

Navigating COVID-19- Topic changes weekly

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6:00 pm- 7:00 pm

Presenters:

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Yun Boylston, MD, Burlington Pediatrics
Zach Feldman, MD, FAPA, Raleigh Psychiatric Associates

It's 6:00. Let's get started. Good evening everybody. Thank you for participating in a webinar on navigating COVID-19. This evening we are focusing on pandemic primary pearls, lessons we've learn and how to use those as practices open. Tonight's webinar is cosponsored by CCNC, North Carolina Pediatric Society, North Carolina Psychiatric Association and North Carolina Academy of Family Physicians and North Carolina AHEC. It's the sixth of the continuing series of informational sessions designed to respond to needs you have identified as you navigate COVID-19. We start by recognizing Tom, Elizabeth, and Greg for their leadership in identifying those needs, for their partnership and collaboration of putting on these webinars to respond to those needs. I would also like to thank everybody who is making the type to be on the webinar tonight and for the work that you do every day and for your patients and your staff and your communities. We hope this information you get tonight will help make navigating these trying times easier. Next slide.

My name is Hugh Tilson. I will be the moderating tonight. Let me start by introducing our presenters. You can see Doctor Holly Biola, who is a family physician from Lincoln community Health Center, Doctor Yun Boylston, a pediatrician from Burlington Pediatrics and Doctor Zach Feldman, psychiatrist from Raleigh Psychiatric Associates. Thank you so much for taking the time to be with us. We look forward to hearing from you. Next slide.

After you hear from the we will turn to your questions. We have learned in past forums that presenters will often address your questions during their presentations. We will have time to get to your questions. I encourage you to wait until they are finished before submitting a question. To submit a question, use the Q&A feature on the black bar at the bottom of the screen. The Q&A feature and we will keep track of your questions and will get to them. If you are on the phone, you can't do that. In order to submit a question you will need to go to the webinar questionsCOVID19webinar@Gmail.com. That's questionscovid19webinar@gmail.com. Lastly, please know that we will post these slides and record the webinar and make a recording of it and these lights will be available on the CCNC AHEC website where we have stored the past six of these. I will now turn it over to Holly. Holly, thank you so much.

Holly Biola:

Thank you. I am in a large urban Health Center. That is my frame of reference. Next slide.

I'm just going to jump straight into this. In terms of phase 1 we have been enthusiastically prioritizing the safety of our staff and also patients by ensuring that everyone has masks and PPE for our testers and respiratory assessments. We call all the patients we can to offer virtual visits and keep them at home. We have tried our best to train our staff to do busy deal, video visits ASAP. We have started to offer those. We have screeners out front and members of the staff and providers and frontline medical assistance and folks from registration and interpreters to try and make sure that we are screening everyone for symptoms and checking temperatures on every person who enters our building. Next slide.

We try to do all we can about social distancing or our patients. People come and they take the phone number and they are sent to the car to wait. If they have symptoms, sometimes even if they don't have symptoms. In order to keep the number of the people in the building down as far as we can. We have moved our waiting room chairs to be six feet apart and this is one of the best practices I know of. We have marks on the floor for lining up for the pharmacy and to check in and where people tended to congregate. In terms of social distancing for the staff we are creative about our workrooms. Some people document in the exam rooms and some document in the work room. We have our meetings available on Zoom and calling opportunities for folks to not be in the same room and those of us in the same room are several chairs apart. Our interpreters, even when they are in the building, call into the exam room when we are on a video or with a in person or phone visit. Next slide.

The video visits when possible we've had to train on this as much as we can. See one, do one, teach one and do them all day long of course as much as we can. We had to have some at elbow Tech help from our I.T. staff and from each other and we try to have a Super User in each department to help people who are new to Visio visits. For the in person visit we try to move to a hybrid or the provider would call into the room and make sure that the patient knows to answer the phone and start visit that way to limit the amount of time in the room and case the provider is an asymptomatic spreader. We have the providers reviewing the charts a week ahead of time to try to have a system to indicate to our certified medical assistant whether we want the person to be in person or by video or telephone. It's always a decision made in collaboration with the patient. We are basing our decisions how we think the visit should go based on the last time we saw them. Obviously, things can happen in between. We also have had to change the waiting room. Instead of having an open shelf of books for patients sadly, Book Harvest is trying to make age-appropriate to go bags. Which seems less attractive to the patient but it's something. Next slide please.

So, we thought that maybe we could switch over to the well in the morning and sick in the evening, we've heard about a lot of practices that are doing. That turned out quickly not to work because you are coming in for your two-year-old well-child check, but the kid is sick. They are always sick. We found it very difficult to separate the well and the sick in the way we thought we could. We found that even if we said okay, in the morning only well, parents of babies were just not coming in. They said that is where we come when we are sick. Other people come when we are sick. We will not bring in the baby to you. We

are having to be creative and we are starting to turn our Saturday urgent care clinic into a well-child only clinic. We will try to make the parents of children who are in need of vaccinations feel a little better about coming in especially for well visits that require vaccines. We are a large facility. This morning we were talking about the numbers. We have between 450 and 500 people coming in and out of the front door every day and 200 staff. So, to limit the number of people in the building will require some creativity and we will have to be counting the ins and outs and figure out how to spread people out and when is it time to require everyone to leave their phone number and go back to their car. One of the things when we were trying to hash out how this would work to limit the number is in person visits, we played with the idea of, each provider should have two or three in person if they can limit to that. And we realized we have these procedural sessions where one provider might be doing all the work, you know putting in IUDs and Nexplanon. One provider may be doing a biopsy clinic or a pap clinic. Clearly all those people need to come in. On those sessions we may have to have, to have, we may have to balance that with making another provider or two to 100% virtual for that session. Next slide.

The new duties and jobs created by the clinic: Screeners, not just we had to triage patients and at times send people to the emergency room. From the front door of our clinic. For that reason, we try to have a provider out front who knows enough about adult and pediatric medicine to be able to do that triage as well as a well line for everyone without symptoms. This has to be done in multiple languages at our clinic. Everyone else still must get their temperature checked and ask the screening questions. That is a lot of people. To ask those 500 people all these questions. Bouncers. We don't yet have bouncers, but we will need them to figure out when different parts of the building are too full and maybe we should take your phone number and send you to your car because there are too many people in the room. Swabbers. We have a lot of providers, 45 or 50. They all see the patients but now we need a lot of them to do swabbers. That means shifting of responsibilities. We have been uncomfortable with the number of patients who have had complications after being positive for COVID. We are trying to follow the guidelines of following up with these folks by phone 48 hours after the positive test. Or if you feel even some of the negative tests that is concerned from crumpling at home we have a system set up by which we are sending a pool of people that which we send a patient list of the ones that we want called 48 hours after their in person visit. We now have to have a PPE tracker. This falls into the CFO and other folks that are helping to count when we are low on various forms of PPE in different parts of the building. When do we need to reorder? What is the burn rate? It's not something we had to pay close attention to. We had to figure out who are clean and dirty. Who is willing to do the swabs in the respiratory assessments? We have some providers who do to their age and medical conditions, don't feel comfortable assessing someone who may have COVID. We are trying to respect that and make sure that we help everyone to feel as safe as they can be, and we are trying to identify who those folks are. We had to figure out who can be our video visit tech support among ourselves because can't have I.T. everywhere all the time. Then, the schedule reviewing to figure out who is appropriate for a video or in person or telephone visit. We are having trouble figuring out how to get that

job off the shoulders of the providers to determine what their visit type should be. Next slide.

So, looking ahead to how we are going to mold ourselves into a new and safer practice we need to figure out who we are not reaching. We know that we have patients who are not getting in contact with. They may not have a working phone number. They may have come in for a visit and been sent home and we are trying to keep a list. It is difficult to figure out until you've called and spoke to the person whether he would have access to video and whether there is a middle school at home that can help the grandmother get attached to the call. Our vans are running at a lower volume at this point and can't serve everyone, so we have to figure out what to do about those folks. We are trying to figure out who has a chronic condition or on some sort of list for that and had well child check who has not been seen this year. We have talked also about doing home visits and we are concerned about this new requirement from Medicaid to do a home visit when we don't have any way currently of proving that our providers are immune. We could be carrying a virus into their homes. Once we figure out when and who can go to the homes, we will figure out who that will be safe to do this with. That is all I have brought to the table this evening. Next slide.

Oh, there is more. We are a safety net clinic, so we expect to get more new Patients as people lose jobs and insurance. The patients with insurance will be losing it in a large part and we need to make sure to figure out a way to update everybody's information without all our patients having to present themselves in person to the registration desk. We have found it difficult to keep on top of the changing landscape for where folks can find food for their families. This will be an ongoing challenge. We are looking for guidance from the state and the CDC regarding when we should start to think about testing our staff and on what timeframe. Looking also for help with figuring out the question I was talking about four, figuring out ahead of time who needs to be seen in person. Who needs a phone visit? Who needs a video visit? The last question which we all want to know is, when can we go back to normal. At what point will we know is time for anybody who wants an in person visit to be able to have one? I think that is my last slide.

Hugh Tilson:

Before when get to you, there is a quick question. What is a bouncer?

Holly Biola:

A bouncer is someone who basically who doesn't allow people to stay in the clinic. They might bounce them out back to the car. Like a nightclub. How long has it been? I'm sorry, there are 20 people in the room, and we can only have 10. Would you be willing to go back to your car and let me call you when it's time for your appointment? That would be a bouncer.

Hugh Tilson:

Thank you. All right. Sorry Yun.

Yun Boylston:

No, it's alright. I am Yun Boylston and I am a pediatrician. We are a large independent pediatric practice with three locations in Alamance county and we serve children in around five counties in the surrounding areas. My apologies in advance the slides are a bit bright so if it's a bit much you could tell my pediatric roots. We would love to share our ideas with you, and we appreciate CCNC, CCPN, and North Carolina AHEC and NC Peds and all the partner organizations who make this possible. Thank you. Next slide.

In terms of framing our practice experience and our journey I wanted to take a snapshot at some of our strategic guideposts. Early on we wanted to come together among the partners and among the leadership team and really decide what are our priorities and goals for getting through this. It has been helpful. I don't think these are unique. They are pretty general. Sometimes when you come across difficult decision-making required that will continue to be required especially when you have to decide what to sacrifice and not sacrifice. I think just thinking in this framework can be really helpful. Next slide please.

Some of our successes that we've navigated really well, number one just like Lincoln community health, is telehealth. We started this with avengence. Within the timeframe of getting a working group together and deciding our roadmap for what a good platform might look like. All the considerations that would be needed for how we would work through the check-in process and how does billing works and what are the templates that might be required. The workflows. And, really, within 10 days of practice wide deployment 24% of our volume was telehealth. That is exciting for us. It has been a lifeline and it has been beneficial as well. For us getting to scale quickly was the key. And it has helped our patient population understand that we had the suffering and to be able to provide it with certainly a few glitches, but I think definitely we worked through it well. Billing was critical through all of this. The interdisciplinary team that we have, all parts that make a practice. The clinical staff. Checking in. We were also mindful that is telehealth had to integrate with our current workflows and that the awareness of patient privacy was still really critical and that we would not make compromises, knowing that we had to provide the same quality of care and have the highest expectations for telehealth visits just like we do for the in person visits. Two things we've been really excited about have been, in terms of the nature of the visits, behavioral health visits have taken off with telehealth. Our psychologist, Dr. Kapido, does 100% of her visits via telehealth now. The other MD and practitioners also do a good number and we have a good visit, a good mix of acute visits as well we are piloting a virtual walk-in. One way we got the word out, and the top right corner this is a Facebook video we made. Just to demystify what the process entails. This video walks you through the phone call calling and saying, that might be compatible for our telehealth visit. Why don't we work you through that? It has been helpful to our patients. The bottom photo is a picture of our landing page on Doximity. Next slide.

One component, in terms of how we communicate as a practice, we have tried to communicate with intentionality especially in a time where we are inundated with information and a lot of things are changing even in terms of clinical guidance. Even within the business community and

even within our partners like the bank and a lot of communication channels. So, this is one thing that we have really worked to do mindfully and to do well. Timeliness and transparency are important. A few things I would like to highlight specific to the medication is how we communicated with our employees. All the things that you see on the screen, we have practice wide Zoom huddles which have been successful. We do this every week. Sometimes every two weeks. Approximately weekly. When we have three office locations, we like to get the messaging out in a consistent way. So that everyone receives the same message at the same time. And the zoom huddles are celebratory. We just had, we just got off a Zoom call before this call and we shared slideshows to celebrate all of our employees. We provide information on employment benefits that some of our employees are taking part in. We also provide information on the clinical guidance. Some of the operational changes. So, they have been helpful.

In terms of shared goals, our employees are creative. They are insightful and they have great ideas. So, we have attempted to help bring them into the circle. We are frank with them and we discussed the key performance indicators we are looking out. How many visits per provider are we trying to shoot for, to craft a schedule that has the volume and the flow that we really are striving for. Coming up with some problem-solving strategies together. So, the corner photo shows you how we do a Zoom call, everyone keeps their distance and keeps their masks on. In the beginning when a lot of the scary stuff was coming down the pipe, we really felt we needed to be open and honest. This shows some of the straightforward information. We are committed to you. Even though we do have some temporary reduction in work hours anticipated no one is being laid off. This helps us to be accountable to everyone. Looking back, our first employee specific COVID communication rolled out in February 27th. The lower left corner shows what was texted to our employees saying be here in the morning. We are shutting down the waiting room and more info to come. Next slide please.

The fun part but a critical part of some things we've done is to really increase our social media engagement. This is our Facebook page. We post a variety of different things. The videos have been particularly popular. If you look at the bottom the second and fourth and first are all videos. The second one is with Dr. Kapeido, our psychologist giving helpful tips to parents on how to approach anxiety in children during the age of COVID. This was really popular. Received close to 6000 visits currently. The last one was a fun video that we did for when local systems shut down school. It says we hey we are in it together. Keep reading. Do your chores. Trying to make it fun and positive. They have helped spread the word on our efforts. The third post, a group of us got together with other community-based organizations and we packed food for the children of the Alamance school system because we were going into the Easter holiday, trying to help them have access to food. Next slide please.

In terms of financial strategy, the things we need to be mindful of and the things to keep a pulse on, this is a prescriptive, but it gives you an idea about the things that we've worked on. One would be different ways to look at income, recognizing that cash flow for independent practices would be really critical. Coupled with the top priority at the moment. One way that we conceptualized the exact

effect of COVID financially for us has been one model with taking the ranges of revenue and expected revenue and then we match that to the target reduction in expenses that would be required to basically breakeven. Another model, because we are not used to the drastic reduction in volume, we looked at benchmarks from last year and said, how far off are we from the lowest revenue month that we are comfortable and aware of? For us it was June last year across the 12-month calendar. What are some levers to pull? What are the differences? What is the makeup of the visit? Much more of a thought process. In terms of the real-time dashboard there are different things we try to keep an eye on so we can have proxies or estimations of what our current revenue is looking like without having to pull a bunch of the monthly balance sheets. A lot of that takes a bit of time to pull together. Trying to create a real-time check of what is going on. Expense management. Certainly, everyone on this call is mindful of this. Keenly aware of all the liabilities. The last item that I have here is in terms of leverage options. Of these our practice has been fortunate. We have a long-standing relationship with our bank. We did benefit from the PPP loan. We have not taken part in some of the others, we try to keep aware of all the options available. We know how many days and with what terms our line of credit could be pulled. The economic disaster loan, we had not completely looked into that. We received word that Blue Cross Blue Shield may be able to offer some prepayments. We have not done that either but being aware of this should we get to certain trigger points. Next slide please.

This is an overview of how we view our operational expenses. I imagine for all the other independent actresses it will look similar. These are the major cost drivers. Payroll is number one. We have been mindful of this. What is the patient to provider ratio daily? What is the average reimbursement per visit currently compared to index benchmarks? Vaccines. This is interesting because we are in a difficult situation where the vaccine rates are down and that is quite concerning. But we want to buy vaccines and to have them. That is also for our private vaccines. These are big ticket items in terms of accounts payable and liabilities that we bear. So, we are just in a kind of an uneasy situation. Then, lab and clinical supplies. We have drastically reduced our supplies Strep test and flu tests and all the point of care tests. And the variable expenses that go down with the reduction in patient volume. We have tried to monitor that closely. And overhead expenses certainly. These are difficult to get a move on but to be mindful of these as well. Next slide please.

With just the multidimensionality of healthcare and of being a medical home, we are mindful of the communities we serve. Certainly, some of the vulnerable and underserved populations, we could do better, but I think we have been mindful. One is our integrated mental health program. It has been a godsend. I think there's going to be a critical need for very long time to come. We are fully committed to offer that within the medical home. In terms of understanding how this is going to change healthcare needs in North Carolina, over the past month we've worked to accept more patients covered under Medicaid, recognizing that we see the need and we know that enrollment will surge with funding cuts and all the things that come together that we recognize will be a problem. We are trying to do our part to provide access for healthcare. Our practice, fortunately, has bilingual providers. We have strong connections and partnerships with our local

Hispanic community. For example, we have taken part in promoting this since 2020. Working with our community through this seems to be a natural extension. Next slide please.

This is not the scariest but possibly the second scariest. This is from our practice. In terms of the concern for declining vaccine rates, as a pediatric practice we keenly appreciate this. We have a patient panel of about 18,000 patients. This gives you an estimate of the magnitude what we are working with. We pulled some numbers, and this gives you a breakdown of the volume of vaccines that we administered last April and this April. Some of this is frankly quite scary. With the AAP guidance recently in terms of promoting well visits 2 and under we seem to be doing fairly well but what is scary is the reduced vaccine rates in the 4-5- and 10-11-year crowd. These vaccines associated with kindergarten and middle school visits; they are down by 50%. We take this personally. We are proud of our vaccine efforts. We receive recognition annually for our high vaccine rates. We hope to move the needle on this. Next slide please.

This is the slide that keeps me up at night. For children the greatest concern for children in the age of COVID is the risk of invisibility. A lot of this started with some complacency that children aren't affected by COVID at least clinically. But there is real suffering. Comes in many forms, not just directly through the virus. Food insecurity, we have certainly seen that. A surge in mental health concerns. Children are losing valuable educational opportunities. And we know that the vulnerable populations and the health disparities. COVID isn't equitable and it brings to light more starkly social economic and geographic considerations. If you want to do a Zoom call you have to have decent Wi-Fi and good broadband access. We hope that for children they are not marginalized, and they are included in the treatment, research and prevention and as well as testing efforts that are underway to combat COVID. Next slide.

For us, next steps include a couple of different things. One is our practice this week is rolling out universal source control and universal source identification. We are working actively to screen our employees. This primarily entails daily temperature checks with a basic questionnaire screening that we will implement across all sites. We have gotten really good and responsive scheduling. Gone are the days where you schedule an appointment three months in advance and it stays on the books. We really are retooling our scheduling weekly if not more frequently. It takes a lot of manpower. Our staff are critical to this. And this is our pie in the sky. We are here. We would love to contribute to the testing effort. We are just not capable in terms of our PPE supply as well as our access to testing. We have close to 2000 IV machines that are sitting idle. As much as we gently harassed the Abbot rep but we it is clear we are not a priority, but I think it's important to discuss the role of a medical home in test and trace. In terms of the national dialogue. I don't think this is being done. In terms of the medical home, this is where all the STI are diagnosed, all the whooping cough. The partnerships and the communications channels on the workflows exist within primary care and I would hope that it is acknowledged and supported. I think there is an opportunity for us in the age of COVID. That gets us to the last point which is reinforcing the medical homes. This is where the symptom list for COVID it really not that straightforward.

Sometimes a fever or headache is not due back to COVID. There are many other things. I think receiving quality, timely assessment for all things COVID and beyond, I think that's really critical. This is something that is being missed out on. Next slide.

In terms of all the resources we have benefited from the folks on this call and the NCP society has been phenomenal. CCPM, absolutely. We get a wealth of information from our business community and even though the bandwidth can be limited I think it serves us to take advantage of getting information in a lot of different ways. If you have limited time, the top three would be the Tuesday Solution Share with NCP society and the CCNC webinar that we are on currently and the Thursday evening DHHS webinars. These are important. Thank you. I appreciate your time and patience and please let me know if you have any questions.

Hugh Tilson:
Zach, are you there?

Zach Feldman:
Yes, I'm here. Can you hear me?

Hugh Tilson:
Yes, we got you.

Zach Feldman:
I didn't know if we were doing questions in between or?

Hugh Tilson:
A couple of them are quick and so can we just do a couple of those quick ones?

Zach Feldman:
Sure. Yeah.

Hugh Tilson:
How many providers and staff are at Burlington pediatrics?

Are you still on? Can we get you back for a couple of seconds?

How about this, why don't we loop back and go back at the end for those.

Zack Feldman:
Gotcha. I'm good with that. All right. So, my name is Zach Feldman. I am an adolescent, child and adult psychiatrist. I see a full age range. I am with a group Raleigh Psychiatric Associates. We are what would be considered large by psychiatric standards, but small by other group standards. We have eight psychiatrists here and a therapist and psychologist. Or staff is much thinner as I listen to these presentations of these large organizations. I'm impressed by the challenges you have had to overcome with large staffs that you had to work with. We have three full-time staff members, we have been at four, but we are three currently. Things are simpler for us. Some other things -- we don't have the support on the other side of it. Next slide.

In looking at our experience I was reflecting back over the past couple of months here. Looking at some positive changes that have come through this. Silver linings. I think that in psychiatry particularly in terms of practice management, we tend to not move necessarily forward as quickly as some other fields. Our practice only got going with EHR about a 1 1/2 years ago. Other fields did this 5, 6, or 10 years ago. One thing they came from this was us being able to brace change a little more within our practice. Our experience going to telemedicine was amazing. We went with a platform called Doxy that a lot of people are using. We have been impressed with the flexibility for a practice our size and being doable. We converted to telemedicine very quickly. One person, my pediatrician colleague, mentioned the behavioral health switched over quickly. We switched over quickly. We were at close to 100% within five days of initiating this. I think that really will strengthen our practice going forward you in terms of being able to look at change and being able to adapt to future situations that may arise, other things we have been put into place having to do with our phone system. Suddenly it appears somewhat antiquated. It is about six or seven years old without remote capabilities as the loft of internet-based ones. So, we are switching that over. We have been making modifications were practice management software to operate remotely. All of that will help us in the future when we navigate things like hurricanes or other snow, or the office will be able to operate in a remote way at that point. The other thing, with psychiatry a lot of times people will be in the office and I won't see them all day because they will be seeing patients. Through this we have been engaging as a team a lot more within our office also with external colleagues. People outside our office. Through professional organizations just friends and people we've known from training and sometimes reconnecting with people. So, I think that has been a positive. Engaging with our professional organizations as well. The North Carolina Psychiatric Association and the North Carolina Medical Society as well.

Staff communication has also been something that we have been improving through this process. Getting to a sense of teamwork in our office, like I said we are pretty small in terms of our staff, but we can get a little bit, the way the organization is set up a lot of the stuff numbers are dedicated to different providers. This has been more of a unifying process for us.

Finally, engaging with patients. That has been positive. We have been reaching out to people were proactively calling out people to see how they are doing and calling them up to let them know that we are switching to telemedicine and how this works. We have a little more leeway to do this being a smaller practice and with psychiatric practices we have a lot fewer patients per provider than a primary care practice would. That does allow us the luxury to be able to reach out in person. A lot of people have appreciated that reaching out and some other people, it has been hard to get them into the clinic in person for a variety of reasons including transportation issues sometimes anxiety about leaving the home. They have been more willing to participate in treatment by telemedicine. So, we have been able to make a lot of progress on that as well. Next slide please.

For us the technology was a big step. We had only been with EHR for 1 1/2 years. Maybe as a field that was not looking at COVID directly, we

were not as up on everything as early as some other fields were. It came upon us quickly, it felt like it, that we needed to make big changes quickly. The biggest thing for me and for our practice was to talk. This increased our collaboration and with outside groups and professional organizations and calling of people and saying what are you doing? Getting back in touch with people from training and talking with training directors from UNC where I trained and things like that to get an idea about people are doing in different places. Getting some feedback from the big organizations. In terms of lessons learned in that, in a time of crisis and in terms of the process we look at changing what we need to do immediately to get to the crisis then look at making longer-term changes as time allows and when things are not moving as fast. Trying to use existing frameworks of the current workflow where possible and not revamping everything, but to see what we can bring from our previous experience and adapt that to telemedicine.

In terms of the short-term, making that a priority but also looking, if we can turn it into a long-term solution at the same time. Recognizing the stress of change for the providers as well as staff and patients. This is all kind of fundamental to the process. I think that recognizing that and seeing how we can help each other help ourselves in terms of self-care as we working to work with our patients. Next slide please.

In terms of reaching out to our patients, we are a private practice. Most of our patients are fairly reachable with a small minority that we have trouble reaching. A lot of times this is not due to social economic issues but to more kind of the mental health issues and anxiety and avoidance and things like that. Trying multiple methods, different people respond with different methods. We have a little more flexibility because we have fewer patients we are seeing. That gives us more flexibility to reach out in person per provider. I had many sincere thank you people saying thank you for the phone call. Other people prefer email, or a more generalized approach and some people appreciate the reaching out looking for them or their kids' wellbeing. Next slide.

Looking ahead at how things are going to be different going forward and how we are going to ease our restrictions and where it is a work in progress, we are looking at a gradual reopening. We basically have gone to all telemedicine at this point. We are figuring out how we will work with we start to get people back in clinic in person and when that is going to happen. We are looking at probably starting off on a on limited basis and having only certain providers on certain days seeing people to minimize the number of people coming in and out. Again, that is a luxury afforded to us in psychiatry, but it will be more difficult in primary care. We can keep the numbers down so things don't get crowded. Over time giving patients the choice of whether or not they want to continue with telemedicine. I got a lot of positive feedback from patients that would prefer it going forward and try to figure out how that will work in terms of what the standard of care will be in terms of getting people in for in-person appointments when necessary, going back to the anxiety issue. For a lot of people, they are more willing to do a telemedicine appointment, but it is also a therapeutic process for them to come in as well and try to negotiate how that is all going to work out. Maintaining these positive changes

and being flexible as we are move forward is going to be the key for us. Next slide please.

The resources, it's hard to describe how helpful these have been over the last two months. Of course, the colleagues within our organization and everybody looking at things and piloting different things and trying to come up with our best solution to solve our problem. Again, reaching out with similar practices and training programs and people at the bigger hospitals. Professional organizations and the specialty societies in the North Carolina psychiatric Association obviously. A little more specific to things going on in psychiatry but North Carolina Medical Society has been amazingly helpful and all the problems that relate to medicine in general and looking at things with a bigger picture and helping us to integrate with other specialties. Other things that we check with, the North Carolina Medical Board, looking at their stance on different things as we look at this. What is okay with the medical board and what is not. Then the malpractice carrier has been pretty useful in discussing this with us. This transition. Mostly in terms of reassurance that what you are doing is okay. They also had good resources as well. Then, back to the specialty organizations on that website resources, the NCPA has been maintained and increasing list of resources we have been able to utilize along the way and the APA of the national level. They have information on telemedicine that has been remarkably useful.

That about wraps up my talk. I'm happy to take any questions.

Hugh Tilson:

Great. Thank you so much. We have a couple of questions. As a reminder you can submit your questions using the Q&A feature at the black bar at the bottom of the screen or by sending an Email at questionsCOVID19webinar@Gmail.com. First question is what is a virtual walk-in? How do you do one?

Yun Boylston:

A virtual walk-in is an attempt to model the morning walk in which is popular across all of our offices. Essentially it offers a telehealth at the point the phone call or the request comes in. It seems straightforward in theory, but it took some problem-solving and working through the flow. Essentially, when a parent calls and says I'm concerned about pinkeye and the scheduler might say we can offer you a scheduled telehealth visit or are you available now? Would you like to have your visit now? If the parent agrees to that, they will work through the billing in the telehealth consent and the patient is emailed instructions on our website and there are some other informational resources about the telehealth visit. They log in and there is a provider who was partially blocked to accommodate the visits that show up on the schedule. Hopefully, within minutes the visit is picked up and completed.

Hugh Tilson:

Thanks. While we have you, can you discuss responsive scheduling?

Yun Boylston:

Yeah so responsive scheduling is essentially, the part that makes it responsive is receiving either real-time or as close to real time as possible communication from your scheduling team and the schedulers.

For example, at the end of each day the managers and the partners receive a breakdown of all the visits that were offered and all the open slots across offices and the no-shows. We are seeing a lot of shift in terms of, for example, the 30 minutes well visit slots have really taken off. They have booked up. If that is where the demand is, we need to open up more slots in the template. If it turns out we had a good number of sick visits in one location that was open, but the other office booked up quickly, trying to accommodate really the scheduling and the demand. In order to optimize the visits, we can schedule and complete.

Hugh Tilson:

Great. One quick question is, how many providers and staff do you have?

Yun Boylston:

We have eight physicians, five advanced practitioners and our staff of approximately 45 among our care team which includes our referrals coordinator and our clinical team and our front office staff. And our managers as well. The total providers and employees in our group is just over 60. We have one of the providers on the call and he'll text me if I got that wrong, but I think that is pretty accurate.

Hugh Tilson:

Its directionally consistent so we will go with that.

Two general questions. What do you look at as an indicator to increase your visit? How will you know when it's time to do that?

Yun Boylston:

For our practice, we are trying to actively drive that. That is one of the reasons why in the past we've been looking at helping our staff understand that this is the need in the community, and we need to vaccinate children. Where actively working on reports. And so, for children due for their well visits. Part of our staff, we have deployed our staff in that way because some other tasks we may not have a need for. In their downtime they are making phone calls to families giving them, encouraging them to say this is what we recommend. These are important. These are the things we are doing within our practice to make sure that you have a safe visit.

Holly Biola:

And we are trying, at Lincoln, all we can to get people to do video visits. If it has to be in person and we do that. And if they can do either then we telephone.

Yun Boylston:

Holly has a great point and that is something that the AAP has encouraged and supported is virtual well visits. Certainly, if you have an eight ruled that is up to date that might be a good opportunity to talk about the anticipatory guidance that is important during this time when they are home. Then, they offer guidance on how to complete the clinical exam part. That is something we are actively pursuing. We have a quite got to that point yet. I think it is something that a lot of practices including many of the pediatric providers who are on the call that they are leading the way on as well.

Hugh Tilson:

One last question. Can you discuss how you are doing hospital follow-ups at these times?

Yun Boylston:

We are doing mostly virtual, especially since some of these Patients are COVID positive. There has been kind of a kerfuffle figuring out what do you do with someone who needs follow-up labs urgently post hospitalization and they were positive 5 days ago six days ago. So yeah, we are trying to figure out our policy. It is mostly virtual.

Hugh Tilson:

Anybody else wants to answer that?

Zach Feldman:

I was going to say from a psychiatric standpoint we are doing them virtually. The standard procedure that we've always done is taking referrals. This takes out a lot of the guesswork of infection control and things like that.

Hugh Tilson:

So, its 7 o'clock and will you indulge me with one more question? When you go back to in person visits will you all be wearing masks? How will that work with psychiatric patients?

Zach Feldman:

Yes, that's an excellent question. We were just discussing that today. My personal feeling is that I feel like I have more of a body language connection if I can see someone's face via telemedicine versus seeing them in person with a mask. I think what we would try to do, what I would try to do that I would leave this up to the different providers, but probably wear a mask in common areas. My office is big enough that I could sit six feet away from the person as we are talking, and we could take off the masks at that point. We would have to do some disinfecting of the area after the visit. That would be my plan.

Holly Biola:

This is Holly. We never stopped doing in person visits. We wear masks and we will continue to do so until the CDC tells us not to.

Hugh Tilson:

Well its 7:02. Thank you for staying a little bit late. One comment was, a huge shout out to Holly and Lincoln community health. So, I'll say that but I also want to give a huge shout out to Yun and Zach of you for your time tonight. Incredible information. It is perfectly timed for the consideration of what comes next. I appreciate the thought you put into this and making time for tonight. Thank you very much. Any final comments before we say good night everybody?

Holly Biola:

No. Thank you so much.

[Indiscernible - overlapping speakers].

Hugh Tilson:

Go for it, Zach.

Zach Feldman:

Thank you to everyone out there. doing your great work that you are doing.

Yun Boylston:

Yes, I would absolutely echo that. Hugh, thank you for this opportunity. And this is, I'm the messenger, but this is a collective effort from our practice and our community of healthcare providers. Thank you.

Hugh Tilson:

Thank you. Have a great evening. Stay healthy and stay well.

Goodbye. [Event concluded]