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Community Care Physician Network

NCAFP

North Carolina Psychiatric Association

Community Care of North Carolina

Navigating COVID-19 Webinar Series
Today’s Presenters

- **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
Navigating the New Normal

Betsey Tilson, MD, MPH State Health Director, CMO, NC DHHS
Shannon Dowler, MD, CMO NC Medicaid
North Carolina has taken aggressive action to save lives.

Policies were put in place to slow the spread of COVID-19, so fewer people get sick at the same time and our hospitals can care for those who are seriously ill.
And we have flattened the curve

Fewer people are getting sick at the same time.
Trends - Our Metrics

We will look at a combination of metrics to inform decisions to ease restrictions.

- COVID-like syndromic cases over 14 days
- Lab-confirmed cases over 14 days
- Positive tests as a percentage of total tests over 14 days
- Hospitalizations over 14 days
Testing and Tracing - Capacity

Ensuring that we continue to identify who has COVID-19 and who has been exposed, while keeping our frontline workers safe.

- Tests completed per day
- Ability to conduct widespread tracing
- Supply of personal protective equipment
The percent of visits to the Emergency Department for COVID-like illness is declining.
Trends
Trajectory of Cases

New cases in North Carolina are still increasing, but more slowly. There has not been a downward trajectory over the past 14 days.
Trends
Trajectory % of Tests that are Positive
Percent positive for SARS-CoV-2 by date of report among EIR labs

The trajectory of positive tests as a percentage of total tests over 14 days is **not** declining.
Hospitalizations help us understand our capacity to respond. There has not been a downward trajectory over the past 14 days.
Testing and Tracing - Capacity

Testing
• Increase daily testing from 2,500 – 3,000 people per day to 5,000 – 7,000 people per day.

Workforce to Conduct Contact Tracing
• Increase from 250 tracers to 500 tracers.
• Carolina Community Tracing Collaborative https://communitycarenc.org/carolina-community-tracing
• Deploy digital tracing technology.

Availability of Personal Protective Equipment
• Adequate supplies to fill requests for at least 30 days. Currently, have less than 30 days of gowns and N95 masks.
Phase 1
Stay At Home order remains in place, people can leave home for commercial activity

Those retailers and services will need to implement social distancing, cleaning and other protocols

Gatherings limited to no more than 10 people

Parks can open subject to gathering limits

Face coverings recommended in public

Restrictions remain in place for nursing homes and other congregate living settings

Encourage continued teleworking
Phase 2
At least 2-3 weeks after Phase 1

Lift Stay At Home order with strong encouragement for vulnerable populations to continue staying at home

Allow limited opening of restaurants, bars and other businesses that can follow strict safety protocols (reduced capacity)

Allow gathering at houses of worship and entertainment venues at reduced capacity

Increase in number of people allowed at gatherings

Open public playgrounds

Continue rigorous restrictions on nursing homes and congregate care settings
Phase 3
At least 4-6 weeks after Phase 2

Lessen restrictions for vulnerable populations with encouragement to continue practicing physical distancing

Allow increased capacity at restaurants, bars, other businesses, houses of worship and entertainment venues

Further increase the number of people allowed at gatherings

Continue rigorous restrictions on nursing homes and congregate care settings
May need to dial the dimmer switch up or down depending on Trends.
# Overall Guiding Principles for the New Normal

<table>
<thead>
<tr>
<th>Guiding Principles</th>
<th>Objectives</th>
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<tr>
<td>1. Increase social distancing</td>
<td>Structural/physical space modification to enforce distance</td>
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<td>Limit density</td>
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<td>Minimize opportunity for sustained exposure</td>
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<tr>
<td>2. Implement hygiene protocols</td>
<td>Disinfecting surfaces and common spaces</td>
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<td>Systematic hygiene routines</td>
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<td>3. Monitor workforce and participant health</td>
<td>Establish and enforce sick policy to support disease suppression</td>
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<td>Implement systematic symptom screening</td>
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<td>Recommend resiliency and support resources</td>
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<td>4. Protect vulnerable populations</td>
<td>Identify and protect high risk for severe disease</td>
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<td>5. Provide education to build awareness and</td>
<td>Proactive information dissemination</td>
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<td>combat misinformation</td>
<td>Identify and address misinformation</td>
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Outpatient and Ambulatory Settings

- Continue some element of Triage and Telehealth

- Infection Prevention and Control Guidance

- Hierarchy of controls and Preservation Strategies – Engineering, Administrative, and Personal Protective Equipment Controls
# Infection Prevention and Control Guidance

## Table of Contents

1. Minimize Chance for Exposures
2. Adhere to Standard and Transmission-Based Precautions
3. Patient Placement
4. Take Precautions When Performing Aerosol-Generating Procedures (AGPs)
5. Collection of Diagnostic Respiratory Specimens
6. Manage Visitor Access and Movement Within the Facility
7. Implement Engineering Controls
8. Monitor and Manage Healthcare Personnel
9. Train and Educate Healthcare Personnel
10. Implement Environmental Infection Control
11. Establish Reporting within and between Healthcare Facilities and to Public Health Authorities
12. Appendix
Requesting PPE


- Other Health Care Facilities

PPE Request – ReadyOp Survey Tips

• Please make sure to complete the survey in its entirety. Please provide numbers and contacts that can be reached.

• If you hit submit and survey does not give you the below message, then your submission did not record.
Operationalizing some other things

- **Well child visits**
  - Prioritize well child care/ vaccination through 24 months of age
  - New medicaid well child visit telehealth guidance

- **COVID-19 surveillance**
  - [https://flu.ncdhhs.gov/providers.htm](https://flu.ncdhhs.gov/providers.htm) - ILINet provider application in the link at the bottom of the page
    - anita.valiani@dhhs.nc.gov or at erica.wilson@dhhs.nc.gov.
**Virtual and Telehealth**
**NC MEDICAID**

**WAVE 0**
**MAR 7-13**
Virtual Health Capabilities
Developed codes for ALL Medical and Licensed Behavioral providers to pay for telephonic visits

**WAVE 1**
**MAR 14-20**
Virtual Health Capabilities
Developed Codes for ALL Medical providers to pay for patient portal (electronic) communication
Developed Codes for ALL Medical providers to pay for MD to MD Consults
Telehealth Capabilities
Developed Parity payments for ALL Medical, Clinical Pharmacy and Licensed Behavioral providers for all telehealth visits

**WAVE 2**
**MAR 21-27**
Telehealth Capabilities
Developed Parity payments for Physical Therapy, Occupational Therapy, Speech Therapy, Audiology, Dental and Expanded Behavioral Health providers

**WAVE 3**
**MAR 23-APR 3**
Telehealth Capabilities
Developed Parity payments for Diabetes Educators, Local Education Agencies(LEA), Child Development Service Agencies(CDSA), Registered Dieticians, Lactation Specialists and Expanded Behavioral to include Autism Spectrum Disorder specialized therapies and Expanded Dental

**WAVE 4**
**APRIL**
Telehealth Capabilities
Early April: Optometry Services, Remote Patient Monitoring
Mid April: Prenatal Services(combination home nursing/telehealth), BH Expansion
Late April: Well Child Care(combination home nursing/telehealth)

**WAVE 5**
**MAY**
Switch Determination
Early May: Identify what financial authority exists to continue COVID capabilities
Mid May: Identify what triggers will indicate the Switch

**NO NC CASES**
**FIRST NC CASES**
**NC Community Spread**
**NC Widespread**
**NC Acceleration**
**NC Re-Opening Potential**
Telehealth and Telephonic Ratios with Total Services | 12/30/19 – 4/19/20

- Telehealth and telephonic service ratios increase in early March coinciding with DHB’s telehealth/telephonic policy changes
- Total visits (grey line; numbers on right axis) decreases with claims adjudication
- DHB visit counts (previous slides) and CCNC service counts and ratios vary, but the resulting trends are similar

Data pulled from CCNC dashboard, containing mainly primary care and OB claims
During the most recent week of the observation period, the ratio of telehealth/telephonic to in-person care delivered to Asians/Pacific Islanders (green line) was 4.3% lower than the next lowest subgroup, Blacks (blue line) and 8.6% lower than the highest subgroup, Native Americans/Alaska Natives (black line). The Asian/Pacific Islander subgroup is relatively small, averaging 1,347 claims per week included in this analysis, compared to the Black (27,581 claims/week), white (58,002 claims/week), and Native American/Alaska Native (1,762 claims/week) subgroups.
Telehealth and Telephonic Ratios for Peds | 12/30/19 - 4/19/20

Data pulled from CCNC dashboard.
Compared to other provider subgroups, the ratio of telephonic to in-person claims for FQHCs is extremely high; 13.61% in the final week of the observation period. Pediatrics, registered the next highest ratio; 2.53% for the week starting 03/23/2020.
On April 27, HHS launched a claims portal to reimburse providers and facilities for COVID-19-related testing and treatment for uninsured individuals.

- As part of the CARES Act and the Families First Coronavirus Response Act, the U.S. Department of Health and Human Services (HHS) will provide reimbursement at Medicare levels to providers and facilities for COVID-19-related testing and treatment of the uninsured.

- Health care providers must register through the [COVID-19 Uninsured Program Portal](#) to participate in the program. Once registered, providers may request claims reimbursement through the portal beginning May 6, 2020 and can bill for qualifying services back to February 4, 2020. Providers can expect to begin receiving reimbursement in mid-May.

- Program and portal training will be available April 29-30, 2020 (see portal for details).

- More information about the program, including details about covered services, is available [here](#). HRSA also maintains a frequently asked questions (FAQ) page about the program [here](#).
Primary Care COVID-19 Infrastructure Support Strategy

NC MEDICAID

**All Providers**
- Allow Virtual Care (telephonic and portal)
- Allow Telehealth at Parity
- Implement COVID Differential Rate for Telephonic at ~80% E&M Parity
- Practice Support through AHEC/CCNC Contracts
- Fund COVID Triage Plus Line through CCNC Hardship Payments

**Primary Care Medical Homes**
- Increase PMPM Payment April-June
- Allow Pregnancy Medical Home incentives telephonically
- Open Obstetrical Care via Telehealth
- Open Well Child Care via Telehealth

**FQHC and RHC**
- Implement COVID Differential Core Service 120% for FTF and Telehealth April-June
- Allow Distant Site Telehealth
- Reimburse Virtual and Remote Patient Monitoring Payments at FFS

**ADDITIONAL RESOURCES:**
- Free Telehealth Platforms through CCNC & NCMS
- Additional Training Office Rural Health HRSA Dollars for FQHCs
- Federal Dollars for All Clinics Medicare Prepayment Program
Staying Ahead of the Curve Vulnerable Populations

Protecting Vulnerable Populations: Medical/Behavioral High Risk, Hard to Reach Populations, Medically Underserved

OUTREACH

COMMUNICATION

RESOURCES & INTERVENTIONS

CONSULTATION TO ALL NC DHHS WORKSTREAMS
Thoughts about reopening primary care practices

David Rinehart, M.D., FAAFP, President NCAFP
Susan Mims, M.D., MPH, FAAP, President NCPeds
Quick timeline review

- March 3  First COVID-19 case in NC
- March 10  Governor Cooper declares State of Emergency
- March 14  Closure of schools and limiting large gatherings
- March 17  Closure of sit-down restaurants
- March 18  Elective surgeries stopped
- March 24  First NC death from COVID-19
- March 27  Stay at Home order
Reopen criteria from Sec Cohen, April 23

**Where We Are Today**

**Trends**
- Trajectory of COVID-like syndromic cases over 14 days: ✔️
- Trajectory of cases over 14 days: ✗
- Trajectory of positive tests as a percentage of total tests over 14 days: ✗
- Trajectory of hospitalizations over 14 days: ✗

**Capacity**
- Testing:
- Contact Tracing:
- Personal Protective Equipment:
Balancing act

- Treat patient's needs, current and preventive
- Protect patients from additional exposure
- Protect staff

Open gradually, thoughtfully
SPFP visit types over time

- Face to Face
- Nurse/Lab
- Telephone
- Video

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Environmental Controls

- "Patients will want to smell fresh paint"
- Waiting room? 6 feet apart
- Plexiglas dividers?
- Well and sick areas, separate entrances?
- Separate respiratory/COVID-19 clinics?
- Adequate PPE
- Proper staffing model
Workflow adjustments *before the visit*

- Educate patients, call ahead, plan
- Telehealth, telehealth, telehealth
- Telephone, portal (and combo care)
- No extra visitors
- Space out visits, including lab
- Well visits AM, sick PM?
- Patients bring/wear masks
- Some staff at home on Telehealth, some in office
- Separate well care provider and sick care provider
- Assistants do thorough “rooming” by phone
Workflow Adjustments *at the office*

- Parking lot as waiting and visit area
- Telephone triage, intake and education
- Temperature and questions at the front door or in car
- Masks all around, obvious handwashing, no handshakes
- Make it thorough, do it all in one visit
- Minimize time in office – exams, labs, immunizations
- Minimize # of staff contacts
EMR adjustments

▪ Online scheduling reflects reality?
▪ Portal clearly states office situation?
▪ Telephone visit template
▪ Telehealth visit template
▪ Portal visits, asynchronous "E-visits"
Telephone and Telehealth Visits

- Consent to treat
- Patient location
- "synchronous real-time audiovisual communication"
- Length of visit, for telephone (start and end times or total)
- Persons on the visit (spouse, daughter, etc)
- Ensure confidentiality and focus
While you are waiting...

- Flexible and innovative
- Review your patient panel
- Call your elderly patients, check on them
- Run reports of gaps of care
- Proactive practice - well care, chronic dz care, vaccines
- Fix up your EMR templates
- Website and on hold message up to date?
- Communicate via social media
Questions for us all

- Who and how to test for SARS-CoV-2 ongoing?
- Role of serology? Immunity questions.
- Contact tracing workflow
- Acceptance of telehealth over time, payment over time
- Best practices for telehealth vs face-to-face
- Payment model for primary care
L. Allen Dobson, Jr., M.D.
CEO
Community Care of North Carolina
Paycheck Protection Program and Health Care Enhancement Act

- **HR 266 PL 116-139** is 4th stimulus bill from Congress
- Added $310B to PPP
  - Earmarked $60B for community banks and smaller lenders
- Added $60B to SBA’s Emergency Economic Injury Loan Program
- Added an additional $75B to the Provider Relief Fund
  - Subject to same conditions as original $100 billion, but no word on how HHS may target the allocation.
Provider Relief Fund

▪ **First tranche** ($30B) released via direct deposit or mailed by 4/24 based on Medicare FFS reimbursement for 2019

▪ **Second Tranche** ($20B) released automatically; will be reconciled with initial payment so total allocation is proportional to your share of 2018 net patient revenue. Cannot receive 2nd until attested to first; must sign a second attestation and submit revenue information for verification

▪ **New emphasis on “limited use and purposes”**
  
  o [A]ll payments may only be used to prevent, prepare for, and respond to coronavirus, and ... shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus.

  o If a recipient does not have lost revenues or increased expenses due to COVID-19 equal to the amount received a recipient **must return the funds**
Provider Relief Fund

- “[A]ll recipients will be required to submit documents sufficient to ensure that these funds were used for healthcare-related expenses or lost revenue attributable to coronavirus.”

- **Targeted payments to Medicaid providers still possible in Round 3 or with the new $75B in funding.**
Questions?