A NAWHC Industry Roundtable

COVID-19 INFORMATION, RESPONSES AND RECOMMENDATIONS for Worksite Health Center Sponsors and Partners
Agenda

• Welcome and Purpose of Call
• Current Status and Clinical Recommendations on COVID-19
• New Study on Employer and Clinic Partner Responses
• Discussion and Recommendations from Health Center Partners for Employers
The Coronavirus: Taking Steps for Workplace Readiness

Tim Newman, MD  NAWHC
Medical Director Council
Worksite Center Medical Consultant
Today’s Discussion

- An overview of the Coronavirus
- A comparison of epidemics/pandemics
- Concerns for spread of illness
- Prevention: following the guidelines
- Strategies for workplace readiness
- Other workplace considerations
An Overview of the Coronavirus

- The coronavirus family
  - SARS (2004, from Asia) - 8098 total cases
  - MERS (2012, from Arabian peninsula) - 2494 cases
  - COVID-19, from China) - 212 K cases globally

- Transmission of illness
  - Incubation phase 2-7 days; up to 14 days
  - Contagious ~1 day before illness (5-7 days-TBD)

- Typical symptoms - 80% have mild or no symptoms
  - Onset 5-7 days- fever, cough, difficulty breathing
  - 15% require medical care, 5% critical care

- Individuals at risk
  - Elderly with chronic health conditions, such as serious heart or lung diseases, diabetes, cancer
A comparison of epidemics & pandemics

- COVID vs flu: contagiousness ~ 2X
- COVID vs flu: severity/death rates
  - MERS = 34 % and SARS = 10 %
  - COVID = ~1-3 % (TBD)
- Seasonal flu (2019-20) = 0.6%
  - Widespread status
  - 20K deaths/33M cases
- H1N1 influenza (2009) = 0.2%
  - Pandemic status
  - 12.5K deaths/60.8M cases

COVID-19 – 3/18/20

Seasonal Flu – 3/7/20
Concern for spread of Illness

- World Status – global pandemic (3/11/20)
  - China – “0” COVID cases currently (~ 1/2 of total cases)
  - Increasing cases in essentially all countries
- Current US status – sporadic, clusters
  - Total confirmed cases – 9300
  - Deaths – approx. 140
- Treatment / Prevention
  - Antiviral meds – new ones under development
  - Vaccine – approx. 1 year out
- COVID-19 Test Kits Availability
  - 2 M sent to public health via CDC
  - 4 M by week of 3/23 via commercial labs
Prevention: Following the Guidelines

- Public Health Measures
  - Wash hands often with soap and water, use sanitizer if not available
  - Cover your nose and mouth with a tissue when sneezing & coughing
  - Cough into your sleeve if no tissue available
  - Be careful to avoid touching your eyes, nose, & mouth
  - Clean or disinfect objects & work surfaces with household cleaning products
  - “Social distancing” techniques advised
  - Face masks & respirators for healthcare workers or ill patients
  - Domestic vs. international travel guidelines
    - International travel restrictions per CDC
  - Public events – sports, concerts, conferences, schools
  - Driven by state decisions and regulations
Strategies for workplace readiness

- Return to Work Process per CDC risk assessment guidelines
  - Target high risk countries travel (China, S Korea, Iran, Italy, Japan, Hong Kong, others)
  - Establish COVID/Flu hotline (800#)
- Medical case management of employees/household members
  - Risk assessment/evaluation
  - Medical determination of risk category – none, low, medium, or high
  - Recommend care plan, including self-isolation up to 14 days
  - Work availability status provided to HR/supervisor
- Expand RTW process to flu-like & COVID community illnesses
- Education & awareness initiatives - all levels of company
- Integrate with Behavioral health EAP
- Coordinate pandemic plan with Business Continuity
Other Workplace Considerations

- Initiate practices to mitigate workplace illnesses and minimize exposure
- Modify HR policies/practices to support public health recommends
- Identify essential business functions, jobs and roles, and critical supply chain elements
- Address flexible work practices at worksites, remote work capabilities and schedules
- Set up procedures to activate company infectious disease response plan
- Monitor CDC updates to modify medical and workplace practices
COVID-19 Employer Sponsored Clinics

Mercer Worksite Clinic Consulting Group
March 16, 2020

Presenters: Sandy Goldstein, RN and Andy Halpert

Report prepared by David Keyt, David Zeig, MD and Sandy Goldstein, RN

welcome to brighter
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Introduction

- Mercer is actively working to support our clients in managing the COVID-19 pandemic. The impact of the Coronavirus changes with each news cycle and we continue to see more markets exponentially impacted.

- For employers who offer onsite clinic services (17% offer Primary Care - Mercer 2019 National Survey of Employer-Sponsored Health Plans), a unique set of demands exists, with opportunity to directly influence patient care, manage associated risk, and do their part in flattening the curve of cases.

- All onsite or near-site employee health clinics must be prepared to evaluate and manage risks or questions regarding possible exposure. Health care workers in all levels of the system – including laboratories, emergency services, clinics and hospitals – need to be informed about the virus and its transmission. They also need to have proper infection-control equipment and be prepared to safely isolate, transport, and quarantine potential patients. If an employee or supplier is found to have been exposed, there should be protocols for transport, communication and decontamination.

- Recognizing the unique challenges faced by the sponsors and managers of employer onsite and near-site clinics, Mercer’s Worksite Clinic Consulting practice initiated discussions with eight of the largest employer clinic management organizations in the market. The intent being 1) to complete due diligence on behalf of mutual clients and 2) to collaborate and share best practices to best serve the needs of the populations they serve. The collaborative approach focused on population health, including but not limited to: workflows to optimize the interest of public health, employee and patient safety to protect and mitigate risk, response to human capital limitations, identification of supply chain barriers and contingency preparedness planning. A summary of the best practices used by these employer clinic management organizations is offered in this document.

- Mercer continues to monitor market activity and facilitate information sharing related to preparation and response to this pandemic. We want to thank all of the organizational leaders who participated in these discussions for their time and commitment to keeping the lines of communication open and transparent as we address this public health crisis together.
Best Practices

Review and Update Your Existing Plans

- Refer to CDC website daily for their existing recommendations and updates as information changes frequently.
- Triage and separate cold/flu patients immediately; these patients are informed to wear masks on entry – triggered with door sign or as triaged by front desk.
- Educate staff and employees entering the clinic regarding proper hand washing hygiene and respiratory etiquette.
- Clean spaces regularly with EPA approved agents that kill virus/bacteria.
- Create an educational voicemail for callers to help self-triage based on symptoms which assists caller with a decision tree – going to PCP, onsite clinic or ER.
- If a patient is suspected as having COVID-19, notify local and/or state DOH authorities.
- Co-infection is possible, but it is important to rule out other infections since we are still in the flu season.
- Following guidelines from CDC – work on getting testing available where available (Quest, LabCorp, DPH, etc.) and make those connections now.
- Promote social distancing, handwashing, cleaning in all communications.

Note:
- There have been cases in China where steroids have been found to increase the severity of symptoms. Exceptions may apply.
Best Practices
Review and Update Your Existing Plans

- Since there is a shortage of surgical masks, N-95s and other PPE, CDC is approving use of non-FDA approved masks (as worn by construction workers as an example which don’t have to go through same standards as medical products). Working with your supply chain to track inventory and push to hot spot locations as the demand dictates. Secure additional supplies based on distribution limits/availability.
- Host internal emergency preparedness and response drills and table top exercises – mock drill scenarios with individual clinics followed by debrief and critique – local site specific.
- Host collaborative meeting with client operations managers (facilities, safety, HR, etc.).
- Determine contingency plan to address staffing shortage or clinic closures.
- Provide clinicians with contact info for local public health organizations and advise they reach out pro-actively.
- Decentralizing specific guidance to the regional/local levels, as local level public health is providing more specific information given the significant regional variation.
Best Practices
Don’t Make Your Staff or Patients Sick

- Reduce the number of ill people requiring face-to-face examination:
  - Utilize all virtual health capabilities including phone, video, and text/secure communication, shifting as much care as possible. Check plan documents.
- Instruct clinically ill staff to stay at home. Determine how best to enforce this mandate.
- Keep the right level of care in your clinics to the highest level possible relative to skill sets, capabilities and resources – while maintaining your risk strategy.
- Segment sick patients in a designated waiting room if possible.
- Use of SharePoint sites with protocols (handling PUI etc.) – how to be prepared, cleaning guidelines, PPE use etc.
- Centrally track COVID-19 screening cases, results and disposition. Monitor and track patients identified as PUI – central surveillance log (nurse coordinator managing the follow ups for reporting 24-48 hours, and following up with each of these patients).
  - Remember: Privacy Practices and HIPAA laws to protect personal health information
Best Practices
Protect Staff and Patients by Implementing New Ways of Working

- Convert your current scheduling functions into a “COVID-19 Advice Center” or “Nurse Triage Center.” The RN triage can direct patients to the appropriate access point for care.

- Use telehealth and nurse call capabilities first. Encourage patients to call first, distribute this communication to all employers to redistribute to all employees.

- Are state regulations lifted to expand virtual visits and emergency provider credentialing? There is federal momentum in this regard, so keep up to date.

- Protect patients by continually monitoring the schedule for patients who have at-risk signs and symptoms (fever/cough/fatigue/SOB), call those identified and redirect to virtual visit when it makes sense.

- Post signs outside of door educating patients on surgical mask use if sick, respiratory etiquette, hand washing hygiene etc.

- Have patients enter at the rear of the clinic and/or have testing occur in the parking lot if that work flow makes sense. This might include staged screening tents in parking lots and open areas on campus.

- Create internal training videos for all facilities on how to handle a PUI and other guidance.
Best Practices

Prepare for Absenteeism of Staff

- Create a centralized taskforce and governance structure to monitor the clinical activity, emergency preparedness and human capital limitations. This should include triggers for communicating to the masses and implementing contingency plans. Taskforce should consist of all skillsets/disciplines and report to senior leadership.

- Keep up to date and regularly communicate CDC and local public health guidance regarding clinician exposures, self quarantine recommendations and return to work clearance for healthcare personnel after infection.

- Repurpose clinical staff confined to their homes to be part of a virtual care team if possible. This team can work together remotely to triage and serve patients via telephone or video visits to forestall the need for an in-person visit.

- Consider how to support higher-risk staff (i.e. older staff, those with chronic health conditions etc.) such as preferential use of N95, virtual assignments only etc.

- Review employee sick policies, occupational health policies and procedures for RTW. Pivot eligible staff to work from home in the case of a 14-day quarantine.

- Support employers who have international travel and prepare for potential mandatory confinement (include WHO Guidance).
Best Practices
Communicate, Communicate, Communicate

- Maintain frequent communication with local and state health and governmental officials.
- Have a point person as a liaison to the local Department of Public Health authorities who can communicate back to their clinical teams regionally, especially where there are numerous clinics in one market/state.
- Establish a Clinical Response Team, physician led – team of clinicians tracking CDC, WHO info and informal resources who summarize and distribute more broadly.
- Think carefully, weigh risks and information in real context, be pro-active and not overly reactive.
- Established an Emergency Response Command Task Force – all departments represented, reporting to C-suite.
- Frequent communications to clinical teams – protocols, guidelines, how to deal with potential positive cases.
- Prepare a plan to communicate with your staff at least daily on the status of the disease in your community and organization. Especially communicate how you are dealing with the issues. This could include huddles, email correspondence, town halls, “all-client” calls, webinars (CMO), series of FAQs for employees/patients to submit questions.
Best Practices

Communicate, Communicate, Communicate (continued)

- Communicate with the employee population regularly (and the client) via patient app.
- Post information on the intranet (e-banner on the portal) and include information for appointment scheduling, nurse call hotline and telehealth. Communications to client employees via the client’s “coronavirus” communication channel. Blog post with regular updates from the clinical teams and HR communications.
- Establish an employee hotline for your clinical team and staff that provides guidance and resources real-time. Staff hotline with clinical leaders.
- Educating employers on slowing the number of patients to not overwhelm the healthcare system (i.e. flattening the curve).
- Client HR folks taking the brunt – keeping them informed at the client level by working closely with your client HR partners.
- Track lessons learned for post-pandemic response debriefing and process improvement.
Best Practices

Review and Address any Contractual Requirements

- COVID-19 is likely to impact clinic performance in numerous ways:
  - Lower than expected utilization
  - Clinic staff absence
  - Operational cost variance
  - Clinical outcomes

- This may impact existing vendor-employer contractual performance guarantees. It is recommended to review contractual language for transparent discussion.

- Telemedicine support needs to be reviewed at the contractual level to identify potential issues, and prepare for discussions with vendors. (note Coronavirus Appropriations Act will be easing restrictions on Medicare rules which should translate to private payers).
Best Practices

Regulatory Considerations

- In response to HSA-compatibility concerns stemming from recent state mandates and carrier efforts to provide first-dollar COVID-19 coverage, the IRS issued Notice 2020-15, which provides tax relief to health plans as a result of the public health emergency posed by COVID-19. Specifically, the Notice provides that a health plan that otherwise satisfies the requirements to be a HDHP under the Internal Revenue Code will not fail to be merely because the health plan provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible.

- If clinic access is extended beyond those on the employer’s major medical plan, employer should be mindful of ERISA group health plan requirements, namely disclosure of the benefit and potential need to offer COBRA continuation coverage.
Thank You

Questions & Answers