Transcript for NC AHEC Telehealth Virtual Office Hours Webinar
April 13, 2020
12 pm – 1 pm

Presenters:
Lakeisha Moore
John E. Jenkins, MD
Randy Jordan, CEO

Please stand by for realtime captions.
 The webinar will begin in about five minutes.
   Or Moderator will begin in about one minute.

Lakeisha Moore:
Good afternoon, everyone. Welcome, I thank you for joining us today for the Telehealth virtual office hours webinar series. Joining us today for the Telehealth virtual office hours webinar series. I am Lakeisha Moore with North Carolina Office of Rural Health and Rural Health Initiatives. I am joined today by Dr. John Jenkins with the Greensboro area health Education Center (AHEC) and some of his partners from AHEC too. We are also joined also joined by Randy Jordan, CEO and some colleagues from North Carolina Association of Free and Charitable Clinics. We're excited to have them and also our other special guests join us during today's webinar.

During today's webinar, we will be sharing some telehealth implementation best practices and other telehealth resources across our State. If you would like to ask a question during the webinar please type your question by clicking on the Q&A icon that you will see in this webinar, and we will work to answer as many questions as we can, time permitting. Also, if you need technical assistance during the webinar you can email Technical Assistance COVID-19 at Gmail.com and they will work with you. Also, a very special welcome today to our safety net site across the State. Once again, we are excited to talk with you today about telehealth implementation best practices that we have seen across our State amid across our State amid the COVID-19 pandemic. We hope you will be able to incorporate and adopt some of these best practices into your into your organization and workflow.

Next slide.

 Let's go over some agenda items and housekeeping items before getting started. This week Lisa Renfro from AHEC will start us off with information on how to receive continuing medical education or CME for this webinar. Then Dr. Jenkins will join to share telehealth best practice implementation tips, and also review some of the things we covered in previous webinars today. We will also be joined by Felicia Coates and Paula Locklear from AHEC who will answer some frequently asked telehealth questions we have received. Excited to have Randy Jordan CEO here, the Deputy Director both of North Carolina associated free and charitable clinics joining us, along with their colleagues Dr. Andrew Barbesh, teleneurologist, where it will be great to hear their story of how they been able to implement telehealth in many of their member practices of free and charitable clinics across the State. We also will have Jessica Brimmer, a specialist at our State Web Health Information Exchange NC health connects, who will share resources available for you as you care for your patients virtually. Then Robin McArdle, Office of Rural Health telehealth Specialist is on the line also to share your questions that you send to zoom Q&A.

Some quick housekeeping items before getting started. This webinar is being recorded and will be available on the Office of Rural Health and a AHEC with the slides. If we are unable to answer questions during the session today, know we will consider that question for future telehealth webinars. It definitely helps us understand questions that you have and helps us formulate content of things we want to cover. So without further ado, we'll turn it over to Lisa who will share with us how we can receive CME for today's presentation. Lisa?

Lisa:
 Thanks, Lakeisha. To obtain CME credit, CEU or contact hours for this call you must have an updated my AHEC account with an updated cell phone number listed. If you do not have an have an account or cell phone number associated with your existing account, you will be prompted to create or update this information once registration is completed. To register your attendance for today's webinar please text 13406 to (336)793-9713. Both the code and phone number are listed on the current slide. For additional instructions on how to register using the text registration system please number are listed on the current slide. For additional instructions on how to register using the text registration system please visit www.nwahec.org/textreg as shown on this slide.

 Next slide.

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. I will now pass it over over to John Jenkins, our subject matter expert.

John Jenkins:
 Thank you, Lisa. This is the third episode of our continuing series on telehealth implementations here North Carolina during the COVID-19 crisis, and so we will transition this to beyond the Covid crisis. I'm excited about when that day occurs. We have a great, great program today. I would like to start off with a quote from Charles Bayless, a North Carolinians who lives in in the Raleigh area. He is a retired provost from West Virginia University. He is also a leading expert on energy policy in the United States. He said the first thing you got to do is recognize the environment you are in. And that it takes a different set of skills. You have got to think that everything you have learned was learned in the past. I might be able to be the best manager and operate a practice a year ago in a different environment, but things have changed, so you have to look at what plan is going to work in this environment.

We're talking on a very practical level today about our telehealth pearls for best implementation. Remember we always start with the why. It's about access, access, access. We want to give our patients the ability to get the care they need in the time they need it. We have a message to convey to them to stay home, to wear a mask, to be socially distant, too wash their hands. We need to remind them that we are here for them, and we're still here for them as we have always been in our clinics across the State. Now we feel we can manage most of the chronic and acute needs through virtual technology while keeping them safe at their home sites, or if they have to go to an essential job to be able to allow them to reach out from their job to ask us for care. And don't forget the Covid three: cough, fever, and shortness of breath.

Today's Webinar, we have people from across the State helping us. I will be taking you through the operational pearls, Paul will go through the coding questions and the answers you have submitted. The North Carolina Association of free and charitable clinics will share their great experience with operationalizing virtual help during this crisis, and Jessica Brimmer will give us some really important tools for us to be able to know about our patients as we do these virtual visits.

What were our virtual operational pearls? In telephonics, we learned from one of our clinics to always call the patient by the patient's name. This gives the assurance that you know who they are and allows you to establish an immediate relationship bridge. Make sure there's a smile in your voice. Know the limits of the media. Remember people cannot see you in telephonics so they have to hear you, so your voice has to be clear, and again you have to enunciate clearly. Never hang up first. This was a pearl from one of our practices that told us patient were very disquieted if they hung up. Set the visit expectation. This can be done by one of your team members before the visit by reaching out to the patient. Follow a familiar flow. This gives them confidence. Dress professionally. If you always have a stethoscope around your neck, have a stethoscope around your neck. If you wear a wear a white coat, wear it. Have a neutral,no distraction background. Be sure to get consent for a virtual visit, and this is a unique consent explaining the media you are using. Document in an office note because we are posting these with help with parity, so Medicare is paying for these as office visits so document in an office visit form. What the patient models for

documentation that can advance documentation complexity, and most of the visits are going to be 99213 for established patients and 99203 for new patients.

Consider a Covid clinic separate. So that the volume of patients who just need routine follow-up acute on non-Covid issues or need to be managed with diabetes, hypertension, other diseases don't have to go to the same line of access. Have a safe lab draw and immunization routine. We learned some clinics are doing drive-by lab draws and drive-by immunizations for well children and other needed labs to give the confidence to their customers that they would be safe. Or do a walk-in visit for virtual visits. We learned about a one-click that uses tablets so when a person shows up for a visit they had them fill out a tablet and they complete the visit in their car. Develop FAQ's on how to complete a visit and be sure to publish that on all of the sites so patients will be confident they know what to do.

The six fundamental visits we are talking about, the Covid screening course underlies every contact we have during this crisis. We talk acute wellness visits. This is an opportunity to contact the well patients especially well Medicare patients, and give them the confidence that the practice is still there for them and answer Covid questions. Acute visits around sore throats, coughs, colds, other appropriate acute visit to avoid people from using our EDs and our urgent cares for simple acute problems during this crisis. Follow-up visits, scheduled and rechecks converting those if at all possible. Management of chronic problems, protocols of labs and also protocols for how for how to manage hypertension, diabetes, COPD, asthma are key components to set to work in our practices today. And then, specifically, to our Covid crisis we talked about telemonitoring, and in session one we gave you a slide about how you can operationalize telemonitoring for the COVID-19 quarantine to help have regular contact with the patient. Then as we move out of COVID-19 you can use telemonitoring for your CHF, COPD and asthma patients, as we learned about one of our Partner clinics was doing already before the Covid crisis.

Last but not least I am going to tease you for what we are going to do in future sessions. We'll talk about how we can use virtual visits for our primary care in the future. We look here at patient who had a new patient wellness visit. The exam was mailed, and appropriate screening labs were ordered. Patient was identified to have obesity and hypertension. They had a follow-up visit to see if the hypertension was under control, it wasn't. A protocol was launched to help the patient monitor blood pressure. A sensor was launched and found that his hypertension was not in control. The Team Member referred to a Pharmacist who titrated his medication. Then about halfway through the year he had a sick visit. This was an acute visit that the patient generated to see one of the Team members for flu like symptoms. Finally, the year capped off by a repeat wellness visit at the end of the year and care gap closures were obtained in the patient online schedules, the care gaps and labs. This is the possibility of virtual care for the future.

Now I'm going to turn it over to my teammate, Paula and Felicia, who will answer five questions you put forward to us about Billing and coding. Guys, take it away.

Felicia:
 Thank you, Dr. Jenkins. This is Felicia Coats and I am going to ask some questions that were frequently asked questions during sessions and then Paula Locklear will answer those for you. First question: **Is there a difference in telehealth and telephonic coverage for new versus established visits?**

Paula:
 Good question. At this time there is not a difference between telehealth and telephonic coverage. CMS is going pay as new patients or established patients during the emergency.

Felicia:
 Great. Second question. **What are the payer requirements for coding, specifically the evaluation and management visit code, modifier, and location of service**?

Paula:

Each payer has a specific requirement for documentation. The platform you are using, your CPT code or HCPC code that may be generated, your modifiers and place of services. Providers will need to speak specifically to their policies and plans to make sure they are giving those codes correctly. At a later point we will also be presenting a little more specific case studies to help providers.

Felicia:
 I want to add, Paula, that there are some great coding tips by peers on their AHEC website that can be accessed now. Next question: Dr. Jenkins talked about this. **Are annual wellness exam, physicals, or well-child checks covered by telehealth?**

Paula:
 Annual wellness for Medicare are able to have telehealth now, but in terms of wellness visits and well-child for children, at this time those have not been approved. They are in the works of being looked at but at this time they are not covered under telemedicine.

Felicia:
Thank you. **Are FQHC and health centers able to perform and bill for telehealth with Medicare and Medicaid patients?**

Paula:
    Another good question. Yes, at this time they can do virtual visits, and are to use a billing code G 0071, those have to be audiovisual visits, and they have to use a HIPAA compliant platform.

Felicia:
Last question, what is the effective date for payers so that we can retroactively file claims?

Paula:
 We all want to file our claims and get paid as soon as we can, and each payer is paying at different time frames, so it's very important to try to keep a watch on what they are doing. Medicare and Medicaid made their effective date for March 6 of 2020, and the other plans have set date based on their payer policy changes, so your provider should contact each of those payers to get that specific date.

Felicia:
 That's all of the questions, Paula. We will turn it back over to Lakeisha Moore.

John Jenkins:
 Actually, I am going to take over. That was really great, and next week you guys are coming back and going to give us case studies about Billing and coding so we can really see some of the things we need to operationalize in our practice under the new reality that we are doing many of our visits now on a virtual platform or telephonic platform. The other part of next week I will give you a little teaser is we're going to learn about practice sustainability. How do we understand what we need to do to keep our cash flows, and to be able to play our staff and our providers and our clinics? Next week is going to be exciting when it comes toward the end of the month, so lots of questions I'm sure will be asked.

I will remind everybody and our ladies just mention this, the North Carolina AHEC has telehealth resources as well as Billing and coding resources, and this is the website that you can go to find out about COVID-19 telehealth resources. Also the AMA has multiple resources. This particular practice release guide have ideas about about small business loans, advance payments and other ways you can keep the light on during the Covid crisis.

Now I want to turn it back over to Lakeisha Moore. Lakeisha, will you introduce our colleagues from the North Carolina Association of free and charitable clinics?

Lakeisha Moore:

Absolutely. Thank you so much, Dr. Jenkins. And thank you, AHEC team for an informative and nice review, and also some of those FAQs that were getting around telehealth billing. I see more questions coming in around telehealth billing. Felicia and Paula, I definitely hope you'll stick around as we go through some of those other telehealth billing questions.

Thanks, Dr. Jenkins, for transitioning us over to our friends from North Carolina Association of free and charitable clinics. Excited to be joined back today by Randy Jordan, CEO, and Mark Scheerer, Deputy Director both of North Carolina Association of free and charitable clinics. Also we have Dr. Andrew Barbash, teleneurologist who will share their telehealth story about implementation at their member practices. Randy, thanks for joining us.

Randy Jordan:
Thank you so very much for having us on the program. It is amazing to me that the story we are going to tell is only 30 days old, for the most part because we have been involved in the rapid deployment of telemedicine among North Carolina Association of free and charitable clinics. Just a little bit about our association. We represent 67 member clinics across the State operating in 73 counties. We each year take care of more than 80,000 uninsured patients in North Carolina. Our services are provided sometimes by full-time staff, but also often from volunteers, and so those volunteers are often retired physicians, retired nurses or retired Pharmacist who practice inside of our clinics. That is our setting, and so the amazing part to me and I still marvel is that on March 16, we began with a standard start to implement telemedicine among our clinics, and two weeks later we were successful in standing up 36 clinics with telemedicine so that they can be fully operational. The two-points of our strategy which we want to emphasize in today's presentation are number one, the active assistance we provided to our members on on-boarding telemedicine, they were not just handed a manual, they had people help them go to the process. Secondly, as importantly, we believe in the important of integrating new telemedicine technology into their existing workflows and trying to make that as simple as possible.

Before we get into the techniques, I would like to share one story that brought this whole circumstance home to me. On March 12, our Association Board of Directors were having a meeting to discuss COVID-19, except a much simpler occurrence. It was that we had had our annual meeting scheduled towards the end of April, and the purpose of the Board meeting was to discuss whether to postpone the meeting, of course. But as we were in the middle of the meeting our Board Chair's eyes darted out the office door into the waiting room, and then there was some active conversation that was taking place, and then there was some active conversation that was taking place, animated between her and a member of her staff. We sort of lost her for the meeting for about a minute. She then came back and was able to carry on with the business of the meeting. What we realized later was in that moment, that 1-minute where she was distracted, that was the moment when the first possible COVID-19 patient walked through their clinic door, and they were just not clear what they should do. So, we are pleased that telemedicine has provided a solution for our clinics for both to protect their staff, and as I mentioned earlier, some of them are retired and at high-risk position with COVID-19. For their otherwise well patients, so that they are not infected in the waiting room by other patients inadvertently, and also to the target population that we serve, the underserved and homeless who are also at high-risk for COVID-19 infection.

I said earlier that most of this conversation has taken place over the last 30 days. I do want to tell you as part of our story that we had a two-year head start on the topic of telemedicine, but in a different format, and in a different deployment strategy. Two years ago, Dr. Andrew Barbash, who is on our call today, as well as another neurologist in North Carolina volunteered to provide our clinics free Neurology specialty consults. Probably the hardest consult for a free and charitable clinic to get, and we were fortunate that telemedicine vendor had donated that platform for that specialty consults used for free to our member clinics. We had a head start on learning how the telemedicine experience was embraced by our member clinics, and I think that helped us when at the onset of COVID-19, and now I am on to my third slide. There you go. And one more, please.

At the onset of COVID-19, when our leadership decided to rapidly deploy this strategy of clinic choosing telemedicine to do several things. One was to triage and screen patients before they entered the clinic setting

either from home and sometimes out in the parking lot. And also to treat patients. This strategy was different. We were not relying on telemedicine to access the specialty care physician who is outside the clinic. We were actually using a new paradigm. That was for telemedicine to be a new modality for us to administer primary care to the patients, excuse me, to the clinic's very own patients. With the telemedicine vendor we were able to negotiate quickly a favorable group contract, so the arrangement we have in our association is a contract that allows our members up to 55 of them to access telemedicine as clinics.
 Next slide, please.

 In mid-March, the Association's Deputy Director and Dr. Barbash immediately began enrolling member clinics in the platform. We were able to onboard most clinics with a three hour training and implementation period. In some cases, as little as 90 minutes. Another thing that was helpful is that the platform we used required minimal equipment to be purchased, just a regular desktop/laptop computers and smartphone. As I mentioned before, within two weeks our association was able to stand up telemedicine services in 36 of our member clinics. Because we have also promoted the system, we now have a total of 46 clinics in some form of telemedicine.

Now I would like to turn to my colleague and Deputy Director, Mark Scheerer, to share his perspective on what are some of the keys to success on our ability to actively assist our members, and how our members are continuing to use telemedicine during the Covid pandemic. Mark?

Mark Scheerer:
 Thank you, Randy. I want to reiterate what Randy said about our prior experience with Updox and Dr. Barbash. We have excellent relationship with them, it certainly helps on-boarding those 36 clinics. At the very beginning, Dr. Barbash and I talked about identifying a super-user within each clinic. We told each clinic to find someone who could be a point person within your clinic to organize telemedicine within the clinic. We also stressed that it should not be a provider and probably not the clinic Director. This is going to take some time to onboard within the clinic and get users set up, so we wanted to make sure the staff member there had plenty of time to do that. We were able to offer training sessions on a regular basis. Some worked one-on-one with Dr. Barbash, which was incredibly important to get people up and running. We also offered a couple of daytime training sessions, as well as evening training sessions. We also continued to have weekly meetings on Friday at 3:00 for any user and the provider to pop into the zoom room, ask questions of Dr. Barbash, talk to each other, find out what has been successful, see what challenges had been within their clinic and then get the results so they can more effectively use telehealth. There is also a virtual helpdesk. Uptalks has excellent, excellent page on the website with videos on all topics. There are short videos five or six minutes long, so they keep your attention and you do not have to sit there thinking you will have to sit through a 30 minute presentation. Dr. Barbash is also creating daily video assistance that people can watch it their convenience on a variety of topics they need to get up and running. One that this telemedicine platform they're using, again, is through Updox and people can use it basically from the very beginning. It a no bells and whistle system that got them up and running through texts, secure texts, and video check which Dr. Barbash will talk more about. Some of our clinics have closed their doors to seeing patients in the clinic. When I say in the clinic, they don't come in, but they completely use telemedicine to remain open so they can see their patients in the parking lot, versus home or whatever, so they do remain open. They are just not seeing patients in the clinic. Others use it for triage, practical things you think about in physicians' offices. Since March 16th, we had these statistics run today. Our clinics had 2300 video chats. Over 1200 SMX text and secure texting. We're excited about that. We think it's a great opportunity for our clinics to see their patients and thinking in 30 days we've had 2300 video chats. I will pass it back to Randy.

Randy Jordan:
 Thank you, Mark. And now Dr. Barbash, our time is running close, but I want you to be able to speak to what is proven to be an essential part of our success about the workflow issue, the role of the practice clinic Portal, and onboarding telemedicine and your view of the future telemedicine in the medical practice settings post COVID-19. Dr.Barbash?

Dr. Andrew Barbash:

I take the perspective of someone who's been doing telemedicine for a long time, you fundamentally believe that this scenario was just a more urgent stimulus for doing what practices really need to be doing anyway. And so, as long as the technology was not driving changes in workflow, that the technology was there to allow people to change. Then we started with the fundamental foundation that is stressful as this situation was, we wanted to help the clinics make a migration towards a way of doing business in the way of interacting with each other, which is important, and with their patients, and potentially, in the future, other colleagues and specialists in more efficient ways. Therefore, we really focused a lot on the foundation of quickly overcoming certain assumptions that people had so that they would not be obstacles, but they would be opportunities. People assume patients did not have cell phones and rapidly found out they mostly did. They found out they felt maybe this will be cumbersome and would only apply to a certain subset. The rapidly found out that was not the case. And we help people practice with themselves quickly so that they could ensure that by the time it was time for a doctor or a provider or mid-level to have a video visit with someone, that it was really guaranteed to be ready, they were going to have a successful experience. By taking that approach, or foundational belief was that it was an unfortunate circumstance but this is an example where certain kinds of changes in healthcare just have to come like a sledgehammer, even though they are the right things to do anyway. And because of the suddenness, however, it has to be done carefully.

That role of the practice clinic is a virtual clinic I established many years ago. The whole idea was to provide that kind of layer of support sort of clinical and operational support between people at the ground level, really trying to solve workflow challenges and in the technology itself, which really just needs to become relatively invisible in the background, which is what has been the case. In terms of the future of telemedicine in medical practice, I have a bias on this one, obviously, having made a career change directed toward telemedicine. But what is really important about an initiative like this is that all of the providers, all of the staff, most of the patients, all began to make this transition and have a new experience of interrelating to people on their phones when that is appropriate via texting, not just making phone calls, but doing whatever is practical. Sometimes you don't need to pick up the phone for whatever technical reason, but as everybody gets a deeper experience and it becomes part of the daily work day, then the staff and the physicians and providers themselves will start coming up with new innovative ideas as to how to apply the same methods for all other elements in their practice. And that, I think, is what is what creates the foundation for future transformation of the practices themselves. The sky is really the limit when you break through that barrier.

Mark Shear:
 Thank you very much, Dr. Barbash. Onto the next two slides I want to acknowledge those who have stood behind us over the last 30 days with their support. On the final slide I want to highlight additional resources available through our association. You will find at the top reference to a four part series that we prepared on our telemedicine podcast. And we certainly offer ourselves for any questions or comments or any ideas that come up on your side where you would like to interact with us. Thank you again, Lakeisha, for our chance to share our story and it's back to you.

Lakeisha Moore:
 Awesome. Thank you so much for sharing and to the NCAFCC team, that is very astounding to be able to implement in such a short time that many practices getting up and running on telehealth, so thank you for sharing the implementation of your practices there.

I do have a reminder to the audience before we transition over to Jessica that if you have questions you can submit your questions through Q&A feature in Zoom. I see a few questions coming in now but wanted to remind you of that. The audio option is disabled to participants but we would love to answer your questions through Q&A if you would get them to us that way.

Now I'd like to welcome Jessica Brehmer, outreach specialist with the North Carolina Health Exchange Authority. She oversees statewide health information exchange, NC Health Connects. Jessica will share resources with you as you can for your patients virtually. Welcome, Jessica.

Jessica Brehmer:

Thank you, Lakeisha. As Lakeisha mentioned, my name is Jessica and I'm on the outreach team for the North Carolina Health Information Exchange Authority. Today I want to share with you that you do have access to Health Connects Portal. We're going to go over some cases.

One is going to be new patients, whether you are seeing that patient via telehealth, telemedicine or in the practice itself, seeing test or lab results on that patient. Also, hospital encounters or encounters at other hospital facilities. We're also connected to the neighboring State via the eHealth exchange, as well as the VA and the Department of Defense. Also, within the clinical Portal you will be able to see vaccines and medication. You may already be connected to NC Health Connects in one of two ways. If you are connected and you are sending data, one could be a uni-directional connection. What that means is that you are seeing the patient whether it's in the practice or virtually. You are entering the visit into your electronic health record. At that point your EHR is going to send the data over to NC Health Connects, and then if you do not have access to where you are seeing data pulled back into your EHR then you can login to NC Health Connects using any Web browser and NC Health Conects is the clinical Portal.

The other way you may be connected is bidirectional. It's the exact same if you are seeing a patient, that information will be entered into your EHR. It is sent over to NC Health Connects and information will be viewable in your EHR on any other patient that you have a patient care relationship with. I would also like to point that we do have 50% of our participants that are sending all patient data. This now includes Duke, wake med and Wake Forest Baptists. What that means is they are not filtering out patient data, so you will be able to see patient data within NCHealth Connects.

To be able to view patient data, you do have to have a role assigned to your account. There is four different roles you can have within NCHealth Connects, and you can see here on the screen there is a clinician role, clerical, PAA, which is a participant account administrator, that will be the person able to request access for other staff in your clinic. There is also a clinician and PAA role combined. This slide shows you common examples of different roles. For example, a clinician role could be a physician, physician assistant, but could be the front desk staff assistant. So, if that person needs access to clinical data than that person could be assigned a clinician role.

The next published slide I'm going to show you a screenshots of our clinical Portal so you know what is available to you. And with COVID-19 there is a lot of useful information. I'm going to point you in the direction of where you will find those test results in those encounters within the clinical Portal. You see on the screen here you have the user name and password. You will click log in. There is always going to be a disclaimer. You must click agree in order to continue. And then this is going to pull up the patient's search screen. We ask you to certify last name, first name, and date of birth, to get the correct individual. Of course, that individual the name will display as well as gender, date of birth and address. Once you are sure you want to want to view that individual, go ahead and click view record. This screen here, you are going to have to declare that relationship. Maybe it's a new patient you are looking up, and it is okay to declare that relationship because you are actively treating a patient, whether it's in the office or whether it's virtually. Also if you are not connected to NCHealth Connects yet, meaning you are not sending data, then our system does not recognize that you have an active relationship with that patient, so that is why it could also ask you to declare that relationship. You can very easily click declare relationship.

This slide here, I wanted to show you. I had mentioned earlier we are connected to the neighboring State via the eHealth exchange. Any time you look up a patient and you see a waiting results from, and you see eHealth exchange, Georgia, or eHealth exchange, VA, if you click refresh, all of that information is going to go away once we have those documents. You just click to refresh, and then the information is going to be stored in the document section. If you let your eyes go to the left screen and all the way down, you would be able to click the document section. That is where you will be able to see the document for that encounter. The next thing is to be allergies and alerts. For example, if there is a DNR on file it will show in the patient alert section. We do not have the ability to store an actual image as a document, so you would have to actually call the facility to get that DNR.

The encounter section, that is going to be able to show you exactly where this patient has shown within the health care system. So, whether that is virtually, receiving telemedicine service, or whether they are actually walking into a clinic, you will be able to see that here. Medications that the patient may be taking, you will have recent and historical. Then we also have conditions. So, if the patient has been diagnosed with COVID-19, the present illness will say, COVID-19. And this is based on the patient walking into a facility, actually getting the test done, the test results populating back into the EHR of the practice, then it comes over to NCHealth Connects and we populate that for you here.

All right, this slide is probably the most important for COVID-19. A lot of you guys on the call are physicians treating patients. Any time that a person has had a test, so whether it's an order or a result, it's going to be here. You will see procedures and results. Anything that is in red, that's going to tell you that it's abnormal. A COVID positive 19 test, it's going to be in red. Any other lab work you're going to see if it's in red, then there is something of that lab that is abnormal. My Executive Director, she wanted me to mention there is a lot of times where we know that the tests are being done but there is a delay in getting the results back, so within our Portal it's going to tell you if the test has been ordered. If you do not see a result there it's because the result has not yet come back in. If you do have that result it will be displayed for you.

 And this slide is going to show you the vaccinations that the patients have. And are last slide is going to be that document section. As I mentioned when we are connected to the neighboring State via the health exchange and click on that refresh tab at the very top, all of those documents from the neighboring states will be pulled into this document section. If you click on a continuity of care document on the right-hand side is going to be an example of what you may see. I know a lot of the physicians I work with like to see a note about that particular encounter, so if you look at the table of contents you can see the progress notes. Keep in mind that we are only able to display the information that we receive. We cannot change it once we get it, and once we get it we just display it into the clinical Portal for you.

Now that you get an idea of what is available to you within the clinical Portal, so how do you gain access? You do have to reach out to you participant account Administrator at your organization. And your PAA will be able to request access for you. If you do not know who your PAA is, reach out to us and we could absolutely put you in the right direction so that we can make sure that you get access quickly. Additional resources for you on our website hiea.nc.gov/covid-19. We are posting new resources each day, please reach out to us as well if you have additional questions. Back to you, Lakeisha.

Lakeisha Moore:
 Thank you so much, Jessica. Jessica will be joining us again on a future webinar to go over some additional resources that are available through NCHealth Connects. We asked her today if we can focus on the patients and the clinical Portal, but I wanted to put out there that there are definitely resources available to you. Jessica will take us on a deeper dive in the coming weeks. Hopefully you will join us for that also.

I did see a question come up come up in our Q&A. I wanted to give a quick reminder how to receive CME credit for today's webinar. You will need a my AHEC account with your cell phone number included in your profile. You can visit www.nwAHEC.org/textREG for full details. The website address is on your screen, along with some of the texting tips if you already have your my AHEC account set up. Full details you can find at the website you see on the screen.

We also wanted to share a new FCC funding opportunity available through some of the Cares Act that the Portal will be opening today. The FCC has announced $200 million in telehealth funding. Once again, the Portal is scheduled to open today. The steps you want to take now if interested in applying for the funding which are listed on the screen, kind of a three-step process of making sure that you have the eligibility form filled out. That's a great way to go ahead and get started. Once again, the link is available. The slides will be available on the ORH AHEC website for more information.

Also a reminder about telehealth technical assistance available to you if you need additional assistance on anything covered today. We had a lot of information of information to cover. Speaking of that, I think we got Robin with Office of Rural Health who has been monitoring your Q&A questions as they come in. Will transition now over to our Q&A portion of today's webinar. Robin, I will let you go over questions that you have for our panelists.

Robin McArdle:
Thank you so much, Lakeisha. I like to start out with the first question. I think this is probably this is probably for Dr. Jenkins. If not, feel free to pass it on. **For Medicaid, my understanding is that telephonic codes are only for established patients?**

John Jenkins:
Yes, that is correct. Just a point of clarification, Medicaid primarily has approved telephonic communication. They allow audiovisual but they also allowed telephonic for most visit types. Medicare only allows telephonic for exchange of digital information, and for your nurse type visits, whereas any provider level visit that you will charge Provider level, it needs to be audiovisual. That is a clear distinction for that.

The other distinction is Medicare is allowing new and established patients. We go back to Medicaid, Medicaid right now, you have to have a relationship with the patient.

Robin McArdle:
Great, thank you so much, Dr. Jenkins. The next question: **Where can we find specific guidance related to tele- behavioral health, especially around testing? For example, is there guidance on administering assessments virtually?**

John Jenkins:
This is very timely, so there is a group of us with AHEC that are preparing a telehealth behavioral health primer. It should be available by the end of this week. We will post it on our AHEC site for your reference, and very excited about the work. This is the practice support team that supports the behavioral health practices. We have been working diligently to get this together and testing it by practitioners who are leaders in this area. More to come on that. Be looking for that by this Friday.

Robin McArdle:
Okay, good deal. The next question: **Do clinics need practice support around Billing and coding for telehealth?**

Lakeisha Moore:
I think the question might be for the Association for free and charitable clinics. Randy, if you want to speak to that?

Randy Jordan:
Yes, thank you. It sounded like a question for us and an interesting one. As I mentioned in our presentation, the great majority of patients that we see in our clinics are uninsured, and so, there is no claims processing experience within most of our clinics. The billing process is not something they need to concern themselves with as they see uninsured patients. However, it's a really fascinating topic because so many things are changing rapidly that the new regulations on telehealth may open the door for free and charitable clinics to consider telephonic interactions with Medicaid patients for the claims could be handled somehow through telemedicine engagement. There's a lot of work to be done there, but there is certainly some help that will be needed in the billing process, and so a long story to say, yes, we would need some help in being able to build claims if we ended up jumping over into the Medicaid patient pool.

Robin McArdle:
Okay. Thank you. The next question is probably for Jessica. Are the VA Medical Centers sharing information on NC Health Connects?

Jessica Brehmer:

We are getting information from the VA. I'm not really sure when they say sharing information on NCHealth Connex, so, meaning, are they getting information back for their patients? I just need a little more clarification on that.

Robin McArdle:

Okay, if the person who asked that question doesn't mind typing mind typing in additional information, that will be great. We will come back to the question. The next question I think for Dr. Jenkins: **I work in public health and prenatal planning. I'm a little confused about whether we can do telehealth without the behavioral component. Would we still use the G-code?**

John Jenkins:

This is where the confusion comes regarding the population. If that is a Medicaid population then you can do telehealth without the visual component. That could be all telephonic in terms of the relationship. If that person has Medicare, then there is a telephonic component that you can do virtual check-ins that can be done by someone supervised by one of your providers, which can be phone calls. That is the G-code, the G2010 and G2012. However, if you are going to bill a provider Bill, which is E and M code 99210 for new through 5 and the 99212 through 5 for established patients, this for Medicare has to have the audio/visual component. It is a little confusing. There is a great cheat sheet that is on the AHEC site that you can download. It's a couple of pages. They have updated this and it's helpful to have with you since you are switching back-and-forth, many of you, between Medicare and Medicaid patients.

Robin McArdle:

Thank you, Dr. Jenkins. The next question: **When you say Duke, Wake Med and Wake Forest Baptist, do you mean they are submitting patient data across all payers versus just Medicaid and State health plans? Also, are there other Health Systems doing the same as well? I think this is for Jessica.**

Jessica Brehmer:

Yes, thank you so much. I actually need to correct my comment. The majority of our participants are sending all patient data, regardless of payer, includes the major hospital systems. 50% are sending the data in real time, and then when I mentioned Duke, Wake Med and Wake Forest, previously, they were a submit only participant, which means they were filtering out all of the other payers except for services, or except for Medicaid, the State health plan and then funds from State grant. Now, the majority of our participants are sending all patient data regardless of payer.

Robin McArdle:

Okay, thank you, Jessica. Back to the other question, they did respond. **I do need to ask if information comes through NC HC for the VA. I struggle to get health information and other immunization records.**

Jessica Brehmer:

Yes, we are connected to the VA we are receiving information if a patient is seen at the VA. I will say that previously the VA was on an end model, meaning they would have to opt-in in order for their services to be sent over to NC Health Connects. However, that model is changing, and I believe it was already supposed to be changed. I was in a clinic a couple of months ago and I did see where we were actually getting information from the VA. So, if the patient showed up at the VA, entered into EHR, we have a live connection and the information is coming over to us. That means any other provider would be able to log into NC Health Connects and be able to view the information for treating that patient.

Robin McArdle:

Thank you, Jessica. I'm not sure, this question, not exactly who it will go to. It says: **I believe they stated they would not audit if there was an existing relationship. Is this correct?**

Jessica Brehmer:

Yes, that would be for NC Health Connects. There is a quarterly audit, and I know a lot of physicians and healthcare staff members are really nervous about the break the seal option. But as long as you are treating the patient you have a patient provider relationship, it is okay to break that seal. We are going to do quarterly audits on those individuals that are able to access clinical information within the Portal, but it is 100% okay for you to access that information as long as you are treating that patient.

Robin McArdle:
   Okay, thank you. The next one is a quick comment. **It says, can you please repost the CE text code I lost my connection as it was being reposted.** And then a question after that says, i**f a patient is unable to complete the visit in telehealth but able to complete via telephone by a landline for example, can a provider still bill for this visit? And is a very different for Medicare versus Medicaid?**

John Jenkins
Remember, Medicare versus Medicaid, Medicaid can be telephonic so you are okay. With Medicare this is the $50,000 question. I'm going to give you very unofficial guidance. The unofficial guidance is that if you start out with an audiovisual visit and the connection fails then you must complete the visit telephonically. Document that it occurred. Document you made an attempt to start up audiovisual, it started off audiovisual and that the technology failed. Then we will see how Medicare responds to it. They have not given a specific guidance, as to my knowledge base on what happens when an audiovisual connection fails and is then completed by telephonic. I think if you start out with that documentation, hopefully, they will understand and will go ahead and allow you to post that charge. But there is no clear guidance on that I know. I will also ask Paula and Lakeisha Moore. If you heard other specifics recently on guidance if an audiovisual connection fails and converts to audio only?
 We lost the audio on that one so it did fail. We will go to to the next question.

Robin McArdle:
   Thank you, Dr. Jenkins. There is just a couple of minutes left in the session so I'm going to point out a couple of comments. One is by Tammy [Inaudible] and it says, please let them know I am updating the cheat sheet with recent payer updates which will be done tomorrow morning. That was one comment. The next says, this is just a reminder that CCNC and CCPN is providing a bunch of telehealth support through the CCPN website. And from [Inaudible] we have the Medicare telehealth billing summary as of April 7, so I'm not sure, Dr. Jenkins, that this is something we can possibly share or how you would like to disseminate the information from this comment. Do you have any idea?

John Jenkins:
 I think everybody's getting that and Chris Wilmington is taking the lead on patient support. We will make sure that information as much as we can get on to our webpages for the AHEC support for practices but I think most I think most of that is already making it on to those pages.

Robin McArdle:
   Okay. Great. Last question, and the rest of them we will have to follow up with e-mail after the session. **My understanding is healthcare providers are required by North Carolina to submit Medicaid and State health plan data. My question is, if many hospitals like UNC, wake med and Duke are submitting all payer data versus just State health plan and Medicaid?**

Jessica Brehmer:
   Yes, so the law states if you are a provider and you are receiving any State funds, so that would be Medicaid, State health plans or funds from State grants, you do have to connect and send patient data to NC Health Connects. However, there are two different agreements that people can sign with NCHealth Connex. There is a full agreement and it has a business Associate agreement within that participation agreement. With that BAA that organization can send all patient data regardless of payer. And on the other side of that the submit only participation agreement, so if there is an organization that has a submit only then they are able to filter out other information. So, they would filter out Medicare information. So, the only information we submit from the submit only organizations would be Medicaid, State health plan or any services where they

received funds from State grants. So, just want to point that out there. It's a great question and a lot of people are confused on who is sending what data. The majority of our hospitals have signed an amendment to the submit only that allows them to send all patient data regardless of payer, especially, during this pandemic.

Robin McArdle:

Okay, great. Thank you so much. I will pass it back up to you, Lakeisha Moore. A reminder to the other three who asked questions, I will make sure we follow up if it was it was not answered today.

Lakeisha Moore:

Great, you so much. We got a lot a billing questions on telehealth coming in. You guys definitely, we appreciate those questions. Next week Felicia and Paula will walk us through case studies. In the meantime, I think CHIP from CCNC put other telehealth billing coding tips on the website, the NCNCC website and AHEC website has great telehealth billing tips. AHEC posted that they are updating that because as you guys know some of those tips kind of change.

Really as a reminder this last slide, we are available for technical assistance, so if you have specific questions like that we definitely try to get back to you in a timely manner to make sure your telehealth billing questions are answered, we can point you to the right direction for resources, so feel free to e-mail or check out the office of rural health or AHEC website.

Thank you again for joining today. We're excited next week to have the Mid-Atlantic telehealth resource center, their Director will join us next week, along with other billing telehealth experts. Excited to have them talk to us a little more about many of the telehealth billing questions you have, and even some of the payers that may be paying in a time where you can get it quicker turnaround on the billing questions you are sending. Dr. Jenkins, one of his colleagues is going to join us to talk more about that next week. Thanks again, everyone. If nothing else, I think for today, and thank you for so many of the questions. Thank you for the thank yous. We appreciate the feedback which helps us develop our content. We are over today on our time but, hopefully, everyone is safe. Glad the storms have come through and maybe we will see the sunshine. I don't know. Pretty cloudy where I am in North Carolina. Once again, thank you, everybody for joining. We will talk to you again next Monday at noon. Take care. Goodbye.

[Event Concluded]