

Transcript for Telehealth Best Practices: Sharing practical ideas during the COVID-19 pandemic, NC
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Presenters:

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Lakeisha Moore:

Good afternoon and welcome. Thank you for joining us today for the telehealth virtual office hours webinar series. I am Lakeisha Moore with the Office of Rural Health (ORH), and I am joined today by Dr. John Jenkins of the Greensboro area health education center (AHEC), and Kim Schwartz and Jennifer Cobb at the Roanoke Chowan Community Health Center. We also have Robin McArdle, office of rural telehealth specialist, on the line with us today. During today's webinar we will share telehealth best practices across the state. If you like to ask a question, please type in the question by clicking on the Q&A icon that you see on the screen. Type your question into the zoom Q&A box and we will work to answer as many questions as we can. If you need assistance during the webinar, please email technicalassistanceCOVID19@gmail.com and someone will assist you.

We also want to send out a very special welcome for the safety net sites that are joining us from across the state. Thank you for the FQHCs, free and charitable clinics and health department and critical access and small rural hospitals. School-based health centers are out there with telehealth as well, so a special welcome to all of you today. We are very excited to share telehealth best practices we have seen across the state amid the COVID-19 pandemic. We hope you can adopt some of these practices into your organization and work.

Last week we kicked off this virtual office hour series on how to get started with telehealth and went over common telehealth definitions and also telehealth billing tips. Last week's webinar recording is available on the AHEC websites for your reference. This week, Ryan Wilkins from AHEC will start off sharing information on how to have continuing medical education (CME) for this webinar. Then, Dr. Jenkins will share telehealth best practices that he has observed virtually this week, followed by our friends Kim Schwartz and Jen Cobb at RHCCHC. Robin will be monitoring the Q&A section for your questions.

Also some quick housekeeping items, the webinar is being recorded and will be available on the websites with slides. If we are unable to answer questions during the session today, we will consider questions for future telehealth webinar topics, so we do appreciate questions you send in. Right now I will turn it over to Ryan, who will share with us how we receive CME for today's presentation.

Ryan Wilkins:

Hello everyone. To obtain CME credit you must have a myAhec account with an updated cell phone number listed and if you do not have an account or cell phone number associated with your existing account, you will be prompted to create or update the information once the registration is complete. To register for today's webinar, please text C7D46 to cell phone number 336-793-9317. Both code and phone number are listed on the current slide. For additional instructions on how to register using text registration system, please visit www.nwahec.org/textreg, as shown on the slide.

This information will be displayed again at the end of today's presentation. Next slide, please.

The continuing education for this program is being provided by Area L AHEC in partnership with the office of rural health and the NC AHEC program office, Northwest AHEC in Greensboro. Specific credit information is listed on the slide. Back to you, Lakeisha.

Lakeisha Moore:

Thank you Ryan. Now, I would like to introduce you to Dr. Jenkins, who started the Center for Connected Care at Cone Health in Greensboro, NC, for their virtual visit strategy. Good afternoon Dr. Jenkins.

John Jenkins:

Good afternoon Lakisha. So glad to be joining our partners to give the best care possible to our North Carolina citizens. As we enter the most worst week in the pandemic, I really found myself focusing on the incredible work done by providers and clinic staff in our state. There is remarkable work being done. So today is part sharing, and part celebrating. My mom once told me, look up from what is happening right now and I asked her why. She says because you have to look up to see what is waiting for you in the future. I am hoping good things are waiting for us in the future as we connect with patients both about COVID-19 and about their medical problems.

Our shared goals for today, we want to leverage the virtual visits for COVID-19 screenings, for acute issues and for chronic follow-up. We want to keep our patients safe during pandemic. The four pillars of that work are clear online information and guidance, proactive conversion of routine follow-ups to virtual visits, offering virtual visits for simple acute issues, practice management of our at risk patients.

I want to take you through the best practices that I saw over the last week. One was at Caswell Medicine Center. What they created was a wonderful telehealth page as part of the web to be able to introduce patients to the why, how and what of telehealth. There's something called the Golden circle and it's in advertising. It tells us how we convince people that they need to do a certain task. We are guided to start with the why then how and then finally, get to the what. Caswell has done an exceptional job in doing this. There's a clear statement of why on their webpage: "this visit is secure, we want you to be safe during the COVID-19 pandemic". Then they used FAQ or frequently asked questions approach. They answered how. They answered cost. They talked about technology that might be needed for you to perform the visit. They told you if it all possible your provider would perform the visit and they also said, if you need a face-to-face visit and it is appropriate and agreed to by your provider, we can still come to the office. They were accepting new patients and stated that. Then talked about other services they offered including behavioral health. Finally, if you recall from last week they had the best practice of putting a number on the webpage that you could call and a person who answered that was trained in the virtual visit to understand how they might help assist you to be able to complete a visit.

Carolina Pediatrics has a great pediatric front door. The why is on the page before this, but afterwards there's a how and talking about a calm setting that is well lit for the child and talking about using smart phone because that is the best way for them to complete the visit. The tools for the visit such as a thermometer or flashlight, so you can see down in the throat. And expectations: the doctor may ask you to participate in the examination and actually do some palpation and help the doctor to figure out exactly what's wrong with the child. The last thing they put on the site was don't be afraid to ask questions.

And Eagle Physicians, I saw some really great practices in place. They were promoting virtual visits with every patient. And they talked about telehealth as being an option for clients on their patient portal, practice newsletter, email, social media pages. When a client called to book or especially when the client called to reschedule an appointment because they had fear about COVID-19, they offered telehealth as an alternative. They redeployed team members because foot traffic was low, so check in and check out personnel were now trained in telehealth support roles. They documented the visit in a standard office note rather than special telehealth note, because of CMS billing rules, that these visits would have parity with our brick and mortar visits. It's a really clever creative solution where the freedom to innovate is with providers. Their portal had a visit link in it but it was a little bit clunky and some of the providers found it too hard to use. They gave the providers the freedom to use free modalities and other modalities to connect with their patients.

For new patients, team members guided new patients through a quick registration process so that they can complete a visit. Then helped them to have the tools to meet with a provider virtually. And the fear of flying. A lot of our patients are scared right now since it is the worst week of the pandemic. So patients expressed concern about coming in for routine lab work and they allayed those fears by setting up an outside lab office

in an adjacent office that they stated to the patients was safe and free of any COVID-19 traffic. The result: after putting the practices in one week, all the Eagle providers are up to an average of 12 virtual visits per provider.

Then I did an interview with Dr. Hunter, a successful provider. He is a graduate of one of our AHEC residency programs and working in a multi-provider site called Bauer healthcare in Greensboro. He set personal goals that were pretty aggressive. He wants to get back to the pre-COVID 19 levels. He experimented with a couple different platforms and found one that he is using now called Doxy me, that allows him to text a link or email a link to patients, where there is a waiting room he can get the patient out of virtually. He uses the medium to the best advantage. He communicates well and remember last week we talked about eye contact and wearing appropriate clothes and having a great background that does not distract the patient. He does that exceptionally well. I know because I am his patient. Interestingly, he was able to lead a patient through the diagnosis of acute appendicitis by having the parent do the palpation of the abdomen and noticed the radiation of the pain as well as location of the pain via camera. That patient was sent for an ultrasound and that day had successful urgent surgery with the removal of the appendix. He states the biggest barriers working with older patients sometimes technology that is challenging to them, so he found if he gets a hold of the son or daughter or even grandchild to go over to their house and help them with technology that it sometimes breaking down the barrier.

The key component to the success, remember: routing the patient calls to telephonic and telehealth, that is really key. We recommend that you provide a script to the team members that the virtual visits are safe and secure and an option that you endorse. Never deny the patient because you don't want to be promoting something when denying something because it creates friction with the patient. Create a process to sign the patient up for the portal, or any application you may be using. Publish the FAQs and know the platform: is there a download and do they have to turn on the microphone and camera before they have a visit? Do they need help from a family member?

Some operational pearls and resources. These are key things we learned from our calls. One was setting up a separate workflow for COVID-19 concerns. I saw this best practice at High Point where they had an acute pulmonary clinic. In that case people with COVID-19 concerns or cough or upper respiratory symptoms were triaged, given appropriate information whether or not they were likely to have COVID-19 or not, given appropriate care plans and referred as necessary if they were high risk patients. This kept the flow of COVID-19 questions out of the office and to concentrate on acute non-COVID-19 issues and maintenance issues like hypertension hyperlipidemia, diabetes. All of the things that people need refills of medications and appropriate periodic monitoring to make sure they are doing well. And especially in this time when we are eating foods we normally don't eat and maybe not getting the exercise we need to get.

This COVID-19 clinic could be staffed by an RN or ABP, it is highly protocol based and provides primarily a triage function that we talked about last week. The thing that the Eagle lab had done was also done with [inaudible] internal medicine, which was setting up a safe site to keep patients away from exposure and give them confidence to get labs done and converting walk-ins to virtual. So if someone walked in they gave them the tools to convert that to virtual symptom back out and let them have a virtual visit, especially new patients coming in that we didn't want to put at risk. And involving caregivers in the exam is also important.

We have also given resources on this slide. These resources will help you see what NC DHHS has provided. And the North Carolina health education centers as well as community care and NC medical society. You will be able to click on those when you get the link and be able to read a little bit about things that are provided by both community care of North Carolina and North Carolina medical society which are free links to free services for you to initiate telehealth if you have not been able to.

So today we are ready for the case study. I am excited to share this with you. I will turn it back to Lakisha to introduce the wonderful ladies that will tell us about what is going on at Roanoke Chowan.

Lakeisha Moore:

Thank you so much, Dr. Jenkins. Yes, we are excited to be joined by our friends Kim Schwartz the CEO and Jen Cobb, the revenue cycle manager and telehealth coordinator at Roanoke Chowan Community Health Center. Welcome Kim and Jen.

Kim Schwartz:

Thank you Lakeisha. Can you can hear me okay?

Lakeisha Moore:

Yes, thanks.

Kim Schwartz:

Great. So you can keep moving that slide along for me and Jen. So Roanoke Chowan Community Health Center is located in eastern North Carolina, so just below the Virginia border and Norfolk, Hampton Roads area. We are commonly known as abroad and I think folks that know us, we have a lot of swamps and bodies of water, and few people. We are definitely a rural area, and that has been one of the major challenges. Next slide.

We have had this motto for a long time of fall forward and learn fast. We are a small organization. We have six sites and 170 employees and about 20,000 patients. In the relative, we are not a big health system but we able to be nimble and to be able to manage quickly and make decisions and so we work closely with the PDSA model of rock 'n roll: okay guys, that didn't work, let's try something new. And that is what we started with March 16 when we started a reduction significant that day in patient visits. Next slide.

And we have been fortunate that we had a telehealth culture since 2006. We were the first community health Center to establish remote patient monitoring telehealth. We have been the recipient of multiple grants, and our major grants have been two HRSA, national telehealth grants.

I came from New Mexico where telehealth reciprocity has been open over 20 years. And there's a behavioral health provider. I saw my patients at a portal located at the VA, and my psychiatrist is located in New York City. When we moved to North Carolina, it was something that we did early on was recognize many of the folks could not get to us but had chronic disease. How can we manage and get them in sooner and quicker, and do it in an affordable way. We established our chronic care management remote patient monitoring program. Currently we monitor around 80 patients and will be advancing that out more. Just as aside, as an FQAC we are eligible to be paid for remote patient monitoring and can get paid through chronic care management through Medicare only. That's part of the reason we been doing it for a long time but why we have not used it with many patients, current patients are using it with ACO, we have been part of the ACO in some type or another for about four years. That has actually has worked out well because they are identified through the nurse case management. We advance this to Medicaid program as well. Then our COVID-19 patients.

A little bit about us, recognizing what is happening. On March 24th, we did a rapid forward movement on the telehealth visits. We are an epic based health center controlled network through OCHIN based out of Portland Oregon and has about 120 FQHCs. We have been using MyChart and epic base for almost 6 years. We have had the portal for quite some time but as you see on the front there prior to COVID-19, we had about a 30% MyChart usage. On March 24 we started the patient must opt out of the chart. One of the things we did was turn off automated appointment reminders that we heard from another collaborative member to do right away. We began a workflow for front desk and created scripts for all phone visit change. On Monday night, on March 23 we made the decision to convert all scheduled visits to phone visit on March 24 so we dove in 100%. Those were not visits that were walk-ins or urgent visits, but all scheduled visits. So the week prior to that, we had a below 50% productivity by week's end. But on March 24, literally the first day that we converted to phone visits, we boosted our productivity by 30%. And we have been consistently at 75% productivity since then. We still are seeing in person visits and similar to the other folks that were mentioned earlier by case-by-case, still encouraging that folks do a virtual or phone visit and we have an

isolated area for all respiratory or any COVID-19 related and that was also a medical MacGyver that we built a wall and door to one of our sections as an outside entrance within the first week to do that as well.

The phone visits were not that difficult to convert through the electronic system. But we need to be sure that everybody knew what we were doing. So we had all user meetings by huddles, we created workflows and scripts with the teams right away and using motivational interviewing style, this is how we can see you. One of our seasoned providers the day that we did all the training the week before said, I don't see people this way and Jen in her diplomatic way said, is it this until the only way you can work and they see you, don't you want to know how? And she said, oh, yes I do.

We did trainings on phone etiquette for the clinical staff. There we talked about being an active listener and focus on the speaker and try not to interrupt and avoid talking to someone else. Keep your mind on the issue being discussed and having good phone manners. Remember it's different and speak slower and more clearly. Just the gentle things and reminders for phone etiquette. Ask permission before putting someone on hold and let them know what's going on and be cautious around who is around and who can hear you. One thing I thought was interesting was: never hang up first, asked the patient to do that. That is an interesting and good guidance. Stay calm and polite even if a patient gets frustrated and rude. The script for the phone visit because we were concerned at the time at the very beginning of the crisis we were hearing all co-pays were eliminated, but we want to be sure we communicate to the patients that at this time we use the script and so you are aware you will be billed for the visit, and that you may have a co-pay. We want to make sure the patients knew and clarified it clearly over the phone.

And one of the things we want to be clear about in the community was what was happening. We are small communities in eastern North Carolina and word spreads fast, so we contacted the local newspaper and said do we have a story for you. The story focuses on how we changed and what we did and how we did it and why. Just exactly what was mentioned earlier. One of the features is our doctor who has been practicing for 61 years, Dr Charles Sawyer, 87 years old, a very good panel and under 1% no show rate. He was ready to see his patients and he is quoted all through the article about how wonderful it is for patients to be able to have that option and last week he also converted some of his visits to video visits. You can click on the link and we have lots of promotional videos around what we have done historically with remote patient monitoring and have been featured all over the country on WUNC and national association of community health centers and we are recipients of BD Building health and communities award. They did a beautiful video on remote patient monitoring and how to connect to your patients. We have a lot of that going on.

And the community promotion video, that is in process, that was effective and went into a launch on the website and our Facebook page to communicate to our patients how and why what we are doing.

On March 27, we fast-tracked activation of virtual visits, utilizing our patient portal. We turned that on Friday, March 27th and activated everyone the following Monday. We started one-on-one provider team training support using a test patient, so we updated the front desk script to identify patients with connectivity to support that virtual visit, which was really essential. That was confusing, we were able to activate something that would probably take three to six months to do and we did that in one afternoon. As you can imagine, there was confusion, but they dove right in.

One thing we want to be clear with communicating to providers is who can have a video visit, and what we want to focus on is anyone who would have an in person visit. That would make it clear this wasn't a substitute, but actually an in person type visit as mentioned earlier. One of the things we want to be careful about is that these were intentional visits. We have a behavioral health full activated program and integrated as well and the behavioral health team got in and activated the case management, rather than once a month calls and contacts. They have been doing once a month contacts as well. We had the question: if you can do it by video, why not by phone? We want to be clear that the video visit substitutes for the in person encounter and not for phone calls. We still need to be able to use the phone and have phone visits but because of where we are at, it is tricky. We want to be sure the team understands that the idea would be the virtual visit and then phone visit if that did not work. We really didn't want the one substituting for the other,

but we have folks that aren't able to access to the broadband issue and connectivity. We had to work hard in clarifying that.

Our clinical support staff are performing their normal duties. As you can imagine, everyone was concerned about how we get to the patient. I will tell you there was a collective sigh on March 24 because that was everyone's anxiety, how are we going to see our people. As soon as it activated and we got up to 70%, people did a collective [sigh], okay now we know how to reach them and get them.

We have the front desk calling and reminding, and we activated last week that the front desk will contact for a virtual visit and they can activate within 24 hours. They literally contact the patient 24 hours ahead of time and obtain consent, and have the patient walk-through and test portal. They want to be careful about that to be able to ensure the patient is ready to do that for the next day when they get to see the provider.

One of the things we give guidance on for clinical staff is creating the atmosphere of the regular visit. So if you really usually wear a stethoscope and white jacket then do that. Look like you normally look to the patient in a regular visit. Be aware of the surroundings and what you look like on camera and what's behind you. I don't know about you but we are doing family check ins on zoom and make sure to have the light in front so the window in front and not behind. Then the other thing we've been careful is to remember to protect patient privacy. Although how we can reach patients has been relaxed, HIPAA has not been relaxed and we have to be diligent about protecting the patient's particular issue and closing doors. We have signs when they are in the clinic and have sent out signs for people to print and those who work in remote as well.

One of the things that we had for a long time is pre-visit planning. We activated that aggressively. The front staff are doing outreach directly to the patients. They are educating on how to use the portal, confirming the appointment, and walking through the check in process if they need to. As I mentioned earlier, check in is 24 hours ahead of time. If the patient has logged on, we can all see that within 15 minutes. We prompt and contact the patient, either text or call and see if there is any barrier. We had have some no shows, even confirming the day before and we are doing a PDSA on that right now, and check-in with the provider what are the issues that we are hearing about that. Our patient satisfaction survey contractor has already activated this week a questionnaire that is specific to whether it was a phone visit or my chart visit or in person visit, so we are sure to find more information around that.

Another key from other folks is verifying the phone number in case the video link is dropped, and so the provider can call the patient and get the link back on. We actually have had some disruption in services and we are trying to check on how long it would take and we do have a question out there with how long they have a video link in case it has been dropped and finished by phone. But I asked the providers not to worry so much and we try to say just keep the connection with the patient. That is the most important thing.

So during the visit, you will see a picture there of one of my all-time favorite people in the world, Dr. Julian Taylor, who is a seasoned provider and has been with us for a long time. He's not smiling there but he smiles on the video link. Smile when you are on the camera. You just made your patients last much better by saving them a trip out, and you know that's one of our main goals to flatten the curve and keeping patients safe, especially our most vulnerable patients. One thing to remind your staff is who is also present and that is an important component around that. We have a proxy component in our MyChart portal and that has been a bit confusing and working on workflows on that, so if you see a child under 12 you have to activate my chart message through proxy component and the same thing with family members as well. Some of the connectivity components have been relaxed, but once they are in my chart they are in my chart and registered, so we are working on workflow and met this morning around that. When we had the first check-in call, we went live on the 24th and that evening we had a check-in call with our providers and Dr. Taylor got on and said that it has gone so well. He got a little emotional and he said hearing what some of his patients said that made him so glad that we have this option. People were so relieved that they were not disconnected from their primary care provider. And over and over again we are hearing this from provider teams that the patients are so grateful. There has just been one or two that said I need to see you and I insist and the

guidance earlier, we try to do that in a safe environment in a way for them to not have exposure to any COVID-19 related visits as well. We do have isolated areas.

Some things that providers have said is to remember to compliment your patients. This is the first time they have done something like this, too, with the provider. I will tell you a lot of businesses are doing this and this is the first time they have done something so personal as a doctor visit this way. Remember we are asking them to help us out as well, and remembering to do that.

The documentation that is required for telephone encounters are below. So remember that providers must document the following in the note: that the visit occurred by telemedicine, the physical location of the patient, the physical location of the provider, and any names of people that are participating in the call. This will get corrected when we start doing telemedicine as a routine way of doing business, and I say that to those working on the state and national level but some things automatically happen and when things go back to having open resources.

For billing purposes we instruct providers on how they use the coding of the 99441-3 phone consults. So any payer-specific modifications are made by the HER in claims processing. COVID crisis coding are the exception, and I think everyone has gotten good guidance on what is COVID related. For telehealth, utilizing your regular E/M codes and what we decided to do was train everyone like it is going to be going forward and not the exception during the crisis. We can modify that behind the scenes. On the virtual visit, it is a routine E/M code. There's some really good guidance on that on the Mid-Atlantic Telehealth Resource Center Site. Robin, in fact, is a member of that board. I didn't list that in there but we can put it in afterwards, it's www.matrc.org. There are other good links in there and toolkits. One of the toolkits of that we were part of drafting for the remote patient is on the front page. If you want to use it as well.

Currently as you see this person with her head down and praying, this is Jen's picture. We are holding claims for all payers at this moment in time. We got guidance from the national association of community health centers and the bureau of primary healthcare to hold our claims, because that is literally changing every other day of how they are going to change those. We have been in contact with our third party vendors. And Medicaid we had a call with them on Friday and we've been anxious about sending things and getting them back as denials, and we don't want to double work on that. We are currently holding everything and we can afford to do that for another two weeks, then we will have to let things drop. We are in day-to-day conversations around that and because we want to really do it right and get it right, and not have denials and manage all that. I know folks that are concerned with cash on hand, that is very much a concern for all of us.

What we did was also activate an aggressive panel management on the 27th. We had a conversation with the Bureau of primary healthcare and they were saying to us, please be sure you are staying in contact especially with sliding fee patients and so we pulled that panel of patients. We have about 1300 of those folks and we devised a process for the higher risk which is basically those hospitalized in the last 90 days. Then we worked down from that and currently contacting all those patients that we can and get them in for a visit and since they are sliding fee, that is waived currently on all co-pays. We just want to get those folks in so there's not any billing barriers and so we are just trying to make contact whether virtual or phone visits. We have activated panel management program for chronic disease management, and our priority was diabetes and hypertension management. We have been doing that as a PDSA since October or November and have a plan for that and activating that forward, along with COVID-19 high risk patients. So we are pulling reports and training teams because we feel the case managers can do that like we did for the sliding fee patients but it's better if they hear directly from the provider team. Then we learned also, as you probably know, that if the provider prompts listens as Dr. Taylor would like to see you and schedule a visit he is concerned because of the condition and the situation that is in front of us, he wants to check in with you. So that the language that we are doing. Trying to be careful about not scaring the patient but it's good to check in and we have had nice responses on that.

So our future plans. I literally got a text before I went on the phone with you. We are already testing with you right now in the parking lot, I can look out my window and see it happening. We have about 35 kindle

fires that we purchased through a previous grant. We have two spots that we didn't have to activate a higher hotspot, our current guest link works in front of our windows. We have activated the Kindle fires to download mychart and portal for the patient. We have started a testing and workflow that as CNA goes out, they have PPE and can hand the Kindle fire off to the patient and give guidance on that. We hope it is a component for us and we can get vitals while they are in the parking lot as well. We do have blood pressure cuffs from previous grants with remote patient monitoring and activating out this week as well and as well as the remote patient monitoring program and equipment. We normally go in the home to enroll a patient as our current process, but our vendor in California that we work with for almost 14 years will be able to ship from the California base and the patient can have it in about one week. Ipads are preferred equipment but we are repurposing what we have because we cannot order the new iPads due to backlog from vendors. We are maximizing, we hope to maximize my chart tools as well which you will be able to do [Inaudible] and social determinants of health. All the things you would do as a safety net providers, and specific screenings for chronic disease. Those are some of our future plans, which the future is probably tomorrow.

So the last one as we take a deep breath. I think I mentioned earlier, I am a psychotherapist by training and facilitator for the Center for Courage and Renewal. One of the components we talk about all the time is if you know your WHY, you can bear any HOW. And that comes from a beautiful quote by Victor Frankl who lives in the internment camps and talked about his why, which was to see his family when he got out and that was the vision he kept in his mind. So keeping the vision in mind of what we want for the patients and families and friends and neighbors is to stay connected no matter if we keep the physical distancing, but we still have a connection and are able to keep calm and carry on and keep focus. That is us today. So grateful for the opportunity to share with everyone.

Lakeisha Moore:

Thank you so much for sharing, Kim and Jen. I know it has been evolving quickly.

I do see we have questions about logistics things so we will get to those in a minute. Just a reminder for everyone if you do have questions please use the Q&A function to submit questions. I saw where someone had their hand raised and we don't have the audio enabled for the participants because there are many participants on the call today. But we love to receive the question via Q&A function. I do see questions coming in now, and we will definitely get to those in a minute.

I did also want to do a quick reminder again about the opportunity to receive CME credit for today's webinar. You are able to receive credit for today's webinar if you'd like. Just made sure you have a My AHEC account with the cell phone number updated and visit www.nwahec.org/textreg and we will get you set up if you like to get CME for today webinar. With that, I will turn it over to Robin who is monitoring Q&A functionalities. Once again, if you do have additional questions you can go ahead and submit those now. Robin if you can go over the questions for the presenters, that would be great.

Robin McArdle:

Sure, Thank you so much. So Kim, the first question is: **how are you handling sanitizing of the Kindle?**

Kim Schwartz:

They actually were in covers that can be removed. So we are able to wipe those down and pop them out and wipe down outside as well so as you know it is in the work flow. Folks are handling them with gloves and we have a secure location to be held in a separate area for clean and ready to be cleaned. We have not gotten volume yet, but I'm sure it will happen.

Robin McArdle:

We had a couple comments that are not questions but huge kudos to you for a fantastic presentation. **The next question, can you go over telehealth well child visit for children?**

John Jenkins:

I can go over that a little bit from the research that we did with the pediatric group. Again, the pediatricians are asking the family members to have certain tools ready, flashlight, scale to weight the child, tape measure

to measure the child. The pediatrician is actually observing those things and occurring during the visit. And it is not a perfect substitution for a well child visit, but it does reassure that the kid is keeping on the growth curve and moving in the right direction. And some of the pediatric practices are doing the same thing that the adult practices are doing for labs. They are setting up an out of office or secure immunization site where the parents can bring the child for immunization and feel the child is completely safe and out of the COVID-19 flow. Very much thinking outside the box but also knowing we need to touch base with our pediatric patients on a regular basis to understand how they progress through the growth curve.

Robin McArdle:

Great, thank you so much. And Kim, I believe this one is for you. **If you are averaging 12 virtual visits, how long is each visit?**

Kim Schwartz:

We schedule those as 30 minute visits and we are doing that with our phone visits too. The phone visits are much shorter and that helps in that catch up, so they work in another phone visit as well. The virtual visits will eventually be about 20 minutes. Because it is new for everyone including the provider and patient, we are keeping those at the 30 minutes. They are able to squeeze in other additional phone visit for someone who called in for triage. The 12 visits was the folks on the first presentation. We are averaging about 75% of full which is maybe 15 visits a day. They average around 8 to 10 at this point in time. We hope to get them back to full productivity within the next two weeks.

Robin McArdle:

Great, thank you. Next question: **What are the three documentation criteria required for E/M coding using virtual telehealth visits?**

Jen Cobb:

Robin, this is Jen Cobb, I can answer the question. What Kim was referencing was the three components of E/M visit being the history, exam, and the level of medical decision-making. With a new patient you have to have all three of those completed, and with an established patient you need two of the three in order to select the level of service.

Robin McArdle:

Great, thank you Jen. Next question: **Regarding HIPAA, is the concrete guidance on use of non-EHR email such as Gmail and telehealth by non-EHR video/voice platforms such Skype okay to use?**

Jen Cobb:

There is nothing concrete about anything. So I want to say that first. All the guidance that we have been given and it is in writing with the state and Medicare and CMS, is that at this moment in time, you can use these previously not secured or unsecured. So the Doxy Me that was mentioned, we have done FaceTime, Skype and of course have done Zoom, and Google using the smart phone or the android. All of those right now are available to use. Just remember, the platform is what is excused right now for HIPAA because those are not generally encrypted types. Those are our first choice since we opened up the chart portal. If it's too clunky and someone mentioned, we are giving our team the same flexibility to be able to do that with the Doxy me, the patient cannot see the originating phone number so they can use the cell phone number and it is a nice alternative. We have had folks if you turn off the unknown, you can use the *67 for FaceTime and that is something that folks have been concerned about using personal cell phones and the organization doesn't own smart phones to pass out. That is about as concrete as we have gotten so far.

John Jenkins:

Yes, I completely concur. There's a part of the question we have to be careful about and that is using email. You can use an email safely to send a link for the video visit. But actually communicating medical information via Gmail or commercial email at this point, I'm not sure the waiver has granted us any license in that area. Primarily for the audiovisual component of the virtual visit. Since Medicare requires audiovisual to charge those E/M codes.

Jen Cobb:

That is exactly right from our perspective.

Robin McArdle:

Thank you both. The next question is: **Well child E/M are not currently covered by Medicaid for telehealth, correct? How are they approaching these visits?**

John Jenkins:

That is probably something I will take off-line and do research with our practice facilitator that we have on AHEC. We will get back to you on that one.

Lakeisha Moore:

Thank you, this is Lakeisha and we will take that one. Just a reminder that there are great resources on the Medicaid website and they have a specific section when you go to Medicaid for COVID-19 updates and they broke it down to telehealth, what's covered and what's not. That's a great question and a good take away for us. I will also put out there that AHEC has done a nice job of putting great resources like my telehealth billing cheat sheet. If you would like a copy of that cheat sheet, it looked at the major payers that are in North Carolina with Medicaid and give you the codes that are covered for telehealth and also give you modifiers that you need in the place of service all on one chart. It is several pages because there's a lot of changes with telehealth. If you reach out using that information that's on the slide, we can shoot that over to you.

Robin McArdle:

Great, thank you Lakeisha, we appreciate that information. We have two questions left. Oh, maybe 3 now. The next question: **are your providers working from home? Does the billing documentation require that they put in their home address if conducting the visit?**

Kim Schwartz:

We do have providers working from home and 1/3 of our provider staff, 36 providers are in the at risk category over the age of 65 or have a chronic condition or are pregnant. They are working from home and just say that they have a home site for that remote visit. It's all you have to put in that location and they don't put in the personal address. And their team connects with them by phone and by actually using the portal because they literally shift from there. That is working well. And we also have in all the locations, we have an isolated area that is no patient contact for those folks who feel more comfortable with a stronger Internet from the offices rather than from home which that is a major issue for us. Our CMO has no internet access at her home so that is a component that we have in our broadband desert out here.

John Jenkins:

Yes. Medicare is granting the waiver on the originating site as well as the delivery site. That is part of the Medicare waiver. The patient can be at home and provider can be remote.

Kim Schwartz:

I will say, a number of senior providers and them seeing how this works for them, gives them hope for working longer after the crisis, three of them have said that to me. Even coming to the office, I feel safe doing that in the future. That is really encouraging words for the future for us.

John Jenkins:

Amen.

Robin McArdle:

Great, thank you both. **The next questions is: do any of your patients have peak flow meters at home and how do you manage an asthma telehealth appointment?**

Kim Schwartz:

There are wonderful peak flow monitors out there through remote patient monitoring contractors. If you go to the mid-Atlantic telehealth site, they do have listed vendors. We have tested them and have done some PDSAs on the peak flows. They have been expensive and difficult to manage. They have not been historically well utilized tools that download automatically in the software. They are using them for self-report. If a patient has asthma and they asked the patient to self-report, just like you do the weights and blood pressure if they have that at home then they put that in the note if a patient has their own peak flow. The connectivity to actual equipment isn't great yet, but I'm sure it will advance in this day and age.

John Jenkins:

Yes there are vendors out there who are creating incredible things for the future. A company called Propeller, they can monitor the use of the inhaler, and know the strength of the inhale, which will be incredible and a lot of virtual connectivity for peak flow meters that actually supply that information directly into the EHR. But for today the best thing I can recommend is if someone has a peak flow meter that you virtually observe the use of the peak flow meter and look at what it actually is. That moves it from patient reported data to provider observed data. That is a key component to billing.

Kim Schwartz:

Thank you that was good guidance. There are hints and guidance out there on how to effectively utilize at-home tools. If you try and look at the site of a rash or bug bite, put a quarter up against the skin so you don't have to rely on the patient on how big it is but you can actually do a comparison. That is one example. There are many ways out there that folks have adapted. There are other states and other groups that have been doing remote monitoring for a long time and telehealth. These questions, many have been answered historically and the resources that we have at hand are good.

Robin McArdle:

It looks like we have two questions left. If there are anymore that come in after that, unfortunately we will follow up off-line. **The last question is: virtual visits are available using visual E/M code 99201 through 99205. Where as tele-visits are 99414 through 99444. I don't see an actual question and not sure if this is just a comment or if you have any comments on what they wrote?**

Kim Schwartz:

I will bounce that to Jen.

Jen Cobb:

Hey, so for the E/M codes, 99201 through 99205 would be appropriate for new patients. For established patients, you would use the 99212 through 5. For telephone visits, we use 99441 through 99443, and any conversions in the background are payer specific.

John Jenkins:

There is really great information into what Lakeisha referenced earlier from AHEC in the cheat sheet on that because there are some remote monitoring codes which are asynchronous monitoring that you have to be careful about and use the appropriate codes for telephonic conversation.

Robin McArdle:

Thank you. Lakeisha I will pass it back to you and all questions are completed at this time.

Lakeisha Moore:

Great. Appreciate that, Robin. Thank you Dr. Jenkins, Kim and Jen for sharing your telehealth best practices today and answering questions that we had. We are happy also even after the presentation, we do have technical assistance available through the office of rural health and through the area health education center and so if you are on today and said, oh I have specific questions for my site, and how do I get this up and running or want to get a copy of that telehealth billing coding cheat sheet that we talked about, that is

something you can email either an organization, ahec is updating the cheat sheet pretty regularly as changes come out. You can email practicesupport@ncahec.net to see the resource. We want to thank you all for joining us today. For safety net providers, visit the office of rural health website and we do have additional links and Dr. Jackson's talked about different vendors that are offering free and low-cost options for implementing telehealth. If you are still in that stage of figuring out which way to go, there are resources also on the North Carolina area health education site, there are resources and webinars that are going on different topics specific to home health or Medicaid questions. There are quite a few different webinars that are going on in the list available on the area health education website.

With that, we appreciate once again your time today. Thank you all for joining us today and we hope you have a wonderful week. I hope the information today has been helpful and you can look at ways that you can incorporate these telehealth best practices into your organization and workflow and remember we are here to help you if you have any questions along the way.

John Jenkins:

I think you might have an opportunity to promote next week. There are a couple of great people who will speak to us about tools that enhance the ability to do virtual care.

Lakeisha Moore:

Absolutely. Thank you Dr. Jenkins. Next Monday is a telehealth virtual office hour series available here Monday at noon so we'll make sure to send out reminders about that. Excited next week to have the free and charitable clinic association talk about how they implemented telehealth with all their member practices at this point. They have the telehealth implementation down to about one hour to get their clinics up and running and they will share best practices with us. Also we will be joined by the health exchange authority who many of you may have referred patients and have gone out and got tested in places. If you would like to go into the clinical portal and see how to pull different test results from places outside of your walls. We'll go over a demo and resources available through the health information exchange and see health connects. Excited to go over some of that next week, and in the meantime if you have other questions or things that you would like us to cover, definitely we are here for you and we are in this together as you see hashtags #alonetogether, we want to make sure we get resources out to you and happy to take suggestions that you may have of things you would like us to cover specific to telehealth Thank you Dr. Jenkins for bringing that up.

Thank you again. Take care and be safe and see you next week.

[Event Concluded]