

Transcript for NC AHEC and ORH Telehealth Webinar Series
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Presenters:

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Please stand by for realtime captions

This meeting is being recorded.

Lakeisha Moore:

Good Monday afternoon everyone, welcome. And Thank you for joining us today as we wrap up the telehealth best practices webinar series. I am Lakeisha Moore with the North Carolina office of rural health, ORH. And I am joined by Dr. John E Jenkins with the Greensboro Area Health Educational Center AHEC for short and some very special guests, including Mei Wa Kwong, the executive director for the Center for Connected Health Policy, and Amanda Martin, executive director for the Center for Rural Health Innovation. Remember if you would like to ask a question during the webinar today, you can click on the Q&A icon it is in the zoom window toward the bottom of the screen. You will see it says Q and A. And you'll type in your question there. We will work to answer as many question as we can, time permitting. If you need technical assistance during this webinar, please email technicalassistanceCOVID19@gmail.com. Somebody will assist you. We always like to send a very special welcome to our safety net sites across the state. Welcome and thanks for joining us over these past seven weeks. Can you believe it? We are in session 8. This week we will have Lisa Renfrow from AHEC. She will start off by sharing information about how to receive continuing medical education or CME for this webinar. During today's webinar, we will also review some of the telehealth best practices that have been shared with us over these past seven weeks. Mei Kwong with CCHP for short will share what we have seen in telehealth policy changes, so many changes since the COVID-19 pandemic began. And what telehealth policies we think will stick around long-term? Amanda Martin with the Center for Rural Health Innovation or CRHI, will share effective telehealth practices that she has seen right here in North Carolina. We sincerely hope that the information and telehealth resources that have been shared over the past seven weeks and that we will share today can be incorporated and adapted into your organization and your workflow. Some other 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. Remember if you ask questions during the webinar, if you could please include your name and your email address, in case we need to follow up with you directly regarding an answer, that is appreciated. Many of the billing and coding questions will need to be answered directly by email from a certified coder. So now, I will turn it over to Lisa. And Lisa will share with us how to receive CME for today's presentation. Lisa.

Lisa Renfrow:

Thanks Lakeisha. To obtain CME credit, CEUs, or contact hours for participation in this webinar, you must have a MyAHEC account with them up to date cellphone number listed. If you do not 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 A73DC to 336-793-9317. Both the code and telephone number are listed on this current slide. For additional instructions on how to register using the text registration system, please visit www.nwahec.org/textreg, as shown on the slide. The registration code and telephone

number will be shown again at the end of the webinar. The continuing education for this program is being provided by area AHEC in partnership with the Office of Rural Health, Northwest AHEC and Greensboro AHEC. Credit information is listed on the slide. And now I'll turn it over to Dr. John Jenkins.

Dr. Jenkins:

Thank you Lisa. This is episode eight of our telehealth implementation best practices. It is sad that we are at an end of these episodes. Hopefully they have been very useful as you deploy telehealth in your practices during the COVID crisis as well as using telehealth to meet the needs of your patients going forward. One of the things we will do today is a quick review of the eight weeks of learning we have had together. We have had many special guests come in and share best practices as well as pearls and we're going to review as many of those as we can. Effective leaders help others to understand the necessity of change and to accept a common vision of a desired outcome. That's by one of my favorite authors, John Kotter, who does business books that are good to read. When we got to our why, it was what happened with the COVID-19 crisis occurred in February? Suddenly we saw a huge drop in our inpatient, in-person production. These decreases due to COVID because of fear of our patients and getting to the office and because of new policies with PPE and other protective equipment that had to be in place. So production dropped for many of us, 40%, 50%, 60%. That production continued to drop as we began to pick up the slack with virtual visits. After the pandemic, we agreed that we needed to have some shared goals for telehealth going forward. We knew that we were going to offer virtual visits for simple acute issues. And that is what we did at first. But then many practices began to convert routine follow-up visit into virtual visits, Medicare wellness visits and follow-ups for chronic disease states. Many of you developed very clear online information and guidance to your patients as to how to deploy and use telehealth in their contacts with your office. And then practice management began to pick up the slack with managing are at-risk patients for their diabetes, heart failure, and other conditions that we need to have routine regular contact. We got best practices from many of our area's wonderful leaders and physicians and providers from Appalachian Mountains all the way down to the very tip of our coast in Roanoke Chowan Community Health Center. We learned how amazing these practices were with their quick deployments. North Carolina Association of Free and Charitable Clinics told us any of their members deployed virtual visits in just one week. Several of you have developed really great online information on your web portals. Remote check-in has become standard. And it looks like it will be standard for the next period of time to reduce risks of coming into the office to check in for their visits. Many people are using remote check-ins while people stayed in their car and then were called from their car into an exam room if they needed a face to face. Or if they were in their car and needed an acute visit, a tablet was brought to them and using the parking lot as a hotspot were some of the best practices we saw. Many of our practices created safe spaces where people could to get immunizations or laboratory or to be seen for well child checkups. Maybe safe hours were the clinics were only open for those patients. We learned a lot about platform choice and guidance and as we moved toward needing to have HIPAA-compliant platforms for the future. Although the current guidelines allow us to use things such as non-HIPAA compliant platforms. We also learned that in a pandemic, old dogs like myself can learn new tricks. And we had physicians who are in their 80s reactivated and providing virtual visits for patients in our clinics. It was pretty amazing time. We also got excellent help from our AHEC practice support leaders. Chris Weathington and his team gave us coding expert advice almost every time we came together. I have put in here some links so that you can continue to use these resources, even after our webinar series ends. The North Carolina AHEC websites and the North Carolina.gov guidelines for Medicaid billing as well as the AMA's guideline for how to do practice management and billing and all of these sites are updated on a regular basis and they have the latest and greatest about coding and billing. We also got guidelines from our telehealth resource centers, TTAC and our local mid-Atlantic Telehealth Resource Center. We

learned from North Carolina Health Connects about how we can connect to medical records throughout the state, VA records and national records were available to us, and how we could utilize the service to find out the most recent testing that patients had for COVID-19. We learned about the efforts about North Carolina broadband adaptation. We also learned important things that it is not just that we have a couple of bars on our cell phones that tells us that we have a North Carolina broadband connection, but it is the width of the band that allows the communications. We saw many sites creatively create hotspots, not only in their parking lots but now we are seeing hotspots with school buses across our states so that people can have access to broadband and have virtual visits. We learned a little bit about the future of digital health from Columbia school of business. And we learned about how many devices are going to be connected to us and connected to our practices to provide information and help us to create health and well-being for our patients. And then, what's coming next? In the near future, we will see digital health integrated into our office flows not just because of the necessity of COVID-19. Right now, many of you are experiencing about 70%, 80% of your visits still virtual as you begin to rebalance care delivery towards in-person care. How can you integrate that into your office flow depends upon how you look at the way you visit, schedule, and pre-visit plan. That's going to change and possibly change for the long term. Many of our speakers including Dr. Ram from mid-Atlantic health said that we probably will be doing 20% of in-person care today and 80% of virtual. But as we rebalance, it will probably flip to 80% of in person care and 20% of virtual and the expected 20% of virtual will gradually grow over time. So how do you do that? This chart suggests some pathways for you to think about. Having asynchronous visits, maybe through the patient portal where a questionnaire is completed and responded by an answer that comes back by email or through the portal. These could be templated. These could be for treating specific conditions such as rashes, flu-like symptoms, or even sinusitis by the CDC guidelines. Then virtual visits like you are doing now should be prioritized for one the most effective reason to have a virtual visit and even schedule proactively with your patients. With virtual check in and rooming processes, having various tools, like flashlights, scales, thermometers or blood pressure cuffs, you that can get information for the check in. Then you do the audio, visual, or telephonic depending on the status of the waivers. Finally, our traditional workflows will need to be redesigned to use technology. This is from visit scheduling and pre-visit planning that can be done using telephonic or even virtual communications to the front desk check-in that will be online, patient is waiting in the car. Standard rooming is going to change, efficient use of our documentation, we can have patients fill out questionnaires virtually before the visit so that we save time in the face-to-face visit. And then finally, communicating the plan with patients through the portal, a written plan for them to have and managing patients in between visits. A really exciting time to reinvent care as we rebalance our care delivery. Now, I am going to turn it back over to Lakeisha, who is going to introduce our guest speaker who is here all the way from California.

Lakeisha Moore:

Great, thanks Dr. Jenkins. We have covered a lot over these past seven weeks. I am glad that a lot of these materials are available on the AHEC and office of rural health website. For future reference, thank you for going over the review with us Dr. Jenkins. Mei Kwong, the executive director with the Center for Connected Health Policy, also known as CCHP, joins us today. She will share some of the telehealth policy updates that we have seen during the COVID-19 pandemic. And technical assistance that is available through CCHP. Thank you for joining us Mei.

Mei Wa Kwong:

Thank you Lakeisha. And thank you for having me here today. Next slide please. I am an attorney. I always have to start out with a disclaimer. Any information provided to you today shouldn't not be considered legal advice it's only for informational purposes. CCHP always recommends that you consult with legal counsel if you are looking for a legal opinion. If I happen to mention a company or

show a picture of piece of equipment, know that neither I nor CCHP has any type of financial interest, arrangement or relation or affiliation with such a company. Next please.

CCHP actually was founded in California, as a California telehealth policy organization. But in opportunity to become the Federally Designated National Telehealth Policy Research Center became available in 2012. And we applied for that, it's a grant through HRSA. We received it and have been serving in that capacity ever since. But we also work with a variety of other partners on other projects related to connected health and telehealth. Some of the projects that we work on is a 50-state reports on telehealth policies, Medicaid policies, laws and regulations for all 50 states and the District of Columbia. We are actually also the administrators for the National Consortium with Telehealth Research Centers, which was mentioned earlier. We also do some California specific work still. We convene a California telehealth policy coalition of over 70 statewide groups who are interested in telehealth policy for the state. So you see on this map a little bit earlier, there are 14 telehealth resource centers. My understanding is that you have probably had speakers from some of them. You are probably familiar with TTAC, they are the Technology National Telehealth Policy Resource Center. And then there are 12 regional resource centers that cover specific states and the mid-Atlantic one covers North Carolina specifically. I wanted to stress to you that we all 14 work very collaboratively together. If you reach out to one of us, I like to say you get the other 13 as well. You have a great one representing your state, mid-Atlantic, but know that the others are also available if you have questions perhaps in a different region or on technology or policy.

Next. So I mentioned the 50 state report that we do. As you can imagine, this is a large report. We started this in 2012 and it was 250 pages. And just to show you how telehealth policy has evolved over the years, our latest edition is close to 500 pages. We do two updates to it a year, once in the spring and once in the fall. We were in the middle of the spring update when COVID-19 hit. We did manage to release our updates, the information that is available on our website is the permanent in-place telehealth policies. But it only goes up to February 2020. We do have on our website a separate section for the temporary waivers related to COVID-19, for the states as well as on the federal levels.

Next. So I have been asked to talk about telehealth policies and some of the changes that have taken place. I am going to do a pretty high level overview because there is a lot of detail, a lot of changes that have taken place. What we found is that there are very common themes and changes that we have seen both on the federal and state level. So to understand existing telehealth policy, a lot of it really centers around reimbursement. What gets paid? Who gets paid? What type of services get paid for? And that type of policy can be broken down into four areas where they create specific policies that might have limitations or, you know, to what extent you can use it for. These areas are related to service, location of the patient, the modality that you use and the providers that are reimbursed. We look at the telehealth reimbursement policies, you can see these four areas and what they touch upon as far as how they craft the policy.

Next. I am going to start with the federal Medicare policy first. Before we get into some of the details, understand that Medicare policy, when you are talking about services that are delivered via technology, they split it into two buckets. You have your telehealth bucket, it's very specific telehealth. delivered services. They put the label on there. The thing is, for those services, that is primarily controlled by what is in the federal statute. So the limitations that are on how you use telehealth to deliver services and get reimbursed in Medicare program, a lot of that is dictated by what is in federal law. Medicare also has another bucket of services that they call technology-enabled or communication-based services. They use telehealth technologies, but they do not call it telehealth. And the main reason for that is that it is not an exact replacement for in-person service when you are talking about technology-enabled or communication-based services. So CMS has said these are new

services where we do not have a one-on-one replacement for in-person services, but they use telehealth technology. We recognize the value. They go to this other bucket. Because it is not called telehealth, it is not underneath the same restrictions that telehealth services are. It is not limited by what's in federal statutes when they say telehealth must take place in certain geographical areas only certain providers can use. I wanted to make this distinction very clear to you. As we went through the beginning of COVID-19, there were so many waivers going on, it got a little bit muddled in some people's minds, especially when you're talking about the use of phone. So, understand that there are two buckets in which they will reimburse for technology-delivered services, telehealth, a lot of it is controlled by federal statutes and technology-enabled communication-based services. A different bucket is not controlled by federal statutes, though they have their own policies around there that can limit their use.

Next. The next couple slides, I am going to go through them very quickly. I will point out a couple of things. I think you guys have access to these slides and you can read at your leisure them later on. Again, you see that a lot of the policies and a lot of the waivers that took place were focused on those four areas of type of modality, the location of the patient, the type of provider who can provide a service, and also the type of services that they'll reimburse. What happened with Medicare is they have removed most of those restrictions and they have increased the types of services you can provide via telehealth. For the location of the patient, they removed the geographical limitation and basically the site, the type of building that the patient can be in. Mainly to acknowledge that the patient, a lot of us are stay-at-home, they will most likely be staying at home. Pre-COVID-19, they only allowed a limited set of services to take place in the home, but understanding that they need other types of services before sheltering in place. They have opened up the type of modality. For the most part, it is still live video. However, they have allowed certain services to be done over phone. This is in recognition that not everybody has access to the technology. They may only have a phone as their only way to communicate. So they have allowed that to be a modality for certain services, not all services. The type of provider, this was very big. Medicare had a limited list of providers that would be reimbursed if they provided services via telehealth. And that was because that was a federal statute. They started gradually opening that up for Congress underneath the Cares Act allowed FQHCs and RHCs to be assistant-site provider. Then with their next round of administrative changes, CMS said we think we have power to open up this entire list. So it essentially becomes any Medicare-eligible provider who can provide a service on that specific list of services, which they have.

Next. And that is the fourth area. So type of services in which they will allow to be provided via telehealth and that they'll reimburse. During COVID-19, they added about 80 additional codes. There is specific list there. And on that list, if you download it, you will see that certain ones they'll note that you can do via telehealth as well. We are going to skip over to the next couple of slides. We will go through these pretty quickly. These are a couple of specific changes. Again, I will let you read that at your leisure here.

Next. I just want you to note, I will not go over these specific changes, but you can see that there are quite a few of them. This is actually only a taste of them. There were other changes that they made in order to remove the barriers to telehealth. I have picked out a couple to have on these slides. But that shows you the depth of barriers to using telehealth that needed to be addressed during this particular pandemic. Just to give you an idea, there were quite a few changes that have happened on at least on the federal level. Medicare did have one of the most restrictive telehealth policies out there. But besides just the common ones that most people are familiar with, like the geographical limitations, there were all of these other ones that really impeded the use of telehealth, which is you can only use telehealth in a skilled nursing facility once a month or once every 30 days. So there were other things

that acted as a barrier to these telehealth issues that were wider spread that had to be changed through administrative action or statutory action by having a federal bill passed. Those are links to the research with CMS where some this is referred back to so you have a source of material for it as well.

Next. I wanted to spend a little bit more time on this because I understand that the audience has FQHCs than RHCs on here. So I mentioned earlier that was one of the major policy changes in that they allowed FQHCs and RHCs to act as distant site providers underneath the Medicare program. This has been a little bit, I think, difficult for CMS to get some of the policies down. They allowed that underneath the CARES Act, which was passed in early March. Two weeks later, CMS issued their first guidance and then they updated it again a couple weeks later. It's been a changing environment as far as how are FQHCs and RHCs now supposed to bill for this. They issued an updated guidance on April 30, suggesting how you would do this. I understand there's probably still questions out there. I think CMS is working through the finer details. But this is what they have outlined as far as how FQHC and RHC are supposed to bill Medicare when they're providing a telehealth service. So it's essentially a list of questions. What modality can they use? So they are able, again like live video and certain service via audio only as well, it is basically what the fee-for-service providers will do. So if you download the list, you can see which ones are available via audio only. They are allowed to do virtual communications services, some of those. So that will be discussed later. Other questions that people have now that they are allowing FQHCs and RHCs to provide services, like you know what provider can do it? And they have essentially said any healthcare practitioner who is working at the FQHC as long as it's within their scope. Can providers do it at home because maybe they are working from home that day or maybe they are self-isolating but still able to work, they cannot come in contact with people. They said yes they can do that. What services can they provide? This is interesting one, which has caused confusion for FQHCs and RHCs. They are able to provide all of the services that are on the list that CMS said you can do these via telehealth. I understand some services may not be qualified services that FQHCs and RHCs typically can do. But CMS has said you can do this underneath the emergency situation here.

Next. One of the big things is will the FQHCs and RHC get their usual PPS or IR rate and the answer is no. That was actually in the CARES Act specifically, where it said that CMS will create this methodology based on a fee for service schedule and come up with an amount. That amount is \$92.3. It is for the FQHCs and RHCs. That is the amount that they will get paid. Next. And then, there were other specific instructions that they had for us. I will not spend time going over this. I just want to make sure you have this information here.

Next. Billing, this was one of the things that caused confusion because this is where they did change the instructions from what they had first issued to then their updated guidelines, which was issued April 30. And, it is a little bit tricky here. For services that were provided from January 27 until June 30, they are telling RHCs to use the G 2025 with the modifier CG. They will say that when you submit that, you will notice that you will get paid, it looks like you are getting paid your AIR rate. That's not what's going to happen. They will recuperate the difference there or payout. You typically get less than \$92.03. The reason for this was that CMS could not get the system, the process in place in time. They did not want FQHCs and RHCs to delay providing services or to hold back, so they're saying just submit them, we'll fix it, a few months later, but no, no you are not getting your AIR rate, you are getting \$92.03, but we need you to submit these claims. And then beginning July 1, for those services, you do not need to use CG modifier again. FQHCs are a little bit more complicated in how they want you to bill. So you have got to actually bill three things. First, you have got to use your PPS specific payment codes, this is either from the G0466 to the G0470. Then You have to use the hit code that describes the service and as a 95 modifier. Then you have to use the G 2025 with the

modifier 95. The same thing applies from January 27 to June 30. It looks like you are getting your PPS rate. You are not. You have to reprocess the that. You are going to get \$92.03. And with July 1, you bill code 2025. You do not need to use the modifier, but you could if you want. They said if you want to put that on there, that is fine, you do not need to beginning July 1st. It's a little bit confusing. Part of it was that they needed to do this quickly and that is one thing we need to understand. All of these governments and agencies are working very quickly. They are kind of like patching it together and trying to make it work as best as possible. One of the biggest things is like you know, to try to do this rapidly as well. So it is a little bit confusing. I understand CMS, there are questions that people have that CMS is trying to work through some of those finer questions as well that deals with exactly how to bill.

Next please. I am going to touch briefly on the technology-enabled communication-based services. You have probably heard a lot about them, they're called virtual check-in codes and chronic care management, which are remote patient monitoring services. Again, these are not considered telehealth. They are coming underneath the umbrella for telehealth for CMS, they are under a different category. Not a lot has changed. There has been additional codes for online digital evaluation. But for the most part, these have been up around pre-COVID-19. You can still use these, FQHCs and RHCs can use these, for example the virtual check in codes and the remote monitoring, but not all of them. If your service fits underneath the definition's code, these are available for you to use if you cannot use one of the others service codes that come underneath telehealth. These are options that are available to you in which you can provide services as well and get reimbursed underneath Medicare.

Next. And then, this is just basically what goes on for virtual communication regarding FQHCs and RHCs. I am not going to go over that in too much detail. Next. Additional services, this is very interesting, so CMS has a process in which they decide what services are to be reimbursed via telehealth. Before COVID-19, it was a hard way of trying to get the service on there, you had to apply to CMS and provide substantial evidence with how they termed it or CMS needed to decide if it was going to go on the list with specific service code. What they are saying during COVID-19 is basically you do not have to provide the evidence, just submit a code. They think this should be reimbursed if it was done via telehealth. If they agree with you, they will just automatically put out a list. They will not go through the regulatory process which is what they had to do before COVID-19. If there is a code for service that you typically provide and you think you can provide it over telehealth, submit that to CMS and they may decide to add that to the list of eligible service codes and services as well.

Next. So underneath Medicaid, pre-COVID-19, this was basically what the states were doing in the Medicaid program. Essentially, every Medicaid program was doing something or reimbursing for something through live video. And that varies from state to state. For the remote patient monitoring, that was essentially for most of the Medicaid programs that said the home was an originating site. That was what they meant. It was for remote patient monitoring. Like CMS, Medicare is from a very specific sources, which was important because you are running into the same problems that Medicare had during COVID-19 in that home was not an eligible site for a lot of services.

Next. States also have private payer laws. And that can vary. It can vary from private payers laws that were just a suggestion that private payers cover telehealth all the way to state laws that said they shall cover telehealth services the same way they would in person and everybody falls in between. That dictated how much control the executive officers and the governor had over the health plans during COVID-19, telling them what they should be covering and what they must be covering. Next. So what are the common policy changes we are seeing on the state level? Again, it's mirroring a lot

of what is going on, on the federal level. And that's the major one. Most common one we're seeing is with staying at home, acting as an eligible originating site, allowing telephone to be used to provide services, and then depending on how much power or what the state law says, requiring health plans to cover some type of telehealth services. Next.

Less common changes was expanding to the other modalities, like outpatient monitoring. Depending on what the providers were saying, we are seeing more and more of that, but that was not as common as in the early weeks as the other types of changes. And then waiving consent requirements, as states do have some type of consent requirement related to telehealth, either relaxing those or waiving those. Next. North Carolina policies, again, we are seeing the mirroring of similar policies such as you know, allowing telephone to be used and also expanding the types of services in which they were covering. Also, allowing allied-health professionals, expanding the list of providers in which can provide telehealth delivery services.

Next. So what will this look like in a post COVID-19 world? What will be sticking around once we get through this initial emergency? Next. So some policy changes will remain. I definitely think that they will. There is going to be a lot of questions that need to be resolved. One is the connectivity and broadband issue related to the digital divide. The reason that they have to allow phone to be a modality in which to provide services is because there is that issue of people not having access because they do not have connectivity or they do not have access to the necessary equipment out there and like a laptop or smart phone. You do not want to leave this population behind. But what will you do in order to bring them up? Licensure is going to raise its head again. It has always been a hot topic before COVID-19. But I think there is more urgency now in addressing that. Also, where else are you going to be using the technology as well? What other places can be deployed? During COVID-19, we have gotten a lot of inquiries from different groups that we have never heard of before, the telehealth resource center. We did not hear from them pre-COVID-19. Because it has changed the landscape so much, they are now saying our groups need to look at this as well. So it is definitely, changes will remain. The question is what changes will remain. Next. I wanted to go over a couple of things and resources that are out there. This is a new HHS telehealth website in which there is a section for a patient and for providers. It is the first of its kind from the federal government so that was exciting to see.

Next. Some of the resources that CCHP has, again we have been tracking federal policies and state policies, we do a newsletter related to any breaking changes. So you are welcome to sign up for that. Next. That is it. So I'll turn it back over to Lakeisha.

Lakeisha Moore:

Thank you so much Mei. I know your team has been very busy during this time. And I definitely encourage those that are on the webinar, I will frequent, many times, I will email using the info at CCHPCA.org just to ask quick questions if things are coming up and I just want to you know, run this past year team. Your team is always so gracious, usually within 24 hours to get back. So thanks Mei for sharing. Very very great information and thank you for giving us a peek into what you think will stick around. I think we have questions around that coming up. We are excited to also have Amanda Martin with us with the Center for Rural Health Innovation. Amanda is going to share some of the effective and successful telehealth practices that she has seen right here in our state of North Carolina. Thank you Amanda for joining us. And I'll turn it over to you.

Amanda Martin:

Thank you so much Lakeisha. I am excited to be here. Thank you for the invitation. As said, I am Amanda Martin with the Center for Rural Health Innovation. My organization has been the last 10

years working to use telehealth to bridge the gap for patients in rural areas, especially in North Carolina who lack access to care. I have grown and I do run this organization and I consult across the state and nationwide on topics related to school-based healthcare, especially when it is delivered via telehealth technology. So I am going to take my couple of minutes here to run you through some examples of successful telehealth programs that were already around before all of this started and kind of what is happening with them during this time and what the future looks like.

I am going to start with my first favorite one, next slide please. The Health-e-Schools program is the flagship program of my organization. Health-e-Schools has been in western North Carolina for nine years. And a couple years ago, we expanded down East. And what healthy schools does, if you want to go to the next slide, you can see a little example there on the left. The partnership with a school nurse where we provide telehealth equipment to school nurses so they can present students and faculty and staff to our nurse practitioners who are connected via live 2-way audio video and the peripherals are there. They are small on the picture but you can see that there is a way to look at the throat or the rash, to look in ears and also a stethoscope for heart and lung sounds. And that school nurse presents the patient taking and reporting vitals, ensuring privacy, positioning those cameras and stethoscopes. And then under specific orders, they will perform tests and then assist with carrying out the care plan, whether that could be going back to class, going home. The Health-e-Schools program is devoted to keeping kids in class. This deals with minor things they do not need to miss school for, they can get care at school. During this time, the last couple of months, we have transitioned services to home. There is an example of a kid joining from a tablet in the comfort of their own home. Obviously, our numbers are down. Kids are not at school. They do not have easy access. We are still seeing kids and faculty and staff. And of course they can connect via smart phone, tablet, or computer with a camera. The challenge of course is that we do not get heart and lung sounds and we cannot the inside ears. So it is not quite the same. Our new reality in the future is we are hoping that when school resumes, we will be right there working with the nurses, using those peripheral devices that some of you may be like me looking at the school nurse so close to a kid with no PPE, no mask, no gloves. That will be our big change of course is that there will be more PPE. Let's go to the next slide.

I want to tell you about Eleanor Health. Eleanor Health is in North Carolina, it is a substance use disorder treatment program. It has only been around for about a year. They are brand-new with five physical locations already opened across the state. Are you ready? Asheville, Hickory, Mooresville, High Point, Durham with more sites coming in the next few months. Now, Eleanor Health's vision is to help people affected by addiction live amazing lives. Their state medical directors shared this particular slide with me, there is a lot of information on there. But I thought I would give it to you exactly like it is so you can read all about it. Eleanor Health has always made a point of access. And that has been a really important thing for them. Whole person care, compassionate care, and unmatched access are some keywords when you are talking about Eleanor Health. And, the way that they have done that is by using telemedicine when appropriate. So prior to the pandemic, their medical director tells me they used telemedicine for about half of their visits, but very few of those were with a patient in their home. For the most part, the patient came to the practice. So the telehealth was happening between the provider not in the building but the patient being in the practice. This is an important point. The provider can be remote too. They may not need a physician in every practice every day, all day. But if they are available to remote in when needed, it's a good practice with telehealth to make that provider available in as many places as they need to be. So last week, I hear 92% of Eleanor's visits were entirely virtual. Where both the patient and the provider were in their respective homes but treatment and care continued. They have got interesting ways that they are keeping things moving for this special population. But they are getting it done. In the future, they say it will be balanced. There will be balance of continuing to provide services from home.

There is the case for patients to come into practice locations and receive care. They are already doing telehealth. They have surged a little bit. They will settle in the middle. Next slide.

Let me tell you about another company that has been around. Mind Path Care centers is a North Carolina organization. Here is how they describe themselves: Professional healthcare organizations dedicated to providing mental and behavioral healthcare, which they call mind care through the highest level of clinical diagnosis, treatment, and research of brain and mind conditions. They are 25 years old. They have got more than 160 providers at 20 physical locations in the state. They have been around. They have a nice footprint. Here, in the last several years, they have moved into telehealth. This is to me just stunning.

We can go ahead to the next slide where you will see that I have just grabbed a little snippet off their website, just a pretty picture. More than 160 providers and 160 visits, I find this to be quite impressive. Their telehealth offerings, you can read this right on their website, they allow you to schedule in advance with your existing provider. They offer a blend of in person care and telehealth care. And, they have a virtual waiting room. If you do not want to schedule in advance but you would like to talk to somebody now, you can go to their website and within an hour, during the day, it has got daytime hours during the week. You can be seen by whichever provider is on-call. Which I think is kind of amazing. Here is where it gets good. Their strategy Vice President of strategy an innovation, who is also the director of telehealth, they sent me some very hot off the presses details. Last year, in 2019, they were seeing maybe 100 or so telehealth visits per day. So far year to date in 2020, they have had as many as 967 telehealth visits in one day. They have grown enormously, already doubling last year's numbers in just five months of the year. And then the final bit that I would share about what they have been doing at Mind Path is that they said that prior to the pandemic, telemedicine was about 15% of their total monthly volume. Now, during the pandemic, telemedicine is about 95% of their total volume with no real loss in total overall volume. I think that is fantastic, to be able to convert so much care and not miss any steps with those patients. Okay. Now, my fourth example that I want to share with you is here. And this may resonate a little bit more with some of the folks on the call. This is Dr. Smoker. He is a family doctor with his own practice. He has two locations, Burnsville in Yancey County and Spruce Pine in Mitchell County, once again in North Carolina. And this is in the mountains outside Asheville, like an hour outside of Asheville. Dr. Smoker has in these two practice locations, a total of about three FTE providers. While he has known about telehealth for a long time, because he is a good friend of mine and he knows what I do with the school-based program, he has never really done it before. When I asked him why not, he says, "I am busy. My day is always full. My patients don't have to have telehealth." All of those things fell apart a month ago. Clearly, in-person volumes are down. Now, the doctor's ACO that he is a part of furnished a telehealth platform for their practices to use. So it is free to him right now to use this. And so he is. And what he gave me for numbers, he said about 30% of his visits are virtual. Of those, about 65% are video. The other third our telephone-only. Keeping in mind, that he is serving a very rural population where those broadband challenges are serious. Right? So you may have a smart phone but not any connectivity to be able to do a video chat over it from your home. So, they have adjusted all sorts of things with their volumes down, workflows are adjusted for example, people do not wait in the lobby, they wait in the exam room until their appointment time, that sort of thing. But, they also have the option of doing that video or phone visit. So he is pretty happy with it. He is not sure if he will stick with it. I asked him and maybe he is listening today, so I hope I do not misrepresent what he said. He said, "I do not know, what is the cost benefit analysis. It is nice to get paid but there is some expense. There may not be the demand." If his schedule is busy with people who can come in person, why should he keep doing telehealth? I think that goes to the core of it. They are going to continue to be patients who need services via telehealth. And just because your

practice is full does not mean that you are meeting everybody's needs. So I hope that the Dr. Smoker's practice will continue to offer telehealth. We will have to see.

I would go to my next and final slide to say that there are so many resources. I know you have already seen the mid-Atlantic Telehealth Resource Center talked about twice at least in this webinar. I need to put one more plug in for it. This particular website that I linked here is a page with all of these resources for right now. So just trying to respond as quickly as possible and be part of getting telehealth up and running, honestly, if you were ever going to do this, now is the time. Like Mei said, a few minutes ago, we do have uncertainty about exactly which of the regulatory changes are going to stick. But you have never had so much help available to you as you do right this minute. So I implore you to be motivated, make it happen. Take advantage of these resources and will the program that will serve your patients and your practice now and into the future. So with that, I will hand it back to Lakeisha, thank you.

Lakeisha Moore:

Thanks so much Amanda. Thanks for taking us on a tour. I feel like I took a ride across the state to see other things that are happening out there with telehealth across our state. As a reminder to everyone, if you can submit your questions using the question and answer function at the bottom of the screen. I see one person actually had their hand raised. We are not able to open up the audio option due to the number of participants. We would love to answer your questions through the Q&A, so if you can put your questions in there, Robyn is going to get to our questions in a moment. Also, I wanted to remind everybody about the CME credits that are available for today's webinar. So that information is on your screen now. Reminder you need a MyAHEC account with your cell phone number included. You can visit the www.nwahec.org/textreg for the full details there. So, Robyn, it looks like we have had some questions come in for our panelists. I will go ahead and turn it over to you so we can get started with Q&A.

Robyn, I think you are still, there you go.

Can you hear me okay?

Now we can. Gotcha.

Robyn McArdle:

I was telling you a whole bunch of information. So my apologies. We do have a couple questions that have come in during Mei, your part of the presentation. If you do not mind, I am going to pass them your way. The first one from Charles Drew. **And Charles says I am curious if you can review requirements for FQHCs in more detail. Also, if can you comment on the likelihood that these changes will be extended longer than the summer.**

Mei Wa Kwong:

So for the more detailed one, I would say refer to the slide and the guidance. I am not sure specifically what you might want me to focus in on. It has been general. FQHCs is allowed to access providers. They are allowed to provide all of the services that are on that list of services that are covered. They are allowed to use audio, but it is connected to the specific service that they said can be done via audio. And then, you are getting the \$92.03 as your rate and not like your usual PPS rate. That probably works out better for people, for FQHCs and RHCs who typically get less than \$92.03. I am not sure how many of those are out there. But it is definitely not as great for those who may typically get more than that. As far as what will likely stick around, I have not spoken to any policymakers. So this is just my guess as far as the landscape, what is going on. We are not going to immediately go back to everything as normal like it was pre-COVID-19. We are still going to have people limiting their contact, probably still sheltering in place, especially if they're in that vulnerable

population. My guess would be that allowing the home to be an eligible platform will definitely stick around. The expanded services will probably also stick around because gain you have got to get more services to those folks who are in the home. The services one, this is easier for CMS to do, they do not have to wait for Congress to take action on that. They can go ahead and do that. Also, I do think probably, they will try to keep the expanded list of providers. That is a little bit trickier on the Medicare side of things because that would require an act of Congress to do that. So that could be a trickier thing. The Medicaid programs, where they have been expanding that list, they have an easier time doing that. So those are sort of like the three areas where I think they will stick around. The trickier one, if you are talking about going back to my topic area on the reimbursement policy and how it is structured, the fourth one you'll remember is modality. I am not quite sure if those changes for the phone will stick around. If they do, they will probably be in more limited fashion. I think probably the areas of greatest likelihood of policy changes sticking around is increasing the list of eligible providers, the types of services they provide and allowing the home to be a site for expanded services.

Robyn McArdle:

Great, Thank you Mei, I appreciate that. I wanted to draw attention to Deborah Parkinson. You sent in a question with information pertaining to the modifiers. So we will follow up with you about that after the webinar. I wanted to make sure you knew we did see your question. **So, another question that we have Mei says do you think Medicare will sustain quality changes in the future? I think that you got into that. I did want to mention that question.** And then Donna --

Mei Wa Kwong:

I would like to mention one thing about that. For the Medicare changes, I have heard something, be alert in July. July is typically when Medicare issues their changes for the following year. It is in there for the physician fee schedule change. That is when they issue a lot of their policy changes there. I have heard that they are looking at what to keep permanently. We may see a hint of that or we may actually see what they are keeping permanently in July. July is going to be the next marker unless Congress does something.

Robyn McArdle:

Okay, great, thank you so much. **Donna asked, are you aware of any paperwork or template that needs to be completed by the health department to perform?**

Lakeisha McArdle:

Hey Robin it's Lakeisha, I will take that one. I know Donna, I think we had a chance to connect to you with Susan Haynes Little who is over at DPH. There are specifics that I know Susan was gathering for you, so definitely we will follow up with you directly regarding the health department question. Thank you for posting that.

Robyn McArdle:

Thank you Lakeisha, I appreciate that. We have other questions. We will follow up with those after the webinar. Jamie, I know you asked a question. We will follow up. We appreciate all of the questions and comments and feedback. I will pass it back off to Lakeisha at this point.

Lakeisha Moore:

Great, Thank you so much Robyn. And thanks all for joining us over these past few weeks. I think we all learned so much, in such a quick amount of time. I do want to send out reminders. This is our last session. On the screen now, you will see where telehealth technical assistance is still available. Although we will not continue with the live webinars right now, in the series, we definitely plan to

do some ad hoc webinars based on your feedback. But want to let you know that telehealth technical assistance is available through us and also through Office of Rural Health, AHEC, and CCNC. Additionally, as you have heard today, many of our federal partners, the mid-Atlantic telehealth resource Center who North Carolina is aligned to, they also provide technical assistance. You can even talk with folks like Amanda Martin who has been a great partner, especially those that are launching school-based health programs. Many times, she is available through matrix. And then also, Mei, her organization, CCHP, they also are great partners to reach out to if you have specific policy questions, especially on the federal level, related to telehealth. They are a great resource. And then Dr. Jenkins, in our last minute here, I know that the AHEC team, you guys are doing really exciting things coming up here in the near future with telehealth. If you want to share with us some of the things you have going on?

Dr. Jenkins:

Sure, so I will share with you one thing that is on the schedule. On May 27 at 12: 30 p.m., you'll see on the AHEC site, you can sign up for virtual training for your providers. We will be talking about website manner, how to use the camera, how to communicate more clearly, how to create empathy and be able to really make that an effect visit for your patients. We will also give hints about virtual diagnosis. What are some of the techniques you can use to make the patient your partner in physical diagnosis? What simple kind of devices in your previous planning can you ask the patient to have to get those vital signs necessary for documentation? A lot of us believe that in July, we will see some continuation of the policies both in Medicaid and Medicare with coverage of virtual visits. I think really getting your professional staff, your physicians, the nurses who are going to do communications, with a really good understanding of website manner will make your program effective. Then we will have a series of podcasts. Be aware of those. Look on the AHEC site. There will be different speakers from across the country on virtual visit techniques and pearls. Look forward to continuing this discussion. It has been a great ride for the last eight weeks with a fantastic team. I thank Lakeisha and our Department of Health and Human Services, I think our AHEC partners and everyone who has been a part of this wonderful series.

Ditto to that. Thanks everybody for joining us. Take care and be safe. We will be in touch soon, I am sure with everyone. Take care everybody, goodbye.