COVID-19:

Practical Guide for Health Care Providers

COVID-19: WHAT WE KNOW

Initial Impact

A number of reports from other countries, as well as in the U.S., have indicated that people with underlying heart disease, diabetes, or high blood pressure may be more vulnerable to severe or COVID-19, with mortality rates two to three times higher than in the general population.[1]

We recognize the urgency and increased risk of a complicated course of COVID-19 for the approximately 120 million people in the U.S. who currently have one or more cardiovascular disease[2] and the 34.2 million people in the U.S. with diabetes.[3]

High Risk for Severe Illness

Based on currently available information and clinical expertise, those at high-risk for severe illness from COVID-19 include:[4]

- People aged 65 years and older
- People who live in a nursing home or long-term care facility
- People of all ages with underlying medical conditions, particularly if not well controlled, which includes people with:
  - Chronic lung disease or moderate to severe asthma
  - Serious heart conditions, including heart failure, coronary artery disease, congenital heart disease, cardiomyopathies, and pulmonary hypertension
  - Conditions that can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications. Severe obesity (body mass index [BMI] of 40 or higher)
  - Diabetes
  - Chronic kidney disease and who are undergoing dialysis
  - Liver disease

Data from the initial COVID-19 outbreak in Wuhan, China, shows an overall mortality rate of about 2% among patients with the virus. But the rate was 6% in patients with high blood pressure. The rate was also elevated for people with diabetes, cardiovascular disease, chronic respiratory disease and cancer.[5]

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COVID-19 IMPLICATIONS IN THE MANAGEMENT OF T2D AND CVD PATIENTS

Prevention and Precautions for COVID-19 for At Risk Populations

For all patients that are at higher risk, prevention is key in limiting the spread of coronavirus.

ENCOURAGE YOUR PATIENTS WHO ARE AT HIGHER RISK TO:

Follow necessary COVID-19 precautions and social distancing practices. Wash hands often and stay at home to limit exposure to the virus. For more information, go to CDC's resources on Coronavirus:

- CDC coronavirus COVID-19 home page
- Preventing infection
- COVID-19 symptoms

Continue treatment plan to manage diabetes and reduce cardiovascular risk based on standard clinical practice.

- Continue glucose tracking
- Stay hydrated
- Continue medication plan

Maintain physical activity and healthy eating habits

Sticking to plan is important now more than ever. Encourage patient to track and support plan by the following:

- Personal health trackers and apps
- AHA and ADA Support communities
- Diabetes Self-Management Education and Support (DSMES)

Patients with type 1 or type 2 diabetes should be well-stocked with their medications and supplies.

- Prescription oral medications (have more than 1 vial of insulin and ask your doctor for a 90-day supply)
- Ketone testing supplies, syringes and other diabetes supplies
- Electrolyte drinks—sugar-containing or with artificial sweeteners
- Household items and groceries to stay at home for a while in case of sickness or emergency declarations

If urgent care is needed, it's important that patients call their primary doctor before going to the emergency room.
Wherever you are directed, take all devices (CGM, insulin pumps), your medications, and a list of all medications with you.
Very ill patients who have diabetes with high fever, cough and shortness of breath should call 911.

Use telehealth services where possible, i.e. DSMES services, doctor's visits, nutrition therapy and other medical care.

If signs of stroke or heart attack are present, it's important to call 911. Know the signs and symptoms.

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Patients Diagnosed with COVID-19 and With Higher CVD Risk

For patients who have been diagnosed with COVID-19, the recommendation is to continue their treatment plan based on standard clinical practice. For patients with hypertension, ischemic heart disease or heart failure and on ACE-i or ARB medications, the AHA, the HFSA, ACC and ADA at this time recommend continuation, of angiotensin converting enzyme inhibitors (ACE-i) or angiotensin receptor blocker (ARB) medications for all patients already prescribed for indications.[6]

IF YOUR TYPE 2 DIABETES PATIENTS ARE DIAGNOSED WITH COVID-19, ADVISE PATIENTS TO:
If urgent care is needed, patients should call their primary doctor before going to the emergency room.
Patients should consider taking all devices (CGM, insulin pumps), medications, and a list of all medications with them. If management and space is a concern in the emergency room, a family member should consider bringing those supplies if the patient is admitted.
Very ill patients who have diabetes with high fever, cough and shortness of breath should call 911.
Encourage patients showing signs of stroke, cardiac arrest, or heart attack to call 911 immediately. Current trends are showing that individuals having heart attacks and stroke are not calling 911. For more information, encourage them to know the signs and symptoms.

IF YOUR TYPE 2 DIABETES PATIENTS ARE DIAGNOSED WITH COVID-19 AND/OR HOSPITALIZED:
Maintain good blood glucose control.
A higher likelihood of severe disease and a higher mortality rate.
Hyperglycemia is an independent risk factor for poor outcome of COVID-19.
Reduce exposure risk with PPE usage and following additional precautions.
For patients who are safely able to self-monitor their glucose levels, consider having patients self-monitor when safe to do so.
Use continuous glucose monitoring (CGM). Restrictions for the remote glucose monitoring devices have been waived during COVID-19 in select patients.
For additional information on diabetes in-hospital management, go to the Diabetes Care in the Hospital: Standards of Medical Care in Diabetes—2020.

ADDITIONAL COVID-19 RESOURCES

Patient Resources on COVID-19

AHA: Heart.org/covid19

ADA: Diabetes.org/coronavirus-covid-19

Professional Resources on COVID-19

AHA: Professional.heart.org/covid-19

ADA: Professional.diabetes.org/covid

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ENSURING PATIENTS RECEIVE OPTIMAL CARE

Emergency 1135 CMS Waiver

In response to the COVID-19 epidemic, CMS has issued an Emergency 1135 CMS Waiver. Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of healthcare services while at home. According to CMS/Medicare, telehealth/telemedicine is the exchange of medical information from one site to another through electronic communication to improve a patient's health.[7] Traditionally, CMS limited Medicare reimbursement to rural settings and office setting, telehealth visits can be provided outside a patient's home.

Here is a summary of the waiver:

- Medicare will pay for telehealth from patient's homes starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients.
- Prior to this waiver Medicare could only pay for telehealth on a limited basis: Designated rural area and when they leave their home and go to a medical facility or hospital.
- Waiver will pay for telehealth visits, including evaluation and management visits (common office visits), mental health counseling and preventive health screenings.
- There are three types of Medicare Telemedicine Services: telemedicine visit (use of a telecommunication system), virtual check-in (brief 5-10 check in via telephone or telecommunication visit) and e-visit (a communication through online patient portal).
- People with higher risk for COVID-19 can visit with their doctor from their home, without having to go to a doctor's office or hospital.
- HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.
- Qualified providers who are permitted to furnish Medicare telehealth services during the Public Health Emergency include physicians and certain non-physician practitioners, such as NPs, PAs and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish services within their scope of practice and consistent with Medicare benefit rules that apply to all services. This is not changed by the waiver.
- For more information go to Medicare Telemedicine Health Care Provider Fact Sheet.[7]

Managing Office Visits

- Consider scenarios to receive patients to reduce exposure, for example create two different "well" vs. "sick" clinic locations to reduce exposure.
- Have patients wait in car prior to appointments or space appointments out from one another.
- Scheduled office visits spaced apart to limit other patient-to-patient waiting room exposure.

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Telehealth Visits: Getting Started

COMPLETED	STEPS	DETAILS
	Prepare patient for visit.	Gain permission (consent form) from patient. Have patient download telehealth communication platform prior. For patients who cannot connect via telemedicine, make sure they have an option for live visits or access.
	Identify patients that are appropriate for telehealth visits.	Call them or send instructions on what to expect to help them prepare for the visit.
	Prepare office for the visit.	Have an office telehealth plan. Identify telehealth software (Electronic Health Record, Skype) and test system. 1135 Waiver does allow for FaceTime and Skype. Waiver does not allow remote communication that are public-facing remote communication products, like TikTok, Facebook Live, Twitch, or chat rooms, such as Switch. Have teams test system and find a dedicated quite space for visits. Train staff. Identify a private room with little external sounds. Test audio.
	The televisit.	Provide good documentation. Documentation should include details on ▪ Assessment and treatment ▪ That informed consent gained from patient for use of telehealth ▪ Visit was appropriate to use telehealth ▪ Benefits of telehealth ▪ Platform used (type of Electronic Medical Record used, Skype, etc.) ▪ Any limitations from visit Support a good visit ▪ Make a good connection with the patient ▪ Check in on mental health of patient ▪ Provide consistent eye contact and interaction with patient; Try to limit charting during visit
	Verify billing standards. For more information on CMS guidelines for telehealth, go to CMS Provider Fact Sheet.	CPT codes for medicare telehealth visits: ▪ 99201-99215 (Office or other outpatient visits) ▪ G0425-G0427 (Telehealth consultations, ED or initial inpatient) ▪ G0406-G0408 (Follow-up inpatient telehealth consultation furnished to beneficiaries in hospital or SNFs) Virtual Check-ins: HCPCS code G2010 E-Visits: 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services.

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7. https://professional.heart.org/professional/ScienceNews/UCM_505836_HFSAACCAHAstatement-addresses-concerns-re-using-RAAS-antagonists-in-COVID.jsp
   https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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