

Presenters:

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Hugh Tilson:

This webinar is part of a weekly series of informational sessions put on by North Carolina Medicaid, CCNC, and NC AHEC. We've got a ton of great timely information for you tonight, including an update on Medicaid policies, followed by a panel discussion on telehealth and perinatal care. We'll then respond to your questions and close with a list of services. My name is Hugh Tilson, and along with Dr. Shannon Dowler and Dr. Tom Wroth, we'll be moderating tonight's forum. We're joined tonight by our panelists: Dr. Kate Menard, who's a professor of obstetrics and gynecology at UNC, and Dr. Arthur Ollendorff, who's an OB/GYN at Mountain AHEC. Thank you, both of y'all for making the time to be with us tonight.

Next slide. After our presenters provide their updates we'll turn to your questions. If you're participating through the webinar, please submit using the Q&A function on the black bar on the bottom of the screen. It's that Q&A function on the black bar on the bottom of the screen. If you're on the phone, you can't do that. So please submit questions to [questionsCOVID19webinar@gmail.com](mailto:questionsCOVID19webinar@gmail.com). It's [questionsCOVID19webinar@gmail.com](mailto:questionsCOVID19webinar@gmail.com). We'll record this webinar. We'll make that recording, a written transcript of it, and these slides available on the CCNC-AHEC website, probably tomorrow at the latest. Let me now turn it over to Shannon. Shannon?

Dr. Shannon Dowler:

Alright, thanks Hugh, I appreciate it. So I will tell you that I'm in an unusual circumstance. Usually when I do a webinar I'm sitting in a relatively normal place. But today I'm in a big parking lot of a poultry plant, where I've spent the day, where there's a COVID -- a high number of COVID-positive cases from this particular plant and a lot of vulnerable populations that we're trying to make sure get testing, as they should. So we've been out in the rain and the wind, taking care of folks. It's been a really cool joint effort between a local health department, a community health center, some of the National Guard with the civil response team have been out here helping us, and then the plant as well. So it's been a fun day. I will tell you after six weeks of back-breaking policy work at my computer, it feels really good to be walking around in scrubs with an N95 on. However, my family has said I am not allowed to return home. So that does mean that my team has carried the weight big-time this -- the last five-or-six days, as I've been helping manage this -- this COVID rise from the poultry plants and I just want to say a special thanks to everybody. Christoph leaned in -- Christoph Diasio, a pediatrician. And Sandhills Pediatrics has been a huge help with the team. Steve North jumped in, a family physician up in Spruce Pines. So thanks to them, and of course my A-plus-plus team at Medicaid -- just awesome.

Alright, so next slide. So last week we unveiled the new codes around pregnancy care and how to do that around using telehealth. After that -- immediately afterwards -- I started getting some questions around telephonic care with obstetrics and that started a whole lot of conversations and discussions about what we can and can't do. One of the unique things about Medicaid, compared to doing things, you know -- whether it's the right thing or the wrong thing, or the easy thing or the hard thing, is we're governed by a lot of rules that come down from the federal government. So from the Centers for Medicare and Medicaid services. And so we have to have authority from them to be able to do certain things. And that keeps us, sometimes, from being able to just flip switches as easily as people would like us to. So you guys are smart, you know that I went into this long-winded explanation because it means I'm not going to do what y'all want me to do. So I'm -- I got that. But we were unable to place telephonic codes as acceptable codes to count as E&M visits for pregnancy. So you can, if you have a pregnant woman and the only way you can take care of her is through a telephone call, you can bill for that as a telephonic code. But it doesn't count as part of the global

package or the prenatal OB package. Those are only for face-to-face and telehealth visits. And the telehealth, again -- real-time, two-way, audio-visual communication. We are going to allow for billing for the telephonic outside of that, and it will be at the higher rate that we've set, that should be built and in the system within the next 24 hours -- I believe it's going to be implemented. So, later on in the call, Dr. Menard and Dr. Ollendorff are going to share with you best practices around how to take care of pregnant women remotely, and what they've learned and how they're doing it in their practices, and to give some general clinical guidance to everyone. So I hope you'll stay on for that part of the call, because I think it'll be really important. And we're going to give you a little information now about what's happened with the new policies we've been working on this week, that will go live next week, and then also Tom's going to share some data. Our teams have been working together to really study and look at what's happening with telehealth and telephonic care, since we've turned it on so rapidly. And we have some interesting data to share with you.

Okay so, next slide. Just a reminder in the durable medical equipment side of things, we are working on blood pressure -- the blood pressure devices are available. And then scales and portable pulse oximetry, as orderable DME equipment. A reminder, it can't go through a pharmacy -- a lot of folks have been trying to do that and are getting frustrated when it doesn't work. It can't -- it won't be reimbursed through a pharmacy; it has to go through DME. On the website, again, is this link. We've done the work of going out there and trying to list all the certified DME equipment that Medicaid's got on its books, to make it easier for you, so you don't have to call around yourself. But make sure you are doing that through DME, it'll save you a lot of frustration.

Alright, next slide. Alright, so, well-child visits. I think there was a reason we waited to do the preventive care things until the end of our telehealth work; and it's because we knew how hard it was going to be. This is a really tricky area. Going back to the authority question that I talked about earlier around prenatal and telephonic. In the well-child space, we have this whole set of rule we have to with children that are very unique and very specific. And in the rules -- the way it's written is that you actually have to have a physical exam of a child to get reimbursed for the care of the child because of our federal guidance. And they have not come out and changed that. What we did is we did a deep dive and we looked around the country to see who's doing it anyway. And we found quite a few friends that were doing it anyway. And we felt like after we reached out to CMS to ask for permission -- and we're still waiting to hear back from them. But we feel like enough people around the country are doing this -- and based on the American Academy of Pediatrics' recommendations and a lot of our partners -- that we're going to go out on a limb and do this and feel pretty good that CMS is going to come back and say 'oh yeah, of course, we meant that you could do that.' So we are making well-child visits available through telehealth. There are some caveats. We went around and around on the team about the age. What age is appropriate? And ultimately we settled on what the American Academy of Pediatrics is recommending, which is -- the first 24 months, the preference is to have that be face-to-face if it's possible, and then after that being acceptable, 24 months and older, to do through telehealth. We are not doing a solid line there, though. We're kind of doing a dotted line. So if you feel like, in your clinical judgement, the patient is going to be best served by doing telehealth at zero to two, in the home, for whatever reason -- if the risk-benefit ratio is such that it's better for that child to have a sort of partial well-child check at zero-to-two, in their home rather than coming into your office, we want you to be allowed to go for that. And so we just are asking that --

Hugh Tilson:

Shannon, I think we lost you. Shannon, did we lose you, are you there? I think she's gone.

Beth Daniel:

Do you want me to continue?

Hugh Tilson:

That'd be great.

Beth Daniel:

This is Beth Daniel, I work with Dr. Dowler and Dr. Diasio and the group. What I think she was going to say is we just want you to document the reason of why the best risk that -- your best clinical judgement, it was best served for the child to have a telemedicine visit instead of coming to the office and that's where this says 'accept other extenuating circumstances.' Just document that and then you get the child in any of the times you use telemedicine to deliver well-child care, no matter the age, just get them in as soon as it's safe or when this is over -- whatever works out for the family and for your practice, to have them in for a face-to-face, and do a good exam, and catch up with what they need for vaccines. Some providers are going to be doing vaccine drive-throughs. Dr. Dowler, are you back on? I thought I heard her. Anyway, I think that this covers the fact that we wanted to draw that dotted line between 24 months. And then do the well-care multiple -- things via telemedicine, and then get them in for hands-on, which is what the feds require anyway, as soon as possible.

Dr. Shannon Dowler:

Hey Beth, this is Shannon. I made it back on, I don't have a screen, but I have a voice.

Beth Daniel:

Go ahead.

Dr. Shannon Dowler:

We knew this was going to be crazy-town tonight and sure enough it is crazy-town. So I'm going to probably -- since I can't see the slides -- I'm going to let Sandy continue on, but let me say that we think that we've wrestled -- so if the solution's not perfect and you don't feel like it's perfect, please know that we spent a lot of time. We read -- every state that's doing well-child care through telehealth -- we read their policies, we've compared them, and we really analyzed them. And we think what we're doing is the best thing for the people that we take care of, but also to be practical in your practices. And so we are going to allow you to have that second visit to bill for -- a second visit to finish what you didn't do and do the immunizations. What we don't want is a whole state full of kids not getting their immunizations. We have enough of a problem with that in North Carolina. We don't need any extra help. So we really want to make sure that immunizations and that follow-up care is happening. Is Christoph on the phone? I'm not sure if he's on the phone and able to speak. He just --

Dr. Christoph Diasio:

Hey, this is Christoph. I am here; sorry I joined a little late.

Dr. Shannon Dowler:

Yeah, do you want to speak a little bit about the well-child policies we're putting into place? Not around the billing specifics, but just around philosophy and the guidance that we put together.

Dr. Christoph Diasio:

Sure, yeah, thanks. I appreciate being able to be involved. You know I think this is just mission critical for pediatrics so we continue to deliver well-visits. I think a lot of folks went into this with the idea, well I'll do the younger kids -- that those older kid checkups are maybe less, you know, important. We already heard anecdotally of eight-year-old checkups where the child during this coronavirus thing, you know, was having acute depression and suicidality because they were getting so freaked out by what was going on in the news and the parents had no idea. So there's a lot of important things that happen at those well-visits. So it's very important that they continue and, you know, if in your local environment it's still safe to see the patient in-person, then see them in person. But for those parents that really need to be at home, for whatever reason, I think this is a great strategy. There's a big article in the New York Times today about declining vaccination rates. And so I think we're really going to need to lift up that it's really important to keep up to date with those vaccines, especially in the young children, but even in the older kids. Because we're not going to be able to -- whenever this all ends we're not going to be able to get everyone through at the same time that needs catch-up. So I think this is a good step in the value of well-visits, and I'm really pleased with where things landed.

Dr. Shannon Dowler:

Yeah, thanks Christoph. And the next slide is a table -- I can't see it so you might be on that slide already. What I don't want to do tonight in this call is to go into great detail in it, because we still haven't finalized our bulletin. But what we're going to do is, I hope tomorrow we'll have our bulletin published so you guys can be thinking about it -- how you're going to do this in your practices. And like we've done, our cadence we've done for the past two months is, we'll tell you about it tonight, it'll be live next week, and in our meeting -- our Thursday night call -- we're going to go into some great tips and tricks like Dr. Menard and Dr. Ollendorff are getting ready to do for OB, which we unveiled last week. So I think the meat of it is going to follow in the bulletin and then on the call next Thursday night -- next Thursday when we get our friends from around the state talking about how to implement this. Anything else the team wants to say about well-child before we move on?

Hugh Tilson:

Nevin, will you advance the slides before -- is that -- okay. Great, thank you.

Dr. Shannon Dowler:

I can't see the slides, so Sandy why don't you hit the next one?

Beth Daniel:

Sandy got called off -- this is Beth Daniel.

Dr. Shannon Dowler:

Okay you know, what's the slide? Tell me the slide and I'll [Indiscernible]

Hugh Tilson:

Post-partum depression.

Beth Daniel:

Post-partum depression.

Dr. Shannon Dowler:

Okay, why don't you talk about that Beth.

Beth Daniel:

Okay, so the covered service is the CPT code listed, 96127, and this is done in the -- with the -- you know you usually bring them in for the office visit and it's done with the mother there with the baby via the in-person visit. We could do it telemedicine visit or telephone call, patient portal, it should be provided on the same day as the in-person or telemedicine visit, there. There's some more guidance about that and there's guidance about FQHCs having that as part of their well-child -- their well-woman visits, which they bill as the T1015 and the well-child visit they're allowed to bill fee-for-service for this service. We can go onto the next slide.

Dr. Shannon Dowler:

Is the next one the respiratory therapy?

Beth Daniel:

Health and Behavioral Intervention by Local Health Departments?

Dr. Shannon Dowler:

Yeah, that's you too. You do that -- that's all you.

Beth Daniel:

This one is just something specific to what health departments have been doing since the Baby Love Program. And we're just making it available for them to have their LCSWs or their other professionals provide this service via telemedicine. Next slide. This is respiratory therapy Dr. Dowler.

Dr. Shannon Dowler:

Oh yay, we landed. So there has been a request from the respiratory therapy world to add some telehealth visits for them. I'm not going to go into a lot of detail -- that'll be in the bulletin, which codes are allowed. The main caveat, I will say, with the respiratory therapy codes is the equipment has to be in the home. So spirometry, ventilator management, those sort of things can be done appropriately through telehealth if the equipment's in the home and the family's used to using them. But obviously you can't do that remotely if it's not already there. I think that goes without saying. But there is going to -- we are going to have some more flexibility for respiratory therapists coming up next week. What's the next slide?

Hugh Tilson:

Tom takes over now.

Dr. Tom Wroth:

Alright, great. Hi everybody, it's Tom Wroth. You guys have any --

Dr. Shannon Dowler:

Before you get into the data, I just want to say a big shout out to CCNC partnering with us on this data collection. We asked for this back at the very beginning before we turned the first code on for virtual or telehealth -- saying we want to study this and we want to understand what's going to happen when we do it. And it's been very cool. So the data lagged a huge amount because our claims process for practices is really variable. So take this with a grain of salt. But I think it's super interesting, and so I asked Tom to share it with you tonight. Now I'm quiet.

Dr. Tom Wroth:

Great, thanks Shannon. Yeah, and it was interesting to think back -- it was a month ago that we did our first webinar and started to roll out these concepts. So I think what's so amazing about this data -- and we'll fly through it pretty quickly -- is just how fast everybody took up these new ways of providing care. And this initial data is just, I think really exciting, and I think we'll learn quite a bit as we follow this going forward. So this first slide really looks at a couple things. The first is really looking at the drop-off claims. So that's that gray line there. And you can see there's about -- even with the claims lag we predict about a 60% drop-off in that first period of time. And then you can start to see that the telehealth ratios to the percent of claims that are from telehealth codes starts to tick up, exactly when we rolled out those first telephonic codes.

So let's go to the next slide. And this one starts to look at telephonic versus telehealth. So again the gray line is showing the drop-off in face-to-face claims. And the blue line takes off right when those policy changes. But then as we rolled out the telehealth codes, you can see as a percent of all of the telemedicine, broad telemedicine codes that practices started to do audio and visual together. So you can really see the trajectory of that. And again there's claims lag in that and it goes up to the end of March. So more data to come.

Could you go to the next slide? And then we get into different practice types. So there's -- we're combining here in this slide -- you can see there's some really interesting survey data put out by NCP and NCAP about the inclination to implement telehealth and the perceived needs for assistance in telehealth across different practice types. You can see the pediatricians really leading there in a way. And here you can see the pediatricians with the quickest uptake -- the middle blue line -- and the family medicine practices in the middle, and then these are rural health centers, so not FQHCs, the rural health centers, with slower up-ticks. So just very interesting as we're trying to provide support across different practice types.

Could you go to the next slide? And this kind of looks at age groups. So remember the last couple of webinars, we've been talking about the perceived barriers to telehealth, and here we have some data to really watch and react to. So the fastest uptake of telehealth is really the younger 0-20 year-olds and 40-64 year-old

groups. So you've got the 21-45 in the middle there. And then the slowest uptake there is those that are greater than 65 years old. So this confirms some of the theories that we had, kind of going in, and gives us a sense of which patient populations we may need to target with more supports and more marketing, as well.

So let's go to the next slide. And this looks at the aged, blind, and disabled versus non-aged, -blind, -disabled. Remember the aged, blind, disabled are the most expensive, sickest, highest-risk patients – individuals. And you can see here, that we've got good uptake on the aged, blind, disabled folks, versus non-aged, -blind, -disabled. And so that's, I think very reassuring for that high risk group.

Could you go to the next slide? And these last couple of slides are really just showing the overall trends across different practice types. And now this is kind of looking at telephonic versus telehealth, and as Dr. Dowler has really been telling us, and pushing which I think is really good, as we are trying to get telehealth going. We think this is much more sustainable and better quality of care if you are able to see the patient, see the home, and more possibilities with physical exam and other things. So here are the pediatricians. You can see again, that one-week lag in the policy changes. But then telehealth with audio and visual really takes off there on the week of 3/16.

And next slide is looking at the family medicine docs. Again a good trajectory on the telehealth and sort of a little delay there on the telephonic. I'm not totally sure what that means, but we'll continue to follow that.

And next slide. And this is the FQHCs. Remember that billing for the FQHCs is different and we had to use telephonic predominantly in the beginning, and there's been lots of work done by the DHB group with the FQHCs to work through the billing for telehealth and the telephonic. But this shows you some initial data; the really nice up-tick in the telephonic codes and the beginning starting in March 16.

And next slide, that might be it. Oh and OB/GYNs, relevant to our webinar tonight. And remember with OB/GYN they bill the global codes for perinatal care, so it's really, kind of funky, as far as the claims data that you collect. But you see here a really nice up-tick in telehealth and telephonic, preceding that. Again, by practice group, those of you on the webinar, just kind of seeing where your practice type is in this journey. And what's exciting here is there's more data to come, and there's going to be a lot of interesting things that come out of this.

So next slide. Can Dr. Dowler -- do you want to cover the hard-of-hearing population?

Hugh Tilson:

I think she jumped off. Could you jump on this one? Beth are you there?

Beth Daniel:

I'm having difficulty un-muting myself. I know this is something that's been brought to our attention and I have not been involved in this discussion. But just know that it's being addressed -- it's being looked at. I don't have an answer for it.

Hugh Tilson:

Great we'll follow-up in future webinars. Next slide. Next slide. Can we talk about this?

Next slide. Alright, so what's coming up next, you can see more information on well-child update on the PMPM change, and we've gotten already questions about when that might happen. Telephonic rate change, FQHCs, RHCs, core rate changes, those are coming up next. As well as guidance for skilled nursing facilities, telehealth, and dialysis. So those are policies under development by the division. Tom or Beth, do you want to add anything to those?

Dr. Tom Wroth:

No, that's great, you got it Hugh.

Hugh Tilson:

Alright, I can read. Next slide. Alright Kate, you're up.

Dr. Kathryn Menard:

Thanks for the opportunity to participate. I have some material to share. I was asked to kind of give an overview of how in my practice we've moved very-very quickly to use of telephonic and tele – and then pushed hard toward video care in our prenatal care. My personal practice is high-risk obstetrics – I'll speak to sort of general obstetric care and a bit about the high-risk care as well.

Next slide, please. So we're going to talk about strategies to deliver safe prenatal care during this pandemic.

Next slide. And then kind of three principles I think -- that I put forward that we follow. There's one to reduce the in-person visits -- prenatal care needs to happen, this is essential care and preventative care, that we never wanted to skip a beat in it. But to reduce the in person visits by clustering the care around the time when the women really need to be in the office. And that's when they need an exam, of course, when they need laboratory studies, so the blood draw -- the prenatal visits where a blood draw is indicated -- when they come in for injections, their immunizations, or there might be an influenza immunization, or TDAP, or 17P injections -- when they need ultrasounds, those visits when -- and for the high-risk patients that need stress testing or fetal heart rate monitoring. Doing as much as we can and packing those visits full of care.

Next slide, please. Another principle then is to maximize the support that we can using telemedicine, including remote monitoring. So video visits whenever possible, we can learn so much more about when we can see them in the home as we've discussed before. I have done a lot of this myself and I find that I can really get close and see the body language, see the expressions, understand the stress, and communicate so much better than I would be able to by phone. Video isn't always an option for all of our women as you all know. So when video's not an option, having phone visits is an alternative system -- it has been very-very important. We have worked hard to do remote monitoring -- very thankful that we've been able to put in a place an option for getting blood pressure cuffs and monitors, and there are materials posted on how to help women learn to take their blood pressures properly and monitor blood pressures at home, in our practice. These blood pressure measurements are being submitted through the portal. We are on Epic at UNC and patients can submit their blood pressures through that patient portal. And that's actually going quite well. Now weight, many women have scales. Now the DME -- we can get them for Medicaid recipients through DME as well. Kick counts are a great way to monitor fetal activity. Do you need a heart rate? We don't have something in place to do fetal heart rates -- fetal heart tones at home. But kick counts are a reasonable substitute. In pregnancy, women learn to take their own fundal height. That's an option. We certainly haven't implemented that practice-wide. But that's an option too.

Next slide, please. And then the third major, important principle that we've implemented is strict precautions when person-contact is necessary. As many of you have done we have, too. We have a very strict patient wellness screening program in place, where everyone gets a call before they come into the office, the day before, with the typical screening questions. And if there's positive responses to any of that, they don't come to the well -- to the obstetric office, they go to an office that's specifically to evaluate them for the possibility of COVID and testing. We have very strict staff-wellness screening, asking them about whether they've had a fever or any symptoms. And then, each moment they are reporting those at 6am -- to managers -- another wellness check when they come into the office to make sure that staff are getting the attention they need and not bringing things into the office. We have implemented a wait-in-the-car policy, where -- if we brought all the patients that we are seeing into the waiting room, it would be hard to keep people six feet apart. And even six feet apart is not comfortable. So we are calling people in from the cars and that took a little bit of effort to implement. But day-by-day it's getting to be more and more acceptable. Our care providers are wearing masks. Our patients are asked to wear a mask. Early on, we limited the number of support persons that came into the ambulatory space. But we are certainly welcoming partners to join by cell phone. And for those very important engagements where they really are an integral part of the care decisions -- for the difficult decisions -- the partners are coming in, as well. And then we have this, it was in the office, so it's not a big office, it's a -- 'give me six feet' -- you know it has this great song that they put out where this --

'give me six feet' -- and people are conscious of staying six feet apart in the office. And we shut down certain work stations so that the staff that are -- typically would have been somewhat shoulder to shoulder are not. We are spacing people across in their computer workstations.

Next slide, please. So what about the schedule, the prenatal care schedule? Typical 13-14 visits, some of that can be done virtually. So we put together kind of a -- at UNC, kind of a standard way that we would go about it. And then for this presentation I drew on what we're doing at UNC and then what information I had from a couple other resources, and just sort of outlined this for y'all, who may still not be moving to as much virtual health, but want to and we don't need to re-create the wheel. So this kind of -- the initial intake can be a nurse triage visit -- for us it's a triage visit with the nurse, where they decide whether they're going to go to maternal-fetal medicine, or whether they're going to go to midwifery, or whether they're going to go to our general OB/GYN practice, based on risk and patient preference. And a lot of education can happen at that time, particularly related to COVID, environmental exposures, emergency numbers, et cetera. The next visit is a virtual visit with providers -- with the physician, or nurse practitioner, nurse midwife, that reviews history and details. The PMH risks screen is something that can be done virtually and billed as a virtual visit. That can also be done through the patient portal, if you have that option. Labs can be ordered and set up, and then when they come for their next in-person visit, is when they can get that viability scan. They can get their screening for aneuploidy, their prenatal labs, and all of that in one place, at the same time where they are getting their physical exam. So that 11-12-week visit is packed full of everything.

Next slide, please. One thing we've done is -- we've also moved our genetic counselors out of the office -- all their work now is being done virtually.

Can you advance the slide for me please? Next slide. Great. I missed one, then. In between the 12 week and the 20 weeks -- there we go, 16 weeks is a virtual visit, and then 20 weeks is when they come back for their anatomy scan. And then packing that visit -- so every time they come into the office for a -- they get their vital signs and their weight done. And of course the wonderful nursing education that goes along with those. People have asked about urinalysis, and for low risk patient urinalysis, each visit is not routine and there is evidence to support that, it is really not that necessary with the culture, and the early prenatal visit, if that is normal repeated urinalyses. In our practice at UNC, for our low-risk patients, urinalysis each visit is not routine. And there is really evidence to support that, that it's really not necessary. The urine culture in the early prenatal visit, if that's normal, then repeated urinalyses are not indicated. We do them in our high risk patients, the women at higher risk of preeclampsia -- whether they be a multi-fetal pregnancy, women with chronic hypertension, history of preeclampsia, need those urinalyses. So we'll get them when they're coming in for their visits for other reasons. At 28 weeks they come in in-person for their diabetes screen and for some bloodwork. Rhogam if indicated in TDAP and they'll get a UA at that point. Lots of emphasis on fetal activity monitoring, since we're not doing heart tones at every visit, during these virtual health visit. And we are doing and being very deliberate about doing depression screening -- we're able to do that through our patient portal. But doing it more frequently than we even have before. At 32 weeks, that could be a virtual visit for a low-risk patient. For our high-risk patients, often they're needing a growth scan and coming in for another reason, and so they'll get their blood pressure in-person. They'll get weight done and urinalysis is done at that point, as well. And then the ever-important patient education. I've just listed examples of topics, it's not all-inclusive. But it's just really important not to forget that it's not all about the provider visit. If we are doing more virtual work; the patients learn so much from the nurses when they come into the office. We need to be able to substitute some nursing time for them on the phone for education, as well.

Next slide, please. And then at 36 weeks, there's a time when -- previous slide please -- at 36 weeks is the time when they'll come in for an exam and we confirm presentation by exam at that point, it's the time we do the Group B strep culture. Again, packing multiple services into this particular visit. And then the ever-important nursing education. 37 and 38 weeks can potentially -- if they're feeling good fetal movement, they are able to perceive all that, they have a home blood pressure monitor. They can do that at home, in our opinion, and that's been supported in other expert documents that have been circulated since this all started. At 39 weeks, if they are not yet delivered, an in-person visit is a good reasonable thing, planning for preferences, with respect to induction of labor or post-date testing. And then delivery happens. Postpartum,



really important time to stay in close touch with the patients, and a check-in at 10 to 14 days with blood pressure checks. They've already got their home blood pressure monitors and they're all set to do that. And then all the anticipatory guidance that comes with good postpartum care. And the 4-6-week visit can be virtual as well we've gotten really good feedback from patients about satisfaction with a virtual visit. If they need to come in for placement of an IUD or something like that, of course they need to come in, or if they're concerned about not coming in for an in-person visit, we certainly bring them in. But, not many people want to bring a newborn into the office, now or ever really. So we've gotten really good feedback on that. One important overarching guidance on this is that it's all about when you set things up. We found that it's really all about understanding -- talking to the women about, you know, why it -- the risks and benefits of, I guess, a remote -- a combined model with remote care and in-person care. Minimizing exposure is important to the women; it's important to us. There's benefit to that. But we need to make sure that it suits their needs emotionally, as well. Some women just emotionally need the face-to-face care, and in that situation we welcome them to come in.

Next slide please. What I described is probably a reasonable timeframe for uncomplicated patients. But there's a lot of situations where women have medical or obstetrical issues that require more in-person attention -- women with hypertension, diabetes, glucose monitoring. Hypertension and glucose monitoring can be done through patient portals, but the testing on the baby, and the non-stress testing, and the additional ultrasounds that are required, require in-person visits. One of the things we're doing for that, though, is we're having -- some of them are coming into the office having those nursing services, having those ultrasounds, having all of that done. But then, potentially talking to the provider through a virtual means. And that's working well for many of our patients too.

Next slide please. And then a couple tips. I guess, helpful adjuncts that we've had in our experience -- the short time amount of doing this is -- as I mentioned the patient preference and consent to the alternate model is very important. We want women to be comfortable with their decision; we want them to feel supported. It's been very-very helpful to have a patient portal -- in ours it's MyChart through Epic -- for enhanced engagement. It eases communications -- questions, comments can be answered quite easily, that way. Blood pressure and blood sugars can come through that portal and it really makes things much more seamless. Many of my partners and providers said they feel so much more connected with their patients now that they're more actively using those portals. Support services that can be done through telemedicine, that have been a great adjunct, include lactation, nutrition consultation, genetic counseling, behavioral health, even the PMH care managers are offering support services through telemedicine, as well. And maternal-fetal medicine consultation, all of this can be done through telemedicine, and for some -- it's easier for women to get it this way, than they did in the formal model. I do want to emphasize that the pregnancy care managers are out there. They are engaging women. If we have submitted risk screens on patients, they are being received; they are being entered. The care managers might not be in your offices, so they may not be embedded and you're not seeing them. But they're out there working and if you haven't been in continued conversation with them regarding your integrated care, then I'd urge you to find out where they are and how you can best communicate with them. Because they are out there working, just not in the office. I would also emphasize that LARC -- if you want to do virtual, if you want to do -- if you don't want to bring your patients in for a postpartum visit -- if they want to do that through video visit instead, consider immediate postpartum work while they're still in the hospital. That's just one less time they need to come into the office. And then this past week, something we put in place at UNC is a separate space, specifically for COVID-positive OB/GYN patients. We are fortunate we haven't had too many COVID-positive pregnant women that we follow. But, we know it will come and women are going to still need their OB care. They're still going to need their testing. They're still going to need those services. So we've got a separate place specifically set up to do OB care for our COVID-positive patients. It's a privilege to work at a place like UNC, that's that big, where we're able to do that. But I'm really thankful we can put that in place.

Next slide please. I just put here for your references a couple of resources. The ACOG website and the Society of Maternal-Fetal Medicine website have some wonderful resources available to us. And there's really only -- there's a coded randomized trial if you're interested about reduced visit numbers, and using remote-monitoring modalities that I've referenced there. And then on the CCNC pregnancy medical home

website, there's some guidance for telemedicine, specifically for obstetrics, and some guidance about ordering blood monitors, and so on. And finally your OB champions and your OB coordinators in your region should be a great resource. Use the CCNC website, if you're not in touch with them and you want to email your OB champion in your region, or your OB coordinator. That information is all on the CCNC website.

Next slide. I looked at this website that AHEC offers and it's fabulous. Arthur, I'll let you speak to that.

Dr. Arthur Ollendorff:

So yeah, I'm Arthur Ollendorff. I'm at AHEC in Asheville. You know, we have a pretty large practice as well, being a safety net for 18 counties. But we also have the experience of working with a lot of our regional partners and a lot of the smaller areas. We do very similar things to what Kate was describing at UNC. But I wanted to give you this resource that Suzanne Dixon and some of the other people at MAHEC put together. It was really our way to communicate with our region, to give them guidance. So a lot of this is about rightsizing it to your practice. Everyone is a little bit different -- how they can do it and what resources they have and they don't have. And a couple things I was thinking that might be similar, maybe a little different to what UNC is doing. One is around postpartum visits. We are choosing to do a 3-week telehealth postpartum visit. It's kind of similar to what we did before. We were doing a lot of 2-3-week visits and we want to make sure we really, you know, stay in touch with our postpartum moms during a difficult and challenging time, in general and then you add the COVID issue to it. We felt better to really keep in touch with them. And the other thing that we really were looking at is -- really looking at every visit that we have face-to-face and are we maximizing the value, very much like what Kate said. And that's also true of antenatal testing. So we really look carefully. You know, who really needs antenatal testing and how often? And sometimes we were doing twice-weekly non-stress tests. That can be replaced with a single biophysical profile. So that exposure risk is actually minimized because they're coming into the office half as often. But a lot of it is just trying to figure out the workloads. And I think the things that Kate mentioned: who does the education, how do you get your nurses involved, you know how do you deal with non-English-speaking patients and how you can get your interpreters part of that, how do you get your pregnancy care managers involved on those calls? It's really coordinating with them and depending on the platform of telehealth you're using. Getting them involved in pre-visit planning or post-visit discussions. So the richness of all the things we were doing face-to-face can be, potentially even enhanced on -- in platform that patients are comfortable with.

Dr. Kathryn Menard:

Thanks Arthur. I just glanced through some of the chat questions as Arthur was talking and one thing I want to emphasize is what I've outlined and what Arthur's described are simply guidelines. It's just sort of a template of what you could do, and not what one would have to do. Okay?

**For example, a question came in saying I don't do ultrasounds in my office, it goes to a different -- they go to a different place for their 20-week ultrasound. Could that 20-week visit then be via a video?**

Of course, because you've got a nice ultrasound that was done yesterday. You see a heartbeat; you know all of that. Right? And then you can get on a video visit, you can see her face and you can do all the questions. You can do -- you know, you just need that remote blood pressure monitor and a scale and you're good to go. So modify all of this to suit your practice needs and don't feel locked into the guidelines. It's just a template of a way to -- you know, sort of principles and way to think.

Dr. Arthur Ollendorff:

Okay, and one thing the MAHEC MFMs have done, and they've talked to the community about that, is that we do have patients coming to our office for, you know, a targeted ultrasound. We're also doing a blood pressure check or maybe a weight, if the patient doesn't have access to those things. And then actually putting that in the report and telling that to the providers. So once again it minimizes another visit that the other provider may have needed, face-to-face. I think it's just learning how to, you know, negotiate and work together, is really what it's about.

Dr. Kathryn Menard.:

And the other thing we've done to try to minimize the number of times one might need to come back for ultrasound; I think our anatomy scans have traditionally been, you know, 18-19 weeks. But so often, you can't see everything really clearly, and there was -- you know, we were bringing people back to complete the survey. So we've pushed that out to 20 weeks, a time where we can more likely -- the baby's a little bit bigger and we can more likely can get everything. So we are spacing some of those things out -- you know, kind of risk-benefit, kind of balance in this time, as well. Hugh did you want to take questions?

Dr. Tom Wroth:

**I was going to ask a question, Kate or Arthur. So there's a couple questions in here about breast-feeding. One is, are you seeing any issues with breast feeding rates based on some of the varying guidance on separating the mom and baby after birth? I'm assuming that means the mom's COVID-positive. And then also describe a little bit how you're doing lactation consultation -- and whether you are doing that through telehealth.**

Dr. Kathryn Menard:

Arthur, do you want me to take that?

Dr. Arthur Ollendorff:

Sure.

Dr. Kate Menard:

What we're doing -- we fortunately haven't had very many COVID-positive moms. But there's a nice resource that the American Academy of Pediatrics put out related to guidance on management of infants born to COVID moms. And since there have been -- there's been, you know, reports of transmission, our plan is to separate at birth. If we get -- the mom from the baby at birth. If we get that mom to pump and breast milk -- and feeding the baby breastmilk according to these guidelines. It's on Arthur's website. I encourage you to look at that if you're interested in that newborn care, is permissible. So we don't have enough experience to say, you know, how that has gone, because fortunately we haven't had very many.

Dr. Arthur Ollendorff:

And, Kate, for us it's been a discussion. So we had a really good communication with our pediatric providers about how we want to approach, you know, rooming in versus separation. And then really decided to make it a shared-decision-making model, because there are pros and cons -- there's a lack of evidence. A we've had very few COVID-positive moms, but most of them have chosen to remain -- and they've been breast-feeding because that is an acceptable thing to do with proper hand hygiene, wearing a mask. So I think it's just that education up-front, you know, before delivery, at the time of delivery, has been really helpful for us and having that unified voice among the pediatric and the OB providers about, really how to counsel in the time of uncertainty.

Dr. Tom Wroth:

**And Arthur, that's a great comment. And I think it addresses one of the questions about whether you're seeing increased communication and collaboration with the pediatric provider. And it sounds like this is sort of a situation that has enhanced that. A couple quick questions. There's one around postpartum care and for women that would choose to do an IUD, let's say, at the postpartum visit, are you delaying that until we get further through the pandemic, that procedure?**

Dr. Kathryn Menard:

We are not. We are fortunate to be able to offer immediate postpartum LARCs, so they can be placed in the hospital. But if they desire an IUD, they'll come back for their usual in-person postpartum visit and have that placed.

Dr. Tom Wroth:

**Okay, makes sense. There is a question about women who are getting beyond 39 weeks. And Arthur I think you might have addressed this, I wasn't totally sure, but I wanted to check. When you get into doing NSTs for -- leading up to potential induction, how are you handling that?**

Dr. Arthur Ollendorff:

You know we've followed our normal NST schedule as best we can. And like I said we're trying to -- when there's the indications for bi-weekly NST, make it into a single biophysical. I do think what I've noticed, I'm not sure if it's our guidance or unintentional. I think we're doing a -- I sense more inductions at 39 weeks. Just because it eliminates a lot of the doubt and uncertainty and the difficulty of trying to manage all those things, especially when people have, you know sort of, middle-risk -- not super high, but not super low risk conditions. I've spent a lot of time in labor and delivery the last month and I think that's really the approach we're taking, when we just don't know how to do it right and the patients want an induction of labor at 39 weeks, which has some decent data around it. We have been doing that. But also being able to do antenatal testing, when indicated, for people who want to continue pregnancy for their past-39-40-41 weeks.

Dr. Tom Wroth:

**Makes sense. So I'm looking at the time trying to think of a couple of last questions, then we'll transition over to Hugh for some more Medicaid policy questions, then wrap up. So overall I'm hearing that, so far in the beginning, there is really good uptake of some of the remote patient monitoring, and also telehealth in general. We are finding there's technology barriers and you're using other modes to see those women. Any other tips as far as women that really aren't using the patient portal, or can't use the remote patient monitoring? What are you all doing to provide care when there are patient barriers?**

Dr. Arthur Ollendorff:

Yeah, I mean I think for us, you know, especially, you know in the rural areas that we serve, that can be an issue. I think we've seen a lot more in-person visits for people who just don't have access to telehealth. Then video's been a little bit problematic for us, just from bandwidth. You know, and just where we sit especially -- not so much a national proper, but outside. So I think a lot of it is rightsizing it and doing the best you can. We want people to get care. You can still spread out visits, to some degree, and it's just rethinking each of those visits and, you know, where can you meet the patient, and what access do they have, and trying to improve access. And really do the best you can. But it's not equal for everybody and it's never equal for everybody. I think we are seeing those pockets of people who just -- their resources make us need to do something different. And we want to value that and do the right thing for each patient, each time.

Dr. Tom Wroth:

**And kind of a follow on that -- how are you all involving case managers for high-risk clients during visits or in-between visits?**

Dr. Kathryn Menard:

I think right now there's been so much evolution, so fast. I think this is something that really we need to focus on, is how to involve those that are there. The case managers are out there, but the connectivity of -- you know, having them embedded in the office was a great way to get face-to-face visits -- face-to-face encounters happening and for them to interact more directly with the care team -- the care providers. And with them remote, it's more difficult. But they can, you know -- and that's really an office-to-office or practice-to-practice communication about how best to do that. Some of the care managers have access to the medical record and can talk with providers through, you know, Epic chat or different mechanisms, that way. Sometimes just good old-fashioned phone calls. And it's going to be practice-to-practice. But those care managers should be reaching out to you and you to them. You know, the best care managers, we've always said, in the pregnancy medical home program are ones that you would invite to your office Christmas party, because they're so much a part of your staff. And don't lose track of them. They are there and they're there to help you and help your patients.

Dr. Tom Wroth:

**That's great, Kate. And Kate and Arthur, one last question. Really amazing work on putting together this prenatal care schedule and there's a question about, you know, really what -- how well telemedicine-telehealth -- what will happen after we get through the pandemic? So a question to you all, do you think that the prenatal care schedule may change based on our experience with this? That there's an efficiency here and more satisfaction and convenience for patients, and quality remains high?**

Dr. Kate Menard:

So I have given that a lot of thought already, and, you know, what we're doing right now in this experiment is something that we wouldn't have been able to do in 10 years with an IRB. So I think there's a lot more to learn, about really where the potential misses are, and there's a lot more studies to do. But I would project that we will -- the OB care model will change. What I think we're definitely going to be able to do in North Carolina immediately, is more comfortably extend specialty and sub-specialty care to rural areas, through telemedicine, that we've been wanting to do, but haven't done as fast as we wanted. I see there's a lot of advantages to -- you know, for care here right in North Carolina to extend our services better.

Dr. Arthur Ollendorff:

And Kate I agree. I mean one of my colleagues said we have done 20 years of innovation in two weeks around telehealth. And I think it's a great opportunity to see what really works. And I do think being able to extend certain types of care to rural areas will definitely occur. Because now that people become more comfortable with platforms. You know, it's just the speed and all the practices that I've been talking to have gone to telehealth. And how quickly and even how simply can be from this handheld app. There's a lot of opportunity. And hopefully that happens, we'll learn from it. Hopefully not lose the momentum.

Dr. Kathryn Menard:

You know, there will be -- hopefully these telehealth codes that we're able to use now, you know, will also be available to us, right? You know, Medicaid cannot promise that isn't going to go back, but we're going to of course need codes that are available.

Dr. Tom Wroth:

Kate and Arthur, thank you so much. That was really wonderful. There's a lot of questions we didn't get to. Hugh, I want to pass it back to you to take us through to the end.

Hugh Tilson:

Great, next slide please. So this is where we're supposed ask questions, we've already done that.

So, next slide -- next slide. We have a number of resources that are out there to help you as you navigate telehealth. You can see that CCNC is partnering with DocsInk, Medical Society with Presence, and community health centers with Doxy.Me.

Next slide. And if you need practice support, please contact either CCNC or NC AHEC. We work collaboratively -- there's no wrong door. We're here to help you. That's how you get up with us.

Next slide. There's a survey that's out there right now trying to help assess where providers are in COVID preparedness. And you can see a link to the survey there. If you haven't filled it out please do so, it'll help the state as it develops its responses.

Next slide. Really exciting new resource, that really I should let Tom talk about. But, COVID-19 Triage Plus. You can see the call -- dial-in number, seven days a week. And it provides great triage services -- great resources, and a great place to get questions answered, where your patients may not normally be able to get those. Tom, is there anything you wanted to add about that, before I move on? Because this is a huge development.

Dr. Tom Wroth:

No, it's great. It's staffed by some of our RN care managers with really great training. So this is a way to offload some of the calls that may be coming to you. And yeah, we're -- it's going really well so far.

Hugh Tilson:

Yeah, just make sure your patients know about it. Next slide please. Ton of Medicaid resources, so this slide has them. And I want to just kind of make sure you see that, that Medicaid-specific questions or concerns at the bottom. [medicaid.covid19@dhhs.nc.gov](mailto:medicaid.covid19@dhhs.nc.gov). They will respond quickly to your specific questions. And I will let you know that we will forward all the questions that we didn't get to tonight, to them as well for their specific response.

So, next slide. CCNC and AHEC have partnered to come up with the website. You can actually see the slides for tonight on there. Sorry about the dog in the background. And all kinds of updates on all kinds of other webinars we've done, and all kinds of great information.

Next slide. I want to remind you of other webinars that are going on. There's a telehealth webinar that is done by the Office of Rural Health on Mondays. And then on Tuesdays CCNC, the Academy of Family Physicians, Pediatrics Society, and Psychiatric Association partner on resources available as you navigate the CARES Act. And then every Friday, the Division of Public Health has a webinar on updates from the -- Friday updates from public health. Sorry about that.

Next slide. That's it. So if we just pause, it's 6:29pm. We wanted to thank Kate and Arthur for all the work that you did to get ready for this -- your time. Tom, thanks for stepping in and doing a great job, as always. Thank everybody who is doing the great work with their patients back in the community and we hope that this was helpful. Really appreciate all that you do and before I sign off, let me just turn it over to Kate, Arthur, and Tom, for any final words.

Dr. Tom Wroth:

Thank you all. We'll see you next week.

Dr. Kathryn Menard:

Thanks everybody. And know that -- obstetrics care providers out there, know that you can count on your OB champions, and they are a great avenue to me. I put my email on the slide too, if there are things that you need, things that can help you with. Please feel free to email me.

Dr. Arthur Ollendorff:

Just thanks everybody for listening. And we are available to help look at all your resources in your communities. And just be safe.

[Event Concluded]