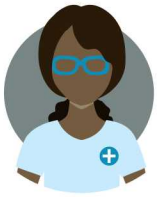
NATIONAL ASSOCIATION OF Community Health Centers®

RE-IMAGINED CARE in the Era of COVID-19

Responding strategically and decisively during this public health emergency is essential for health center survival and positioning for the post-pandemic period. The following list of recommendations and actions was gathered from discussions with many health center, primary care association, and health center-controlled network leaders who were at the epicenter of the pandemic at its start. This synthesis of insights is intended to guide health centers that have not yet experienced, or are just beginning to experience, a surge of COVID-19 cases. While these recommendations do not reflect the comments of any one person or organization, including NACHC, they offer a set of lessons learned that have been corroborated by many on the front lines of the COVID-19 pandemic.



Create a Leadership Command System

- **Recommendation:** Organize a control and command system with key organizational leaders and open lines of communication among all levels of staff as a means to guide the health center through this emergency phase.
  - This leadership command group should consist of 5-6 key business area representatives, including: Chief Executive Officer, Medical Director, Finance Director, IT Director, and other key business areas such as dental, pharmacy, or behavioral health.
  - The leadership command group should meet in daily huddles, with key decisions and direction cascaded through the appropriate division leads (e.g., operational, clinical, financial, etc.). Mechanisms must be in place to gather input from front-line workers so information can run up and down the chain of command, with discussion and decisions as part of daily leadership huddles.
  - Engage the Board early so they have an understanding of what the transition to virtual care means and the importance of this transition to health center sustainability.
- **Rationale:** The uncertainty and chaos of the changing environment requires **open and continuous communication with a clear bidirectional path to authority and action.** Ongoing communication is required throughout each day – informed by all levels of the organization – and structured for centralized, date-driven, and informed decision-making and direction.

Deploy Virtual Visits Now

- **Recommendation:** Make plans to move the vast majority of patient visits to virtual care in the next four months, regardless of the volume of COVID-19 cases in your community. Exceptions may include: childhood immunizations, OB/GYN with complications, and other medically urgent needs.
  - To stop the spread of COVID-19, individuals are asked to stay home unless medically necessary. These instructions, along with patients' fear of acquiring COVID-19, have resulted in a sharp decline in patient visit volume…and, thus, revenue.
- **Rationale:** To stay viable and competitive now and post-COVID-19, health centers must **develop competency in providing virtual care.** Current revenue-friendly provisions and relaxed regulatory requirements support the movement of care to a virtual setting.

Promote New Virtual Care

- **Recommendation:** Develop needed scripts, signage, and protocols to redirect patients from in-person visits to virtual visits, and explain why it's safe and easy for patients to receive care this way.
  - Messages about new virtual visits and services should be released before, or at least simultaneous with, the rollout of virtual visits. In addition to health center messaging strategies (phone, email, website), use local media to widely promote this new service.
  - Instruct patients who are concerned about symptoms related to COVID-19 to visit CDC's Coronavirus Self-Checker. Share the locations of testing sites where patients can be referred. Instruct patients to seek medical attention if they have moderate-severe COVID-19 symptoms.
  - Inform patients of any visit-types that may still occur in person (e.g., OB/GYN) or services offered through drive-by clinics (e.g., immunizations, lab draws).
  - Include instructions (outlined in staff telephone scripts and on health center website) for patients to access emotional/mental health support, with hotline numbers for urgent needs.
- **Rationale: Provide staff with training, guidelines, and tools for virtual care.** Staff require clear guidance and simple language to help patients learn how/where to seek care.

Identify Patients to Contact for Virtual Visits

- **Recommendation:** Leverage new/relaxed requirements around telehealth to generate lists of patients in order to initiate contact and transition patients from in-person to virtual visits.
  - Create a list of patients who were scheduled for in-person visits and contact them to transition their visit to virtual care.
  - Generate a list of patients who meet eligibility criteria for CMS/Medicare care management services (e.g., two or more chronic conditions, behavioral health needs, etc.) and contact them for enrollment in telephone care management (video connection is not required for CMS/Medicare care management services). See NACHC's website for guidance on eligibility and revenue opportunities for CMS/Medicare care management and virtual communication services Reimbursement Tips.
  - Develop a list of Medicaid patients who have not been in engaged in care and contact them for virtual care (proactive approach assumes state Medicaid reimburses FQHCs for telehealth).
- **Rationale: Health centers need to proactively identify, contact, and transition patients to virtual visits and care management services.** Engaging patients in virtual care and services provides vitally needed patient care while generating revenue needed to keep health center staff employed.

Define Limited In-Person Visits

- **Recommendation:** Establish a schedule (e.g., specific days/hours) when your health center will see the very few patients who need to be seen in person.
  - For patients where virtual care is not feasible or possible, establish parameters around which patients will be seen in person (e.g., children < 2 years of age for immunizations, OB patients within certain parameters, etc.).
  - For patients who require an in-person interaction, define whether the in-person encounter will occur within the walls of the health center or outside (e.g., drive-by immunizations or lab draws).
  - In cases where a health center will see both 'well' and 'sick' patients, provide care in separate locations. This helps minimize staff and patient exposure to COVID-19 (well clinics) while protecting staff who deliver care to patients who are sick or present with respiratory symptoms (through the use of proper protective equipment). Any settings where care is provided in person (well or sick) should take appropriate measures to screen patients (e.g., symptom review, temperature).
- **Rationale:** Health centers should **separate care and services for the generally healthy and vulnerable populations from patients who may have COVID-19.**

Create Capacity for Patients to Schedule Visits

- **Recommendation:** Build the capability for patients to schedule their own visits. Deploy IT staff to develop, or activate capabilities that exist within the electronic health record, for patients to schedule their own visits.
  - While the transition of patients visits from in-person to virtual will require a high degree of personal touch and communication in this crisis phase, health centers can look to develop more automated scheduling options for the post-COVID-19 period.
- **Rationale:** To efficiently deploy staff to patient care activities, and away from the time-intensive process of scheduling patient visits, **create patient-driven scheduling systems.**

Mobilize New Revenue Opportunities

- **Recommendation:** **Maximize new/additional sources of revenue through CMS/ Medicare telehealth, care management services, and virtual communication services** while managing your burn rate by identifying areas where expenses can be reduced or eliminated without reducing quality.
  - NACHC offers brief, informational and 'how-to' documents to guide health centers in CMS/Medicare care management and virtual communication services, including details about how to bill for these services. For example, through CMS/Medicare: telehealth ($92.03); telehealth visit + a monthly chronic care management or behavioral health integration interaction ($158.80); virtual communication services ($24.76). Reimbursement Tips.
- **Rationale:** With dramatic reductions in revenue from decreases in patient visit volume, it is imperative to focus on new revenue opportunities while reducing unnecessary expenses. Telehealth and virtual care management and communication services offer an important avenue for new revenue.

Secure Medicaid Revenue

- **Recommendation:** Work with your state primary care association (PCA) to ensure your state Medicaid Office is revising policies and payment practices to reimburse FQHCs for virtual visits at the PPS rate.
  - Advocate for payment of phone-only visits at the same rate as audio/visual visits during the COVID-19 crisis period.
- **Rationale:** **Adequate payment from Medicaid for virtual visits** is necessary for health center survival.

Mobilize Medicare Revenue

- **Recommendation:** Redeploy staff to support the delivery of virtual care with a focus on activities that generate revenue.
  - Train providers and staff to provide telehealth visits ($92.03).
  - Call every eligible/willing Medicare patient to offer enrollment in one of the four (4) CMS/Medicare reimbursable care management services ($67 – $142/month).
  - Engage ancillary staff, when possible, in supporting virtual patient visit workflow (e.g., "rooming" patient; gathering medication history) and performing other patient care activities that generate revenue, such as support for SBIRT screening ($17) and remote blood pressure screening ($15).
- **Rationale:** **Maximize available CMS/Medicare reimbursement for virtual patient care and services** (telehealth, care management services, virtual communication services). Often (though not always), states and payers follow Medicare's lead with regard to payment.

Access Federal COVID-19 Relief Resources

- **Recommendation:** Submit applications to receive the various Federal COVID-19 Relief Resources.

Redeploy Staff

- **Recommendation:** **Define new staff roles and reallocate staff to use technology to provide virtual care infused with human compassion.** Set the goal of transitioning to nearly 100% virtual patient care in the short-term. **Provide staff with training, guidelines, and tools for virtual care.**
  - Consider provider and staff inventory as the total number of available FTEs not bodies in a building – and be bold and creative in redeploying all staff to functions that support patient care and services.
  - Establish/strengthen partnerships with local organizations that can augment support for patients in areas such as food, housing, employment, and counseling.
- **Rationale:** Workforce strategy tied primarily to in-person visits is antiquated. Even after the COVID-19 crisis, health centers will need to revisit assumptions and limitations that define workforce capacity and demand as connected to in-person care. Staff require appropriate training, guidelines, and tools to effectively deliver virtual care.

- **Recommendation:** Create dedicated phone lines for such areas as: (1) general inquiries; (2) triage; (3) enrollment and ongoing follow-up for care management services; and (4) consultation (e.g., Virtual Communication Services (VCS).
  - Ancillary staff can direct calls to appropriate lines and answer general inquiries (including directing patients to CDC's Coronavirus Self-Check for COVID-19).
  - RNs can manage increased triage calls, especially during COVID-19.
  - RN/MA/LPN/CHW/SW/BH can enroll patients in care management and/or conduct monthly care management check-ins.
  - Providers can respond to patient requests for consultation (e.g., VCS).
- **Rationale: Before considering staff furloughs/reductions, redeploy staff to areas of increased demand and to activities that drive up patient virtual visit volume and revenue.** Deploy as many staff as possible to services that both meet patient needs and generate revenue, including care management and virtual communication services.

Create a COVID-19 Work Policy

- **Recommendation: Develop a workforce policy to test and care for employees who suspect COVID-19 infection.** Provide clear information about when employees can return to work following a positive COVID-19 test.
  - Employees with symptoms should be instructed to remain at home. Establish policies for when they can return to in-person work after quarantine (for any work that still takes place at the health center).
  - Anticipate staff absences due to COVID-19 infection. For each critical operational lead (clinical, finance, administration, etc.), identify a back-up point person who is cued up and informed throughout the crisis period.
  - If nearly all or most patient visits are virtual for the short term, returning staff to work is largely a matter of when the employee feels well enough to work virtually while under quarantine.
- **Rationale:** Staff recovering from COVID-19 infection can perform virtual visits or other functions (when they feel well enough) because contagion is not an issue. For staff performing necessary in-person visits, it is imperative to prevent unnecessary risk to others by not providing in-person care too early. COVID-19 is very contagious, even when a person is asymptomatic. To prevent the spread of COVID-19 to the health center's vulnerable populations, it is important to follow CDC guidance on when to return to work.

Focused COVID-19 Testing: Support Public Health Partners' Testing

- **Recommendation:** While a health center's decision regarding COVID-19 testing will be driven by a number of factors, including the impact of COVID-19 in the community, availability of tests and personal protective equipment, and testing availability at other locations, health centers may choose to focus on enhancing testing capabilities for patients in the context of primary care while deferring large-scale and community-wide testing to local public health authorities and hospitals.
  - More widespread testing may be warranted in certain instances, such as groupings of agricultural workers, homeless settlements, or in locations with limited public health testing capability.
  - Communicate and coordinate with community stakeholders to ensure services are coordinated and aligned.
  - Health centers should establish the capability (e.g., sufficient supply of tests, personal protective equipment, and training) to perform focused COVID-19 testing in the context of primary care and testing of health center employees.
- **Rationale:** Diverting health center staff and resources (in many cases already thinned) to the task of widescale or community-wide COVID-19 testing could jeopardize health center's ability to deliver its core mission-critical health care activities. The health center should **remain focused on business continuity and serving the health care needs of the safety-net population.** This could include a partnership whereby health centers identify patients in need of COVID-19 testing and the local public health authority, possibly onsite, completes the testing and any needed contract tracing. Mass testing events may be better conducted by public health entities and hospitals in centralized locations with resources (staff, PPE, etc.) devoted to this purpose. Any health center testing efforts should involve planning and coordination of testing with local public health authorities and hospitals.

Position for "New" Markets (Back to Core Health Center Mission)

- **Recommendation:** **Secure your market share and viability by offering services and business lines** that reinforce the unique role of health centers, with services **other providers can't readily replicate or perform as well.**
  - Re-energize activities related to assessing and addressing social risk factors, connecting and partnering with community-based organizations, and mobilizing a "circle of care" beyond just primary care.
  - Consider complementary business lines related to economic development and jobs, food security, housing, and transportation.
- **Rationale:** While competency in the area of virtual care is essential, it is only part of what is needed to survive and thrive in the future health care market. As other providers outpace and outspend in the deployment of technology, new business lines that differentiate health centers from other health care providers are critical for operational survival and for the safety net populations health centers serve.