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COVID-19 Hub

Outpatient CV Care: Prioritizing During a Pandemic

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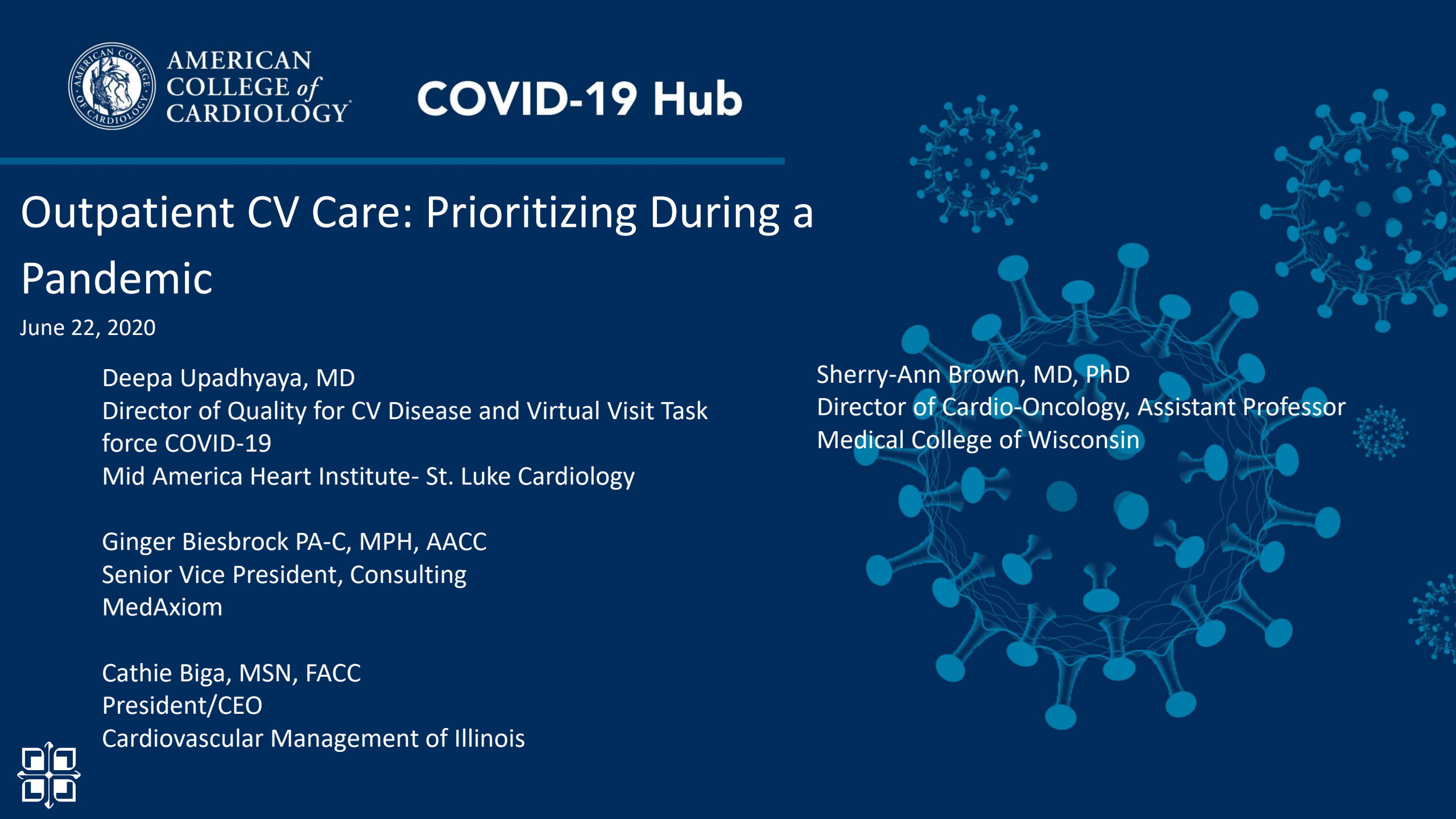

Balancing Virtual and In person out-patient care

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Discolosure

- None

The Big Players

- WHO – a 75 year old, UN agency that deals with international public hearth efforts.
  - Based in Geneva, most recent budget 4.4 billion
  - Partnerships with GHI conduct international research, setting norms, tech support and monitoring world wide trends
  - Ex: Small pox, Ebola, nutrition, sanitation, malaria, TB
- CDC- National public health institute of the US, a federal agency, headquartered in Atlanta

You are not alone

- Do we start scaling up or do we scale back again?
- Which patients should be seen in office which can be virtual?
- Do my schedulers need to be on site or at home?
- What is the best clinic schedule template?
- How is this going to affect billing/collections? Our long term viability?

Virtual vs. In office Evaluations

- Our Current model at MAHI:
  - Define the patients that MUST be seen in office: (there are always exceptions)
    - New patient consults – new CHF, valvular heart disease, even calcium score
    - Reevaluation- patient calling in with acute chest pain, SOA, increased edema, “not feeling well”, AAT clinic- need ECG ** these patients need to pass the COVID-19 Screening*
    - Physician request- physician can preview clinic: CHF/transplant, Structural, EPS, complex PCI
    - Patient request- Some patients only want to be seen in the office, we take this as a sign they may not be feeling well
      - Remote locations, work pressure, finance, convenience

Clinic Template:
How many virtual vs. In-office

Current situation:

- On average each physician sees : 3 patients in office (vary 2-9)
- On a day of '9 in-office' they are behind
  - Acuity, room turn over, one MA per doc
  - Getting more efficient as we adjust
- Total patients seen: 20 (during COVID surge we were down to 16)

Current Pitfalls of Tele-Health

- Eye-ball gestalt of a sick patient
- Physical exam
- ECG
- Edema evaluation: the camera doesn't work!
- Not all patients have accurate scale and blood pressure cuffs
- Provider engagement: feels like a video game
- I do anticipate technology to make this better:
  - More streamlining, patient will prepare, EKO stethoscope, Zio/AliveCor

Guidelines for in office visits

- Unofficial, these are NOT direct recommendations from the ACC
- Practices at Mid America Heart Institute:
  - Help everyone
  - The provider sets the tone, try to maintain a positive environment
    - Stress levels are high
  - PPE: Level 3 mask for everyone + change level 1 mask in between pts
  - No visitors with the patient
    - Exception: frail, needing assistance, memory/cognitive impairment, minor (congenital)
    - In alignment with hospital policy

Future view & Second wave

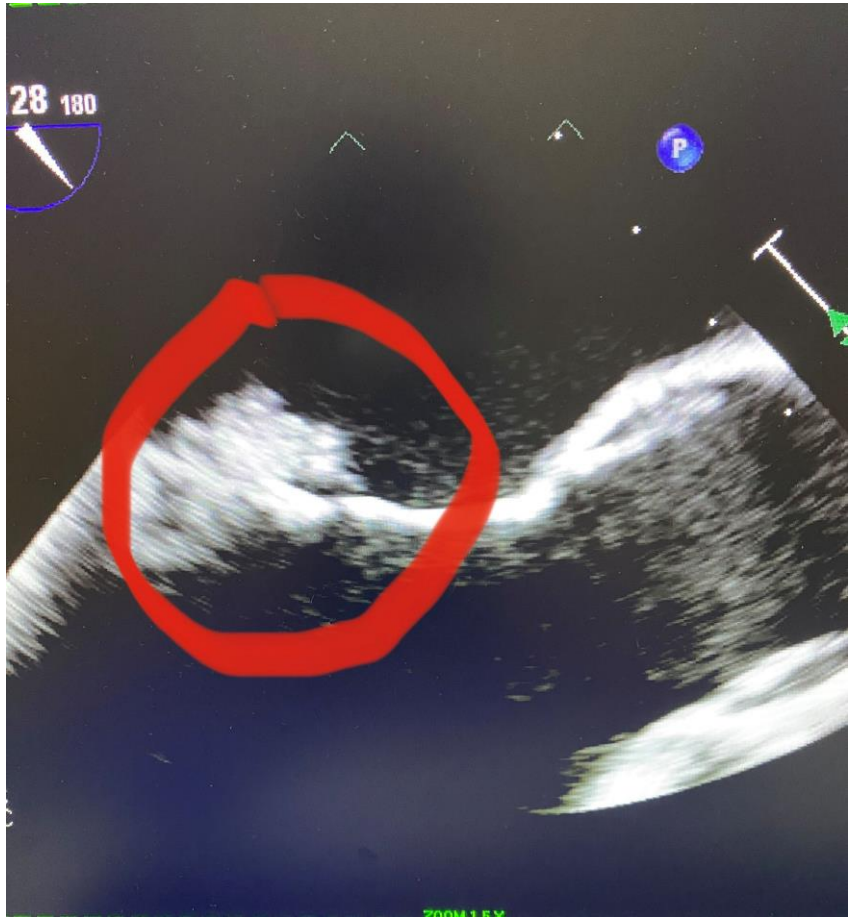
- Seema Verma: “The genie’s out of the bottle on this one. I thin it is fair that the advent of telehealth has just been completely accelerated, that it’s taken this crisis to push us into a new frontier, but there is absolutely no going back”.
- “clear example of untapped innovation”
- Curious to see what happens to state line issues in the long run

Future Model

- We anticipate:
  - 5:5:5:5 model
  - 5 virtual, 5 in office, 5 in office, 5 virtual
  - Always with flexibility, patient comes first and must get seen
  - Increase patient, staff and provider
  - Long term: allows for good patient triage with more stable patients getting faster access to APP care and sicker patients to get higher level of care
  - Improve access to care

Example

- NC 18 y/o male no prior history, 6’4- tall, family is tall
- Plays basketball in college
- Presenting symptoms: Fevers, Chills, temp- 105.3, WBC- 15
- Got Z-pack 1 week prior to presentation, cultures negative
- Septic emboli to the brain



Anecdotal Rise

- Tachyinduced CM
- Severe decompensated CHF/Ambulatory CG shock
- Late presentation of MI
- Endocarditis, culture negative
- Etiology: Patient fear, patient/provider presumption they have COVID-19

Humor in Medicine

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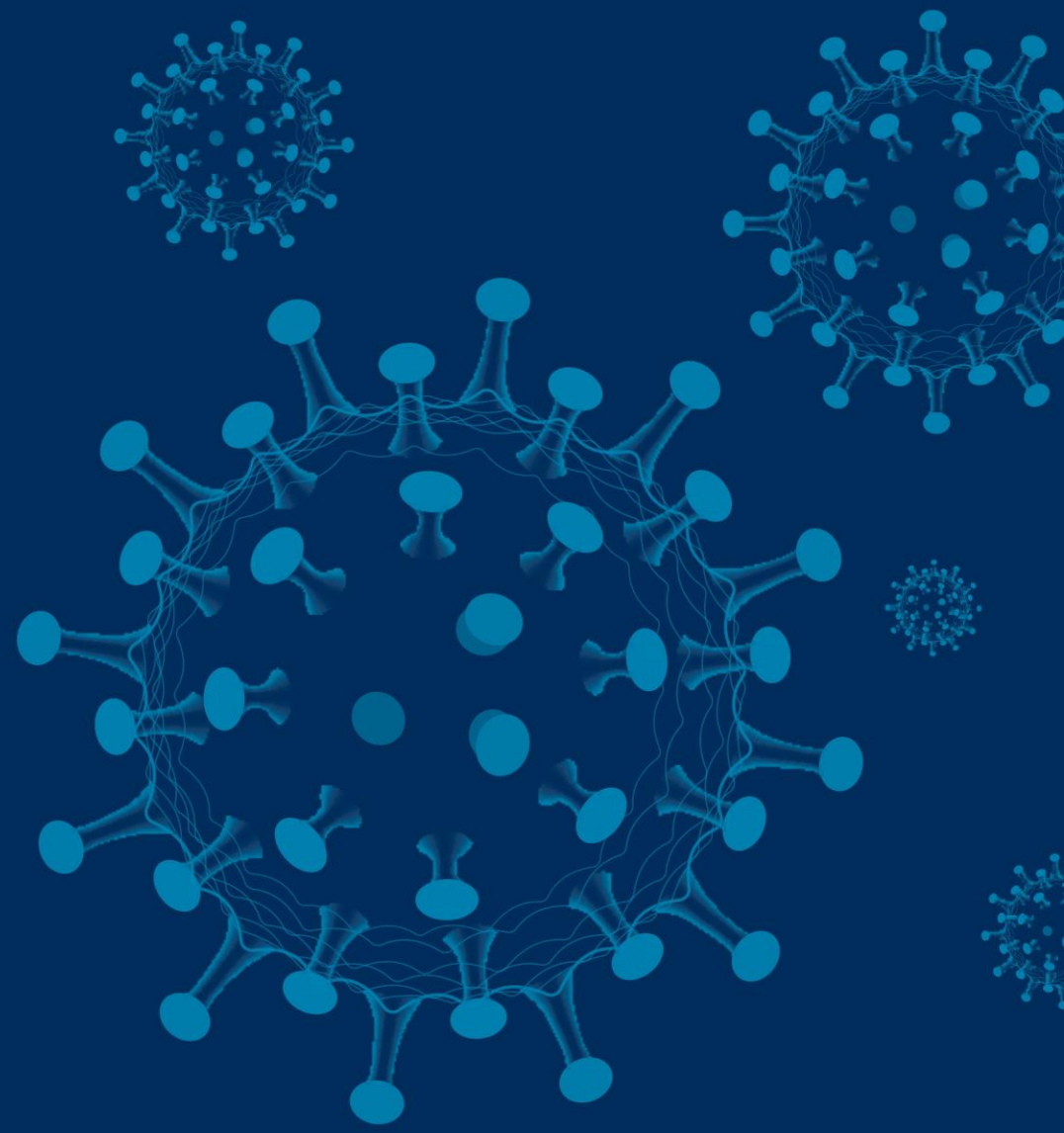
Changing of Staff Roles Developing the "New Normal"



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Overarching Considerations

- Patient and Team Safety
- Patient Flow
- Top of License Roles and Responsibilities
- Virtual Care Options
- Revenue Cycle Considerations

Developing the Framework

Virtual vs Face to Face

PATIENT TOUCHPOINT OPTIONS

Touchpoint	Virtual Option	Face to Face Option
Registration	X – phone, portal	X
Insurance verification	X – phone, portal (pic with phone)	X
Rooming Requirements		
• Medications	X - phone, portal	X
• Vital Signs		X
• PMH, PSH, FH, SH, ROS	X – phone, portal	X
EKG		X
Check-out	X- phone, portal	X Traditional vs MA to do simple check-out
Follow-up scheduling	X – phone, portal	X
Pre-procedure preparation	X – phone	X

ANCILLARY SERVICE OPTIONS

Touchpoint	Virtual Option	Face to Face Option
Monitors	X – mail in and company options	X – masks for all
Anticoagulation	X – lab draws, home monitoring	X – masks, car
Device Clinic	X – remotes if all normal	X - masks
Pre-procedure planning	X	X
Imaging Services		X
Cardiac Rehab	Pending	X

Scheduling

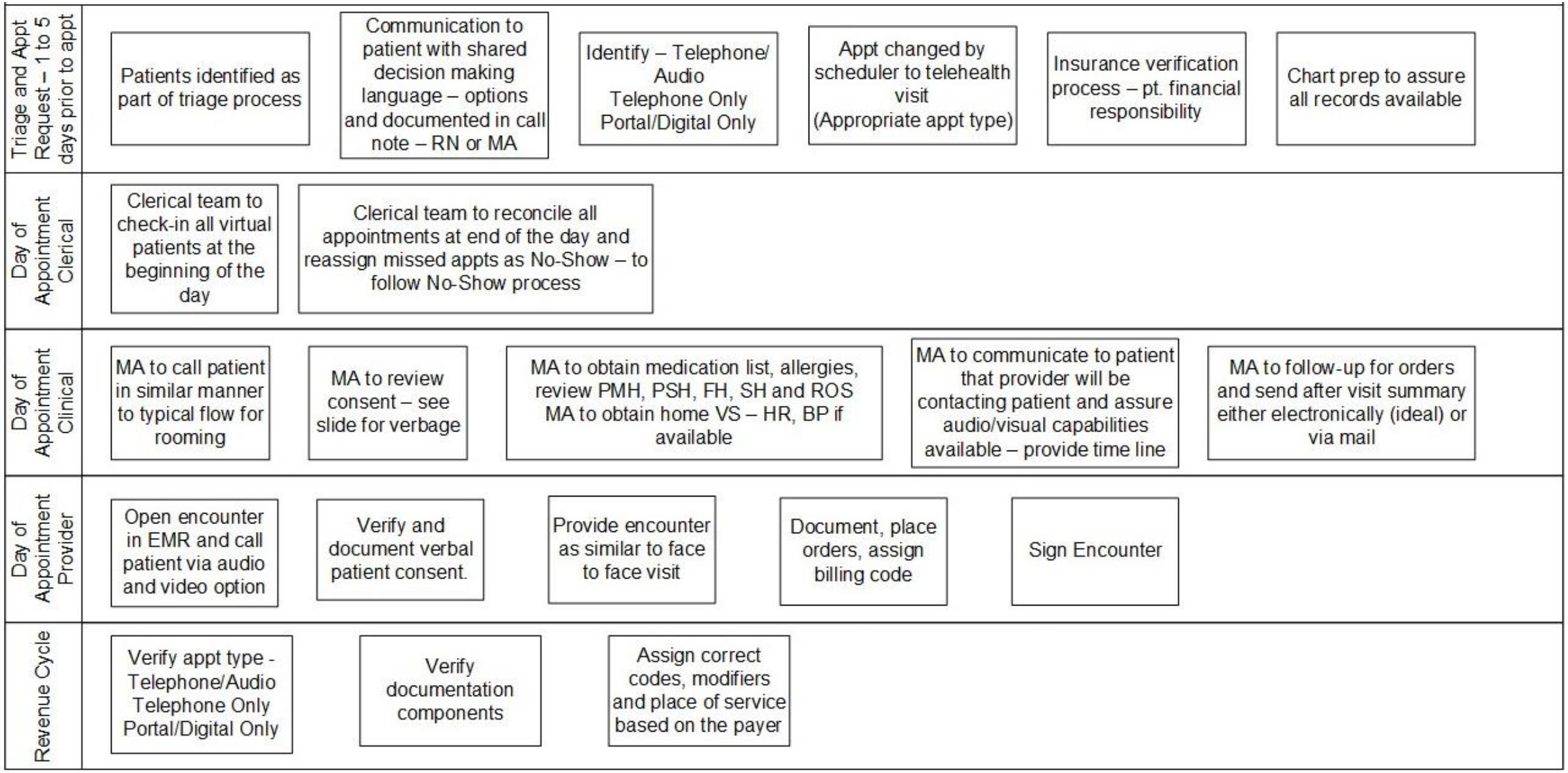
SCHEDULING

PEARLS

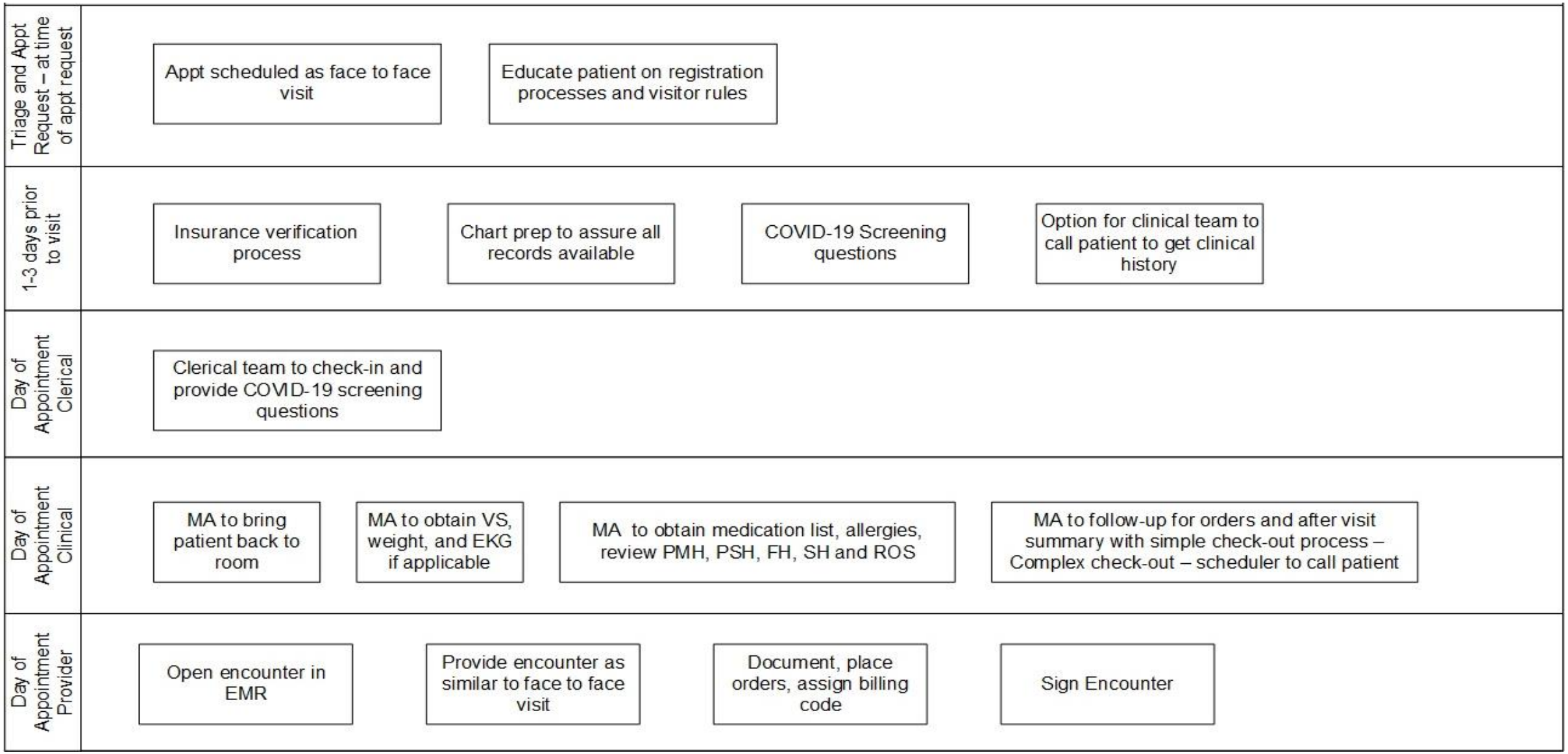
- Block schedules to minimize transitions
- Allow time for cleaning between patients
- Understand your math - # of patients in the clinic at a time
- Maintain identical ‘flow’ for virtual and face to face visits (IE – MA role, support, etc.) – ‘FLOW’ will dictate your time allocations
- Educate patients on what to expect – virtual or face to face
- Use Clerical team as virtual superuser educators for patients

Workflow/Roles-Responsibilities

TELEHEALTH VISIT FLOW



FACE-TO-FACE VISIT FLOW



Sample Block Schedule with Pre-visit ‘rooming’

Regular Clinic (option 1)			Regular Clinic (option 2)	
9:00	New		9:00	New
9:15			9:15	
9:30	F/U		9:30	New
9:45	F/U		9:45	
10:00	New		10:00	New
10:15			10:15	
10:30	F/U		10:30	F/U
10:45	F/U		10:45	F/U
11:00	New		11:00	New
11:15			11:15	
11:30	F/U		11:30	New
11:45	Lunch		11:45	
12:00	Lunch		12:00	Lunch
12:15	Lunch		12:15	Lunch
12:30	Lunch		12:30	Lunch
12:45	Lunch		12:45	Lunch
13:00	New - Virtual		13:00	F/U - Virtual
13:15			13:15	F/U - Virtual
13:30	F/U- Virtual		13:30	F/U - Virtual
13:45	F/U - Virtual		13:45	F/U - Virtual
14:00	New - Virtual		14:00	F/U - Virtual
14:15			14:15	F/U - Virtual
14:30	F/U - Virtual		14:30	F/U - Virtual
14:45	Same Day add on - Virtual		14:45	Same Day add on- Virtual
15:00	F/U - Virtual		15:00	F/U - Virtual
15:15	F/U - Virtual		15:15	F/U - Virtual
15:30	F/U - Virtual		15:30	F/U - Virtual
15:45	F/U - Virtual		15:45	F/U - Virtual
16:00	F/U - Virtual		16:00	F/U - Virtual
16:15	F/U - Virtual		16:15	F/U - Virtual
16:30	F/U - Virtual		16:30	F/U - Virtual
21 patients			22 patients	

Key Take-Aways

- Utilize taskforce or workgroup with key stakeholders
- Start with the patient and the objective of care that needs to be met
- Map out that need – current state and future state – asking what can be done virtually, electronically, etc.
- Assign team members based on skill set, patient flow, license-level, and resource availability- don’t be afraid to utilize a time study
- Develop your standard work processes and educate
- Round often with performance management/optimization needs in mind
- Develop metrics to measure outcomes – volumes, patient experience survey data, provider/team feedback, etc.

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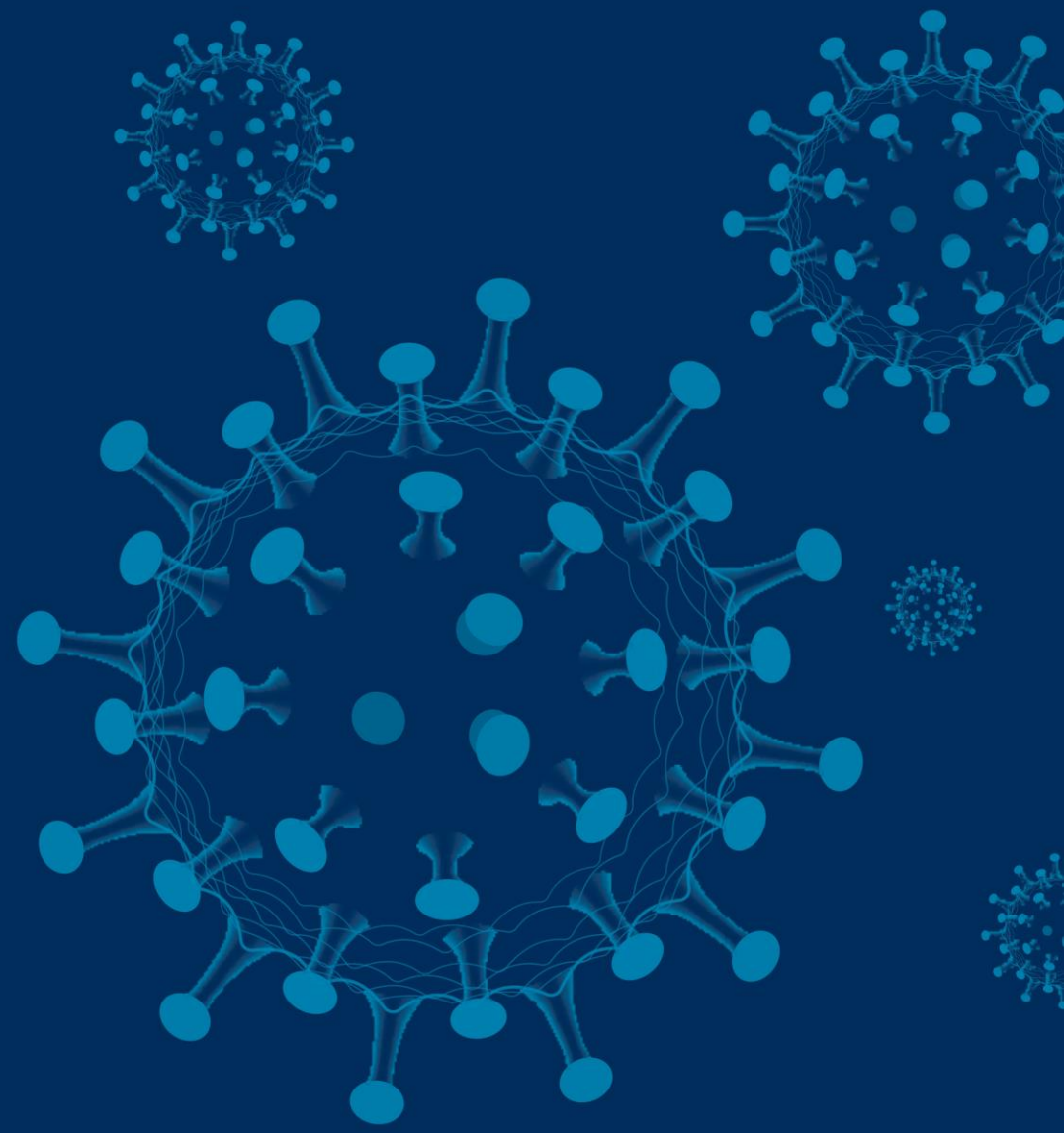
Learning from our experiences to ensure CV care for the future: Emergence



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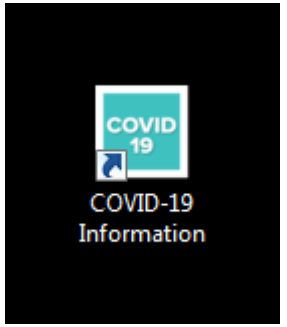
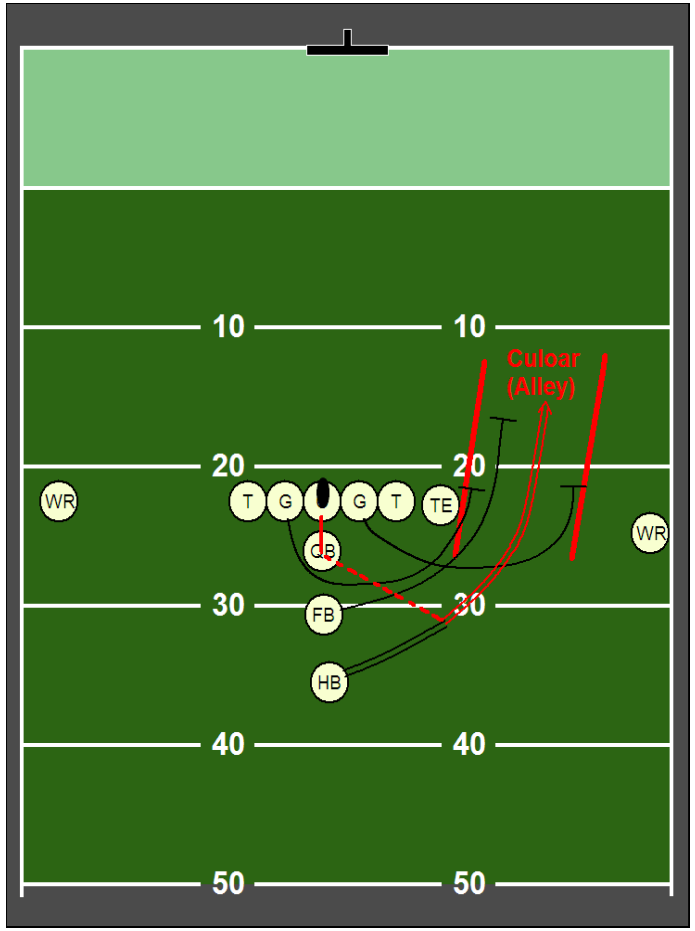
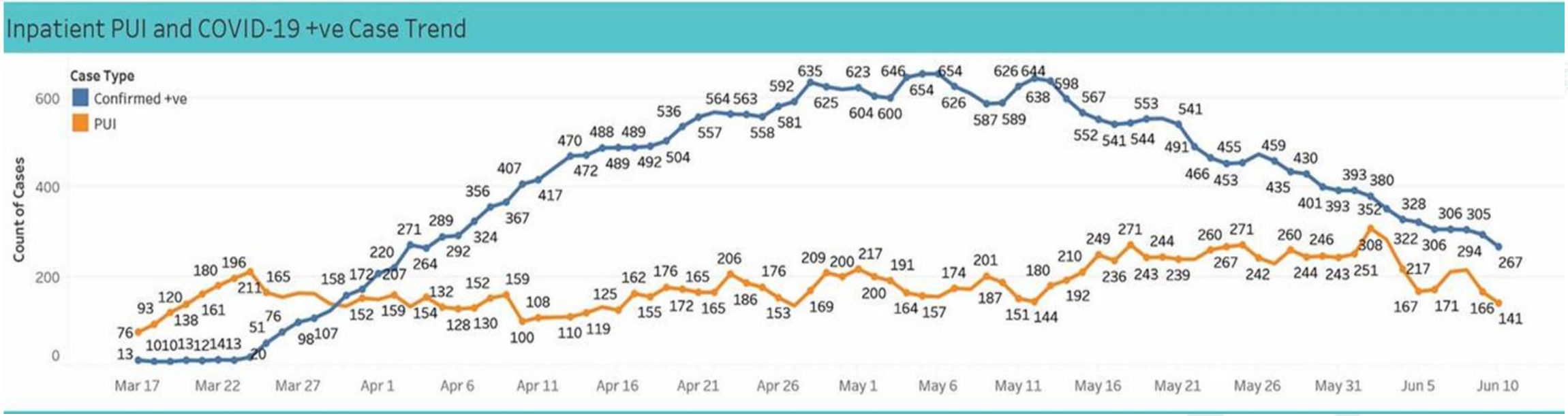
From shutting down……

Play book





To re-emergence



And into the future

- As we look into our crystal ball:
  - Where will we be a year from now
  - What's on the horizon
  - How do we prepare

Telemedicine

- Telehealth
  (Real-time Audio & Video)
  E&M service Codes
- Virtual Check-Ins
  (Telephone, Image, etc.)
  CMS G2012
- Audio Only – Telephone Visits
  CPTs 99441-99443
- E-Visit
  (Portal, email, EMR, etc.)
  CPTs 99421-99423
- Remote Patient Monitoring (RPM)
  (Digital Technology to collect data and transmit securely)
  G2010, 99453, 99457-58

Let's remember how Telehealth was

- Regulated by geographical areas
- Not approved from home
- HIPPA compliant format
- Can't cross state lines
- Billing by site of service mandated
- Could not be used for new patients
- Etc……

AMA Coding Scenario Info

CMS will allow telehealth office visits to be selected and documented based on total time on date of visit via CMS total time

New Patient		
	CPT Typical Time	*CMS Typical Time[4]*
99201 99202 99203 99204 99205	10 min 20 min 30 min 45 min 60 min	17 min 22 min 29 min 45 min 67 min
Established Patient		
	CPT Typical Time	*CMS Typical Time[4]*
99212 99213 99214 99215	10 min 15 min 25 min 40 min	16 min 23 min 40 min 55 min

https://www.ama-assn.org/system/files/2020-04/covid-19-coding-advice.pdf

What do you need to watch

- When will the PHE – Public Health Emergency – expire
  - 2nd 90 days ends 7/20/20
- When will the National Emergency end
- State's emergency disaster exceptions
- CMS rules and regulations
- Private payer rules
- CDC and TJC and your state public health departments

Have a plan for Emergence and beyond

- COVID-19 Awareness
  - ✓ Know your zip code
  - ✓ Incidence
  - ✓ Prevalence
  - ✓ Clusters
  - ✓ CDC guidelines
- Preparedness
  - ✓ PPE
  - ✓ Testing
  - ✓ Supply chain
  - ✓ HR
- Patient Safety
  - ✓ Communication
  - ✓ Screening
  - ✓ Testing (?)
  - ✓ Visitors or not
  - ✓ Social Distancing

Day of test considerations

- All patient-facing staff should wear a facemask at all times
- Screen patient for COVID risk +/- temperature
- If patient has suspicious symptoms, PPE for staff and facemask for patient
- Maintain 6 feet as much as possible
- Patient should come alone if possible

During test considerations - nuclear

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- If COVID suspected, one tech to don PPE and other to run the scanner
- Terminal clean if patient COVID+ or concerns for COVID+
- ALL equipment should be cleaned between each test in compliance with local infection control policies
- Minimize # of staff required to provide face to face patient interaction and minimize amount of time with patient by assuring all needs are met with each interaction

During test considerations - echo

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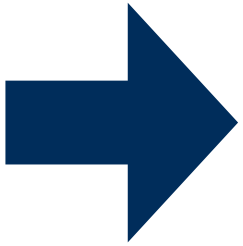
- Plan ahead for echo to allow for focused sequences of images that are needed for decision making
- Consider increased use of ultrasound enhancing agent to improve image acquisition
- Minimize scan times by excluding students and novice practitioners

Protocol Considerations

Goal is to minimize exposure



- Select protocol with shortest duration of scan time
- Single day or stress only
- Consider PET if available – faster throughput
- Consider reduction treadmill use – utilize pharmacologic as preferred for both echo and nuclear
- Consider pharmacologic agent with shortest infusion time, etc.

New TJC recommendations

- Released 6/3/20
- Healthcare organizations should continue to follow CDC recommendations for universal masking of staff, patients, and visitors
- All patient facing staff should wear face shields

Healthcare organizations should no longer be operating under crisis standards of care and no longer following contingency strategies for use of gowns, eye protection, or facemasks when they resume elective procedures and ambulatory care. In areas that experienced a large surge in the number of COVID-19 cases, many hospitals and healthcare organizations were unable to follow their usual policies and procedures and had to resort to "crisis standards of care." The effectiveness of crisis strategies is uncertain, and they may pose a risk for transmission of infectious diseases between healthcare providers and patients or other safety concerns. Therefore, the volume of care delivered under crisis standards should be limited, and an expansion of services to elective procedures and ambulatory care would be inappropriate until patient care activities are back within routine standards

Office Guidelines for PPE

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Adjustments in these guidelines are subject to changes in standards of care and/or supply chain availability

Tier	Situation	PPE for Patient Care Activities
Tier 1 (Asymptomatic patients)	Universal Masking All Office Staff Universal Masking + Standard Precautions All patient –facing staff	
Tier 2 (Symptomatic Patients)	PUI/COVID-19 Evaluation and treatment Clinical staff in close contact with patient (close contact defined as within 6 feet for 10 min or more)	
Tier 3 (Symptomatic Patients)	PUI/COVID-19 In Respiratory Center OR when collecting NP swab Clinical staff in close contact with patient (close contact defined as within 6 feet for 10 min or more)	

https://www.jointcommission.org/en/resources/news-and-multimedia/newsletters/newsletters/joint-commission-online/june-3-2020/preventing-nosocomial-covid19-infections-as-organizations-resume-regular-care-delivery/

Centers for Disease Controland Prevention (CDC) https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Key Take-Aways

- Governance
- Communication
- Understand YOUR market
- Know the clinical tiers that your clinicians have agreed on
- Solid communication plan for patients
- Plan for the next surge – bed availability, patient safety, access to care

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COVID-19 TAKE-AWAYS

- Needs of Patients & Team: Safety, Flow
- Map Out Current/Future State of Needs & Solutions
- Virtual & In-Person Care Options
- Solid Communication With Patients & Team
- Plan & Yet Be Flexible; Site Customization