Transcript for Telehealth Implementation Best Practices
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Please stand by for realtime captions.

Lakeisha Moore:
Good afternoon and thank you for joining us today for the Telehealth Virtual Office Hours Webinar Series. I'm Lakeisha Moore, with the North Carolina Office of Rural Health, or ORH for short, and I'm joined today by Dr. John E. Jenkins with the Greensboro Health Education Center AHEC and some of our other partners at AHEC and other special guests. Jay Ostrowski, who is the CEO of Adaptive Telehealth and Jeffrey Sural, Director of the North Carolina Broadband Infrastructure Office, or BIO for short, will also be joining us today. During today's webinar, we're going to be sharing some telehealth best practices and lots of other resources from across our state.

So remember, if you would like to ask a question during the webinar, please type your question by clicking on the Q&A icon that you'll see within Zoom and then we'll work to answer as many questions as we can in the time permitting. We're going to leave a good amount of time for questions towards the end of the webinar so we will try to address them all. Also, if you need technical assistance during the webinar, please email technicalassistanceCOVID19@gmail.com and someone will assist you with getting connected to the webinar. I also want to send a very special welcome today to all of our safety net sites across the State. We appreciate you and the work you are doing to keep our patients and North Carolina safe and healthy during this COVID19 pandemic.

We are also excited today to share lots of telehealth best practices we have seen. We will actually check back in with our friends from the Roanoke Chowan Community Health Center. We've got Kim Schwartz with us today. And we will also talk about some ways that you can incorporate the best practices we have seen across the state in your respective practices in your organization and your workflow. This week, Lisa Renfrow from AHEC will start us off by sharing information on how to receive continuing medical education, or CME, for this webinar. Then Dr. Jenkins and special guests Chris Weathington and Kim Schwartz, along with Paula Locklear and Felicia Coats from AHEC will also join us to talk about billing tips and some of the workflow best practices that they have seen in their practices and working with others across the state.

Glad to have Jay Ostrowski, CEO of Adaptive Telehealth and also MATRC, the Mid Atlantic Telehealth Resource Center consultative partner who is also going to share with us technical assistance opportunities and also some best practices he's seen, especially in the behavioral health field. And then we will have Jeff Sural, who is joining us from the Broadband Infrastructure Office to share some broadband resources that are out there. So, lots of information to cover today.

Robin McArdle, who's with the Office of Rural Health, one of the telehealth specialists, is also on the line and she'll be monitoring the Q&A to make sure we get your questions that you sent in through Zoom answered.

So, quick housekeeping items before we get started, this webinar is being recorded and will be available on the Office of Rural Health and AHEC websites with the slides. So if we are unable to answer your questions today during the session, we will definitely consider those questions for a future telehealth webinar topic and I will say a lot of questions we are getting on billing and coding, we want to make sure we get those right for you, so those questions, if we do not answer them directly during the webinar, we have your email address and we are committed to following back up with you directly to make sure we are getting you the right telehealth billing and coding information you need. I will go ahead and turn it over to Lisa who is going to talk to us about how we get CME credits for today's webinar.

Lisa Renfrow:
Thank you Lakeisha. To obtain CME credits, CEUs, or contact hours for participation in this webinar you must have a myAHEC account with an up to date cell phone number listed. If you do not have an account or cell phone number associated with your existing account you will be prompted to update this information once registration is completed. To register your attendance for today's webinar please text DF5C1 to 336-793-9317. Both the code and phone number are listed on the current slide. For additional instructions on how to register using this system, please visit www.nwahec.org/textreg, as shown on this slide.

The continuing education for this program is being provided by Area L AHEC in partnership with the Office of Rural Health, the NC AHEC Program Office, Northwest AHEC and Greensboro AHEC. Specific credit information today is listed on this slide. Now I'll pass it over to Dr. John Jenkins.

Dr. John Jenkins:
Well welcome to episode five. We start with a quote always, "Quality in a service or product is not what you put into it. It is what the client or customer gets out of it". I think in healthcare we refer to that as being patient centered. We have a conversation today with Kim Schwartz and Chris Weathington about some of the experiences they are having out in the field with telehealth and then a conversation with our two coders, Paula Locklear and Felicia. Remember, what it is about is the "why", is access, access, access... and remember, what it is about is what we are doing, is finding out about how telehealth in the COVID crisis is affecting our ability to serve our patients.

We shared this last week, and it's worth going over one more time. Most of us have experienced a significant drop in monthly production due to the COVID crisis. Our inpatient visits have dropped off significantly. Some of you are getting back to having some inpatient visits for labs and other purposes, but primarily we have been using telehealth as our main modality and that has affected our ability to produce what we want. Hopefully we are turning

the corner here in late April, May and our production is going to increase. And that will be due to our implementation of whether or not we're using all visit types: the acute, the chronic visits, maintenance visits and wellness visits. That we are using, shortening the time if we can, some of you started 30 minutes for a telehealth visit if we can get that down to 20 minutes it will allow our production to go up.

Having all of our providers understand the necessity of using telehealth for communication and understanding that RVUs are the way we measure production, not necessarily the work effort that we're doing. The future we will reach together depends on the next steps that we take. And those that will be charting a new strategy, and some of our second-half speakers will be talking about the new strategy for what we do in telehealth in the future.

There are three imperatives to telehealth in the future. One is supporting the front line. We like to do it in practice improvement and talk about this as standard work. Standard work is created with the people who do the work so that each member of the team can own that standard work. We talk about starting slow to power up, many of you are in that middle range now where you are trying to increase your frequency of utilization of digital health and virtual health tools. Develop support training for your providers so they have confidence that they know exactly what to do on the call and how to react on the call. Things like eye contact and things we have learned in the past about not being the first person to hang up. The measure to improve both your leading indicators of how many of the visit types you are doing and your lagging indicators as to how you have improved health metrics around gap closures, people monitoring their diabetes, hypertension control, things like that. Remember your front door is now digital and train your staff and your providers.

Inform the customer, patients have service expectations in the digital world. The best way to succeed is to create clear expectations about what is going to happen, both on your webpages and in the communications you have with your with patients. And then, exceed them if possible.

Market the why, the how, and the what, we talked about that last week. Have customer friendly FAQs so the customers know exactly what kind of questions they can find answers to, answers they can find digitally so they don't have to bother the staff. Solve for on time scheduling, that is kind of critical. Nobody wants to wait online waiting for a provider to enter a room. Know and engage your customer, remember we talked about a simple way to know your customer is to address them by their first name and then have a customer support line.

Last but not least, the technology should be invisible. It's not the technology, it is a visit. Choose technology that makes it as simple as possible for the patient. We have talked about some of those platforms which are really easy and that don't require downloads. Practice to make sure the team is comfortable with the process. Be intentional with your scheduling goals, so as you ramp up, make sure you are not ramping up too fast for the individual providers and plan for different types of visits.

Remember, you are prototyping. And I love this, Kim is going to talk about this later, prototypes are messy. You're learning by doing. Prototypes test ideas and fail - you fail quickly and move on. And prototypes spark new ideas, so listen to your team. Speaking of listening, Chris Weathington is someone who listens to our practices and provides great practice support. So Chris, tell us a little about the practice support team and what they do.

Chris Weathington:
Thank you Dr. Jenkins. We have a statewide team of about 35 practice support coaches with extensive practice management HIT experience. And these coaches can work with your practice on a variety of different practice support needs. Historically we have been able to help practices around quality improvement EHR optimization and selection. Medicaid meaningful use, Medicaid transformation and HIE training. We also provide virtual health training as well and that includes helping practices with evaluating their virtual health options for solutions, billing, coding, and clinical workflow redesigns. They're able to work with you on site or virtually. Now during COVID-19 we are only able to help virtually, but at some point we'll be able to come on site as well. So those are the services that we are able to provide.

Dr. John Jenkins:
I am amazed by your team, Chris. Tell us some of the telehealth success examples you've seen as you work in the practices on a virtual basis.

Chris Weathington:
Well, some of these items you've already mentioned. What we've seen so far, for those practices that seem to be doing it really well, one of the first things we are noticing as a common theme is practices where there is very strong practice manager and medical director collaboration and leadership, or a physician champion who works very closely with the practice manager. Leadership is key. They set the tone, the staff look to them for guidance and they look to them for instilling a sense of optimism and ingenuity within the practice.

Another item we are noticing for those practices that do it really well is they standardize their workflows. These are not complicated workflows, these are very simple workflows around different types of visits.

Also making sure that the staff are practicing to the top of their licensure, to the top of their capability, implementing scripts so that staff if they are on the phone or they're corresponding by email, they have something that they can use when they are communicating with the patient or the family member. At least something to get them started until they get the hang of it.

And then also, when I mentioned earlier visit types, getting a little creative with the types of visits. Don't get yourself so boxed in and you are only considering one type of visit type for a televisit. Another thing we are seeing is while the practice may have a preferred virtual health solution, they really need to be flexible with the patients. So, if I have a vendor I am using, that is great. But if the patient is very comfortable with FaceTime or Facebook or Skype, try to work with the patient on what they are comfortable with, and then over time you might be able to get them to acclimate to your preferred virtual health solution.

Well implemented pre-visit planning is really important. Having your staff invest time to make sure they get the needed information from the patient for the virtual health visits, getting the patient comfortable with the technology or the next steps that are needed so that when the provider actually executes or begins the virtual health visit, all of that has been taken care of and it will also help ensure better patient compliance and reduce the no-show rate.

One other item we are seeing is parking by Wi-Fi hotspots and the use of tablets for patients. I believe that Kim Schwartz is going to talk more about that. That's a really creative option especially for patients who may not have access to Wi-Fi at home.

Focusing on high-risk patients is really important. They are talking about, this is the next silent pandemic. The fact that patients with underlying health conditions are deferring their care, or choosing not to come into the office, and it is these patients who are most at risk for COVID19 complications in the hospital. So, taking the time to pull maybe once a week or once every other week and focus on a condition such as diabetes, or hypertension or asthma or transitions of care management.

And finally practice on the staff members. That is one thing we are seeing is the notion practicing on staff members to work out the implementation bugs. Getting feedback from the staff on what seems to be working, what is not working and tweak your workflow accordingly.

Dr. John Jenkins:
That's great. What are some of the challenges you have seen?

Chris Weathington:
Well, there's going to be natural challenges no matter what you do when you're trying something new so some of the challenges we have seen are that some providers and staff are very resistant to telehealth. I would caution them to be very careful about saying we are not going to do telehealth, because this can have unintended consequences. Waiting too late or giving up temporarily can have dire fiscal and productivity consequences for your practice. Not willing to be creative and try things out, listening to ideas from the team.

Some of the other things we have seen is an unwillingness to invest time in standardizing the workflow or maximizing the use of your administrative and clinical staff. I heard from one practice, they were seeing less than 10 patients per day on their patient panel, but the providers and staff said they simply didn't have the time to invest time in workflow standardization or implementing telehealth. You really need to be mindful to put your feet in the water.

Letting perfection be the enemy of good – it's a work in progress. Just keep it simple is my motto. Don't let perfection be the enemy of good. And finally letting your professional colleagues or competitors get ahead of you. For practices that have chosen not to do this very well, just know the competitor or the physician practice down the street that has, they will win over patients from your panel. And those patients will start to go to those practices that are really embracing telehealth because this is going to be the new norm post COVID-19. I am not saying that payers, they're going to loosen the rules or pay at the level of an office visit post COVID19, but they surely are going to do something to make telehealth a viable 21st-century solution.

Dr. John Jenkins:
So Chris, let's end with a few things that make you smile. What are some of the "aha" moments you have had when you are working with practices?

Chris Weathington:
I think seeing how far practices have come in telehealth in a short period of time, normally when a practice takes on a new EHR something significant with technology, it typically requires several months or as long as a year to fully evaluate their options. So I think the survival instinct has really kicked in and it's amazing to me how far practices have come along with what they are doing. Especially with the creativity, the adaptability and just really jumping into something brand new. When the COVID-19 pandemic is gone, I think the successful practices will be those who have enhanced the patient experience through - this is a really nice opportunity to take telehealth and find what is working, what is not working, and how can you optimize the overall patient experience with convenience, access to care, and so on.

And then I think finally, payers in the government are finally learning how this can work in addressing the public health needs. I think unfortunately we have waited until a pandemic to see what is possible. But if you take the silver lining approach, I really think this is going to be a great opportunity for payers in government to understand that telehealth can be a very important component of a medical practice. It doesn't necessarily replace the on-site visit value but it can supplement it.

Dr. John Jenkins:
Fantastic. Thanks Chris. And everybody - be sure to reach out to Chris and his team and your local AHECs to be able to have the practice support you need.

Now let's talk a moment with Kim. So welcome back Kim. Kim is the CEO of Roanoke Chowan Community Health Center. Glad to have you today!

Kim Schwartz:
Thanks John. It's nice to be with everybody and you know I'm a huge champion of AHEC and the work that the practice teams have done with us and have our own practice coordinator embedded in our group and FQHCs in eastern North Carolina. So, we are completely ambulatory care and one of the things for us during this crisis is the recognition that there is a lot of front-line work going on. About the third week we came into on Tuesday. It was the Monday after Easter that somebody had come on that Monday and done a sidewalk chart for us. So we love the "We Can Do It" and the nursing mask and how much fun that is and the team, we are so excited about that. And we've had folks in the community just randomly put thank you notes on our windshields in the parking lot at all of our sites. And the Board of Directors has been consistent about sending out thank you's and their pictures to say thank you, that's one of our Board of Directors from Woodland there on the picture in front of us. So being able to acknowledge our staff and how hard they are working and everything is changing so quickly. So, we are trying to provide lunch once a week, I wish we could do it every day but acknowledge that it is a little tricky sometimes.

I think our other big thing is that we recognized early on that there was an extra responsibility to those who are working face-to-face. We don't have a lot of cash as an FQHC but we took a page from another one of the FQHCs out in Alaska and instituted back to March 30 a hazardous vacation leave, so you can see how we acknowledge that with our team. I think that was a real big issue for us. To recognize what it means to wear a mask, and gloves, and all the PPE all day long. And then those of us who have to be on site, that the work just has to go on. I think hearing from our team that was a great acknowledgment and it's a temporary

policy. We were really careful about that and consulted legal on that to make sure that everyone knows it is a temporary policy in place.

The other thing is about communication and, I think that is what everyone is trying to do is get an A+ in communication here and being very intentional about weekly communication. I make weekly videos and the Board there you can actually see right there she did a video for us as well too and just doing it about three times a week we do and update and on Fridays what I think is really special is that we talk about celebrations and we have an updated patient satisfaction survey since COVID even, and a great contract that has been working with us so we actually put in the positive comments because often they recognize individuals and there is something really special about that as well.

So, what is important to our staff is knowing their position in the organization. So we've committed from the very beginning to get them every two week updates, about two weeks at a time, so this past week we were able to say "Yep, we have full benefits and all positions covered through May 8th", and we are committed to doing that two weeks at a time.

John, you asked me to talk about what was working well, and really appreciated Chris' shout-out to some of the work we've been doing. Jay and I have known each other for a long time and we have been doing at the community health center remote patient monitoring since 2006. So, we love the highlight about the work around telehealth.

So very quickly we instituted nurse case management using our RPM nursing team with three folks and now we have nine working in that team. But we are monitoring those folks that are COVID tested and suspected while they are waiting for results and if they get a positive result until they are released by their provider. That has been a lifeline for our patients, being able to have questions be addressed, for them to be able to feel confident about what quarantine means, what isolation means, to have questions from their family be addressed, and also keep track of their clinical condition as well too and document that in the chart. That's right through the weekend as well too and some of the folks are so ill that we actually have to monitor and check on them twice a day. So that has been a blessing to have a system already in place, we didn't have to create a workflow, it was there, and we were able to activate that specific to COVID.

And a shout out about our curbside, this has been a huge success. We have a number of senior providers that have been anxious about getting vitals on their patients. How do we get them with it being such a vacant area for broadband, how do we get that information from our patients. So they literally pull up to the parking lot to get instruction and then they make their appointment or we give them the reminder and we download MyChart right there and we can do vitals in the parking lot. That has been just a godsend for our patients.

We have been having some challenges around privacy, and how to keep privacy there. But one day last week I came in about 8:30 in the morning and there were nine folks in the parking lot in our spots. We had to quickly do another workaround on that, because it is not a scheduled appointment, so we had multiple people scheduling for the same four spots we had at one time so we had to talk about a quick change and being able to adapt that EHR was incredible.

Now, this is on Facebook and this was an exciting thing to see our nurses are making each other headbands and some with matching masks so they called it the headband and mask

brigade and took a picture one day two weeks ago. This is the “We are all in this together” mindset. I overhear conversations with patients and the nursing staff and account representative staff at the front say, “this is new for us to. We are going to figure it out together”. I literally heard one of the folks say, “I have got all the time in the world let’s figure this out, and let's just keep the patients from feeling anxious about the process”. They have been able to be so kind and intentional with them, because everyone is learning together. That has been our attitude, everybody had on their desk, a wristband from our HR team, RCCHC Strong, be strong we are all in this together.

This week we celebrate our 15th anniversary as an FQHC and so we are going to have spirit week, so regardless of what is going on, we have spirit and it's a blessing to know we are all in this together.

So the other thing we had to adapt very quickly was our pharmacy, we had two in-house pharmacies and 15 partner pharmacies in the communities we serve. And that is our number one revenue source. So we had to very quickly adapt so folks wouldn’t have to come in to our in-house pharmacy so we established drive up. Those parking spots that you see were front parking spots for medical staff so we had to take those away and work on a system and that has been a great adaptation for our team to be able to use. The pharmacy is drive up and curbside.

And then probably the thing I am most excited to share is that anybody can do this. When we talk about the potential, this is Dr. Charles Sawyer who has been practicing for a very long time, two weeks ago he had our third highest in productivity and we have patient permission for this picture here in front of you, but she was in the parking lot at a hot spot visiting with Dr. Sawyer who happened to be in his office and they are actually having a visit. So, when someone is saying to me, I can't do this, this is difficult, I say why don't you let Dr. Sawyer coach you through this. He is doing it very well. And then they say “I can figure this out”. And I think the other thing, and John you and I talked about this a couple of weeks ago, where I have a couple of seasoned providers that happen to just be exceptional providers that are now seeing that telehealth is a means for them to continue working and to be able to continue longer than they initially thought, it's a little less stressful, they aren't exposed to so much. So that has been really, really exciting.

So, to talk about what can be improved. So not realizing how long it takes to get a patient on a virtual visit. I think in the industry, if you need to do a web visit and I have done one myself and I load everything myself, but if a person has never done a virtual visit, or is not familiar with using any kind of web link at all, maybe not Zoom, to be able to enroll them into our portal through MyChart and get them accustomed to have a virtual visit, we’re been doing time studies and it averages 35 to 45 minutes of prep time. That is a long time and that’s non-billable time. And then we are actually in the process right now of doing time studies for how long it takes for a virtual visit, how long it takes for a telephonic visit and we have curbside visits, hot spots, in person visits and in-person sick and COVID related visits. In our remote two sites, a single provider could be doing five different types of visits in one day so we are working on time studies right now of how to work that in our schedules. Is 30 minutes really enough time? What does that look like?

As an FQHC, we are responding to the call, and we’re seeing patients virtually that we haven't seen before as well. We still have the records of those that are existing patients but now we are seeing those folks in the community that don't have a PCP or don’t have access,

so that's also a whole other issue, how do we put that in the time studies? We are working on that from a QI perspective and that is more work than we have ever thought. Usually it would take several years to go through these processes.

But our biggest barrier, truly, is that in our area we have less than 50% broadband access. Some of that is actually because there is not broadband and our CMO lives somewhere where she doesn't have broadband access in her home and it's only 10 minutes from our clinic site. Then there are financial barriers, even if there is service, for people to be able to afford the subscription fee. So, when we are being told that virtual visits don't have parity for billing for telephonic visits, it's a little frustrating, because recognizing we may not have any other way than to do a telephonic visit for someone to keep us safe and keep our staff safe, and to be able to have that connection with the patient. That for us is something we are also tracking in a QI way. We started just today a workflow for if it is a telephonic visit, what is the reason why, so we can track that. Is it because they can't get to the clinic because they don't have transportation or to get to a hot spot, or is it because they don't actually have any connection whatsoever? We have some branching logic questions we are doing in a quality means as well too.

And then, this totally surprised us, I was looking out my window which it backs up to the pharmacy area and I saw a dog in the back of a pickup in line in the pharmacy and generally we have about five cars in line and I saw a dog in the back of a pickup and I went, well isn't that quaint, and then I thought, oh my gosh, safety for our staff. So, there really have been issues around that. We've contacted Chick-Fil-A to find out what they do around things like that. There is nothing on the books anywhere, John and I talked about this, talked about banks, that banks have real drive-up windows, there is a window of folks going out to the parking lot because we don't have the means for a drive up, so we have all kinds of dynamics about how do we keep safe around this kind of thing. We can refuse service, no one likes to do this, but how do we keep safe? And it's our culture to have the dog jump in the back of the pickup. So those of you that are QI sensitive, any kind of responses and actions around this, send them to John so he can send them on to us and we will test them.

So some –"ah-ha" – We're living in an area where we're hurricane prone and we recognize that right away we were able to quickly adapt. People ask us all the time - How did you adapt so much? I have some friends in Maine, and I said we are used to quick adaptations. We had some internal jokes, we'd be on national calls, we had instituted something on Tuesday and were on a call on Friday, and we joked "Oh, they're so Tuesday". We are ahead of the curve because of our emergency preparedness. The first four weeks we were having daily emergency preparedness meetings. And then we realized, as we were coming on for preparation in May for June for hurricane season, we needed to change our focus and call that the updating and planning meeting to meet three times a week for about 30 minutes and we still have our emergency preparedness team getting ready for hurricane season, just praying that that is not going to happen at the same time. So, those are some things that we're trying to do in preparedness that we would not have ever thought about.

And I think you mentioned this earlier but there is not much need to explain to everybody the why, we know from day one that our five prime directives are to Flatten the Curve, Keep folks out of higher levels of care, Conserve PPE, Access to care and Safety for everyone involved. Everyone recognizes that's in our organization that giving access to the patients, keeping our staff, we've got 180 staff, and keeping everyone funded and in positions, and

pushing that, have a sense of urgency around the “why” so that has been a blessing. And then the “how” and the “what” we are working as we gather along as well.

And then I think the biggest “ah-ha” and actually one of the folks that went ah-ha! is keeping everyone informed of such a big job and recognizing that we all are involved in this on a regular basis.

The last part is the FQHC health equity piece that we have been involved in flattening all kinds of curves for a long time. It wasn't a big surprise to us to hear about the issues around equity and poverty, so for us taking that as our challenge to elevate FQHCs, and the community health center movement, we were built for just such a time as this. We’re taking it day-to-day.

Dr. John Jenkins:
Perfect, thank you so much Kim. That's an inspiring story of what is going on in your practice there. So, we are going to go to a couple of questions that happened last week from our coding and billing experts. I am going to start off with Felicia. Felicia, there was confusion last week and several of the questions over telephonic and telehealth. Can you clear this up?

Felicia Coats:
Sure. Telehealth generally refers to a virtual visit where there is audio and visual communication between the provider and the patient. As they discuss the patient and their medical condition or health concerns, they can see each other, they can hear each other. Whereas, telephonic refers to audio only. Again, it is a virtual visit between a provider and a patient but it is not face-to-face. Just think of holding a telephone, and that pretty much explains the telephonic visit. The provider and patient can only hear each other, but they cannot see each other.

Sometimes during a telehealth visit the video may fail so the visit has to be completed by telephonic. That is understandable and that can still be a telehealth visit.

Dr. John Jenkins:
Very good. So, Paula- Blue Cross Blue Shield – they had some new guidelines for covered visits. Can you give us a brief understanding of what has changed?

Paula Locklear:
Yes, so this is a good opportunity to go back and correct some of the things we had in our last webinar. With Blue Cross Blue Shield, they do have some new guidelines that did come out that would allow for telehealth visits, typically audiovisual platforms, but during the pandemic many patients may not have access to viable internet services. So, Blue Cross Blue Shield of North Carolina is allowing these audio visits to be considered virtual visits and treated as a face-to-face visit. This audio only visit will be billed in the outpatient office code that has been established for established patients as well as new patients. It’ll require place of service [indiscernible] and a modifier in that case.

Dr. John Jenkins:
Very good. I understand that a lot of the Medicare advantage plans are allowing us to use telephonic visits when people don't have the technology?

Paula Locklear:
Yes.

Dr. John Jenkins:
So, Felicia, one last question for you, we had some confusion over the service codes, can you clear that up for us?

Felicia Coats:
I certainly can, and we apologize for that. We have the places of service inverted last week for rural health centers and federally qualified health centers, so an RHC place of service is 72 and an FQHC is 50. And if there's any doubt, those places of service are listed in the CPT book.

Dr. John Jenkins.
Perfect. And so Paula, finally, my nurse had a triage call prior to an office visit, and then I had a virtual visit scheduled or an office visit scheduled. Can I bill for the triage call as a telephonic call and bill for the office visit?

Paula Locklear:
That's another interesting point. When we looked at this, you would not bill separate for the nurse triage call that prompted an office visit within 24 hours of the patient's call. If the provider documents a review of the triage notes in the office visit, they may use this time to influence the level of the CPT charge at the follow-up visit.

Dr. John Jenkins:
That makes a lot of sense. And I think the scenario doesn't support the time limited codes. And remember that virtual check-ins are provider given and they're intended to prevent the need for a visit. Like, if you saw somebody and they provided blood pressure readings and you said, you are doing fine, they're not perfect but there where I want them to be, and you can keep the scheduled appointment coming forward. So that is great information for us. So I'm going to turn it back to Lakeisha to introduce our final two speakers.

Lakeisha Moore:
Great, thank you so much Dr. Jenkins and the AHE team. Congratulations to Kim and the RCCHC team for 15 years as an FQHC, great learnings there and wow, how telehealth has grown so quickly here. Glad to be joined today by Jay Ostrowski, the CEO of Adaptive Telehealth and also one of the consultative partners with the Mid Atlantic Telehealth Resource Center, or MATRIX for short. MATRIX is the telehealth resource center that supports North Carolina. So welcome Jay, to talk about some of the telehealth technical assistance that is available through MATRIX.

Jay Ostrowski:
Hi everybody, thanks for having me, and congratulations again Kim on great work in telehealth and in person practice. I am Jay Ostrowski and I wear a few hats, I primarily do telehealth consultations and help create software in my role as a consultative partner for the Mid-Atlantic Telehealth Resource Center. I work with companies locally here in North Carolina and across the country and even some across the world to help get their services started or refined to help basically select the technologies, create the workflows, train staff that sort of thing. Let me go to the next slide.

As you have heard before, success in telehealth is not as linear as we would like it to be. It's a little bit of a messy process. And I know that feels really nervous for a lot of people that want to be professional and they really want to do things well, and correctly, and not have liability. I spoke with a group of nurses yesterday for a school system that said we have to convert to 100% telehealth and we feel really nervous about the things that can go wrong. I would go ahead and say, yes, there are things that can go wrong but there are many things that can go right. When you get engaged with the telehealth resource Center, and AHEC and others, they will help you be safe in this practice and select good technologies. As we talk about experimentation with processes or technologies, we are not talking a free-for-all, there are certain ways to do this safely in a HIPAA compliant manner and thoroughly. Even though they're relaxing the enforcement of HIPAA, we still want to be as preferred by the government to have HIPAA in mind not just because of the rules, but the safety that that brings for patients and for providers. Especially for some of our behavioral health, mental health issues, or STDs, things like that could be something that your patient does not want exposed on the Internet, right? There are many technologies ways you can go about doing this safely. It really is just a matter of doing some education and some handholding with some people that have done this before.

Remember telehealth is not new. It's been around for a long time. Some people say 150 years, some people say 70 years- certainly at least the last 50-60 years in university settings and other places. Companies like Kim Schwartz have been doing it very well for a long time. So you're not the first and you're not alone. We want to help you be successful and maybe make that not as much of a messy process but get you on the right track as soon as we can.

So I want to encourage you also personally that you can do this. There are many people who have gone before you and we are here as a telehealth resource center to both encourage you and not make you look bad in front of other people. So we can meet even privately with you to coach you through that. And I know AHEC does that as well.

And I also want to throw out some ideas here as you might have your primary care visit but there are a lot of other services that can be done through telehealth, and to be encouraging people that are in your practice, that there is quite a lot that you can do with telehealth. Quite a lot of times we mistakenly, we mistakenly compare telehealth with in person visits. We want our telehealth visits to be at the same standard of care as in person, but I think saying they have the same kind of feel of an in-person visit may not be the case. However, you can get the work done and research is very strong that telehealth visits can help meet treatment goals and are very effective.

So, if you are new to this, and you're thinking, you cannot get your head around this, it is good to talk with somebody and do some reading. We have some resources here that we want to share with you.

So, if you type in MATRC.org that'll get you to our MATRC website. And as you can see right in the dead center is a link to COVID19 resources. And there are quite a lot of resources under that one link. But in general, this page was pre-COVID19. There were a lot of resources here and sometimes it can be too much information, so these buttons on the right side if you want to click search, chat, or even request technical assistance. Next slide.

So when you click on that COVID-19 link I shared with you, there will be some drop-down menus, so each of the sections are made even for your mobile phone if you're on the go. You

can click on these and get different sections that tell you more about what's available in your area. Next slide.

So, say for instance you are into tele-behavioral health, maybe you have an FQHC where one size doesn't fit all. We have different departments, each department can take on what fits their use case because the regulations and the requirements are different for each licensure. Or license type and service type. We try to break that down, this is an example of the subsection in there, there is a link to the tele-behavioral health center of excellence and a link to a video I created which is an overview of what you need to know and here's what you need to do to get this up and running. If you have a substance use disorder services, there are some links there to other resources so that you can keep drilling down into more and more resources depending on what you need. Next slide.

So for instance, for the federally qualified health centers, there is another section here that tells you about the scope of services in the federal tort claims act and reimbursement and basically how to develop a program. The FQHCs, they're normally short on cash as we all know, and we need to make sure our resources count and that they are right on target. I will also encourage you guys that even though you don't have broadband in a lot of areas, while we know it is growing, there are many new technologies on the market that do cater to low bandwidth calls. So I am a licensed professional counselor and supervisor and I see people sometimes on bandwidth as low as 350 to 400 KB which is less than half a megabyte. That's not the ideal call, not the high-definition call I need for a dermatology appointment. It is sufficient for a mental behavioral health consult. And that is a way of extending care to places where we didn't think it was normally possible.

Again, sometimes the experience is not the same as in person, but the care quality can be the same as in person. But in your training as you're onboarding you work with people that do this work, they will help you with some tips and tricks on how to maintain that eye contact and how to build rapport and overall create a new muscle memory as you're doing this. Again, you're not alone, many people have done this before you. Next slide.

So, going back to that original MATRC.org, I want to call your attention to the tele-behavioral health center of excellence, that is under a tab called hot topics. There that and there is remote patient monitoring and tele-MAT and so much more, depending on the resources that you want to see. But some of these have videos if your boss needs to get their head around this, or somebody new, they are quick videos that show you, here are the issues with HIPAA compliance that you need to think about, here's what clinic to clinic vs clinic to home looks like. Just to give you, the videos give a high-level touch point of getting your head around this quickly but then you can scroll down, next slide.

When you scroll down, there are other drop-down menus with more. So, the theme here is even more, you can look at the clinical guidelines, the issues of the crossing state lines, HIPAA compliance, financially. Next slide.

There is even a section on the reimbursement for different entities and insurance companies. We have a national directory of insurances that are paying across the U.S. Next slide.

Every other Friday I am online live for about two hours. If you would like to get a hold of me and ask me questions about telehealth in general, or any specific questions as you get stuck on something, I wanted you guys to know that I'm available, that you just go to the MATRC

page, scroll down, halfway through, click here to join the live meeting and it will open up a webinar page and you can join and turn on your video or not. But you can just ask us anything about telehealth and we would be happy to help you every other Friday. Next.

We also have another resource for you called the tele-mental health comparisons.com. Tele-mental health comparisons.com. This is a vendor neutral site that we created a long time ago that we keep updating pretty frequently when we get new information. But when you go here, you click on the entity which you are looking for, like a private practice software, provider network or enterprise software or maybe consumer software, and a lot of these are usable for non-mental health, maybe ambulatory care as well. But when you click on this, it will give you drop-down menus that show you a lot more options. You click on the criteria that you need and it will narrow down hundreds of options down into a few options that are HIPAA secure and meet your criteria of what you are requiring in there. As soon as you contact a vendor, a lot of things will change and they will work hard on selling you stuff, but this is a place you can go to ask a lot of questions. While I have a software that I work with, this is not biased in any way, all the data is from the vendors, this is a good place to shop if you are looking for this.

The reason I bring it up now, some of you may have already selected something, and when you're selecting something you might say, this will do for now and that is quite fine. But as was mentioned, we need to be thinking about this in a long-term framework because while the wave will come and go, some of the water is going to stay here. It might be ankle-deep or waist deep, we don't know, but we will always be doing some telehealth from here on out. So, we need to be thinking about what is it that is more sustainable long-term. You might want to experiment with two or three other softwares to see which one has the better flow or experience or which one is more adjustable to fit your needs. I am here for you every other week or you can go to the site and ask for technical assistance at any time and we are happy to help you with more resources as you need them. Just let us know, thanks. Back to you guys.

Lakeisha Moore:
Thanks so much for sharing Jay. Wow, I know we have had a lot of different resources that we have shared today during the webinar and I see our time is ticking away. Happy to be joined today by Jeff Sural, who is the Director of the Broadband Infrastructure Office here in North Carolina or BIO for short. We'll definitely want to go through some of those resources, just wanted to remind those that have sent in questions, if we are not able to get questions today, because we put in your email address, we can link back to your email with your questions. So if we don't get to them live, we will commit to following up afterwards. But right now I would like to turn it over to Jeff who's going to share some of the Broadband Infrastructure Office resources that are available for us in this state. Thanks for joining us Jeff.

Jeff Sural:
Thanks Lakeisha, and thanks to AHEC for having me. I will try to be very, very quick so we can get to some of your questions. Basically, I will cover some of what we have done in response to COVID and a little bit about what's going on around the state. Again, my name's Jeff Sural I am the Director of the Broadband Infrastructure Office, we're a division of the North Carolina Department of Information Technology, and we have a team of about 10 people that work on enhancing, facilitating, broadband deployment and adoption throughout the state. We have been working hard over the last several weeks to try to get folks who are

not connected or who do not have adequate broadband service or connectivity in some way or another. We have also been monitoring what is going on around the state and this slide gives you an idea of some of the things we have been looking at and coordinating with our partners and emergency management, also with the Internet service provider community and with the DHHS, Office of Rural Health, state librarian, Department of Public Instruction, and others. Next slide.

Where we are in regards to the state connectivity, this is cable setting. So according to the FCC, the Federal Communications Commission, which receives information from internet service providers, about 95% of North Carolina households have access to broadband. Broadband is defined as 25 megabits per second, download speeds 3 megabits per second, upload speeds, basically that means you can stream video or maybe do some gaming and conduct some work by Google and email without any slowdown in their connectivity. Next slide.

Obviously I won't get into this, because this has been an ongoing conversation at the state and federal level, but we think the 95% number of access is overstated and what we have done is looked at the problem and the datasets a little differently, and in this map you can see the red areas of trouble spots in the states. Basically where we don't think there's enough bandwidth or access to bandwidth for folks. Next slide please.

So we started to create our own maps. So we rely on other data other than the FCC, and in this map you can see the red colored areas, brown colored areas, light-colored areas are more of the problems with access, and as we get into deeper blue we see better access across the state. This is for wired service only, not wireless service.

And then of course the providers provide the information to the Federal Communications Commission on their coverage data. So, we're beholden to that information at this time, we are trying to find better ways to collect data, including surveys, and you can keep scrolling through these, but this gives you an idea of the different providers and their coverage areas in the state. And you can look back at these slides to get a good idea.

Now, these generally tend to be a little bit overstated and one of the things we have done is create a survey with a speed test tool that's on our website right now. We partnered with Farm Bureau and we did one for the farmers and we are wrapping that up at the end of this month, and other data that we collect around the state we're doing with our partners at the Office of Rural Health and if folks like Kim have data they are collecting that would certainly be helpful to bring in or we can partner with you all to help you develop the questions that we need the answers to. And how people navigate through the survey. Sometimes people aren't familiar with upload/download speeds, internet connection, broadband, or service providers, so forth.

The other problem we have in the state in addition to access to broadband is adoption rates, the subscription to an Internet service. A lot of times we also define it as meaningful use of an Internet service. So we would include for example, telehealth in that.

The biggest barrier to adoption to folks signing up is cost. The other factors we have seen in studies, including research studies that we did on our own in the state with ECU, are relevancy or digital literacy. So if you look at the slide you will see that our adoption rates are

pretty low in North Carolina. If the 95% number is true, then less than 60% of those folks are actually adopting which is pretty low and troubling. Next slide please.

We've created our own map using different factors and federal data. You can see the darker colored areas are where we have the biggest problems with adoption rates. Obviously, you've seen other maps in North Carolina indicating distressed counties or low income areas similar to this map validating that cost is the primary challenge or barrier to buying Internet service. Next slide please.

So, in a neat response, we have been working with internet service providers across the state. They have taken a pledge from the FCC not to charge for late fees for customers with enough Wi-Fi spots. We did a call with all internet service providers a couple weeks ago and many have gone above and beyond that pledge to provide low-cost offerings for creating Wi-Fi services. Those services and those public Wi-Fi spots can be found in our resource map here's the link and the slide. And I will provide it at the end of the slide.

And now we are working with the Department of Public Instruction to get out equipment for bus Wi-Fi and we just had an announcement last week where AT&T, Google, and Duke Energy have all contributed funds to support equipment for bus Wi-Fi so that students can get access and frankly the general public can get access by having these buses parked in certain areas and emitting a Wi-Fi signal that the public can access. Next slide please.

We also have a rural broadband grant program to execute payments through. Next slide. And near term solutions: we have a number of things we are working on to try to get better internet to folks who don't have it now. Next slide.

There are some other federal rules and barriers we are trying to knock down, including working with D.O.T. policy to make sure there is no roadway project and we can lay in infrastructure. Next slide.

And we are working with you guys to identify the number of students who don't have access and getting them either a hotspot or some other type of device for connectivity, next slide.

And then, long-term solutions are of course, basically our biggest problem or biggest funding. We just need money to incentivize providers to go to areas where market forces are not working. Predominantly in rural areas or sparsely populated areas where there is just not a business case for them to establish service. We have seen success in areas, remote areas of state in the past with federal grant funding that has supported broadband. And we want to continue to push that, there is a large program from the FCC that will be available later this year for internet service providers. We have our own program if you want to see more money invested in that, in the general assembly. Then there's some other policy issues that we'd would like to see resolved to solve some problems with local communities, being able to install, for example fiber optic cables, for service providers.

And also a tax credit for a lifeline subsidy which would help, we feel like would really help not only students but patients in the state. Those folks that might not be able to afford a service, but would reduce their billing and of course we've worked with the state in creating the plan four years ago. We wrote a chapter on telehealth and I think one of the biggest recommendations was making sure that telehealth cost or expenses were reimbursable. I think

that is the main incentive and driver of folks, not only for providers but also for patients to accept that type of service and sign up for a broadband service. Next slide.

Here are some additional links for resources if you need them, and we can be available to help or answer any questions that you have. Thank you.

Lakeisha Moore:
Thanks so much to both Jay and Jeff for sharing. Like I said, today we definitely had a lot of information based on a lot of the feedback we're getting. We wanted to get out to you guys, just a reminder of a few things before we sign off today. If you would like CME credit for participating in today's webinar, you can visit Northwest or nwAHEC.org/textreg and we will make sure that you get the information that you need in order to get credit for today's webinar.

Then, just a reminder about technical assistance that is available through the Office of Rural Health and also through the area AHECs, thank you for everyone who has joined today and sent in your questions. Just because we are a little bit after the 1:00 hour we are going to commit to reaching out to you with the answers to your specific questions but I did want to open it up to everybody, whether you were able to put in a question or not, if you do need specific technical assistance getting up and running with telehealth at your site, please reach out to us. We are happy to work with you in order to get you where you need to be with telehealth.

So, thanks again for joining us for today's webinar. Reminder, next week we're going to focus a little more on pediatric and adolescent use of telehealth and look at some specific best practices there. We are excited to have Dr. Jenkins who is reaching out to some of his colleagues, who are going to share some of the things they have going on. But then also starting to make that transition into what does telehealth look like, even as we transition out of COVID-19, this pandemic, and we are able to still keep telehealth around with us, kind of longer terms.

We'll have some of the folks from the technology access centers at the federal level come in to talk about the digital technology that is available. And then also looking at some of the policies that we are hoping, we are asking some of the folks at the center for connected health policy to start looking in their crystal ball and telling us what we think may stay even after things begin to transition into telehealth being more a part of our mainstream practice.

Hopefully you will join us for those but definitely information's on your screen now for technical assistance in the meantime. Thanks again for joining us today and we will talk with you soon. Take care everybody, bye-bye.

[Event Concluded]