Family PACT Webinar
September 17, 2020

Providing Family PACT Services During COVID-19: Understanding Benefit Changes

Michael Policar, MD, MPH
Professor Emeritus of Ob, Gyn & Repro Sciences
UCSF School of Medicine
michael.policar@ucsf.edu

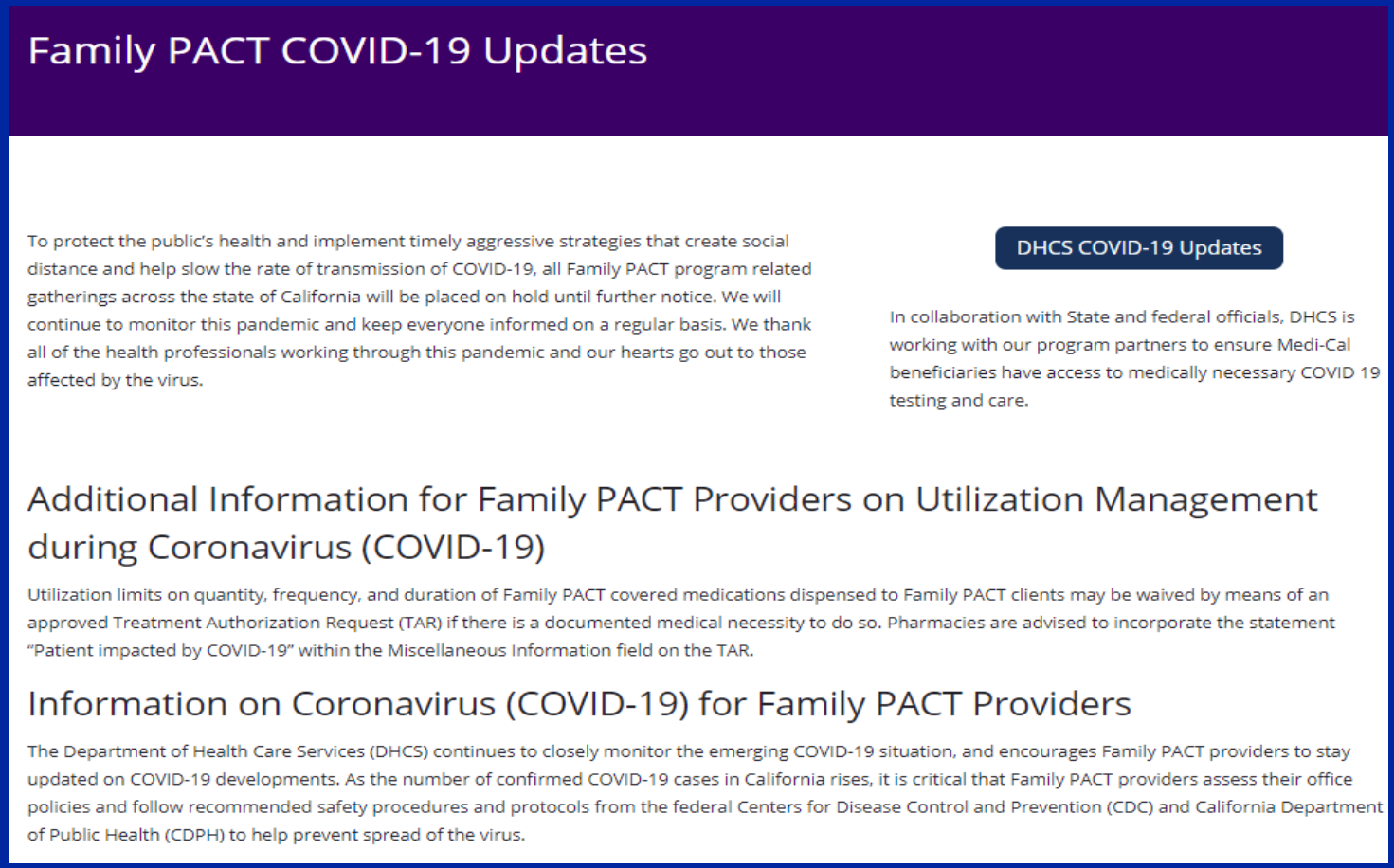
Evolution FPACT Telehealth Policies

- Pre- public health emergency (before March 2020)
- Current policies (March 19 -present)
- Many will sunset (phase out) after PHE is over

Policies evolve frequently

- References are at the end of this presentation
- All have hot-links to source policy

Where Can I Find Family PACT Policies About Telehealth Visits?



Family PACT COVID-19 Updates

To protect the public's health and implement timely aggressive strategies that create social distance and help slow the rate of transmission of COVID-19, all Family PACT program related gatherings across the state of California will be placed on hold until further notice. We will continue to monitor this pandemic and keep everyone informed on a regular basis. We thank all of the health professionals working through this pandemic and our hearts go out to those affected by the virus.

DHCS COVID-19 Updates

In collaboration with State and federal officials, DHCS is working with our program partners to ensure Medi-Cal beneficiaries have access to medically necessary COVID 19 testing and care.

Additional Information for Family PACT Providers on Utilization Management during Coronavirus (COVID-19)

Utilization limits on quantity, frequency, and duration of Family PACT covered medications dispensed to Family PACT clients may be waived by means of an approved Treatment Authorization Request (TAR) if there is a documented medical necessity to do so. Pharmacies are advised to incorporate the statement "Patient impacted by COVID-19" within the Miscellaneous Information field on the TAR.

Information on Coronavirus (COVID-19) for Family PACT Providers

The Department of Health Care Services (DHCS) continues to closely monitor the emerging COVID-19 situation, and encourages Family PACT providers to stay updated on COVID-19 developments. As the number of confirmed COVID-19 cases in California rises, it is critical that Family PACT providers assess their office policies and follow recommended safety procedures and protocols from the federal Centers for Disease Control and Prevention (CDC) and California Department of Public Health (CDPH) to help prevent spread of the virus.

https://familypact.org/covid-19-updates/

Telemedicine in Medicare and Medicaid

- "Telehealth Visits"
  - Based on rules before March 6, 2020
- Communications-based Technology
  - Virtual Check-Ins
    - Short patient-initiated communications with a healthcare practitioner
    - Virtual check-in visit (G2012)
    - Virtual check-in: store and forward (G2010)

Telehealth Visit

- Real time interactive audio and video telecommunications
- Providers: MD/DO, NP, PA, CNM, CRNA
- Have an established relationship with a practitioner
  - "DHHS will not conduct audits during this PHE"
- E/M billing codes
  - 99201-99205: Office E/M visit, new
  - 99210-99215: Office E/M visit, established
    - Place of service : 02 (telehealth)
    - Modifier -95 (telehealth visit)

2020 Problem Oriented E/M: Face-to-Face Time "Midpoints"

New	Time
99201	≤ 15 (10)
99202	16-25 (20)
99203	26-37 (30)
99204	38-53 (45)
99205	> 53 (60)

Established	Time
99211	≤ 7 (5)
99212	8-12 (10)
99213	13-20 (15)
99214	21-33 (25)
99215	>33 (40)

E-Consults

- Description
  - Interprofessional telephone/Internet/electronic health record E/M service provided by a consultative physician/QHP, including a *written report* to the requesting physician/QHP
- CPT Code
  - 99451: ≥ 5 minutes of medical consultative time
- Different from CPT codes 99446*-99449*, which require both verbal *and* a written report to the requestor

QHP: qualified health professional

* Not Family PACT or Medi-Cal benefits

March 19, 2020

Virtual Check-In Visits

- Synchronous discussion over a telephone or A/V *to decide whether an office visit or other service is needed*
  - Clinician may respond to patient's concern by telephone, A/V, secure text messaging, email, or a patient portal
- Initiated by the patient
- Established relationship with practice
- Not related to a medical visit within < 7 days and does not lead to a visit in <24 hours (or soonest appt)
- Patient verbally consents to receive virtual check-in
- HCPCS code G2012: 5-10 min of medical discussion

Virtual Check In: Store & Forward

- Remote evaluation of video and/or images submitted by an established patient
  - Interpretation with follow-up in < 24 business hours
  - Not originating from related E/M service provided <7 days or leads to E/M visit < 24 hrs (or asap)
- HCPCS Code G2010
- Example
  - Client has a genital skin lesion that s/he is willing to self-photograph and submit for evaluation

Telehealth Visit

- No restrictions on provider location or patient location
- Use any phone, tablet, laptop or desktop computer that allows audio and video communication
- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits

Can Telehealth Visits Ever Be Telephone-Only?

- May be necessary if
  - A clinic does not have an A/V platform
  - The client doesn't have access to a computer or a smartphone
  - Internet access is unavailable or slow
- During the public health emergency
  - Covered by Medicare and some commercial plans
  - Considered to be "an encounter" in Title X
  - Now covered by Medi-Cal, Medi-Cal Managed Care and Family PACT


DHCS
California Department of
HealthCareServices
Family PACT
Planning • Access • Care • Treatment

June 23, 2020

State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth-Other-Virtual-Telephonic-Communications-6-19.pdf

Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19)

June 23, 2020 (*Supersedes April 30, 2020 and March 24, 2020 Guidance*)

Overview

In light of both the federal Health and Human Services Secretary's January 31, 2020, public health emergency declaration, as well as the President's March 13, 2020, national emergency declaration relative to COVID-19, the Department of Health Care Services (DHCS) is issuing additional guidance to enrolled Medi-Cal providers, including, but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, dentists – as well as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal 638 Clinics. This guidance is relative to all of the following:

Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to C-19

- How telephonic-only visits can be considered as "telehealth visits" during the PHE
- One section of the Guidance applies to Family PACT providers (pages 7-9)
- The Guidance contains additional instructions for FQHCs, Rural Health Clinics, and Tribal 638 clinics

"Telehealth and Virtual/Telephonic Communications Relative to COVID-19"

- Family PACT providers – including, but not limited to, MDs/DOs, NPs, PAs, and CNMs, will provide and bill for telephonic visits using the appropriate and regular CPT or HCPCS codes that would correspond to the visit being done in-person
  - Point of Service (POS): 02
  - Modifier -95 (after E/M code)

"Telehealth and Virtual/Telephonic Communications Relative to COVID-19"

Must meet all requirements of the billed CPT and must meet these conditions

1. Documented circumstances involved that prevent the visit from being conducted face-to-face, *such as*
   - The patient is quarantined at home
   - Local/state guidelines direct the patient remain at home
   - The patient lives remotely and does not have access to the internet, the internet does not support HIPAA compliance, etc.

"Telehealth and Virtual/Telephonic Communications Relative to COVID-19"

2. HCP* intends for the virtual/telephone encounter *to take the place* of a face-to-face visit, and documents this
3. HCP believes that the covered service or benefit being provided is *medically necessary*
4. The covered service or benefit being provided is *clinically appropriate to be delivered via virtual/telephonic communication*, and does not require the physical presence of the patient

HCP*: health care provider

"Telehealth and Virtual/Telephonic Communications Relative to COVID-19"

5. HCP satisfies all procedural and technical components
   - Detailed patient history
   - Description of benefits or services provided
   - Assessment of the issues being raised by the patient
   - Medical decision-making, as applicable, which includes
     - Pertinent diagnosis(es) at the conclusion of the visit
     - Recommendations for diagnostic studies
     - Follow-up or treatments, including prescriptions
6. If requirements not met, use HCPCS G2012

Family PACT Telemedicine Visit Coverage

Code	Description	Modality
G2010	VCI: Store and forward	E-mail photo
G2012	Virtual check-in visit	Telephone
99451	E-consult	E-mail
99201-4 **-95**	Telehealth visit (new client)	Audio-visual or Telephonic
99212-4 **-95**	Telehealth visit (established client)	Audio-visual or Telephonic

Not covered: Digital e-visits, telephone E/M codes (99441-3)

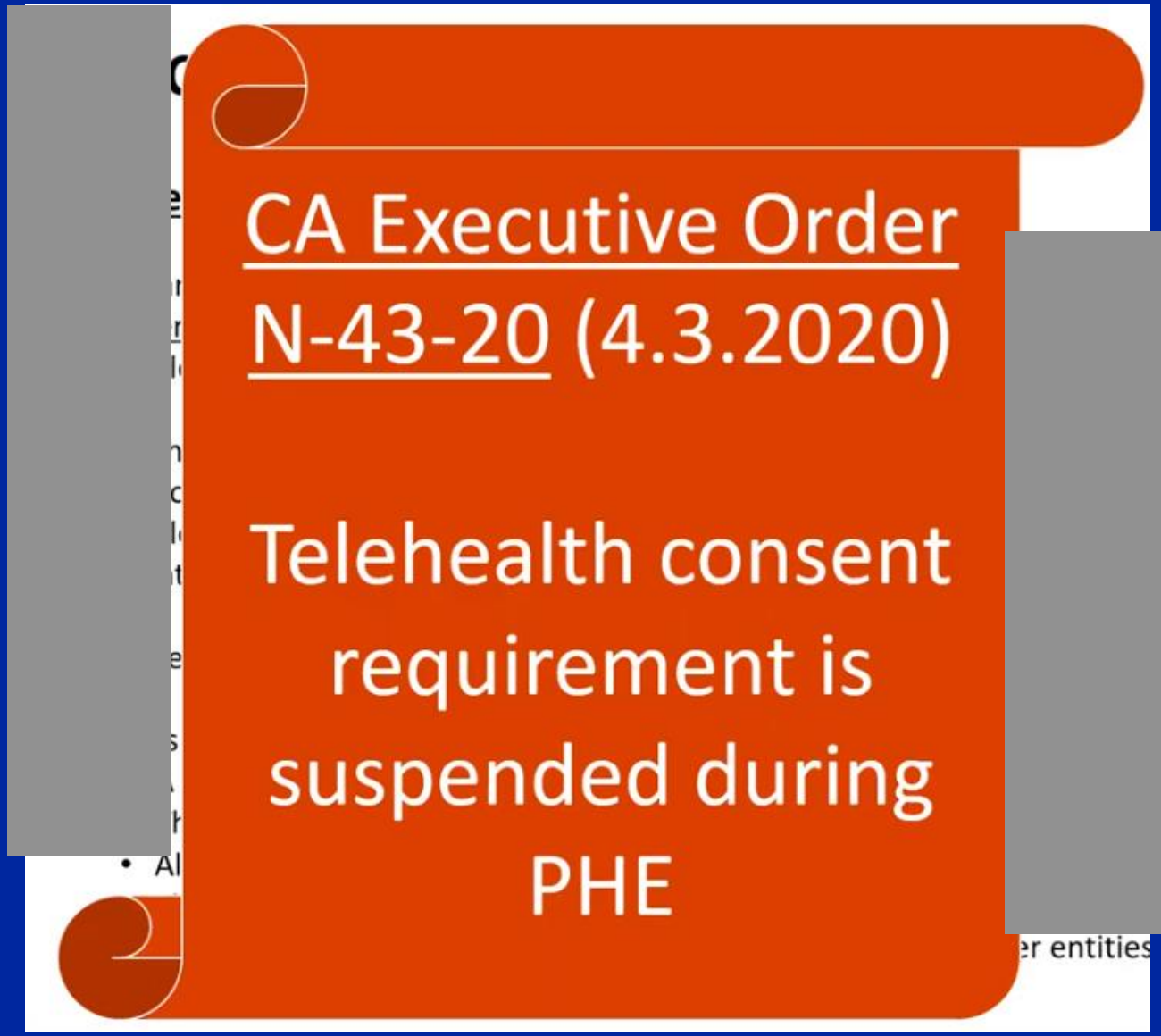
Telemedicine Platforms

- EHR telemedicine module
- Proprietary telemedicine products
- New telemedicine products (see NFPRHA guidance)
  - Zoom, doxy.me, eVisit, Vsee, Vidyo, Bluestream, SimpleVisit, Mend NOW Telehealth, Spruce Health
- During PHE
  - Skype
  - Apple FaceTime
  - Facebook Messenger video chat
  - Google Hangouts video

HIPAA Requirements Relaxed During the PHE

- DHHS has issued a limited waiver of certain HIPAA sanctions to improve patient care during PHE
- HHS' Office for Civil Rights will not impose penalties for noncompliance that may not comply with privacy rule
- DHCS recommends you review that guidance re: providing services via telehealth + telephonic visits

Is written or verbal consent still required for telemedicine services?



Recognize the Benefits for Your Practice

- Keep patients and staff safe by reducing in-person visits and travel to and from the office
  - Most patients love the convenience
  - Clinicians can work from home
- Allow patients to access your practice instead of the ED or a commercial telemedicine service
- Enable continuity of care
- Utilize visual assessment and physical exam
- Save PPE for in-person visits at your clinic
- Generate visit-related revenue

Practice Logistics

- Announce the availability of video visits on your website, patient portal, phone system, e-mail to patients
- Prepare a script for your scheduling staff to use when interacting wit patients
- Prepare a simple patient guide on how to connect for the visit and e-mail it to them

Conducting the Visit

- Ensure quiet, private, well-lit conditions
- Ensure that the patient can see and hear you clearly
  - If not, switch to telephone call (clinician calls patient)
- Verify 2 patient identifiers (name, DOB)
- Explain the benefits and limitations of a telemedicine visit and obtain verbal consent
- Keep your EHR available on the same or a second device
  - Acknowledge that you're looking away from camera when checking labs, writing notes

Clinician Set-Up for Tele- Visit

- Ensure a clutter-free environment (check behind you for personal artifacts and remove them)
- Look professional, as you would in-person, in clinic
  - Wear professional attire
  - Smile!
- Position computer/tablet/phone 2 ft away at eye-level
- Make sure the door to your room is closed
- The patient can show you monitoring data (e.g., BP)
- *Have a clock nearby to record the length of the visit*

https://swtrc.wistia.com/medias/fwcw1c3hyn?wtime=1m14s

The Physical Exam

Visual assessment

- General appearance
- Skin tone and rashes
- Clarity of thought and speech
- Eye redness
- Respiratory rate
- Work of breathing
- Gait

With patient assistance

- Self-palpation
- Range of motion
- Close-up camera views (oropharynx, skin lesions)
- Results of home monitoring device (BP)

Documentation

- Start note with: “Telemedicine Visit”
  - Note whether A/V or telephonic-only
- Patient consent for tele- visit
- Patient location at the time of visit
- Provider location at the time of visit
- Who’s present and their role (family members, etc.)
- Use of interpreter: language, identification
- All other unusual components of in-person visit

More Changes Since March 2020

- Prioritization templates
- Office procedure protections
- Curbside pick-up: methods, lab tests, injections
- Clinic and pharmacy dispensed medications
  - Mailing and curbside
- Adaptations of clinical practices
  - BP determination
  - DMPA-SQ
  - Syndromic management

Case Studies

Case #1: Hybrid Visit

- A new client calls to request a visit to initiate contraception
  - Informed that the clinic is open in limited circumstances and that most visits now are done by telemedicine
- A/V telehealth visit; discussed all available methods
  - Time with clinician: 27 minutes
- Copper IUD chosen
  - After discussion, verbally consented to placement
- Seen in-person for the procedure *3 days later*
  - UPT done because of confusing menstrual history: negative
  - Cooper IUD was placed without difficulty

Which Visits Should Be In-Person vs Remote?

- Develop written policies that prioritize which client visits will be in-person or remote
- Critical to revise the policy frequently based on
  - Current local or state physical distancing laws
  - Availability of staff and PPE
  - Whether utilizing curbside pick-up or mail

Prioritization of In-Person and Virtual Visits During COVID-19: A Decision Making Guide for Staff

Sample Prioritization (Triage) Template

Postpone	Telephone call	Telemedicine visit	Schedule as available	In-person, same day
Well-woman visit	Method refills	Contraceptive counseling	IUD, implant replacement or removal	IUD, implant placement
Most colposcopy (ASCCP)	Emergency contraception	DMPA-SQ counseling, instruction	DMPA-IM (clinic, curb-side)	Heavy vaginal bleeding, pelvic pain (PID, IUD complication)
		Syndromic tx of STD, UTI		Sexual assault
		Pregnancy testing and diagnosis		

Case #1: Answer

Visit	POS	CPT code	ICD-10 code	Supplies
#1	-02	99203-95	Z30.09 Encounter for other general counseling and advice on contraception	None
#2	-11	58300 Insertion of IUD	Z30.430 Insertion of IUD	• J7300 (Copper IUD) • 58300UA (supplies for IUD insertion)
	-11	81025 Urine pregnancy test	Z32.02 Preg exam or test, negative	none

POS (Place of Service) 11: office. Clinics and FQHCs have other numbers

Comment: Case #1

- Visit #1
  - CMS-defined “telehealth visit”, which should be coded on the basis of video time with the clinician
- Visit #2
  - ICD-10 code is different than for visit #1
  - E/M code is not billed on this date of service, since there was no “separately identifiable service” performed while in clinic

What Makes SARS-CoV-2 Infection (and COVID-19) More Likely??

Inhaling a *large dose* of virus

- By breathing someone else's air (plume)…
- In an enclosed, poorly ventilated, setting…
- For an extended period of time...

Risk Factors for Horizontal Transmission of SARS-CoV-2

	Factor	Higher risk	Lower Risk
P	Proximity	< 6 feet	≥ 6 feet
E	Enclosure	Small room; poor ventilation	Outdoors
T	Time exposed	Longer than 10 minutes	Shorter
A	Activity	Singing, loud speaking	Limited speaking
P	Protection	No hand washing, mask, PPE, or cough etiquette	Consistent use
P	Prevalence	High risk groups Those with C-19 symptoms	Isolated people
S	Silent spreaders	Pre-symptomatic (1-2 days before symptoms)	
S	Super spreader events	Many people in close proximity, without masks, singing or shouting, for extended periods of time	

Minimize Exposure Risk During In-person Visits

	Factor	Clinical practice
P	Proximity	Few staff in room; maintain distance ≥ 6 feet
E	Enclosure	Use largest exam room with negative pressure ventilation; if not, open windows
T	Time	Minimize the time client and staff are in exam room
A	Activity	Limit loud talking
P	Protection	Masks for all; consider face shield during placement
P	Prevalence	Pre-screen client and staff: SOB, cough, fever, *chills, sore throat, muscle aches, new loss of taste or smell*
S	Silent spread	Contact with C-19 patient ≤ 14 days?
S	Super spreader event	Participate in super spreader event ≤ 14 days?

Minimize Exposure Risk During In-person Visits

- Remote advance registration, counseling, and consent
- Have client wait in car; intake prior to entering facility
  - Screen for symptoms prior to visit and at arrival
  - Delay procedures if symptomatic; refer for testing
- Screening temperature check recommended by CDC, but very limited utility
  - Misses asymptomatic and some pre-symptomatic persons
  - Fever may be masked by use of NSAIDS
  - Forehead thermometers prone to inaccurate readings
  - Never use as sole intervention

Minimize Exposure Risk During Procedures

- All staff and clients must wear face masks
  - Plus, face shield for clinician performing procedure
- Upon entry, direct immediately into an exam room
  - Use largest room; esp. if neg pressure ventilation
    - Otherwise, open windows
  - Minimize staff and support people in rooms
  - Limit (or prohibit) non-client visitors
  - Minimize moving between rooms
- Monitor PPE supply and adjust use according to CDC guidance

Follow-Up After IUD Placement

- In-person follow-up (string check) visits were optional even before PHE
  - No routine follow-up visit is required
  - More frequent follow-up visits: adolescents, persons with certain (or multiple) medical conditions
- Check-in can be done by telemedicine, as needed
  - To discuss side effects or other problems
  - If she wants to change the method being used
  - When it is time to remove or replace the IUD

Case #2: Hybrid Visit

- Established client wants to speak with clinician about implant
  - Has been in place for 4+ years…would like a new one
  - No side effects or other problems
- A/V telehealth visit with clinician
  - Time with clinician: 15 minutes
  - After discussion, verbally consented to implant replacement
- Seen in-person for the procedure 5 days later
  - Expired Nexplanon replaced without difficulty

Duration of Use For LARC

	FDA-Approved	Evidence-Based
Nexplanon	3 years	5 years
Liletta	6 years	7 years
Mirena	6 years	7 years
Skyla	3 years	3 years
Kyleena	5 years	5 years
Paragard	10 years	12 years
DMPA-IM	13 weeks	15 weeks
DMPA-SQ	13 weeks	15 weeks

Case #2 Answer

Visit	POS	CPT code	ICD-10 code	Supplies
#1	-02	99213-95	Z30.46 Surveillance of implantable subdermal contraceptive	
#2	-11	11981 (insertion) 11976 (removal) of subdermal implant	Z30.46 (includes checking re-insertion, and removal)	J7307 Etonogestrel implant (insertion kit and supplies) 11976UA (removal supplies)

Case Study #3: DMPA SQ by Telemedicine

- Ms. B is a 30 year old established client who has been using DMPA every 13 weeks for the past 2 years
- She called for an appointment 2 weeks before her next injection was due, but was hesitant to come in
- A/V telehealth visit: 15 minute discussion with a clinician about her alternatives
  - Decided to try self-injection of DMPA-SQ
- One unit was delivered curbside by pharmacy to Ms. B
- What the "alternatives" to DMPA-IM?
- How to code this visit?

Alternatives to DMPA-IM

- In-person visit, IM injection in clinic
- In-person visit, curbside injection
- Switch to self-injected DMPA-SQ
- Switch to a “bridge” method
  - Progestin-only pills
  - Combined hormonal methods: OC, patch, ring
  - Barrier method

How Does DMPA-SQ Differ from DMPA-IM?

- Pre-filled and ready to use at home, so client is in control
- Uses shorter, smaller 26 gauge X 3/8-inch needle and smaller volume to inject into skin instead of muscle
  - Potentially less pain
- 30% less hormone; may reduce common side effects
- Some clients experienced local site irritation and soreness on first and second self-injection
  - Improves over time
  - PPI: 1/100 experience dimpling at injection site

DMPA-SQ for Self-Injection

- Contraindications and side effects are same for DMPA-SQ and –IM
- Dosage adjustment of DMPA-SQ and –IM is not necessary for BMI
- Use clinical judgement to determine whether delivery method is appropriate for a specific client and document decision

Client Resources on DMPA-SQ Self-Injection

- NFPRHA Self-Administration of DMPA
- Detailed package insert instructions
- Bedsider.org: Depo SubQ: The do-it-yourself birth control shot
- Reproductive Health Access Project: Depo-Provera Sub-Q User Guide *(available in English, Spanish, Simplified Chinese, Traditional Chinese, Hindi, Vietnamese)*

Case Study 3: Answer

	CPT code	ICD-10-CM code
Procedure	None	
Drug	Pharmacy will bill for one unit of DMPA-SQ	
Lab in-house	None	
E/M	99213-95 POS: 02 (telemedicine)	Z30.42 Surveillance of injectable contraceptive
Modifier	-95 Telemedicine	

- FPACT and Medi-Cal cover self-administration of DMPA-SQ only when dispensed by a pharmacy during public health emergency

Case Study #4: Malodorous Vaginal Discharge

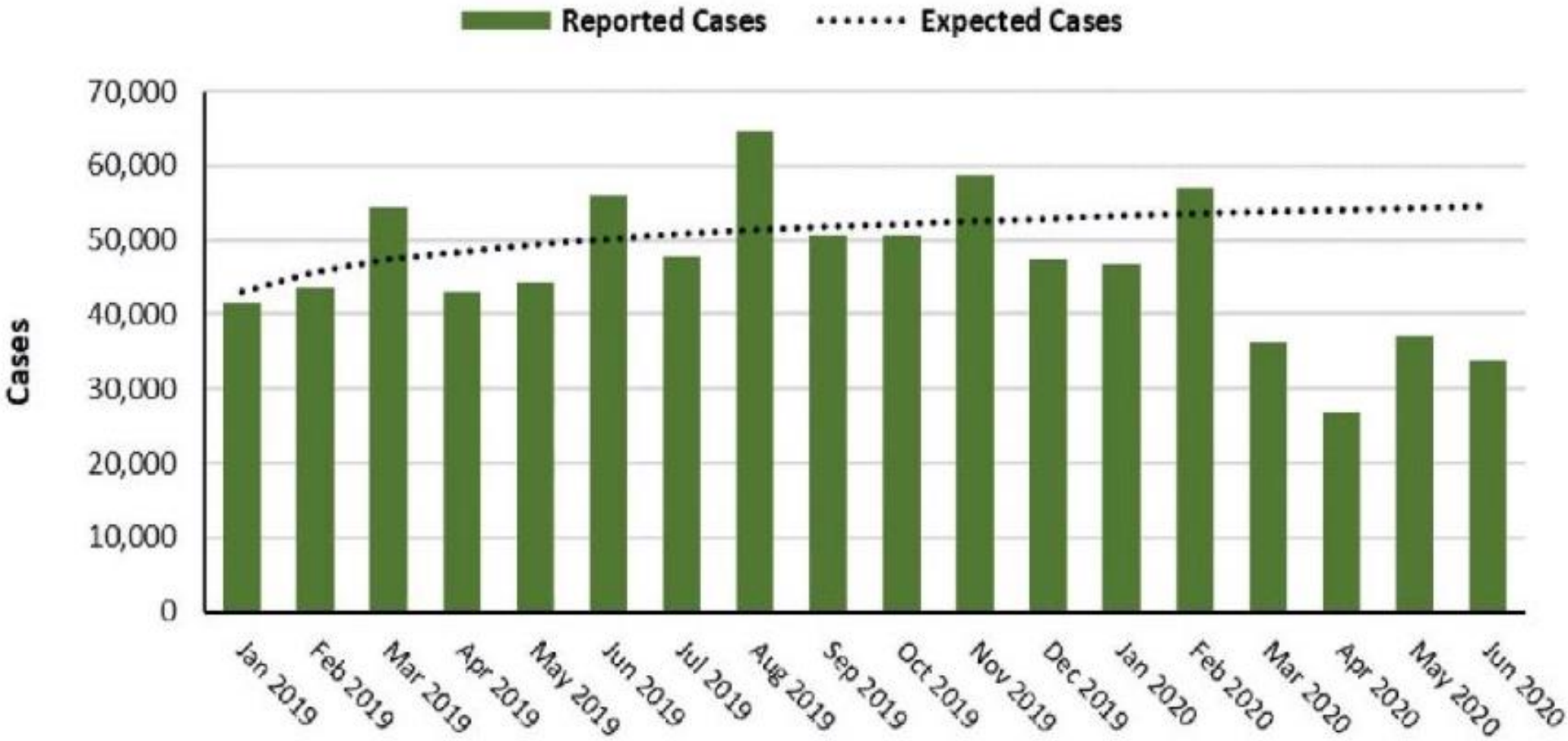
- Ms. L is a 35 year-old established client who states that she develops vaginal discharge and malodor “every 2-3 months”
- Diagnosed with BV 18 months ago; since then, has been treated four times, each with a different topical drug
  - Each treatment improved malodor “for a while”…has started douching to manage malodor
- Due to PHE, she would like to avoid an in-person visit
  - Had telehealth visit (A/V) that lasted 27 minutes
  - Prescribed metronidazole gel suppression; picked up 2 tubes of medication curbside

National Shortage of CT/GC NAAT Tests

- CDC letter 9.3.20: current shortage of STI test kits and laboratory supplies, most notably for CT/GC NAAT
- Priority of kits in short supply (vaginal swab for females)
  - Routine screening of females < 25 years of age
  - Targeted screening of females ≥ 25 years of age
  - Extra-genital CT/GC screening not recommended for females
  - MSM: prioritize rectal and pharyngeal screening above urethral (or urine-based) testing
    - If severe shortage, prioritize rectal testing over pharyngeal

https://www.ncsddc.org/wp-content/uploads/2020/09/Diagnostic-Test-Shortage.pdf

Gonorrhea Cases Reported* and Projected Cases** by Month, Jan 2019 – Jun 2020



* Cases reported through NNDSS as of Jul 30, 2020;

** Projected mid-point of expected cases estimated by log-linear regression based on cases reported by month Jan 2019 through Jan 2020

Syndromic Management of STDs

- Treatment based upon a “best guess” of diagnosis, using symptoms and a description of physical findings, but without the use of laboratory tests
- Studies show that this approach is:
  - Fairly sensitive for making a correct diagnosis (especially BV, candida vaginitis, +/- genital herpes)
  - Not very specific (i.e., many false positives possible, resulting in over-treatment)

Summary of Vaginitis Findings

	Itch/ Burn	Malodor	Frothy	Color
Candida	I: Yes B: Sometimes	No	No	White
Trichomoniasis	I: Yes B: No	Yes	Yes	Yellow Sometimes white
Bacterial vaginosis	No	Yes	Yes	White “homogenized milk
DIV	Yes	No	No	Profuse white or green
Physiologic	No	No	No	White

Vaginal Discharge: Remote Evaluation

- Recurrence of BV or vaginal candidiasis, treat based on a telephonic or telemedicine visit
- For a new problem, obtain a thorough patient history via telehealth; consider empiric treatment
  - Malodorous discharge s/o BV or trichomoniasis, metronidazole 500 mg BID 7 days will treat either
  - Vulvar irritation/itching + white discharge, treat with fluconazole 150 mg PO or 3-day topical antifungal

Self-Sampling and Curb-side Pick-Up/Drop-Off

- Some clinics have used curb-side for pick-up and drop-off of vaginal discharge sampling kits
  - Stoppered-plastic or glass tube with 1 cc fresh saline
  - Pack of sterile cotton tipped swabs
- At home, swab vaginal walls, place the swab into the tube and cap, then drop it off at the clinic asap
- Can be used to sample for gonorrhea/ chlamydia NAAT with (separate) appropriate collection container

Vaginal Discharge: What About GC/CT?

- CDC guidelines do not recommend empiric treatment for GC/CT in patients w/vaginal discharge
- For patients with new vaginal discharge who need evaluation, testing for GC/CT is recommended prior to treatment
  - Exception is patients with known sexual contact to GC/CT

Case Study #4: Answer

	CPT code	ICD-10-CM code
Procedure	none	
Supplies	N/A	
Drug	Metronidazole gel x 3 tubes S 5000 –generic drug, or S 5001 –brand name	N76.1 Subacute and chronic vaginitis
Lab	none	
E/M	99214 (2020 E/M by time) *99213-15 (2021 E/M by time)	N76.1 Subacute and chronic vaginitis
Modifier	-95 (telehealth visit)	

* Why this range? See next slide

E/M Codes: Time Defined

January 1, 2021

- Prepare to see the patient (e.g., review test results)
- Obtain and/or reviewing separately obtained history
- Perform medically appropriate exam and/or evaluation
- Counsel and educate the patient/family/caregiver
- Document clinical information in the health record
- Independently interpret results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Questions?

Family PACT: Sources of Information

- Family PACT Provider FAQs during COVID-19 (4/20/20)
  - https://familypact.org/wp-content/uploads/2020/04/FPACTProviderFAQ_COVID_19_EQ.pdf
- Family PACT Update: DMPA-SQ Guidelines (4/14/20)
  - https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_31.aspx
- Family PACT: Guidance for Virtual/Telephonic Communications Relative to the COVID-19 (3/23/20)
  - https://www.dhcs.ca.gov/Documents/COVID-19/Guidance-for-Virtual-Telephonic-Communications.pdf

Family PACT: Sources of Information

- Update to Information on Coronavirus (COVID-19) for Family PACT (3/26/20)
  - https://www.dhcs.ca.gov/services/ofp/Documents/OFP-Notice-COVID19-Update.pdf
- Update to Information on Coronavirus (COVID-19) for Family PACT Providers (3/27/20)
  - http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_16.asp

Medi-Cal: Sources of Information

- CA DHCS Telehealth Frequently Asked Questions (10/19)
  - https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx
- Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to COVID-19 (March 24, 2020)
  - https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth_Other_Virtual_Telephonic_Communications_V3.0.pdf

Medi-Cal: Sources of Information

- Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to COVID-19 (June 23, 2020)
  - https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth-Other-Virtual-Telephonic-Communications-6-19.pdf

FPNTC COVID-19 Resources

- COVID-19 and Family Planning Services FAQ
- What Family Planning Providers Can Do to Meet Client Needs During COVID-19
- Prioritization of In-Person and Virtual Visits During COVID-19: A Decision-Making Guide
- COVID-19 Social Media Toolkit for Family Planning Providers
- Help Staff Reduce Stress During COVID-19
- NCTCFP COVID-19 Resources

Family Planning COVID-19 Resources

- NFPRHA COVID-19 Resource Hub
- UCSF Beyond the Pill: Contraception During COVID-19: Best Practices and Resources
- RHAP: Contraception in the Time of COVID-19
- KFF: A Look at Online Platforms for Contraceptive and STI Services during the COVID-19 Pandemic
- Upstream USA: Ensuring contraceptive access during the COVID-19 pandemic

ACOG COVID-19 Resources

- COVID-19 FAQs for Obstetrician–Gynecologists, Gynecology
- ACOG/SMFM Outpatient Management of Pregnant Women
- ACOG Managing clients Remotely: Billing for Digital and Telehealth Services
- ACOG COVID-19 Topics

CDC COVID-19 Outpatient Clinic Guidelines

- Interim CDC Guidance on Handling Non-COVID-19 Public Health Activities that Require Face-to-Face Interaction with Clients in the Clinic and Field in the Current COVID-19 Pandemic
- Outpatient and Ambulatory Care Settings: Responding to Community Transmission of COVID-19 in the United States
- CDC Guidance for Healthcare Facilities
- CDC Information for Healthcare Professionals

ACP, AAFP, and AMA Telehealth Resources

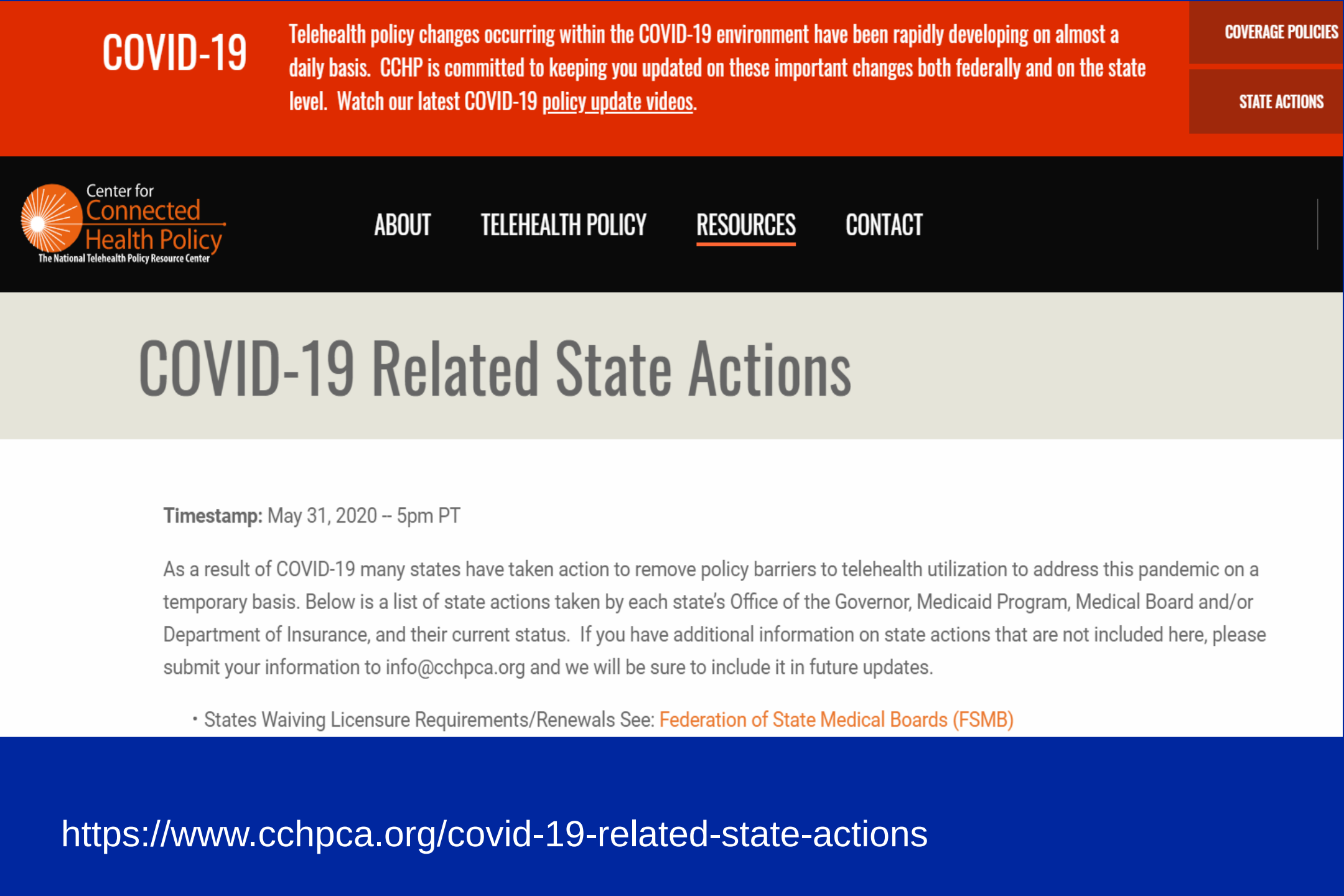
- ACP: A Checklist for Incorporation of Video Visits
- AAFP Checklist to Prepare Physician Offices for COVID-19
- AAFP Using Telehealth to Care for Patients During the COVID-19 Pandemic
  - Contains helpful list of telemedicine vendors
- AMA quick guide to telemedicine in practice

More Telehealth Resources

- Essential Access Health Telehealth Essentials Resource Hub
- DHHS: FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency
- The National Telehealth Policy Resource Center
- CMS: General Provider Telemedicine Toolkit
- Medicare Telemedicine Health Care Provider Fact Sheet
- Medical Economics: Telehealth primer: How to set up a program quickly

http://caltrc.org/

https://www.youtube.com/watch?v=aWWGcF-HINc


COVID-19
Telehealth policy changes occurring within the COVID-19 environment have been rapidly developing on almost a daily basis. CCHP is committed to keeping you updated on these important changes both federally and on the state level. Watch our latest COVID-19 policy update videos.
COVERAGE POLICIES
STATE ACTIONS
Center for Connected Health Policy
The National Telehealth Policy Resource Center
ABOUT
TELEHEALTH POLICY
RESOURCES
CONTACT
COVID-19 Related State Actions
Timestamp: May 31, 2020 -- 5pm PT
As a result of COVID-19 many states have taken action to remove policy barriers to telehealth utilization to address this pandemic on a temporary basis. Below is a list of state actions taken by each state's Office of the Governor, Medicaid Program, Medical Board and/or Department of Insurance, and their current status. If you have additional information on state actions that are not included here, please submit your information to info@cchpca.org and we will be sure to include it in future updates.
• States Waiving Licensure Requirements/Renewals See: Federation of State Medical Boards (FSMB)
https://www.cchpca.org/covid-19-related-state-actions

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

JUNE 9, 2020

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Coronavirus Disease 2019 (COVID-19)

Your Health | Community, Work & School | Healthcare Workers & Labs | Health Depts | Cases & Data | More

Healthcare Workers

- Testing
- Clinical Care
- Infection Control
- Optimize PPE Supply
- Potential Exposure at Work
- First Responder Guidance

HEALTHCARE WORKERS

Healthcare Facilities: Managing Operations During the COVID-19 Pandemic

Updated June 28, 2020 Print

Summary of Recent Changes

Below are changes to the guidance as of June 9, 2020

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-hcf.html#outpatient-ambulatory

HEALTHCARE WORKERS

Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

JULY 15, 2020

Updated July 15, 2020 Print

Summary of Changes to the Guidance

Below are changes to the guidance as of July 15, 2020:

- Added language that protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html