As we were not able to answer all your questions during the webinar, we have compiled responses to all unanswered questions. If you have any further questions, comments, or concerns, please email Covid19bulletin@hawaiipacifichealth.org.

TESTING:

- Q: Given all of the limitations of COVID-19 antibody testing (false positive rate, +test does not mean immunity, etc.), Shouldn't there be an informed consent process for patients? It has significant potential for harm if the patient does not understand what is safe or use the information to justify not following social distancing, etc. thus exposing themselves and others (Example: Patient thinks they are immune because they had a positive antibody test).
- A: If I were ordering this test for individual patients, I would certainly want them to know the limitations, and would make sure I discussed it with them.

- Q: We are keeping everyone with a cold at home. Do you want us to start testing them now?
- A: We have seen such a decrease in respiratory viral illness with all of the physical distancing, mask wearing and attention to hand hygiene that we are in a good place to test if needed. Not sure I would do that unless there is a useful consequence to knowing the result.

- Q: Please speak to COVID-19 testing needed for prior to elective procedures and clarify that urgent/emergent procedures does not need to wait for COVID-19 testing result.
- A: We have expanded our testing prior to elective procedures, and other urgent and emergent cases too. The biggest concern is that an interpretation will then be made that results must be back before appropriate care has been provided. This is not the case, especially in light of the very low incidence of COVID-19 disease activity in our community currently. If it is safe to wait for results, ok to do so; If not safe, don't wait.

- Q: Will we require elective procedure patients to self-isolate between COVID-19 testing and their procedure?
- A: No, we do not require self-isolation between COVID-19 testing and patient's procedures.

- Q: I think Singapore tests travelers with spit testing. Is that reliable and would that be considered (for employees/travelers)? Or pooled initial testing?
- A: Several reports have indicated that saliva has detectable SARS-CoV-2 and might be a viable alternative to nasopharyngeal swabbing. The viral shedding appears to decrease with the passing of day's post-symptom onset, as it is for nasopharyngeal swabbing. Therefore, the timing of sample acquisition is important. The lab is currently attempting to validate the testing of saliva.

  Pooling of samples has been considered, especially as this makes sense with low disease prevalence and increased test volumes. However, there are several issues involving pooling that needs to be addressed (such as the potential sample dilutional effect causing loss of sensitivity, logistical issues involving the coupling and decoupling of specimens, etc.). As the current testing volume is manageable, the lab will table sample pooling for now to avoid the potential disadvantages. However, the lab will re-consider sample pooling should the need arises.

PPE:

- Q: Please provide an update on PPE supplies, specifically CAPR face shields which are currently being wiped and re-used repeatedly. Can we expect to get to single use on items such as this, or other re-used items such as the N95 masks?
- A: We do have a supply of CAPR lenses that are used for a day/shift and then discarded. We also have added to the stock of the ones that can be wiped down and re-used. If there are any in use that should be swapped out, please feel free to do so. The supply chain worldwide for all of these items is still tenuous, so we decided not to change our re-use protocols at this time. We see increased COVID-19 incidence as likely in the coming months and want to be in a good position to deal with that.

TREATMENT:

- Q: Do you recommend Heparin SQ/Lovenox daily/BID for DVT prophylaxis for nursing home/SNF patients?
- A: I would strongly consider using prophylactic Lovenox once daily for non-hospitalized patients at SNF/nursing home with active COVD-19 or recently discharged from hospital with COVID-19 infection (up to 30 days post-hospitalization). Probably not worth BID dosing of Lovenox if patient is not hospitalized.

IT:

- Q: Last week you said it's possible to do a Medicare Wellness Exam and that you ran it through legal dept. However, part of the Medicare Wellness exam requires actually giving the patient a recommended screening schedule to the patient. How do you recommend this occur for the Wellness Exam?
- A: If it's for an initial Annual Wellness Visit, (G0438), this schedule can be documented in various ways within EPIC (or other EMR) and can be shared with the patient verbally, followed by sending that screening schedule to the patient electronically (email, fax), through a patient portal (MyChart) or even mailed. For a subsequent Annual Wellness Visit (G0438), the screening schedule is likely established and can simply be reviewed/updated and reiterated with the patient. It can also be shared similar to the initial AWV.

- Q: Can we get Doxy.Me for outpatient use for General Peds?
- A: Yes, it is already available for all HPH employed physicians. Health advantage Connect providers can contact their support team for setup.

- Q: Is there a reason you expect everyone to use Doxy.me but the specialists get to choose whether to participate in e-consults?
- A: This is incorrect, we expect all HPHMG members who have an outpatient practice to be on doxy.me and would like everyone to participate in e-consults as we develop those services with IT and as clinicians.

HPH:

- Q: Our waiting room and clinic areas pre-COVID-19 were insufficient for the number of physicians and patients seen. With adequate social distancing even getting back to 35% of our pre-COVID-19 level will be a challenge. With the limitation in efficiency of Telehealth visits reaching our pre-COVID-19 productivity (RVU) will be a challenge. The question then is, how will the HPH medical group value services provided by its physicians especially the specialists?
- A: Please discuss your specific clinic difficulties with your clinic leadership to work through this as every clinic is different and it's important that at the local level these issues are addressed. Globally, HPH is looking at alternative locations/means to obtain vitals and patient waiting. At this time, we expect all providers to use alternative visits where appropriate (telephone and video visits). Our focus should be how we can continue to provide for our patients' needs now and in the future in the safest clinically appropriate manner.

- Q: Can we please talk about physician compensation during this pandemic period? Can someone provide more details how physicians will be compensated starting this month and going into the future please?
- A: For all HPH employed providers, we will be continuing pay through May as communicated in Ray's message throughout the system and we will continually be assessing this and communicating on this front. We intend to continue to pay all employees who are doing the things are that the organization needs. We expect our providers to continue to meet the clinical needs of their patients as best they can, given the circumstances, including working in alternative clinics and Surgicare Hawaiʻi, adopting video and telephone visits where appropriate, and helping develop clinical pathways for our patients to facilitate e-consults.

- Q: Post pandemic, can you discuss where telehealth will be and how we can integrate into our practice?
- A: Telehealth allows patients to stay connected to their doctor when it is difficult to physically visit, and patients have responded with great appreciation for our implementation of it during the pandemic. Whether the crisis lasts 6 more months or 6 more years, Telehealth will remain an essential tool for providing timely, safe and convenient care. It will be continue to be used widely and many patients will expect it as an option.

  The HHP Webinars have provided great updates on technical and coding information for Telehealth. Currently HPH is working on plans to support telemedicine delivery with Pre-Testing sites that can collect vital signs along with other tests prior to scheduled Telehealth visits.

  Providers are finding telemedicine very useful to conduct a wide variety of visits, but practices should integrate email, telephone and video visits only where clinically appropriate. It cannot be used for every patient or every clinical scenario. Therefore, we need to refine our skills at not only delivering care through different modes, but recognizing which type of care is most appropriate for a given situation.

- Q: Why are we going to do in-person visit only for 50%? Is it more efficient/productive, more profits, higher pay (for the hospital), or is it because COVID-19 will still be there?
- A: I would turn this question around to say that we are planning to utilize telemedicine for approximately 50% of our patient visits. Telehealth (video visits) was adopted by HPH as a strategy during the COVID-19 pandemic to provide the best possible care during a time of great uncertainty. It remains a cornerstone for our HPH strategy moving forward because of a number of reasons:
    1) It is a safe way for patients and providers to communicate, especially because we expect future COVID-19 activity in our community until there is an effective vaccine.
    2) The quality-of-care with video telehealth visits is comparable to face-to-face visits and better than telephone visits in many specialty areas.
    3) Patients seem to like it due to convenience and safety.
    4) Many of our patients are reluctant to come to the hospital/clinics at this time due to fear of COVID-19.
    5) State law guarantees payment parity between face to face visits and video telehealth visits going back several years (with commercial and Medicaid insurance). Medicare rules have also allowed payment parity recently during the pandemic. Similar rules changes have recently accounted for better reimbursement for telephone visits as well, but this may not last long after the pandemic.

Video telehealth visits are not appropriate for all clinical situations. However, because it is effective in most situations, and safe for patient and provider, and because patients like it, we believe telehealth is here to stay. It is ONE important tool in our toolkit of ways to engage our patients effectively.