Navigating the New Normal

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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 are looking at a combination of metrics over the last 14 days.

- COVID-like syndromic cases
- Lab-confirmed cases
- Positive tests as a percentage of total tests
- Hospitalizations

We are also looking at our capacity for testing, tracing and personal protective equipment.
Trends
Trajectory of COVID-like Syndromic Cases

The percent of visits to the Emergency Department for COVID-like illness is **decreasing.**
Trends
Trajectory of Cases

New cases in North Carolina are **slightly increasing**.
The trajectory of positive tests as a percentage of total tests is decreasing.
Trends
Trajectory of Hospitalizations

Hospitalizations are level.
Where We Are Today

**Trends**

- Trajectory of COVID-like syndromic cases
- Trajectory of cases
- Trajectory of positive tests as a percentage of total tests
- Trajectory of hospitalizations

**Capacity**

- Testing
- Contact Tracing
- Personal Protective Equipment
Phase One

Modified Stay At Home order remains in place.
If you leave home, know your Ws:

**WEAR** a cloth face covering.

**WAIT** 6 feet apart. Avoid close contact.

**WASH** your hands often or use hand sanitizer.
Phase One

- Most businesses can open.
- Retail businesses can open at 50% capacity with frequent cleaning and social distancing.
- Parks and Trails are encouraged to re-open.
- Certain businesses (gyms, salons, bars, theaters, etc.) will remain closed.
- Restaurants continue to be take out and delivery only.
- Gatherings still limited to 10 people, but gathering outdoors with friends is allowed.
Phase One

- Employers are still encouraged to telework when possible.

- Childcare centers that follow strict cleaning requirements can open for working parents or those looking for work.

- Worship services of more than 10 people allowed outdoors if socially distanced.

- View more details about Phase One at nc.gov/covid19
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

- Tightened
- Loosen
- Tighten
- Loosen
- Tighten
- Loosen
## 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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<tr>
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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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<tr>
<td></td>
<td>Systematic hygiene routines</td>
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<tr>
<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 combat misinformation</td>
<td>Proactive information dissemination</td>
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<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
**NC MEDICAID COVID CLINICAL RESPONSE**

**PHASE 1**
March 1-15

- Pharmacy: Early Refills
- 90 Day Supply
- Extend Emergency Supply
- Move to preferred if shortages

**PHASE 2**
March 16-31

- Disaster Spa Preparation
- Appendix K Edit and Resubmission, Limited Early Implementation
- 1135 Waiver Submission, Edit and Resubmission, Approval
- 1115 Waiver Submission, Edit and Resubmission, Approval

**PHASE 3**
April 1-30

- Disaster Spa Submission
- 1135 Waiver Implementation
- 1115 Waiver Implementation

**Virtual Health:**
- Reimburse telephonic medical
- Reimburse telephonic therapy and psychiatry

**DME:**
- Remove PA on respiratory supplies
- Remove limits on certain supplies such as gloves, masks, incontinence, etc...

**LTSS:**
- Allow PASSAR to be telephonic
- Allow PACE to implement emergency

**Appendix K:**
- Submit to CMS CAP-C, CAP-DA, TBI, Innovations

**Telehealth:**
- Wave 1: Expansion Medical, Clinical Pharmacy, Psychiatry, Broad policy revision including allowance FOHC/RHC Distinct Site
- Wave 2: Specialized Therapies (PT/OT/ST/ Audiology), Dental
- Wave 3: LEA, CDSA, DM Educators, Dieticians/Lactation, Expand ASD Services

**Other:**
- Add Transport Reimbursement
- Establish COVID Triage Plus Line (CNC/ AHEC)
- Expand Practice Support for Telehealth (CNC/AHEC)

**Virtual Health:**
- Remote Patient Monitoring
- COVID Telephonic Rate differential for Medical
- Pregnancy Risk Screen and Postpartum F/U
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
New Coverage Requests?
Email Medicaid.COVID19@dhhs.nc.gov
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<th>VULNERABLE POPULATIONS</th>
<th>DATA/MAPPING TELEHEALTH UTILIZATION: Kelly Crosbie</th>
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<td>TRANSITIONING AND PRESERVING TELEHEALTH GAINS “The Switch”: Keith McCoy/Dowler</td>
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<td>SUSTAINABILITY AND NEW NORMAL</td>
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Telehealth Provision Opinions: Top 5 to Preserve?

- Telehealth Payment Parity
- Telemedicine
- Telephonic Reimbursement (Parity/Original)
- Telepsychiatry
- MD to MD Consultation

*Informal Snapshot of Early Survey Results from Telehealth Workstream Members to Identify the TOP 5 provisions to consider keeping on after the State of Emergency*
COVID-19 Provider Infrastructure Support Strategy

**Direct to All NC Medical Providers**
Initiate Virtual Care (telephonic and portal)
Deployment of MD to MD Consultation Codes
Cover Broad Telehealth at Parity
COVID Differential Rate Telephonic at ~80% E&M Parity
Retroactive to 3/10/20
Implement Remote Physiologic Monitoring
Creation of Enhanced Hybrid Home-Telehealth Visit
Practice Support through AHEC/CCNC Contracts
COVID Triage Plus Line through CCNC
Hardship Payments for Practices

**Medical Homes**
Interim PMPM Payment adjustment
Pregnancy Medical Home (PMH) Incentive via virtual or telehealth
PMH Obstetrical Care via Telehealth
Open Well Child Care via Telehealth

**Safety Net (FQHC and RHC)**
Allow Distant Site Telehealth
COVID Differential Core Service at 120% for FTF/Telehealth April-June
Allow Virtual and Remote Patient Monitoring Payments at FFS

**ADDITIONAL RESOURCES:**
Free Telehealth Platforms w/ CCNC/NCMS
Additional Telehealth Training ORH
HRSA Payments to FQHCs
CARES Act Funding
Medicare Prepayment Program
Uninsured COVID Payments (HRSA)
HHS Launches COVID-19 Uninsured

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.
1. Effectively reach the population to provide COVID related education and guidance. (Michelle Laws/Jacquelyn Clymore)
   
   TACTIC 1: Create patient facing culturally competent content in multiple languages.
   TACTIC 2: Identify lay leaders and influencers to partner to share critical messages with “hard to reach” populations.
   TACTIC 3: Utilize a variety of venues/platforms in which to communicate and engage (TV, radio, newspaper, website, social media, virtual townhalls, etc...)
   TACTIC 4: Recognize need for spiritual connection for health and wellness and encourage alternate worship opportunities.

2. Connect people to medical and behavioral care providers regardless of ability to pay. (Jeremy Collins, Debra Farrington)
   
   TACTIC 1: Offering testing sites for underserved communities and medically disconnected people to create a medical home relationship with an FQHC or other healthcare provider.
   TACTIC 2: Identifying resources to expand coverage for COVID specific care (federal waiver, legislation, etc...).
   TACTIC 3: Expanding virtual and telehealth services and uptake for chronic disease management and prevention (i.e. smoking cessation, stress mgmt, etc...).
   TACTIC 4: Recognizing testing bias and creating resources to educate healthcare providers to minimize unintentional bias effect.

3. Link people to needed resources to address social determinants of health. (Debra Farrington, Cornell Wright)
   
   TACTIC 1: Partner for housing and quarantine resources with FEMA.
   TACTIC 2: Identify and link to food resources for people experiencing food scarcity (seniors, children, etc...)
   TACTIC 3: Unemployment support for out-of-work individuals, long recovery from hospitalization, etc...
   TACTIC 4: Provision of medical, pharmacy and other needed supplies.
   TACTIC 5: Connect to transportation resources.

4. Protect Essential and Front Line Workers from intimidation, exposure to COVID, all while honoring worker rights. (Shannon Dowler, Michelle Laws)
   
   TACTIC 1: Engage state and local leadership to enforce best practices related to COVID prevention and care to include timely testing, paid sick leave, etc...
   TACTIC 2: Engage local business community to support outbreak management in community businesses.
   TACTIC 3: Respond rapidly to address urgent needs for economic and social supports.
Modeling COVID-19 in North Carolina: Update for the North Carolina Medical Society

Aaron McKethan, PhD
Senior Policy Fellow, Margolis Center for Health Policy, Duke University
Adjunct Professor, Duke University School of Medicine
CEO, NoviSci, Inc.

May 6, 2020
Key Parameters

- April 4 model (brief published April 6)
  Composite “weather forecast” of three models evaluating hospital capacity under “maintain” and “lift” scenarios
  - What is the probability demand will exceed hospital supply?
  - 25x multiplier for known cases
  - 4.4% hospitalization
    - 30% require ICU
    - 14-day length of stay.
  - Scenario 1 (“Maintain”)
    - samples approximated $R_0$ between 1.3 and 2.5
  - Scenario 2 (“Lift”)
    - samples approximated $R_0$ between 2.5 and 3.0 after the end of April

- April 22 model (brief published April 28)
  “Uncertainty analysis” varying key parameters of one of the models from the prior forecast.
  - How many total infections?
  - How many people require hospitalization?
  - 10x multiplier for known cases
  - 2.2% hospitalization
    - 30% require ICU
    - 14-day length of stay.
  - Simulation 1 (Blue)
    - Sampled $R_e$ between 0.9 and 1.3
  - Simulation 2 (Yellow)
    - Sampled $R_e$ between 1.3 and 2.0
  - Simulation 3 (Red)
    - Sampled $R_e$ between 2.0 and 2.5
Composite Estimates Across 3 Models (April 6)
Estimated Cumulative Infections (reported + unreported) for 3 Scenarios (April 28)

Models assuming 10x (#cases / #diagnosed) multiplier.
Acute Bed Demand Estimates for 3 Scenarios (April 28)

Number of North Carolinians

Date

Models assuming 10x (#cases / #diagnosed) multiplier. Thick black line = current estimated capacity.
ICU Bed Demand Estimates for 3 Scenarios (April 28)

Models assuming 10x (#cases / #diagnosed) multiplier. Thick black line = current estimated capacity.
Key Take-aways

- We will likely begin the month of May with lower-than-expected viral spread.
- We have immediate and near-term hospital capacity available.
- The announced gradual reopening plan is a phased approach.
- Despite these notes of near-term optimism, it is very important to avoid a sense of complacency about the potential impact of COVID-19.
- As the state continues to expand the scale of its public health response (e.g., testing, contact tracing, etc.), we must continue to monitor short-term COVID-19 trends and act quickly to mitigate rapid upswings.