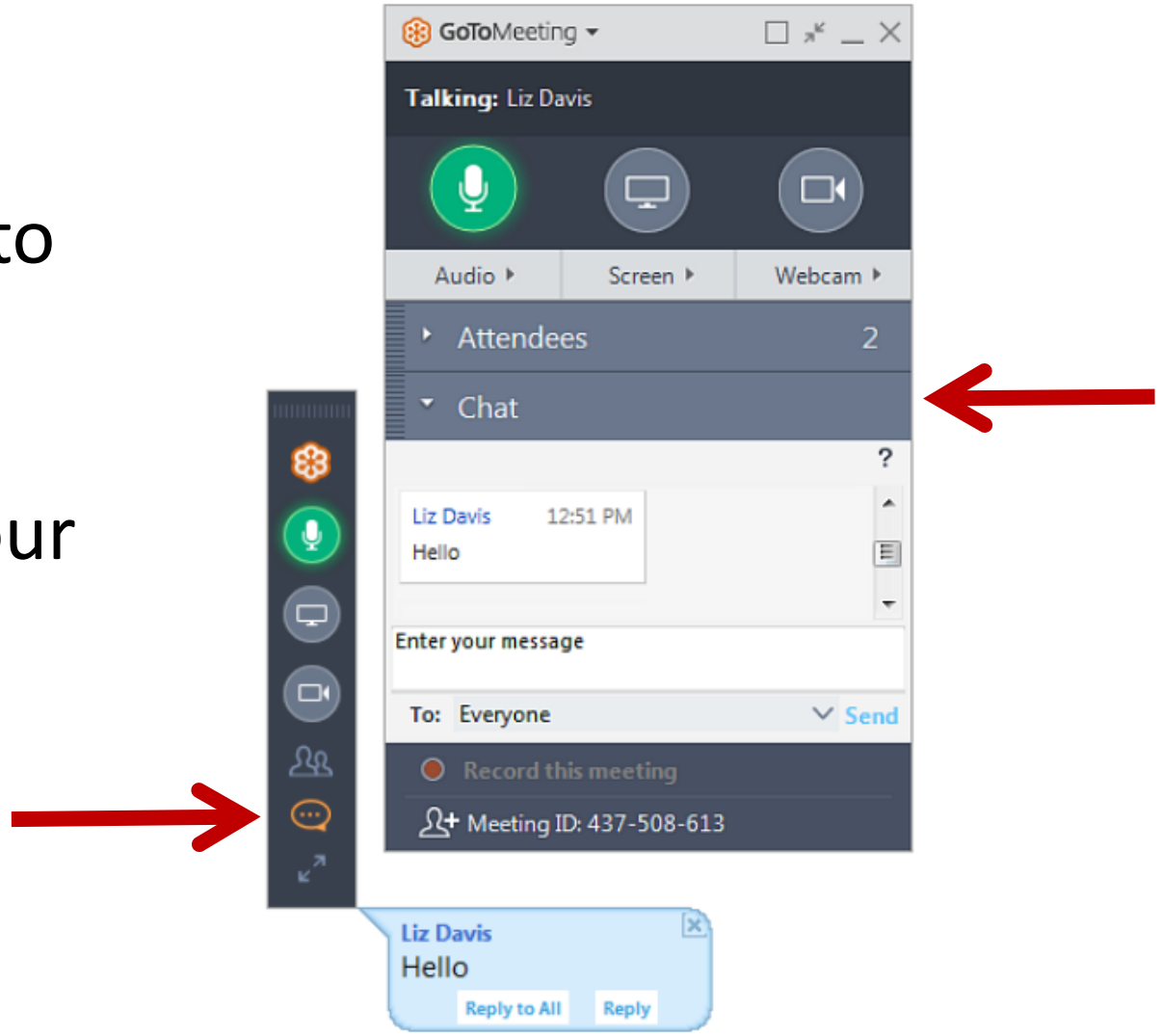
# To Ask A Question

- 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 Situational Update
- Practice Reactivation Guidance
- Upcoming Programs and Resources

# COVID-19 Situational Update

**Ben Kruskal, MD**

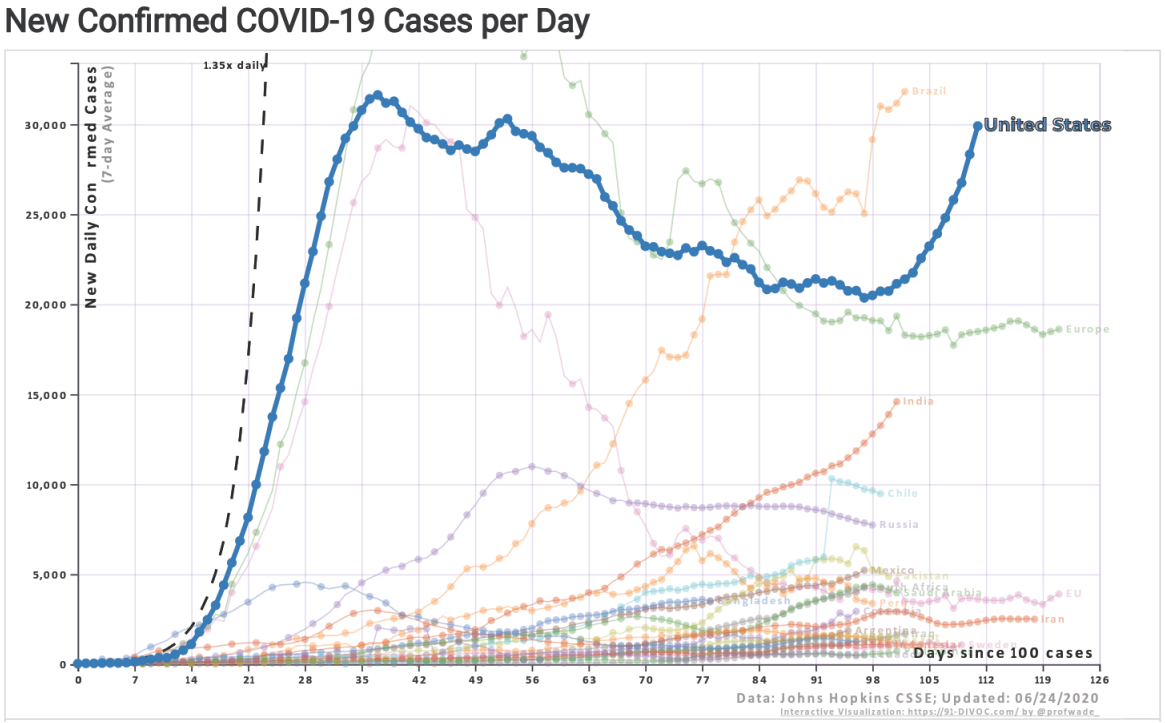
**Medical Director**

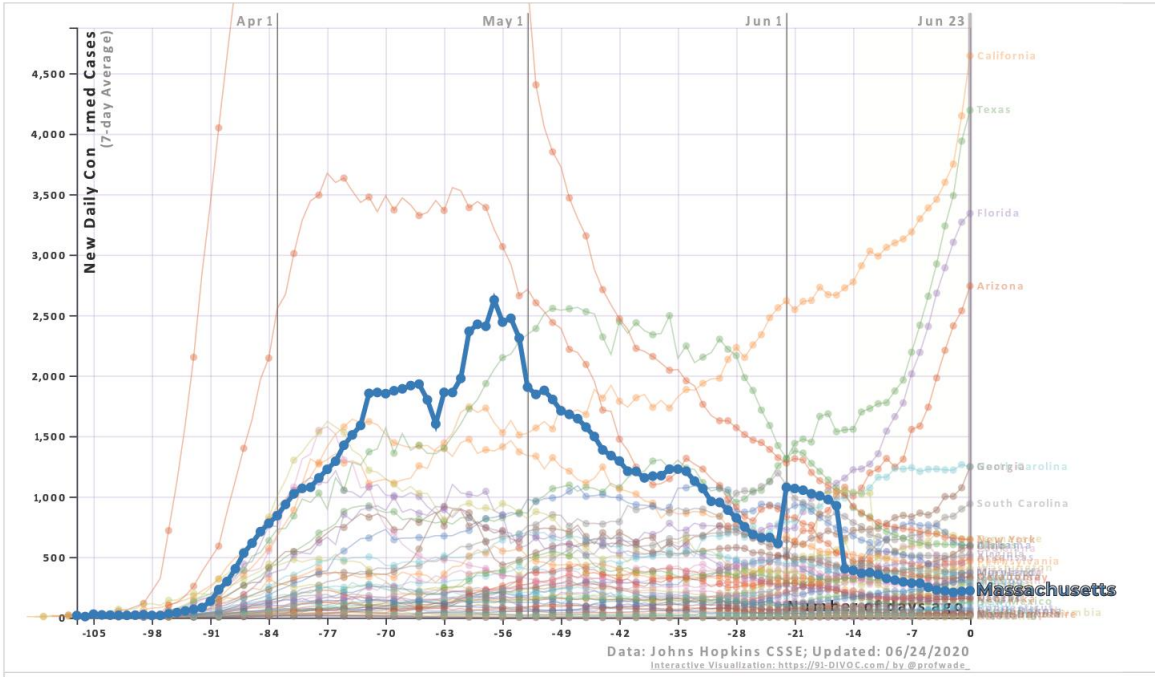
# Section Agenda

- Situational update
- News of the week/reminders
- Phone triage in the era of COVID-19
- COVID-19's effect on volume and acuity
- COVID-19's threat to practice survival

# Situational update: numbers

- Mass
  - Total:  106K cases/7.7K deaths
  - Daily new: 266 cases/59 deaths
  - Avg # of hospitalized pts: ~1000
- Tests/day: 5-10K
- Avg PCR+ rate: 2.5%



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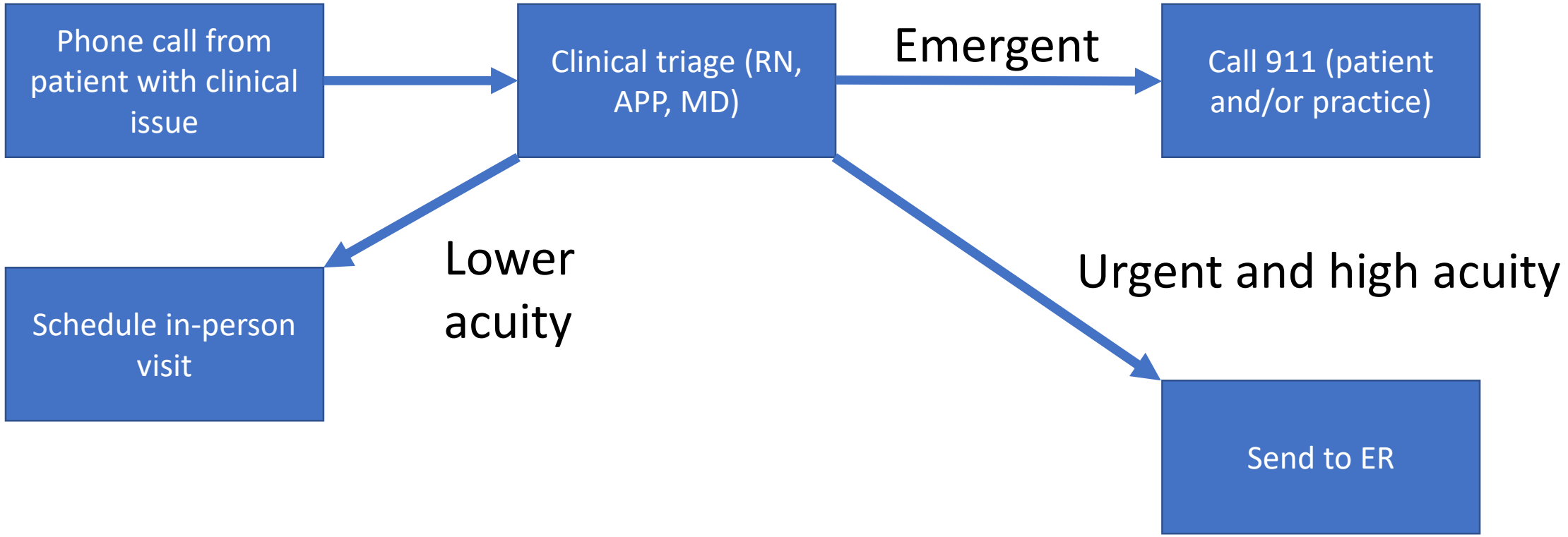
# News of the week/quick reminders

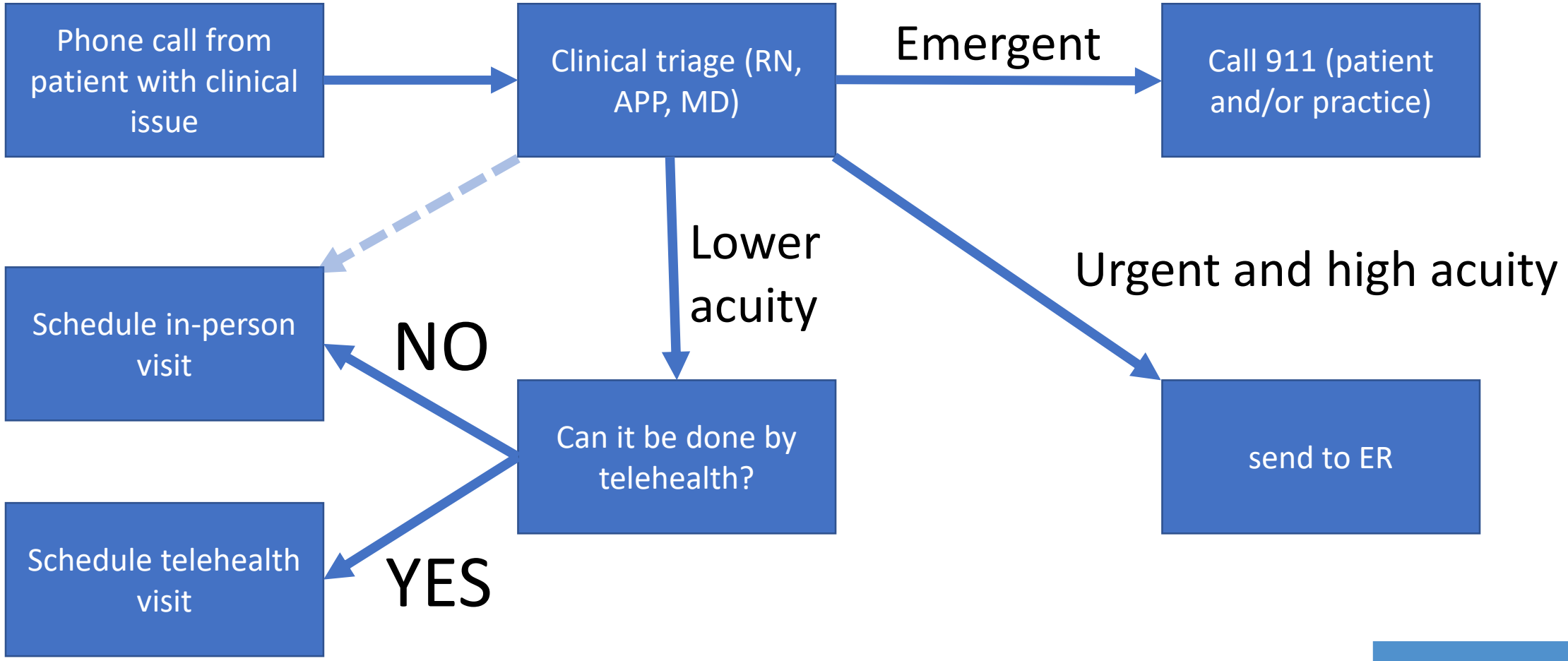
- Mass. Senate considering a bill which will maintain payment parity for telehealth for 2 years while the Health Policy Commission studies the issue and makes a recommendation

- **Hydroxychloroquine**: NO
- **ACEIs/ARBs**: Continue
- **Dexamethasone**: Helpful for CRITICALLY ILL PTS ONLY
- **Asthma**: Maybe not a risk factor for severe disease?
- **Transmission**
  - Indoors>>outdoors
  - distance and time no thresholds
  - Any kind of mask or face covering reduces transmission

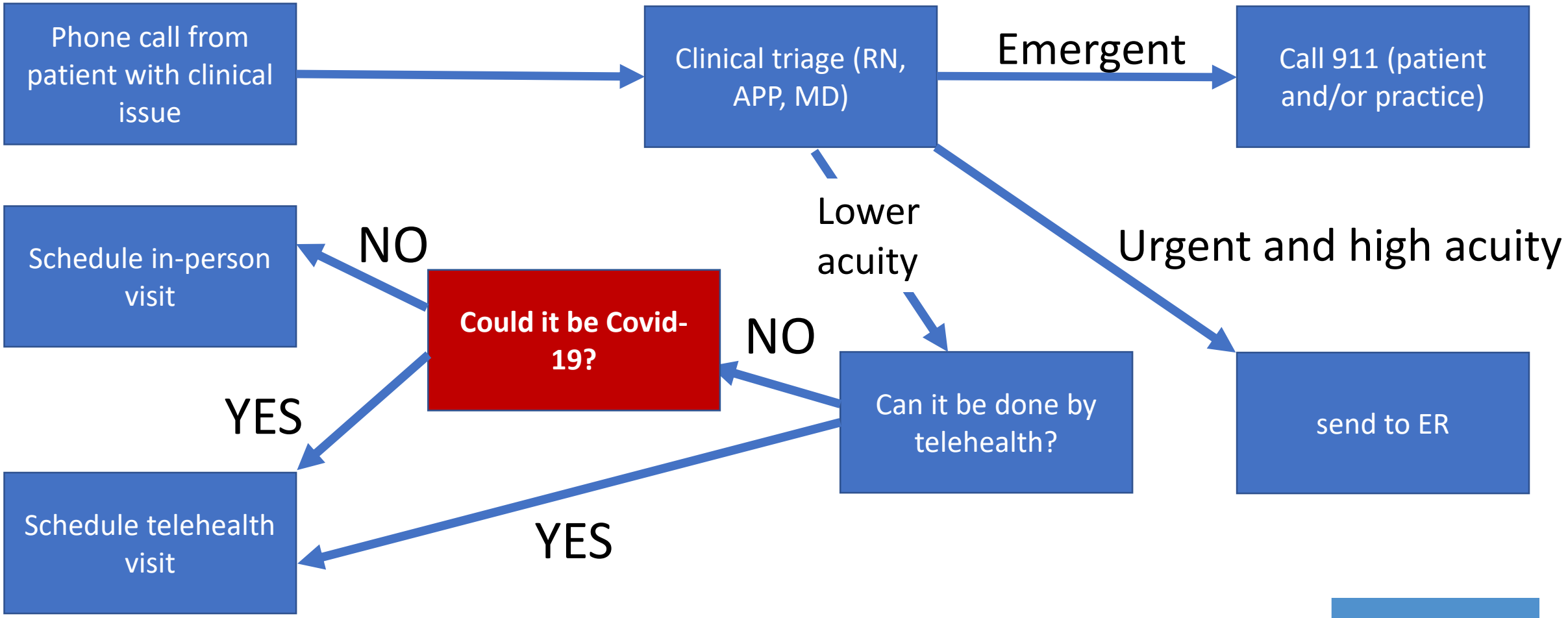
# Clinical phone triage decision tree (pre-COVID-19)



# Clinical phone triage decision tree including telehealth



# Clinical phone triage decision tree
## including telehealth and COVID-19 concern



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# Empiric data on LOW risk to health care personnel

- "Lai et al[2] described a cohort of 110 HCWs with symptomatic COVID-19 in a tertiary hospital in Wuhan, China, with more than 7000 beds that was designated to care for patients with COVID-19 in both outpatient and inpatient settings during the early phase of the epidemic. From January 1 to February 9, 2020, one-third of HCWs were deployed to high-risk areas, including fever clinics and wards, to care for 10 830 patients with confirmed or suspected COVID-19, and 17 of 3110 frontline HCWs (0.55%) were infected with SARS-CoV-2. This relatively low infection rate is reassuring, as it suggests that personal protective equipment, if available, can protect frontline HCWs directly caring for patients with COVID-19. However, the infection rate was higher, at 73 of 4433 HCWs (1.65%), among non-frontline HCWs who only cared for patients who did not fulfill the clinical and epidemiological criteria of COVID-19. Another 20 of 2012 HCWs without direct patient contact (0.99%) were also confirmed to be infected, which suggests a community source of infection." *Lai X, Wang M, Qin C, et al. Coronavirus disease 2019 (COVID-2019) infection among health care workers and implications for prevention measures in a tertiary hospital in Wuhan, China. JAMA Netw Open . 2020;3(5): e209666. doi: 10.1001/jamanetworkopen.2020.9666*
- Incremental risk to health care personnel (above community transmission) ~0.5%

# Empiric data on LOW risk to health care personnel (cont.)

- "Overall, health care workers in the Netherlands who were found to be infected were employed in 52 different hospital departments. The diversity of working locations among them suggests that hospital outbreak was unlikely; instead, the HCWs most likely acquired SARS-CoV-2 in the community."
  *Kluytmans-van den Bergh MFQ, Buiting AGM, Pas SD, et al. Prevalence and clinical presentation of health care workers with symptoms of coronavirus disease 2019 in 2 Dutch hospitals during an early phase of the pandemic. JAMA Netw Open . 2020;3(5):e209673. doi: 10.1001/jamanetworkopen.2020.9673*
- Same noted at Tufts Medical Center. No departmental clusters, rate of infection same in non-patient care areas as in patient care areas.

# COVID-19's effect on volume and acuity

- Net primary care (including in-person and telehealth) and ED volume are down
- Even normally urgent issues like chest pain/MIs, stroke, and workup of new cancer diagnoses are generating many fewer visits
- Two COVID-19-related contributors
  - Fear of infection
  - Cost (bigger concern now related to job loss/recession)

# Changing physicians

- **1/3 of people are considering changing PCPs because of the pandemic** (twice the pre-pandemic baseline)
- What factors affect choice of PCP and other care sites right now?
  - Safety
  - Reputation (Crowd-sourced)
  - Convenience (Control, choice, immediacy)
  - Affordability (loss of coverage, economic disruption)
- When appointments were cancelled due to the pandemic, 10-20% of patients were waiting to reschedule; 25-50% rescheduled with another provider or facility
- **Practices with strong safety communications are filling schedules 3x faster than those without**
- **Convenience, confidence and cost**

# Control/convenience/immediacy: whether and when to seek care

- For problem-based (reactive) care

- If an app or web site were available to guide patients through this, 66% of patients would use it; 60% would consider changing PCPs/health systems to get this capability

# Segmentation helps reduce fear

- Separate possibly infected (acute illness) from likely uninfected (wellness and chronic disease care)
  - Virtual >>spatial separation> temporal separation ??

- Wellness and chronic disease care
  - VIRTUAL, if possible
  - Eliminate waiting room for in-person care
  - Convenience, safety

# Virtual care is an expectation now

- Has quickly gone from *value-added* to *can't-do-without-it*
- Excellence in this space will rapidly distinguish practices
- (Initially begun quickly and without much planning; now with some breathing space, many are refining their approach and smoothing out their process, which will confer a significant competitive advantage)

# Practice survival is no longer a given

- Patients are showing us that less care is needed
- Safety is a distinguisher right now (Confidence)
- Patients want care on their own terms (Convenience)
- Cost must be lowered

# What can I do?

- Make sure your practice is safe, looks safe, and that you communicate to your patients often and effectively that you are keeping them safe: instill them with Confidence
- Make care as Convenient as possible—you're competing with retail clinics and urgent care sites
  - Online scheduling (e.g. ZocDoc)
  - Manage whatever you can without a face to face visit
    - Email/patient portal messages
    - Secure texting or instant messaging
    - Telephone
    - Video visit
- Understand and consider patient Cost for every suggested action (visit with you, visit with a specialist, prescriptions, imaging, etc.)
- Consider whether a different payment mechanism makes sense (e.g. PCP sub-capitation)

# COVID-19 Situational Update

## Questions

# Phase 2 Reopening Guidelines

**Ben Kruskal, MD**

**Medical Director**

# Phase 2: Reopening Guidelines from the State

- Whatever can be done by telehealth should STILL be done by telehealth.
- While routine care may now be provided in the office face to face if not possible to do via telehealth, providers should still prioritize more high-risk/urgent situations over routine care. (DPH suggested list)
- Defer non-essential care if PPE (or other essential materials) is in short-supply, or care would unavoidably include aerosol-generating procedures (high risk of Covid-19 transmission)
- For essential, non-deferrable invasive procedures, rooms must be left empty between procedures long enough to remove any possible airborne contamination.
- Elective cosmetic procedures may not be done in Phase 2

# Phase 2: Additional Policies Required

- Three additional written policies need to be formulated and attested to:
  - Prioritization policy for scheduling and delivery of non-urgent care must be established and applied consistent with healthy equity principles; the provider must attest that they are utilizing this policy in their determination of which patients should be seen in person.
  - Non-essential elective invasive procedure volume must be monitored to ensure it is not endangering PPE supply for essential procedures and services.
  - In addition to the infection control requirements of Phase 1, procedure rooms must be left empty in between procedures for a specified time frame necessary for sufficient air changes to occur to remove possible airborne contaminants, before disinfection

# Phase 2: Prioritization of clinical care: Principles

- Whatever can be done by telehealth should STILL be done by telehealth

- URGENT issues always come first (acute non-deferrable care for potentially serious issues)
- The prioritization policy should promote equitable access to care for all populations, without regard for patient's insurance type
- Defer elective non-essential care (procedures or other) that either:
  - Increases risk of possible Covid-19 transmission (e.g. aerosol-generated procedures)
  - Consumes scarce resources (e.g. PPE, or any vital item in short supply)
- Defer elective cosmetic procedures
- The prioritization can be modified by clinical judgement, but needs to be justifiable

# Phase 2: Prioritization of in-person care (continued)

- **First tier**
  - High priority preventive services (e.g. cancer screenings for HIGH-RISK patients)
  - Pediatric immunizations and other high preventive value care
  - Urgent procedures that would lead to high risk or worsening if deferred
- **Second tier**
  - Acute illnesses requiring in-person visit
  - Chronic illnesses
  - Patients with BH dx, disability, and/or SDOH risk factors regardless of insurance type
  - Adult preventive care which must be done in person
  - Progressive conditions which will worsen without intervention, or with sxs negatively affecting ADLs or QOL
  - Monitoring health status or progression of illness

# Phase 2: Room air clearance after invasive procedures

What are invasive procedures?

- Anything involving skin incision
- Injection into joint space or body cavity
- Cystoscopy
- Sigmoidoscopy
- Excision and deep cryotherapy of malignant lesions
- Invasive ophthalmic procedures
- Oral/dental procedures such as tooth extraction
- Podiatric procedures such as removal of ingrown nail
- Skin or wound debridement
- Colposcopy and cervical/endometrial biopsy

# Phase 2: Room air clearance after invasive procedures (cont.)

- For essential, non-deferrable invasive procedures, rooms must be left empty between procedures long enough to remove any possible airborne contamination.
- Time needed depends on ventilation rate (air exchanges per hour, ACH)
  - Find out the ventilation rate in your procedure (exam) rooms if possible
  - If not, typical patient care areas like exam rooms have 6-8 ACH
  - If perfect distribution of ventilation occurs, 99% clearance in 45 min at 6 ACH
  - https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1

# Phase 2: New attestation required

- New Phase 2 attestation form must be signed by senior person designated as compliance officer for the practice
- Practices with multiple locations may sign and maintain one attestation on behalf of providers at all locations, as long as the designated compliance officer has clinical and operational control over the other locations.
- Health care providers must prominently post a copy of the signed attestation form at each of its facilities, clinics, and office locations.

# Additional Q&A

# Helpful Programs and Resources

**Ben Kruskal, MD**

**Medical Director**

# Mark your Calendars

## NEQCA COVID-19 Webinars

**Wednesdays, 5:30-6:30 p.m.**

- **July 8**
- **July 15 – Dr. David Thaler, Neurologist-in-Chief, Tufts MC**
- **July 22**
- **July 29**

## NEQCA Coding Sessions

**Risk Adjustment & more**

**Thursdays, Noon-1 p.m.**

- **July 9**
- **August 13**

**Upcoming:**

**NEQCA Practice Reactivation Drop-In Q&A:**

- **Friday, June 19:** 12:00 p.m. - 1:00 p.m

**NEQCA COVID-19 Updates:**

**Thursday, June 18:** 5:30 p.m. - 6:30 p.m.

**Wednesday, June 24:** 5:30 p.m. - 6:30 p.m.

**Wednesday, July 8:** 5:30 p.m. - 6:30 p.m.

**Wednesday, July 15:** 5:30 p.m. - 6:30 p.m.

**Wednesday, July 22:** 5:30 p.m. - 6:30 p.m.

**Wednesday, July 29:** 5:30 p.m. - 6:30 p.m.

**Coding Sessions with NEQCA - Risk Adjustment & More:**

**Thursday, July 9:** 12:00 p.m. - 1:00 p.m.

**Thursday, August 13:** 12:00 p.m. - 1:00 p.m.

**Recent:**

**NEW:** COVID-19 Update and Cardiovascular aspects of COVID-19 with Dr. Amanda Vest Presentation and Webinar (start video at 9:06) - June 11, 2020

NEQCA Practice Reactivation Drop-In Q&A Presentation and Webinar - June 16, 2020

NEQCA Practice Reactivation Drop-In Q&A Presentation and Webinar - June 12, 2020

NEQCA Practice Reactivation Drop-In Q&A Presentation and Webinar - June 8, 2020

COVID-19 Update with Dr. Cody Meissner: Presentation and Webinar - June 3, 2020

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



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# Take Time for Self Care


## THE FOURTH AIM: HIGHER CLINICIAN SATISFACTION

NEQCA is committed to improving the work life balance and wellbeing of our clinicians by reducing administrative burdens and developing new programs to address these challenges. NEQCA's **Clinician Wellbeing and Satisfaction Council** was established following a review of the findings from a 2019 NEQCA Clinician Satisfaction Survey. Council members serve as advisors, champions, ambassadors and catalysts for wellbeing throughout our Network. The Council is co-chaired by Dr. Andrew Chandler of Hallmark Health Medical Associates/Tufts MC Community Care in Somerville and Dr. Jatin Dave, NEQCA Medical Director. Council membership is open to any interested clinician in the NEQCA Network, including physician assistants, nurse practitioners and other advanced practice clinicians.

This page offers expert guidance and recommended resources, to help understand physician burnout and maintain emotional health and wellbeing.

## CLINICIAN WELLBEING RESOURCES

- **NEW:** Caregivers Grand Rounds June 15, 2020: Finding Balance/ Avoiding Burnout: How to Take Care of Yourself and Your Colleagues
- VIDEO: Caregiving Grand Rounds: Peer Support and Wellbeing in the time of COVID-19 - Joe Shapiro, MD, FACS
- VIDEO: Caregiving Grand Rounds: Witnessing, Loss and Grief in COVID Time: What Truly Matters - Kaethe Weingarten, PhD
- VIDEO: Caregiving Grand Rounds: A Secure Core of Compassion and Awareness for an Insecure Time - John Makransky, PhD
- VIDEO: Caregiving Grand Rounds: Maintaining Compassion for Self and Others-William Kahn
- VIDEO: Caregiving Grand Rounds: Stress Management and Resilience Building at Time of COVID 19



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# 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)

# Final Questions