Transcript for NC Medicaid, CCNC, and NC AHEC Webinar Series for Providers
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Presenters:
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Hugh Tilson, JD, MPH, Director, North Carolina AHEC

Hugh Tilson:
Good evening everybody. Thank you for participating in this evening's COVID-19 webinar. This webinar is part of a weekly series of informational sessions put on by NC Medicaid, Community Care of North Carolina, and NC AHEC. Tonight's session will provide an update on Medicaid clinical policies then you'll hear from a great panel of experts who will provide some applied examples of best practices in response to those policy changes and describe how they're succeeding at using telehealth strategies in their practice. At the end, we'll take your questions.

Next slide, please. My name's Hugh Tilson, and I'll be moderating today's forum, so welcome. As you see you will hear from Dr. Dowler about Medicaid clinical policies -- telehealth experience from the field -- and provide a quick update on resources and supports, and then take questions.

Next slide. Before I turn it over to Dr. Dowler, I'll just take a quick moment to thank everyone for making time in your busy schedule to participate in today's webinar. We really hope it will help you in your important work and help navigating these times a little bit easier for you. After our presenters provide their updates we'll turn it to your questions. We've learned from the past forums that presenters will often address your questions during the presentations. We will have time to get your questions and I encourage you to wait until the presenters are through with their presentations before submitting a question. If you participate through the webinar, please submit your question using the Q&A function on the black bar on the bottom of the screen. The Q&A function on the black bar on the bottom of the screen. We will record this webinar, and we'll make that recording, a written transcript of it, and these slides available to the public as soon as possible, on the DMA websites and on a joint website maintained by CCNC and AHEC. Let me now turn it over to Dr. Dowler.

Dr. Shannon Dowler:
Alright, thank you Hugh. Thanks everybody for joining us. I don't know if anybody else gets a vacation day tomorrow. The one benefit of working for the state is we actually get holidays. Which, when I was in the health system, we didn't really get those. Unfortunately, we've also all worked 45 days straight without a day off, and I'm sure everybody out there is feeling that same pain. But I wanted to see exciting changes for this week. I will tell you it's not as big of a week. A little more space this week around some of the coding and billing issues folks were having and so our pace will pick up again next week. Just a reminder, last week we turned on a whole slew of new telehealth services, from LEAs to CDSAs, diabetes educators, dieticians, medical lactation specialists, and then research-based behavioral health treatments for autism spectrum disorder. So a lot went on last week.

We will go on to the next slide. I'll tell you about what's new this week. The biggest bundle of new clinical services we have is turning on optometry clinical service codes. The bulletin will be out later tonight or tomorrow morning at the latest and those codes will be turned on at the beginning of next week. From the remote patient monitoring side of things, we have started looking at what we can do to help pay for monitoring with patients at home and next week we are going to be turning on some new ones. But for this week, the one that we have decided to grab first is actually a very new code. It was just released by CMS and others in January of this year. So a lot of people haven't billed for this yet. There are actually two codes around patients monitoring their own blood pressure at home, which is very exciting. So you'll remember a

couple weeks ago we made it possible to get blood pressure devices for your Medicaid patients as part of our COVID response. Now they can get their devices and then you can have a code where you can bill for getting them set up on that, talking to them about how you want them to monitor it. Device calibration is the way it's supposed to be but since we're trying to keep people out of our offices, we have created some flexibility on that. Then the next code is the patients doing self-measurement twice a day for a period of time and sending those recordings to you, you review them and give feedback and adjust medicines as appropriate. So that's exciting. I think a lot of us have been doing this for a lot of time -- and it's not been something we could bill for before right now. We are really thinking about this in pregnant women, where all of a sudden they start getting elevated blood pressure toward the end of their pregnancy and we don't want to bring them into the office as frequently because we don't want to increase exposure. So this is a way we can help track them. Also new onset of hypertension and our patients we are finding in hypertensive urgency situations, you can track them a little more aggressively from home. This is supposed to be a 30-day once a month billing, but because of the COVID response we are actually allowing this to be a weekly billing. So we are going to allow folks to bill it up to one time a week. So a maximum of every seven days. Just to make this more available during the COVID time.

The next we did is we went ahead and grabbed the postpartum visit. Next week we plan on having really the whole bundle of obstetric care around telehealth. But this week we want to give guidance that we are going to accept telehealth for the postpartum visit. We just wanted to bring that to folks' attention. We've gotten a lot of questions about it. We looked at what other states were doing and what the guidance was out there, and we decided that, that was going to be something we could do. The other thing, we got a lot of questions about was that pregnancy medical home risk assessment and then the postpartum one, which a lot of our practices really rely on. Of course we rely on the data that comes out of that. We want to let you know now that's okay to do those assessments. [Indiscernible] that code for those.

So, next slide. We turned on the blood pressure monitors, that people could get through durable [Indiscernible] and immediately heard that folks were having trouble getting them. It's new. This is new for the DME companies; this is something we have never covered before. Of course the patient has to meet the medical necessity standard, as is everything with Medicaid, for us to cover it. They need to have a reason to check their blood pressure. What we found is that the DME suppliers and home health agencies can supply that. So if your patients are already in a home health program, they can actually provide that blood pressure device. They don't require prior authorization and the team at Medicaid have come up with a list to make it a little bit easier for folks in the field to find DME providers near them. So this is a link that will be in the website. It is also going to be up on our website to help you find a provider. If you're not sure who to ask for that blood pressure device, we put together a list for you.

Next slide. So other things in development, this week we went live with a 90-day supply of stimulants and buprenorphine, for appropriately identified patients. We have made it -- patients' eligibility will not be terminated during a state of emergency. And that involves NC Medicaid as well as all the different types of Medicaid that we offer. We asked folks to not collect a co-pay when someone is coming in or COVID-related symptoms. Very soon, hopefully next week, we are going to be removing the annual exam requirement for family planning Medicaid services. Right now patients can't get their follow-up care if it has been more than 12 months since their annual exam, which is normally our standard but we are changing that right now because we don't want anyone to lose needed family-planning services during this time and we don't really want them coming in for an annual exam. We are also working on trying to get medication delivery by mail or through a pharmacy delivery service, covered for our Medicaid patients. So we hope next week we are going to have that turned on. A few other things that are in development. But I have to tell you they have to go through fiscal analysis we have to look at authority, sometimes both. So I can't promise you these things are happening but I can tell you I'm working really hard to find a way to make them happen. One is the rate change I've mentioned before for reimbursement for telephonic care. We'd like to apply a COVID differential, which would improve the rate. It won't be full parity with telehealth, but it will be a lot closer than it is now. If I can get that through, which I should know next week if I am going to be able to, there will be retroactive back to the 10th of March. So we would [Indiscernible] difference for folks that have been billing it. I am also working with a team to see if we can't evaluate our per-member-per-month for

medical homes and try to increase the PMPM during the state of emergency time. I hope to have some guidance on that next week, as well. We are also doing a lot of recommending on how we communicate to the folks in the state, to help engage in telehealth and feel comfortable with it. I'm working on a video this weekend, a sort of infomercial. I'm excited to use the creative side of my brain for a couple days. That's actually vacation weekend. I get to make a video. The other thing I will just tell you, it's another -- not a promise -- but something I'm working on, on one of our spas, or state plan amendments that we sent to the feds, we are asking for our breast cancer and cervical cancer prevention program to expand the eligibility so that more women are able to qualify for those services during this time. So lots of work is ongoing.

Next slide. But besides those things, when we come back next week -- I told the team, enjoy your long weekend but get ready to gear up for some fast-moving action. We will be hitting the prenatal services really aggressively and we want to wrap that up next week. And also looking at some other remote patient monitoring services that we can offer with Medicaid. And then the next week we are going to be getting into the well-child care and figuring out how to do that. I will tell you we're looking at it as not just straight telehealth, but how can we pay for both telehealth and nursing in-person at a patient's home, when that's appropriate. So we are looking at ways we can innovate on the care model and do something different during this time. I can't say enough about the clinical policy teams back at the home office at Medicaid; how hard everybody is working. I mean, they have been -- no one has had a day off in a month-and-a-half, trying to get these policies done. It's a bear to wrestle with and I just am so grateful for everybody. But also for the feedback we have gotten from all of you who have been so enthusiastic -- you've sent us feedback, you've let us know when things aren't working, you let us know we forgot to do, which -- those things are going to happen. But we really appreciate your engagement.

Alright let's get to the fun stuff. Next slide. This is just a heads up that this table, this billing table, is going to be up for everyone to see on the website by later tonight. So I don't want you to actually glean anything from this, just know that the breakdown of how to bill and code for everything will be up tonight and --

Next slide. This is the one we put together with all the different payers of the state and we have added a column that links to their billing codes, so we asked them all to do the same format that we're doing with telling you what modifiers to use, what place of service to use, for all their different things. And the plans are sending those into us. We have got about half of them now, you can see there are some -- we hope to get the rest of them in the next day or so and we'll put that up on the website as well. And we think that will help everybody know what to do.

Okay, next slide. I think this is where it's fun. So we are going to turn it over to a bunch of our colleagues around the state to talk to you about their telehealth experiences.

Dr. Tom Wroth:
Great, Shannon. This is Tom Wroth from CCNC; just going to set up the panel discussion here. Really excited to have these voices from the field. So real clinicians doing real telehealth out there, and really what they have learned about telehealth. So some pearls and tips, things that will build your confidence and by tomorrow or maybe it'll be Monday, get into your practice workload.

Next slide. We will be touching on implementation, tips, some of the workflow pearls. Talking about the patient side of things and how to address barriers.

So on the next slide. These are a list of the barriers on the patient side and provider side that we -- our panel here, we have come up with over the last couple of days and are going to try to address over the next few presentations. On the patient's side, how do we help patients get on these different applications and get into this new flow of things and start to trust and enjoy and see the benefit of this mode of delivering care. And on the provider side, lots of issues around compliance and legal concerns and just the implementation concerns and how do you get this into the workflow? How do you use your staff to make providers be efficient and make this meaningful healthcare? So you can read the list of barriers that we have sort of come

together on. But without further ado, I would like to introduce our first panelist on the next slide. And actually Steve, I'll ask you to introduce yourself and we'll get going.

Dr. Steve North:
Great, thanks Tom. I am Steve North. And I am a family doc and adolescent medicine specialist. And I'm also the state medical director for Eleanor Health. I had a chance to talk a couple of weeks ago and was invited back because I didn't slur my speech.

Next slide, please. Choosing a technology partner for telehealth can be challenging. Zoom is one of many options out there. A couple others will be highlighted. In thinking about selecting a software platform, I think it's important to consider what you can launch now and get up and running quickly. One of the challenges that those of us -- the people who practice in large health systems face is a desire to integrate everything through the electronic health record. I know of a health system in North Carolina that was requiring all video visits a week ago to go through their EHR and use the EHR vendor-provided software platform. But it was a barrier because patients needed to have a patient portal account. And so they have actually launched with Doxy.me, which will be highlighted a couple of slides.

Zoom is free. There is also a paid version that is HIPAA compliant. It is a great platform that, at Eleanor Health, we are using with all of our patients for video visits. And we have gone from 0% of our visits being virtual to the home three weeks ago, to last week 85% of our visits were virtual to the home. A lot of your patients are probably already using this. It's easy to download and implement. This is a screenshot of two people having a video chat and one of the challenges is there's no easy schedule integration. In your workflow and your practice, you are going to need to consider how to put Zoom or any other product into the workflow. How do you check someone in? What's the rule for nursing in a virtual visit? And finally, how do you as the provider and know that they are ready?

Next slide, please. There have been a lot of concerns about Zoom bombing recently. There are great resources out there. This afternoon, I went into my settings and wanted to highlight several of the settings that you want to turn on or off. In the upper-left-hand corner, you want to start a waiting room so that everyone needs to be admitted by you as the host. The second is screen sharing. This is where most Zoom bombers are getting into a call and then using screen sharing. So change your screen sharing from all participants to host only. And then on the right, require a password when scheduling meetings. And additionally, make sure that that password is required across the board and that your patients are aware what the password is when you send them the invite to the meeting.

That's all I've got about Zoom. I'll help answer questions later. Next slide; turn it over to Chris.

Dr. Christoph Diasio:
So I'm Christoph Diasio, I am a general pediatrician at Sandhills Pediatrics in Southern Pines North Carolina. I'm also the vice president of the state pediatric society and I am on the board of managers of CCPN.

Can we go to the next slide? Our practice is half Medicaid; we also have a very busy mental health division of about eight mental health providers. We basically, the Tuesday after all this broke loose, put our entire mental health division at home connecting virtually to patients, the portal we chose was something called Doxy.me. I like this one because it is very quick and dirty. It's not a download. It's basically a click this link here and launch kind of thing. We have not felt like the technology has been difficult for even the grandparents to figure out. Most people have been doing video calls for a long time. The thing everyone has to remember, the novel part of this is that payers and Medicaid will pay for it. The technology has never ever been the problem when it comes to video calls with patients.

Barriers, certainly there's limits on data. We've have had some families who have driven to McDonald's and joined to the Wi-Fi network, as a way to get around that. Other barriers around connectivity. Some of the school systems are -- now that we are doing more education at home -- are providing Wi-Fi at home. And so

Doxy is just a very nice simple portal as far as benefits of doing the telehealth. You get more information when you're trying to talk to a depressed teenager and you can see in their bedroom what posters they have on the wall. You get a lot more insight into what's going on with the patient. When our therapists are trying to do relaxation exercises for depressed kid, you can do pretty good job of that when their kid is in the bedroom on their own bed. There's a lot of things about telehealth that are very different than how we are used to practicing medicine, but may actually be an added benefit over what we get to do in the exam room. You get so much more insight into the life of that child. Is there one common room with five other kids running around? And it's clearly a little more limited resources than when you have a child who clearly has a little bit more organization and time at home. So I think we need to look at telehealth as a very positive model that we're going to be able to do things and get information that we couldn't in the past. And the barrier to entry on Doxy.me is really just very low. It's free when you sign up, I don't get any kickback from the company. But I just would encourage people to, if you're not doing this already, at the end of this call go to the website, sign up, and just test it out for free. It's really not difficult. One thing that they have that's a little bit unique, is this "Invite via" that's in the center of the screen here. You can actually send a text message or an email with a link to your clinic. We've set up sort of a group clinic that we call our virtual clinic. Then we have named waiting rooms for each of the docs, so if someone's making an appointment with a certain person, they can click right into that. And I think that's the quick and dirty on what I would say about it. And I'll let Karen go.

Dr. Karen Melendez:
Hello, thank you so much for joining this webinar. I know we've all been working on all cylinders. My name is Karen Melendez, I'm a child and adolescent psychiatrist, medical director at Support Incorporated, which is the child and adolescent behavioral health agency headquarters, just west of Charlotte. I'm also the CCNC network psychiatrist for regions one, two, and three. I'm also on the CCPN board of managers representing the behavioral health membership there. I'm also chair of the practice transformation committee for the North Carolina Psychiatric Association.

So first I want to start off by -- next slide, sorry. First I want to start off by giving the lay of the land for support. We have five locations where we do med management and outpatient care. We also have, of those five locations, we have three locations in which we complete intakes. I have four full time physician extenders that I directly supervise. I also have one part-time physician extender. One of the big things that I think I really want to convey as part of this presentation is how staff support is so crucial for this. You really need to know your staff's strengths and weaknesses and really put them in places where you know that they are going to do well in moving to tele and looking at who needs some extra support. You might need some extra med-assistant time with that provider so that their schedule can keep moving.

We started off by pulling back from text reminders for appointments. Instead we have now gone back to reminder calls. And why that is, is because it's all about preparing the patient for the tele visit. So we know that we need vital signs. We know that we need to either let them download an app because we're using a couple of different means for the Tele visit. In addition, we're also – that med-assistant is starting the promo for us. So they're looking at the schedule and if one of the patients is not ready for their tele visit, they are moving on in the schedule and coming back to that patient. We're keeping that day schedule going and also back-filling appointments. Let's say there's a lull in the afternoon and we didn't get that morning patient, we are still calling that patient back and getting them in. I had 30 patients scheduled and I was able to complete 27 out of those 30 patient encounters, because my med-assistant kept things moving. She opened the notes for me, she documents chief complaints, she's doing a review of systems, she's inputting the measures that we do -- we're doing everything in real-time with the patient. I come into a note that is already been pre-populated with a lot of information and connecting on video is amazing, like Christoph was saying. It's just a whole different outlook. I can't even tell you the privilege I feel in being able to connect to my patients this way. This has not been something that I've ever been able to do before, given the limitations with the majority of our payer panel.

Next slide. So a big thing is it has to be easy. We have to look at the options for Internet access. In our own buildings we extended the Wi-Fi to the parking lot. In our area, Spectrum is providing 60 days of free

Internet. AT&T also has a $10 a month Internet plan. Informing our patients about that -- that all goes back to the reminder calls and prepare patients for tele. The telehealth platform also has to be easy. Is it direct connectivity versus downloading an app? Depending on the payer involved, one app is Duo which is non-HIPAA compliant but it has been quite successful for us, depending on the payers involved. The other thing that I really want to stress here is it's important to set the stage. When you start that appointment, that video appointment with that patient, you want to relieve that patient's anxiety. They have -- most of my patients have never engaged with me in this way through a video option where they are in their home. So I usually start off by saying thank you. Thank you for agreeing to meet with me this way. Thank you for agreeing -- thank you for inviting me into your home. Just talking about here -- I want to explain to you how I am guaranteeing privacy and security on my end. I am here in my office, the door is closed, there is a sound machine outside of my door, and I have headphones in to ensure privacy. Now on your end, what you need to let me know is who all is in the room? And that you need to be okay with them being able to hear everything I am saying to you and what you are saying to me. So I think it's really important to just ease that anxiety and that burden for patients as you are starting the appointment. So, thank you very much.

Dr. Viviana Martinez-Bianchi:
This is Viviana Martinez-Bianchi. I am a family doctor and director of the residency program at Duke Department of Family Medicine and Community Health. And I'm also part of the executives of the World Organization of Family Doctors.

Next slide. I just want to share some of my comments and my personal opinion. I am passionate about improving health and decreasing health disparities. And I think we have with telehealth a really great opportunity -- next slide -- of breaking some of the barriers that can help with health inequities.

Next slide, please. Some of the common barriers that we have looked at – we have patient barriers or aversion to technology and lack of Internet access, limited data, fear of the unknown, no privacy in the home and, sure, how to set up. And the provider barriers. Is this compliant with Medicare rules? Are there legal concerns? How do you implement this? I have low confidence in being able to do an exam, et cetera. So I'm going to go through some of the barriers and how we did this in our office.

Next slide, please. In regards to the patient barriers, the barriers are similar to social determinants of poor health that affect our patients. I think providing phone cards with increased data would be an opportunity. We also have people in the office that we are aligned to help people set up and give them information on how to download the app that they needed, in order to be part of our telehealth program. Many of our Medicaid patients, for example, did not have access to MyChart, the system with Epic that our office uses. It has been a wonderful experience to see people who never had access to MyChart now have access because of telehealth.

Next slide. Other issues are aversion to technology. We have some -- what we call telehealth navigators -- members of the team that have been trained to help the patient navigate the technology and when we are setting up a conference call or the telehealth video calls, there on the side of the patient communicating with them and letting us know: 'they are getting in, downloading the app, ready to go, you are ready to go with him.' In regards to the cost, I hope this is cost free to our patients, especially our Medicaid patients.

Next slide. Some of the common barriers for providers. I think we do need to advocate for clear and appropriate Medicare rules. I look at it as a big part of doing this well, and also figuring out, you know, some of the legal concerns. In a telehealth physical exam can be limited because we are not touching, but we still are able to see a lot. I think being able to document what is it that are we seeing, having a patient walk around and see are they short of breath, taking a look at the color, creating a telehealth mode that really looks at what you're able to see through a video is very important and can probably decrease the concerns that providers may have in regards to is it legally okay, am I putting everything that is possible and not so much put that thought process on the limitations of the exam. Also, within our practice we shared a lot of the templates and dot-phrases that we were utilizing. And that has been very helpful for everybody to become telehealth providers.

Next slide, please. I think we can create guidance videos. I love hearing that Dr. Shannon Dowler is going to create some videos during this weekend to guide people to doing this, because her videos are amazing. There are also multiple exams in the literature that can be used. The prior speaker was talking about having people show their blood pressure machines. I had a patient I was interviewing who had -- is on oxygen, has a pulse-oximeter monitor, she was able to show me her pulse, her pulse-oximeter results, her blood pressure -- showed me that. So we are getting a lot more objective data than we thought, including vitals.

Next slide. And then verbiage during your exam. The last speaker talked about making sure they're in a safe place and that it's safe to speak and that's really important.

Next slide. And then, administrative support is needed. I think, one of the things that we are dealing with is, a lot of people trying to figure out what do we do. The staff can help in this administration portion. Being able to get our patients to login and be able to be online and ready for these interviews on telehealth. The other thing we haven't thought about, but maybe it is a potential. We had a lot of medical students, PA students, and nursing students who are currently without much to do. And they could be guiding patients online on the telephone to be able to do this.

Next. And then how to choose a vendor, many of you have already talked about. We do have -- with Epic we have both Java and browser ready for the patients to be seen through one setting -- we have the other one so there's always a backup plan on board at the time of the visit.

Next slide. Our hope is that; we think about the investment. I think we are all discovering so many benefits of telehealth, that I hope this will continue to be a part of how we practice. We have had people without access to care because of transportation for years and limited ability to get in touch with us. Hopefully this investment will be going beyond the COVID pandemic and we will be able to continue to provide this care through telehealth when possible. Next. Thank you, now onto Karen.

Dr. Karen Smith:
Hello, my name is Dr. Karen Smith. I am a rural physician with 28 years in practice in Raeford, NC, Hope county. Telehealth is not new to our practice. We had the fortune of working with the recovery platform as part of project OBOT for an 18-month timeframe and we used that platform for out medication-assisted treatments program in our office. When it became necessary for us to expand -- extend the telehealth platform to our non-medication-assisted treatment patients, we quickly launched that platform. Since that time, the North Carolina Medical Society has also introduced Presence which is a modification of the current Zoom platform that we are using. We also an opportunity to review the different strategies with the up docs.

Next slide. Telehealth integration is part of the components of healthcare. We see that. It is actually something that we've been doing and it is going to be something that is expected of us in the future. I don't think we're going to get away from telehealth once the pandemic is under control. So we might as well get really comfortable and get used to it. We need to think about what is happening in the home and what did the patient have available that will help them navigate -- it's a new system of care delivery for many people. But it will actually become the way of life. What about the devices already available -- that people are already using for so many other aspects of their life? And now we're saying let's really apply it to healthcare. And then we're going to talk about a little bit of the tele-video examination strategies. There are courses in terms of teaching how do you do a really good tele-video examination and it's amazing how much information we already capture.

Next slide. The good physician treats the disease but the great physician treats the patient who has the disease. And we see that William Osler gave us that valuable information years before many of us were even in medicine. We are just changing how we are addressing and taking care of our patients. But we are still taking care of the patients first.

Next slide. This is an excellent example of a patient who is doing telehealth. But what we have here is a great difference in terms of age and generation. The little lady who is actually teaching her dad how do you navigate this system; she is teaching us now, and dad is making use of this and so when we think about what is actually happening in the patient home, we do have to give credit to the resources that are already available and recognize that our patients really are going to like this if we can get it right. I think it's going to be important for not only the physician to be comfortable with this type of delivery, but also the patients to become comfortable. One of the things that we found important that is necessary to prep the patient for the telehealth visit. So we utilize our electronic health record vendor, the patient portal, giving ample information and ample instruction. But we need to remember that information should be in the format which patients can understand and not be overwhelming. Signed consent. When we look at the CMS regulations as well as the office of civil rights regulations, yes, there have been modified recommendations in terms of modified rules are in place. So there are some considerations regarding the HIPAA. But consents are still required. Patients do need to understand that this is not the typical face-to-face visit and those consents do need to be documented in one manner or another. We need to make sure that patients are actually reviewing those instructions in terms of access into platform. We too utilize our RMAs in our office, our registered medical assistants, to help us with gaining access. Currently about 60% of businesses are tele-video with a very small handful of telephonic business. But this is what we were trying to achieve in order to keep the patient safe and also keep our folks in the office working safe as well. We find that the telehealth visit is excellent for updating information. We are updating the advanced care directives and spending time understanding the anxiety and the stress that patients may be facing in their homes.

Next slide. Our little lady just took over because, you know, in a few years this is how she's going to be receiving her health care. She will be seeing that physician only when it's necessary to have a hands-on physical. For the most part, she's going to get really good care and you can tell she is already excited and ready to be there.

Next slide. So what happens when we don't have the laptop in the home or we don't have the internet access? Once again, we know the smart phones will allow that interaction to occur. The second platform that we use in our offices is UpDoc, and it does allow us to have the tablet access, it works extremely well. We have found that having multi-modal forms of communication does make a difference. Telecommunications is the way of the world. And we can utilize it and launch it forward and continue into the future. We are excited and we're glad that our patients have embraced the telehealth whether it's tele-video or telephonic, we're moving forward. Next slide.

Dr. Tom Wroth:
Thank you so much. And Hugh, question, should we wrap up now or should we do panelist questions first and then do wrap up at the end of the webinar?

Hugh Tilson:
Let's do the panelist questions next. That makes a lot of sense.

Dr. Tom Wroth:
Thank you all so much. That was wonderful and we have gotten a lot of great questions from the chat box -- from the question box that I want to ask you all. So Dr. Diazo, Christoph, I want to start with you -- a couple questions around pediatric care. So when you're doing an adolescent telehealth visit how do you address privacy and consent with that type of visit?

Dr. Christoph Diasio:
Hopefully you have the parent in the home and you're able to get consent for them, a lot of times the way these things work is, the child is in their room, mom will connect with you, you have a conversation, mom will go, you know, leave and go somewhere else in the home if you need to have a private conversation with the adolescent. I mean, you're relying on that young person and who else is in the room. It's not that big a thing. I guess if you were saying what if a teenager connected directly to you and there was no parent able to

give consent, I guess you would fall back on all the same -- at what age do have the right consent for what kind of care rules? I don't know that in person versus telemedicine is functionally different, I am not aware.

Dr. Tom Wroth:
Great, thanks Christoph. And another pediatric question to you, or really any of the panelists. Are folk starting to do well-child checks for let's say three-year-olds who don't need shots or any bloodwork?

Dr. Christoph Diasio:
This is Christoph. I can tell you that no one in the state has currently approved well-visit codes for telehealth, that I am aware of. I have heard some national payers are considering it. And so the current regulations, the letter of the CPT code, I think, would sort of discourage you from doing that. So unless you had it in writing from the payer, I do not think that I could recommend that you do that. That said, I know there is a lot of excitement around this issue. There are Medicaid programs in other states that have done that. And Dr. Dowler already showed us on her slides that, that is something North Carolina Medicaid is looking towards as well. So yes, I would do it, but not yet.

Dr. Tom Wroth:
Very soon though, Dr. Dower. Great so, Steve, Dr. North, you've got a lot of long experience like Dr. Smith with telehealth. Talk to us about a little bit about how you might use remote devices in the home and also around the physical exam. How do you collect that objective data?

Dr. Steve North:
So those are two opposite ends of the spectrum, almost, questions. I will try to answer them both. The first about remote patient monitoring. Remote patient monitoring is becoming easier to set up but it is still difficult. I would recommend that you work with somebody who has experience. Many home health agencies do have remote patient monitoring equipment that they can then place in a patient's home under your direction and you can follow that information. The challenge with remote patient monitoring is that, when an abnormal value comes in, who is monitoring that stream and checking those websites or the feed into your EHR on a daily basis, to see what is flagged, so that you can intervene? EHR integration is a great topic but not easy to set up, especially if you're on one of the large systems like Epic or Cerner that's really controlled by your health system, as opposed our own practices.

Sort of extending from remote patient monitoring into the physical exam. I think the first thing to note is that home blood pressures, heights, temperatures, weights, you can use all of those. When you document, document that this is patient-generated data for their pulse, for their blood pressure. Included it in the note, and use it as valid data in your decision-making but, maybe not included it in your E&M coding if you're billing based on complexity.

The physical exam, I feel that as we have more experience, there's so many things -- visual cues that we take from our patients, that -- when they are there, we notice them and take them into account. When they're not there, it doesn't register in our brain. It's not a conscious effort to say 'does this patient currently have nasal flaring when they breathe?' 'Is this patient not speaking for a complete sentence without taking a breath?' Those are the things that can be included in your physical exam. You can see those visually. You can also see rashes. Rashes are great for telehealth. An individual can zoom in with their camera and you can actually do a screenshot and place that in the electronic health record. The other thing is having a patient show you a range of motion. Have them show you if they're having excursion issues with their breathing. Have the patients get up; move around. Friends of mine in Dallas, in one of the school-based programs, talk about how they evaluate abdominal pain and have a child jump up and down in the room to see -- well, if this is a gallbladder or an appendix, they're not going to want to jump up and down. However, if it's just an upset stomach, having the kid jump up and down should not be a big issue. You can also have your patients show you their lower legs and push down and document the pitting edema that you visualize. So I think the physical exam, while almost entirely visual and based upon conversation for screening and discussion and

depression, is easier than we often think. But we just need to expand the pieces we're incorporating into the exam.

Dr. Tom Wroth:
Steve, those are great tips. Thanks so much, very practical. And just another quick question that you addressed in a previous webinar. Talk a little bit about the lighting that you suggest on the patient side that they use and this question is around looking at skin color for an infant and looking in the mouth of a child.

Dr. Steve North:
Yeah, so looking in the mouth of a child, you probably want to use the light source on the parent's phone if you can -- if they can turn that light on and shine it -- that's going to give you the best looked down into the throat. Looking at skin conditions is a little bit different. Because you don't want to use direct lighting that may cast a shadow in some ways, you really want to have natural lights and then enhance it -- bring it closer to a lamp as opposed to the glaring bright light from the back of the phone. A lamp creates a more diffuse light -- and bring it close and get the picture there.

Dr. Tom Wroth:
Great, thanks Steve. Dr. Smith, a question for you. Practicing in a rural area, you have a lot of patients that don't have broadband, have issues with being able to use data or minutes on their phone. Anything you have done to provide access to those patients with telehealth?

Dr. Karen Smith:
So we have been very fortunate and that has not been a major issue for us. Patients have actually had enough minutes. We have made it very efficient by making sure the intake was completed by our RMA and the amount of time for the visit with me was also efficient. We have done some strategy to decrease wait because we recognize that going from the RMA to the physician can prolong wait. And so we have daily huddles with our team and we look at all of the extraneous issues that come up and we do our PDSA in terms of trying to address it.

Dr. Tom Wroth:
That's great, thank you. Dr. Melendez, you talked a lot about using your staff and getting back up to that word that we hit here, productivity. That is so important in running your business. Talk a little bit about how you helped your staff transition to those new roles.

Dr. Karen Melendez:
Well I think we were very lucky in that we have some telehealth options for all our patients. We have multiple offices and certain locations are closer to their home and what have you and due to transportation issues, they may need to go to that office when a provider may not necessarily be there. So there was some experience already with tele and we were just able to ramp it up, to really, you know, just galvanize the workforce overall, is to say -- you know, here are the goals. We need to see our patients, we need to continue managing their care, and everybody just jumped in. Everybody played their position -- knowing their position and playing their position well and reinforcing what's needed. And the daily huddle that's a great idea. I would launch certain things on a Monday, we were having a Skype for business call with the team, three options on a Sunday. So 30 folks across the board got on Sunday calls 20-30 minutes like, hey this is the plan for tomorrow, let's get it and it's just gone well.

Dr. Tom Wroth:
That's great, thank you. An I think that one of the issues, Dr. Dowler I might ask you this one. I think a lot of the practices are struggling with you know -- in this transition the decrease in volume and trying to get our patient populations, our patients comfortable with telehealth. The question is, are patients aware of telehealth and what is the state doing to help them transition?

Dr. Shannon Dowler:

That's a great question. We actually have a letter going out to all of our members. It'll go out to every household that has a Medicaid member in it, talking about telehealth and encouraging beneficiaries to engage in telehealth with their providers of all types. We also have a virtual poster that we've been working on that'll be available with social media and other places encouraging telehealth. I'm working on this video, which is sort of an infomercial on getting folks comfortable with telehealth. I think it's important that we're all talking about it. So there's going to need to be sort of a widespread push, so it really needs to come from your practices as well. But if they hear from your practice and then they hear it from Medicaid, and they hear it on their local news station, I think people will get on board pretty quickly. That's the big thing I am pushing, is that if you have chronic diseases and they get destabilized during this time because you're not doing your normal care and routine care, then your risk of having a terrible complication of COVID is much worse. So kind of encouraging folks to think about it, in terms of don't just do it because you're sick, do it to stay well, so that if you get infected you are in better shape from it. So you're coming at it from a lot of different angles but it would take all of us to get the message out and get folks comfortable. We did just do a breakdown of our numbers doing some data analytics with CCNC on who is using telehealth. And the under 50 crowd is definitely more comfortable with it, you can tell they are using it more than the 50+ crowd. But I was pretty impressed with the 50-85, or whatever that range was, there are quite a few in there. So I think we are seeing all age groups utilizing it and the more [Indiscernible] that will be.

Dr. Tom Wroth:
That's great, thanks Shannon.

Dr. Christoph Diasio:
This is Christoph, just to jump in a little bit, there are some other things that are going. The Peds Society started a social media information. And there's a toolkit for practices, that the pediatricians should all have in their email from our executive director, as well as letters to the editor. One of our docs actually just did a Spanish-language interview with Univision. That's in the peds link, so if people want to share that for the Spanish speaking native patients.

Dr. Steve North:
Two days ago they released a great how-to guide that is free to everyone. You can download it off the AMA website but it is 120 pages of step-by-step implementation and evaluation guides.

Dr. Tom Wroth:
That's great, Steve. If you can share that with CCNC/AHEC we would be happy to give that up on the website as well. Great and, let's see. Dr. Dowler, one other thing, you touched on it, but can you talk a little bit how you are coordinating with other payers on the payer counsel to try to align some of these efforts.

Dr. Shannon Dowler:
We are working really hard to make sure that we are using a little bit of peer pressure to make sure folks are covering things and you will see that on that chart we have. There's a lot of agreement and folks are covering a lot of the same things, which is important. There is of course going to be some variation in the billing and coding, I feel terrible for the practice management staff that are dealing with coding and billing stuff right now, because it's got to be a nightmare. In that chart we're going to have as much alignment as we can find. But we're also using that payers counsel to think about other strategies and one of them is telehealth. So they're also very interested in how we address telehealth and get folks using telehealth as well. Because they don't want folks to get complication of their diseases, it's not good for the bottom line. And of course they care about everybody. But we are working with that payer counsel and the whole DHHS, the whole division is working on a -- what we're calling a telehealth lane to make sure that as a state we are addressing telehealth. So there's a ton of resources going into that right now. I think this is actually one of the lights -- the bright spots coming out of this state of emergency has been our ability to move technology forward so quickly. Some of these things are things we have been trying to do. For a little over six months I have been trying to advance telehealth that entire time, but didn't have budget ability. And now suddenly we are in a

crisis and so I get to do it. How do we get to keep it on, is the next question? So we have done all this work, how do we make sure we get to keep using it?

Dr. Tom Wroth:
That's great Shannon, thank you. It is one of the positives coming out of this. Never let a crisis go to waste. How can this improve care and transferred care for the better. So just looking at the time, 6:26pm and Hugh, I'd like to ask you to take us through some of the and wrap us up.

Hugh Tilson:
Great, next slide please. I wanted to make sure everybody is aware of some new federal financing available for telehealth. $200 million for one program and another hundred-million for an additional three-year connected care pilot program. You will see later on we will give you the slides and make them available so you can click that link yourself to find more information about how you can avail yourself of it. We've heard all these great ideas and great ways of doing things, this is a way to help you pay for it.

Next slide please. Some of our state partners are doing partnerships of their own so you can see CCNC, Medical Society, and Community Health Center Association have partners with specific telehealth vendors, to help you get aligned with a specific telehealth product.

Next slide. One of the of the other great things to come out of this, is that CCNC and AHEC are really partnering well on a lot of things, but one of them is to support practices in telehealth and you can see the services that both of us are providing. Really no wrong door if you need help, call any of us, we'll be happy to help you get started and work through workflow, work through patient education, billing and coding. You can read the list, but we're happy to help you with that.

Next slide, please. We're also happy to help you figure out how to navigate COVID-19. Many of the same things, coordination of care, transition to care management, QI work. Then as you start thinking about what comes next, how you get upstream a little on support for social determinants of health.

Next slide. So here's how you can contact us and again, no wrong door. If you have a need, contact any of us and we'll make sure we can provide the services that you need to help you navigate COVID-19 and to deploy telehealth services more broadly.

Next slide, please. I did want to bring to your attention a survey that's gone out by the state. As the state is figuring out how best to support providers and deal with the COVID-19 wave, they have been focusing on hospitals. Really important to do that and congregant living settings. They're realizing that asking information from providers is important. They recognize that there's a lot of surveying going on. One of the questions related is telehealth and is there way for us to better help you as you adopt those practices? So please, if you haven't gotten this, if you have got it please fill it out and we'll follow-up with you.

Next slide. Another huge resource for the state is COVID-19 triage plus. Your practices, your patients can call us statewide -- inbound call center providing timely information with clinical triaged by nurses using the latest guidance. Please know that number; please distribute it. Please see the numbers -- the days that are out there and please know that this is open for all patients, not just Medicaid patients. It's a great resource for patients and their families, and for your practices.

Next slide, please. You can go online and get all kinds of these resources. One thing I would just say is if you have Medicaid specific questions, Medicaid.COVID19 at DHHS.nc.gov is your place to go. They do a great job of cataloguing and responding to your questions.

Next slide, please. We are maintaining a website jointly with CCNC. We're trying to put this all together in one place to make it easy for you. If you go to community cares website you can see there is COVID-19 information, trying to make it user friendly and call out a lot of the noise so you can just get usable, timely information there.

Next slide. Lastly a reminder of some of the other webinars that are going on, we have a series on Tuesdays that we are partnering with -- it's CCNC, AHEC, family physicians, Peds Society, and the Psychiatric Association on COVID-19 resources. Reminder that on Fridays, although not tomorrow, because of the holiday, DPH experts are available to you to help navigate clinical issues. Every Thursday from 5:30pm-6:30pm you have this webinar for up-to-date information and great case studies about how to deploy it.

Next slide. We've already handled our questions. So that's all that I have got. Dr. Dowler, do you want to give us some take-home comments and then we can call it an evening?

Dr. Shannon Dowler:
Thank you everyone for your engagement and for continuing to join us on Thursday evenings. I hope that the content's helpful for you. If you would like other information or different information, you know to just send us the feedback. That Medicaid.COVID19 source -- if we can't answer your questions on the call or we didn't get to them, send it through that site. We have a whole team of people working on answering questions, and we're cataloguing all the Q&As. Thanks everybody for your amazing work out in the field and taking care of North Carolina. I am hopeful that we will all enjoy Summer in a very different way than we are enjoying Spring. We appreciate your engagement and look forward to talking next week.

Hugh Tilson:
Thank you everybody.

[Event Concluded]