Caitlin Hungate:

You are still connecting to your audio and we will begin momentarily. Okay. Hi everyone, this is Caitlin Hungate, she/her pronouns, with the New York State Family Planning Training Center and welcome to today's Office Hour on case studies for family planning, telehealth visits. I am a training and technical assistance provider with the New York State Family Planning Training Center and I'm really honored to be with you all in this hour together.

Caitlin Hungate:

A few housekeeping items before we dive into the cases. The event is being recorded and we will post the recording on our website in a few days along with the slides. Everyone is muted for now, but this will be interactive and we welcome your questions. And so we invite you to use the chat function at any time with your questions or comments and then certainly when we get to discussion, welcome you to unmute and join the conversation.

Caitlin Hungate:

So we'll have a brief presentation about a couple sample visits. They can be seen via telehealth and the flow and how that works in terms of providing these services via telehealth. And then like I said, please feel free to use the chat at any time during our hour together. And you are also able to unmute your line. So please use whatever is easier for you and what is accessible for you today.

Caitlin Hungate:

I am joined by my colleague Chanel Richmond. She is named as the New York State Family Planning Training Center. Thank you Chanel for joining and helping with technology. So if you have any issues today, please feel free to message the New York State Family Planning Training Center icon and Chanel can help with your tech issues. We encourage you to participate as you're able to do so. We welcome your ideas, input and questions and participation today. And please consider filling out an evaluation of today's office hour as we go along and I'll post that in the chat momentarily.

Caitlin Hungate:

So our learning objectives are on the next slide in our hour together and I'm not going to read them out because you can read them yourself, but we'll be going over a couple example cases and then hopefully you'll be able to identify team members and then in conversation with your peers, identify as strategy.

Caitlin Hungate:

So the team that's joined with you today from the New York State Family Planning Training Center is myself and Chanel and we are a small but mighty team and we are joined by Katie Colby and Becky Milner as well. So you may have seen them on other events previously and I'd love to turn it over to Dr. Michael Policar and Emma [inaudible 00:02:51] to briefly introduce themselves as well. Next slide please.

Dr Mike Policar:

Okay, well I'm first on the slide so I'll go first. I'm Mike Policar, I'm an obstetrician gynecologist [inaudible 00:03:10]

Emma:

And I'm Emma [inaudible 00:03:12] and I'm a family nurse practitioner by training and I have the pleasure of working with a lot of family planning folks but also federally qualified health center colleagues around sort of thinking about telehealth implementation from a clinical perspective.

Dr Mike Policar:

Great.

Caitlin Hungate:

Great. Thank you so much to both of you. And this is a Zoom meeting, so I see [inaudible 00:03:38] thank you for joining by video. It's nice to see a face to a name and I invite anyone if you are able to, if you are not totally fatigued by the zoom tiles, feel free to turn on your camera if you want. If you are unable to or do not want to, that's also okay. Just know that we've set it up this way so that it can be more interactive and conversational with you.

Caitlin Hungate:

So the next thing, before we turn it over to Dr. Policar and Emma around case studies specifically is, we want to hear from you. So we're going to put a link in the chat to go to mentee and then I'm going to pull up the mentee poll in a second as well. So, if you can please go to www.mentee.com. Thanks Chanel. You'll see the exact link in the slide and it should pop up to the poll. So I'm going to share my screen. Chanel, if you can stop sharing, that'd be great.

Caitlin Hungate:

Okay, just give me a second. Here's my Zoom poll. There we go. So, "Are you currently providing telehealth service?" So again, you can use the link that Chanel chatted in the chat or go to mentee.com and use code 2-9-3-8-8-0-0-0. So far we've got four responses that are saying, "Yes, you currently are providing telehealth services."

Caitlin Hungate:

And if mentee is not something that you are able to access please feel free... Great. I see a few folks have used the chat, so looks like everyone has either used the chat or has been able to go to mentee.com, you are providing telehealth services so that's great. So we're going to move on to the next question.

Caitlin Hungate:

And again, you don't need to. Seems so linked. This is an open ended response, "So how would you describe your current telehealth usage?" So again, you can just use the same mentee link and just type in a few words to tell us how you're using telehealth or the chat.

Caitlin Hungate:

So for everything like birth control, emergency contraceptive, STD physicals. Great. Morning and afternoon appointments that are weekly, it works well. That's great to hear. Two times a week. Gender affirming care, wonderful. Birth control contraceptive starts and then emergency contraceptives, it used to be free up in person slots, that's great. And then Michelle added to the chat, follow up visits, one-on-one health education to support in person and remote. Great.

Caitlin Hungate:

So it sounds like a lot of you are doing incredible work via telehealth and trying to fit it into their practice. So we'll go to the next question and the final question before we turn it over to Dr. Policar. And what types of visits are you most often providing via telehealth? So you just shared the range of visits, but what are you most often providing via telehealth? Refills, okay. Refills for contraceptives. [inaudible 00:07:31] I see follow up visits. So I hope that was connected to this one but it may have been the prior question and I'm sorry, I may have missed it.

Caitlin Hungate:

Okay. Refills. Okay, that seems to be a common one so far. Follow up visits, test results and birth control visits. Birth control results consults. Thanks Sarah. We'll give it about 10 more seconds so feel free to use the chat or the mentee. In pregnancy counseling, okay. STD testing request, great. Okay, so thank you all for just taking a few minutes... Top referrals, okay.

Caitlin Hungate:

I'm going to stop sharing my screen and then I'll pass it back over to Chanel so that we can dive into some cases. And it sounds like maybe similar to some of your most often or your regular, most frequent visits provided via telehealth. So thanks for taking a few minutes to share.

Emma:

Well great. I just want to mention that when we were sort of conceiving of this webinar, the idea was really to kind of get into the nitty gritty on the actual cases and partly because, I think, we all have a strong suspicion that you're providing this care, but when we're moving into new sort of modes of care delivery, it can be really helpful to come together with colleagues and hear that what you're doing is indeed the thing that everybody else is doing or even if we have time to of troubleshoot on some other sticky points.

Emma:

So hopefully this is just going to ground you and support you all in doing the really tremendous work that you're already doing. So our first case study very squarely falls sort of in the area in which you all described, which is a contraception start. But I think this would also be fall into that category of refills that people mentioned.

Emma:

So Miss C is a 21 year old established client who wants to initiate contraception. She had a telephone visit with a clinician that lasted about 25 minutes. Dr. Policar put together these slides that I really appreciated because in other presentations, he talks about charting for time. So he's crossing his T's and doting his I's. So this client previously used combined oral contraceptives for three years. There were no significant problems or difficulties, she's had no new health conditions since her last refill.

Emma:

She was last seen two years ago in person. Her blood pressure at that time was normal, 124 over 74. And after having a visit and talking through options, she's decided that she'd like to restart those combined oral contraceptives. And so she picks up 13 cycles of this prescription curb-side or through the mail. And so the big question here that I think weighs on a lot of our minds is, "Does she need a blood

pressure check?" Is this an adequate enough visit or do we need to think about collecting that information in different ways?

Emma:

So next slide. And so I think, again, I'm probably sharing a lot of information that you know, but the idea that hypertension is one of five risk factors for an acute MI and people who are using estrogen containing hormonal methods. And the other risk factors, again, I'm fairly confident that you're familiar with these.

Emma:

So, over the age of 35, a heavy smoker, someone who has a preexisting condition of diabetes or has hyperlipidemia. And so we know that folks who have severe hypertension, meaning their systolic is above 160, diastolic above 100 or a known diagnosis of hypertension with vascular disease, that this falls into that medical eligibility criteria for contraceptive use. It's category four. So, this in some ways would suggest that someone who has hypertension or these other risk factors wouldn't be prescribed combined oral contraceptives.

Emma:

And so the general recommendation, and I think the practice that we were all most familiar with before transitioning to telehealth, is that blood pressure was a part of every single visit that we did when starting someone on a combined oral contraceptive. And some people would go so far as to have rechecks for an oral contraceptive start and repeat blood pressure at that time as well.

Emma:

And so the question is, "Can we feel comfortable in this situation giving this client birth control pills without measuring her blood pressure?" So here, I think everything that we know in the previous case is not suggesting that there's any contraindication to prescribing this, but there's a way that we want to control and want to know, given that last blood pressure was two years ago.

Emma:

So we'll go to the next slide. And so, in general, I think what we can feel comfortable with and what there is literature to support, is the idea that for folks who have had a normal blood pressure within the last three to five years that's been documented and no other cardiovascular disease risk factors, which it sounds like Miss C falls into that category, which again is typical for most 21 year olds, but we don't want to make that presumption. We can feel comfortable prescribing up to a year supply of oral contraception. The patch or the ring.

Emma:

What would we do if there was a client that had a history of high blood pressure? How might our care considerations change? So one of those things is to say, certainly making sure that this client gets referral to services for hypertension management. And so that may be something that needs to go outside your agency or perhaps you have a partnering agency, or you or other clinicians would feel comfortable initiating that treatment.

Emma:

And then another option that's available is certainly considering non-hormonal methods of birth control. Again, I'm telling you things that you already know, or progesterone only birth control.

Emma:

Next slide. But given that this is a telehealth encounter, how can we think about what options are available to us? So I think as we mentioned before, this is a client who had a normal blood pressure that was documented within the previous two years. So she falls within that range of having a normal blood pressure within three to five years. And certainly you can reassure her based on that information that this is a safe choice and you can discuss the risk that an estrogen containing contraception. I mean, I think there's always opportunity to talk about risk as this risk changes over the course of a women's lifespan as well.

Emma:

It certainly would be appropriate to encourage her to go into the supermarket or other community locations to have her blood pressure measured. She could come into the health center at a different time that was convenient for her and make a lab visit or any of those options. Some clinicians who really want to have that confidence that she has a normal blood pressure with this new form of contraception may prescribe three months at a time and then refill the remainder of the year based on that follow up blood pressure reading.

Emma:

And if none of these options are available to you and you continue to be concerned about her risk for hypertension, you might consider prescribing a non estrogen containing contraceptive until you could get her in, confirm that her blood pressure is in the normal range, and then switch back. For most of us though, we don't want to be switching women back and forth on their contraception.

Emma:

It increases all the numerous side effects that we're familiar with. But I think these slides will be shared out as a part of the recording and there are citations within the slides. And so what I anticipate is that this question about blood pressure may or may not be within your practice environment, something that you've been talking about. And these are sort of the hope in talking about this. Not a complicated case, a very familiar case, but that this gives you the comfort to sort of clarify what you all would do and feel that you are continuing to provide really good care. So hopefully we're just giving you those tools to kind of further that conversation.

Emma:

If there's questions that are particular to this case that people want to raise, experiences that you've had, insights, bumps in the road, we would love and invite those at this time. No news means you guys got this. No problem. You knew how to do it all. You're like, "Yeah, we got it." Oh good. Okay, good. I mean I think that we were also like that's if people are squarely comfortable with this and this is just supporting you and going forward with what you're doing. Then I'm going to pass the mic over to Dr. Policar and I look forward to chatting more at the end.

Dr Mike Policar:

All right. Caitlin, can you hear me okay? Yes. All right. And Caitlin and Emma, if I break up, I really apologize that unfortunately I've got some instability in my internet connection this morning, but if you can no longer hear me, let me know. All right, so the next case that we have has to do with what's called syndromic management of STD. So this [inaudible 00:18:22] states that she develops a vaginal discharge with a foul odor every two or three months.

Dr Mike Policar:

She was diagnosed with bacterial vaginosis 18 months ago and since then has been treated four times, each time with a different topical medication for her VD. And with every one of those treatments, she improved in terms of her discharge and the foul odor of the discharge for a while. But it keeps coming back and she doesn't like it and her partner objects to it.

Dr Mike Policar:

So what she started doing is douching to manage the foul odor. However, given the fact that she's concerned about some of the restrictions of the public [inaudible 00:19:10] vaginitis managed with a telemedicine called to avoid an in person visit. So a telemedicine visit happened with audio and video, it lasted 27 minutes. And of course that's important as it comes to billing. And given the fact that this sounded like yet another episode of bacterial vaginosis, she was prescribed metronidazole vaginal gel suppression, which is you're treated with vaginal gel for a week or 10 days [inaudible 00:19:42] twice a week. And she was able to pick up two tubes of the medication by curb-side.

Dr Mike Policar:

Next slide. There we go. So, as I said, this is what's referred to as syndromic management of a sexually transmitted infection. It's based on our best guess of a diagnosis using a combination of how the patient describes her symptoms and in addition, how she describes the physical findings of what her discharge looks like. Is it green, yellow, white, bloody? But we do all of that without the use of laboratory tests in order to be able to make a diagnosis.

Dr Mike Policar:

Studies show, and there are, by the way, quite a few studies on this, primarily from underdeveloped countries, particularly [inaudible 00:20:34] that syndromic management of STIs is fairly sensitive for making a correct diagnosis, especially for bacterial Vaginosis, Candidal Vaginitis, works fairly well in regard to genital herpes, but it's not very specific. That is to say that oftentimes we over diagnose and there are too many [inaudible 00:20:59] at the time that this case was occurring and we were in the middle of the public health emergency, it was just a matter of being able to handle this through an AB telemedicine visit rather than the risks involved to the patient of actually coming into the clinic.

Dr Mike Policar:

Next slide. Okay. Now one of the things that we use is a table like this to actually [inaudible 00:21:27] discharges due to, based again, on what the patient tells us in history and what she perceives as physical findings. And each one has its own unique combination. So for these various types of vaginitis, the kinds of questions you ask are, "Do you have itching and burning? Does the discharge smell bad? Does it have a frothy or a bubbly character to it? If you can see that and what color it is it?"

Dr Mike Policar:

So for example, a candidal vaginitis will almost always itch and burn. By the way, the I stands for itch, the B stands for burn, it almost always itches, sometimes it burns, but it doesn't smell bad, it doesn't have any bubbles associated with it. And it's white, a trick infection, [inaudible 00:22:15] it does have an amines or fishy odor associated with it. It does have a frothier bubbly character. It's yellow or green or sometimes white.

Dr Mike Policar:

Bacterial vaginosis, because it's not an inflammatory condition usually doesn't have much in the way of itching and burning, but it does smell bad. It is frothy and it looks like homogenized milk is spilling out of the vagina. Next is DAIV, desquamative inflammatory vaginitis, which is not very common. It is particularly more common in peri and postmenopausal patients. It's not an infection. [inaudible 00:22:54]

Dr Mike Policar:

So it causes lots of itching. Sometimes burning, doesn't smell bad, it's not frothy. And there's a sort of a thick green or sometimes yellow issue, white discharge. And then down at to bottom is just a normal discharge, a physiologic discharge, which doesn't itch burn, smell bad, doesn't have bubbles, and it's usually white. So given the unique combinations in each one of these, we have a really good preliminary idea of what's going on with the patient.

Dr Mike Policar:

Next slide. There we go. Okay. So what's decided in her case is that she does have recurring VD and we're going to go ahead and treat her for that. So in general, [inaudible 00:23:42] candidiasis. Those are people who are really pretty easy to treat with either a telephonic only telemedicine visit or with an audio video telemedicine visit.

Dr Mike Policar:

However, if a person has a brand new problem and we are fairly sure about what's going on based on the criteria that I showed you earlier, then we can consider empiric therapy. So if for example, a person has an odorless discharge as our patient did, SO stands for suggestive of bacterial vaginitis or atrophic vaginitis. We can just treat them for both with Metronidazole 500 milligrams orally twice a day for a week. And that'll treat either bacterial vaginosis or trichiniasis.

Dr Mike Policar:

On the other hand, if a person has lots of irritation, itching, white discharge, particularly if she's had candida in the past, then we can assume that this is vaginal candidiasis treat it with oral fluconazole, single 150 milligram tablet or a three day over the counter topical antifungal, or one that [inaudible 00:24:51]

Dr Mike Policar:

Next. Okay, now what about a vaginal discharge in a person who gives a history that might go along with having gonorrhea or chlamydia? So let's say for example, our patient said, "I did have a new partner three weeks ago, and then starting one week ago, I've been having this really thick white, gray vaginal discharge and I'm afraid I might have picked up something from this new partner." So here there's a

possibility that the discharge is actually a cervical discharge because she's newly infected with gonorrhea, chlamydia or both.

Dr Mike Policar:

And so in that circumstance, if you're considering the possibility of gonorrhea and chlamydia in association with this vaginal discharge, this, [inaudible 00:25:55] early, but instead to bring her in and to be able to get a sample for gonorrhea and chlamydia NAP test and then to be able to, if you want, go ahead and treat her after that test sample has been obtained.

Dr Mike Policar:

And by the way, there are a fair number of clinics, particularly out here in California that have worked out ways of actually getting the vaginal sample for gonorrhea and chlamydia based on a person coming to the clinic. She waits in the parking lot, she's handed a test kit, she goes home and samples her own vagina and then brings those testing materials back to the clinic [inaudible 00:26:37] for gonorrhea and chlamydia. As long as a person is able to go to their clinic or another site to pick up these materials for sampling, she does that at home and then drops that off at the clinic and can still be screened.

Dr Mike Policar:

Next question. I'm sorry, not the question. Next slide. Okay, and this just gives a little more detail about that. So self samples of vaginal fluid of urine, particularly for males. And there's that about even self sampling for rectal with swipe rectal swabs or pharyngeal swabs can be done at home, transported back to the clinic for a curb-side drop off or to a contracted laboratory test deposit site. I'm seeing lots of those in places like grocery stores lately, and that's a way, again, of a person having the [inaudible 00:27:34] or somewhere else. And then the last two bullets just give a little bit more idea about the kinds of testing we should be doing for gonorrhea and chlamydia with or without [inaudible 00:27:46]

Dr Mike Policar:

Next slide. Okay, this just gives you a little bit more information about how to do curb-side pick up and drop off of these vaginal discharge sampling kits. Basically all that needs to go into the kit is a stopper, either plastic tube or a glass tube with a CC of fresh saline in it, and then a pack of sterile cotton tip swabs. Now what I told you about before for gonorrhea and chlamydia, you're going to hand the patient whatever you're using in your clinic as a sampling medium. This has to do with getting a sample of the vaginal [inaudible 00:28:28] at under the microscope.

Dr Mike Policar:

So when the patient self samples, you want her to be able to bring that back to the clinic as soon as possible. A staff member goes out to her car, picks it up, and then you, as the clinician, can have a look at it under the microscope in the clinic.

Dr Mike Policar:

Next slide. Next? Okay. All right. So we'll wind up with our formal presentation now where [inaudible 00:29:03] you know that most people have found from the availability of being able to do telemedicine visits. I mean the reality is, that it's good for our patients and it's good for staff. Most patients love the convenience of being able to do this from their smartphone, from their home computer and not having

to park at the clinic and wait for their visit. So they love that convenience and clinicians oftentimes really love it because they can do a lot of this work from home rather than having to come into the clinic.

Dr Mike Policar:

It allows your patients to access your family planning clinic instead of having to go to an emergency department or use one of the commercial [inaudible 00:29:50] sorts of telemedicine services like the Pill Club and Plush Care and many of the others. Instead, they should be using your clinic for this. It enables more continuity of care. You can, as you know from doing this, take an equally good history, even some amount of visual assessment and physical assessment over your telemedicine hookup and continue to bill for the services that you do. And I'm going to be [inaudible 00:30:26] billing for collection for your telemedicine visits.

Dr Mike Policar:

Next slide. Okay. Now one thing that I want to mention before we go to these two questions. We're going to have group discussion for the next half hour or so, but will you advance to our resources please because I just want to mention something very quickly. So skip this slide and the next slide, we'll go back to them. Okay, so there are lots of resources out there on this topic of providing, [inaudible 00:31:01] but what I want to tell you just in case any of you have to leave early, is that the Reproductive Health National Training Center, Caitlin's organization has developed some absolutely wonderful job aids and a variety of training materials that have to do with providing telemedicine services both during the public health emergency and after the public health emergency.

Dr Mike Policar:

And I particularly want to mention the very first one, which is called prioritize [inaudible 00:31:34] link, is the fact that we have lots of job aids there that will help your front desk people working with clinicians to make the decision about whether or not a person can have a telemedicine visit or whether they need to actually come into the clinic for a visit. And then there are many, many other resources as you can see, telemedicine services from an inclusive, equity driven, trauma informed care approach. Telehealth etiquette for family planning service based on work that Anne Finn and I did.

Dr Mike Policar:

And then there are a number of other sources where you can go as well. So let's go back a couple of slides and let's go ahead and talk a little bit about how telemedicine is working for you and what questions you have.

Caitlin Hungate:

Thanks Dr. Policar and we welcome you to use the chat or unmute your line and just jump into conversation and certainly welcome. If you have questions about either of the cases or even digging more into the self swab or how that works in your setting, feel free to just use the chat or unmute yourself to kind of reflect on the two cases or other clinical scenarios that you have some questions or reservations about.

Dr Mike Policar:

Well, while we're waiting for your questions, I'd love to ask you all a question because I'm really curious about it. So remember the last question that I asked was, and as clinicians you may not know the answer

to this, but, what have you been hearing from the folks that are doing the billing for your practice about whether or not there have been problems with how you code for telemedicine visits or using the 95 modifier and that sort of thing? And have you successfully worked [inaudible 00:34:01] program and State Family Planning Programs than others to be appropriately paid for your telemedicine visits?

Dr Mike Policar:

But while we're waiting for you to answer, I am going to answer Sarah's question, "How close together can a tele visit and an in person visit be? Is there a limit between time?" And the answer is, if you're billing a standard ENM code of [inaudible 00:34:43] as I said a moment ago with most payers that has a 95 modifier after the, let's say 9-9-2-0-2 all the way to 9-9-2-0-5 for a new patient, 9-9-2-1-2 to a 9-9-2-1-5 for an established patient.

Dr Mike Policar:

Any of those would have a 95 modifier after that. So no, if you have a telemedicine visit with a patient one day and then you see her the next day or the day after to let's say an IUD placement or an implant placement or removal, then both of the visits ought to be paid as long as the claim is done correctly. There are two new types of visits that have [inaudible 00:35:29] virtual check-in visits.

Dr Mike Policar:

So what are the virtual check-in visits? It is one that's actually sort of a tele-dermatology code and that one is, if a person let's say has a skin lesion and needs to have a decision [inaudible 00:35:55] can actually take a selfie of the lesion on their skin, send it to you, you can come up with a preliminary diagnosis and decide whether or not the patient needs to come in. And then you can bill for that as a virtual check-in visit.

Dr Mike Policar:

And at least most Medicaid programs will probably pay around $15 or $20 just for that short [inaudible 00:36:24] reason I bring that up is because of the fact that in that circumstance there needs to be a short lag between when you do the decision, whether or not the patient needs to come in and when they actually come in, if you are using those virtual check-in codes. But if you're not using those, then the frequency of the visits that you can bill is the same whether they're virtual or whether they're in person.

Caitlin Hungate:

Thanks Dr. Policar. What other questions do you folks on the line have? Questions about other clinical scenarios or just other questions about providing family planning services virtually? And while we're thinking, I want to punt it to Emma, I feel like you have something to say, so I'd love to have you jump into the conversation as well.

Emma:

Caitlin and I got to participate in a workshop with family planning folks in San Francisco at the... I'm always butchering this acronym, sorry, our RHNTC sister organization, the National Clinical Training Center for Family Planning. And one of the things that came up that I just want to bring all of our attention to is the fact that people were feeling this sort of conflict between saying, this is a telehealth

or a telemedicine encounter, but what happens if you need to come in later to give a sample just in that sort of second case study that Dr. Policar shared.

Emma:

And so one of the things is, we talked about expectation setting across staff. And so when the folks who are doing scheduling are going over pre-visit information, they'll often say at that time, "Just so that you know, it may be that in the course of your visit it's decided between you and your provider that having an in person exam would be the best strategy or that you may need to drop off a lab sample."

Emma:

And so people were feeling this kind of push and pull about saying, and also staff was feeling this too. If we schedule a telehealth visit and then they just need to have an in-person visit later on, what's the point of doing a telehealth visit? And so I think doing some expectation setting can be helpful. I think also those telehealth encounters can help staff and providers sort of identify how soon does someone need to be seen for an in-person visit.

Emma:

So I think someone mentioned in the chat that having this flexibility means that we can be more responsive to more patients, I think. And another sort of spin on this is also just thinking about the way that we have information. I mean, if a patient needs to drop off a lab sample, they can do that around their convenience a little bit more than around a scheduled encounter. So again, we've taken to referring these as hybrid visits and I think actually Dr. Policar, that's something that you mentioned in a previous conversation, but again, I didn't know if that was something that had come up in telehealth provision or if that was something that may be worthwhile to talk through.

Dr Mike Policar:

I'm really glad you mentioned [inaudible 00:40:08] that's so typical nowadays where a good example is in a person who's interested in IEP or an implant for example. So what a lot of clinics did during the public health emergency they're still doing now is that they are doing the initial family planning counseling as a telemedicine visit where they go through the questions about reproductive intentions. And if you don't want to get pregnant now, what are the things that are important to you as you choose a method of contraception [inaudible 00:40:45] based on what you're interested in?

Dr Mike Policar:

Let's talk about some of these things in more detail in a shared decision making approach. So that might be like a 20, 25 minute visit, something like that. But a patient decides to have an IUD or an implant and then she's scheduled a day or two later, assuming that those insertion kits are around the office, and then comes in for her replacement.

Dr Mike Policar:

And that's like a classic circumstance of a hybrid visit that hopefully will continue long after the public health emergency is over, that rather than have [inaudible 00:41:25] twice that to take time off of work or away from her family or lost opportunity cost when the first visit, where it can just be absolutely as comprehensive, absolutely as helpful, do that one as a telemedicine visit. And then come in a few days later to have your tests done or to get your procedure done. That takes 10 or 15 minutes for the most

part. And then you've had minimal contact with other people in the clinic and you've only had to come once.

Emma:

Yeah, there's a good question in the chat Dr. Policar that I want you to take, but yeah, so there's research, and again, I know this data for primary care, not for family planning, but I think it's a reasonable kind of inference, which is that when we calculate travel time and then also time in the clinic, patients are taking upward more than two hours for an in person visit.

Emma:

And I think about what the ramifications are in terms of leaving a job, finding childcare, whatever those issues may be. So anything that we can do to, I think, understand and kind of orient around the busy lives that our clients have. So I think this idea of the options, the birth control sort of conversation and informed consent happening, and then the IUD insertion happening within a 15 minute slot is both around increasing accessibility and availability for all of our patients and then ideally making this more manageable for folks that have busy lives.

Emma:

But there's this lovely question from Sarah in the chat and Dr. Policar, I don't know if you want to take it or if you want me to respond.

Dr Mike Policar:

Well, I'll take a first shot at it and then I'd love to hear your opinion about it as well. So Sarah's question is, "Is there a minimum that needs to be met through a telemedicine visit? Or rather, what is the minimum that needs to be met during a telemedicine visit?" It's going to depend a lot on what the payer's expectations are. So again, I'm going to give you sort of a very California centric approach given that that's where I live and where I work.

Dr Mike Policar:

And the example that I'll give is in our state Medicaid program in California, which is called Medi-Cal. And basically what they say is that with a standard audio video, telemedicine visit, that they are basically completely equivalent to an office visit. So whatever you would document in an office visit, you would document in a telemedicine visit, [inaudible 00:44:17] in end code you're going to use for example, is either going to be based on total time or it's going to be based on medical decision making.

Dr Mike Policar:

One or the other, whichever one gives you the highest code. Okay, so basically most of your payers will talk about equity between, [inaudible 00:44:39] and what that means is what you chart, what you do at the visit. How you bill for the visit is what you're paid for the visit is going to be the same, whether that visit is face to face or whether that's a telemedicine visit.

Dr Mike Policar:

Now another example that I'm going to give from the California Medicaid program is during the middle of the public health emergency, there were lots of complaints about the fact that, "Oh, we want to do telemedicine visits but you're telling us that it has to be an audio video visit. We don't have the ability to

do the video part, we can only do this telephonically." Either the patient doesn't have a computer or she doesn't have a smartphone or she's really worried about confidentiality.

Dr Mike Policar:

Or here in our clinic we're not set up [inaudible 00:45:31] that some payers will pay for telephone only telemedicine visits, but they have stricter requirements. So in our case, for example, in California, they say, "If you're doing a telephonic only visit, these are the things that we expect that you have to document why the patient is having this visit by telephone rather than AV or rather than coming into the [inaudible 00:45:53] telephone only visit."

Dr Mike Policar:

You have to document what the location of the patient is and whether or not she has other people with her. You also have to locate or document rather the location of the clinician whether they're at home and in the clinic. And so it's a little odd that those expectations only apply to telephonic only telemedicine visits. It doesn't apply to regular audio, video, telemedicine visits. But I only bring all that up to say that you have to be very familiar with what your telemedicine visit, [inaudible 00:46:35] whether it's telephonic only or whether it's audio, video.

Dr Mike Policar:

And then the last thing I want to say about it and hand it over to Emma is to emphasize this is a moving target. More and more states are starting to say, "From our point of view, the public health emergency is over with, and therefore we are now looking at going back to some of the rules that we had even before the public health emergency. And on a particular date we're going to be [inaudible 00:47:11] previous rules." And so you really have to keep your eyes open for that as well. Emma, your turn.

Emma:

Yeah, that was great and got into the myriad of other expectations. We do find, Dr. Policar's in California. I'm in Colorado. I do lots of work with people in Maine, like what we find in, you know, all are from New York. So I think this issue around the regulations and policies are really sort of enacted at the state level. And so we often recommend the Center for Connected Health policy.

Emma:

This also becomes tricky if you work close to a state border. And so there can be some complications there. So we really encourage people to be familiar and then constantly updating. I think given the complexity and the numerous additional elements that Dr. Policar mentioned, and he was talking about it in terms of the telephonic encounters, but we see people developing templates for documentation that include some scripted language and in terms of consent, safety, where can we reach you if for some reason technology fails because I think that's a kind of another element that is different and then the clinician and then the patients geographical locations.

Emma:

But I think, so what we've heard is that people often sort of script and do a kind of template that then gets filled in. And even if that's something you're just cutting and pasting from word and dumping in to your narrative windows, there are some EHR that are more sophisticated and are kind of built out to prompt folks. But the quick and dirty thing that most people have done is just this or some sort of quick

scripts thing in their EHR. So because it's a lot of elements and we do hear about people getting charges kicked back because these aren't included. And so we know that that is an administrative burden.

Caitlin Hungate:

And the only thing I wanted to add Emma, to what you referenced... So in our resources, and they're hyperlinks, so you should have access to them after the webinar when it's posted, is the link to the northeast telehealth resource center, which serves New York. And if you've joined any of our other telehealth office hours or telehealth events before Danielle Louder with the Northeast Telehealth Resource Center has supported some of these conversations and they certainly are well positioned to support you, navigate some of these state policy questions of payer and things like that.

Caitlin Hungate:

So if you're looking for more specific guidance around payer policy in New York, I highly encourage you to reach out to the Northeast Telehealth Resource Center because they serve New York as well as other New England and Northeast states, but that's really what they do and follow and look to the Center for Connected Health Policy to kind of inform their work. So just wanted to add that.

Caitlin Hungate:

Emma thank you for mentioning the telehealth resource centers. So what other questions do you all have for Emma or Dr. Policar? Clinical scenarios or questions like Sarah had about, what is a minimum that needs to be met? What other questions or still pain points are you experiencing or having reservations about with virtual visits or telehealth visits for family planning?

Emma:

One of the questions that's come up in other webinars is just varying levels of success around bringing back teaming in the telehealth environment. So there's been questions about like, "How are people integrating health educators or community health workers?" And so again, our responses is, "In lots of different ways." But I don't know if that's also a kind of... There's tremendous opportunity in telehealth and I don't want to minimize that at all. But we have lost some ground in terms of working as integrated teams.

Emma:

And so I think just again, if that's an area of interest to you, again more often within the primary care side, but also on the family planning side, this is things that your colleagues are thinking about and trying things and finding that they work and don't work. So again, if that's an area that is related or interesting to any of you, I would invite any observations there. Yeah, Glennis?

Glennis:

Hi. So my name is Glennis, I work at the door. Well I'm the manager of health education. So what we would normally do, we would make health dedication, would definitely contact the YP first, the young person first. So we find out exactly everything that they need. So when the practitioner goes on, it's really quick.

Glennis:

So we already know where we're going to send the medication to. We got pharmacy, we make sure that they have insurance and if they don't have insurance, it's either we can mail it to your house, you can come pick it up. So there's other ways. What we normally would do to get around it and for instance, let's say, young person's parents doesn't know they're on birth control, we would ask them like, "Where you want us to mail it to?" Would do that.

Glennis:

Or if they're away to college, we'll mail it there, so through the pandemic, I think telehealth is... To me, I love telehealth. I really do. I really love telehealth because I think sometimes we get to have a deeper conversation with them than when they're in person or they'll call back and say, "Hey, I forgot to ask you this." So it really works.

Emma:

Glennis thank you so much for the enthusiasm. Just to get the nitty gritty, are you saying that your engagement with the client, is that happening asynchronously at a different time from an actual visit or right before the visit?

Glennis:

Right before the visit. Before the visit, yeah. So we set them up so they'll know exactly what's going to happen, right? So it's like, "Hey tele." And then boom, we set them up and let them know this is what's going to happen. All the questions that we ask and the provider has it. So when she comes in, she'll know what you need, so you will not have to repeat yourself.

Emma:

Great. Those nitty gritty details that we know are so instrumental to actually connecting the dots for patients. But yeah, we have found that this idea of a kind of navigator role, which I think is, again, that's not necessarily been new staff within the agency, but often has been someone who had a previous role and is now assuming these other roles. And part of it is, you're doing this lovely navigation for patients in terms of getting their birth control, but also potentially helping them sort of ease the transition to engaging with technology.

Emma:

Because we know that signon and successes signon is really a significant factor in determining whether people have a positive telehealth encounter. So I love your enthusiasm and that example. And the thing I just mentioned really quickly and then give Dr. Policar a chance to respond, is that there were all these ways, when we were in a class, Caitlin you've heard me say this 27 times. There are all these ways that when we were in the physical environment of a health clinic, that we could socially navigate the kind of lags in treatment.

Emma:

So if we were behind by a couple of minutes, we would leave people for a little bit longer in the waiting room and then we would leave them for a little bit longer in the exam room. And these are really difficult to socially navigate within the virtual space. And so we find that having teams be engaging with patients, that that's a way to create a little flexibility around what are inevitable of lags and hiccups over

the course of a busy clinic day. So thank you Glennis for that. Anyway, Dr. Policar, did you have something else that you wanted to respond?

Dr Mike Policar:

Nope, I'm good. Thank you.

Caitlin Hungate:

Well, thank you. So I'm going to take the ball back if that's okay, and we can skip to the resource slide. Glennis, I love your enthusiasm as well. I think for telehealth to thrive within an agency or as part of the care delivery, you need a champion. And it sounds you are the champion, a telehealth champion within The Door. So it's wonderful to hear your enthusiasm.

Caitlin Hungate:

I know that Dr. Policar mentioned several of these resources already, but all of them are hyperlinked and you'll have access to them, especially as your agencies are thinking to reengage in community engagement work and participation and kind of do some more community work as we're in a different phase of the Covid pandemic. Definitely take a look at that second resource around taking an inclusive, equity driven and trauma informed approach that's really around centering historically marginalized and underrepresented communities and hearing from them, their concerns, their hesitations, their fears. Just kind of listening to them in terms of barriers to telehealth and trying to address those and kind of center that in your communication.

Caitlin Hungate:

All of these are really great resources for you and they are free of charge. One thing I wanted to say before we go to the thank you slide is our next Telehealth Office hours will be joined with Dr. Policar and Emma again. And I'm really excited that that will be spending time talking about all the different contraceptive competitors. I know there's a better word for it, but the companies that are online where clients could get, on demand contraception, go on to a website or use their smartphone and get a pill and get care that way, outside of the walls of your health center, whether it's in person or virtually.

Caitlin Hungate:

And so we're focusing on that because it's really important to consider how that plays into the landscape of care delivery and certainly as you think about your telehealth services and your in person services, how to fit, understand the competitors and the awareness of all of that. So I just wanted to plug a teaser for the next office hours, which will be in our e-news very shortly for you all to register.

Caitlin Hungate:

So thank you so much for joining. Our hour went really quick. Thank you. I hope you'll join me in thanking Emma and Dr. Policar. It's such an honor and pleasure to work with you both and bring your expertise to the conversation. Thank you all for your active participation in the mentee meter, in the chat and jumping in on the phone. It's really wonderful to hear from you and your questions and how you're navigating family planning services virtually and what works well for your organization.

Caitlin Hungate:

So as a reminder, we'll have the materials from today's office hour, both the recording and the slides, which will again have all of the hyperlinks of resources posted within the next two days on nyffptraining.org the next few days. Our final ask is if you can complete a brief evaluation of today's office hours we put in the hyperlink in the chat? We really would appreciate your feedback, what works, how we can improve, and what are topics you want us to kind of dig in further.

Caitlin Hungate:

We really appreciate it and use it to inform our future events and again, think about what other topics would be helpful and supportive for you and your teams within your agency. Thank you again for joining our hour and this concludes our hour together. And have a wonderful rest of your day. Thanks all.