GEDC | THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

EXPERT PANEL WEBINAR

Monday, May 11, 2020 | 3:00pm Eastern; 2:00pm Central; 12:00 Noon Pacific

ED-based Models of Telehealth for Older Adults

MODERATOR: Don Melady, MD

Please visit gedcollaborative.com

COVID-19 Resources gedcollaborative.com/article/covid-19-resources/

EXPERT PANEL

Kevin Biese, MD
Emergency physician,
University of North Carolina

Jeffrey Davis, MSc(HPM)
Director, Regulatory Affairs
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Michael Kurliand, MS RN
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Kevin Curtis, MD,
Telehealth Director
Geisel School of Medicine at Dartmouth

GEDC
THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

Vision

A world where all emergency departments provide the highest quality of care for older patients.

Mission

We bring best practice into action.

We transform and evaluate interdisciplinary best practice in geriatric emergency medicine.

We build and distribute practical, evidence-based clinical curriculum and quality improvement tools that support sustainable, quality care for older adults.

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Zoom Webinar Pointers

1. All microphones have been muted.
2. Hover your mouse over the Zoom window to bring up five icons in the bottom center
3. Q & A Function will NOT be used.
4. Click on **Chat** function, the icon on lower right.

Webinar RECORDING & SLIDES will be available at gedcollaborative.com

GEDC

ED-based Models of Telehealth for Older Adults in the Age of COVID-19

Geriatric Emergency Department Collaborative
May 11, 2020

@theGEDC

GEDC

Launching an ED Telehealth program during COVID-19: Real-world implementations for older adults

GEDC

Journal of Geriatric Emergency Medicine

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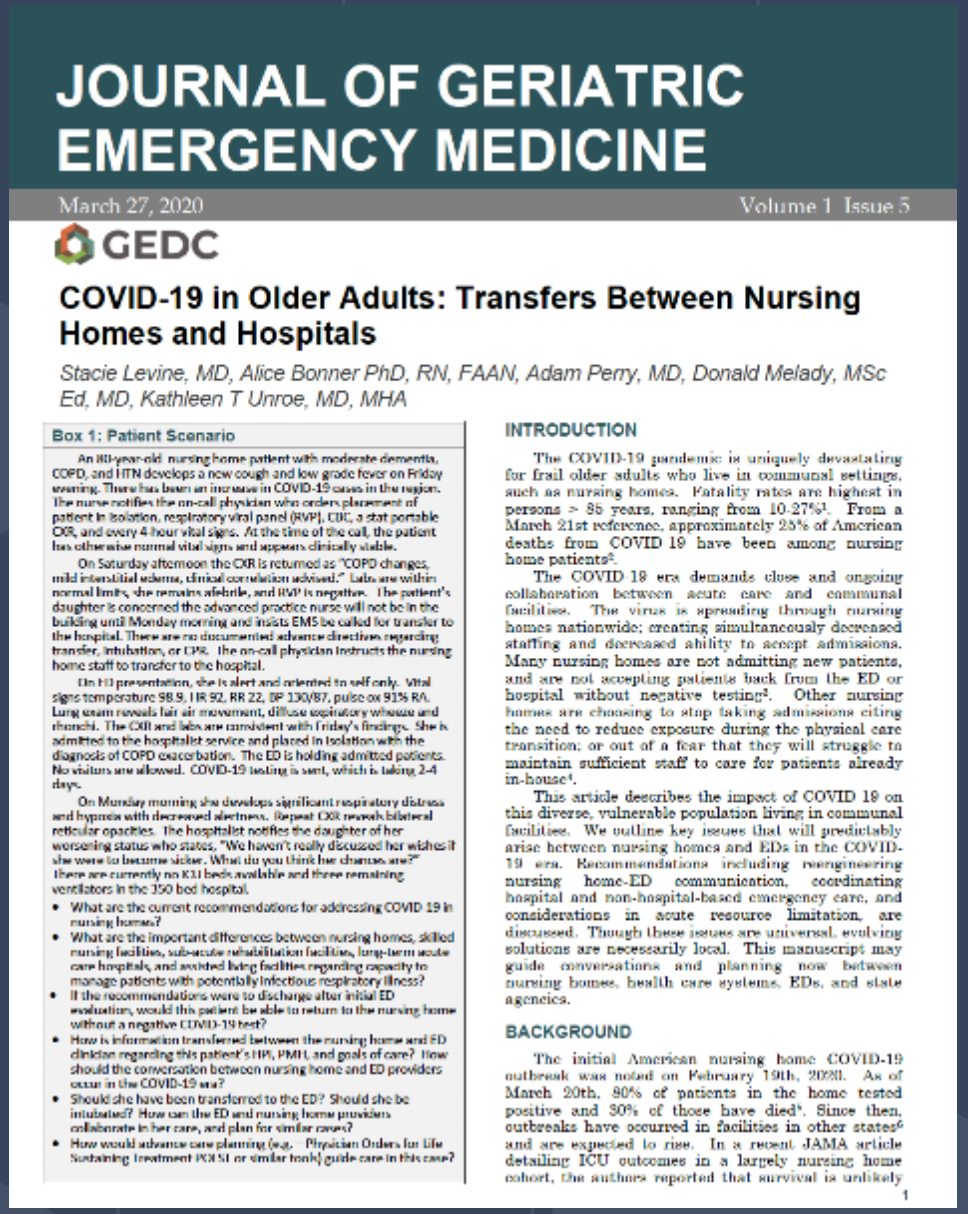

JOURNAL OF GERIATRIC EMERGENCY MEDICINE

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GEDC

COVID-19 in Older Adults: Transfers Between Nursing Homes and Hospitals

Stacie Levine, MD, Alice Bonner PhD, RN, FAAN, Adam Perry, MD, Donald Melady, MSc Ed, MD, Kathleen T Unroe, MD, MHA

Box 1: Patient Scenario

An 80-year-old nursing home patient with moderate dementia, COPD, and HTN develops a new cough and low grade fever on Friday evening. There has been an increase in COVID-19 cases in the region. The nurse notifies the on-call physician who orders placement of patient in isolation, respiratory viral panel (RVP), CBC, a stat portable CXR, and every 4 hour vital signs. At the time of the call, the patient has otherwise normal vital signs and appears clinically stable.

On Saturday afternoon the CXR is returned as "COPD changes, mild interstitial edema, clinical correlation advised." Labs are within normal limits, she remains afebrile, and RVP is negative. The patient's daughter is concerned the advanced practice nurse will not be in the building until Monday morning and insists EMS be called for transfer to the hospital. There are no documented advance directives regarding transfer, intubation, or CPR. The on-call physician instructs the nursing home staff to transfer to the hospital.

On ED presentation, she is alert and oriented to self only. Vital signs temperature 98.9, HR 92, RR 22, BP 130/87, pulse ox 91% RA. Lung exam reveals fair air movement, diffuse expiratory wheezes and rhonchi. The CXR and labs are consistent with Friday's findings. She is admitted to the hospitalist service and placed in isolation with the diagnosis of COPD exacerbation. The ED is holding admitted patients. No visitors are allowed. COVID-19 testing is sent, which is taking 2-4 days.

On Monday morning she develops significant respiratory distress and hypoxia with decreased alertness. Repeat CXR reveals bilateral reticular opacities. The hospitalist notifies the daughter of her worsening status who states, "We haven't really discussed her wishes if she were to become sicker. What do you think her chances are?" There are currently no ICU beds available and three remaining ventilators in the 350 bed hospital.

- What are the current recommendations for addressing COVID 19 in nursing homes?
- What are the important differences between nursing homes, skilled nursing facilities, sub-acute rehabilitation facilities, long-term acute care hospitals, and assisted living facilities regarding capacity to manage patients with potentially infectious respiratory illness?
- If the recommendations were to discharge after initial ED evaluation, would this patient be able to return to the nursing home without a negative COVID-19 test?
- How is information transferred between the nursing home and ED clinician regarding this patient's HPI, PMH, and goals of care? How should the conversation between nursing home and ED providers occur in the COVID-19 era?
- Should she have been transferred to the ED? Should she be intubated? How can the ED and nursing home providers collaborate in her care, and plan for similar cases?
- How would advance care planning (e.g. Physician Orders for Life Sustaining Treatment POLST or similar tools) guide care in this case?

INTRODUCTION

The COVID-19 pandemic is uniquely devastating for frail older adults who live in communal settings, such as nursing homes. Fatality rates are highest in persons > 85 years, ranging from 10-27%[1]. From a March 21st reference, approximately 25% of American deaths from COVID 19 have been among nursing home patients[2].

The COVID-19 era demands close and ongoing collaboration between acute care and communal facilities. The virus is spreading through nursing homes nationwide; creating simultaneously decreased staffing and decreased ability to accept admissions. Many nursing homes are not admitting new patients, and are not accepting patients back from the ED or hospital without negative testing[3]. Other nursing homes are choosing to stop taking admissions citing the need to reduce exposure during the physical care transition; or out of a fear that they will struggle to maintain sufficient staff to care for patients already in-house[4].

This article describes the impact of COVID 19 on this diverse, vulnerable population living in communal facilities. We outline key issues that will predictably arise between nursing homes and EDs in the COVID-19 era. Recommendations including reengineering nursing home-ED communication, coordinating hospital and non-hospital-based emergency care, and considerations in acute resource limitation, are discussed. Though these issues are universal, evolving solutions are necessarily local. This manuscript may guide conversations and planning now between nursing homes, health care systems, EDs, and state agencies.

BACKGROUND

The initial American nursing home COVID-19 outbreak was noted on February 19th, 2020[5]. As of March 20th, 90% of patients in the home tested positive and 30% of those have died[5]. Since then, outbreaks have occurred in facilities in other states[6] and are expected to rise. In a recent JAMA article detailing ICU outcomes in a largely nursing home cohort, the authors reported that survival is unlikely

1

Meet Our Presenters

Dr. Kevin Biese

Jeffrey Davis

Michael Kurliand

Dr. Kevin Curtis

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Dr. Kevin Biese

Jeffrey Davis

May 11, 2020

Overview of COVID-19 Telehealth Flexibilities

Jeffrey Davis, ACEP's Director of Regulatory Affairs

https://www.acep.org/globalassets/new-pdfs/advocacy/summary-of-covid-19-telehealth-flexiblities-revised-4-30-2020.pdf

- Telehealth services can be provided from any location including both urban and rural areas.
- HIPAA waiver for use of everyday communication technologies like FaceTime or Skype.
- Telephone (audio-only) codes can be billed.
- EMTALA medical screening exam can be conducted via telehealth.

MEDICARE

- ED E/M codes, critical care codes, and observation codes all temporarily added to list of approved Medicare telehealth services. Telehealth services are paid at same rate as in- person services.
- Place of service is considered the same as if service were conducted in-person; a 95 modifier should be included on the claim if provider and patient are in separate locations.
- Waiver allowing physicians who are licensed in one state to provide services to patients in another state

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Four Points to Remember

1. **Anywhere:** Telehealth services can be delivered regardless of location.
2. **Equal Payment**: Telehealth Services are paid at same rate as in-person services.
3. **Coding:** Use same place-of-service code as in-person services (ED-- 23) AND Attach modifier -95.
4. **Temporary:** All these changes only last for the duration of the pandemic.

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Regs & Eggs blog

I have blog focused on federal regulatory affairs, "Regs & Eggs." Every Thursday morning, while you're eating your breakfast, I provide weekly updates on the major federal regulations impacting emergency medicine.

- ***Click here for the current edition.***
- ***Click here for previous editions.***
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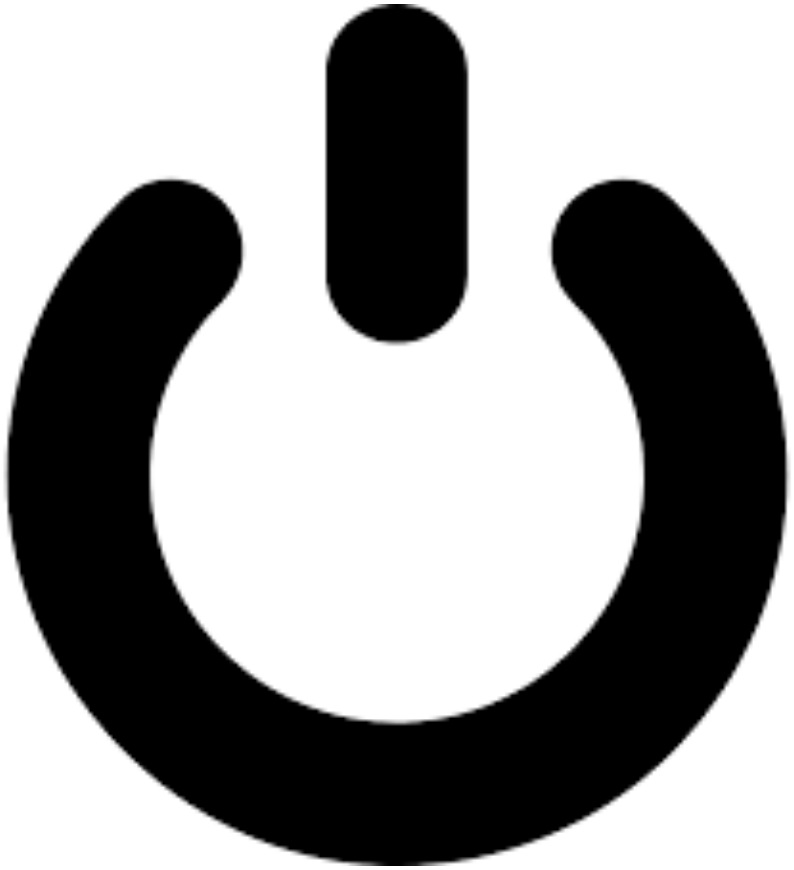
COVID-19 Federal Updates

Federal agencies have been continually providing new COVID-19 guidance. ACEP tracks federal agency announcements and provides updates on our website here. Keeping checking our website for the latest information that impacts emergency medicine.


Michael Kurliand

Help PALTCs avoid unnecessary transports and hospital utilization



Make or Break Principle for Rapid Deployment:

#1
Keep it simple for both organizations

1:4 | 1:40

Make or Break Principle for Rapid Deployment:

#2
Commitment

Inform & Scale

https://www.westhealth.org/covid-19-resource-center/

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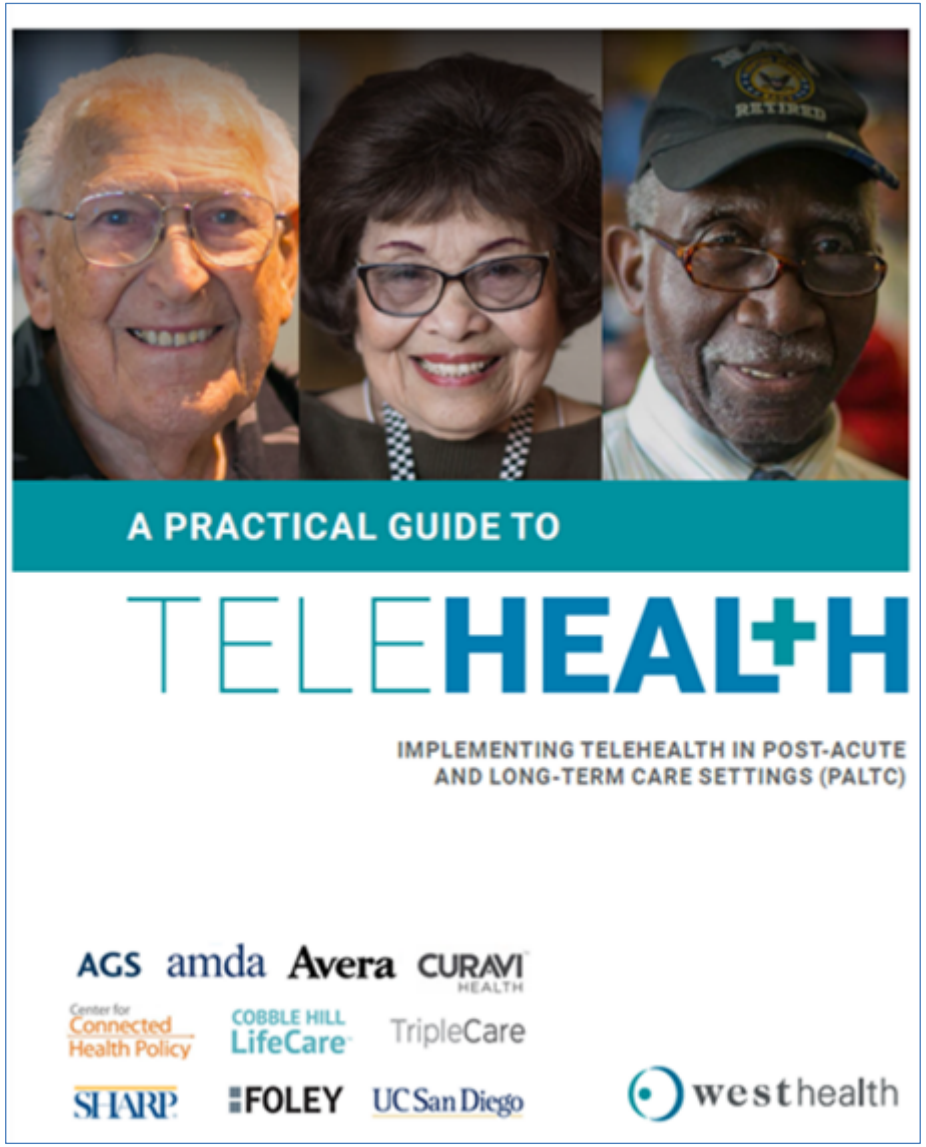
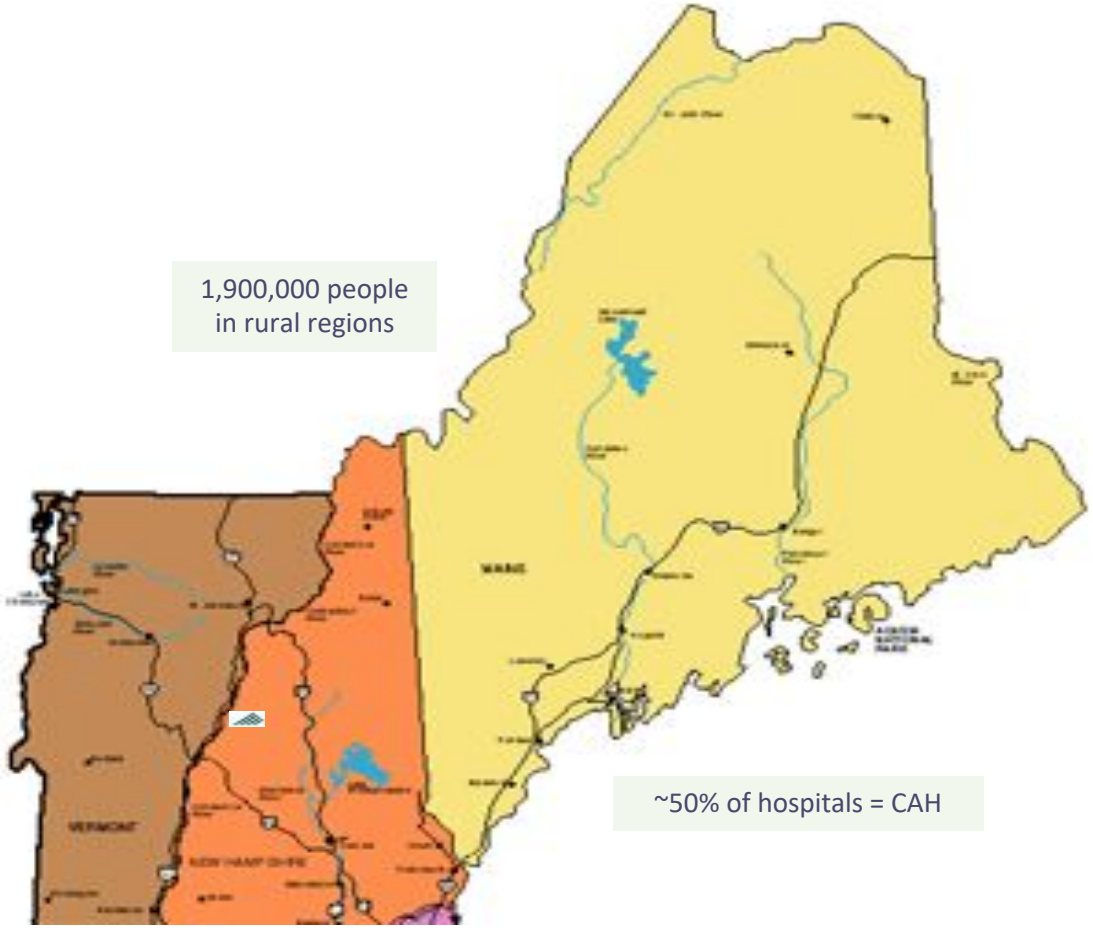


Dr. Kevin Curtis

A Hub and Spoke Model in the Rural Northeast



1,900,000 people
in rural regions

~50% of hospitals = CAH

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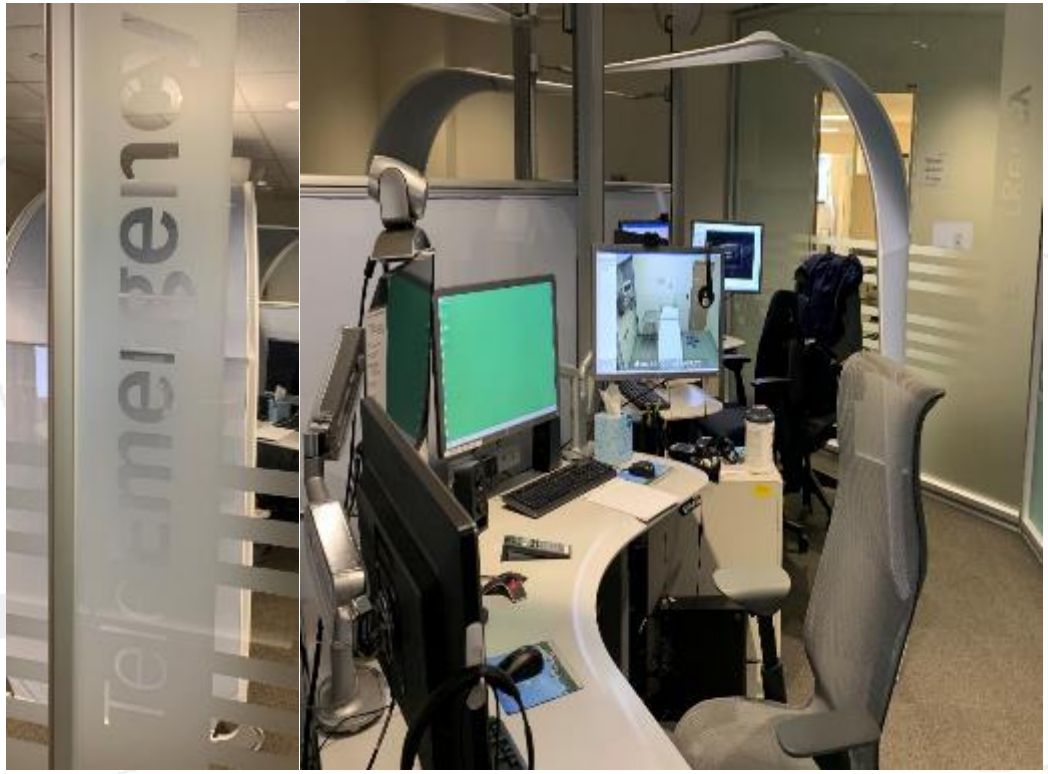
Telehealth Mission

To help deliver outstanding care
to the region
independent of patient location

TeleEmergency TeleEmergency TeleICN TeleNeurology TeleICU TelePharmacy TelePsychiatry Outpatient Virtual Visits Inpatient TeleSpecialty ent Virtual Visits

Dartmouth-Hitchcock TeleEmergency



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