Transcript for Healthcare Professionals Webinar Series
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5:30pm – 6:30pm

Presenters:
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Dr. Tilson:
Good evening everybody we will get started in five minutes.

Our moderator will begin in about one minute.

Good evening everyone. It's 5:30 PM. Let's get started. 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, CCNC, and NC AHEC.

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We've got a ton of great, timely information tonight including an update on Medicaid policies, followed by a panel discussion on telehealth and chronic disease management. We'll then respond to your questions and close with a list of resources.

My name is Hugh Tilson, I'll be moderating tonight's forum. Our presenters are: Dr. Shannon Dowler, chief medical office for North Carolina Medicaid; Dr. Tom Roth, president of CCNC; Dr. Steve North, family physician and medical director of Eleanor Health and also an adolescent medicine specialist; Dr. Debbie Ainsworth, a pediatrician in Washington Pediatrics in the eastern part of our state; and Dr. Sam Cykert, a colleague of mine, who's a general internist and director of medical education at NC AHEC. I thank all of you for your time tonight to be with us and the expertise you'll provide.

Before I turn it over to Dr. Dowler for the Medicaid policy update, let me just thank everyone for making time in your busy schedules to participate in this webinar. We hope the information we provide tonight will help you in your important work and make navigating these trying times a little easier.

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We will get to your questions after you hear from our panelist. There are two ways to submit questions. First is by using the Q&A feature at the bottom of the screen. It's the Q&A feature in the black bar at the bottom of the screen, if you are on the webinar, as a way to do it. If you're on the phone, you can't do that, so send us a question at questionsCOVID19webinar@gmail.com. We'll send all these questions, whether we get to them or not, to Medicaid so they can respond and get you answers to your questions. We will record the webinar and make slides, the recording, and the transcript available either later tonight or early tomorrow morning.

So, Shannon? Up to you now, thank you.

Dr. Dowler:
Thank you. It's great to see everyone, not really, to talk to you I guess since I can't see you. I can't believe it's been two months since we've done these weekly updates. I had a moment of clarity this week that there are a lot of these things happening and it must be very tiring for all of you in the field. We have really appreciated the attendance and participation. It's given us terrific ideas. It's helped really impact the policies that we are able to turn on and change. If we didn't have that sort of bi-directional communication, I don't think we would have come through the COVID pandemic as well as we have so far. Thank you for joining us again tonight.

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So, last week we released the hybrid home-telehealth visit, which I am particularly excited about and not sure why exactly, but I'm particularly excited about this. Probably part of it is I used to love doing home visits and seeing what was going in my patients' homes and it became really impossible to continue doing that in any cost-effective way. You pretty much had to do it off the schedule or on your admin time. But, having someone have eyes on the patient's living environment really makes a difference. And, so, Telehealth has opened that up for us in a way that, at least for Medicaid beneficiaries, has not really been available historically. And this new visit, where you combine sending one of your trusted staff members into the home while you are on telehealth, it sort of makes that telehealth visit three-dimensional. I'm not sure if this is something the field is going to get excited about - I learned today that the portal communication that I turn on is one of the first things I turned on because I was sure that the field would be so excited that all that work they did on these portals, doing communication back to patients so they could bill for that and get paid and get RVUs for the work they're doing, and it turned out I just had a report run on the busiest week of billing, the highest number of charges came in the second week of April and it was 13. So, for our 2.12 million beneficiaries, there were only 13 charges in one week for portal communication. So, I might have missed it on this hybrid home-telehealth combo. I hope I didn't though. We're thinking of this right now, especially in the pandemic, around your high-risk pregnancy, uncontrolled chronic illness, well-child for more vulnerable populations - infants - or someone who's medically complex. Certainly, if you want to keep your family members that would be high-risk if they join in an office visit and the ability to do some of those touches, like vaccines, labs, and vitals, what we're seeing is our quality and evaluation team is working alongside CCNC to measure care gaps, and we're seeing care gaps are going up pretty significantly, and nowhere more so than in the vaccines base. Big significant changes, you know, we're seeing it as well with people behind A1cs and other things, but this idea of having a visit where you can combine a few things together seemed like an interesting idea.

Who can use this code? We've made a bulletin clarification just to let you know that this can be used broadly. This is sort of a creative option if your practice is interested in the creative option on providing care differently, and so tomorrow you should see that update to the bulletin, but the formal one was put out earlier this week and I hope you'll consider using it with some of the cases that we're going

to talk about later today. They're going to maybe give you some ideas how you can use that.

Next slide.

Alright, so, I know that this is often in health departments, but a lot of FQHCs also take family planning patients and some other private practices do. So, we wanted to clarify where we were with the North Carolina Be Smart Family Planning Program, which has an acronym of MAFDN, which does not match those words, but that's a point of contention between me and public health. Pretty much what we have done is made a lot of expansion with family planning visits, so, telemedicine can be used for new and established patients, telephonic can be used for establish patients. We have temporarily suspended the requirement for an annual exam. When you submit your claims, if they have not had the annual exam yet, you don't need to put it on there. One thing that's really important for everyone to know is that both telephonic and telemedicine encounters count towards the benefit limit. So, that's six visits in 335 days, so just be cautious. I got a call from a provider asking questions about billing telephone visits in a health apartment environment and there was some concern that maybe they weren't all really complex visits. You will use your six visits in 365 days pretty quickly, so just make sure you're using them in the best way possible. No prior authorizations required. Right now, we do not have adult preventive health covered under telehealth or virtual health provisions and we don't plan to, and, so, that is why we delayed the annual exam requirement.

From the billing standpoint, if you're doing a telemedicine visit for family planning, you use the GT modifier. Use the CR modifier for everyone, and then FP for everyone if it's a family planning programs. I think a lot of the claims denials have been around those modifiers. So, we will have more guidance out on that tomorrow to clarify it for you.

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Another couple local health department updates. I got some feedback from a colleague that said, "Wait a second, I'm in a health department that does complex care and I want to be able to do that home telehealth visit too." So, we turned that code on for local health to be able to bill for that for those health department that do complex medical care. We also, this week, approved telehealth visits for newborn and postpartum nursing visits to be used in this time in this state of emergency.

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The team has been working on a very cool resource that Kate Menard got us started on about sort of summarizing all these codes and provisions for prenatal care, because it's very confusing. The coding for pregnant women is really complex, and so we've tried to break it down and make it a little bit more intuitive and make it easier for folks to follow. So, we hope that you will jump on that as soon as we release it. We hoped to have it today, but the truth is it will probably be next week, Monday is my guess, before it's done. It's complex enough that our teams had to look at it a bazillion times.

Okay, next slide.

I wanted to comment on some of the things Medicaid has done a little differently. I was on the call Tuesday night where some of our payer friends were updating where they were and what they were doing around telehealth, and I cannot imagine how complicated it is to be a practicing provider right now and trying to sort out all the differences and nuances between all the plans. It's got to be very overwhelming, and I'm sure that's why no one used my portal communication code because you didn't know you could, and not because I was just wrong. But I did want to point out something. I heard one of the payer say something about, "Oh, we are not covering the virtual portal and telephonic because it has these restrictions that you can't be seen within seven days, or if you are seen within 24 hours the code goes away and you cannot bill for it." I just wanted to make sure everyone remembered one of the first things we did was we took away that rule. For the telephonic and portal communication, using that CR modifier means you can wave that seven days 24-hour rule, because it felt not good to us to ask you to do the work and then take a chance on not getting paid for it. So, just making aware of that, we did increase our telephonic rate to 80% of E&M fee for service, we added the portal MD to MD consults, and then the prevention for children and not a lot of payers have done that. We've added a lot of enhanced behavioral service codes. If you don't live in the BH world, you may not be aware of them, but dozens and dozens of codes for provider services in the BH world. I will say we have been in cycles of continuous improvement based on feedback that we've heard from the field and we've been constantly trying to tweak and improve things and catching it if we miss something. Sometimes decisions that we made were not popular, what we were covering and not covering. We still appreciate the feedback and we hope that continues. Right now, Medicaid is planning to extend all the policy provisions that we have made until July 25th at least, but not turning them off before July 25th. We wanted to put that out there so you are aware of that so you could go on and do your planning and scheduling for early summer. The other thing we would like to make sure we do is give your thirty days notice before any modifications to our provisions, knowing that you have full schedules and have got to have time to react to these changes. Whenever possible - there's an asterisk there because there may be some emergency change we have to make and we'll not be able to give you 30 days notice - but otherwise the team will work hard over the next month to see what provisions we keep on long-term, which ones we can keep on short-term, and which ones we turn off and we will be methodical in communicating that to you. And, so, you have the commitment from us that we are going to be as mindful as possible about getting you notice before we change things.

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Having said that, the team is tired. We've been rolling the rock up the hill for two months of trying to create all these policy provisions and turn that tanker around in the canal. We definitely feel like we have done a fairly thorough job, in that we have not met everyone's needs and there're still a handful of folks that feel left out in the process and we're sorry for that. Moving forward, any coverage request will need to go through this Medicaid.COVID19@dhhs.nc.gov email address, and then there's going to be a process where you'll complete a form essentially saying why you think the change needs to happen. The calculations are an ROI calculation. Essentially, any change we make,

if it benefits five providers in the state, it is as much work in cost to make system changes with the effective 500,000 providers in the state. So, we are at a point now where we're thinking about what we are turning off, so it doesn't make sense to invest a lot more energy turning new coverage provisions on. And, it's not because we don't love you dearly, we do, but we also have to balance all the other competing priorities that we're dealing with right now. Some of those around Medicaid transformation for two months and we've really looked away as we tried to respond to COVID rapidly, but we have to think about that when the general assemble is back. We don't know what our future looks like, so we need to think about all the day-to-day Medicaid work as well.

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I guess before I talk about this slide I will say that, in light of the fact that we are not doing a lot of new policy changes moving forward, we've made the decision to change the cadence of these webinars. We're not breaking up with you, but we just need to take a little break. We're going to take three weeks before our next one and my hope is that's going to be on May 28th. My hope is that you use that hour over the next three Thursdays to have dinner with a family member or walk your dog or do something that brings you some energy and joy, and know that we will be back in a few weeks and hopefully at that time we can forecast for you what we see coming down the line in the future.

From a payment standpoint, we've done a lot with Medicaid to provide support for the infrastructure, providers, we know some practices had to close, a lot of practices had to reduce their hours or staff and make other changes - it's been an incredibly difficult time for everyone. But, there have been quite a few things we've turned on and, again, just making folks aware of those things, because it's hard that we have these updates every night of the week and there's a different update you can go to. So, it's really easy to miss the accommodations that have been made by different people involved in this. Just this week, we turned on a hotspot map, which will help our AHEC providers supports find places to go. I'm going to show you a picture of what that looks like in just a minute to help you with telehealth provisions. That's pretty exciting, and the other thing that is big news is the legislator approved a 5% increase in provider rates, and so that 5% will apply to all the service rates for the eligible providers. If folks already got a bump, they don't get another 5% bump, but for those that didn't, which is most of you, there is a 5% increase and it will be for all service codes including ENM codes and that will be retroactive to March 1st. When we'll get the check, I'm not sure. The team has just now gotten this mandate, so they have to figure out how to do this with the other five million, they're processing hardship payments every day and doing a lot of these other changes at the same time. They are on it, and they're working on their plan right now. Hopefully we'll be able to put that out in a bulletin soon to give you the details of that. That was exciting news and a real positive. We can thank our fellows downtown on Jones Street for fellow friends for getting that 5% increase for all of you.

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This is the hotspot map that I was mentioning. This is very cool. They created this with the idea of helping our practice support know where

to go to provide practice support. They base it on a few things. One, what is the risk in that population of having a lot of COVID high-risk patients based on comorbidities. They also look at vulnerable populations and the minority population penetration and whether there was an access to care issue based on the number of medical homes and distance to medical homes, whether there's high-speed Internet in the practice, and then AMH got added and what we've discovered is that that is not a terribly reliable measure, because the individual does not roll into this. So, if the practice is AMH, but you as an individual may show up as "no," so we're going to take that field out. What we are going to do with this is do in overlay on this of who is billing for telehealth codes. If we hotspot and find areas where there is total vacancy of telehealth utilization, then we can go in and provide some really intentional practice support and see what we can do to help practices get up to speed on being able to use telehealth. It's our belief that a lot of the telehealth changes that have gone into place are going to stay on. I think they're going to be able to keep some things, so we want to make sure that everyone is able to use them, because we're seeing some real positives.

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This is the data from the COVID Triage Plus Line and the screening that CCNC has been doing for us with calls. You can see that numbers went up significantly and when 211 started sharing calls with them. You can also see that a lot of calls are people who screened positive. Thanks to CCNC for taking on that work, and make sure your practices and patients know about this resource, because they can call that line instead of tying up your phone line.

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Okay, Tom, I'll kick it over to you.

Dr. Wroth:
Okay, thanks, Shannon. We're really looking forward to this panel tonight with Dr. North, Dr. Cykert, and Dr. Ainsworth. And one of the topics we all have been wanting to get to during the COVID situation is what we do for our patients with chronic conditions, children with special healthcare needs, and those that we're trying to keep out of clinical settings and stay physically distant. Now, with all these policy changes and what we're doing with telehealth and the hybrid visit, we thought this was a great time to bring some of those ideas together and go through a few cases. So, Shannon and I will throw cases to the great doctors and see what they have to say.

First case.

Dr. Cykert, Sam, this is for you. This is a 50-year-old woman with diabetes, hypertension, and chronic renal insufficiency. Probably pretty common in your practice. And, this is a patient that you actually saw in the office right before COVID started, and some things were out of whack. Creatinine was slightly elevated, potassium was a little bumped, and the blood pressure was 180/100. And you started them on an ACE inhibitor, so you probably want to do more monitoring. Using a telehealth visit and the rest of your team, how would you approach this and talk about remote monitoring and hybrid visits?

Dr. Cykert:
Okay, Tom, thanks. This is a really, really important case. As most of you are aware, folks with uncontrolled hypertension and uncontrolled diabetes, they are at the highest risk of ending up in the hospital with COVID and also dying of COVID. The other important point here is, even if this patient does not get afflicted with COVID-19, you are still in a situation where their diabetes, hypertension, and renal failure can kill them. So, with this lady, if you had a digital blood pressure cuff at home, then at least from the blood pressure viewpoint you would know whether or not to get aggressive with titrating medicines with the telephone visit. But, the added issue here is not only is there no blood pressure at home, but an ACE inhibitor started in a patient with renal inefficiency and hyperkalemia, so at this point we don't know if the ACE inhibitor will be helping them or hurting them.

Here is where a hybrid visit really, really fits, and if a person, whether associated with the office or a community health worker who is experienced with blood pressure, but since laboratory is involved it would probably be a nursing level person, but this patient could benefit from a hybrid visit with your advice over the phone and someone taking the blood pressure at the home and also drawing blood to monitor the creatinine and potassium. Control of blood pressure will be very, very important, and there’s some pretty firm data right now that diabetics who come in with lower blood sugars have a better prognosis with COVID, and hypertension control does not hurt either. So again, very important situation. If you can have a glucometer and digital blood pressure machine there, then you can get a lot of it done, but when you need labs like a situation like this, a hybrid visit would be perfect.

Dr. Wroth:
Sam that’s great. Once you have the team member and nurse in the home, are there other things they could potentially do? For example, dietary teaching and those sorts of things that test those sorts of things and you could sort of max pack that encounter as well.

Dr. Cykert:
Yes.

Dr. Wroth:
Of course, with patients not coming to the office, sometimes it's hard to get our arms around patient panels and who's coming and not coming, what are you all doing with your electronic medical records to ensure that you’re seeing your diabetics and hypertensives and others?

Dr. Cykert:
We are actually producing reports. So, we will download our reports of patients with hypertension that are uncontrolled and patients with hemoglobin A1cs that are greater than eight, and we will actively engage those patients for televisits. Mostly video visit. And, for folks who are listening, one video platform that is really easy is Doxy and Me, and the only reason I mention that is that you can actually, we have our CNAs doing previsit and they can call the patient to set them up for the visit and text them, and the patient gets on the visit by hitting the link on the text and, boom, the smart phone is on. It's all pretty easy right now, I'm not selling things for Doxy and Me, but I

found it to be easy for the patients, especially those who are not computer savvy.

Anyway, we’re generating these population lists, and particularly in this time where COVID hasn’t hit its peak and you may not have patient engage a lot in video visits, you can proactively call in these folks, get them under control, and improve the prognosis for both COVID and chronic disease morbidity beyond.

Dr. Worth:
That’s great, Sam. Great use of electronic record, the team, and this is engaging the patients which is so key here and also the additional benefits of keeping folks that are high risk for COVID safer. Thank you so much.

So, Shannon, going over to you for the next case.

Dr. Dowler:
Alright, so, Debbie, you have a young man, a 12-year-old, who has got a chronic lung disease, a tracheostomy, and he is wheelchair-bound. And I am wondering how you might use the hybrid home visit to get other members and other team members to see this child?

Debbie you may be muted.

Or maybe you hung up?

Is she still on there?

Dr. Worth:
Debbie, are you muted? There you are.

Dr. Ainsworth:
I had to unmute in both places.

Dr. Dowler:
Yeah, it’s a trick on this one.

Dr. Ainsworth:
Yeah, I see that.

Thanks for the opportunity to share what we struggle to do, and kudos to you guys, I've been dealing with Medicaid for a long, long time, and I’ve just been very impressed with how fast and how well things have been going on so far.

With this guy, one of the things is, for most kids that have tracheotomies in this kind of scenario, there's some type of an aide or private duty nurse or someone that is attending to this patient on a regular basis. That is where you can bring that other team member in that you may only see when you come into the office. Being able to get that nurse or CNA on the phone and being able to see what do the secretions look like? How fast is he breathing? How labored is the breathing? I think it's a great way to be able to assess the need for what needs to happen next.

Dr. Dowler:

How could you, how to you think you could use telehealth in a patient like this to help you assess their home functional status? Maybe in a way that you couldn't do before?

Dr. Ainsworth:
Well, one of the things that I've been finding is that you learn a lot about a household just by seeing what's in the background. And, so, taking the opportunity to have the nurse show me how he gets to his bedroom or walking around in the room. How does he maneuver with his wheelchair? How cluttered is the house? Is it a safe environment for someone that is in a wheelchair? I think you can get glimpses into that that you just cannot get from being in the office when they come in.

Dr. Dowler:
So, let's say he took a turn for the worse and you were really struggling with what to do with him, but his pulmonary consultant was two hours away and it would be very challenging to get him there during this time and high-risk for him. How much do you use that MD to MD consult code?

Dr. Ainsworth:
Absolutely. That's the case out here in rural eastern North Carolina. Everyone is one hour to two hours away. So, yeah, that capability of being able to send a message directly to the pulmonologist and trying to get them on the phone, they usually have special nurses that know these kids really well. Even if you cannot get to that doctor, being able to talk to someone in that office that can get the message to the pulmonologist and start to have that conversation of what can I handle here and what do I need to go to you for? It's a great opportunity to have that consult and dialogue.

Dr. Dowler:
I'm interested, we'll find out soon, I have the team running the frequency of how often specialist are using that code when we call in with questions so it's interesting to see if it is taken up and adapted or if my portable communication stroke of genius falls flat. But, it's nice to think that we can, when we make those calls, that the specialist can get paid for providing that important service and saving the child and family traveling, possibly.

Great. Do you want to go to the next case?

Dr. Wroth (32):
Alright, Debbie, you are still up. This is a real case from you, and this would have been a routine visit prior to COVID, but got a little bit complicated. So, you got a seven-year-old and the mom has called in saying she would like a telehealth visit because she has a rash all over. How do you proceed with this visit?

Dr. Ainsworth:
We were using Doxy as well, so got her all lined up and we called her, I mean invited her via text, and she shows up on my screen. And initially she was telling me about the rash all over. It really didn't itch a lot. She had a history of eczema, but the mom said it seems to be a little bit different from her eczema. Started asking questions and going through review of system, and she didn't have fevers and didn't have a runny nose and, again, the rash didn't itch much. It kind of popped up all of a sudden, and she had a little bit of a sore throat.

One of the things that I have been learning is how to direct a parent to get a good view of the rash, and lighting is an issue, and a lot of times, at least on sunny days, the family said let's go outside, because light is better out there. And, so, she did. She took her outside and she showed me the rash. And it was kind of a maculopapular all over rash. So, I was like, well, I really think we need to make sure she doesn't have strep throat, because of the way this looks on the screen. And mom could not bring her in that afternoon, because she had to work and she lives about one hour away from our practice. So, we got set up for a visit the next day, and when the provider that saw her actually saw the rash in person, she thought it was more typical of an eczema rash. Now, it would have changed between the day before, but anyway it was a different scenario than what I would have guessed the day before.

Dr. Wroth
Interesting. Let's talk about chronic conditions and say this was more of a chronic eczema visit. Talking about the light and other things, how would you approach doing telehealth visits for chronic eczema in terms of physical exam and those sorts of things?

Dr. Ainsworth:
If people have good enough cell phone coverage and internet access, what I have found really helpful is for them to send me a picture rather than using the video portion of the camera. So, getting up really close and having them take a picture and texting it to the office cell phone. Then, I can get a better, clearer, just a better view of what the eczema looks like. They can usually tell you it's worse than the usual and in different spots, and so I think it's a great opportunity for you to be able to do that. The last thing that you want to do is take a healthy kid with a skin condition and get them exposed to whatever else is going on, whether it is COVID or flu or strep or whatever is going on in the winter.

Dr. Wroth:
Great, thanks, Debbie. Alright, Shannon, back to you.

Dr. Dowler:
Let’s see. Alright. This one I think is for Steve, my buddy Steve North up in the mountains. This guy is a 40-year-old who suffered an MI while he was bear wrestling in the Yancey County, and discharge from the hospital with a new ischemic cardiomyopathy, so he’s got heart failure and heart disease. They called to say that he needs to be seen in hospital follow-up. What are some of the tools that you can now use with provisions that we’ve made in COVID world to take care of this guy?

Dr. North:
So, Shannon, I think there are a lot of different things. One is remote home monitoring, so getting a scale into the home so that, as he is recovering from lacerations and bites from bear wrestling, we can weigh him every day and make sure that his weight isn’t increasing or decreasing too much to be a proxy for his edema. We can do remote blood pressures and have him report those. We can also use video visits to see him individually. I can ask to pull up his pants and push on his lower extremity and see what his edema looks like. That would be the start of what I’d do.

Dr. Dowler:
Yeah, so like JVD, you could probably see good JVD on a telehealth visit?

Dr. North:
Yeah, probably, probably, a big guy.

Dr. Dowler:
Yeah, with good lighting.

Dr. North:
Absolutely, good lighting. You could.

Dr. Dowler:
It's possible. Yeah, go ahead.

Dr. North:
We can also ask a home health nurse or care manager to go out and [Indiscernable] the RN could be the person presenting the patient virtually and you could use their lung exam and listen for a heart murmur. If you trust that individual and their ability, then absolutely. In your documentation, you would want to put 3+ mitral valve murmur heard by CC and CRN as opposed to claiming it as your own, but I think that using an additional staff member is a great idea.

Dr. Dowler:
Yeah, and so, what about the remote physiological monitoring? With real-time? Do you have experience with that up in the west?

Dr. North:
Yeah, so, continuous blood pressure would be a great thing to use in this guy. We could look over the course of two, three, or four days and see how his heart rate is doing, how his blood pressure is doing, and where the variation is so that we could optimize blood pressure control and improve his cardiac functioning as well.

Dr. Dowler:
Yeah, okay, so let's say the nurse goes in the home and calls you and says, "He's not safe at home. His wife is going to kill him because he keeps bear wrestling, and so he's worried for his safety." You identify there is a domestic violence situation. What are some things you might do to try to find resources for him?

Dr. North:
So, I think one of the first things you can use is the NC Care 360 platform and create a case there, because in addition to him needing a domestic violence shelter for men, there also could be food insecurity issues. If he's out of work because he has significant lacerations and new cardiomyopathy, then the finances could be rough. So, NC Care 360 could help connect with local resources. You could also call 211 and they can begin case with NC Care 360 for you.

Dr. Dowler:
Or the CCNC care manager might be able to plug-in for you.

Dr. North:
Yes.

Dr. Dowler:
Alright, great. Tom?

Dr. Wroth:
Alright, so, next case. We're going back to Dr. Ainsworth. This is a 10-year-old with ADHD and persistent asthma. I'm sure you've seen many patients like this before. So, let's talk about the telehealth visit in general. Let's start with ADHD and how you approach that with the parent and child, and let's start there.

Dr. Ainsworth:
Okay, so, we've been doing a lot of ADHD telehealth medicine visits and like we've talked before, just getting a glimpse into the home has been so helpful for understanding where families are coming from. I generally start with, how do you think things are going now that you are doing school from home and how is that work for you, and for most of ADHD kids it's not going so well. Everyone in the room will agree that it's a struggle. Going through the usual how's sleep, how's your appetite, have you lost any weight recently, is there a scale in the house you can put him on, let's making sure he hasn't lost any weight. In our office, we use a Connors form, and we have a modified Conners form that's only 10 questions, and the families are used to answering that on every ADHD medication. So, I then say, "Remember the form and we will go through that verbally and you'll tell me how you think he's doing" based on when he is on the medication. We go through that questionnaire and then take it from there. One of the things that happened this week was I was watching the mother and grandmother and I said, "So is the patient in the room?"

"Yeah, but he doesn't have his close on yet."

So, I said, "Okay, it's 11:30 in the morning, he's not dressed yet, clearly things aren't going well." So, it opens up an opportunity for me to start talking about, "I know you're at home, but you need to keep him on a schedule, you need to get him up, you need to eat regularly." We've had a lot of kids probably that pediatricians are running into where the kids are staying up all night, they aren't going to bed, so they've gone from getting up at seven in the morning and bed at eight or nine o'clock at night to staying up till one or two in the morning and getting up at ten and eleven in the morning, and, so, that does not work well for ADHD medications because that keeps them up later the next night. So, it really gave me an opportunity to start to have that conversation about structure and trying to make him get up out of bed and let's do some work for a couple hours.

Dr. Wroth:
Yes, great use of telehealth and getting the family involved.

Okay, so, let's go back here. We get through all the ADHD part, and mom says, "By the way, she's waking up and coughing once or twice a night, and we're using more albuterol than usual." How would you approach, this child has pretty significant asthma, how would you approach that piece via telehealth?

Dr. Ainsworth:
The first question is always, "What medicine are you taking, and have you been taking them?" So many of them will start to ramp up that

they've done well for a while, and it's starting to be spring, and maybe I don't need my Flovent or my Qvar anymore, or you told me to stay home and I need to refill and I haven't been able to pick it up yet. Making sure that they take all the medications that they are supposed to take, and that is something that you can go into NC Tracks and track their medication use. You never want to, when you find out they haven't been on their Flovent for two weeks, because they have not picked it up, it makes it easier to not ramp up their therapy if they haven't been taking their medication.

The other thing for flair ups is, always make sure that they are using the spacer, and maybe you say, "Let me get my nurse to come in and talk with you again about how to use that spacer. Let's go over that one more time." If they don't have one, you can get the spacer for them through D&E services.

Dr. Wroth
That's great. So, you can even do some teaching there and get the nurse to come in and finish that visit up as well.

Thanks, Debbie. Back to you, Shannon.

Dr. Dowler:
Who is this question for?

Dr. Wroth:
It's really dealer's choice, Shannon.

Dr. Cykert:
It's me. it's me.

Dr. Dowler:
Alright, so, you have this 56-year-old new patient and accomplished psychic from New York City and she decided she wants to relocate to North Carolina because there's less COVID here. And, she makes an appointment right when she gets here, because she has a feeling that something is not right with her. In the office you say, "Wow, I think you've got hypertension," which she does not believe because she is a psychic and she's pretty sure she would know it if she had hypertension. Having said that, she's just coming in from New York, so you don't want her hanging on the office for frequent blood pressure checks. So, what might you do with this young lady?

Dr. Cykert:
That is great. One thing that we've done is we have established strict screening protocols in our clinic, and no patients with risk of COVID or known exposure at all is coming within the walls of the clinic, and if there is any suspicion at all, we have a respiratory diagnostic tent in our parking lot. So, even for non-COVID illnesses, if there is COVID risk then that person gets seen by someone in full personal protective equipment. And one thing about this case is, I took my mid-day walk today and I saw several new New York plates in the parking lot, and this is not that out of the realm of reason. On a patient like this who comes in for the first time, we see them in the protected same-day clinic, we do all the acute hypertension stuff and get them going on therapy. Then, we would take advantage of the lack of one week rule on the follow-up visit and get frequent telehealth visits at home to make sure we are getting the blood pressure under control. And, we would

also make sure that we go through durable medical equipment and get this wonderful lady a digital blood pressure cuff so that we can get blood pressures regularly with our CNA pre-visit calls. And, another thing we are doing with the pre-visit is, at least once we are screening with the PHQ9 and GAD to ensure we are not missing bad depression or anxiety with the COVID environment, and we have started SSRI prescriptions over the phone and in patients that we know.

To sum that up, as a new patient, we tried to get the patient originally seen and in a COVID safe environment either through respiratory diagnostic center or clinic depending on how she is screened, and we would follow up frequently with telehealth visits with the digital blood pressure cuff. And, just for one more last point of emphasis, control of chronic disease, especially hypertension and diabetes, is going to improve prognosis if the patient gets COVID, and of course for the long-term chronic disease morbidity we want to get chronic disease visits done.

Dr. Dowler:
Excellent, that was a home-run.

Alright, I think we have a little bit of time left, and I see there are questions in the queue. Should we do a few questions and answers?

Dr. Tilson:
Absolutely. Are there any in particular that caught your eye?

Dr. Dowler:
I haven't actually really gotten through them, I was just captivated.

Dr. Tilson:
Well while you're looking, **let me just throw out a couple that have a theme around hybrid visits that involve staff going into houses and going out into the community and how do we help our staff to make sure they are safe and comfortable in that role? Are there best practices? Where can we get resources?**

Dr. Dowler:
Yes, that's a great question. It's critical that if you're going to send a staff into a home, we need to do that prescreening just like if you were going to bring that patient into the house, or, I mean, into your office. So, calling to make sure that no one is sick in the home and no one has been exposed to COVID-19 - that you ask those basic questions. And, then, if it feels like a safe environment for your staff member to go in, I know some people are choosing to have the clinical time outdoors, like on a front porch or back porch if it's a possibility, in trying to decrease exposure to other people and solid surfaces. Gowns, there is a shortage of gowns right now, but certainly if you felt like there is a risk you can put someone in a mask and a gown. But, I think a lot is around your judgment about whether it is a safe environment. If you have care managers or nurses that are going into the homes anyway, because you got a super vulnerable person and you will do that, then I would advocate for doing that prescreening at least by phone to decrease the chance of an exposure. And, then, protecting the patient by wearing mask, the 3W's that the state is pushing out right now, which is to wear a mask for basic covering, to wait and try to keep a social distance from people, and then wash your

hands. So, we would want the 3W's to be in place, too. That is really a practice decision.

Dr. Tilson:
Great. **We're getting questions about the rate increase and from the behavioral health world, since that will go through the LME/MCOs and do you have any sense of whether it will be passed through by the LME/MCOs?**

Dr. Dowler:
I do not believe the rate increase applies for the behavior health LME/MCO world. To get that formally answered, send an email to our finance team.

Dr. Tilson:
How long do you think the 5% will stay in place?

Dr. Dowler:
That I do not have the answer to.

Dr. Tilson:
Earlier on, I think Steve was talking about a case manager, and we got a follow-up question and, **I was told case managers cannot be part of the hybrid visit because they are "not appropriate delegated persons." Can you talk about that?**

Dr. Dowler:
That was not one of the scenarios that we talked about when we made that code. We left it intentionally vague, and the vagueness was more about practices who have trained medical assistants who are in the practice for years and you trust them completely to be the ones to go into the home. We didn't want to make it just an RN, for instance, because that would then exclude people that would be totally appropriate for provide this service. We left it vague and so I will keep it as a vague answer. It's an appropriately trained, delegated staff person. That is how I will answer that question.

Dr. Tilson:
Okay, I'll move on to another one. **How are clinicians approaching three-way visits, like family, translator, clinician or mom, dad, clinician where parents are separated or teacher, family, and clinician etc.?**

Dr. Dowler:
I've heard of people doing group visits like this. Are there other panels who have done this that want to speak up about your experience?

Dr. North:
Yeah, this is Steve North. That has been mentioned a couple times in the platform Doxy.Me, allows you to add callers onto the visit. I think that is in the paid version, which is $35 a month, and you also have to have the paid version to do the texting of the invite. But, I will doing my chronic pain group visit tomorrow afternoon via a video platform. And I have in the past brought parents and the school district brought a parent in from home to discuss ADHD medications.

Dr. Cykert:

And Steve, just so you know, I'm not paying for Doxy and me right now. It’s through the COVID time and letting me send out blank.

Dr. North:
Spectacular, Sam. I wasn’t aware of that. Great. Why did I pay the money?

Dr. Ainsworth:
I paid the money too.

We have not tried to do a three-way yet, but I was aware that it can be done.

Dr. Dowler:
There’ve been a couple questions around the health department newborn and postpartum and that bulletin should be out tomorrow and that will have the code table and all the details. I know it's approved, and may actually be out tonight. So, go out to our Medicaid website and that bulletin, if it's not tonight, it will be there in the morning.

Dr. Tilson:
Does the use of physician-to-physician consult code only allow the consultant to be paid, or can the provider taking the time to seek consultation get paid as well?

Dr. Dowler:
It's just the consulting provider that gets paid in that situation. The idea is that you are tying that into some kind of visit you had, so you can use the bill on time, and you can certainly use that time that you spent calling and consulting related to that visit.

Dr. Tilson:
In less complicated patients with hypertension with recent titration or newly diagnosed hypertension needing titration, would you consider using home BP monitoring equipment with the patient doing the blood pressure with an FDA approved automated blood pressure monitor?

Dr. Dowler:
Absolutely. That can be billed and normally the way the code is written by CMS once a month visit. And we have changed it using the modifier that you can use it weekly for this. I know when I have uncontrolled hypertension patients I want to see them back in the office every week, and if we are not bringing them into the office you need to get paid for reviewing those blood pressures and making modifications. So, you can do that weekly for this time period.

Dr. Tilson:
You may not know the answer to this one, but **are we getting a stimulus payment from the state, especially for pediatric patients?**

Dr. Dowler:
I don't know what that means exactly. Free money?

Dr. Tilson:
It had been Medicare based.

Dr. Dowler:

Oh, we’ve asked CMS to do something like the Medicare. The secretary has written and called and there was a CMS call earlier today that I was not on because I was in another call. There should be news about that. I’m hearing soon, but have not heard yet. There’s been a lot of energy trying to get that approved.

Dr. Tilson:
Can you have your trusted staff member take pictures and send them to a dentist and have the dentist remote in after to provide you home-based prevention-oriented screening pediatric dental care?

Dr. Dowler:
I will phone a friend. Beth can you answer the question? Or is Mark Casey on the phone?

Beth:
I have not studied the telemedicine, or the dental telemedicine, that they’re putting out this week well enough to know if I can answer that question.

Dr. Dowler:
Send that one into the Medicaid email.

Dr. Tilson:
When billing these smart services via telehealth, you should bill with GT modifier and the FP modifier? Use both modifiers?

Dr. Dowler:
Beth, you take that one.

Beth:
Yes, if you're doing a telemedicine visit on a family planning patient you would need to put the FP modifier as well as the GT modifier and the CR modifier.

Dr. Dowler:
So many modifiers.

Dr. Tilson:
The last comment we got is a big thank you for all you are doing, and it seems like a great way to kind of wind up these questions. So, big thank you to our panelists Steve, Debbie, and Sam and thank you so much for carving out time in your evening. And, Shannon, as always great job and thank you so much for all you’re doing for the people of North Carolina. Before we hang up is there anything you want to say to everyone?

Dr. Dowler:
It's really been a privilege to do this partnership with AHEC and CCNC to put these weekly updates together. It's really CCNC poking me and saying, “Have you done your slides, have you thought about this yet,” and then Tom putting cases together and doing the haranguing, and you and his team doing everything to get the logistics set up which are beautiful every time. So, I really have appreciated this partnership, and of course the special guests that come on. And, I cannot say enough about the Medicaid team that I’m lucky enough to work with and how hard everyone has been working the last two months. It has been unbelievable. Thank you to the field and the listeners for your

bidirectional feedback. We appreciate that relationship. We look forward to talking to you in three weeks on May 28th for our next webinar.

Dr. Tilson:
Thanks everybody. Be safe.

[Event Concluded]