NC FQHCS & CARING FOR PATIENTS DURING COVID-19: INTEGRATING TELEHEALTH

Hosted by the NC Community Health Center Association's
Health Center Controlled Network (HCCN)

MARCH 26, 2020

THANK YOU FOR JOINING US TODAY

ZOOM MEETING HOUSEKEEPING

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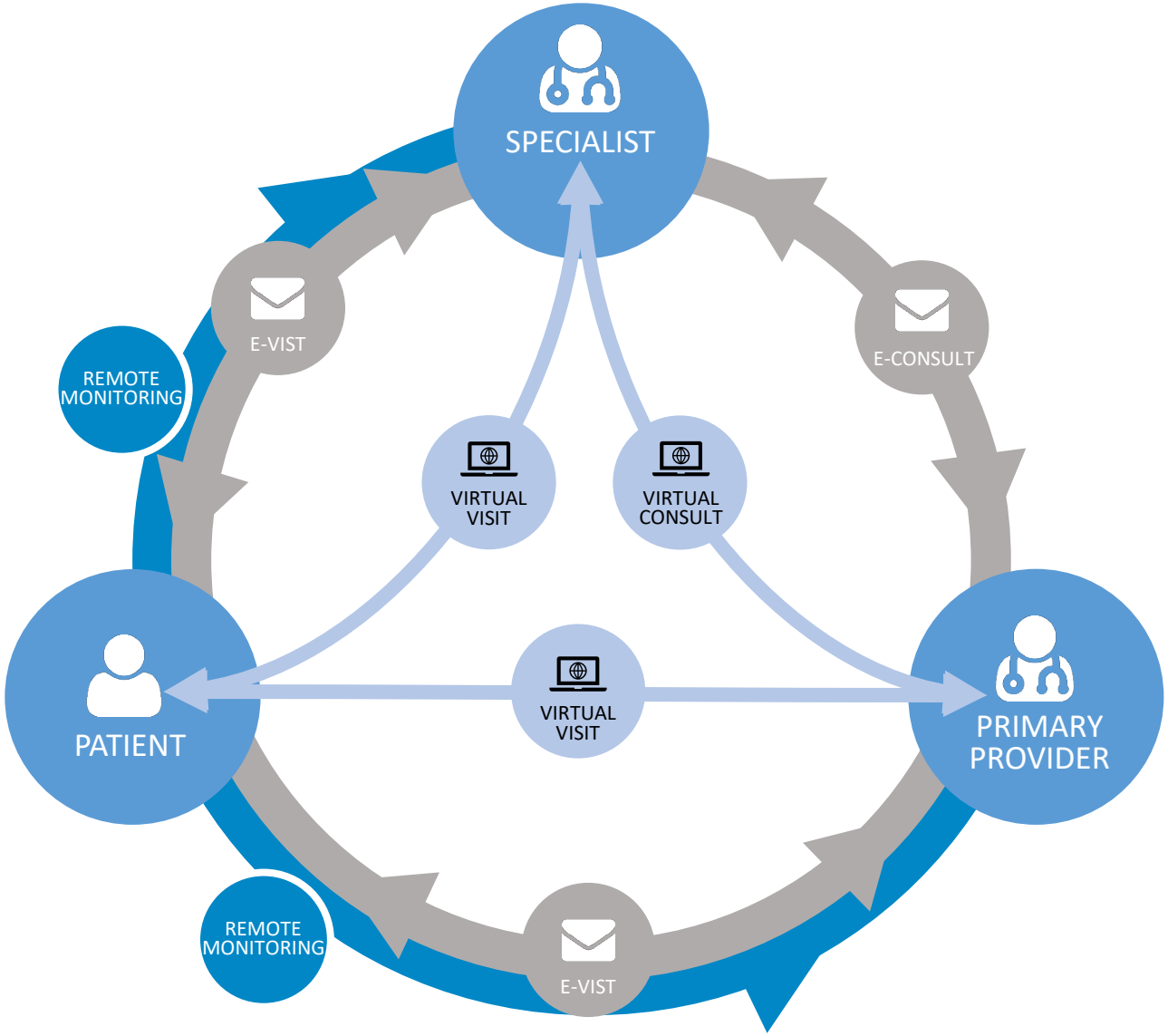
TELEHEALTH FRAMEWORK



- **Key Terms:**
  - Originating Site: Patient
  - Distant Site: Provider
  - Store and Forward
  - Qualified Provider
- **Understanding Service Types:**
  - Virtual Health Visit (Provider⇔Patient)
  - Virtual Check-in (Provider⇔Patient)
  - E-visit (Provider⇔Patient)
  - E-Consult (Provider⇔Provider)
- **Other Considerations:**
  - Consent
  - Documentation
- **Other Terms/Models/Use Cases**
  - Project ECHO™
  - Remote Patient Monitoring

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OVERVIEW: MEDICARE AND TELEHEALTH RE: COVID-19

- The Administration's changed Medicare telehealth coverage on March 18 in response to the COVID-19 National Emergency, but left our Federally Qualified Health Centers and Rural Health Clinics
- CARES Act of 2020 (Pending) incorporates FQHCs and RHCs
- CMS's other recent expansions of telehealth under Medicare

MEDICARE TELEHEALTH FLEXIBILITIES UNDER MEDICARE FOR FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

- **Legislative environment is evolving rapidly**
- **March 25th version of the pending Senate and House bills both include the following sections**
  - **Section 3704. Allowing Federally Qualified Health Centers and Rural Health Clinics to Furnish Telehealth in Medicare:** During the COVID-19 emergency period, Federally Qualified Health Centers and Rural Health Clinics may serve as a distant sites for telehealth consultations. This would allow FQHCs and RHCs to furnish telehealth services to beneficiaries in their home. Medicare would reimburse for these telehealth services based on payment rates similar to the national average payment rates for comparable telehealth services under the Medicare Physician Fee Schedule. It would also exclude the costs associated with these services from both the FQHC prospective payment system and the RHC all-inclusive rate calculation.
  - **Section 3211. Supplemental awards for health centers:** Provides $1.32 billion in supplemental funding to community health centers on the front lines of testing and treating patients for COVID-19.
- **Interpretation of telehealth provision**
  - Temporary
  - Applies to “Medicare Telehealth Services,”
  - Beginning either March 6, 2020 or on date law is enactment (unclear).

MEDICARE TELEHEALTH EXPANSION FOR THE COVID-19 VIRUS NATIONAL EMERGENCY

To reduce the transmission of the COVID-19 virus the Centers for Medicare & Medicaid Services (CMS) has temporarily expanded the scope of coverage of one type of telehealth service under Medicare

- Medicare telehealth visits: Physician office visits conducted via two-way audio/video
  - Expanded to include urban areas
  - Pending expansion to include rural clinics and FQHCs as distant sites (COVID response bill expected to pass on 3/25)

CMS is also encouraging patients and providers to use the other types of telehealth services currently available under Medicare

- Virtual check-ins: Short telephone calls between patient and clinician
  - No change, but available in urban and rural areas since 2019
- E-visits: Short communications between patient and clinician through an online portal
  - No change, but available in urban and rural areas since 2020
- Remote Physiological Monitoring (RPM): Clinicians monitoring a patient's condition through electronic monitoring devices
  - No change, but available since 2018
- Disease-specific expansion for End-Stage Renal Disease, Stroke care, and Opioid Use Disorder
  - No change, but available since 2019
- Medicare Advantage Plans can offer members any telehealth service from anywhere
  - No change, but available since 2020

RECENT POLICY CHANGES EXPANDED MEDICARE TELEHEALTH, ENCOURAGED BY CMS DURING THE COVID-19 EMERGENCY

Services reimbursable under Medicare	Description (technology)	Types of services	Technology	Originating sites (location of patient)	Distant site practitioners and providers	Payment and cost-sharing	Effective
Medicare telehealth visits	Physician fee schedule office visits conducted via telehealth technology. Visits are considered the same as in-person office visits.	Various: For example, evaluation and management, psychotherapy (individual and group), nutrition, health risk assessments, ESRD, diabetes management, substance abuse treatment, critical care consults, subsequent hospital care, subsequent nursing facility care, stroke care	Two-way audio & video technology permitting real-time communication (e.g, smart-phones, video-chat)	Urban or rural, including the patient's residence	Practitioners: Physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists certified registered nurse anesthetists, clinical psychologists, social workers, registered dietitians and nutrition professionals Providers: Any health care facility including FQHCs and rural clinics	Provider payment: Physician Fee Schedule payment (various) Patient out-of-pocket costs = 20%	March 6, 2020 through end of the COVD-19 emergency

Exceptions provided by the Secretary of Health and Human Services (HHS) for the COVID-19 National Emergency

- HHS will not conduct audits to ensure that a prior relationship exists between patient and clinician
- Healthcare providers are permitted to reduce or waive patient cost-sharing
- HHS will exercise enforcement discretion and waive penalties for HIPPA violations by health care providers who serve patients in good faith through everyday communications technologies such as Skype and FaceTime.

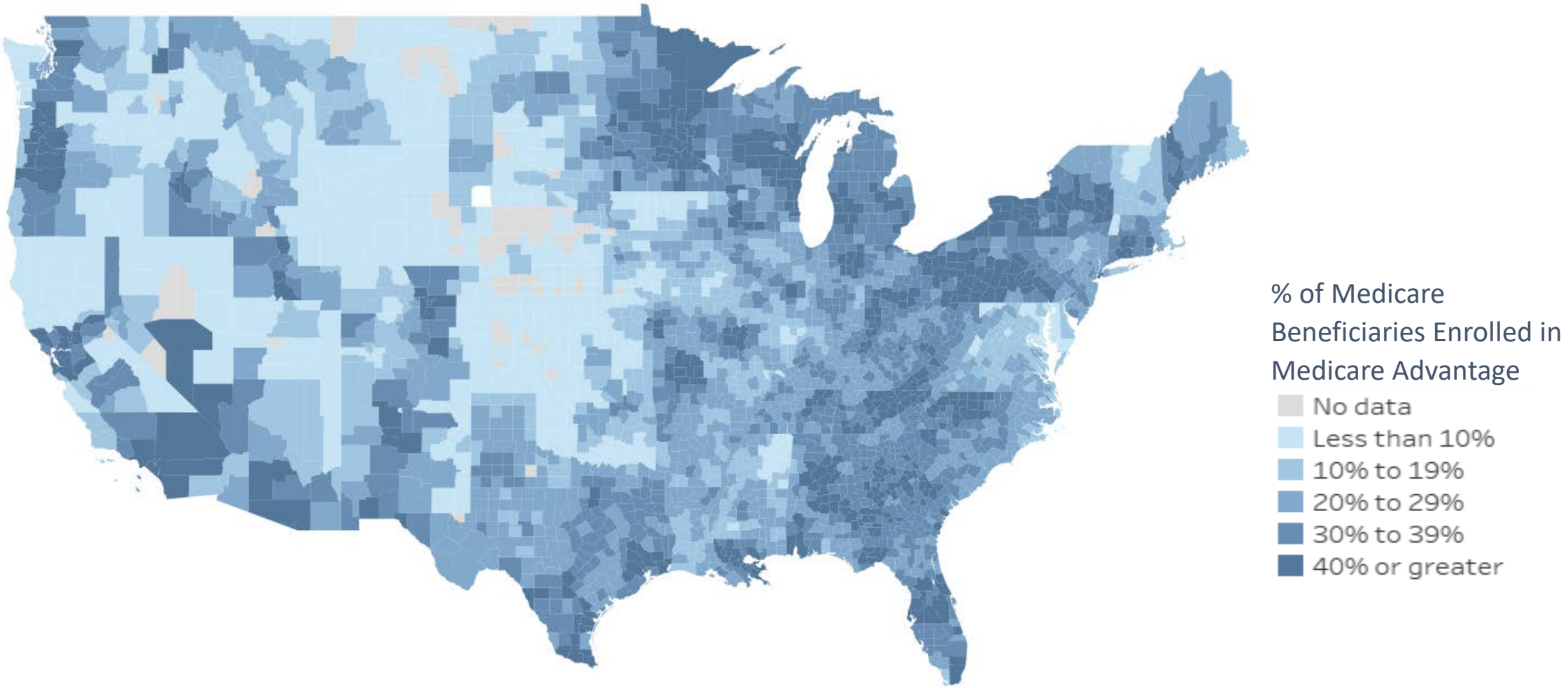
KEY POINTS: USE OF TELEHEALTH IS ABOUT TO INCREASE

- In response to the COVID-19 virus, physicians, health systems, and Medicare Advantage plans are likely to expand their use to telehealth services to limit the transmission of the virus

- Use of telehealth in urban areas will increase rapidly and Medicare physician spending will grow to new levels
  - Urban telehealth visits from patient's homes and nursing homes
  - Virtual check-ins used to limit visits to providers for those without COVID-19 virus
  - E-consults between physicians
  - Remote physiological monitoring (RPM) of patients in their homes by physicians and other clinicians
  - Physician visits conducted via telehealth in urban and rural areas when care involves patients in certain disease groups (end-stage renal disease (ESRD), stroke, opioid use disorder)
  - Medicare Advantage telehealth services for any patient in an urban and rural areas or from the patients' home

- Providers most likely to increase their use of telehealth in the coming year(s):
  - Primary care physicians
  - Specialists provide routine care to existing patients
  - Behavioral health clinicians
  - Nephrologists, cardiologists performing stroke care, and OUD specialists serving urban areas
  - Geographic areas with high levels of Medicare Advantage enrollment

TELEHEALTH GROWTH UNDER MEDICARE ADVANTAGE WILL BE GREATEST IN PARTS OF THE COUNTRY THAT HAVE THE HIGHEST LEVELS OF MEDICARE ADVANTAGE ENROLLMENT



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OVERVIEW OF NC MEDICAID TELEHEALTH POLICY CHANGES FOR FQHCs

NCCHCA/HCCN Webinar

MARCH 26, 2020

RECENT NC MEDICAID RESOURCE

04/03/2020: This slide updated and subsequent slides removed to reflect updates from NC Medicaid.

Telehealth for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) (FAQ Sheet Released 4/1/2020)

https://files.nc.gov/ncdma/covid-19/COVID19-QA-FQHC-RHC-2020.pdf

North Carolina Payers Telehealth Policies in Response to COVID-19

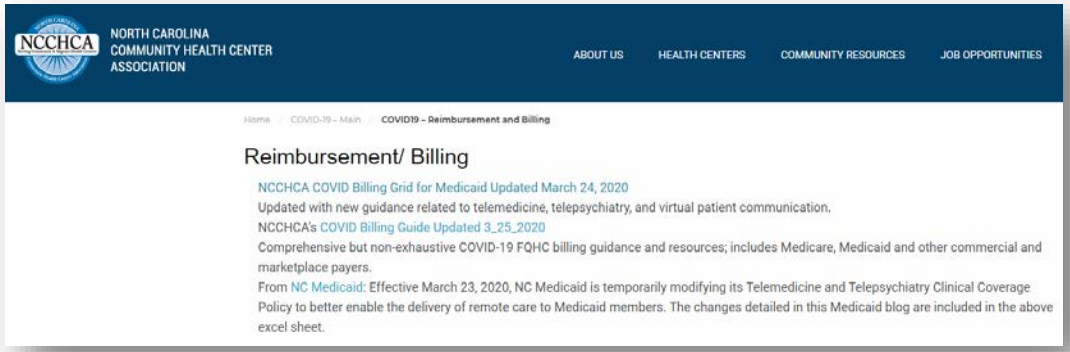
https://files.nc.gov/ncdma/covid-19/NCPayers-Telehealth-Policies-COVID19-2020.pdf

SPECIAL BULLETIN COVID-19 #28 [ADDENDUM to Bulletin #9 Effective March 30, 2020]: Telehealth Provisions - Clinical Policy Modification:

https://medicaid.ncdhhs.gov/blog/2020/03/30/special-bulletin-covid-19-28-addendum-bulletin-9-effective-march-30-2020-telehealth

NCCHCA RESOURCES

- **NCCHCA COVID-19 Webpage**
  https://www.ncchca.org/covid-19/
  - **Reimbursement & Billing Resources:** *(Working Documents)*
    - **FQHC Medicaid Billing Grid:** includes all the details in these slides re: services, codes, criteria, who can bill, modifiers, etc.



- **NCCHCA COVID-19 Daily Digest Email**
- **NCCHCA COVID-19 Email Inbox for Questions**
  - **COVID19@ncchca.org**

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DIRECTOR OF POLICY

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HRSA COVID-19 FAQs re: TELEHEALTH

Does FTCA coverage extend to telehealth visits with non-health center patients? *(Added: 3/24/2020)*

When in-scope services are provided through telehealth on behalf of a deemed health center to individuals who are not patients of the health center, and all other FTCA Program requirements are met, such services are eligible for liability protections under 42 U.S.C. 233(g)-(n), pursuant to 42 CFR 6.6. Health centers and providers are encouraged to consult with private counsel and/or consider the purchase of private malpractice insurance when undertaking activities that may not be within the health center's scope of project.

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- The individual receives an in-scope required or additional health service;
- The provider documents the service in a patient medical record consistent with applicable standards of practice; and
- The provider is physically located at a health center service site or at some other location on behalf of the health center (e.g., provider's home, emergency operations center).

Health centers should focus services provided by telehealth on serving patients and other individuals located inside their service area or with areas adjacent to the covered entity's service area. It is recognized that in the current public health emergency situation, patients outside these areas may seek health center screenings and triage by telehealth. Health centers that continue to maintain services for target populations in their service area and provide occasional in-scope services via telehealth to individuals outside these areas would be providing services within the Health Center Program scope of project for all such activities.

HRSA COVID-19 FAQs re: TELEHEALTH

Can a health center use telehealth to provide services to a patient at a location that is not an in-scope service site? Can this occur if neither the health center provider nor the patient is at an in-scope service site (e.g. both the provider and patient are at their respective homes)? *(Updated: 3/24/2020)*

From a Health Center Program scope of project policy perspective, this is allowable if:

1. The service being provided via telehealth is within the health center's approved scope of project (recorded on Form 5A);
2. The clinician delivering the service is a health center provider; and
3. The individual receiving the service is a health center patient.

HRSA strongly encourages health centers that provide, or are planning to provide, health services via telehealth to consult with professional organizations, regulatory bodies, and private counsel to help assess, develop, and maintain written telehealth policies that are compliant with Health Center Program requirements; federal, state, and local requirements; and applicable standards of practice. Likewise, HRSA encourages health centers to consider the range of issues that would support successful implementation of telehealth. Please review PAL 2020-01: Telehealth and Health Center Scope of Project (PDF – 520 KB) for more information.

Health centers do not need to request a change in scope to deliver in-scope services on behalf of the health center from the provider's home or from another location that is not a Form 5B Service Site.

For questions about FTCA coverage, please contact Health Center Program Support

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Are there any new Health Insurance Portability and Accountability Act (HIPAA) flexibilities or considerations for providing telehealth visits using readily available technologies such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype? *(Added: 3/25/2020)*

The HHS Office for Civil Rights issued a Notification of Enforcement Discretion for telehealth remote communications during the COVID-19 nationwide public health emergency on March 17, 2020, which indicates HHS will not impose penalties for noncompliance with regulatory requirements under HIPAA rules in connection with the good faith provision of telehealth during the COVID-19 emergency. There are also Frequently Asked Questions on telehealth (PDF - 94 KB) available.

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Advance Community Health COVID-19

3.26.2020

Safety and Risk - How We Are Protecting and Screening our Patients

- As of 3/19 at 4pm, any patient presenting with respiratory complaints, fever, known contact with COVID-19 will not be seen at regional sites and only seen at Southeast Raleigh RDC.
- Patients are instructed to stay home, self-care and self-isolate, unless medical care is needed.
- As of 3/25 at 4pm, no patient is able to enter a facility and will directed to obtain a telehealth/telephone visit except for POD visits.

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Safety and Risk - How We Are Protecting Staff

- Similar strategies for protecting employees as with our patients with the following exceptions:
  - Evaluating best practices and forthcoming guidance
  - Return to work guidance
  - Develop strategies to screen employees for infection
  - Promoting social distancing within our current workflows (i.e. virtual visits, GoToMeeting)
- Disperse workspaces, consolidated sites & isolated
- Increased communications and trainings (i.e. Daily debriefs with workgroups, daily leadership meetings, traveling roadshows, and just-in-time training)
- As of 3/19 at 4pm, any patient presenting with respiratory complaints, fever, known contact with COVID-19 will not be seen at regional sites and only seen at Southeast Raleigh RDC.
- As of 3/25 at 4pm, any patient seeking care at any site will be directed to call for a telephone/telehealth visit. Patient will only be allowed in for POD/Essential visits

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COVID-19 Workflows

- RN COVID-19 screening – implemented on 3/5; 5 Total Revisions – Stopped 3/26
- RDC workflows – implemented on 3/17; 5 Total Revisions – Stopped 3/23
- Telephone Visits – implemented 3/24; 2 Total Revisions
- Telehealth Visits – in development

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COVID-19 Past Clinical Pathway & Process Overview

RN Call Group and RDC Go Live: Tuesday, 3/17/20

Patient calls into the main line

Patient will select option 1 to speak with an RN if COVID-19 symptoms are present

RN conducts COVID-19 screening via phone

Patient is added to the Respiratory Diagnostic Center (RDC) schedule if COVID-19 screening results are positive

Patient arrives to the RDC for their scheduled appointment:

- Greeter at Respiratory Etiquette Station
- PRR for check in
- MA for intake
- Provider visit
- Flu &/or Strep test &/or COVID-19 test are completed per provider's clinical judgement and results of flu/strep tests

Patient is discharged. If medications or pharmacy consult is needed, will utilize ACH Pharmacy Curbside service

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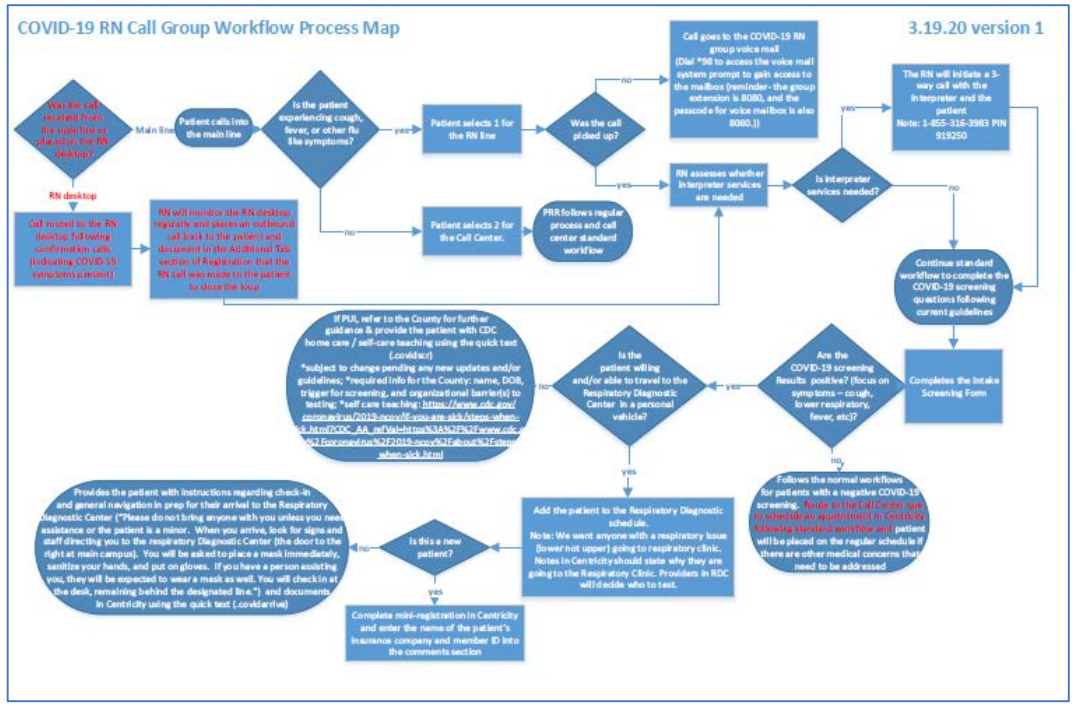
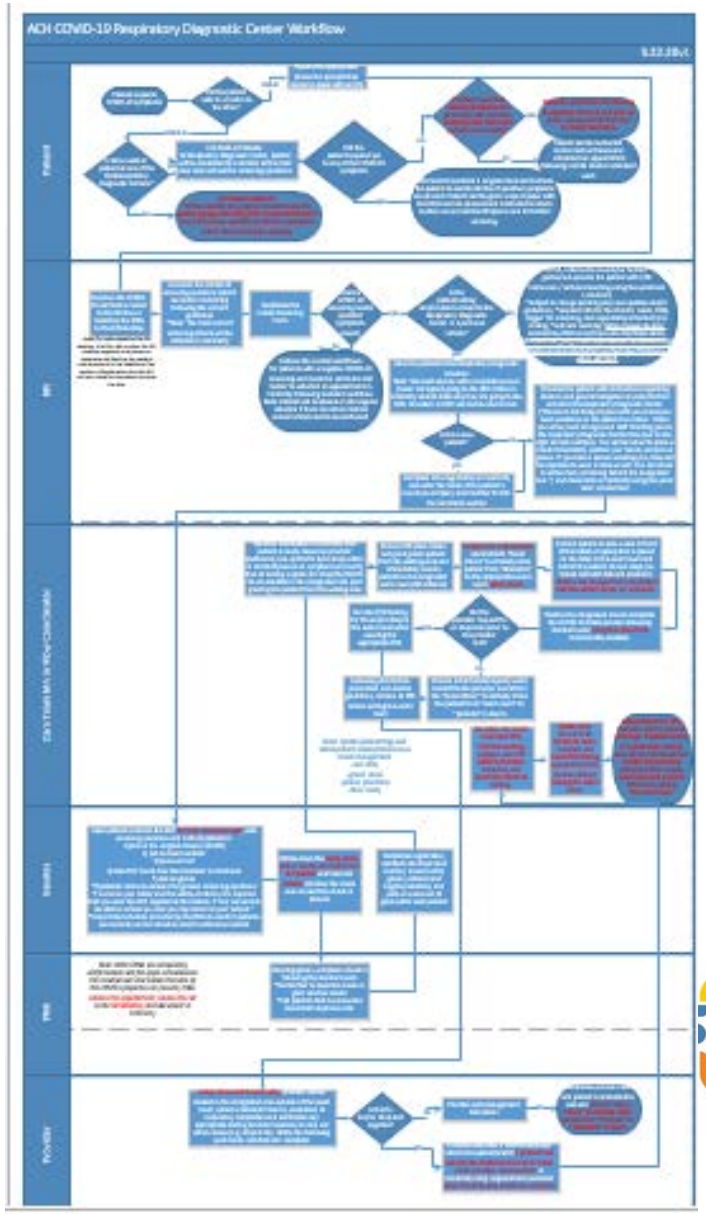
Video: The Patient's RDC Experience

- https://youtu.be/KJifImwTmP0

RN Call Group Line & Respiratory Diagnostic Center Workflows





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COVID-19 Current Clinical Pathway & Process Overview

Telephonic Visits go live 3/25

Patient calls into the main line

Patient will be scheduled for a telephonic visit

PRR completes over the phone check in

Provider provides care over the phone

Assess need for F/U or POD Care

Patient arrives if needed for POD Care

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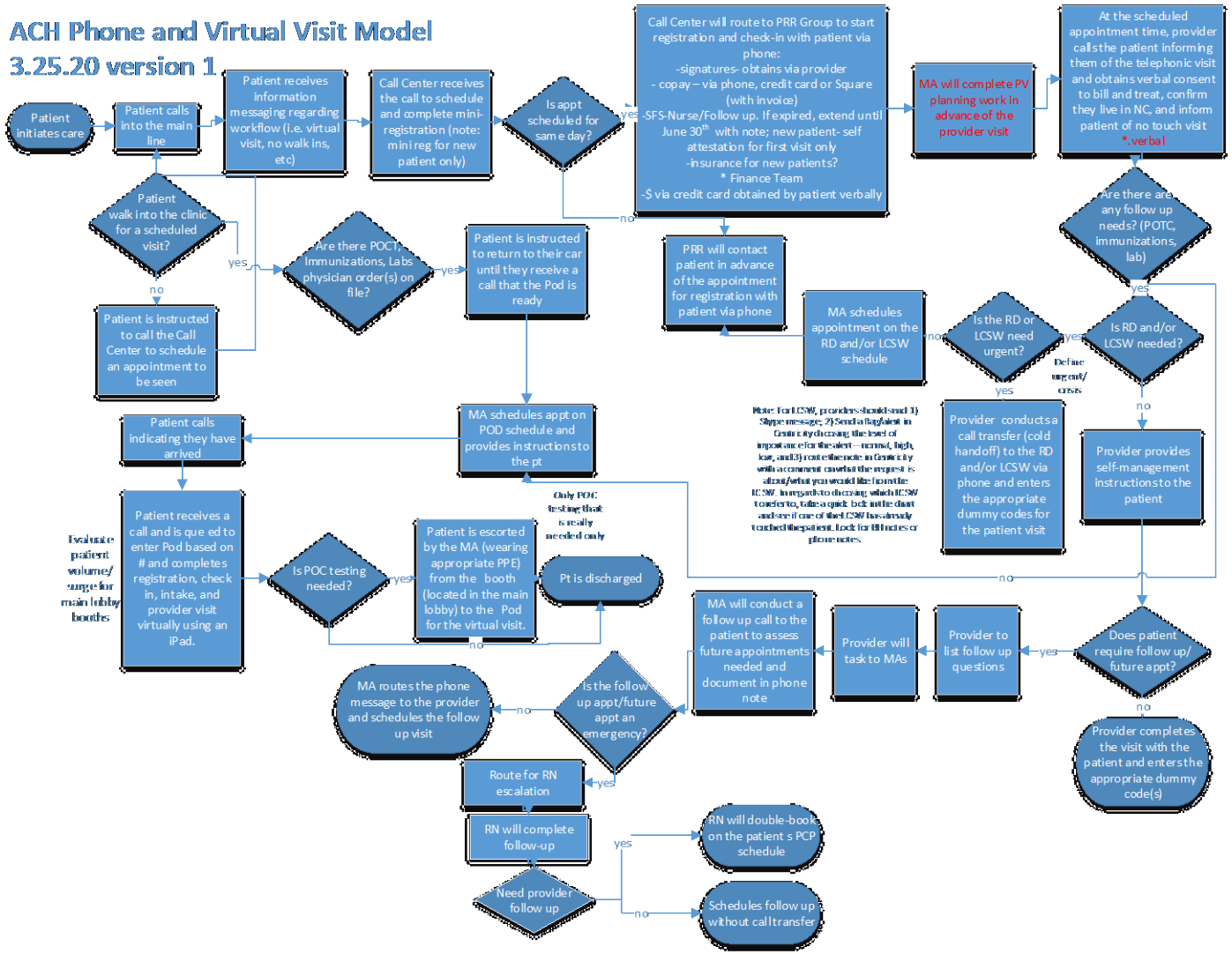
RN Call Group Line & Respiratory Diagnostic Center Workflows



RN Call Group Line & Respiratory Diagnostic Center Workflows

Category	Medical
Essential Services on Site via POD/Virtual Care	IF PTS SCREEN NEGATIVE (1.No Fever, 2.No Respiratory Complaints, 3. No Known Contact) OK TO SCHEDULE THESE VISITS: • < than 16 months WCC ONLY • Essential injections (B12, Testosterone) • POCT Testing • Lab Work • Coumadin Clinic
Telehealth Services (Use Script)	• Acute Visits, including patients with respiratory symptoms, • All other visits (EXCLUDING NON ESSENTIAL BELOW) schedule a telehealth visit with the Pts PCP on their Telephonic schedule
New Patients	• Schedule Essential Visits same as above for established patients
PHONE NOTE TO PCP & RN for further triage	• Follow normal procedures with no appointment availability or Urgent Triage
NON ESSENTIAL DO NOT SCHEDULE (Use Script)	• AWV • Physicals • WCC >16 months

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RN Call Group Line & Respiratory Diagnostic Center Workflows

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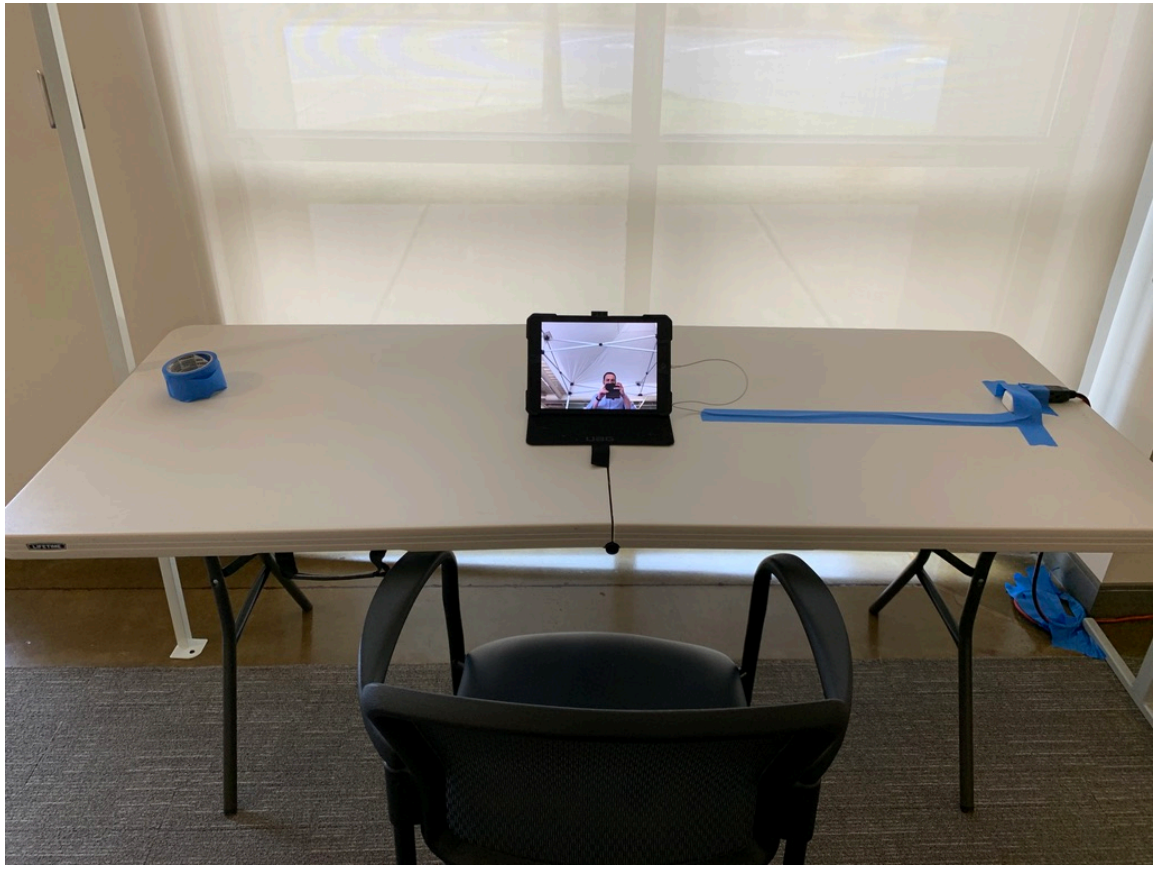

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Current Concerns and Strategies to Respond

Current Concerns	Strategies to Respond
Lack of PPE and clinical equipment	Utilize virtual visits to minimize the need for PPE Prioritize PPE and clinical equipment for patient care
Lack of COVID-19 tests	Forthcoming state guidance will de-emphasize testing
Health of our staff and high-risk staff	Establish work from home for high risk and isolate staff.
Ability to keep a functional, healthy workforce	Develop processes to limit staff risk and evaluate current concerns through frequent communication and feedback mechanisms
Criteria of high-risk patient categories keep fluctuating	Leverage technology to minimize face-to-face direct patient contact (i.e. telehealth, virtual visits)
Unknown implications of telehealth on our patient population	Development of POD care
Funding constraints	Work with partners to understand grant opportunities
Fast moving and continuously evolving guidance and best practice	ACH has established an Incident Command Structure with several section groups developed to work on multiple projects at once
Multiple sites create challenges in assessment, implementation, and evaluation	Develop standardized work

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Packet

- Telephone and Virtual Visit Model - Workflow Process Map 3.25.20v1
- Standard Process Map_Pre-visit Planning
- PRR Call Center Cheat Sheet
- Provider Cheat Sheet
- MA Cheat Sheet

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