Navigating COVID-19 Series: Navigating the New Normal

April 28th, 2020
6:00 pm- 7:00 pm

Presenters:
Hugh Tilson, JD, MPH, Director, North Carolina AHEC
Betsey Tilson, M.D., MPH, State Health Director, Chief Medical Officer, NC DHHS
Shannon Dowler, M.D., Chief Medical Officer, NC Medicaid
Susan Mims, M.D., President, NC Pediatric Society
David Rinehart, M.D., President, NC Academy of Family Physicians
L. Allen Dobson, Jr., M.D., CEO, Community Care of North Carolina
Shawn Parker, Esq., Attorney, Smith Anderson

Hugh Tilson:
It is 6:00 so let's get started good evening everybody. Thank you for participating in tonight's webinar on navigating COVID-19. This evening we're focusing on navigating the new normal. 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 fourth in a continuing series of informational sessions designed to respond to needs you have identified as you navigate COVID-19. We start by recognizing Tom, Elizabeth, Robin and Greg for their leadership in identifying those needs, for the partnership and collaboration putting on these webinars to respond to them. And also want to thank everybody for the work you are doing for your patients, staff, your communities and every day we know it is a challenging time and we hope the information you get tonight will help navigating these times a little bit easier. Next slide.

My name is Hugh Tilson, next slide please. I will be moderating this evening. We have a star-studded panel for this evening. Dr. Betsey Tilson, our state's health director, and Shannon Dowler, the chief medical officer in North Carolina Medicaid, and will get us started and discussing navigating the new normal and will turn it over to Dr. Susan Mims who is the president of the North Carolina Pediatric Society and Dr. David Reinhart who is the President of Academy of Family Physicians who will give us their thoughts about the reopening primary care practices. As always, Dr. Dobson will provide color commentary and we will save him until the end so we can provide updates about the CARES Act and other financing alternatives and Shawn Parker will chime in as is needed. Next slide.

After the panelists have provided their updates, we'll turn to your questions. If you're participating using the webinar, you can can submit your questions using the Q&A function on the black bar on the bottom of the screen. If you are on the phone, you can't do that, so please submit your questions through questionscovid19webinar@gmail.com. That's questionscovid19webinar@gmail.com. We'll record this webinar and will make the recording and the transcript and slides available to the public on the CCNC/AHEC website hopefully this evening and certainly by later tomorrow at the latest. Dr. Tilson, the floor is yours. Betsy are you there?

Betsey Tilson:
I am sorry, I am here. I was on mute. Can you hear me now? Great! Thank you all and really happy to be here tonight. Shannon and I have a lot of content packed slides and so we want to jump right into it and go through the slides fairly quickly so that we can have a good content-based discussion on the back end. Next slide.

Hopefully some of you have seen Secretary Cohen and Governor Cooper last week roll out some of the vision for this new normal. Thinking about testing, tracking and trends and making sure what the plan of action for the state will be going forward so I want to review some of those slide so you know what we're looking at and how are we toggling what decisions we make based some of the trends. So, I just want to make sure you knew where we were and following along and have you follow along with us. So, the first thing is that, to date North Carolina has taken a lot of aggressive action to save lives and to what we call flatten the curve and as we all know that has been the stay-at-home order and a lot of those community navigation strategies to really slow the spread across the state. The next slide.

You will see that those strategies have been successful and we have flatten the curve and you can see North Carolina there in that Carolina Blue, we have able to flatten the curve and that's great but we cannot stay here forever so the next phase of that how do we think about listing some of these more robust community mitigation strategies but still trying to keep that curve as flat as possible and be sure we can provide care to the people who need it. So thinking through the goals of our strategies and to ensure that not everybody gets sick at the same time so people who do get sick we have the medical care available for those people who need medical care and we will have to be in this new normal for a long time until we get a treatment or a vaccine. So, then the goal will be to keep the rate of infection where we can provide the medical care for people who need it and not get sick at the same time. Next slide please.

So some of the things and trends we look at to see what we call the kind of dimmer switch when we can slowly start opening and maybe having to rap back but we'll be looking at a lot of different metrics but these will be some of the four metrics that we look at and none of these metrics are perfect on their own. We are looking at a gestalt of all these together as well there will be some other metrics as well. But four key metrics we'll look at. Some of you may be familiar with our influenza like illness surveillance that we do every year with flu. We have been able to adopt it into more of a COVID like surveillance so you're looking at the syndrome cases through that surveillance and we are looking at the number of lab confirmed cases but we know that lab confirmed cases are in undercount of everybody with infection and second were looking at the percent positive test of Oliver test and that will give us an idea as you start expanding testing and we know will probably start seeing more cases as were expanding testing but we want to get a sense of the prevalence in the community increasing or is just that we are testing more and finding more and finally the big piece is about to be sure we're not overwhelming medical systems so they are looking at hospitalizations as well. Next slide.

So those are some of the trends we are looking at and then the alternative to stay at home in the community mitigation is a more targeted approach to decrease the rate of spread and that's our testing and tracing capacity so we want to be sure we have the capacity to do more test per day and we're ramping that up and being able to the widespread tracing when they do find somebody with a positive test and then the other piece in terms of capacity, do we have enough personal protective equipment so our medical people including you all have the ability to see patients that need care regardless of that level so we need to make sure we have the capacity to do that as we are opening up the dimmer switch. Next slide please.

Just a little bit of where we were last week. This looks at our syndromic cases this is we have a system called NC detect were able to look at symptoms that come to the emergency department and you will see the white and blue line are our flu-lines from past years and the yellow is in this line and you will see the first two peaks were flu and then the third peak was we think the COVID like peaks. You will we see that line coming down. This is really a measure of healthcare seeking behavior, people are going to the emergency department for COVID like illness or people maybe are just not seeking care. There is one statewide surveillance tool that we can use, and you can see that line as people come to the department for COVID like illness is coming down. Next slide.

The next one is looking at, the number of last confirmed cases again we know this is an undercount that will get trends and you will see we had an increase and then we are still slowly going up but it's a slowness of slowing and we are starting to kind of level off that so we have been seeing over the past couple weeks it's a little bit of level off of the delay of increase. Next slide.

We also want to look at the percent of tests that we're doing are positive and that's that yellow line and you can see that they're running about 10% or so of the tests that we are doing are positive so not seeing a huge uptick we are seeing it pretty level so that's an indication of the prevalence in the community is not increasing but it is not decreasing yet. Next.

And then are hospitals, you can see we are slightly picking up but not a huge escalation and today we still have capacity in our healthcare systems to care for patients so we're kind of leveling off there. And then what are our goals for testing and tracing our goals for capacity we have been testing about 2500 to 3000 people per day were hoping to ramp up to an average of about 5000 to 7000 per day and we have already 250 tracers that are part of our local health department. We are going to try and double that to 500 tracers and that is our new partnership with Community Care of North Carolina and AHEC to be able to have our new hire up the search capacity to help with the health department tracing and will also be thinking through a not just active tracing but also passive tracing and think through the digital technology to support that and then finally our PPE and currently we do not have that full capacity of PPE for all of our healthcare providers that we need so we are still working on the reorg still in need of PPE that's where we are with the capacity. Next slide.

So assuming and we're not there yet but assuming that we meet some of our trend and that would be at a consistent leveling or decreasing those trends in the looking like we have that increased capacity and that will mean we can start opening up probably many of you know that the stay-at-home order was extended until May 8th and depending on how things look in a week or so we could potentially start opening up. Phase 1 would be opening up to some of our nonessential businesses but and our part to the outer areas but still keep some of the restrictions in terms of gathering and our congregate settings and nursing homes in place but starting to open up some of our business sectors.

If we look okay after couple weeks in phase 1, next slide, phase 2 will start and we can potentially lift that stay-at-home order but still encourage our buildable populations to stay home and we can start opening up our sectors of our businesses restaurants and bars and I'm sure, Allan, you're happy to see that and houses of worship and entertainment venues like theaters starting to increase number of people that can gather but still again protecting our most vulnerable and nursing home and congregant care settings so we will see how that looks for couple weeks and then phase 3, next slide, we can start really loosening up and allowing more capacity in our business sectors and our recreational centers and the houses of worship and people are getting more and more out and making sure they're coming into medical care as they need for their primary care conditions and their well child care. So that is very brief there just want to make sure you all have seen that last week and what the roadmap is for the next at least month or two. Next slide.

So this is a kindergarten version of the previous slide salon we had put on and this is what the redline is what would've potentially happened if we did not put all these things and strategies we have a huge surge in peak of our cases overwhelmed on medical system and we would not of been able to handle it instead the green line is what are expecting that you see that flattening of the curve and as we start seeing that coming down we may start loosening up some of those restrictions remain starting like translating the wrong way so we made need to tighten backup in and see how her going and move them back up see how those trends may be tightening backup so we may be seeing over the next year this idea of the dimmer switch that we make it brighter darker as we go through so we have to see and follow our trends on that. Next slide.

So, as we think about navigating this new normal what does that mean across all of our sectors? We do have overall guiding principles for again all of our businesses and healthcare all of our sectors and there is the pieces that everybody needs to be thinking about regardless of their setting and that is some elements of increased social distancing and not having too many people in one place so as we think through the probably still be an element of telemedicine or ways of not having all of your patients being clustered together and enhance hygiene protocol and again continuing really good cleaning of your services and really good cleaning of people's hands and we need to think about marginal workforce as well and thinking through the sick policies for your staff and we need to continue to protect our vulnerable populations again those people most at risk for severe disease and thinking through your high-risk patients and how we

continue to protect those populations and be sure that we're doing good education for your patients for providers for the public as we navigate this new world so those are our generic principles across all of our settings and are trying to customize those for different settings. Next slide.

So thinking through how this looks in a more ambulatory outpatient setting I wanted to be assure there's some really good guidance and on the deck these are hotlinks to the CDC guidance so you can really dig into as much detail on that as you want and again I think there will be some element of triage and telehealth and Dr. Dowler can talk more about that and that will get some of those social distancing as well as protecting our highest risk and most vulnerable. I think there's going to need to be a sustained emphasis on infection prevention and control guidance and again that's going to be a lot of those cleaning of your surfaces and also the personal protective equipment and thinking through what we call hierarchy of control and preservation strategy to continue to think about what we learned into engineering and administrative and personal protective controls and engineering thinking through some of that physical modifications you may be doing in your practices making sure there are plastic screens up between of your front desk and your patients and the administrator thinking through scheduling and maybe have sick and schedule different times of the day and then again the PPE's I think there will be much more enhanced especially this year of infection prevention and this hierarchy of control. Next slide.

This is just if you go to one of those links this gives you the idea of all the different things to think through as part of this hierarchy of control and again thinking through patient placements do you have waiting rooms separately and are you doing a lot of your training for your personnel on hygiene and on personal protective equipment so make sure you are thinking through all of these infection prevention and control guidance and you get the hotlinks all of this details you can get through that prior slide. Next slide.

So, as part of this you say PPE, but we don't have PP how can we get PPE and we know this has been a huge, huge issue and we're trying to get PPE out to you. It's starting to loosen up more so we are seeing feeling like we can get some more out and I wanted people to know that we now have a new webpage on a website and a new way that providers can request PPE so that link at the top is getting you directly to our DHHS website where providers can request PPE and the outpatient providers that fall under the category of healthcare facilities so if you click on the link for healthcare other healthcare facilities it will bring you to what is called ready ops survey. You will see the ready ops and then there is field to you are what you practice with your contact number what is your burn rate what you need and you can put request in through this ready ops survey and make sure all of that is complete and you submit those surveys button and you want to make sure you see that sign in the bottom that says your entry has been successfully submitted successfully so that they way that you can directly request PPE from us. One really important piece is as the people are already starting to do we have a huge surge in PPE request don't do it on a Friday night if your practice is closing for the weekend because our team will get it and reach out to directly and then they need someone to get in touch with so if you do it make sure

that there's somebody our goal is that we can at least response request within 30 minutes so do it at a time you practice is open and someone can reach back out to figure out the logistics of getting it to you. Next slide.

Some other things as well I think it was great everybody clamped down but we do need to get people back into care especially thinking about well child visit and there was a guidance, a CDC guidance as well as Medicaid guidance and thinking about getting kids back into well-child visits especially prioritizing our kids up to 24 months of age and just yesterday I saw some data kind of of scary data that's looking at immunization rates or request and use of vaccines for children and immunization supply has dropped pretty precariously so we're all a little bit nervous about this and we defiantly want to be sure that our kids are getting in especially up to 25 month getting there well-child visits and getting the vaccinations and Dr. Dowler will talk about some guidance that came out yesterday about this for some elements of the well-child visits in telehealth. And then I think the last slide for me is the other piece that we would love for you to be part of the response for us in part of it is the response for us-- back one. Back one. The COVID-19 surveillance, our strategy is multipronged, and one is those ED visits, but another element is what we call our ILI, influenza-like illness net. Influenza like net and it will be in like the COVID like net that and is a providers across the whole state that submit swabs to us and it's sent to the state lab and usually it is submitted to see if it's for but they can submit to us and we can test for COVID-19 and he gives us a really nice random sample across the state so we'd love to have more a providers submitting samples to us. One of systematic people that you think might have COVID-19 but also, we want to use this network as a way to be able to start swabbing asymptomatic people. We are definitely learning more and more there's a lot of asymptomatic disease out there is also people that say people were coming in for their well-child visit or a laceration or some non-respiratory illness we also want to get some swabs of a systematic people to get a better idea across the state and a systematic way of a asymptomatic spread so we would love, love, love to get more providers in our ILI net and we have struggled a little bit to get a sufficient samples because people are not coming into practice so really we like to get more providers to have this year robust part of the strategy and you can see the link to the page for that and it's an application of the bottom of the page and also the contact of our people who are in charge of our surveillance programs you can reach out to directly. So that ends my part of it and I'm going to turn it over to Dr. Dowler to dig into more of the telehealth support and we will go from there.
Shannon Dowler:

Thank you. Those of you that have been on the Thursday night calls we do each week to update on the Medicaid changes and you have seen this visual I'm a very visual person and this is how I have organized what the approach ended up being and you can see just rapid development and really for telehealth so last week on our Thursday night webinar we unveiled the well-child care although I was doing testing in a poultry facility and had to get disconnected in the middle of the call I appreciate the team continuing on so the special bulletin did come out with more explicit guidance on doing the well-child care and this Thursday night you're going to hear from a bunch of colleagues who are

going to talk about we're going to do more of our interactive panel where they're going to teach about best practices around well-child care using telehealth so I think that's going to be a really night good night on Thursday and I encourage you to join us for that. And then in May I'm thinking about, I've already started it, but the bulk of it is in May is what's to switch and when we talk about tightening and loosening and tightening and loosening. We are not going to be able to keep all the policies turned on for telehealth on perpetuity we know that and I said that from the beginning that we don't have the authority or the budget and some the things we've turned on and at some point some of the things we're going to have to turn off. So what we want to make sure we do is understand what are the things we turned on that really created value and really made a difference in the care that we are providing not just the Medicaid beneficiaries but across the state how are we modernizing telehealth rapidly in a way that actually made our system of care better. And so, we are studying that and we're spending a lot of time digging into the data as it evolves. To understand that better I've got a statewide team of folks helping me make those decisions and make recommendations to the DHHS leadership team and we're working with the payers counsel to see if we can align as we did with this telehealth you want to align across the state as much as possible. So, when the changes are made we are doing it consistently across payers if at all possible. So, you and the clinics are not having to wonder which patient has what insurance and what can you do with them. We will try to make this as consistent as possible and I'll give you little teaser this Thursday night we are unveiling what we're going to do all the teaching run well-child and telehealth which I think is going to be really good but we also going to unveil a new thing called the Hybrid Home Telehealth visit so this is a new innovation that we have come up with the best of both worlds and are also going to talk about turning on telehealth for specialty providers for patients in skilled nursing facilities so that they don't have to the leave the facilities to see a specialist and we're also turning on some new coach for dialysis patients to receive telehealth as part of their dialysis care. So, you'll hear more about that on Thursday night. Next slide.

So Kelly Crosby and others have been looking at the data starting back in March on what's happening with telehealth and virtual health utilization and I thought I'd share some of this with you as we're getting further out in the claims adjudication happening so we're getting more data being reliable and they created a ratio so face-to-face visits to telehealth or to telephonic care and what you see is as soon as turn on this policy you started seeing the folks using them which is really impressive there was not a delay -- sorry there is a fire truck going past my apartment. So, there was not the delay I would've expected I mean I'm just incredibly impressive with how everybody jumped on and started using modalities of care. Next slide.

This slide we just got this afternoon, and it is looking at telehealth utilization by race. We're actually looking at by gender, by age, by race and we're going to be looking at it by geography and one of the things you want to learn is who is using it and who's not and if they are not why and how can we help them use it and in the geography area were looking to see where we need to provide support in the form of broadband versus where are there practices were we can do hotspot intervention and try to help break down barriers for them and help

them utilize telehealth so what you see here is who is using it and how and I just think it's interesting this is very early data so I'm not I would not make any decisions based on it today but I'm looking forward to having a few more weeks of data to track on this. Next slide.

This is how the pediatricians are doing and they picked up the phones right away and return on the phone they were the first group to say all right, we can do telephonic care if we need to and as soon as we turned on the telehealth really went gangbusters on utilizing telehealth in their practices really impressive uptake in utilization and I'm excited to see how the well-child care works for practices and I will reiterate what Betsy said around weird still trying to push people to have children under 2 have their well-child care in the office and we are covering it and Medicaid if it needs to happen under 2 but with a caveat that you need to document that there's a compelling reason why you are doing that well child care for a child under 2 in the home instead of in the practice and we think there's going to be compelling reasons. There's good because this was the right thing to do so we do not want to make it impossible because we still think that better than the child not coming in but we really want them in the practice get their immunizations and you will see what this new code we are really saying the hybrid home visit telehealth code could allow for you to have vaccines done in the home while the provider is on telehealth for the visit and we are just trying all sorts of creative ways and we are worried about immunization rate and getting folks caught up knowing that they are behind right now. Next slide.

This is an interesting look at how the federal centers have reacted it's important to understand that up until March 9th they were not allowed to build distant sites for anything they were not allowed to do any of the virtual care or telehealth care they can only do consultative where they had someone at their site who saw a specialist for telehealth so they do not have any infrastructure for doing this work themselves because they were never allowed to do it and when we turned it on they medially went to the phone and started using the phone to reach patience and you can see how the growth in telehealth is really taking off and those practices are incrementally engaging in telehealth with their patients. They tend to be safety nets are taking care of the more vulnerable, marginalized population they're probably running into barriers you don't see in other areas around access to telephones or minutes on the phone or web connectivity in their home because they cannot afford it not because is not geographically available so I just wanted to point that out because there is an impressive uptake in telehealth for those. Next slide.

Just a heads up that fresh hot off the press on the 27th a new portal was created by HRSA so he can apply for reimbursement for uninsured care for COVID specific care so I just saw that Alan had some slides at the end covering this I want to take away his content but I put this in the slide deck as well and I thought it would be important for folks to know about and they're going to be taking claims as soon you have to get registered and I would say like all things money is going to go fast so the more coordinated you are and being ready to get things on the portal the higher the likelihood of getting reimbursement for the uninsured care. Next slide.

I have shown this in the Thursday night is a broad view of what we have done specifically in the Medicaid space but our partnerships and relationships to try to support infrastructure of primary care. It is very high level view around turning on the virtual and telehealth capabilities and we are increasing the rate for telephonic reimbursement and we are not paying full parity because we believe that telehealth is the horse we got our money on and we want folks to really engage and invest in telehealth resources that we understand at this point in time that everybody's doing the best they can so we want to raise the reimbursement rate for telephonic care and we also lean that our contract with AHEC and CCNC to shift to telehealth and we use those resources to help fund the triage + line CCNC is standing up now to help the whole state regardless of payer to get access to information around COVID and of course you have the hardship payments we put in place and we have increased the per member per month for medical homes and we have added the well-child and obstetrical care by telehealth and we are doing something and we are helping getting all the federal dollars and this things in the space and they both put out platforms that were free for members for a period of time to get on telehealth and really impressive response. Next slide.

Betsy mentioned the vulnerable population so I'm working I'm helping lead a group with Michelle on how we stay ahead of the curve in our new normal taking care of vulnerable population and we are specifically looking at how we work with communities of color and medically and behaviorally high-risk populations as far as how we're doing medication and outreach providing them with linkages to resources that they need and helping all the work streams across the department as we react to COVID making sure we are thinking about the care of vulnerable populations and everything we do. Next slide.

And that takes me to my last slide which is this reminder that in all things you're doing, we're doing it with the health equity lens that's never been more important than it is right now and it is a shame we would have to say those words out loud but the fact is we still have pretty significant health disparities in our state and we are seeing those disparities intensifying and worsen in certain communities particularly our essential workers who are now dealing with outbreaks in the places they work and continue to try to care for a populations that are marginalized and have otherwise not had full access to care so I put that out there because truly and everything we are doing now at the department level we are thinking of things with a health equity lens and if you ever have ideas or suggestions recommendations we are open and interested in hearing them because this is really incredibly important for keeping our states healthy. I think that was my last slide and I will turn it over to Susan and Dave, I think.

David Rinehart:
Thank you very much. Susan and I are going to tag-team this a little bit if we might and what we have done is we try to collect a few thoughts about reopening and how we might do that and they mostly come from you all come from your practices and what you will have been doing. We've trying to ask around and see the thoughts of everybody how they feel we can manage this, and we have a few thoughts for you on that. Next slide.

So, this is just a quick reminder of how quickly this has all gone we are less than two months from our first case in North Carolina and all of this stuff has happened it's just amazing. Next slide.

This is a reminder that we're not quite there yet. This comes from the Secretary Cohen's talk as mentioned we have a way to go before, we do that phase 1 opening but we are getting there. Next slide please.

So what we have is a balancing act as the start up our practices we have to protect our staff and protect the patients of course from additional exposure and we need to meet our patients needs well their current health needs and preventative needs that we haven't talking about and everyone agrees I think that the idea is that we should open gradually and thoughtfully and take this a step at a time. Next slide please.

This is a real-world example of how things have happened in my practice actually in I think like many of you probably as well the blue line is where we're seeing about 600 patients per week face-to-face came crashing down and we thought that connecting with we started connecting with telephone and telehealth pretty quickly and refill pretty proud. However I suspect many practices are similar to the square your total of your visits and so forth now really don't come close to achieving that activity that we had before this all happened so we have a long ways to go and we have to figure out how to open things up and this is quite devastating I think a lot of practices financially.

Susan Mims:
That goes along very much with what I heard from talking to practices as many practices are feeling at about 40% of the volume even with the combined and that really speaks to being able to open up be thinking about how to do that and in a safe manner that protects the community that protects patients and their staff.

David Rinehart:
Some environmental controls and then we'll talk about some workflow changes. I think one of the ideas is to smell fresh paint so to speak our patients are not going to want to come into an office but does not look clean and fresh and disinfected and so forth to keep that as a thought in your mind as you look at your offices and we still have waiting rooms and they need to be due are six feet apart distance of course we have dividers and we mentioned earlier we might need to go up and we have sick areas also have discussed a little bit already in some communities some systems have separate COVID-19 clinics respiratory clinics and keeping some offices completely try to be completely clear of COVID-19 and other offices were resend those patients that's another thought . Of course we need to have adequate PPE and our staffing has taken a huge hit as everybody knows and we almost saw I think we had to furlough people or put their hours and so forth because of the problems and figure out how that staffing ramps backup as we go through this.

Susan Mims:
I'm talking to practices and all surprised at the creativity and that people have used to protect her patients and their staff. Some of the things probably they cannot keep forever but one practice even put a

tent with a Porter Johns for urine collections but I was really for their respiratory sick they separated the respiratory sick like you said a COVID clinic from their other sick patients so and I know that the practices I talked with trying to figure out we have done this in this acute phase and now what does that look like going forward in I think we will have some other examples to share with you.

David Rinehart:
Next slide please. Before the visit workflow adjustments what might you think of course we need to educate our patients as much as we can to call ahead and I think that message has been out there on the news and so forth and I hope that's what is really getting out there is that they set up and do some planning before and then I think we all agree that telehealth has been extremely beneficial in this pandemic time and we also have the telephone and portal visits and then forget them we have a lot of other patients and broadband issues and so forth were a telephone works pretty well for a lot of people and we need to be talking about how we don't want to bring extra visitors to the office and need to space out our visits and the double booking travel book I don't think that's going to be a reasonable thing to do in this time and we need to have our patients spate spaced out quite a bit more which decreases efficiency sometimes but that's an important part of this. A lot of practices are doing well-visits in the morning and sick in the afternoon and the ideas being clean your office very well overnight and in the morning you have a little cleaner office and I think a lot of people are trying some of that of course we asked patients to wear their masks and another way that we decrease --

Susan Mims:
Unless they are two years old in which case the probably pull it off.

David Rinehart:
Decrease traffic in your office is that people at home we can do telehealth at home some of your office staff can work from home and that decreases the mixing of people in your office so the welcome providers and sick care providers and assistance doing rooming especially where adults older patients there is a lot of time spent doing med rec and EHQs and all sorts of quality metrics that are assistants to and there's a reason why a lot of that could not be done by phoning ahead of time or even electronically in some offices.

Susan Mims:
I was in several of the peds practices and family practices and they have the nurses all the check in process all happening ahead of time and sometimes it's in the car while the families waiting in the car and actually some of the family said we actually like that because its spring an lovely outside. They felt like they weren’t having to crowd their kids all around the office and had them contained in their car. So, they kind of like that waiting there until they came in. And I did want to just share about the telehealth I know, Dr. Dowler asked, where is the value at and per my conversation but if my heard that there are many, many benefits from virtual health and people really don't want to go completely back there times when it works much better and part of this is related to the technology. Technology is great until it isn't in the virtual visits can be quite helpful especially in certain situations and the overwhelming ones that I heard from everyone I talk to is behavioral health. I hurt stories of how

providers were able to see into a teenager's room kind of see where they and even bond with the provider by showing them some of the favorite things. So many people felt like they opened up more and in other situations it was not so helpful I did hear somebody having a kid do jumping jacks to see if they would have appendicitis but clearly patients times when they do need to come in and a lot of providers are being very creative in how to do more and more through virtual help and moving forward definitely I heard they will want more support on how to improve that. Maybe some of the barriers as you mentioned especially in rural areas or Internet access just bandwidth or access with vulnerable populations speaking of which my Internet is unstable right now and visual image but it's not a visual image and then people who are challenged just with unfamiliar with technology but overwhelmingly I heard people we don't want to go back but would like to continue to develop that value out of telehealth. And virtual health.

David Rinehart:
Workflow adjustments at the office to this parking lot as a waiting area or visit area and sometimes you keep that your inside waiting room sparse and have lots of telephone triage and a lot of practices are having someone at the front door not allowing and reading people at the front door with taking their temperature and not sure how great that is but maybe somewhat helpful in asking questions and directing them sometimes back to their car sometimes into a sick area in the office and masks all around, handwashing and making the visits a thorough once you're there and you got that exposure see if we can do everything we can at that one visit and so there is a procedure or elaborate immunization to be done and see if you can get it done during that visit and not have to have to bring them back time and again and minimizing the number of staff contact as a goal as we move forward through this time.

Susan Mims:
One thing to add I think is one of the challenges I heard is that people are being very creative and how to combine modalities to get the care to patients in the way that they need to get it and I think one of the challenges I heard is when they combine those modalities they're not sure how to build how to handle that so that might be a challenge for Dr. Dowler and the hybrid homes telehealth team which I was excited to hear about that in looking into that but there's some examples I heard someone visit my start virtually and then he either because technology failure board has to switch to telephonic or is telephonic and the parking lot and then you just minimize the time exposure and just bring them in for the things they need and I think when you get there well care we think of a committee to do the screening some things that the education piece can be done telephonically so I think there are some opportunities to really improve the telehealth on how we perform an telehealth overall some excited to hear that they're looking into that support.

David Rinehart:
Next slide. Just a few adjustments you might think about making sure if you do online scheduling make sure is reflecting what you’re really wanted to do in your portal and clearly states about what's going on in your office and hopefully that template that you like for telephone visits an telehealth visit and you can fix them up and also a lot of

people doing with the asynchronous portal type B visits as well and make sure that those things work on those things with your EMR. Next slide.

And a few things to mention in your template my understanding is that it is best to have you want to get paid for and document properly so you get paid properly for your visits make sure you have a consents to treat that were just not cold calling people and charging them without their knowledge and patient location I think that's not an issue now but if a mother is staying with your daughter in Texas your potentially practicing medicine out-of-state and be sure you mentioned that it's a real time audiovisual communications get that full visit in there and for telephone visits my understanding is you do billing based on length of time you spent on the phone so somehow either looking at your phone how much time you spend or whether your EMR has a timestamp the document that in your telephone visits and is probably nice to mention who you had on the visit in that house and confidentiality and focus I think Susan my talk about this.

Susan Mims:
One thing you think about when he talked about was part of the visit and then we also especially when thinking about adolescents who is not part of the visit depending on what you're addressing something about confidentiality issues and can a child really be alone to have that confidentiality and a tele-visit or virtual visit. Also thinking about focus I heard some stories about kids who are babysitting their younger children or attending their other things so that can be a challenge and how we set patients up educate them ahead of time for that virtual visit can be helpful. And video can help over telephonic here and some of those circumstances.

David Rinehart:
So, we have some extra time here since the visits are down so be thinking innovatively and maybe reveal your patience panel and see who needs what. Call your elderly patients, they love it. And make sure they know what they ought to be doing during this time and gaps of care fixing up your templates working on your website and you’re on hold make sure they're up-to-date and communicating all the stuff out of social media as well those are some of the ideas as we wait.

Susan Mims:
I want to emphasize that the practice this is something that I think we often try to do we try to learn our panel find out who is not getting the care but I think that the opportunities to slow down during this time when our panel templates have not been so full and has really allowed many of the practices I talked to to proactive care and I heard from many how rewarding that was they said that they were able to find people who really needed services and get those services to them and they were so appreciative and patients are getting what they needed so that was one of those practices that people mention when we get busy again we really see the benefit of this not necessarily the providers but the office staff or the staff in the practice when they get to see the benefit of that they're hoping that will help them keep that prioritize and not go back to predominately focusing on reactive care just answering those telephonic calls and that's something that people said they wanted to be able to keep looking forward.

David Rinehart:
This is our last slide just some general thoughts about where we are going to be here. The testing is ongoing, and we don't know when that leaving the serology and who is going to be immune and so forth lots of questions and that will change a lot of this workflow as we decide some of those things. We might help public health somewhat but contact tracing of our patients to help at least support that. The big question is what how much acceptance of telehealth will a patient show over time and how will they be paid for of course and huge question for us all and I'm interested to see some studies come out I hope on what type of visits we will end up being better done by telehealth or worse done by telehealth than face-to-face and seeing as we get more expense with this what type of visits really should continue on telehealth in which one we really need to go back to face-to-face for sure and this whole pandemic has brought up I think for many of us the whole idea of how primary care his paid for and I think you might just do I think many of us are getting capitated to care in general but if our whole panel were capitated through this thing our financial situations for many, many practices would be very different than they are today so that is a thought for ongoing on that's going to affect our payment models in the future so that is all.

Susan Mims:
I was going to I fully agree with you, Dr. Rinehart, about seeing what we can do with virtual health and very excited about the well care being added into this we do know patients likely to be seen for a portion of that care but being able to see how we can increase and catch up on the well care that people have missed especially in light of the immunization data that mentioned earlier and another we don't want to have another outbreak because we got behind in our immunizations I think combining that several of the practices I talk to are going to providing that proactive approach to well care as things begin to open up and really try to get those well visits done timely and get the immunizations get the care that people need even chronic disease management that has been missed when people were staying home and I think that will be coupled with the messaging that the doctors' offices are doing all of these things with the environmental control and workflow changes to be a safe place go I think that's good to be a really important message to get out to our patients that just because you're in a pandemic you don't stop needing care and that is helping in so many different ways as I think some those are some the key messages I heard and again how important how helpful the communication that we have had has been and that's one thing that I know people would like to keep up maybe not 4 to 5 webinars per week but something indication whether it's around best practices being here or just communication of the latest changes to all of them. One thing I want to finish up with is I practice in so many different practices and while everyone is doing something and oftentimes really innovative and unique things to meet the patient needs and so everyone is eager to be able to do more to help their patients I was really inspired by what I heard so thanks to everyone out there who is really doing this on the front line in taking care keeping people healthy.

Hugh Tilson:

I think we have time for a couple more questions and I do want to make sure we thank all of our panelists for all that they're doing. Dr. Mims and Dr. Rinehart and our volunteers, we know that a lot of work so thank you so much for that. Dr. Tilson and Dr. Dowler we know you are working tirelessly for the people of North Carolina, so we have a couple of questions related to testing and it goes to that first bullet that's on the screen. Should recommend that our patients -- sorry, that's not the right one.

The question is in what phase would you see a need to screen for COVID-19 for all healthcare staff in the practice asymptomatic disease in order to help practices promote the safety of coming in for care when needed so do you see that as a way that practices can help to ensure their patients on a go forward with this new normal?

Betsy Tilson:
Thank you for that question in this issue of testing asymptomatic people have been coming up a lot. So right now that's not a recommendation for routinely testing asymptomatic people as can be proactive preventive thing and I will tell you why it's a little bit hard is that if you are going to do it, its kind of a screening or surveillance thing you have to keep doing it because just because somebody is negative today does not mean they might not be positive tomorrow so we have to keep doing it every week instead probably what will be better and a lot of our settings is the study of personal protective equipment, right? So having the patient be masked in the providers be massed in more of prevention strategy then repeated testing of your asymptomatic staff to try to get a sense if they're positive or not so that not a recommendation at present thinking through more of the preventive strategies that were talking about infection prevention strategies.

Hugh Tilson:
Thank you. Dr Dowler one of the questions that keeps coming up is how long can we count on telehealth payments to stay where they are what is your prediction about that?

Shannon Dowler:
That is such a tricky question. We started a group back in December on telehealth modernization for Medicaid and we already had quite a few meetings and it was pretty clear that we do not have the budget to do it that we do not have it had been in the legislature of the summer and it ended up getting through and we were trying to do some things that we felt like were important but we do not have the budget to do it because we literally do not have a budget so I think that that's where we are kind of stuck right now and I think we're going to be pushing pretty hard for somethings to stay turned on not all of it and there's no way all of it can stay turned on I mean I get that but if we can demonstrate that this replaced visit I think, I think from the finance when they're predicting the cost of telehealth it is based on additive visits and not replacement visits and I think will be able to demonstrate pretty well that this was a replacement which would help me make the case to keep things turned on. We will be pushing for it and I know in the state of emergency ends a lot of our authority ends with Medicaid so then we have we have to start following different rules and right now we know that that state of emergency goes to the end of July and I suspect it will go longer than that this is at the

federal level and then in you have to be a time period where we unwind things. Someone asked me a question can we count on it being in here for one year? I would not count on it in here for a year. Do I think three months for sure six months probably and my hope is we get to keep some of this stuff turned on and that the other payers keep it turned on things that are really important like parody payments.

Hugh Tilson:
We are almost out of time so let me turn it over to Dr. Dobson. Next slide.

Allan Dobson:
Great job everyone. We are going to touch bases quickly and Shawn is on the phone as well on what's happening on the finance in side and what it means for you we can revisit this next week if we need to and as you probably know the stimulus bill was passed by Congress and it added $310 billion for the payroll protection program which is really important because that was the program we recommended that you consider applying for because it gave you really two month of your salary support for your staff plus some extra for the rent and utilities. That is additional funding has gone through and the good thing is that about $60 billion of it was earmarked for community banks and smaller lenders in the hopes it will get to the smaller practices and were more likely to do their banking through the community and smaller lenders and as we said before please talk to your bank about getting on the list if you have not and if you are already if you're ready applied in your line you should be put on through and your money should be secured. If you have not completed your application, please do and if you're thinking about it please talk to your CPA or your banker. There is actually also another $60 billion put into small business administration economic injury loan program which is a program that's been in place for that also ran out of money so that provided $10,000 emergency relief and was forgivable just like the Payroll Protection Plan that's forgivable and also has some additional loans that you can get at reasonable interest rates and spread out. Another additional funding would additional $75 billion to provide a relief fund and if you remember that showed up in your bank account based on your Medicare billings. It is subject to the same conditions as before and but no word of how HHS will target this particular allocation. Next slide.

The first provider relief fund the first tranche went it was $30 billion in the second tranche another $20 billion is supposed to be released automatically as well and I believe that is correct, Sean, we believe they will just give another payment like they did before but as we said last time you need to certify and sign your attestation for the first payment before they will send you a second payment.

Shawn Parker:
If I can add, most or some will get it automatically just if they had a first round and will do two attestations and some will have to apply and provide information and it's going to balance what you received on the first time and what you will receive this time based on your proportion of the 2018 revenues. Also as you will see here while the first tranche is kind of broad and every patient has a possible case and therefore if you treated anyone you should feel comfortable taking the money in the second tranche of money really has some limitations

to it and it puts more of an emphasis and if you don't have lost revenue or increase of expenses and don't keep these funds in your second attestation while you have to do it twice is going to be some additional terms including submitting your general revenue data and you're going to consent that HHS may publicly disclose payment amount to you so therefore there is a chance they might be able to drive your gross receipts so that the first 30 and second 20 are part of what's in the general allocation for the general distribution and we will go with the last bit of it on the last slide.

Allan Dobson:
I think the last thing is no news on the targeted payments for Medicaid providers and in the secretary did request from HHS and secretary that they be allowed to get funding out of this second tranche in this funding to pass on to the Medicaid providers because pediatricians and will be OB don't normally see Medicaid so we will see what happens with that. Again, I think the moral of the story is still the best source of support for you during this period of time is the payroll protection program which is the cleanest and forgivable than the other money for Medicare is are good but we will keep you posted on other funds in the state is working on his budget and their bills and there may be opportunities there which we can address in the future webinars. So Hugh that's it and thank you for everyone who participated in what you're doing to take care of your patients and your communities through this extraordinary time and again, I will salute our other panelists in particular Shannon for their leadership then no I don't think you signed up for this when you joined the administration but thank you for being there.

Hugh Tilson:
And before we go just, I want to remind everybody will have this webinar every Tuesday and next week are planning a panel of payer representatives to talk about their views on telehealth so hope you can join us then. Thanks everybody for all that you do and especially to the panelists really appreciate you making time for us tonight. Very helpful discussion. Take care everybody.
[Event concluded]