Transcript of DHHS Provider Forum on Revised Outpatient Guidance
March 24, 2020
5:30pm – 6:30pm

Hugh:
Good evening everybody, let's go ahead and get started. Thank you for participating in this evening's forum on the recently updated provider guidance on COVID-19 ambulatory testing and management. I will be moderating tonight's forum. Thank you again for making the time to join us, tonight you will hear from the Department of Health and Human Services experts who will describe updated guidance and will then respond to your questions related to the guidance released. I want to observe we have received a number of questions in advance of the forum, many will be addressed by the presenters as part of the presentations as they describe updated guidance. Many were not related to the guidance and may not be addressed tonight. We are going to coordinate responses to those questions in future forums. For more information about future forums please visit the website. After the presenters have finished I will present questions that relate to the guidance to them.

Please use the Q&A function to submit those questions, please do not submit questions using the chat function only the Q&A function. Again, if you're unable to get your question answered this evening we will work to coordinate responses. This forum will be recorded and a written transcript of it and a slide deck will be made available to the public. Please use the Q&A function to submit questions when the time is right for the questions. If you are attending by phone I will not be able to take questions from you during this call. Our presenters tonight are Dr. Betsy Tilson, she's the State Health Director and Chief Medical Director of the North Carolina Department of Health and Human Services. Dr. Zack Moore, State Epidemiologist and Dr. Shannon Dowler, Chief Medical Officer for North Carolina Medicaid. I will now turn it over to our presenters.

Dr. Tilson:
Great, thank you. I will go through a little bit of the agenda so you know what we will be talking about and then we will get into it. So I will talk a little bit about the new provider guidance and hopefully that is in your inbox. It was pushed out as many provider channels as we could yesterday including to the North Carolina Medical Board and to the professional societies, so hopefully they are in your inbox and you have seen them so we will go through a little bit of those high-level guidance.

We will then talk through the rationale behind some of the guidance, where we are in those stages of addressing this pandemic and how we will be using alternative ways in terms of surveillance and tracking because I know that is a big question and then we will turn it over to Shannon who can talk about policies in place that will help you operationalize some of this guidance, especially the use of telehealth which was a big part of the guidance. And then in the appendix you will see much more details, links to the provider guidance and to other more detailed guidance.

So that is what we will cover. Next slide please.

Just to highlight, especially in the bigger provider guidance we know that there is a lot of depth but we wanted to highlight one of the biggest changes that people with mild symptoms of COVID-19 are being recommended to stay home unless they need medical care and to reach out to their provider telephonically or in another virtual way to talk about their symptoms. This is consistent with CDC guidance, people with the illness should stay home, we will talk through that and what that means and the rationale for that. The other piece I want to call attention to, mild symptoms meaning assigning as and there will need to be clinical judgments but the fever and cough without shortness of breath, difficulty breathing and chest discomfort so we want to make sure you see that upfront.

Next slide please. The other thing that happened late Sunday night as we were drafting these guidances, is CDC put out a slightly modified high risk categories. That includes people 65 and older, before they said older people, now they have landed on a number consistent with what North Carolina had done. Chronic lung disease, bringing in asthma specifically, heart disease. This is a new category, BMI greater or equal to 40 including continuing underlying chronic health conditions specifically those that are poorly controlled including diabetes, renal failure and immunocompromised groups which were in the high risk category. Although they have not fully put pregnant women into the high risk category they brought them a little bit higher and said that pregnant women should be monitored closely as they are known to be at risk for poor outcomes with other viral illnesses. Still the covert specific data does not show pregnant women to be at higher risk for COVID-19 related illness but that data is preliminary and small so we are being cautious based on data from other respiratory illnesses to be vigilant with pregnant women.

And then this is not specifically in the CDC guidance but we wanted to be forward thinking and we are starting to see data in general that children seem to be at a lower risk for severe illness but we are starting to see studies that indicate infants may be at higher risk, so we wanted to put this on the radar. This is not in the CDC guidance but we have seen some data so we wanted to be proactive in making sure this is on your radar

Okay, so with those two changes that were in the --, I won't go through the full guidance but wanted to talk to some high levels. Our recommendation, (and I did a media press today) we will push out public messages more broadly but the guidance should be that people who have mild illness, fever and cough should stay home and they should contact their providers to help with triage and assessment of symptoms. Then you will see in the guidance we are encouraging clinicians to use telehealth, tele-video, telephone triage, alternative ways to interact and triage patients other than in person visits. When Shannon comes in, she will say how we are working with Medicaid and other payers to make that a sustainable practice. So patients who have no symptoms should stay at home and we are not recommending that they need testing for COVID-19 and they should stay home to recover. This is consistent with guidance from the CDC.

We are also saying patient should contact their providers initially and as long as they are doing fine that's great, but also if there are signs

or symptoms of worsening disease so worsening fever, shortness of breath, difficulty breathing we are counseling patients to call back. I assume you would tell your patients to call in and we are proactively saying if the patients are in a high-risk category, then more outreach and follow-up for that set of patient populations is recommended. Of course, escalating medical care if worsening symptoms should occur.

We are also helping to guide what patients should be prioritized for testing. These are guidance and suggested prioritization. People with severe respiratory symptoms, those that are hospitalized, those for whom clinical management would be different if they are infected. That is a little bit vague but there is wiggle room. Those are high risk settings, so congregate care settings, long-term care settings also I would put homeless people spending time in shelters in this congregate living setting. And then healthcare workers and first responders are the patients we would suggest be prioritized for testing. And then patients who were having severe symptoms.

Again, we are encouraging that other causes of respiratory illness including the flu are tested. Although the flu is coming down if you are focusing on flu surveillance it is coming down but we still have the flu out there, so we are suggesting to think about other reasons and respiratory illnesses.

And then what we have heard from people is, 'now you're just giving up on your control measures' and that's not true. What we are saying is people should stay home and that they should self-isolate. So those control measures we have been doing in partnership with local health departments are in play. People should stay home and self-isolate. And then we have clinical criteria and this is consistent with the CDC, but when the patient meets the clinical criteria they can be released from self-isolation and can come back into the world. Those patients need to meet all three criteria to be considered recovered. That includes at least seven days have passed since symptoms first appeared, at least three days or 72 hours had passed since there is no fever without fever reducing medication and three days or 72 hours had passed with improvement in respiratory symptoms. So the patients will self-isolate for a minimum of seven days but longer until they meet the 72 hour clinical criteria.

Patients do not need a negative test result, and this is something we are messaging hard to businesses as well, for people to come back to their employer if they meet the clinical criteria. This may be something you get with providers like, I need a note from my doctor and these are the clinical criteria you could use.

And then we are saying, close household contact with persons who are self-monitoring should also basically self-quarantine, limit outside interaction, self-monitor for symptoms and then they self-isolate if they have symptoms.

We have all the patient facing handouts on our website. I asked the webmasters to put these documents in the provider link so you have the provider facing document and the patient facing documents in there and that includes what to do if you're sick, how to do self-isolation at home

and how to care for someone at home so all those documents should be in one place as the web folks are pulling that over.

Next slide. That goes through some highlights of the changing guidance and then I will turn it over to our epidemiologist to tell you why we are doing this based on our response to this epidemic. So I will turn it over to Dr. Zack Moore.

Dr. Moore:
Thank you. Everything is rapidly evolving so you should expect that there will be some forthcoming updates and probably more specificity around testing priorities coming out in the near future. In terms of the testing guidance, of course our whole point in this is to save lives and that is what we are most concerned about. We are concerned about everyone, but most concerned about the people who will end up requiring hospitalization and medical care, and making sure we do everything we can.

As it says on here, to decrease spread, flatten the curve concept and then also preserve resources to make sure that our healthcare systems and workers are best able to take care of people when we have what we expect will be a sizable surge in healthcare need based on the experience pretty much everywhere else. In terms of decreasing the spread, you know the concern with bringing in people who don't otherwise need medical care. Clearly, it's about the possibility for increased opportunities for transmission and that includes people who do have COVID-19, can spread illness to others and it creates exposures or opportunity for exposure to healthcare workers, and to other high risk people. Also, if people are coming in for testing, that does create exposure opportunities for themselves.

We hope that everyone has got infection prevention ready perfectly, because we know every time someone does come into the healthcare system that possibility is there. And in terms of preserving resources, you know we are mindful that we have national shortages and supply chain issues, that really are across-the-board as a wacko mole thing when you think you figured out something for one piece, there is another piece. Whether that's masks, gloves, swabs, across-the-board. So, we really want to be mindful of that and making sure we are being good stewards of those resources and that recommendations reflect that.

So personal protective equipment and supplies will be needed to protect front-line workers and to care for people with more severe clinical symptoms. Of course, we certainly want people to be very clear, we are in no way suggesting that anyone should get substandard care or that they should tough it out at home if they have health concerns. As said, we are trying to feature prominently in this messaging people should reach out with any healthcare concern they have. And you know, we know great strides have been taken by many of you in terms of making yourselves available through remote opportunities and you will hear more about that later.

So you know these test results will not have impact on most people, those with mild symptoms, you know we know the data and I'm sure you have heard 80% will not require any type of medical care. And, for those folks at

this point with the treatment options still being investigational and really more reserved at this point with severe illness, there are no specific changes in management that would be based on those results for most people.

And then something that we hear a lot which is a very reasonable question is what impact does this have on surveillance? There are two parts to that, one just on the sort of basic concept of the containment to mitigation. If you cannot identify every case, you cannot follow up with every case and issue isolation orders and quarantine orders, so we are not giving up on those things. We are continuing to encourage those local health departments that have not experienced widespread transmission in their communities, that have the capacity to do that case follow-up while they can. But we are recognizing as we do reach a situation of more widespread transmission, individual follow-up for all cases is not going to be feasible in terms of doing a contact investigation and outreach to all the contacts, and that is already happening in some counties and we have seen elsewhere.

We recognize they have to prioritize some of the high-risk situations where we know the chance for rapid spread and severe illness are the most serious, particularly long-term care but also other congregant living settings. And there is also concern about the impact on surveillance more broadly, not on the individual level. But I guess the first thing I would like to emphasize, I think everyone is aware that the case counts we have here and the case counts we have been tracking globally are not a great reflection of what's going on out there in this community. And the more widespread it becomes the bigger the difference between what we get in the laboratory confirmed case count and the actual burden of disease and trends of disease in the community and this can manifest in multiple ways. Right now, there is a piece of it that is increased access for testing and demand driving up, although certainly this does reflect disease transmission, but that plays a role in driving up those numbers. And then I think there are other ways in which you know those case counts can certainly underestimate and not be a great way for tracking the course of this in our state.

So, to address that, what we are doing now is tailoring influenza surveillance tools. We have, and possibly some of you are familiar with, influenza surveillance systems in the weekly reports. Those systems we believe will lend themselves nicely to this pandemic. They are also intended to be used when we have pandemic influenza and can be tweaked to help us track this, also potential, widespread respiratory illness.

So there are several components of that that we probably don't need to get into now, but you might be hearing more about soon, as hopefully, the next couple of weeks at the state level and nationally, we start utilizing and publicizing those types of surveillance tools. Just for some examples, there is the national network of providers that report data on influenza-like illness in their practices, and collect specimens to submit for flu testing, and that operates across the country. We have a very robust system of providers in North Carolina and we have reached out to them to make sure they can continue to submit specimens so we can have a more stable baseline for what the proportion positive is for

samples with fever and cough and outpatient settings. That is one piece of information that can help us track this over time in a more evidence-based way.

We have a whole host of healthcare data sources and surveillance in North Carolina, we are very fortunate we get data on every emergency department visit. We rely on this heavily with influenza and tracking influenza - like illness at the emergency department and we can track the proportion that get admitted, etc. So we are going to be using the same system for monitoring emergency department visits during this. We have information on hospitalizations and admissions for respiratory illness so there are several different pieces. It is several different data systems we use to get a holistic picture and we believe this will help us to guide those important decisions about huge and impactful mitigation measures that you see now, whether it's mass gatherings or school closures, the shelter in place orders that are happening in some places that will help us understand and give us a better actionable data for making those decisions. Okay. I think that is all I'm going to cover and turn it over to Dr. Shannon Dowler.

Dr. Dowler:
Thank you. This is the part where I will tell you some of the good news in the work we have been doing to be more supportive of telehealth and virtual visits. We have been convening a pay counsel and we have discovered a lot of us that are covering patients in the state are very aligned, and we are probably covering a set of services no matter who the payer is and that is true for telephonic visits and electronic visits and telehealth.

So, the virtual visit is when we talk about audio or visual, it is usually asynchronous so not happening at the same time if you think about a portal communication you might get from a patient or the audio telephone visit. When we talk about telehealth we are talking more broadly about audio and visual simultaneously and we have found telehealth is broadly covered with a range of flexibility as a response to COVID-19 across all payers in North Carolina.

We surveyed them and we found out nobody was requiring prior authorization, and this is true for Medicaid. They are not originating at distance site limitations so it's probably open. We want folks to use telehealth services and we are paying at parity, every payer says reimbursement at telehealth is paying at parity meaning you get the same reimbursement you would for a face-to-face visit. One of the things that's exciting, as we are now allowing look-alikes to be distance sites and that is something Medicare had not approved in the past and Medicaid followed suit with Medicare guidance. But in response to COVID-19 this is open to everybody, so we want folks using telehealth to take care of the patients as much as possible. Not only so the vulnerable patient stays home but so providers can be at home and work. We know some of you will be exposed and quarantined and you might feel fine at home and you might want to provide care to your patient and we want you to do that.

I will tell you we are working on this in phases, because the Medicaid program is so large and the first wave last week we went live with

medical behavior health and the clinical pharmacy codes. This week we are working hard to get speech therapy, occupational therapy, physical therapy, audiology and dental codes finalized, so I hope to have those amounts by Thursday evening with the different codes that will be covered. And then it should be online by Friday with the build complete in the system by Monday. By the way, all the codes will be retroactive back to March 10 because we know a lot of you are providing telehealth services for your commercial patients and you may have been doing it out of the goodness of your hearts for Medicaid, we want to make sure you get paid so we will have this retroactive. The next wave we have started is a broad group of providers including LEA, CBSA, non-licensed BH providers, optometry, registered dietitians, and diabetes educators so teams are proposing policies for that group and we hope to have it built and in the system and publicized by the end of next week and then built into the system a couple days later.

As that is happening, we are making changes to pharmacy policies, durable medical equipment, we are doing things to make sure there are few administrative burdens that folks are facing in the field taking care of patients. We are reducing burden and increasing access with policy changes. This is some guidance we are putting out from the payer counsel of the recommended codes to use, the diagnostic codes when you take care of patients with covert symptoms. This came out from the CDC and we thought it might be helpful for providers and practices to have if they were not aware of these codes, the pay council agreed these would be covered. We said yes, we endorse this so if you're consistent using the codes you should not have problems with billing from that perspective.

I know it is a lot to take in and there have been a lot of changes happening rapidly so I want to point people to the Medicaid website specifically for the Medicaid population. We will have a frequently asked question page coming out tomorrow that will answer a ton of the billing questions. There are recorded webinars from two prior presentations. We have another presentation coming up Thursday night where we are going to focus on sharing the new codes and then helping you understand how to operationalize and do this telehealth and virtual health in your practices in partnership.

We are, on the website, linking to a bunch of telehealth resources knowing that some practices are more mature in the space than others. We have a lot of resources you may want to utilize. I want to point you to your LME/MCO's to get advice on what's being covered, they are allowed to have separate policies in addition to the Medicaid policies so we will set up a webinar to try to answer some of those questions. We also have a website, sorry an email address you can send questions to. That is also on our website, but you can also send your questions there and we will try to answer them as quickly as possible.

One of the things I have heard is it sounds like a lot of the health systems are uncomfortable allowing for some of this virtual and telehealth care. We have tried to make it as easy as possible to provide the care. We have opened up the codes broadly, removed restrictions so folks complaining will not get anxious so we are trying hard to help this be available for all of you. Whether you are an independent or employed practice. If you're having trouble moving forward with some telehealth

services, I would be interested in hearing from you to see if we can touch base to help your system understand why we encourage the use of this virtual and telehealth care.

The last thing I will say is there a lot of fake news about what's covered and what is not from our conversations with the payers. Everyone is broadly covering telehealth at parity, so you get paid the same amount as a face-to-face visit and that is always significant. There are other rumors. I would encourage you if you have questions to go straight to the website, for Medicaid we will be listing a table where the payer coverage will be in one consolidated table that you will be able to see which may help answer some questions. I am going to wrap up now so we can turn it to questions and answers.

Hugh:
Great. Thank you. We are getting a lot of questions. Many of them are not related to the guidance. We have put some information in the chat about how to access other forums. So, check the chat for links to other forums where we can focus more on questions that are not related to the guidance specifically. **We got a number of questions about some of the broad implications of not testing and this one kind of sums up some of those. Will not testing for COVID-19 give a false sense to the media and the public that the disease is not spreading since the news is reporting numbers daily?**

Dr Tilson
I will take this one, the first thing I want is emphasize we are not, not testing. There will be a lot of testing. We will be testing people who are hospitalized, healthcare workers, front-line workers, people in long-term care facilities, people with more severe disease or with a change in medical management. So we will be testing. There will be a lot of testing, it's just that testing people just with mild disease is not good for anybody's health and it is not where we need to use resources, so there will be a lot of testing. I'm not worried about that. There will be a lot of testing and again with some evidence-based surveilling strategies that will be used, it will also show widespread disease so there will be plenty of positives and with the surveillance we can continue to show the spread of the disease. So as we think through all of the different parameters and how do we protect people's health I don't want to just test for the sake of another number to scare people. There will be plenty of testing and surveillance so if we think through how to protect health and resources, this is where we need to move. But again I want to make sure we know it's not that we are not testing, but people who are mild can stay home and recover at home.

I agree and people are looking for numbers going up there will be numbers going up and unfortunately, we expect there will be a lot of severe illness and a lot of death. We are at this point, right now where certain parts of the state are more fearful or more tuned in maybe and others are not feeling this so we know that there is a bit of difference in the perception and how well people are adhering to the recommendations. Also recognize that people are going to be looking at the case count in one way or another. I don't know the actual magnitude of the number will be meaningful to people but we will still be doing testing and we will have

case counts and I recognize some of the other flu surveillance things like tracking influenza like illness and looking at proportion positives will not resonate with everyone and that is maybe for those who are looking for a deeper dive. But we think it is important for being able to have a better evidence-based approach to decision-making.

Hugh:
Great. Thank you. Can you comment on guidance for healthcare workers with close contact to COVID positive patients or symptomatic patients without PPE protection? Many institutions recommend a healthcare worker can return to work after exposure as long as they are asymptomatic and wear a mask. CDC guidelines vary, based on level of PPE. So a lot of questions about workers and how to navigate exposure. A separate question about PPE but how to navigate back to work and managing families after exposure if still asymptomatic.

This is critically important for healthcare workers, safety and also being able to staff healthcare systems and hospitals during the anticipated surge. I should say we are aware, the CDC, they do have detailed guidance on what is considered high, medium or low risk in terms of exposure and healthcare settings. I won't go into that and without looking at it it's pretty complicated, but it does have to do with whether there are masks and the type of PPE being used and contacts and procedures. But there is also an acknowledgment with the CDC guidance in places where there is active community transmission and healthcare workers may be having exposures, unprotected exposures with households outside of the healthcare setting and that basically, in a nutshell, employers or hospitals have the option to allow those workers to come back in and do careful self-monitoring and then isolate if they develop any symptoms.

So, two quick comments on that, one is we know there's new guidance coming out from CDC on types of exposures and risk levels and what's recommended. We don't know what that will look like, but I expect that pretty soon. And two, there were a lot of concerns about asymptomatic transmission. We know that is a thing that can happen with COVID-19. And I think the reasoning behind that guidance on return to work and self-monitoring in places of community transmission on the individual per person basis, the likelihood is much lower for transmission from somebody asymptomatic than somebody who is symptomatic so there is specific guidance on source protection for people who have had unprotected exposure and are going back into work. And so yes, there is guidance out there now, we know it's going to be shifting a little bit but obviously everyone will have to work within their networks and different hospitals and employers are going to make their own decisions based on how best to protect their patients and maintain staffing needs.

Hugh:
Thank you. A subset of that is the CDC website today still says to wear N95 masks for swab collections and yesterday's memo allows surgical masks. Which is right?

The CDC guidelines say that you can use N95 or facemask for swab collections. They have a recommendation for either, so they are in line with what's in the provider guidance.

Hugh:
A question about telehealth and the effects of the decrease in volume as a result of encouraging people to stay home and telehealth parities and any advice on two things. Question number one, is there a way to help make practices more sustainable using this model to offset the increased volumes? And then the second piece of that is as providers increasingly exposed to COVID is there any mandating to stay at home, statewide policies? So two different but related questions. Shannon are you muted?

Dr Dowler:
Sorry I am having technical difficulties again. Can you repeat the telehealth component of that question?

Hugh:
Essentially the question is even with telehealth, volumes are down. So much telehealth is not replacing those volumes, any thoughts about how to help make practices that are suffered from decreased volumes more sustainable as patients are being increasingly asked to stay home.

Dr. Dowler:
I think I would be really proactive in scheduling patients for routine visits using telehealth. I know I got a call, for reasons that are unclear to me, about my mother having a visit with the bone density clinic the other day and confirmed they were following up with a telehealth visit so I think that's happening with a lot of specialties being proactive with routine follow-up and using virtual care and telehealth and remembering return on these telephonic and communication codes. We have never been live with those, so when you call the test results you can bill for those services now and that is new and different.

Hugh:
A follow-up to that is how are we making Medicaid patients aware of their ability to use telehealth?

That is a great question. We have been heads down working 14 to 16 hours a day trying to get these codes live and I will confess we have not been as beneficiary focused as we might have liked to have been. So I think it's going to fall to the practice to tough base with patients especially folks that are behind due for follow-ups or calling for refills to convert those visits.

I will also say from the state level we will be pushing out public messages a lot so those are for all of ours people including Medicaid people so we will be doing a lot of public messaging as well as around this.

Hugh:

A question about children who are often asymptomatic, how do you protect yourself if we are not testing children?

Dr. Tilson:
This is Betsy, I think there are a couple different things and there will be some adults that are asymptomatic as well. So, doing a test on the child is, doing a test is not going to protect you and there is some recommendation, because we have community spread, and there will be asymptomatic people everywhere, there is a suggestion, and we have in the guidance, taking a mask and glove for all patients not even just the respiratory because there will be some asymptomatic patients as well. Whether or not you test them.

Hugh:
Should contacts of those that are symptomatic not go to work when they are in the quarantine period?

We have that in the guidance and include the patient facing guidance what we are recommending as much as possible is household and close contacts can stay home as much as possible for 14 days, self monitor for symptoms. And then when they become symptomatic, do the same thing with the symptomatic person. As we are moving into the new phase the health department has been issuing legal isolation and quarantine orders, we will move away from legal orders but that is a recommendation they should be self quarantined for 14 days.

Again the counties that have not had a lot of cases or any cases, in many cases they are using those individual isolation quarantine orders but we acknowledge that is not something that's going to be routinely possible for them when they get widespread transmission.

Hugh:
A lot of questions from mental health providers about telehealth and how that is all going to be covered including distinction not just behavioral but also audio and visual, Shannon can you give some detail about behavioral health as well as distinction if any between telehealth that is audio and telehealth that is visual?

Dr Dowler:
We are referring to virtual health as things that are either only visual or only audio and often asynchronous so a telephone call, portal communication, that would fall into virtual care and then for telehealth it is audio and visual simultaneously in real time. That is how we are separating the two. There are telephonic codes that can be reimbursed for behavioral health for counseling with reasonable rates even though they are not full telehealth and then there are a lot of telehealth codes covered for behavioral health so I would point you to the Medicaid website on the COVID page. We have special bulletins related to the new codes that have been released and it defines exactly what codes are covered by each provider type and it will answer a lot of these questions.

Hugh:

As you are talking about that, questions about preventive health services, well-child checks for telehealth reimbursement and new patient visits.

Dr Dowler:
Great question. The preventive care we are pushing, we want to make sure we have all the different types of providers, something in the telehealth space before we go to preventive care. We have a team looking at that and if we have a prolonged period of time not wanting patients to come into the office, how do we get immunizations to kids? How do we get pregnant woman taking care of?

We are thinking about different modalities we may need to provide, but the first priority is making sure everybody has access to using some form of virtual and telehealth resources. What was the other part of the question?

New patients.

New patients are excluded from telephonic and portal communication codes but they are not excluded from telehealth codes. You have to make sure you document enough parts of the exam to meet the coding guidelines but new patients are allowed to be used for telehealth and we will give examples of that on the Thursday night webinar.

Hugh:
Thank you. Questions keep coming in about the idea of lockdown and the combination of broader testing in lockdown as an effective strategy. Would you all be willing to comment on that?

Dr Tilson
I am happy to. Again, we are not going to be able to test our way out of this in terms of using testing as a way of surveillance or identifying everybody. We are needing to switch to evidence-based surveillance, also as we think through the control measures we are pivoting control measures so we will be testing and doing a lot of control measures especially around the high risk population where we know we could have outbreaks and spread. People at home are still going to be getting the same isolation and quarantine instructions that they would be doing otherwise. And so all of those measures are still in place, its just not necessarily all with the legal orders and those concepts. And again we will be pivoting a lot of the testing and contact tracing and outbreak containment and a lot of the high risk settings.

And then in terms of lockdown in North Carolina we have been really ahead of the curve on community mitigation strategy based on what the level of community spread is, in North Carolina we have had a lot of testing. I think we are the fifth highest in the country in the number of tests we have done. We were very proactive, got a lot of testing out so even before we had evidence of community spread we were acting as if we had community spread and we have put in many community mitigation strategies that are kind of way ahead of where we are in terms of testing because we knew being dependent upon testing individuals was not a good way to know where we were with the epidemic. So you have seen us be very aggressive

in a lot of mitigation strategies. Everything is still on the table. I know this lockdown has been brought up a lot. Everything is on the table. What it really means, how to operationalize that, how to get out of that, we are thinking through that, but we have been very aggressive in community mitigation strategies to date.

Because we knew we could not rely on individual lab tests as a way to understand the spread of disease. We have been acting as if we had community mitigation so we will continue to put everything on the table. But what we need to put into place, and that is what you will see, is surveillance strategy. Where is evidence-based surveillance, so we know when we come to a mitigation strategy when we need to do more. So that's the importance of pivoting to surveillance because we have to have evidence-based strategy to guide decision-making moving forward and to also understand when we come out of that. So that is one of the important benefits of this strategy.

Like everyone else we are trying to learn as much as we can, as fast as we can from people that have gone before. So we are hearing a lot about what was successful in Hong Kong or Singapore or South Korea and we want to learn from those lessons. It's hard to tease out the effectiveness of one piece of the strategy versus another. And we are working with modelers to try to look at that, as well as we can, in terms of what's going to be the biggest impact and in terms of widespread testing as part of our strategy you know given some of the reasons why or some of the challenges or problems with that, but there is the reality from a resource perspective that we are not into the worst part of this yet. And we have heard from other states about running out of testing supplies, PPE and you know looking at the supply chain it's not really clear, help is on the way. We are trying everything we can to access everything we can to get it out to providers and we do appreciate the importance of widespread testing in strategies that were used in other countries. We are also very mindful that we don't want to get into a situation where we suddenly have a huge surge in hospitalizations and we have no PPE so I think it is a balance we are trying to strike.

Hugh:
Thank you. I am getting a fair amount of questions about workforce. And two threads, one relates to this notion of essential workers or essential employers and how to help healthcare workers be designated as those especially in the home care environment and in the group home environment. And the other is related to more questions about when it is safe to be at work after exposure. I know you have spoken about that but I'm still getting a lot of questions so if you could reiterate some of those.

Dr Tilson:
So the first question how do people get designated as an essential business or essential workforce. This comes into play if we go into a lockdown, but only essential businesses- and I'm hesitating because I have- through the governor's office you can submit a rationale for why you want to be an essential business and I am trying to find the email that can submit the designation. Obviously, we are getting a huge amount of those questions as we go through this conversation of lock down and

include essential businesses and everyone is asking how to become an essential business. If we are sending out written answers than I can get the written answers of that email on how to try to get yourself designated as a essential and then there was a second question which I have now forgotten what was the second part?

Hugh:
It goes to the question of exposed workers and when it's safe for them to be there and when it is not and how to navigate that quarantine. Versus non-testing conundrum.

I might have eluded to that in an earlier response of exposure to healthcare workers and the current guidance including guidance for situations of community transmission where there is acknowledgment that employers make are to have essential workers come back in and do careful self-monitoring and isolation if they develop any symptoms.

We certainly will prioritize healthcare workers and if they have any symptoms we will prioritize them for testing as well.

Hugh:
A real quick tactical thing. Will the documents regarding testing management and isolation be available in Spanish to give to Hispanic patients?

Dr Tilson:
I believe it is already in Spanish and on our website. I thought of that last night as well, so yes.

Hugh:
Have paramedics been considered as providers that can provide telehealth in the patient home? Increasing patients don't want to be transported to the hospital for a variety of reasons and wondering if that is an appropriate and successful strategy being thought about in the future.

Shannon are you on mute? Or do you not know?

Dr Dowler:
I'm sorry I'm multitasking trying to answer people's questions at the same time. Ask that again.

Hugh:
Paramedics - are they going to be eligible for telehealth reimbursement?

Dr Dowler:
We have been working hard on the no transport reimbursement rate and we got to landing it when we discovered that would require authority from the federal government because it was a change in current authority. As we are continuing to push pretty hard to have it so paramedics can go to the home, assess a patient, maybe provide a nebulizer or some basic service that keeps them from having to take the patient to the hospital unnecessarily and still get a payment. So that is a hot topic we are

working on. It does require federal authority and a change in state plans so we are working on asking for permission to do that right now.

Great.

Hugh:
A question, we are expecting testing results to take 10 days to get, will there be rapid results tests available or other ways of expediting test results?

Dr Tilson:
I would say we are getting more and more backlog and so what we want to be sure of, is that we have expedited results especially for high-risk people where we would be doing something different. So this is exactly one reason why we are thinking through, the state lab still has a turnaround within one day. Our commercial lab we know is getting more and more demands so you will see the backlog longer and longer so you need to think about prioritizing to the patient for whom the test results will make a difference, have a higher priority and you said, so you have someone with illness or recovering at home it takes seven days to get the lab test back, your kind of done it is the same thing. So you are seeing a demand in testing with a longer backlog and that is a problem if I prioritize patients or people for whom management is different we won't be able to get the results back. You are absolutely right that is another reason why we are thinking about who needs to be tested and who does not. For the folks with mild illness recovering at home, we don't want them in the backlog we want to be sure priority patients get a turnaround on the test for priority patients so that is exactly one of the reasons.

Hugh:
Shannon I get a number of questions along these lines but can we get telephonic visits paid at the same rate as telemedicine visits for audio and video?

Dr Dowler:
No, right now portal visits and telephonic visits are paid at a lower rate. With the idea that time spent and the intensity of the visit and what you are able to cover is less. Could that change if this ends up being a longer time period? Possibly. We are seeing a ton of flexibility around HIPAA and what is considered compliant technology right now so patients with a smart phone can use FaceTime or other applications and it does not have to be, they don't have to necessarily download an app like they would in some other modalities. So we have seen that elderly patients are often the ones that are suspected of not doing this very well or are having difficulty with technology, they have been responding positively and it is going well.

I heard an anecdotal story of one patient who said why have we not been doing this all along? She liked getting her care that way.

Do providers need to complete PUI forms for patients who are being tested?

Dr Moore:

Apparently I learned from my team I was incorrect, it is needed and I apologize I don't have the right details. It is all in the guidance but that is needed for those submitting to the state laboratory of public health until we change our policy, you know we will try to streamline the submission process but I think it still necessary for those, apologies I am a little behind on those changes. It is all up on the website in the guidance document.

Hugh:
Great. It is almost 6:30 which is the end of our time. A couple observations, we got almost 300 questions so I promise you we did not get to all of your questions, I did my best to try to find general themes and pick questions that reflected general themes. So if I did not get to your specific question I apologize. I want to remind you we will make this webinar and a transcript available. We will make the slide deck available as well.

I want to encourage you to check in on some of the other webinars that are coming up. Go to the AHEC website for more information on those. Lastly, wanted thank our panelists for their diligence, their time, their passion, the great work they're doing for the state of North Carolina. And I want to thank all of you who made time to be here to learn about this new guidance for the work you are doing. **Before we hang up do you have any last words panelists?**

Dr Dowler:
I would just say keep the questions coming. My direction, it's critically important we want to get this right so when we are turning on rapid policies and making changes, there will be glitches and we know that. We are moving at light speed compared to how fast we have normally deployed new policies so get in touch with us and let us know if things are not working.

Dr Tilson:
Yeah, I want to thank you all for participating. I know some of these changes are uncomfortable. I know we are moving fast. I know some things may not seem intuitive but I will assure you that we are thinking through this as thoroughly as we can with the data we have, looking forward as to what we are going to need to do. We are trying to make the best decisions possible to flatten the curve. To protect our healthcare workers, to protect patients and save lives. So I understand especially some of this around not testing people with mild disease makes people uncomfortable and I understand it, I hope you understand the rationale and we are looking forward. Right now testing is not the crisis, we have not hit the crisis yet and we are looking ahead to when we really have a crisis. So I hope you understand that, I hope we have talked through the rationale well and you can be comfortable, we are bringing information to patients even while not testing the patient who will be home in isolation, that should protect people and then help us to have resources when the crisis really does hit. I understand it is uncomfortable and having to pivot but I hope you know we are trained to make the best decisions possible for the health and well-being of North Carolina, that is front and center in our decision-making. Anything else?

Dr Moore:
No, I appreciate everyone's time. I'm sure we will be talking more.

Thank you all very much for all you are doing. Have a nice evening everybody.

[Event concluded]