NEQCA COVID-19 Update

April 14, 2020

About this presentation

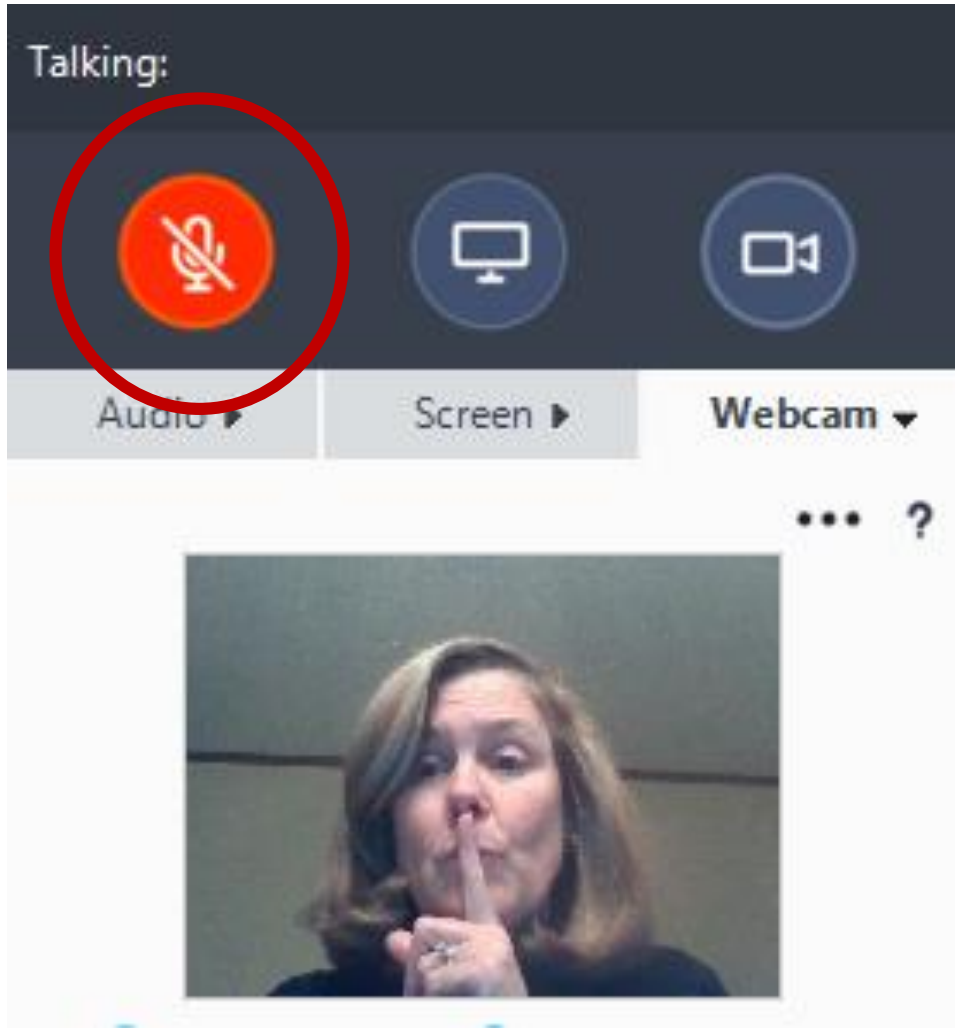
On Tuesday, April 14, NEQCA provided a clinical update on COVID-19, for NEQCA's LCO Leadership including Presidents, Administrators and Medical Directors. Topics discussed include crisis standards of care, the role of Palliative care and NEQCA care management. Disclaimer: The information in this presentation is relevant as of 4/14/20. The situation, however, is changing rapidly. To ensure you have the latest information on COVID-19, use the resources below:

- **Stay Informed: Enroll in MDPH COVID-19 Text Notifications**
- COVID-19 Cases in Massachusetts (Map)
- COVID-19 Cases in Mass: Mass DPH (Data)
- The COVID Tracking Project
- **Global and National impact:** Centers for Disease Control
- **Situation in Massachusetts:** Massachusetts Department of Public Health
- **COVID-19 Resource Center:** Infectious Diseases Society of America
- **Travel Restrictions:** U.S. State Department

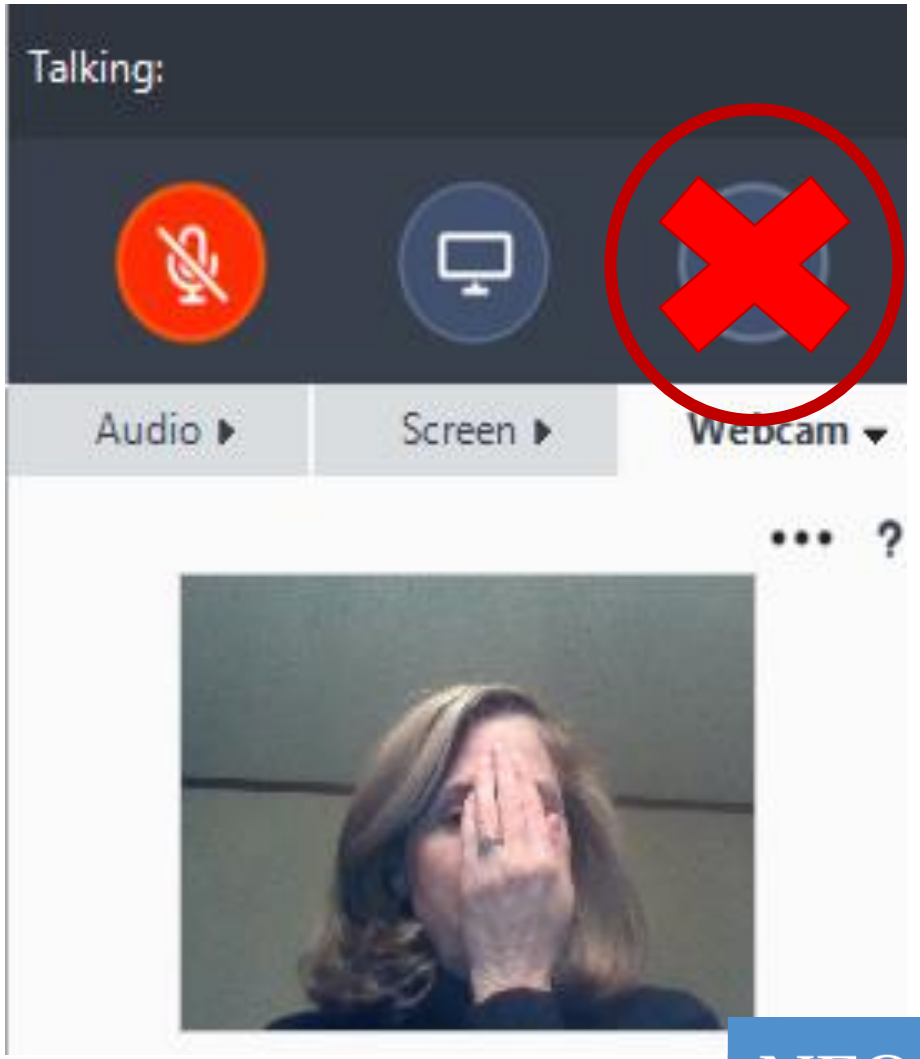
Agenda

- Webinar Moderation Guidelines
- Opening Comments
- COVID-19 Situational Update and Crisis Standards of Care
- Role of Palliative Care During Pandemic
- NEQCA Care Management Update
- Helpful Resources

Please Mute



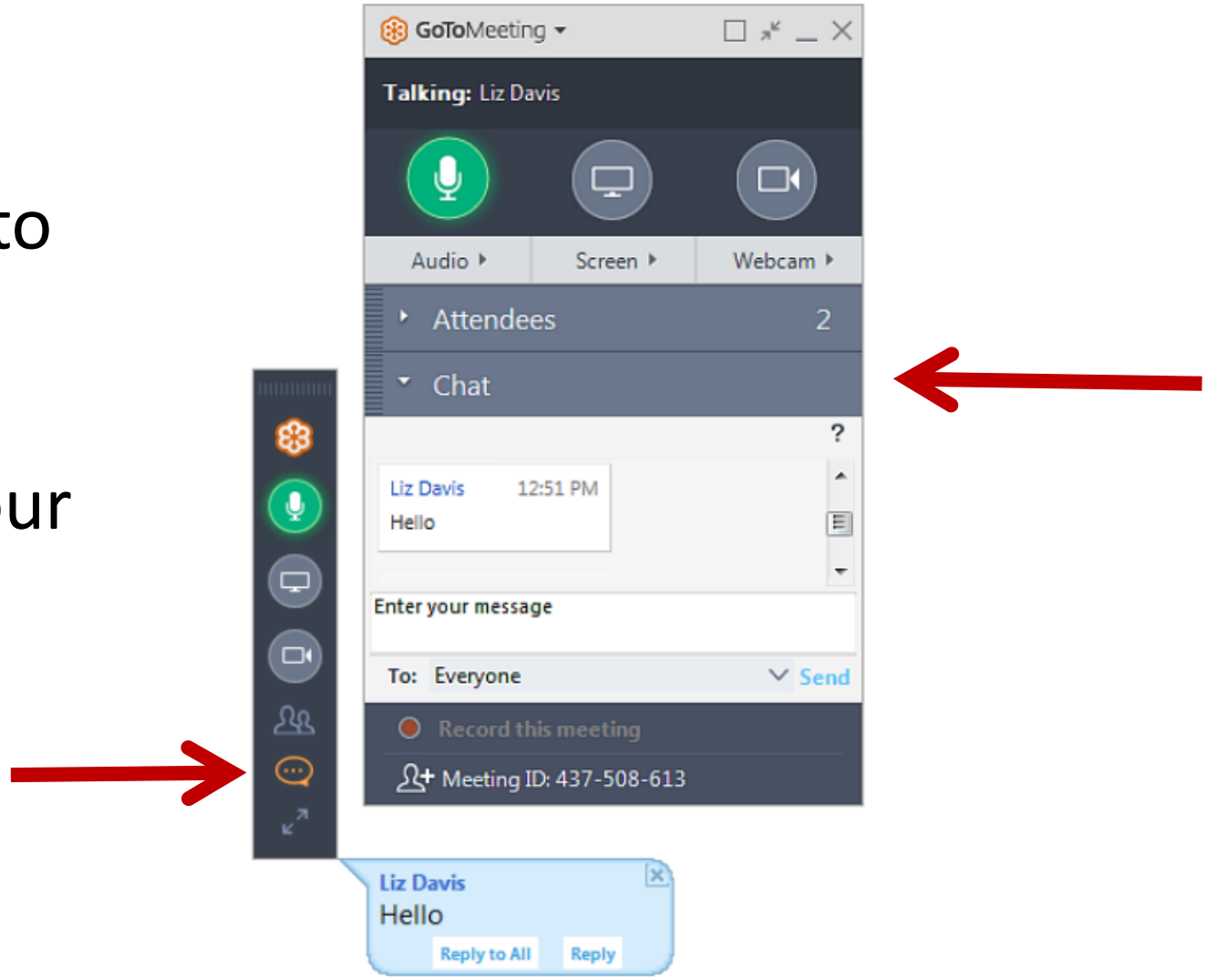
No Webcam



NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

To Ask A Question

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



NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

Opening Comments

Joseph Frolkis, MD, PhD

CEO and President

.

COVID-19 Situational Update and Crisis Standards of Care

Ben Kruskal, MD

Medical Director

NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

Current Situation (as of 8 a.m. 4/14/20)

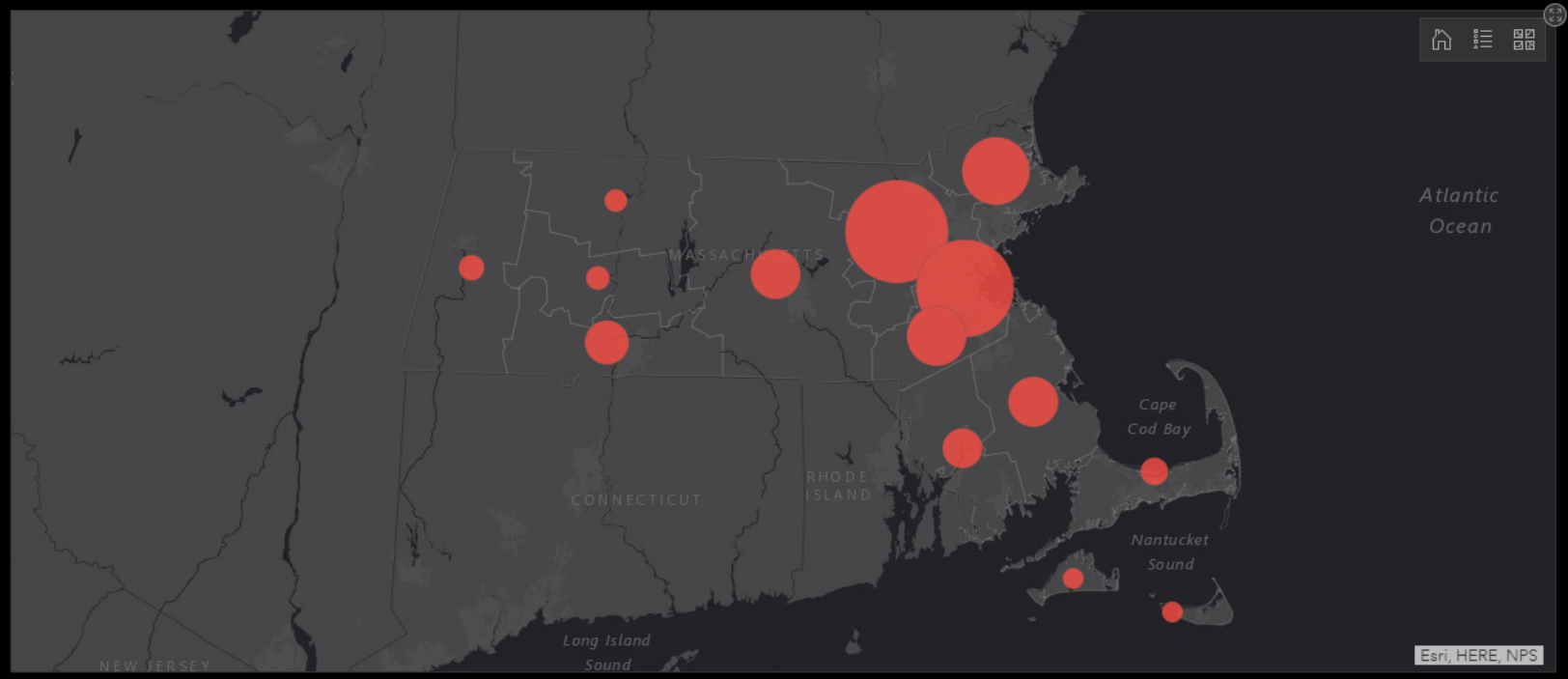
Tests/hospitalizations/deaths

- US 578K//23K
- Mass 27K/2.3K/844
- Wellforce 158 inpatients (including ICU)
- Field hospitals Post-acute care: BCEC, DCU Center (Worcester), Joint Base Cape Cod, Lawrence Memorial Hospital
- Tufts/Floating specialists available by telehealth!

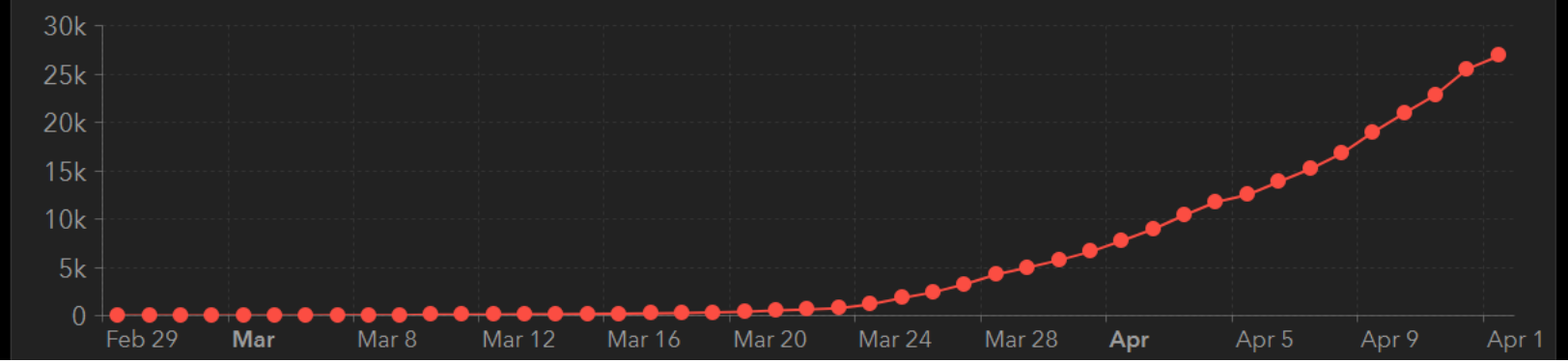
Coronavirus COVID-19 Cases in Massachusetts

Total Cases
26,867

Cases by County
- **5,983** MIDDLESEX
- **5,579** SUFFOLK
- **3,413** ESSEX
- **2,838** NORFOLK
- **2,141** PLYMOUTH
- **2,128** WORCESTER
- **1,694** HAMPDEN
- **1,394** BRISTOL
- **502** BARNSTABLE
- **447** UNKNOWN
- **355** BERKSHIRE
- **224** HAMPSHIRE
- **148** FRANKLIN
- **12** DUKES
- **9** NANTUCKET



Total Cases Over Time



Total Deaths
844

Sex
- **14,038** Female
- **11,954** Male
- **875** Unknown

Hospitalization
- **17,849** Under investigation
- **6,678** Patient was not hospitalized
- **2,340** Patient was hospitalized

Last updated on
4/13/2020

Data from Massachusetts Department of Public Health and MEMA
Updated based on data availability, usually around 5pm daily.

Link on NEQCA COVID-19 Website

NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

Crisis Standards of Care: Part 1

An **ethical framework for allocation of scarce resources** during a crisis/disaster/pandemic which temporarily overwhelms our ability to deliver usual care to every patient

- Based on prior local input in terms of which values to prioritize
- Work in Mass and nationally: mid 2000s including Mass citizen engagement
- IOM produced national reports in 2007 and again in 2012
- Mass group published results of local work in 2009, has been revised locally in 2017 and just now

Crisis Standards of Care: Part 2

Three stages

- **Conventional** standards of care (how we normally provide care)
- **Contingency** standards of care (when demand/circumstances force us to do things differently but we are still able to deliver the full level of care to all patients; e.g. use of additional/alternate spaces; redeploying staff outside of their accustomed specialties)
  this is where we are now
- **Crisis** standards of care [volume and severity of patients overwhelms our limiting resource(s) and forces us to make choices about which patients get the limiting/scarce resource(s)]

Crisis Standards of Care: Part 3

Key principles

- *Maximize number of lives saved*
- *Maximize number of life-years saved/stages of life*

- Prioritize people for scarce resources based on predicted short term and long term survival using objective tools (e.g., SOFA score for short-term)
- Patients who don't get scarce resource still get maximal possible support including palliative care as indicated
- Constant re-evaluation and possible transfer of scarce resources to higher priority new patients
- Prioritize people who are essential to the public health response—e.g., treating patients, maintaining societal order

Our Goal: To Save Lives

- Hospitals keep critically ill patients alive
- By **keeping unnecessary visits out of the EDs,** our practices give the hospital more capacity to deal with more severe emergencies
- Nobody should be seeing *possible COVID-19* unless they have appropriate PPE
- **Keep practices open**
  - So you can continue to provide care
  - So you can survive financially

Avoiding ER visits

- Collaboration with local specialists to avoid ER visits
  - Identify, connect with key specialists
    - Orthopedics (Injuries/?fractures; ?Plain films available?)
    - General surgery (Lacerations, FB)
    - Ophthalmology (FB, injury, acute visual changes)
    - ENT (FB, acute hearing loss)
  - Make masks available in small numbers when requesting they see your non-respiratory patient
- Remember Shields available for urgent CT/MRI
- NEQCA Central looking into home care for IV infusions (fluids, some meds)

COVID-19 Transmission/Precautions

- **Route of transmission: Respiratory droplets**
  - **simple facemask ("Surgical mask") is effective**
    With Eye protection, gloves (Gowns)
  - **N95 NOT needed in outpatient setting (NO Nebulizers)**

- **Surfaces +/-**
  - Soaps and any surface disinfectant are effective
  - Includes quaternary ammonium (quats like Lysol/benzalkonium), 70% alcohol, dilute bleach (1:100 for this purpose), peroxide and any soap or detergent meant for surface cleaning

What to do if you don't have PPE

- **Cloth masks**
  - A few studies suggest these are **significantly less effective** at preventing other respiratory viral infections or penetration of particulates than standard disposable surgical masks
  - **"Has to be better than nothing" ???**
    - Good for source control
    - Potential risk: outside surface gets contaminated, touch can infect us
- **PPE from state?**
  - https://www.mass.gov/info-details/guidance-for-requesting-personal-protective-equipment-ppe

What care can be delivered without risk?

What can you do via telehealth?

- Acute care & triage
  - Respiratory disease (possible Covid-19)
  - Other acute urgent issues (injuries, belly pain, severe gastroenteritis)
  - Some requires follow up hands-on care (exam, treatment)
- Follow-ups for chronic disease
  - HTN: does pt have home BP cuff?
  - DM
  - Asthma: symptoms, Peak flow
- Preventive care/Annual wellness visits/Well child care
  - Necessary immunizations (e.g. infants) require face-to-face visit
- Remember creative physical exam via telehealth
  - Inspection
  - Self- or family member-palpation; jumping up and down to assess abd pain

Testing for COVID-19 – Part 1

- **Currently PCR is only technique available**
  - Detects viral RNA fragments, not intact/transmissible virus
- **Why test/who to test?**
  - ONLY symptomatic individuals (negative in asymptomatic doesn't mean they're not incubating)
  - Who they have exposed? (Public health relevance; HCW, first responder, congregate settings like SNFs, group homes, etc.)
  - Very sick patients (relevant inpatient for cohorting, infection control, possible clinical trials)
  - High-risk outpatients (follow more closely)
  - Contact tracing and quarantine/isolation: DPH/Partners in Health/Community health centers

Testing for COVID-19 – Part 2

- **Testing options**
  - *Specimen collection at full service testing sites* (list on DPH website, updated daily), test sent by them to their preferred lab
    - Pt can sometimes be tested based on clinician order if pre-screened by clinician for eligibility; sometimes must be seen by testing site clinician
  - *Specimen collection in office*
    - Test run by Quest (or other commercial lab)
    - Working on arranging: test run at Tufts Medical Center
  - Swabs becoming more available—from labs and suppliers (Also 3d printing)
  - Viral transport medium available from labs (Quest, Tufts)

COVID-19 PCR: False positives and negatives

- **False positives**
  - Residual viral fragments persisting on the mucosa after transmissible virus is all gone (Same principle applies to other tests for infection using PCR detection, e.g. Chlamydia): we don't know how long
  - Laboratory contamination
- **False negatives**
  - Swabbing technique
  - Choice of anatomic site (Sensitivity: NP >OP > Nose)
  - PCR inhibitors (e.g., from inappropriate swab)
  - Timing (e.g., during early incubation period

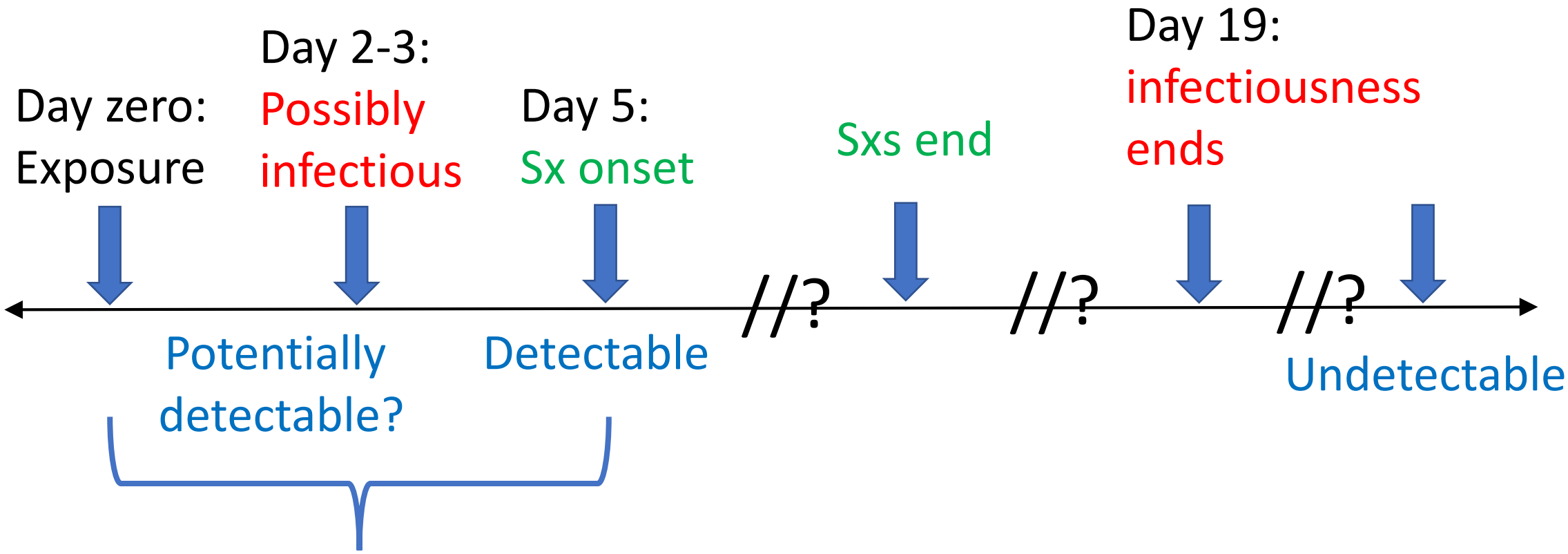
Protective immunity?

- Not well characterized yet for SARS-CoV-2/COVID-19 but…

- In comparison with other respiratory viral infections
  - The reason we recover is because an immune response occurs and eradicates the virus
  - Duration of protective immunity varies; some lifelong, some months or 1-2 years
  - Antibodies (most easily measured component of immune response) may or may not be the protective mechanism
  - Convalescent plasma as treatment
  - Covid-19 early reinfection likely very rare
    - Apparent cases are likely false positives: residual viral fragments persisting on the mucosa after transmissible virus is all gone

  - Serology testing starting to be available (commercial; Tufts Medical Center around end of April)

Timeline of SARS-CoV-2 infection



Incubation period 2-14 days

//?= unknown length of time

Remote Assessment of Respiration

- **Non-medical grade pulse oximeters and apps**
  - Inexpensive pulse oximeters sold online
  - Pulse oximetry smartphone apps
  - I DO NOT RECOMMEND use at this time
- **Clinical triage tools**
  - None validated; some expert opinions
- If using telehealth, remember inspection as well as listening to speech

Potential Treatments

- NOT RECOMMENDED: hydroxychloroquine and chloroquine (+/- azithromycin)
  - No real evidence of efficacy. Initial “studies” deeply flawed.
  - Real risks!
    - Brazil study high dose arm stopped due to high number of patients with severe QTc prolongation and more deaths in that group
- Investigational IV: remdesivir, biologic anti-cytokine storm (tocilizumab, sarilumab)
- Convalescent plasma

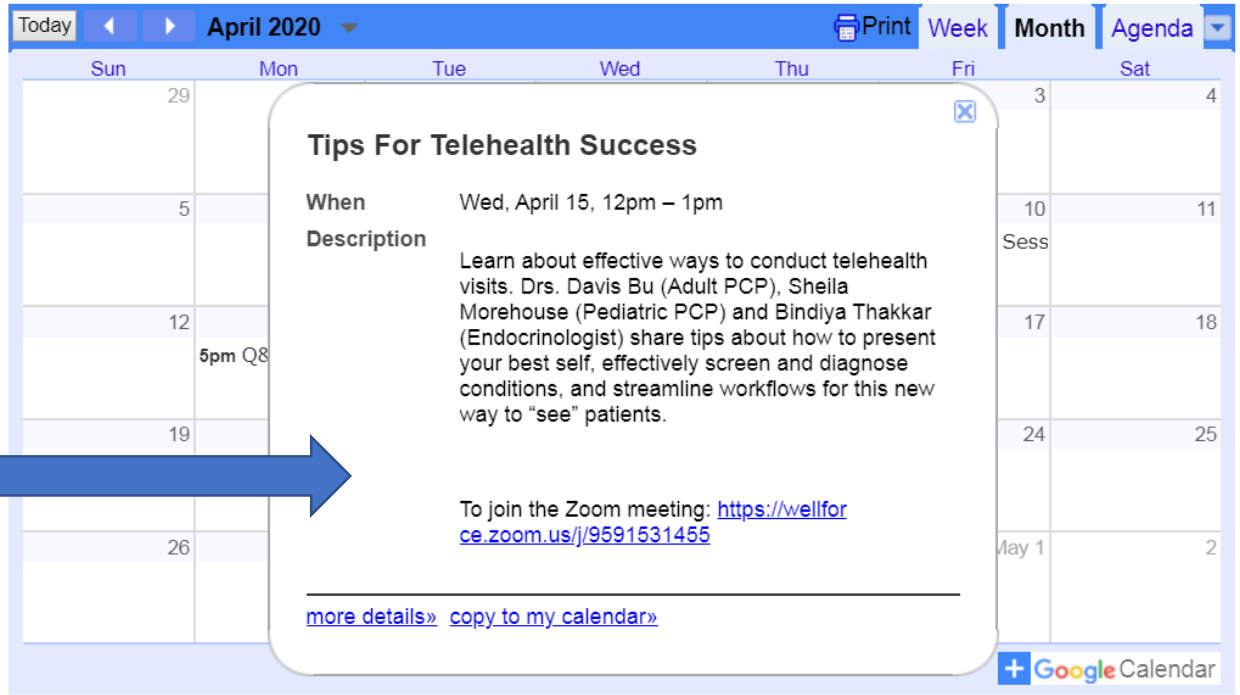
Tomorrow: Tips for Telehealth Success

Wednesday 4/15
Noon - 1:00 p.m.

Featuring
Dr. Davis Bu (Adult PCP),
Dr. Sheila Morehouse (Pediatric PCP) and
Dr. Bindiya Thakkar (Endocrinologist)

Visit neqca.org for meeting details

PROGRAMS FOR OUR NETWORK



NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

COVID-19 Situational Update and Crisis Standards of Care

Questions.

Role of Palliative Care During COVID-19 Pandemic

Jatin Dave, MD

Chief Medical Officer

Outline

A. Three Core Applied Principles of Palliative Care in view of COVID-19 Pandemic
    1. Tips on communication
    2. Prognostication scales/tools
    3. High-yield resources on Primary Palliative Care especially on symptoms management
B. Additional tips on applying these principles virtually (when using telehealth)
C. Indications for additional help for Specialist Palliative Care

Three Core Applied Principles of Palliative Care

1. Discussion of Patient Wishes/Goals/Expectations, Articulation of Goals of Care, Sympathetic repeated-Stepwise Explanation of Facts and Align Treatment Plan-Communication
2. Minimize suffering via aggressive symptom control
3. Psychosocial support including for family/caregivers

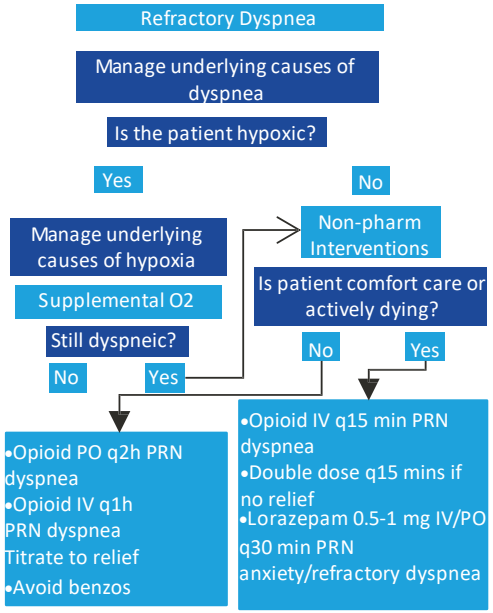
Role of Palliative Care in COVID-19 Pandemic

- **Communication:** Engage all patients to plan treatment decisions in advance (starting with the highest-risk patients); Provide step-wise guidance at each stage/visit, and summarize/document using standard format (MOLST)
- **Aggressive Symptoms Management:** For three groups of patients:
  - People with symptomatic COVID-19
  - People dying without ventilator support
  - People requiring hospitalization and ventilatory support

  Help manage patients at HOME who DO NOT WANT to go to hospital (and appropriately care for those who do not want to receive ventilator support).
- **Psycho-socio-spiritual Support:** For patients/families including the care of bereaved families including the care newly deceased bodies with dignity

A Pocket Care on Palliative Care for COVID-19

Relief of Dyspnea



Non-Pharmacologic Interventions:

- Bring patient upright or to sitting position
- Consider mindfulness, mindful breathing

Pharmacologic Interventions:

- Opioids are treatment of choice for refractory dyspnea
- For symptomatic patients, using PRN or bolus dosing titrated to relief is more effective and safe compared to starting an opioid infusion

Dosing Tips:

- For opioid naïve patients
  - PO Morphine 5-10 mg
  - PO Oxycodone 2.5-5 mg
  - IV/SC Morphine 2-4 mg
  - IV/SC Hydromorphone 0.4-0.6 mg
- Consider smaller doses for elderly/frail

Opioid Quick Tips

Pharmacodynamics of Opioids:

- **Time to peak effect / Duration of Action**
- **PO Opioids: 30-60 minutes / 3-4 hours**
- **IV Opioids: 5-15 minutes / 3-4 hours**
- Time to peak effect is the same for analgesia, relief of dyspnea, and sedation

Other Opioid Principles:

- **If initial dose of IV opioid is ineffective** after 2 doses at least 15 minutes apart, double the dose
- Typically **need 6-8 hours of controlled symptoms to calculate a continuous opioid infusion**
- **If starting a continuous infusion**, do not change more often than every 6 hours. Adjust infusion dose based on the 24 hour sum of PRNs

Relative Strengths & Conversion Table

Opioid Agent	Oral Dose	IV Dose
Morphine	30	10
Oxycodone	20	--
Hydromorphone	7.5	1.5

*Avoid fentanyl due to shortage

If Using Opioids, Start a Bowel Regimen:

- Goal is 1 BM QD or QOD, no straining
- Senna 2 tabs q HS, can increase to 4 tabs BID
- Add Miralax 17 gm daily, can increase to BID
- Bisacodyl 10 mg suppository if no BM in 72 hrs

Tips on Communication Skills

What They Say	*What You Say*
How bad is this?	From the information I have now, your loved one's situation is serious enough that your loved one should be in the hospital. **We will know more over the next day**, and we will update you.
Is my mother going to make it?	**I imagine you are scared.** Here's what I can say: because she is 70, and is already dealing with other medical problems **it is quite possible that she will not make it out of the hospital. Honestly, it is too soon to say for certain.**
Shouldn't she be in an intensive care unit?	You/your loved one's situation does not meet criteria for the ICU right now. We are supporting her with treatments (oxygen) to relieve her shortness of breath and we are closely monitoring her condition. **We will provide all the available treatment we have that will help her and we'll keep in touch with you by phone.**
What happens if she gets sicker?	If she gets sicker, we will continue to do our best to support her with oxygen and medicines for her breathing. If she gets worse despite those best treatments, she will be evaluating for her likelihood of benefiting from treatment with a ventilator. I can see that you really care about her.
How can you just take her off a ventilator when her life depends on it?	Unfortunately her condition has gotten worse, even though we are doing everything. She is dying now and the ventilator is not helping her to improve as we had hoped. This means that we need to take her off the ventilator to make sure she has a peaceful death and does not suffer. I wish things were different.
Resuscitation Status COVID-19	***Example Language***
Approach to when your clinical judgment is that a patient would not benefit from resuscitation	Given your overall condition, **I worry that if your heart or lungs stopped working, a breathing machine or CPR won't be able to help you live longer or improve your quality of life**. My recommendation is that if we get to that point, we use medications to focus on your comfort and allow you to die peacefully. This means we would not have you go to the ICU, be on a breathing machine, or use CPR. I imagine this may be hard to hear.
If in agreement:	These are really hard conversations. **I think this plan makes the most sense for you.**
If not in agreement:	These are really hard conversations. **We may need to talk about this again.**

When/How to Call for Help

[Insert Your PC Program Contact Info Here]

We are here to help. We've got your back.

In addition to typical circumstances and consults, please consult us if:
•Patient in respiratory distress and not getting comfortable with initial efforts

Additional Resources

www.capc.org/toolkits/covid-19-response-resources/

Download these apps (Google Play or App Store) for more palliative care resources:

VitalTalk Tips (Communication)

Fast Facts (Symptom Management)

Current as of 3/27/2020. Stanford Health Care. Acknowledgements: MGH Continuum project, CAPC, VitalTalk, Gary Hsin, Karl Lorenz, Stephanie Harman, Ashley Bragg, Shireen Heidari, and Grant Smith, Modified by Diane E. Meier

A Bit More On Communication

- Explore, understand and document patient's goals of care

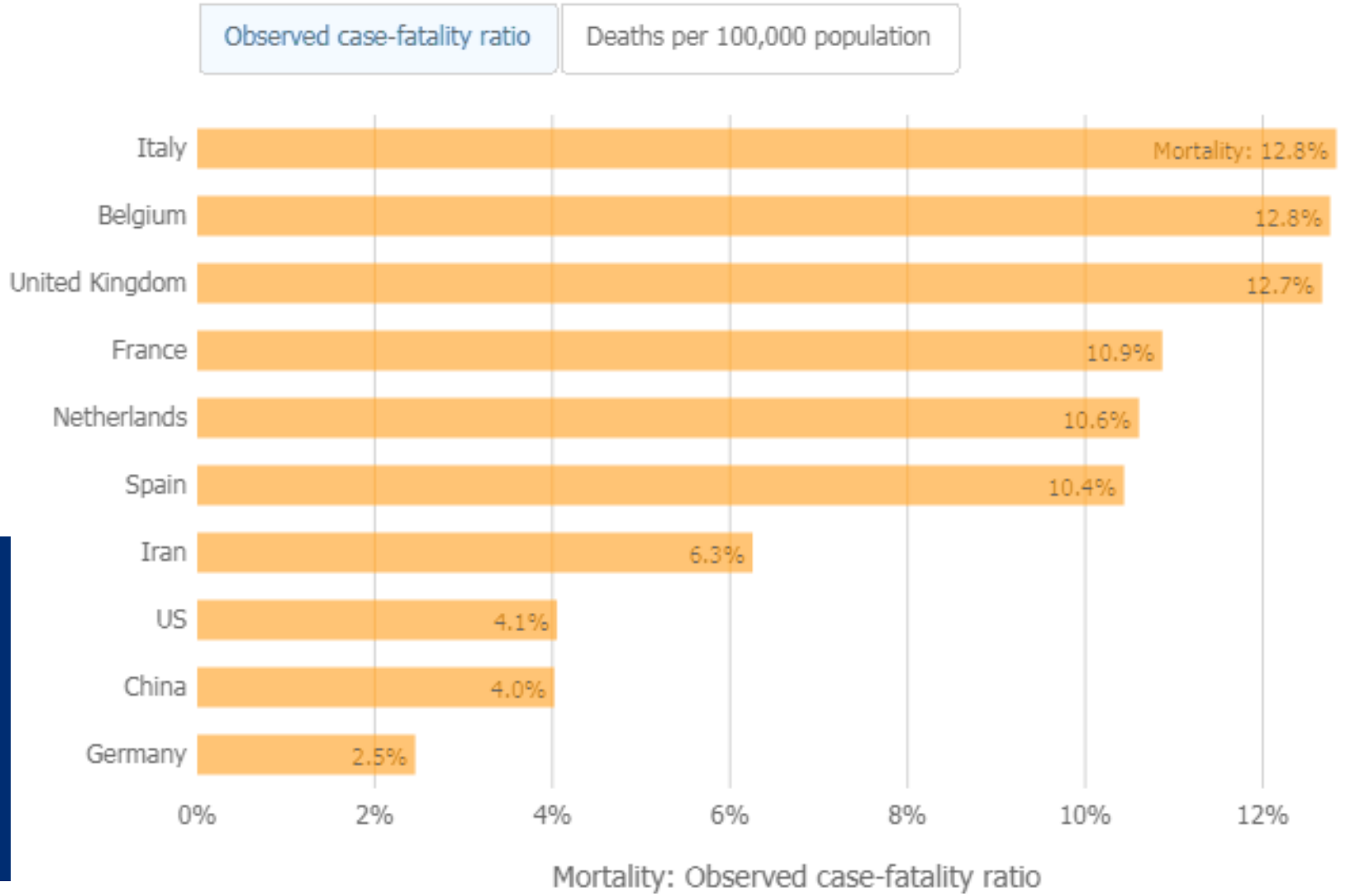
- Check, with patient permission, share the facts on COVID-19 and expected trajectories and its implications based on patient's goals of care

- Align, negotiate and develop a mutually agreed upon care plan with clear directives and directions (e.g., using if … then …)

COVID-19 Facts (as of April 8, 2020 at noon)

	Reference:			Mass DPH Data 25,475 (out of 116,730 tested, i.e. 22% test positive rate)		
	Risk of Hospitalization	ICU Stay/Ventilatory Support	Case-Fatality Rate	Risk of Hospitalization	ICU Stay/Ventilatory Support	Case-Fatality Rate
Overall	20%	3% (higher in some studies)	2%	2,235 (8.8% Hospitalization Rate among test positive)		756 deaths (~ 3% mortality among test positive)
Once Hospitalized	NA	20%	13%			
Once In ICU	NA	NA	Up to 65%			
Comments	LOS	LOS				

Mortality Rate varies by many factors including % Older adults,# of Tests, Healthcare response, Time to follow up



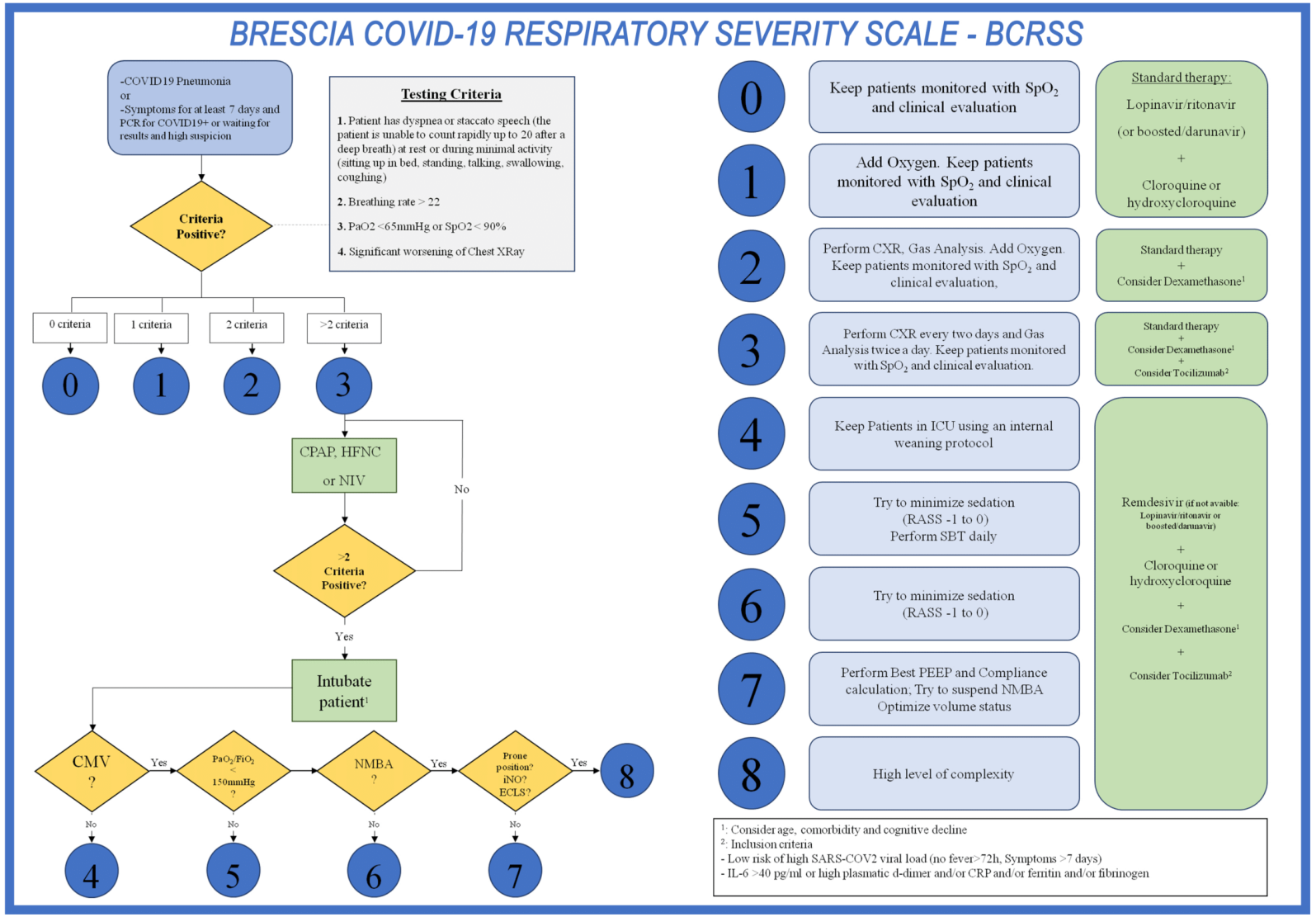
JOHNS HOPKINS
UNIVERSITY & MEDICINE

CORONAVIRUS
RESOURCE CENTER

https://coronavirus.jhu.edu/data/mortality

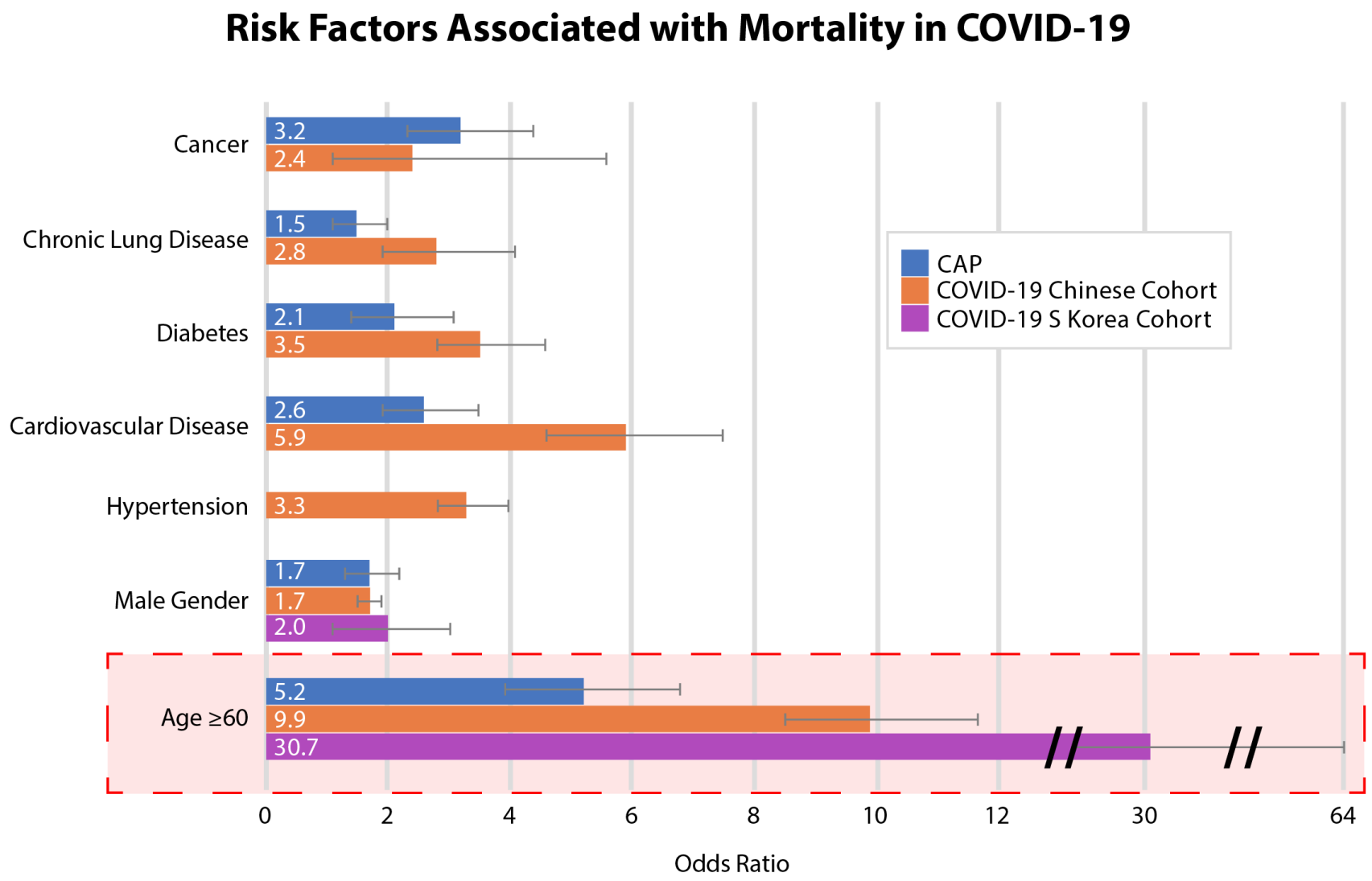
NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

An Example of Severity Scale to Guide Treatment



https://www.mdcalc.com/covid-19#nnt

More User-Friendly Summary of Risk Factors

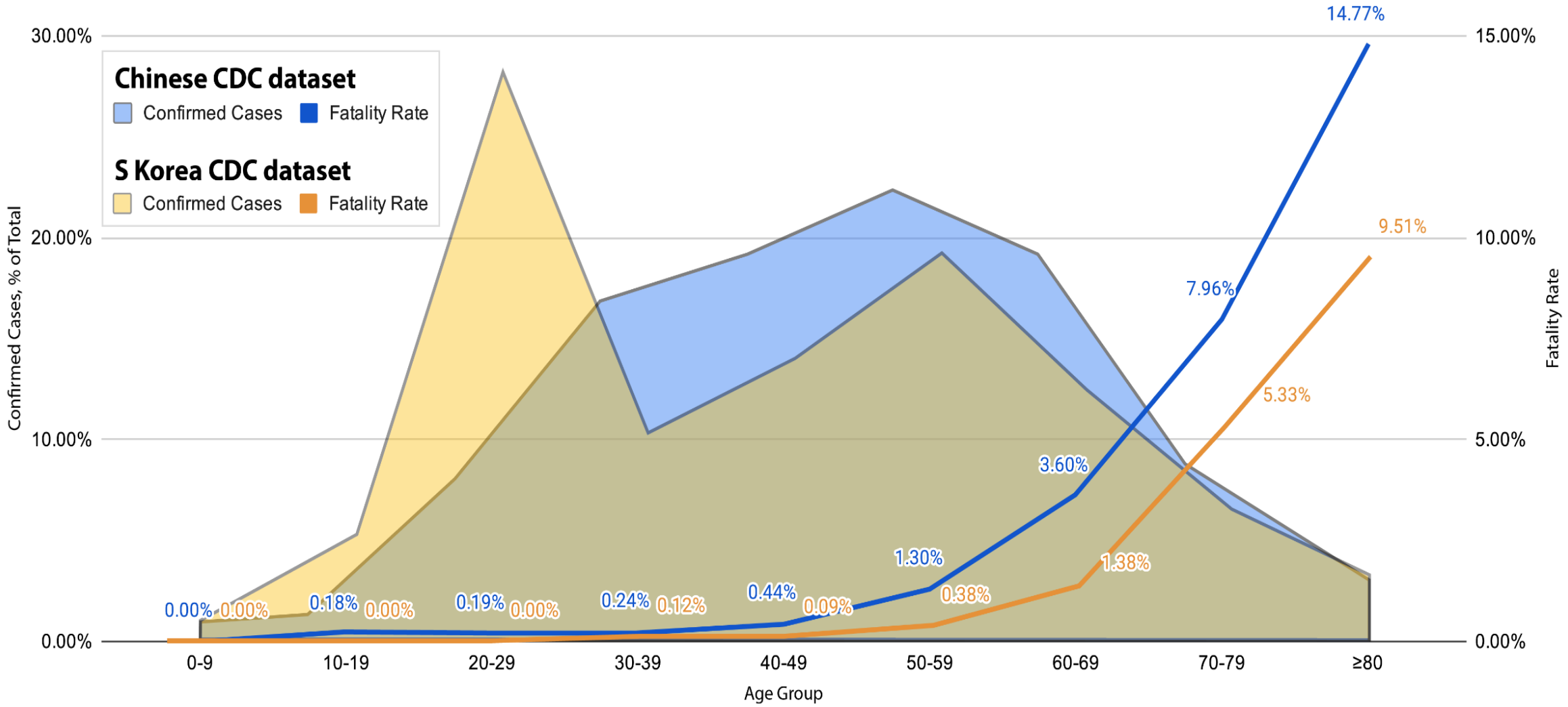


NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

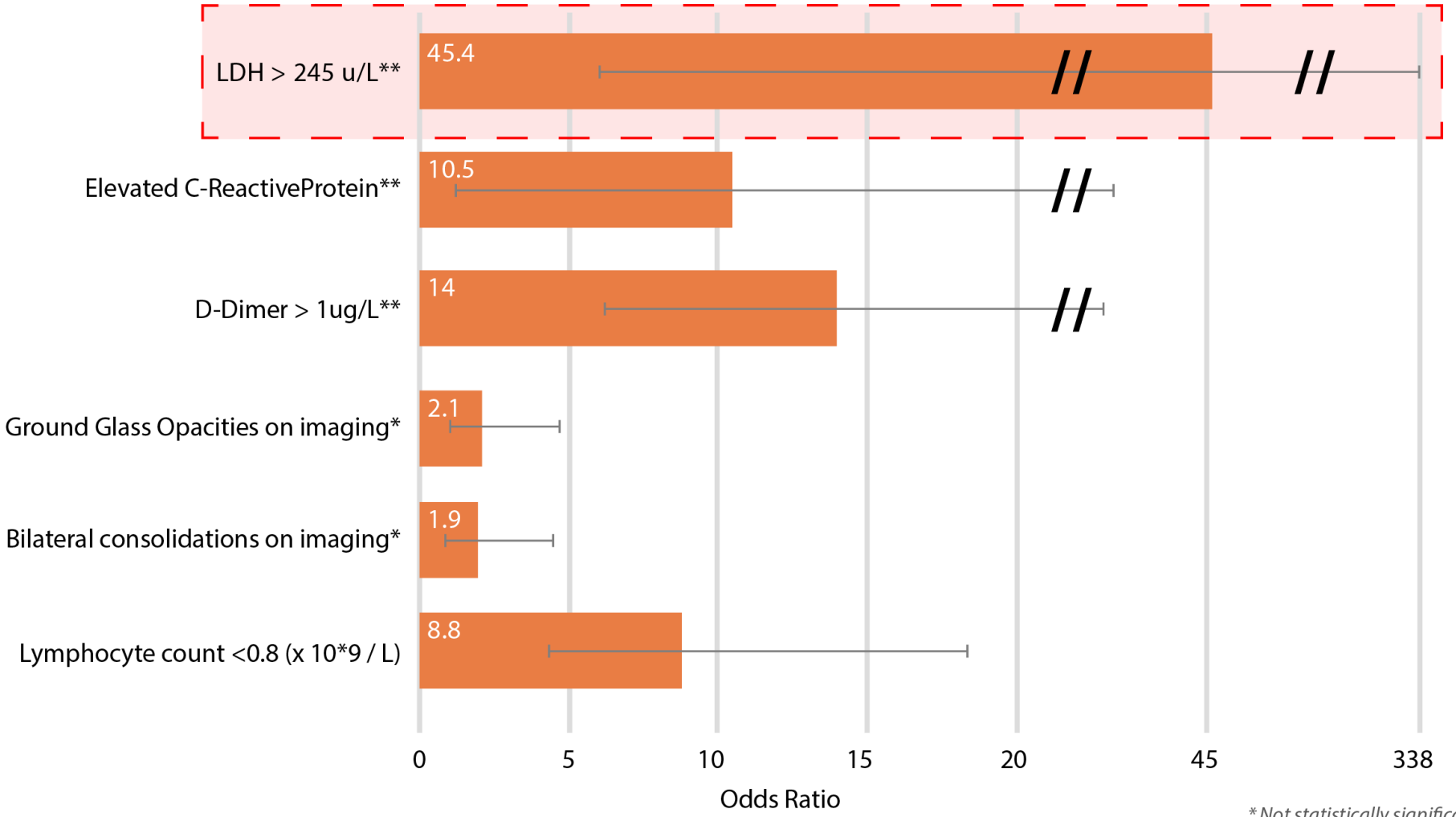
More User-Friendly Summary of Risk Factors

	Odds Ratio and 95%CI		
Factor	**CAP[1]**	**COVID-19[2,3] Chinese Cohort**	**COVID-19[6] S Korea CDC Cohort**
Age ≥60[†]	5.2 (3.9 - 6.8)	9.9 (8.5 - 11.7)	30.7 (14.7 - 64)
Male gender	1.7 (1.3 - 2.2)	1.7 (1.5 - 1.9)	2.0 (1.2 - 3.1)
Hypertension	-	3.3 (2.8 - 4.0)	
Cardiovascular disease	2.6 (1.9 - 3.5)	5.9 (4.6 - 7.5)	
Diabetes	2.1 (1.4 - 3.1)	3.5 (2.8 - 4.6)	
Chronic lung disease	1.5 (1.1 - 2.0)	2.8 (1.9 - 4.1)	
Cancer	3.2 (2.3 - 4.4)	2.4 (1.1 - 5.6)	

Chinese CDC and South Korea CDC Confirmed Cases and Fatality Rate by Age Group



Laboratory values associated with mortality



** Not statistically significant*
*** Limited validity due to wide confidence intervals and small sample sizes*
***Note:** this is early data with a small N resulting in wide error margins*

Laboratory Values Associated With Mortality

Laboratory Value	Odds ratio and 95% CI
Lymphocyte count <0.8 (x 10*9 / L)	8.8 (4.3 - 18.4)[7]
Bilateral consolidations on imaging	1.98 (0.89 - 4.5)[8*]
Ground Glass Opacities on imaging	2.1 (0.99 - 4.7)[8*]
D-Dimer > 1ug/L**	14 (6.3 - 31)[3]
Elevated C-Reactive Protein**	10.5 (1.2 - 34.7)[7]
LDH > 245 u/L**	45.4 (6.0 - 338)[7]

Fatality Rate by Age Groups Derived from Chinese CDC[2] and South Korea CDC[6] datasets

	Chinese CDC dataset[2]		South Korea CDC dataset[6]	
Age group	Deaths/confirmed cases	Fatality rate	Deaths/confirmed cases	Fatality rate
0-9	0/416	0%	0/83	0%
10-19	1/549	0.2%	0/427	0%
20-29	7/3619	0.2%	0/2301	0%
30-39	18/7600	0.2%	1/842	0.12%
40-49	38/8571	0.4%	1/1141	0.09%
50-59	130/10008	1.3%	6/1568	0.38%
60-69	309/8583	3.6%	14/1012	1.38%
70-79	312/3918	8%	28/525	5.33%
≥80	208/1408	14.8%	25/263	9.51%

Summary of Facts on Prognostication

- Older (esp those over 80): Men with co-morbidities are at the highest risk
- Selected group of younger adults also appears to be at risk (? Healthcare providers, Those with co-morbidities)
- Children seem to be lower risk

Goals of Care Discussion via Virtual Visit with a Family Member

Doctor	Family
Hello is this Ms. McNally? I'm Dr. Back from the COVID response team	Hi.
I understand your father has tested positive for COVID	Yes. I'm very worried. I feel guilty that he got it in a nursing home. I thought that place would be ok.
Anyone would be worried. And there is no way you could have known this would happen.	I suppose so.
Is it ok if we talk about what COVID means for your father?	Please.
May I first ask if you are the person who makes medical decisions for him.	Yes. I'm his surrogate whatever you call it. I have the papers.
Perfect. I like to make sure I'm talking to the right person.	That's me.
I need to give you some background. Most people who get COVID have a mild or moderate illness and don't need the hospital. The people who most often get a severe pneumonia with COVID are older and have existing medical problems, like your father.	You know, I've heard that on the news but have been afraid to think about it.
Well that's a very normal reaction. COVID has put all of us in a tough situation.	Yes. And I know that you are so busy.
We are doing our best under the circumstances. So I hope your father has a mild case and can stay where he is. We can make sure he gets all the treatments he needs. However, if his COVID becomes severe, it will almost certainly take his life.	I was afraid you would say that.
It's not what any family member wants to hear. Given that, if the worst case scenario happened and he was going to die, do you think he would rather be in the hospital or be at home—I mean at his nursing home.	Gosh. That's a big decision.
I can see that you want the best for him.	Absolutely.

Source: Vital Talk

Goals of Care Discussion via Virtual Visit with a Family Member (continued)

Doctor	Family
Let me put it another way. If he didn't have dementia and was as sharp as you or me. And he understood COVID and what would happen if he got a severe case. If he were sitting here with us, what would he say.?	Oh he would say, enough already. I'll stay here. But I don't know.
It sounds to me like If you put on his hat and become him, he'd say 'enough already. But if you put on your hat , you'd say, I don't know. Do I have that right?	Yes. I'm not ready to lose him.
Tell me more.	He's always been there for me and my kids. He's the backbone of the family. He always believed in me.
Would he believe in you now? To speak for him?	When you put it like that, I know the answer. I just don't like it.
It's not the kind of decision anyone wants to make. It does sound like you two may have talked about this?	He told me when he was first diagnosed with dementia, back then he was just a little forgetful, nothing big. We were driving to the park to walk the dog. He turned to me and said remember, when I can't do this anymore, it's time to let me go.
Wow, thank you for telling me that.	I had kind of forgotten about that. Its funny—I can see him saying it to me.
Hmm. That kind of memory is a gift. Would it be ok to honor that?	Now it's clear to me. Let's keep at him at his home.

A couple of links to useful videos: https://vimeo.com/401465080
https://www.youtube.com/watch?feature=youtu.be&v=KNHLaNAj08I

Source: Vital Talk

MOLST Order via Virtual Visits

- The **Emergency Update to the EMS Protocol 7.3** cites the following requirements for documenting verbal consent:

  Where it's not possible to follow usual MOLST standards requiring written signatures, clinicians are to document on the MOLST form:

  a) the patient's, patient's health care agent's or guardian's verbal consent;

  b) who witnessed this verbal consent (in accordance with the standards of the health care facility in which the patient is located); and in addition,

  c) document in the patient's medical record the details of how verbal consent was obtained.

- Upon reviewing such a MOLST form for a patient they encounter, EMS personnel are to accept a form that contains a) and b) in accordance with this procedure. As long as the witness portion is documented, EMS can accept it as meeting the standards of the health care facility.

Source: MHA link

Role of Palliative Care During COVID-19 Pandemic

Questions.

Care Management Update

Pat Seidel

Director of Care Management.

Care Management Education

- Signs and symptoms of COVID-19
- Transmission guidelines
- Testing guidelines and sites
- New triage protocols
- Current recommendations to avoid ED utilization, hospitalization and to promote PCP telephonic visits and telehealth when appropriate
- Wellbeing Resources available for patients, providers and their staff
- Reinforcing Advanced Directives and Goals of Care

Care Management Program Changes to Respond to COVID-19

- Monitoring Patient Ping Daily Discharges
  - Identification of patients discharged with confirmed or presumptive COVID-19 and patients at risk for infection for Transitions Assessment and Monitoring
  - Both CM Transition and **Pharmacy** referrals identified for patients at high risk for COVID-19
  - Pharmacists conducting medication reviews to identify patients who would benefit from a Pharmacy call.
- Increasing frequency of check-in calls with “at risk” chronic or complex patients
- Care Managers and Pharmacists able to do Telehealth visits with Amwell

What NEQCA Seeks From Providers

- **Please refer confirmed, presumptive and those patients with pending COVID-19 test results, who are at home, to your Care Manager and continue to refer your at risk patients**
- **Please provide your direct phone number to your Care Manager to expedite urgent matters.** If you use a secure texting system please add your Care Manager to the contact list.
- NEQCA Pharmacists still available to answer **medication-related questions**. They are also available for telehealth video calls or phone calls to patients for indications such as, but not limited to, medication counseling/teaching and inhaler technique counseling.

Supporting Patients in the Home

Consider direct referral for home health or home infusion services

Examples:

- IV diuretic therapy for CHF patients through IV Diuretic Program
- IV Hydration and IV antibiotics
- Home start TPN with dietary support

New England Life Care is one agency that can provide these services. (Information available on website)

Contact your Care Manager to assist with locating services

CMS Expands “Homebound” Definition

- **Homebound Definition**: Beneficiary is considered homebound when their physician advises them not to leave home because of confirmed or suspected **COVID-19** diagnosis or if patient has a condition that makes them more susceptible to contract **COVID-19**. **If beneficiary is homebound due to COVID-19 and needs skilled services, an HHA can provide those services under the Medicare Home Health benefit**. ***Telehealth visit counts as face to face***

Example: documentation in clinical note a patient who would normally not be homebound with COPD is now at higher risk for **COVID-19** and requires in-home services

Care Management Update

Questions.

Helpful Resources

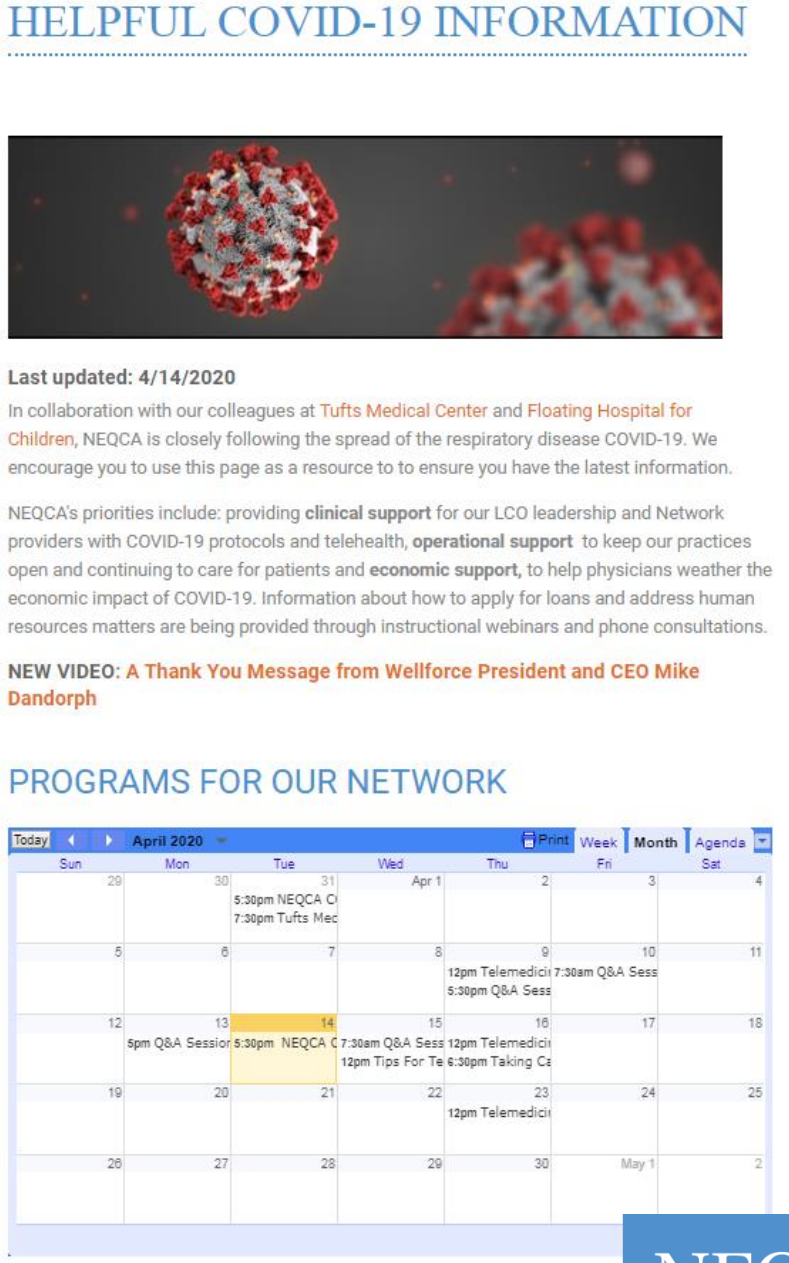
Ben Kruskal, MD

Medical Director

.

NEQCA COVID-19 Website

- **Updated daily**
- Upcoming Programs
- Statistics and Expert Resources
- Clinical Guidelines and Tools
- Medical Practice Sustainability
- Telehealth Services
- Broad Strategies To Combat COVID-19
- Resources for Patients
- Wellbeing for All
- Recorded Webinars, Presentations



NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

This Week

Upcoming:

Q&A Session for Private Practice Physicians: Economic sustainability strategies

- **Wednesday 4/15,** 7:30 a.m. - 8:30 a.m.

Wednesday 4/15, 12:00 p.m. - 1:00 p.m.

- Tips for Telehealth Success with Drs. Davis Bu (Adult PCP), Sheila Morehouse (Pediatric PCP) and Bindiya Thakkar (Endocrinologist)

Thursday 4/16, 6:30 p.m. - 7:30 p.m.

- Taking Care of Your Emotional Health Webinar for Clinicians
- Wellbeing Resources for Clinicians

Telemedicine Coding Q&A Drop-In Sessions: 4/16, 4/23, 12:00 - 1:00 p.m.

- Telemedicine and Coding Presentation - April 2, 2020

Next Week

Tuesday, April 21
COVID-19 Update
5:30-6:30 p.m.

(In lieu of Performance and Quality Committee)

Additional Q&A

Additional Relief From Centers for Medicare and Medicaid Services

In follow up to a provision in the CARES act that appropriated $100B in funds to hospitals, physicians, and other health care providers, HHS has announced that a trounce of $30B will be directed to hospitals and physician practices in direct proportion to their share of Medicare fee-for-service spending.

All facilities and health professionals that billed Medicare FFS in 2019 are eligible for the funds. These are grants, not loans, and **do not have to be repaid**. The automatic payments will come to the organizations (Tax ID number of record) via Optum Bank with "HHSPAYMENT" as the payment description.

Within 30 days of receiving the payment, providers must sign an attestation confirming receipt of the funds and agreeing to the terms and conditions of payment. The portal for signing the attestation will be open the week of April 13, 2020 and will be linked from hhs.gov/providerrelief.

Additional Relief From Massachusetts Health and Human Services

To support health care providers impacted by and responding to the COVID-19 public health emergency, the Baker-Polito Administration is distributing over $800 million in critical stabilization funding to the Commonwealth's vital providers through MassHealth.

More than $300M for other health care providers that are delivering medical care for COVID-19 or providing services that keep residents safe in their homes and out of the hospital, including:

- Over $50M for community health centers
- Over $100M for community behavioral health providers
- Approximately $30M for personal care attendants and $13M for home health agencies
- A $17M increase for ambulance providers
- A $15M increase for physicians and group practices
- $81M in Funding to ensure the sustainability of long-term services and supports

$15M in funding for physicians and group practices will come by way of a 15% increase in professional fee for service billings for the top 100 used MA Health codes (listing of codes has not been published as of 4/13/2020). Rate increases will be effective with dates of service between 4/1/2020 and 7/31/2020 and will be included with all fee for service, MCO, and ACO lines of business. Administrative guidance that will include the codes affected and instructions to the health plans administering payments is due by 4/17/2020.

Stay Safe … and THANK YOU!

Appendix

Palliative Care Resources

- https://qxmd.com/calculate/calculator_731/covid-19-prognostic-tool
- https://www.capc.org/training/learning-pathways/covid-19-response-training/
- https://www.vitaltalk.org/guides/covid-19-communication-skills/
- https://theconversationproject.org/wp-content/uploads/2020/04/tcpcovid19guide.pdf
- https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w#F2_down
- https://www.eapcnet.eu/publications/coronavirus-and-the-palliative-care-response/key-documents-for-italy
- http://www.thewhpca.org/covid-19
- https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit
- https://inkvessel.com/2020/03/18/palliative-care-in-the-time-of-covid/

Primary vs. Specialist Palliative Care

Box 2: Suggested triage tool for referral to specialist palliative care[19]

All clinicians providing palliative care should address physical, social, financial and spiritual concerns

Clinicians who are not palliative care specialists (hospitalists, family physicians, internists, ICU physicians, nurse practitioners, nurses and paramedics) support the following:

- Identification and management of pain, dyspnea, agitated delirium and respiratory congestion
- Management of caregiver grief
- Discussions about prognosis, goals of treatment, suffering and resuscitation status

Palliative care specialist clinicians support the following:

- Patients with complex or refractory symptoms
- Patients who are denied access to critical care owing to a triage protocol, despite wanting aggressive care
- Management of complex depression, anxiety, grief and existential distress
- Requirement for palliative sedation therapy
- Pre-existing opioid use disorder
- Patients with young children
- Patients belonging to marginalized populations, including the homeless, incarcerated persons and Indigenous Peoples, who are at risk of being underserved by the health care system

Source. Pandemic Palliative Care. *CMAJ* 2020. doi: 10.1503/cmaj.200465; early-released March 31, 2020 https://www.cmaj.ca/content/cmaj/early/2020/03/31/cmaj.200465.full.pdf

Box 3: Suggested language for physicians providing support to a patient or family member who is denied intensive care because of resource scarcity

Normally, when somebody develops critical illness, the medical team would offer them intensive care (a combination of medications and machines to support their vital organs), provided that the medical team felt that they had a reasonable chance of survival. However, because of the COVID-19 outbreak, we are currently unable to offer intensive care to everyone who is critically ill. As a result, our hospital is working under triage guidelines, which means that we are offering intensive care only to those who are most likely to be able to survive and recover from their critical illness. You probably have heard about this in the news — all hospitals in the region are working under these guidelines.

I regret to inform you that we are unable to offer you intensive care treatments at this time, as a result of the triage guidelines. Because of your medical condition, the likelihood that you would survive even with intensive care is considered to be too low for us to offer intensive care. The team has made this decision based on the following information:_____.

I am deeply sorry about this situation. This is not the way we ordinarily make these decisions, and I can only imagine how you must feel right now. I want you to know that even though we cannot offer intensive care, we will do everything else that could conceivably give you a chance of recovering, including: _____.

And I promise you that, no matter what, we will also use medication to treat any discomfort, such as pain or shortness of breath. We know that when we treat discomfort appropriately, this is not harmful and may actually help improve your condition.

clans to ensure that any proposed treatment is clinically indicat

Box 4: Suggested language for discussing a treatment plan with someone who is unlikely to survive a critical illness, but whose current care plan would include life-sustaining therapies if indicated

You (your loved one) is currently suffering from _____. We have given you treatments, including _____ , but it seems as though your body is not responding well to them. If this continues, we would need to consider the use of life-sustaining treatments to support your body.

I am very concerned about this scenario; although it is very easy to start life-sustaining treatments, there are many scenarios where we strongly prefer not to because the chances of recovery are poor. That is usually when someone has chronic or incurable medical conditions, or their body has become weaker than it used to be. The other concern is that these treatments can cause a lot of discomfort. Of course, many people are willing to experience discomfort if there is a reasonable chance of a good recovery. But if the treatments cause discomfort and the chances of recovery are poor, we are very hesitant to offer those treatments.

I would like to propose an alternative plan. I would like to suggest that we continue doing the things that we are currently doing, including _____, in the hope that you might still respond and recover. We do not want to take away that opportunity. But if your body does not respond and you get worse, I would suggest that we do not start life-sustaining treatments. Instead, if you get worse, I would suggest that we focus on keeping you comfortable, understanding that any further escalation of care would probably do more harm than good. What do you think about that?