

Public Health Division
Guidelines for Providing Clinical Services in Public Health Offices During the COVID-19
(Coronavirus) Pandemic
04/03/2020

Background

NMDOH has confirmed community transmission of cases of COVID-19 infections in New Mexico. We are providing recommendations to alter priorities and work practices based on Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS) principles (<https://www.cdc.gov/niosh/topics/hierarchy/default.html>) so we can reduce the risk of transmission to staff and clients,. These guidelines may change as the pandemic evolves.

Prioritizing Services/Essential Services

For your information, how the Department of Health is prioritizing services:

To the extent possible, health offices should attempt to provide routine services, although the approach to providing services may shift to enable social distancing (e.g., use of telemedicine over in-office visits). If staffing becomes limited, prioritization of visits should be based on acuity, consequence of not providing the service, and ability to provide a service safely. Each Region and office will need to evaluate these conditions and adjust as needed.

In addition, in accordance with the Public Health Order (March 24), in order to preserve PPE, only healthcare services that are considered “essential” may be provided. The order defines non-essential services as those that can be delayed three months without undue risk to the client’s health (e.g., threat to life, of permanent dysfunction, progression, or undue risk of permanent harm). This does not prohibit emergent/urgent medical care nor the “full suite of family planning services.” A determination of whether a service, procedure, or surgery is essential or non-essential is to be determined based on the training, experience, and clinical judgment of the licensed healthcare provider making the determination within the scope of their practice.

Note that although this order does not distinguish between non-essential services provided in person or through telemedicine, given the intention of preserving PPE, non-essential services that are provided through telemedicine are permitted, where resources permit.

For PHD operations, the following are likely to be essential services, and prioritized, based on imminent risk to the individual or the community that cannot be deferred for three months or longer:

- Active TB
- Current LTBI treatment
- HIV Post-exposure prophylaxis
- Pregnant women with positive syphilis test
- (Probable) syphilis infection
- Emergency contraception
- QuickStarts

- COVID-19 activities – specimen collection, contact investigation
- Infant/childhood immunizations
- WIC visits (food supplementation)
- Significant STD symptoms (e.g., PID, possible chancre)
- Children’s Medical Services
- Pregnancy testing (where home test unavailable or not affordable)
- Contacts to cases of HIV, syphilis
- Complications from LARCs – for example pelvic/abdominal pain (irregular bleeding can be managed via telephone/telehealth)
- LARC Insertion where other methods cannot be used
- Opioid replacement therapy - ongoing

The following services routinely provided by PHD may generally be considered non-essential, but may be evaluated on a case-by-case basis for consideration as an essential service and the need for in-person evaluation if the risk is high:

- TB Contact Investigations
- Epi investigations
- Contacts to cases for gonorrhea, chlamydia, trichomonas
- Abnormal mammogram
- Abnormal Pap
- Breast mass evaluation
- Syringe services
- Routine Family Planning visits
- Continuation of FPP method
- Opioid replacement therapy - new

Finally, the following services routinely provided by PHD are very likely non-essential in that they may be provided another way or may be deferred for up to three months without risk to the client or community:

- New latent tuberculosis infection (LTBI)
- Mild STD symptoms (e.g., probable warts or molluscum contagiosum, probable yeast or bacterial vaginosis)
- Sterilization evaluation (on another reliable method)
- Naloxone
- School immunizations
- Refugee health visits
- Cervical cancer screening
- Breast cancer screening
- Infertility counseling
- HIV Pre-exposure prophylaxis

As noted, if a health care provider determines that a health care service or procedure is non-essential, the Public Health Division reserves the right to re-classify that determination based on the evolving health care needs of the patient, which will be determined based on the clinical

judgment of a licensed healthcare provider within their scope of practice. In the event that a health care service or procedure is deemed non-essential, the patient's health care needs will be re-assessed on a regular basis as determined by the treating provider. No essential healthcare service will be declined or otherwise withheld in order to preserve PPE or maintain public access to health facilities.

In order to minimize risk, and use of PPE, whenever possible services will be the minimum necessary, provided so as to minimize contact time, use telemedicine, and provide outside of the clinic setting.

Telemedicine/Telephone Visits

Recently, Medicaid Assistance Division (MAD) has released expanded guidance related to telemedicine: Letter of Direction #30 (LOD). https://www.hsd.state.nm.us/uploads/FileLinks/63e11e4bdee34c68b133c1607f22bc54/LOD_COVID19_%2330.pdf This applies to all Centennial Care 2.0 Managed Care Options (MCOs) and allows for the use of virtual and telephonic visits.

The Board of Nursing and the Board of Medicine have also released statements about the expanded use of telemedicine during the COVID-19 Public Health Emergency:

Routine Telehealth:

PHD has protocols in place for the use of telemedicine to provide clinical care (such as family planning or TB services). <http://intranet/PHD/documents/PHD-TelemedicineProtocol-201711.pdf>

These existing protocols may continue to be used – note that these protocols are based on the client and the provider both physically being in separate public health offices. In these cases, providers may bill as appropriate for any covered benefits or services using the appropriate procedure codes that are in place.

Expanded Telephonic and E-Visits:

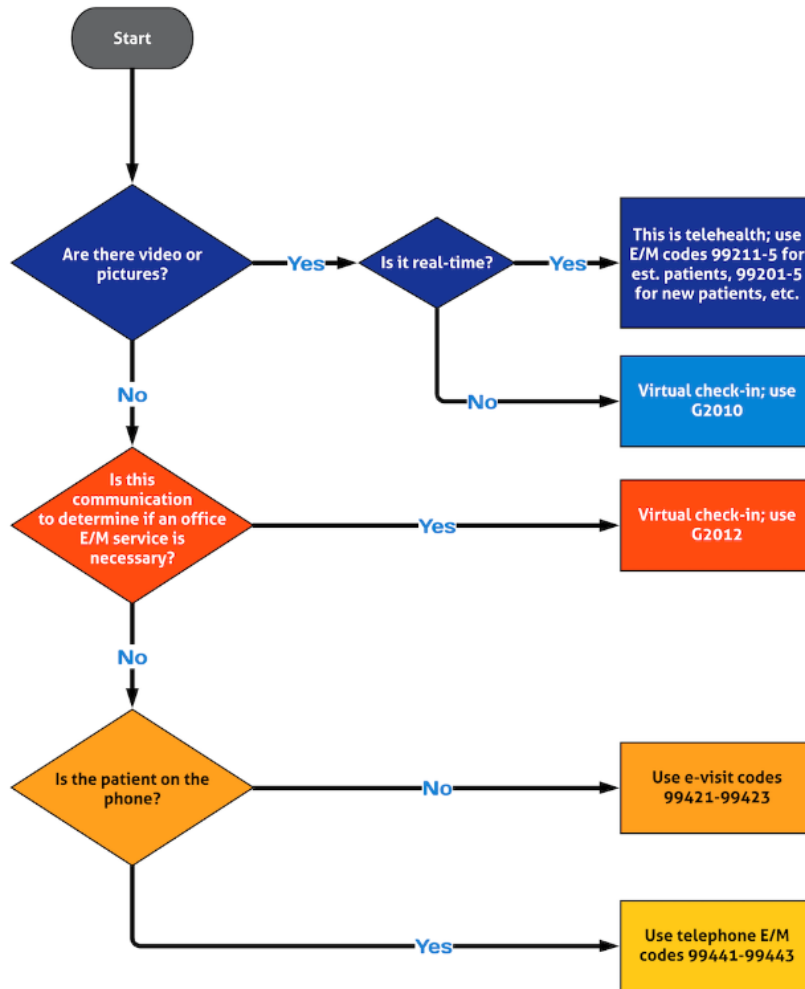
Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who in the case of COVID-19 cannot or should not be physically present (face-to-face).

Telehealth services can be provided in all settings including the client's home (in place through the termination of the declaration of emergency).

- Providers may be reimbursed for brief virtual communications using:
 - Code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 hours, not originating from a related evaluation and management (E/M) service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment. E.g., eMocha for TB care.
 - HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. **G2012 can be billed when the virtual communication occurred via a telephone call.**

Note that when the client is not present in a health office, only one encounter form (for the clinician's location) is created and the Q Code will not be associated with these codes for billing.

- These codes will remain an option through the termination of the declaration of emergency. These codes will be added to our user guide at: <http://intranet/PHD/documents/BEHR-Diagnostic-Reference-Guide.pdf> which is posted to the BEHR tab.
- HSD has allowed behavioral health providers to bill for telephonic visits using the same codes that are currently established for such services. These services will be paid as if the member of received services onsite and in person. This will remain an option for providers through the termination of the emergency declaration and applies for both initiation of care as well as treatment of established patients. Initiation of care can be for any reason, including member self-referral.
- For patients who have a COVID-19 diagnosis add ICD-10 code U07.1



Developed by James Dom Dera, MD, FAAFP. Source: A virtual visit algorithm: how to differentiate and code telehealth visits, e-visits, and virtual check-ins. FPM In Practice blog. https://www.aafp.org/journals/fpm/blogs/inpractice/entry/telehealth_algorithm.html. March 24, 2020.

Privacy Considerations and Telehealth:

Telehealth Enforcement Discretion

The Office of Civil Rights at HHS issued guidance on the emergency use of telehealth technology. NMDOH as a covered entity will not face penalties or breach notification requirements for violations that occur in **good faith** provision of telehealth due to COVID-19. Based on the circumstances and attached guidance, NMDOH staff may use any of the following for telehealth:

1. Skype for Business to Skype for Business
2. Skype for Business to Skype Personal
3. WebEX

4. Zoom
5. Facetime

Specific approval for Facebook Messenger has not been provided, but it may be eligible – check with IT if needed.

Client encounters must NOT be recorded using any of these apps.

Specific Program Guidelines

Family Planning Program (FPP)

- Postpone or reschedule non-essential visits (e.g., well-visits).
- Do not require visits that are not medically necessary (e.g., string checks, implant follow-up visits, satisfaction check.) Consider calling clients at home for a brief check-in.
- Consider the option of at-home test kits for HIV, chlamydia, gonorrhea, and pregnancy (PENDING).
- Offer information about fertility awareness-based methods as an option for clients looking for methods that do not require leaving home.

Essential Family Planning services during COVID-19 outbreak

- Provide clear information about where and how to access available services.
- As long as the state of emergency exists, any services that PHD is able to provide under normal circumstances that can be provided through telehealth and documented in BEHR will be considered Title X services for which you can use Title X funds and report to FPAR. They will count as Title X visits.
- Emergency contraception (oral and if possible, copper intrauterine device - IUD)
 - Local pharmacies may provide emergency contraception (<http://www.rld.state.nm.us/uploads/files/OCConfirmedFinalJune2016.pdf>)
 - Ensure access for patients by checking with your local pharmacy and creating a list of pharmacies that will provide patients this option.
 - The medication may be dispensed to the client in their vehicle.
- Quick start progestogen-only pills (POP), DMPA, OCPs with home/pharmacy blood pressure checks.
 - Local pharmacies may provide contraception (<http://www.rld.state.nm.us/uploads/files/OCConfirmedFinalJune2016.pdf>)
 - Ensure access for patients by checking with your local pharmacy and creating a list of pharmacies that will provide patients this option.
 - See Appendix B for suggested questions for virtual initiation of contraception.
 - See Appendix C for suggested Face-to-Face tips and tricks
- Support existing, continued use of Long-Acting Reversible Contraception (LARC) to the extent possible
- LARC insertion for patients who cannot use other methods
 - Clinicians performing procedures requiring close contact with the client (IUD insertion/removal, implant removal/insertion, Pap smear collection) should use PPE: N-95 mask, face shield, gown, and gloves.
- Contraception for vulnerable groups (adolescents, homeless, sex workers, patients with disabilities, etc.)
- Pregnancy testing
 - Counseling about positive pregnancy tests can take place over the phone/telehealth.
- Requests for dealing with pain & bleeding symptoms in contraceptive users

- Telephone / video consultation and triage; arrange to see face-face if essential (e.g., pelvic pain with IUD, suspected pregnancy symptoms, pain at implant sites)
- Cervical Dysplasia
 - Individuals with high-grade disease without suspected invasive disease should be referred and procedures scheduled within 3 months at referring sites discretion
 - Individuals with suspected disease should have evaluation and procedure within 4 weeks

Lower-Priority Visits

- LARC counselling
- Routine LARC removals / exchanges can be deferred temporarily (see below about extending use)
 - Nexplanon - If the woman is due for change of contraceptive implant reassure her that there is evidence that the implant remains an effective method of contraception for 4 years. If concerned she may be started on progestogen only pill until the implant can be replaced.
- For routine oral contraceptive resupply clients, the client could be interviewed on the phone before the visit to complete the history and counseled. The client could then be met in the parking lot (if pregnancy test or other labs not required) to dispense the medication.
- For routine 3-month Depo-Provera shots, interview the client by phone before the visit. The client may be provided with the administration in their vehicle (e.g., deltoid muscle).

IUD/Implant Duration

<u>Brand name</u>	<u>Type</u>	<u>Duration: FDA</u>	<u>Duration: evidence</u>
<u>Mirena</u>	<u>Progestin IUD</u>	<u>5 years</u>	<u>7 years</u>
<u>Liletta</u>	<u>Progestin IUD</u>	<u>6 years</u>	<u>7 years</u>
<u>Skyla</u>	<u>Progestin IUD</u>	<u>3 years</u>	<u>3 years</u>
<u>Kyleena</u>	<u>Progestin IUD</u>	<u>5 years</u>	<u>5 years</u>
<u>Nexplanon</u>	<u>Progestin implant</u>	<u>3 years</u>	<u>4 years</u>
<u>Paragard</u>	<u>Copper IUD</u>	<u>10 years</u>	<u>12 years</u>

- Cervical Dysplasia
 - Individuals with LSIL may postpone diagnostic evaluations for 6 months
 - Individuals with HSIL, ASC-H should have diagnostic evaluation within 3 months
- Where urine collection is indicated (e.g., pregnancy test, GC/CT testing), if not overly burdensome, the client may be provided with a specimen cup to take home and return.

- For women with a history of normal Pap smears, delay annual visit for 3-6 months and resupply their method, when possible.
- Vitals may be collected at the car, or in the clinic – however, **if the client has had a history of stable, normal blood pressure – or if measuring blood pressure is not practical and the client has no symptoms of concern, vital signs (and weight) measurement may be deferred until the next visit.**
- If a client has Medicaid, consider calling in or using ePrescribing to send an order (e.g., for oral contraceptives) to a retail pharmacy.

References

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

<https://www.cms.gov/files/document/qso-20-13-hospitalspdf.pdf-2>

<https://www.nejm.org/doi/full/10.1056/NEJMp2003539>

Appendix B – Contraception Virtual Initiation

Questions:

1. Do you think you might be pregnant?
2. Have you had a baby in the past 3 weeks?
3. Have you had an abortion in the last week?
4. Have you had unprotected intercourse in the last 5 days?
 - If yes, offer emergency contraception in addition to birth control method
5. When was your last period?
6. Have you unprotected intercourse since your last period?
7. Are you currently breastfeeding and your baby is less than 6 months?
8. How can health care provider be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:
 - If she is ≤ 7 days after the start of the normal menses
 - Has not had sexual intercourse since the start of last normal menses
 - Has been correctly and consistently using a reliable method of contraception
 - Is ≤ 7 days after spontaneous or induced abortion
 - Is within 4 weeks postpartum
 - Is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority $[\geq 85\%]$ of feeds are breastfeeds), amenorrheic, and < 6 months postpartum
9. Are you a smoker age 35 or older
 - If yes, consider progestin only method (POM)
10. Do you have high blood pressure?
 - If yes, consider POM or long acting reversible contraception (LARC)
11. Have you had a blood pressure check in the last 3 months?
 - If no to Q1 and Q2 may start combined hormonal contraception with a three month prescription and suggest BP check in next 3 months.
12. Have you had a heart attack or stroke?
 - If yes, consider POM or LARC
13. Do you have heart disease?
 - If yes, consider POM or LARC

14. Have you had a blood clot (thrombosis) in your lung or in your leg (NOT just varicose veins)?
 - If yes, consider POM or LARC
15. Do you have migraine headaches with aura?
 - If yes, consider POM or LARC
16. Do you have current liver disease or have you had liver cancer?
 - If yes, refer to USMEC, consider LARC
17. Do you have gall bladder disease?
 - If yes, refer to USMEC for characterization of the condition and choice of methods
18. Have you had breast cancer?
 - If yes, refer to USMEC for characterization of the condition and choice of methods, consider LARC
19. Do you take medicine for high cholesterol?
 - If yes, refer to USMEC for characterization of the condition and choice of methods
20. Do you take medicine for seizures or tuberculosis (TB)?
 - If yes, refer to USMEC for specific medication and choice of methods

Appendix C – Face-to-Face tips and tricks

1. Virtual
 - Pre-history history
2. In-person – limited
 - Physical exam
 - Clinic dispensed medication
3. Provide counseling, plan, prescriptions and refills by phone
 - Even when patient is still in the exam room!
4. Waiting room
 - Clear it out!
 - Patients may wait in car, send text when ready to be seen
 - No visitors (except essential caretakers)
5. Exam Room
 - As few staff in rooms as necessary