

ASPR TRACIE Technical Assistance

On July 28, 2020, ASPR TRACIE hosted the webinar, [Use of Telemedicine in Alternate Care Sites](#). During this webinar, presenters discussed operations, management, and lessons learned from using telemedicine in these settings. For additional resources, go to ASPR TRACIE'S [COVID-19 Telemedicine and Virtual Medical Care Resources](#).

Due to the large number of questions received during the question and answer session, speakers were not able to respond to all of the questions during the webinar. These questions were sent to panelists and their answers are provided in this document.

Question 1: What role can you see Emergency Medical Services (EMS)/ community paramedics playing in telemedicine (particularly in communities with limited access to care)?

Answer:

- EMS providers already access telemedicine for medical consultation and medical control. Providers are made available to consult with EMS providers and patients via phone, radio, and video to discuss care plans or treatment advice and follow-up, prescription refills, and to potentially avoid transfers if not necessary.
- There are other examples during COVID-19 of EMS protocols being altered to allow for virtual consults and determination that the patient will not be transported or will be scheduled for an urgent care or primary acute care appointment, such as [this protocol from Arizona](#).
- Finally, there are some services with established community paramedicine programs, where community paramedics can provide an in-person follow-up to a virtual telemedicine visit, when ordered by a physician. Massachusetts [allowed expedited mobile integrated health program approvals](#) due to COVID-19. The new Centers for Medicare and Medicaid Services [Emergency Triage, Treat, and Transport \(ET3\) Model](#) is a current pilot that seeks to support reimbursement for all care provided by qualified EMS providers for beneficiaries regardless of transport status.
- For example, Houston uses the Emergency Telehealth and Navigation (ETHAN) to reduce number of unnecessary transports to the ED, improve unit availability and unit total turnaround times, ensure the focus is on true emergencies, connect patients with a medical home, and improve quality and reduce costs. [This presentation](#) provides the following example: a 911 call leads to a medic field assessment, then a video call to an EMS physician, a patient disposition is determined (ambulance transport to the emergency department [ED], no ambulance transport, other), and then the unit is back in service. The ETHAN program saw significant unit productivity with a 44-minute time savings versus traditional EMS and primary care)
- The [ASPR TRACIE Virtual Medical Care Topic Collection](#) contains resources related to pre-hospital care and telemedicine considerations.

Question 2: Did the panelists document in their Electronic Health Records (EHR)? If so, how did you manage the registration of new patients?

Answer:

- The Javits New York Medical Station (JNYMS) did not use EHR.
- The Illinois Medical Emergency Response Team does not use EHR in temporary medical treatment stations.
- Boston Hope and the Isolation Hotel utilized the existing Massachusetts General Brigham EHR, since the license for the site was supported by Spaulding Rehabilitation Hospital, which is a part of this system. The site was able to register new patients and use the Admission, Discharge, Transfer (ADT) functions of the EHR.

Question 3: There are challenges with using telemedicine and accessing EHR/Electronic Medical Records (EMR) in remote/ rural areas due to internet connectivity challenges or staff not being able to use EMR at all. Would pre-made downtime patient charts (e.g., forms used for patient documentation, etc.) work alongside telemedicine/ telehealth?

Answer:

- The JNYMS did not use EHR so paper charting was definitely implemented and used. Lack of access to the internet was not an issue at JNYMS
- Almost all the work we do is with rural critical access hospitals and they have been able to establish fairly decent connections for daily operations, radiology reads, and EHR access. It has been our experience that all of today's EHR's have VPN access and deviating from the traditional practice model for a given facility is not ideal.
- Although Boston Hope and the Isolation Hotel used our EHR, as previously mentioned, we did explore using our downtime forms as the base paper documentation for the site. Our system has been improving our downtime planning and has recently been updating all of our downtime forms, so they were much more appropriate for potential use than our older legacy downtime forms.
- A back-up plan is always a good idea. ACS planning should have an all hazards approach. Capability planning should include both no-notice emergent events and for strategic utilization, where there is some time for preparation, as in a pandemic. At a minimum, there should be some pre-printed forms; patient tracking, triage note and medical charts. Fifty of each is a good start. Likewise, ACS organization charts, staff sign-in and assignments, job action sheets and inventory management forms should be available. Sample [Hospital Incident Command System \(HICS\) Forms](#) can be found on the California Hospital Association's web page, as well as the Federal Healthcare Resilience Task Force's [Alternate Care Site \(ACS\) Toolkit: Third Edition](#). These forms can be modified to fit the needs of the community/healthcare system operating the ACS. Also as a reminder, it is important to bring pens.

Question 4: What quality standards of care were used for telemedicine? What did the speakers use?

Answer:

- Resources:
 - The American Medical Association lists [ethical practices in telemedicine](#), which include a list of standards of professionalism and ethical guidelines for physicians providing clinical services through telehealth/telemedicine.
 - The Federation of State Medical Boards adopted [this policy](#) on the appropriate use of telemedicine technologies in the practice of medicine.
 - CMS has provided a fact sheet on [Telemedicine during COVID-19](#) and [this toolkit](#) on Telemedicine.
- The same standard of care that existed for traditional visits were the same ones used for virtual visits. If you cannot maintain the standard of care, you probably should not be providing the service.

Question 5: Can you discuss the noise level in ACSs with open floor plans and how patients were able to sleep? Were there quiet hours that were enforced? Also, how was lighting addressed when there are several patients in one large room?

Answer:

- Noise was an issue at JNYMS. There were quiet hours and lights did get dimmed at night. Also, patients were given eye patches and ear plugs.
- All efforts should be made to provide a quieter environment at night. Set a time frame for quiet hours, 10pm-6am for instance. Be sure all staff and patients are aware and that they do their best to maintain it. However, sometimes when there are emergencies or off-hour admissions, it may not be possible. A separate area could be designated for off-hour admissions. Eye coverings and earplugs do help.

Question 6: We met with our regional healthcare networks about establishing an off-site ACS but the decision was made to repurpose spaces in a local facility. The challenge they experienced was patient tracking since the locations were outside of the EHR. It was a challenge in implementing telehealth in these locations because they didn't have a fixed address in the building like the traditional fixed facility rooms. Have any of the speakers found a way to manage the virtual rooms on the fly?

Answer:

- In general, some facilities that have planned to use “flex space” in their facilities have pre-planned and built these flex spaces into modules that can be turned on and off in their EHR. Other facilities have requested just-in-time modifications of the EHR to reflect these additional spaces. [ASPR TRACIE's Considerations for the Use of Temporary Surge Sites for All-Hazards Incidents](#) discusses how Lehigh Valley Health System was able to do this.

- It is possible to build virtual units into some EHRs to help with disaster response. Massachusetts General Hospital has done this as part of our mass casualty plans and can activate a “virtual” minor treatment area if needed outside of the ED. This same virtual unit can be configured for ACS, either as part of advance planning or on the fly, if sufficient technical experts are immediately available.

Question 7: Do you check with the Cybersecurity and Infrastructure Security Agency (CISA) to help with security and update notifications?

Answer:

- ASPR’s Division of Critical Infrastructure Protection (CIP) works closely with [DHS CISA](#) and provides notifications via their distribution list on new updates and relevant resources.

Question 8: How can states request assistance for setting up ACSs with similar capabilities such as the ones presented on the webinar?

Answer:

- ACSs have been established across the country. Visit the [COVID-19 ACS Resources page](#) for helpful resources, particularly the [ACS Toolkit](#), [ACS Funding Summary Tip Sheet](#), and [COVID-19 Alternative Care Strategies short introductory video](#). To discuss ACS needs in your community and for technical inquiries, please contact your [FEMA Regional Administrators](#) and [HHS Regional Emergency Coordinators](#) through State Health Departments and Emergency Management Agencies. These federal representatives can discuss your specific needs and work with you to determine the best available resources.