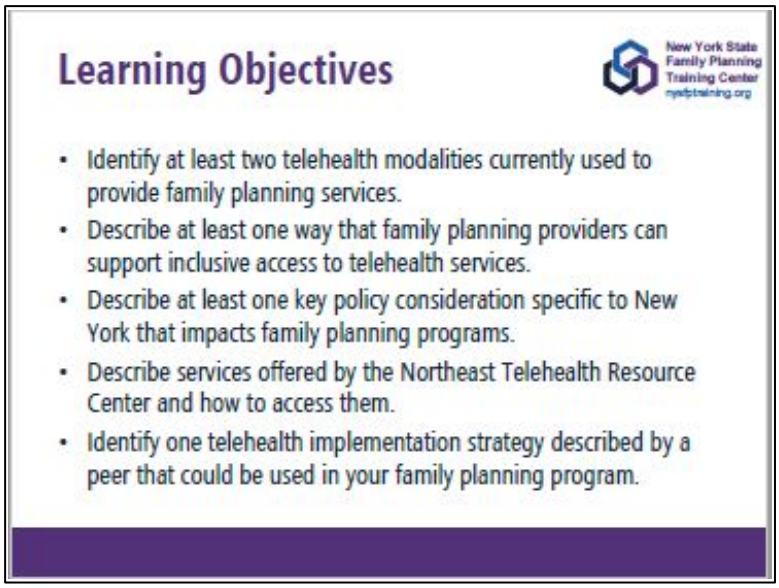
Transcript for Adapting to COVID-19: Implementing Telehealth

October 22, 2020

Katie Quimby: Hello, everyone. Good morning. My name is Katie Quimby. And as the director of the New York State Family Planning Training Center, I'd like to welcome you all to today's interactive webinar on scaling up telehealth services for family planning programs. This webinar is part two of our four-part Adapting to COVID webinar series. Today we'll hear from one family planning program provider, Public Health Solutions, as well as the Northeast Telehealth Resource Center. Before we begin, I have a few very brief announcements. First, everyone on the webinar today is muted to reduce background noise. If you pre-registered for the webinar, you should have received a copy of the slides via email already. We are also recording today's webinar, and the slides and the recording will be posted to our website, nysfptraining.org, within the next few days. We'll also have plenty of time for questions during the webinar, so please feel free to chat in your questions at any time. You can find the chat pod by hovering your mouse over the webinar screen. A panel of options will come up at the bottom of the screen. From that panel, you can click on the chat bubble. If you don't see the chat bubble icon, click on the three dots where it says more and then you'll see that chat option come up which you can click. When you chat in a response, please be sure to send it to everyone so we can all see your responses. And in addition to the questions that you have today, we did receive a number of questions during registration. We will try to answer and address as many of those as we can. I would now like to turn over to my New York State Family Planning Training Center, Caitlin Hungate, who will be one of our moderators for today's session. Caitlin.

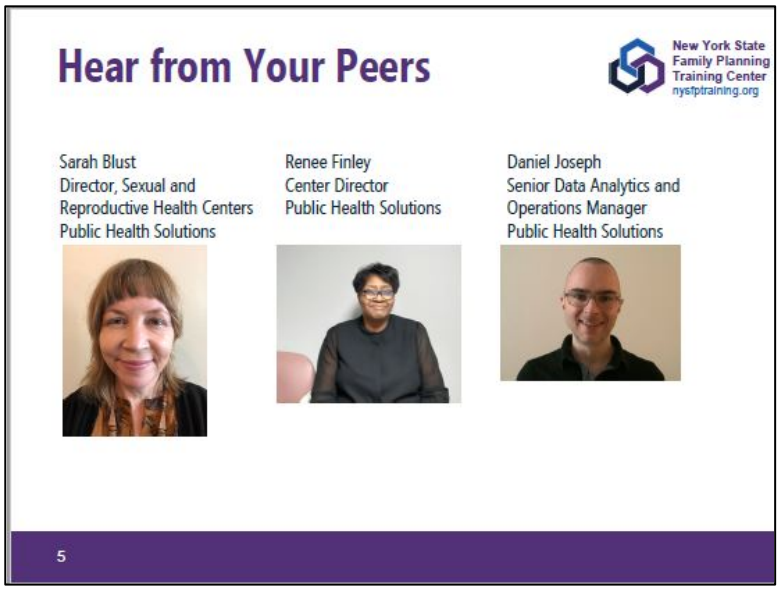
Caitlin Hungate: Thank you, Katie, and hi everyone. Today we are going to be diving into implementing telehealth and scaling up. And before we really dive into the session, we want to acknowledge that for many of you, you've been doing this work for six to seven months now and some of you may have been implementing telehealth before. And so we are really hoping to focus today's conversation about scaling up and sustaining and working through some of the startup challenges, but we want to acknowledge where you all have been in your telehealth journey. We hope today's session addresses your comments and questions that you shared when you registered. And we also want to acknowledge that this is a time of a lot of anxiety. For many of you in your communities, cases may or may not be going up and we just want to hold space for each of you all in today's session as we talk about telehealth. My name is Caitlin Hungate. I'm so honored to be with all of you today. I'm a training and TA provider with the New York State Family Planning Training Center, and I want to turn it over to my colleague, Meg, to introduce herself as well.

Meg Sheahan: Good morning everybody. My name is Meg Sheahan. I am a certified nurse midwife, and I've been providing clinical, sexual, and reproductive health services for over a decade now. I also direct the Title X Family Planning Program in the US Virgin Islands. I've been a lead on the COVID response team down here since February. So I've been involved in every part really of adapting our program's activities to COVID, including launching telehealth from the ground up. I'm also a consultant and technical advisor with JSI to help support the family planning network in the United States. So I'm really happy to be here with everyone today and to learn from you all. Thank you.



Meg Sheahan: In today's session, you will be able to identify at least two telehealth modalities currently used to provide family planning services. Describe at least one way that family planning providers can support inclusive access to telehealth services. Describe at least one key policy consideration specific to New York that impacts family planning programs. Describe services offered by the Northeast Telehealth Resource Center and how to access them. And identify one telehealth implementation strategy described by a peer that could be used in your family planning program.

Caitlin Hungate: And we're going to be launching a poll shortly and if you can please take a minute to weigh in. Prior to COVID-19, was your family planning program providing services via telehealth? Yes or no. And if there's some other nuance, please feel free to use the chat to weigh in on the response and we'll give you about 30 seconds to respond to this poll. Okay, couple more seconds. Can we see the results of the poll if possible? So it looks like prior... So the majority of you, 85% of you prior to COVID, you were not providing telehealth. So this is really helpful information and reflects that all of you or most of you had to bring this up to a quick... in an emergency kind of situation in a global pandemic. So thank you.



Caitlin Hungate: So we want to dive in to hearing from our colleagues at Public Health Solutions. And we're so honored that we have Sarah, Renee, and Daniel to join us and talk with us about their experiences in getting telehealth up and running. And so my first question to Sarah is, can you please describe what your telehealth services looked like pre-COVID?

Sarah Blust: Pre-COVID, they didn't exist. I think we were very much in that 85% category. I was chatting with Daniel the other day and I asked, "Was this part of our...?" Because I've been in this position now for about two years. And so I asked Daniel, "Have we been thinking about this before?" And we hadn't. This wasn't even part of our wish list. It really was very new for us.

Meg Sheahan: Thank you. So given this, what was involved in getting telehealth services operational for you? For example, did you have to make technology purchases or upgrades or changes to the EHR system or changes in the scheduling system and the workflow? And who was involved in all of these changes?

Sarah Blust: Yes, so all of the above. And I'll actually turn it over to Daniel in just a minute to kind of get into the nitty gritty. But I think when you talk about kind of getting something operational, usually, there is a work plan, and there is a team, and there is a timeline, and there are goals and objectives. And everyone kind of comes to consensus on how to move forward. And I think certainly, our operationalizing of telehealth involved those building blocks. But I think like many others, it was really jump off the cliff and get into telehealth. We use eClinicalWorks. A lot of folks from New York City use eClinicalWorks. I'm actually not sure how common it is across the state. But that's our EHR. And we activated our module the same week as we sort of providing telehealth, which I don't think is usually the ideal. So a lot of what was part of our operational implementation was... given our circumstances, was just this sense of impending doom and disaster and that we had to do this now or not be able to provide patient care. But there is something about that which I think allowed all of us to focus and make an incredible amount of progress that is just... I think it's pretty amazing.So Daniel, if you wouldn't mind talking about some of the specifics of our "strategy," that would be great.

Daniel Joseph: Sure. So basically, when we first went live with telehealth visits, it was something that really came up all of a sudden. So we really had to scramble. This involved working with multiple departments across different teams. We started with our IT department where we provisioned and purchased new laptops and webcams for our clinical teams. And this effectively enabled them to now work with our patients completely virtually. We interfaced with our EMR vendor to activate the telehealth module and configure it to align with our existing visit types. We also assigned the front office and back office ECW telehealth modules. And this was the focus when staff were suddenly working from home. We rolled out the ability for our patients to reserve their own appointments online. This created a new process for registering and scheduling patients and freed up our front desk to start to triage other areas that they were not triaging prior to that. We also informed all of our patients of telehealth services via email, patient portal notification, and a text message campaign. We also created a new healow patient care facilitator, staff physician who would call the patient the day before their tele-visit to ensure patients were set up and able to log into the telehealth phone app and to answer any questions. We also implemented a tele-visit gatekeeper appointment for any in-person patient care. So when New York was on pause early in the COVID pandemic, we converted all of our in-person appointments to tele-visits. So for all new patients, we scheduled a tele-visit first before any in-person care.

Caitlin Hungate: Sorry, Daniel. Please go ahead.

Daniel Joseph: Yes. Oh, okay. I mean, really at the end of the day, what we were looking to do was we were looking to get a minimum viable product, which was basically a version of telehealth with just enough features to be usable during that early COVID days and be HIPAA compliant and for us to be able to effectively manage from check in to check out. It was a very difficult time, I feel like, the first month go live.

Caitlin Hungate: Great, thank you so much. And Sarah, I'm curious if you can talk about what family planning services Public Health Solutions provides via telehealth. And has this evolved over the course of the pandemic from March to now and where we are?

Sarah Blust: Yeah. So for us, and maybe this probably differs across all sites, but we were always able to keep one of our centers open. So one of our sites had to close for reasons beyond our control. We were able to keep one of our centers in Fort Greene open. It's remained open the whole time Monday through Friday 9:00 to 5:00 with lots of different changes in hours and staffing and so on and so forth. So I guess I say that to say that our telehealth services were always able to operate in concert with the availability of in-person care. So kind of a typical visit is the start of the care is through telehealth. And then if additional labs are needed, or if this is an insertion or a removal, things that really require in-person care, we've been able to do that. So that's something I just wanted to say. But there are certain things that we have done start to finish that are just remote and via telehealth. And so those are things like contraceptive, counseling and education, management and prescriptions for the pill, for the patch, for the ring, things that don't require an insertion or removal, or an injection. We, of course, do options counseling for folks who self-report a positive pregnancy test. We do preconception counseling, of course remotely or via telehealth. We provide preconception care, counseling, education, behavioral risk factors, screening, social services, social work services, then of course, lab results. But the lab results, you have to have come in for your labs. But we provide the results now over telehealth, which we used to have people come back in for. So I think all of those things have increased patient access, which is just wonderful. And I think all of those things, we're now kind of integrating into our regular way of doing things. And so I don't think we kind of evolved because COVID came. We just, as I said, kind of jumped in. The other thing I would add is that just like a lot of folks, if you have a tele-visit with us and we're giving you a pill prescription, we now mail it to your home if that's what is good for you. We also kind of have the prescriptions called into the pharmacy that works for the patient. And then we also do pill pickups and method pickups, which we really didn't do before either. You really were coming in for a visit to get your method, spending time with us on site. And we really tried to reduce the amount of time that you have on site. So the pickups are now an option with your tele-visits.

Meg Sheahan: Wow, it sounds like you all have done some major, major pivots in a rapid amount of time. So I'm curious, what implementation strategies have really worked well? What are your successes here?

Sarah Blust: So I would love to turn this over to my colleague, Renee, to go over some of the implementation strategies that have worked for us.

Renee Finley: Let me unmute. Good morning, everyone. There have been a number of strategies that we've implemented starting with our front desk staff and making sure we're connecting with the patients. We try to project in advance of appointments. Making sure the patient has access to their healow, making sure they know that their appointment is going to be a tele-visit. We've had some patients who have not been here for a while and they're coming up on their annual appointment. So looking projection wise for the coming week and for those patients, we would contact them, let them know they're going to have a tele-visit. How the tele-visit will work, what the access points are, the options to use the healow or the connection link. If there's a problem, we give them information about how to contact the healow administrator. And it more or less goes from there. And everyone gets assigned our front desk staff to make sure that the appointment goes forward and to make sure that the next appointment is scheduled, assigned to an individual patient. So they may have anywhere from four to 10 patients that they need to contact. And after the appointment, they would follow up from there. We have some patients who in some instances may come in even though they have a tele-visit, they've been contacted. So that can be a challenge because for reasons of making sure there are not too many patients in the clinic at any given time is something we're very mindful of. It could be problematic. So we troubleshoot from there for those patients. So it's an ongoing process.

Caitlin Hungate: Thank you, Renee. How do you and your teams ensure telehealth services are inclusive and accessible toyour patients?

Renee Finley: Let's see. One of the things... Some of our patients on the front end when we talk to them to confirm their tele-visit or the in-clinic appointment, they may have computer issues. Initially, it was a lot of resistance or some resistance, I won't say a lot, to the idea of the tele-visit. I think at this point, the whole of society has embraced the idea of healthcare access starts with a tele-visit. But you have some patients who may be technologically challenged or not have access to it. In those instances, we've been fortunate enough to be able to do a telephone tele-visit. For some of our patients, they may start off as a tele-visit, and then their signal's not good. So it would convert to a telephone tele-visit. So it's more or less, again, on the front end, we're contacting our patients. We know what their challenges are. And they may say up front, "Well, I don't have. I don't know how to do. I don't want to do it that way. I want to do a phone visit." We expedite it because the important concern here is making sure they get access to care.

Sarah Blust: Yeah, 100% what Renee is saying and then I would... Accessibility has been a challenge and I think that's going to be an ongoing... And we actually would like technical assistance on this because especially for folks whose their primary language is not English, we have a lot of support staff that do speak Spanish or French Creole, but the providers don't. And the provider is the one who's having that tele-visit primarily. So for us to be able to bring in our staff who usually do the interpretation, we've had to rely on a conference call, which is not... That's not the optimal way to do things and also the billing is very different. We lose out on billing when we actually spend more time with the patient, involve more staff, and again, are kind of focused on accessibility, which I think is what we're all trying to get to. I think that's something that still needs to be worked out. Honestly, to make things accessible, we really had to rely on just telephone tele-visits a lot of the time. It's kind of a little bit of a pain point I think still in terms of figuring out the best way to do it.

Renee Finley: And I would add to that. In those instances, our ECW allows us to know those patients that are going to require translation support so that we coordinate that in advance of the appointment itself with our staff and with the provider. So that is expedited at the time of the tele-visit. It's not a surprise. We've already prepared for that.

Sarah Blust: And one additional point I'll just bring up, and I think Daniel mentioned it, Renee mentioned and I'll mention it again, but it's kind of this... We created this new role and we kind of gave one of our wonderful patient care facilitators a new role during this time, a healow app facilitator which sounds very fancy, but it worked really well and thinking implementation strategies and accessibility And all of that, that's what was really helpful. Was having someone who was dedicated, who really became kind of the expert on the healow app, who could be the in-person or not in-person, but the in-house tech support. There's folks like Daniel who really are kind of an overarching tech support resource. But someone like our patient care facilitator could really be working with the patient one on one, often spend a lot of time with folks who were older. Could speak Spanish, could really go through everything really in detail, could do that pre-visit planning, and that just made all the difference in the beginning. And now, that kind of skill set has been integrated into Renee's team, the front desk staff, when they do their appointment confirmations. All that information is now conveyed when the appointments are being confirmed, but in the beginning, when everything was just this huge, chaotic, we had to get all our patients converted to telehealth. If we hadn't had that position or that role, I think we would have not done so well in terms of accessibility.

Meg Sheahan: That is so interesting. It sounds like you're all describing some challenges that a lot of us have and finding some great ways to address them. Now, Renee, you had mentioned the issue of patients are scheduled for a telehealth visit, but then they actually come in in-person. And so that led me to a question that I had to sort of drill down to this one point, which is how do you actually... how are you communicating these service delivery changes to the clients? The change from in-person visits to telehealth visits.

Renee Finley: Mm-hmm (affirmative). Well, one of the things... If a patient shows up at the clinic and rare but it happens, one of the things we have to look at, and we have at least one examination room that is available. So based on the timing of it, we would have them go in... if it's possible, we would have them go into that room and expedite the tele-visit.

Meg Sheahan: Oh, that's great. So they're on site, but they're actually doing a telehealth visit?

Renee Finley: Yeah, mm-hmm (affirmative).

Meg Sheahan: That's perfect. Thank you.

Caitlin Hungate: That's wonderful to hear. And at this time, we want to open it up to participants. If you have any questions for Public Health Solutions, please feel free to use the chat. We want to make sure that before we turn it over to Danielle at the Northeast Telehealth Resource Center, you have an opportunity to ask questions of your peers. So please feel free to use the chat and weigh in if you have any questions for Renee or Sarah or Daniel.

Sarah Blust: Maybe as we wait for folks to chime in on the chat, just going back to your question, Meg, about the communication strategy. So I think we did a combination of the text and the email and the portal campaign, and also just plain calling. Especially for our patients that were at the center that closed, we had our staff who knew these patients call. Anyone who'd come to our center in the past two years, we called them and we tried to explain what was going on. And then when our center reopened, we called them again. So it's been a combination I think of those automated options through the EHR, and then also just really trying to get them on the phone or... Yeah.

Meg Sheahan: Yeah. Sometimes those good old phone methods just work. Actually, I did have another question if I can squeeze one in. I think we've talked with many providers over the past few months who have different stories about how well this... [inaudible 00:24:09] different responses from the different types of clients that you serve to telehealth visits. And one reason I ask is because I think that in the beginning, frankly, we thought telehealth was going to be a silver bullet. I don't know if we thought it was going to be but we hoped it was going to be. And in our experience, there are challenges and not all of our clients are telehealth?

Renee Finley: I'll chime in on that one. It's interesting. You're always going to have some patients who are technologically challenged and resistant to the process. But there's been, I would say, a transition to receptiveness. I mean, we've had a few clients who have called in and just, "I want to do a tele-visit." It's embraced. Our ECW allows our patients to make reservations and they pop up in green. So I'm seeing increasingly a number of reservations for tele-visits with specifics about they want to have a tele-visit. So I think it's transitional, it's working well. On a daily basis, you see those numbers going up in terms of people wanting to set one up and then schedule from there. So it's transitional. It's a new process. And I think it's going to continue, but at the same time, I think it's important that we're mindful to also provide care to those that are not open or able to do that tele-visit process. So accommodating that need as well.

Sarah Blust: Yeah, I think we've seen some real frustration with some of our patients around tele-visit. They want to see their provider, and it has been hard, I think, for us to convey the fact that they will be able to get a certain level of care still from tele-visits. Yeah, I think we've turned a corner. I think it does feel more... I think people are seeing the benefits from it. And this is not from the client perspective, but I have heard the provider say that they feel like they can establish more of a relationship in a certain way with their patients which is interesting and I'd love to kind of tease that out a bit more. But I think maybe when you are one on one with someone and you're on video conferencing with them, and it is possible to maybe really establish a rapport in a way that's a little different and that would be great to explore. But there's something about, yes, you can engage, you can develop relationships, you can do your assessments, and I think providers are liking it. But of course, our providers have always had the opportunity to bring their patients in as well. So they've had both options.

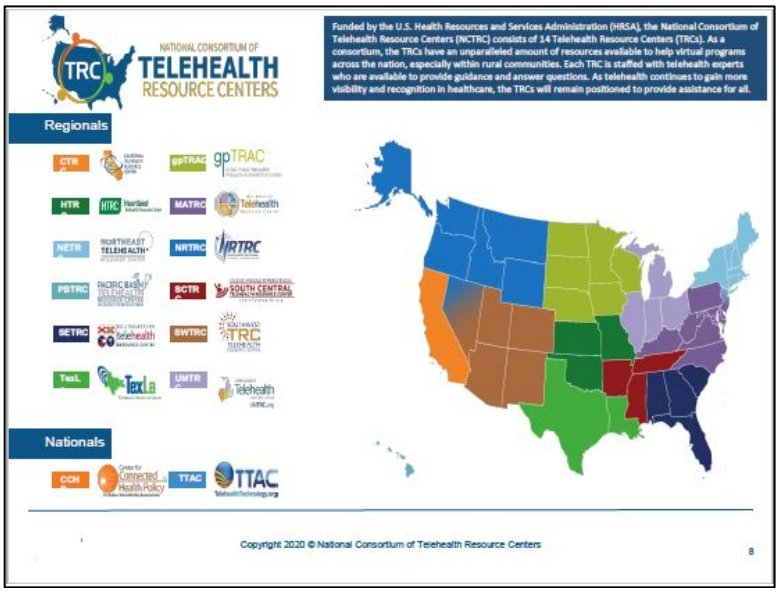
Meg Sheahan: Yeah, that makes sense. I think this is a transition. I mean, I can certainly say as a provider myself, I feel like I can, with certain patients, establish more of a rapport because it's more relaxed. You don't have the hecticness of the environment as much. So that's interesting. I think we have time for one more question if that's okay. And what I'm curious about is what policies or procedures did you have to put in place in order to roll out telehealth? And how if at all, these policies and procedures have evolved with time as the pandemic has unfolded in your area.

Sarah Blust: Well, we had to develop a new telehealth policy from scratch. So that's number one. And I have to say it's not actually final. I think part of what we've had to do is really learn the system first and learn all the ins and outs and learn these... And until we did it, we just didn't know all of these different kinds of really specific challenges that people might encounter. And so as we've understood that more, we put that into the protocol, how to respond to those challenges that come up tech-wise. So that's number one. We had to develop a telehealth policy and that is still actually being finalized. We have a new strategy now for our panels. So we have in-person and tele-visit hybrid panels. I'm curious as to hear how other folks are doing it. We have heard from our providers. They prefer one or the other because of volume and trying to keep some type of volume study at our centers. Renee's done amazing job of balancing in-person and tele-visits. So people are busy, but that's been a challenge and new for us. We do have a Monday tele-visit only process, which everyone seems to really like. It is the one day of the week where we just focus on tele-visits. People get a bit of a breather to kind of prepare for the week. So that's also new for us. We had to roll out a new kind of work from home policy, which you don't necessarily have to have for telehealth. I mean, people can be in the clinic to do telehealth, but because of COVID, because of why we're doing this, it was really important to develop a work from home policy and procedure and how that tied into providing telehealth. And what were the roles and responsibilities of the staff when they were working from home? The providers, it's been really clear as to how they operate within telehealth. With the support team, we've had to really hash that out. So that's been new for us. And I would say as Renee and kind of Daniel mentioned, our appointment confirmation process is new. We do online booking. That's a new process for us, how our PCAs manage those appointment confirmations, the kinds of things they communicate during those appointment confirmations. All that is new. And then finally, the whole healow app facilitator tech support process was new for us too.

Caitlin Hungate: Great. Thank you so much, Sarah and Daniel and Renee, for sharing your experience and process through scaling up and implementing telehealth and this emergency setting. And now we're so honored to transition it over to Danielle at the Northeast Telehealth Resource Center. So Danielle, I'm going to turn it over to you.

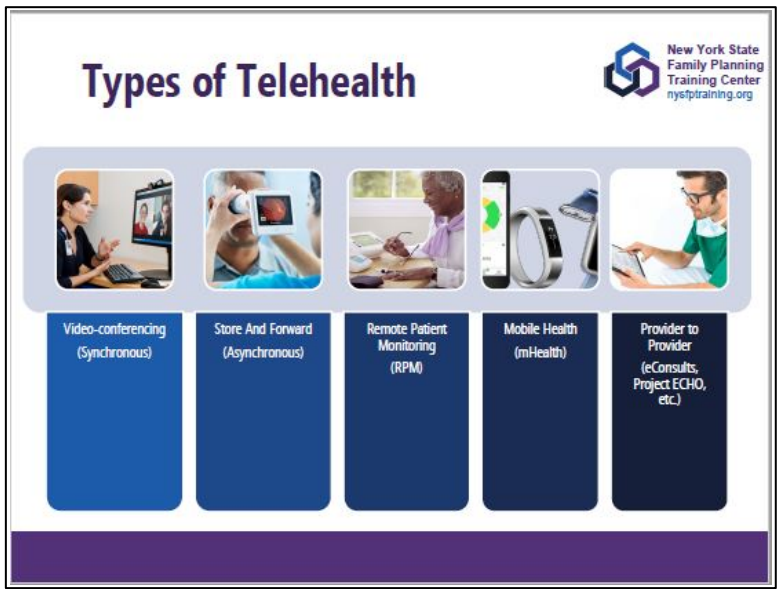
Danielle Louder: Great. Thanks so much, Caitlin. And just to confirm that everybody can see my slides okay, those transitions, right? Thank you so much to Caitlin, to Meg, and oh my gosh, the team, the amazing work that you guys did to stand this up from the ground zero. And I'm sure you learned some lessons the hard way. But wow, I'm so impressed. I actually took several notes while you were speaking, just practical ways to address some of the key issues that people run into when they're launching a program. So awesome job. So just the usual disclaimers. Any info I provide here today is not to be regarded as legal advice. I am not an attorney nor do I personally have any relevant financial interests to disclose. We are completely agnostic and we are federally funded as you all are. And then just some key acknowledgments which I actually think our colleague, Megan Prokorym, is here with us today, which I'm so excited. She's somewhat of a unicorn when it comes to the New York State Medicaid telehealth policy. So if you guys stump me with some questions that are down in the weeds, then I have her to back me up. So I'm psyched Megan is here. Ron Bass with New York State Department of Health and Kendra Muckle who is with New York State Department who have recently done some excellent presentations, Adirondack Health Institute, et cetera, their virtual conference this year. And I call out some presentations that you can all access via links that are in the presentation. And also, just kudos and acknowledgement to the New York State Family Planning team for pulling this all together.

Danielle Louder: So a little bit about the Northeast Telehealth Resource Center. As mentioned, we are federally funded. We're based out of a global public health organization. We're in Maine and Silver Spring, Maryland, but we do public health programs all over the world. And so we are one of our Domestic Public Health Division program. So that's my other hat. I'm a co-director of our Domestic Public Health Division and as well as director of the NETRC or NETRC as we refer to it. And our clinical partners, the University of Vermont Medical Center, who really provides tons of expertise and templates and resources with respect to telehealth implementation, evaluation, et cetera. And we have many other clinical partners that we work with throughout our eight state region which leads me to this map.



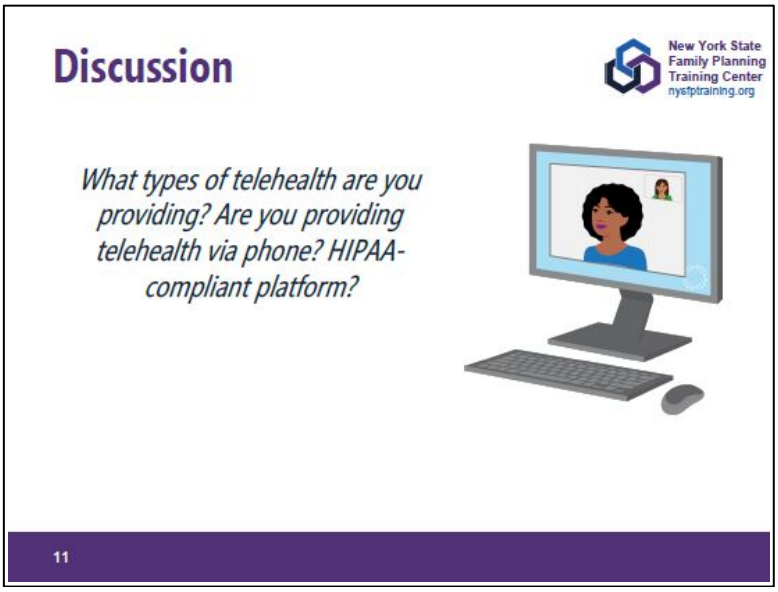
Danielle Louder: We are all funded. There are 12 regional telehealth resource centers funded through HRSA's Office for the Advancement of Telehealth. We have served as the Northeast Telehealth Resource Center for about 10 years now. So I've been doing this for almost a decade. You can see where the light blue region up there and serve all six New England states, New York, and the northern half of Jersey, which we share with our colleagues from the Mid-Atlantic Telehealth Resource Center, but you can see where everybody is sort of covered. The HRSA regions are a little bit different than our TRC regions, but there's certainly lots of overlap there. And I just always like to say if there's something that we don't have at the NETRC, that we have lots of colleagues who collectively will recover all 50 states, the Pacific Basin, and now more recently, Puerto Rico and US Virgin Islands. So if we don't have it, somebody else does. So please don't feel like you have to recreate wheels. We want to save people time, energy, et cetera. And then just a quick mention of our national TRC colleagues, which I hope folks have become familiar with them over the past few months as they were trying to very quickly start up programs that the Center for Connected Health Policy is out of Sacramento, California. And they research and provide resources around the ever changing policy landscape. And we know that's been a moving target over the past few months for sure. And then TTAC, which is the Telehealth Technology Assessment Center out of Anchorage, Alaska, and they kind of take the massive amounts of technology that are out there, digital health, whether it's hardware, software, peripherals, et cetera, and really give folks an unbiased review of how those different technologies can meet your clinical needs, user friendliness, et cetera, and they have a lot of great resources on their website. Reviews of Bluetooth stethoscopes, for example, if you were looking to dig into that.

Danielle Louder: So our services are really kind of meeting people where they're at. If there's something that's new to us, we will research and find the answer for you or a resource. But we provide lots of one to one technical assistance. We do lots of these webinars, especially over the past few months. So more educational events and those types of things. But we dig into protocols and workflows, lots of policy, legal regulatory questions. And that's pre-COVID and during COVID, again, because telehealth policy, unfortunately, has been fairly complex over the years. And that's been one of the biggest barriers to widespread adoption, of course. Technology assessment, so how does the technology meet my clinical needs, meet my provider needs, meet my patient needs, but not break the bank? Right? What are the key questions that you need to ask those technology vendors in order to make sure that what you're investing in is really going to meet your needs? Development, and we've talked about designing over the past few months, wow, lots of toolkits. Educational curriculum for colleges and universities, which is so exciting to us. Over the years, we've had folks approach us and want to do, "Can you help us with an elective course?" Well, now folks are like, "Wow, we really should have a need to build this into our core training across any different number of health professions." So it's becoming expected. And I think students, health profession students, are going to be expected when they enter the workforce to know how to use technology and telehealth. So for us, it's a very exciting time. And then, of course, business and strategic planning. And I know it sounds like the PHS team is thinking, "They had to very quickly adapt and make sure that they could provide access in the moment." But then stepping back and starting to think about this from a strategic level, how do we incorporate digital health into our overall organizational strategy moving forward and having a business plan in order to do that? So that's all stuff we do. And plus whenever you come to us with new requests.



Danielle Louder: So types of telehealth, I really don't think I need to dive into the definitions of these because I think you've all kind of been drinking from the fire hose for the past few months. But I thought I'd just more kind of talk about how folks are using these specific to family planning services within each one of these areas. So video conferencing like we're doing right now, and it sounds like the PHS team certainly has used a lot of this over the past few months. But so most certainly, whether it's contraceptives, counseling, mental and behavioral health, doing screenings, and we're seeing a lot more of this, and I noticed the team has been doing this, but looking at social determinants of health. And can you be doing some of these screenings ahead of time to make sure that the screening is actually a really solid screening that's complete before they go and see the provider whether it's via telehealth or in-person? So it's those types of things, thinking outside the box. And in some cases, you can actually break that out and bill it separately because as a screening med, it's been done completely via telehealth. So store and forward are asynchronous. Sending them images and/or information via secure means, of course, whether it's within your EHR if you're on a shared system or between and really having that information be looked at later per the provider's convenience. There are potentially many different... The picture there is diabetic retinopathy screening, which is a very common use case,

dermatology, but you can think about potentially STI management and thinking about how images might be transmitted between providers if you needed some additional insight, recommendations on a treatment plan, Not really probably going to be using remote patient monitoring in family planning practice, but it certainly has wonderful outcomes with respect to tracking and managing and really the triaging of limited resources typically for chronic illness management such as congestive heart failure, diabetes. But if you have patients who are dealing with those things, it's important to know that RPM or remote patient monitoring can be a really great solution for helping to ensure that they're not having hospitalizations, rehospitalizations, exacerbation of disease. Mobile health, some great use cases for family planning and it sounds like the PHS team has actually been using this a little bit with texting. And we're probably hard pressed to find anybody these days that doesn't have some kind of mobile health. Whether it's apps on their smartphone, or they have a smartwatch, or any different number of things, but texting to remind folks to take contraceptives, there are apps for that. And any different number of things that you'd like to remind folks or help them manage their care. There are mental and behavioral health apps that are similar in nature to that. So lots of potential different use cases. The biggest question or challenge, I guess, with mHealth is, so what do we do with all this data? I think you have to put a box around it and determine for your organization, how are we going to use this? Is there an explicit use case? And how do we use that in order to improve our knowledge, our data, and then to help turn that around and help manage our patients and clients? And then, of course, there's provider to provider which can be electronic consultations, or eConsults, which have been billable for some time. Not necessarily in every state, but Medicare has been reimbursing for eConsults for quite some time. And those are usually asynchronous and really exchanging information typically from one provider to the next and getting recommendations on treatment, evaluation, et cetera. And really kind of building the local providers' capacity and competency to deal with everyday issues that they might not have had a whole lot of training in their particular program. And then Project ECHO is more of a medical education model and really peer-to-peer education, case-based education.



Danielle Louder: So I'm excited because we're able to build in some discussion throughout this presentation. So I would encourage you to go ahead and put into the chat. This is just a question to get us started. What types of telehealth are you using/providing? Have you been using telephone as telehealth? And then are you using a HIPAA-compliant platform? Feel free to answer any and all of those questions in the chat. We kind of got great examples from the team on each one of those too. In Project ECHO, part of the whole philosophy

is waiting. And as you can tell, I like to talk, so making sure folks have their chance. I would say we know that there are many flexibilities under the Public Health Emergency and HIPAA is a big one. The Office of Civil Rights has allowed that in the state of New York, followed suit with allowing for non-HIPAA compliant platforms during the Public Health Emergency. And I know folks had to use those in short-term at the beginning because they really felt it was urgent and it's absolutely right, it was urgent to get access to their patients and clients during COVID. But that's one thing that I don't think is going to stick around after the Public Health Emergency ends. So I would encourage folks, if you aren't using a HIPAA-compliant platform, start looking, start talking with vendors if you haven't already because I think we'll be going back to where things were with respect to HIPAA.

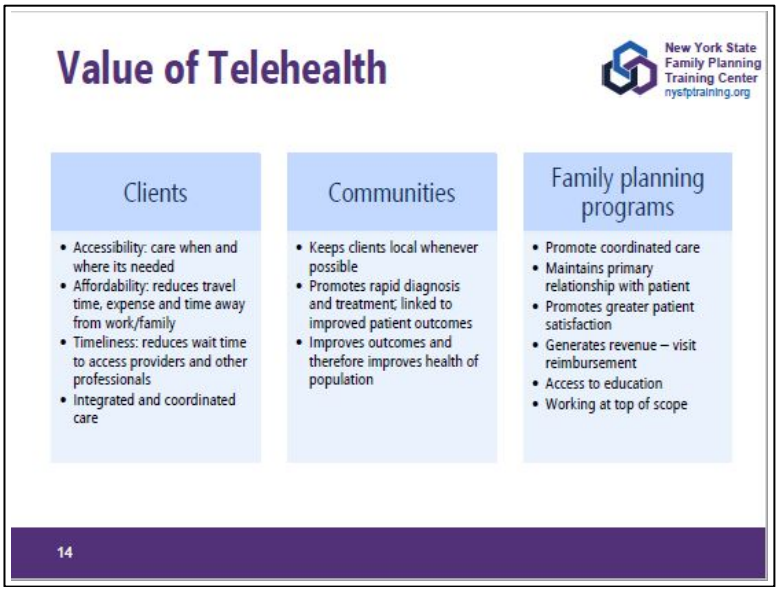
Caitlin Hungate: And Danielle, it looks like we've got a couple people weighing in in the chat. So both Julie Westberg and Sarah [Spadow 00:43:29], and I'm sorry if I'm mispronouncing names here, are both of using HIPAA-compliant platforms. And Julie and her team are providing video and phone visits. And for Sarah and their team, family planning and reproductive health services. So please, folks, please continue to use the chat. We'd like to hear from you.

Danielle Louder: Awesome, that's great. So you guys are ahead of the game. The telephone or audio-only falling under the definition of telehealth, there is question whether that will continue beyond COVID. But I think it's a health equity issue, right? And when Medicare started adding audio-only eligible codes, that's promising. We still have lots of folks who are in rural underserved areas who don't necessarily have access, or they're not comfortable using live audio, video. Maybe they don't have enough bandwidth. So I think it's going to be an important discussion moving forward and there's absolutely policy that's been introduced to make sure that happens beyond or that's allowed beyond COVID-19.

Danielle Louder: So the team did a great job sort of providing examples of all of these. So these are very typical family planning services via telehealth. Of course, contraception, the counseling that goes along with that. There are some wonderful things. I'm psyched to hear that you guys have started to do mailing of contraceptions and things like that. It's so patient and client-centric, and I think that's why you've had some great success with participation and engagement. Certainly, STI care, medications, medication management, medication abortion, which is happening in some states. New York State, you cannot use New York State funds to pay for those services. Consultations of many different kinds, whether that's preconception options, all of those different types of things. Screening and outreach, which I talked just a little bit about earlier.

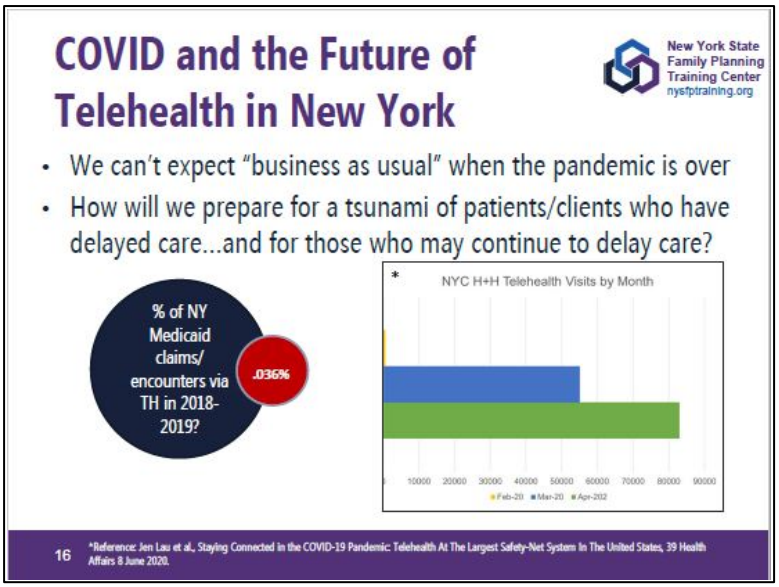
What are those key things that you can make sure you're addressing social determinants of health? Education and counseling are absolutely wonderful use cases. And I've got a great resource that the Kaiser Family Foundation has a wonderful article if you'd like to read through that as well.

Danielle Louder: So special considerations. Privacy is absolute, and across the board, whether it's family planning services. We're working with folks on Sexual Assault Nurse Examiner, a program to transition that over to tele. Privacy is huge. And that's your patients and clients need to know that that's a core concern and that it's being addressed. Showing who's in the room. So making sure that your patient is aware or your client's aware that there's nobody else in the room with you unless they're supposed to be. Absolutely multidisciplinary care happens via telehealth all the time. And so if that's the case, that's okay. Ensuring privacy of the client. And this can be really tough with everybody being at home during a pandemic. Making sure they have a private place. People are having consults in their car, and that's okay as long as they feel safe and they're not driving. We've had that where... And always having that backup plan. If your patient calls and they're in the car and they're driving, you have to end the call immediately and you have a backup plan. So there are some great resources there on guidance, data, and security from the CDC. There's the wonderful Decision Making Guide on prioritization of in-person and virtual. And this is really helpful. There's a lot of specific disciplines that really haven't put this type of resource together and we're getting lots of questions. So what is better as folks come back into the office? What's more appropriate for a telehealth visit versus in-person? And then our colleagues at the South Central TRC have a Telehealth Etiquette Video Series and they go into privacy. And they have some really fun ones of like what not to do. So if you're just looking for a laugh, I'd encourage you to watch those. And then there's also Telehealth Etiquette for Family Planning Visits.



Danielle Louder: Thinking through and we saw some examples of this through the previous presentation, but the value of telehealth, really, you got to look at it across the board. There's benefits to clients, communities and the family planning program and to really when you're designing your program or evaluating it or expanding it, to really think through each of these. But of course, it's about accessibility, affordability where you don't have to take so much time away from work, reduces travel whether it's on public transportation or you've got to drive 50 miles to get to the service. Timeliness, reducing wait times. Absolutely helping people to get to their appointments when they need to versus missing appointments. And that's super important when it comes to family planning services. Integrated and coordinated care really helps benefit obviously, clients, when providers are able to talk with each other and exchange information in real time.Meg Sheahan: Yeah, absolutely. I think this is one of the many ways that COVID is actually going to adapt us for the better. We're going to adopt new technologies, new methods of doing things, telehealth, new ways of conversing, new ways of allowing our clients to manage their own care. And we're not going to go back from these evolutions, which I think is fantastic. Actually, it's one of the silver linings of this. All right. Communities, keeping patients local keeps revenue there. If they're healthier, and if they're managing family planning, for example, then it really improves the outcome of the community as a whole, helps us all to be more productive and contributing to the community. Family planning, the programs themselves, of course, the coordinated care is a benefit and then maintaining that primary relationship with the patient. But also bringing in additional service providers as needed. Whether they need mental and behavioral health services that you can start to create those relationships with specialists, et cetera, or promoting greater patient satisfaction. We know everybody's happier when patients are satisfied. Generates revenue, so visit reimbursement and also thinking outside of traditional reimbursement. Some folks have done some really creative things working with ACOs or others for quality dollars or negotiating incentive payments when they're able to meet certain metrics. I would encourage folks to think outside the box that way. Access to education so that you can work at top of scope, et cetera.

Danielle Louder: So we've said this a few times, but it really... We're super excited about it, but it's too bad that it took a pandemic to really help us leverage the true capacity or potential of telehealth. So these are just a bunch of articles and they're live links in the slide deck if you'd like to check into them. I won't go into them in a lot of detail here. But it's kind of funny, the first article, it was a 20-year overnight success. And that's so true. There are so many wonderful successes with telehealth and people have been creative over the years, but we've never seen such a massive increase in utilization and people... I'm just so impressed with how quickly people have been able to successfully launch with just maybe a couple of roadblocks that they were able to get through. And I think the biggie here that I wanted to point out was telemedicine is projected to account for 20% of medical visits in 2020. So that's pretty amazing. And I think folks looking forward and doing some of that strategic planning I mentioned, they really are talking about, "That's our goal. For moving forward, we want to continue, of course, with patient-centric mindedness at the heart of everything." Telemedicine is not right for everything. Physical exams, for example, while you can do them and there are tools to help you get through that, but it's having all the peripherals in place to make sure that you're able to do at the same quality as you were in person. We haven't necessarily been able to do that during a pandemic because people didn't have peripherals at home, for example. But that's where, I think, we're going.



Danielle Louder: So just connected to that, I wanted to share just a little bit about utilization, specifically in the state of New York, but I think... And Seema Verma, the administrator for CMS said this, "The genie is out of the bottle when it comes to telehealth, digital health." So I don't think we can necessarily expect business as usual when the pandemic is over. I think we are seeing, as mentioned in the last session, we're seeing people who prefer telehealth and that's across all use cases, not just family planning. How will we prepare for a tsunami of patients and clients who have delayed care and for those who may continue to delay care? I mean, now we have flu season coming on top of COVID. Lots of things to consider. But just a guess, what's the percentage of New York Medicaid claims or encounters via telehealth for last year? So 2018 through 2019? If folks want to put in the chat what a guess was. It'd be interesting to kind of see that. All right. 0.36%, and that's not different from a lot of other states either. I mean, there are some states who really have nailed telehealth, and they've been doing it for a long time and they have really progressive policies. But because there's been so much diversity between, for example, Medicare versus Medicaid versus commercial payers, people have been slow to widely adopt it and for good reason, so complicated. And then this is just an example of one health system in New York. So New York City Health and Hospitals, this is the growth in telehealth visits by month. So you can see this teeny tiny February, can barely see it in yellow, and then March, of course, they almost hit 60,000 and going on 85,000. I think it was 83,000 in the month of April. So that's pretty amazing and they were able to keep patients, providers, clients safe reducing exposure to COVID, et cetera. So just really great stuff, and exciting stuff.

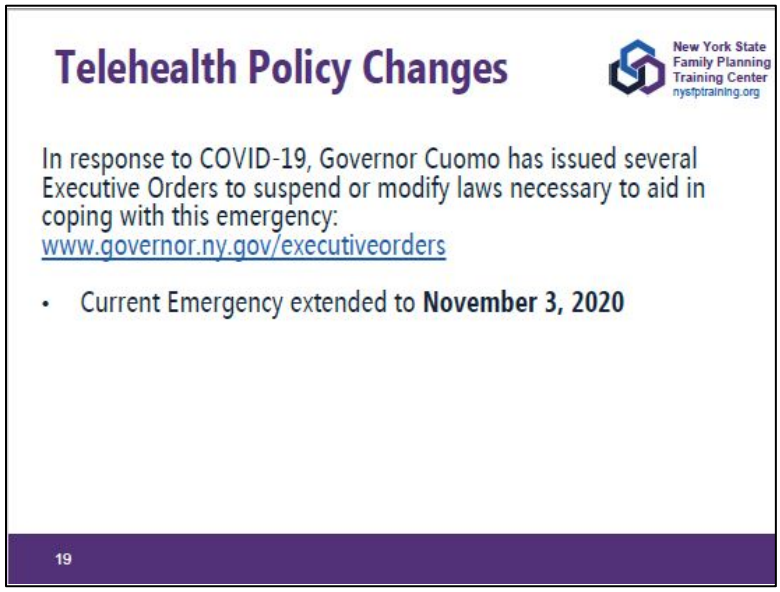
Danielle Louder: So just kind of digging in a little bit, and we talked about this and my ears perked up in several different instances where the PHS team were talking about this. And so strategies to improve quality of care specific to telehealth, I kind of can't say this enough. And it sounds like that the PHS team really invested in this, make training a priority. The technology, yes, it's really important. But your people have to feel comfortable and confident in the technology. And that that goes for the patient and client side, too. Doing the pre-visit check-ins, what type of technology are you going to be using? Do you have bandwidth issues? Do you have questions or concerns? All of that. Do you need interpretive services? All of that ahead of time, but really also making sure your clinical workflows are adapted to telehealth and everybody is comfortable with that and they know how to do that. The troubleshooting. Having the one pager on the device so that, "Oh my gosh, something happened and we're freaking out. But okay, we've got our 123 checklist and it's there and we can fix this and still go on with the consult." Involving end users. And I was so psyched to have the whole... It's a perfect example today, the team. It really is a team effort. That's so important. And it's both patients and providers. Patients are so, especially these days, they're resilient. They're willing to beta-test things for you if you want to try something new. It's low risk for you. Maybe you try it internally, maybe you try it with a handful of patients that are comfortable with technology. But assess the needs and satisfaction regularly. Act on identified issues, quality improvement. Don't wait on that. That's something that's just really vital to fix them in the moment and be transparent about it.

Set and track quality metrics specific to telehealth. And SMART goals, probably people are pretty familiar with that. But make sure they're measurable and specific and identify key concerns and solutions and make sure that everybody gets trained on them so that those quality metrics are able to be met. And then there's a great National Quality Forum, creating a framework to support measure development specific to telehealth if folks have time and they want to dig into that particular resource.

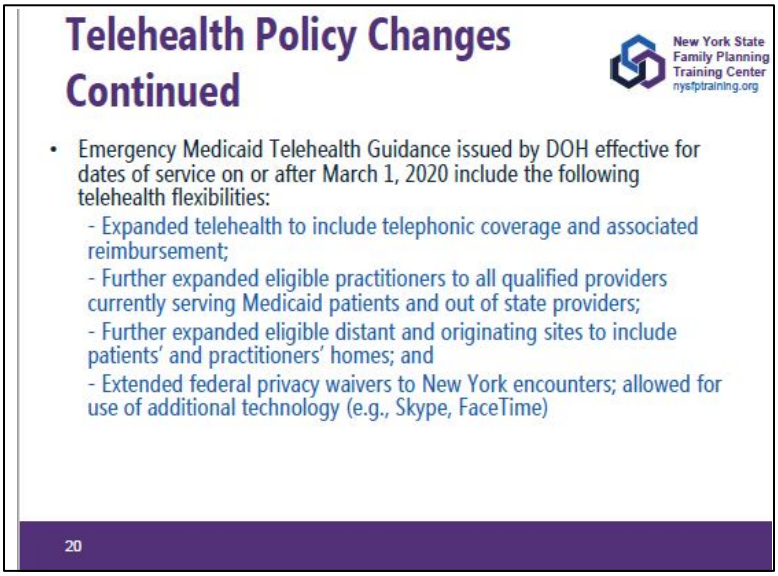
Danielle Louder: So back to a little bit of discussion here. Where do you all see opportunities to improve the quality of care via telehealth? And thinking about, and we always say this with telehealth, it should be the same level of care, you can provide the same standard of care as you could in person. That's really the goal at the end of the day. Or are there particular issues that have come up that you can... oh, that's a quality issue, but you're not quite sure how to fix it? I think a lot of folks have to... Again, they started things up very quickly and now they're having a chance to step back and say, "Okay, we really..." I don't know if we have a breather, but thinking a little bit more strategically and making sure that everybody is well trained, that everything is protocolized are just really important, and that it's part of your day-to-day. So if it's you have new folks coming on, integrate it into orientation, make it an expectation. So it's part of everybody's... And having those roles, that was great. I think it was maybe a specific... healow navigator. Somebody has to take responsibility for all of those different bits and pieces that otherwise could fall through the cracks. And that's all a piece of the quality of the service. So whether it's telehealth or any other different kind of service.

Caitlin Hungate: Danielle, I want to make sure I read this out to you. Kaitlin and her team are saying that they have everything in place operationally to support telehealth, but very few patients want the service and that they're trying to understand what people need or want from the tele-visits. Thank you, Kaitlin.

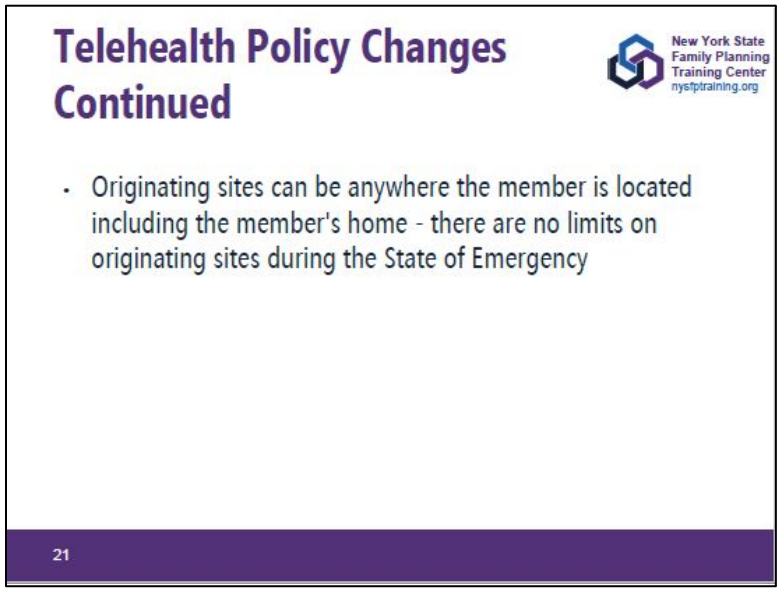
Danielle Louder: Got you. Yeah, that kind of reminds me of patient portals. Right? I think across the board, whether it's medical, behavioral health, family planning services, the use has been abysmal over the years. And so I actually had that question for the team to see whether this has resulted in an uptick in utilization of their patient portal because they've been doing so many of their communications that way and people come to expect. So I guess I would want to dig in a little bit, Kaitlin, Kaitlin with a K, around what are their specific barriers, concerns? I wonder if they would do some quick interviews with you so that you can understand... And maybe you've already tried this, but sometimes it's things that we wouldn't imagine. Maybe they're really concerned about privacy. There could be any different number of reasons. And especially it's a pandemic, maybe they really want to get out of the house. But try to dig into like, what are their specific real and/or perceived concerns? Because sometimes it's just communicating, "Oh, well, we have a solution for that." Yeah, I'd be really interested to follow up with you on that and see if there's anything that we can help out with. ll right. Are we good to move on, Caitlin? Do you think we should probably...?



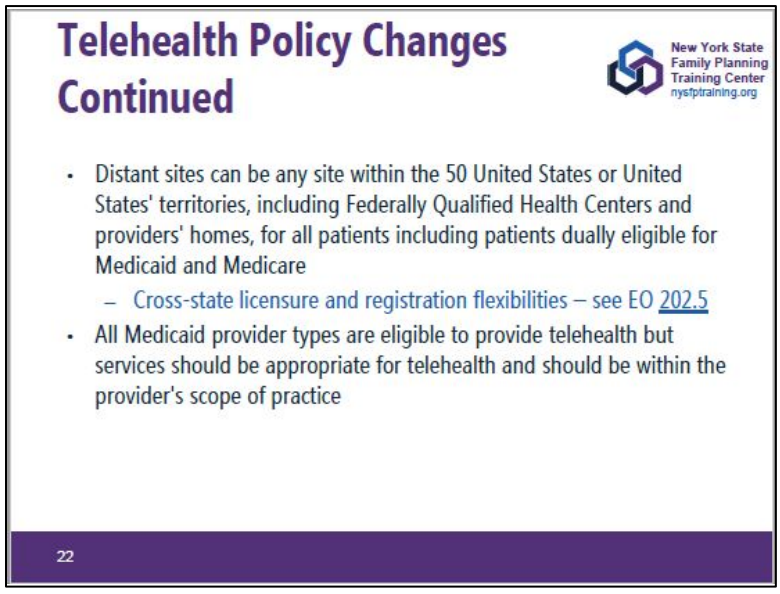
Danielle Louder: Okay. So telehealth policy changes, and this has certainly been a moving target over the past few months. My gosh, we met at the beginning of the Public Health Emergency, the waivers that were coming out from Medicare. Oh my goodness, we just could not even keep up. However, in the state of New York in response to COVID-19 as with many other states, but Governor Cuomo did issue several executive orders to suspend or modify laws necessary to aid in coping with this emergency. And many of those applied to breaking down a lot of the barriers that we've had around telehealth utilization over 20 years. Now, New York State has had a very progressive telehealth policy and it really is not that old. They learned, I think, from the mistakes of a lot of other states and they really took that and implemented a really solid policy and they've addressed as providers and other stakeholders came to them and said, "Oh, well, this is a great policy. But did you mean to set up this barrier with this piece of language because oftentimes, one piece of language can make a big difference? Like coverage parity versus payment parity, for example. That's a lot different." Or requiring prior authorizations before telehealth could happen. Some states have done that and quickly gotten a barrage of feedback from providers that, "Oh my gosh, nobody is going to use telehealth because that's too big a barrier." So anyway, the current emergency has been extended to November 3rd, 2020. I saw one of the pre-questions was, "So when is the PET going to end?" So I thought I might address that here. I wish I had a crystal ball, but my guess is and kind of what we're seeing with trends with states anyway, they're kind of following the Federal Public Health Emergency, but they're doing it month by month. Maine's doing the same. Many of the other states in our region are doing the same. So my guess is that the New York executive orders will continue to be extended through January, which is when the federal, the current Federal Public Health Emergency has already been extended. So that's my guess. And if we're still seeing apprises in COVID cases, and then we have flu on top of that, even if we have a new administration, I don't see the Public Health Emergency ending in January either. Don't quote me on that, but that's just my two cents.



Danielle Louder: So we're not going to go through all of the changes, but these were kind of the key barriers to policy that I thought we would kind of dive into a little bit here today. So the Emergency Medicaid Telehealth Guidance issued by the Department of Health effective March 1 include the following flexibilities. And again, these are still in place at least through November 3rd. Expanded telehealth to include telephonic coverage. And again, the associated reimbursement. This has been huge from a health equity perspective because folks don't have or they prefer not to use, they don't want to be on video. So this has been a really important expansion. And again, we don't necessarily know if the federal government, if CMS will continue beyond COVID-19 with allowing for reimbursement for telephone coverage under the definition of telehealth. That's one of those ones at the federal level that's literally an act of Congress to change the definition of telehealth versus like a regulatory change. But states can and they are doing. Maine already updated their telehealth rules to say, "We're going to permanently allow telephone." It's not in every single case, and it's always... it's not about the provider preference. It goes, "If the patient prefers the and or they don't have a means to connect via live audio/video, then absolutely, conduct it via telephone, telephone only." Further expanded eligible providers to all qualified providers currently serving Medicaid patients as well as out of state providers. So that's a biggie. And you think about some of the limitations that have been in place over the years, but an explicit list of providers that weren't eligible even though they were licensed providers or certified providers. That's been a real barrier. So having this expansion has been really, really helpful. And if I had to guess, I would say that that's probably going to be one of the expansions that continues beyond COVID-19 because we've just seen some wonderful use cases across any different number of types of providers. Further expanded eligible distant and originating sites to include patients and practitioners homes. Again, that's wonderful. It's been a huge barrier. However, we also have to consider and think about, "Oh, well, not all providers have great internet at their house. Not all patients have internet at their house." So accommodating and having that backup plan, doing those pre-visit checks. And even patients being at home, that's a whole different story. Do they have the privacy? Are they safe? Not commenting on what's going on in the background, those types of things. But it also opens up windows to see inside of a patient's home and their environment and what might be going on both from good and not so good perspectives and helping to address that if we can, when we can, when it's appropriate. Extended federal privacy waivers to New York encounters. So that's those HIPAA flexibilities, which we think are not going to be maintained post-COVID. And so New York also expanded their policy to allow for that. So it might be Skype or FaceTime being used. But again, I would caution folks, if you have been using those non-HIPAA compliant solutions to transition over to HIPAA compliant.



Danielle Louder: So just a little bit more around originating sites. They can be anywhere the member is located, including their home. There are no limits on those sites during the State of Emergency. It could be in their car. It could be any different given number of places. Again, and talking about quality and safety, privacy, all of those are key factors to just be thinking about and having that backup plan. And we think about, what's the crisis plan particularly with mental and behavioral health, SUD services, et cetera, but could be for anybody asking where they're located. If you've seen them in their home before, but that's not what you're looking at now. Identifying where they are in case there is an emergency. Do they have an emergency contact? All of those different kind of things that you need to think about when they're in a different location than sitting right in front of you.

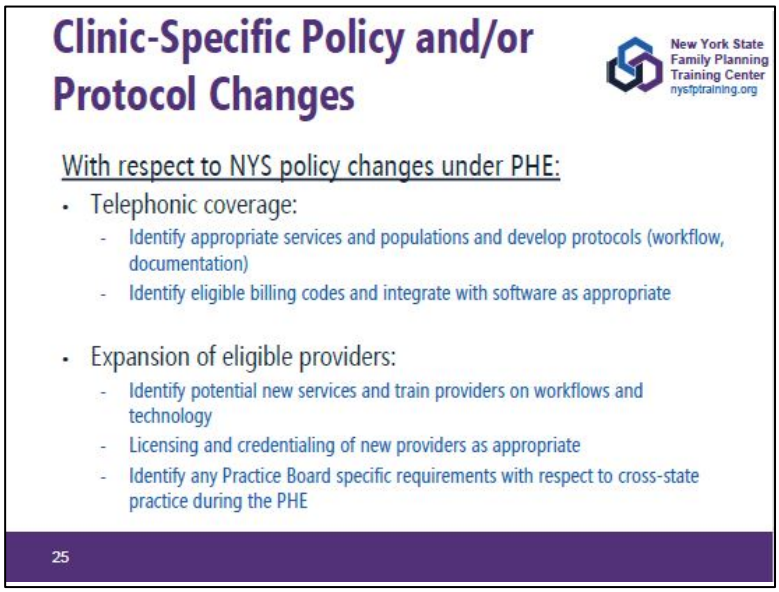


Danielle Louder: Distant sites, same thing. They can be any site. And this is within the 50 United States or United States territories, including Federally Qualified Health Centers, and providers' homes for all patients, including patients dually eligible for Medicaid and Medicare. So we know there are still some licensure and registration

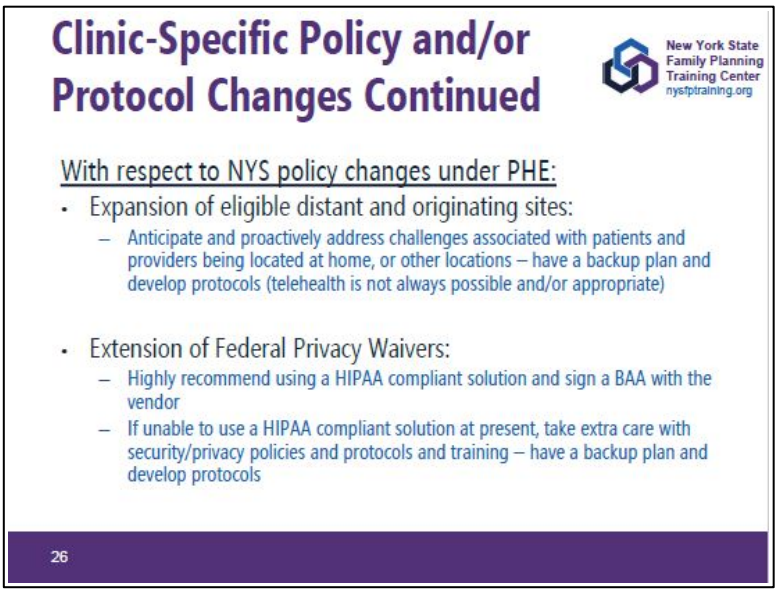
requirements in some states. New York has allowed for flexibilities in that regard. So having providers from other states. Every state has workforce shortages. So if providers from other states can help to address needs, whether it's specialties or any different type of care, then that can be allowed during the Public Health Emergency per Executive Order 202.5 and there's actually a link there if you want to dig more specifically into that. But just different boards of providers have different rules. So I would just encourage you to check into your specific... Whether you're looking to be a district provider and you want to provide services to help out somebody in another state, know what your specific health professions board, what's going on there. And sometimes it's literally you send an email to the board and they say, "Yep, you're good." Which is much easier than pre-COVID. All Medicaid provider types are eligible to provide telehealth but services should be appropriate for telehealth and should be within the provider scope of practice, of course. And that goes to say whether it's telehealth or not telehealth.

Danielle Louder: So flexibilities impact how telehealth may be provided and what services may be reimbursed. So just kind of thinking through that, and I don't know if folks have any comments around that or questions around that. Feel free to hop in if you do. Maybe our colleague, Megan Prokorym, who is with us has any comments on that, she can feel free to hop in. But it looks like we might have something in the chat.

Danielle Louder: Okay. I think I can probably keep on trucking through some of the policy. And this is Megan's... Actually, this good timing. This is the link to Megan's recorded presentation from the AHI, Adirondack Health Institute annual conference just earlier this month. She did a great session. So thank you, Megan, for informing my presentation here today again. And so just some great links to New York State DOH Medicaid updates, including telehealth, frequently asked questions on Medicaid Telehealth Guidance, and then New York State Medicaid Telehealth Guidance. There's a great webinar there. So I guess we certainly can't dig into all the weeds with respect to policy here today. But I guess what I want to convey is that's what the Telehealth Resource Center is there for. So if you have, you want to dig into very specific billing and coding questions, any of that, give us a shout and we'll help you find the answers.



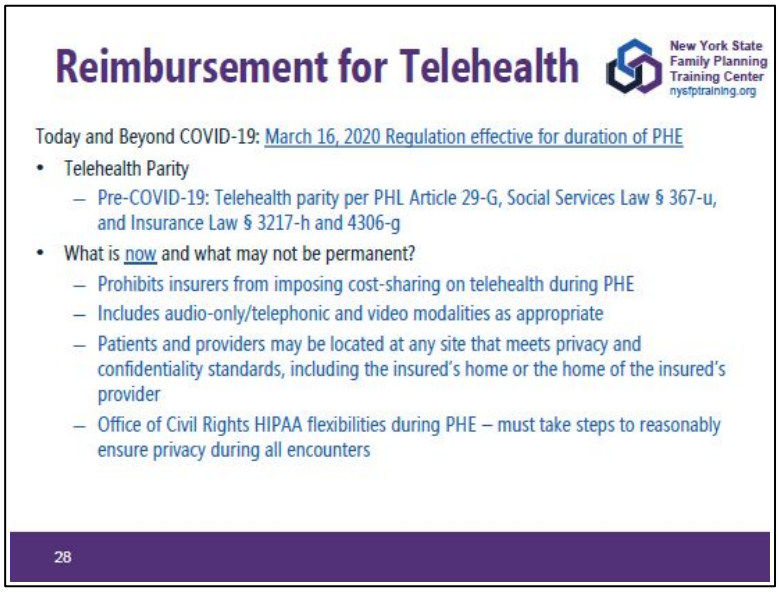
Danielle Louder: Okay. So kind of thinking about all those policy expansions at the state level, we just wanted to kind of provide some examples of what you might need to do locally in your clinic to address those or make sure that you've covered it. So with respect to those changes, telephonic coverage, identify appropriate services and populations and develop those protocols for telephonic. It's not right for everything and we've actually heard a number of providers like, "It's exhausting to be on the telephone all the time. You can't see people." And there's video conferencing exhaustion as well, but just thinking through, who is it most appropriate for and making sure you have a protocol for it. Identify the eligible billing codes, and there's a great resource for that that folks in New York State have developed. So you can just really follow right along with it and integrate with your software as appropriate like the EHR integration. So taking a little bit of work off the plate if you have things kind of automatically set up in your... if you have a telehealth module in your EHR, if you can manually incorporate those things into your billing protocols, et cetera. Expansion of eligible providers, you got to be thinking about identifying potential new services if you have additional types of providers. And then, what's the workflow look like? Licensing and credentialing of those new providers as appropriate. And then identify any Practice Board specific requirements with respect to that cross-state practice during the Public Health Emergency.



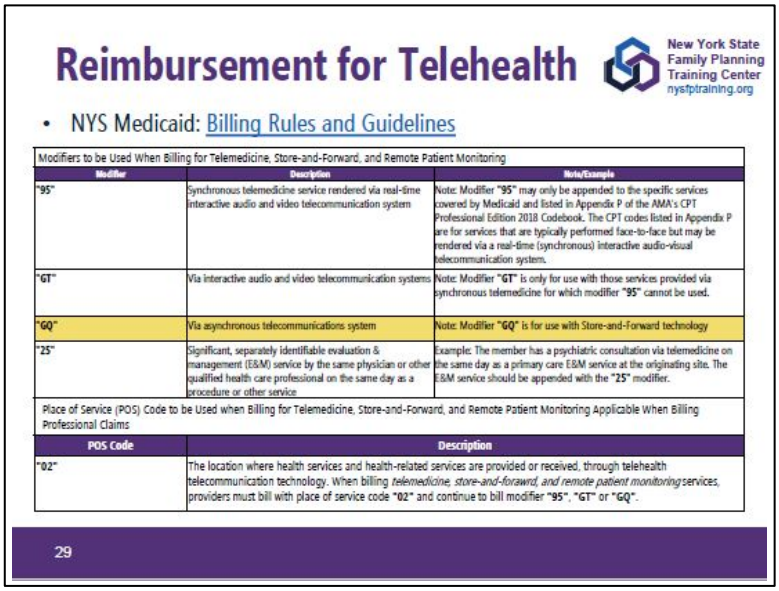
Danielle Louder: With respect to expansion of eligible distant and originating sites, anticipate and proactively address those challenges as we've kind of already covered that with patients and providers being located at home or other locations. If it's not appropriate location, be able and willing to stop the visit and set up another visit. Having that backup plan and have it protocolized. Make sure all of the providers know what to do. Well, I hate to say it, telehealth is not always possible and/or appropriate. And then extension of the Federal Privacy Waivers. Again, harp on this a little bit but highly recommend using a HIPAA compliant solution and signing a Business Associates Agreement with a vendor. That's kind of a red flag if they won't sign one with you. If you're unable to use a HIPAA compliant solution at present, take extra care with security privacy policies and protocols and training and have that backup plan to develop the protocols.

Danielle Louder: So for discussion, what policies and/or procedures do you need to revisit now that you, your team, and your clients are using telehealth? And we had a great discussion of that with the team from PHS.

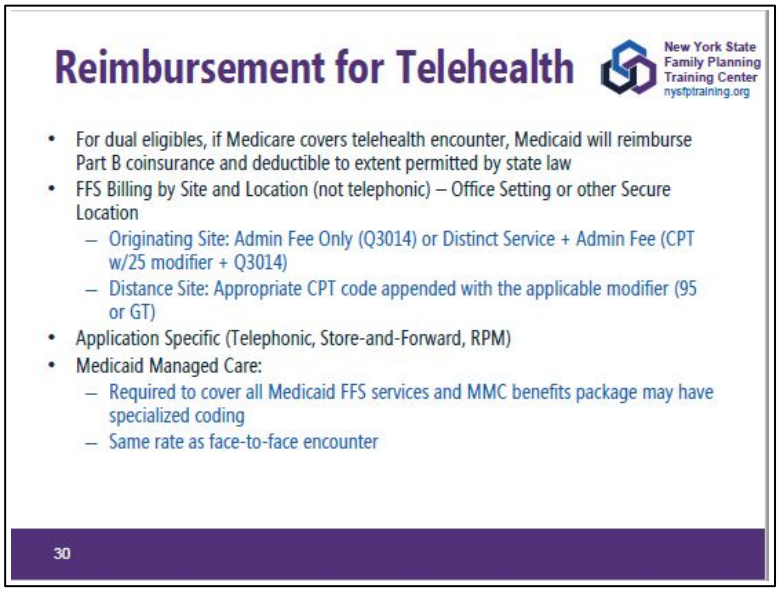
Caitlin Hungate: And please feel free to use the chat to weigh in. And in the interest of time, if we can just keep moving along and we'll just monitor the chat to hear from folks on the call to hear, what policies and procedures do you need to revisit?



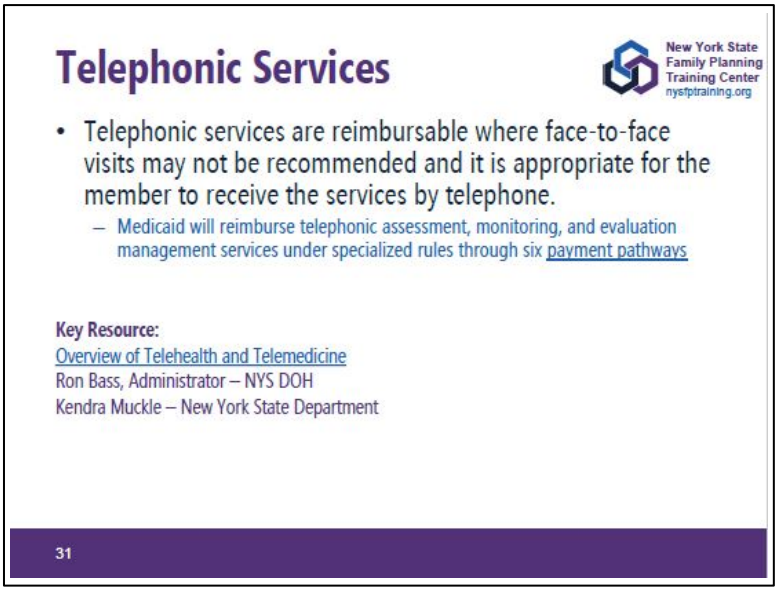
Danielle Louder: Awesome. So these are just some additional. So telehealth parity. Pre-COVID-19, telehealth parity per the Public Health Law or Social Services Law and Insurances, and I think this is what Megan Prokorym was getting to. That there is telehealth parity in the state of New York pre-COVID and we don't anticipate that to change post-COVID certainly. What is now and what may not be permanent, it prohibits insurers from imposing cost-sharing on telehealth during the Public Health Emergency. Guessing that will probably go back to the way it was. It includes audio only and telephonic and video modalities as appropriate. Patients and providers may be located at any site that meets the privacy and confidentiality standards, including the insurance home or the home of the insurance provider. And then the Office of Civil Rights HIPAA flexibilities, again, you still have to take steps to reasonably ensure privacy during all encounters. But harping on that again would make sure you're transitioning toward that HIPAA compliance solution.



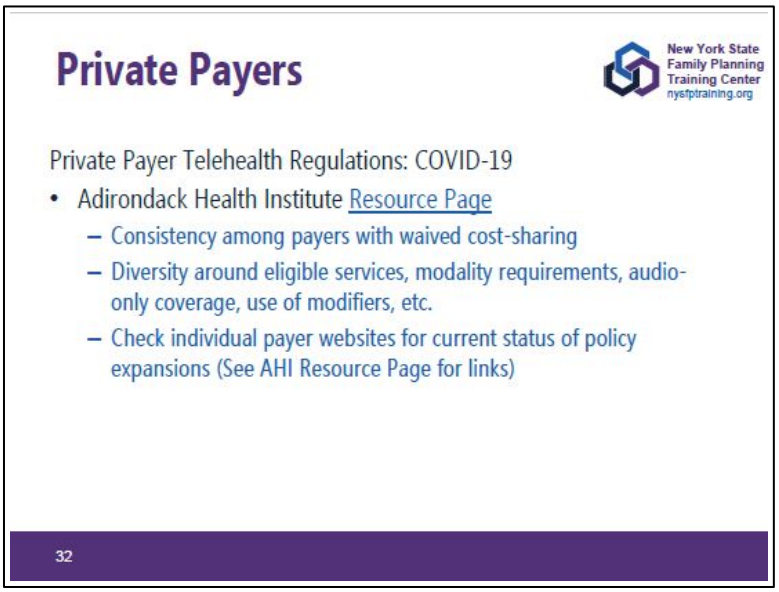
Danielle Louder: Just kind of diving in, and I'm not going to read this table to you because you can read it yourself and you're probably... You have become kind of familiar with this over the past few months but billing rules and guidelines and there's a hyperlink there. But really knowing what the modifiers are that you need to use per the description there for synchronous telemedicine. And then they have some notes here to help guide you through the utilization of that with CPT codes, et cetera. And then knowing the Place of Service Code to be used when billing for telemedicine, store and forward, remote patient monitoring is the 02 Place of Service Code. So, again, I don't think we need to dive into that into too much detail. Call us if you have questions or email us.



Danielle Louder: Reimbursement for telehealth. For dual eligibles, if Medicare covers telehealth encounter, Medicaid will reimburse the Part B coinsurance part of that to the extent permitted by the law. Fee for service billing by site and location, not for telephonic though, the office setting or other secure location. Originating site fees are allowed. That's that Q3014 code. If you're just billing, if you just have the patient there and you're using your technology to help them get services, it's the Q3014. Or if you are also providing a distinct service that day, you can bill for that service plus the admin fee with the modifier in the Q3014 if you are also helping them get services via telemedicine that day as well. And then the distant site, you use the appropriate CPT code appended with the applicable modifier, whether that's 95 or GT. And then application-specific, whether it's telephonic, store and forward, remote patient monitoring. And Medicaid Managed Care, MMCs, are required to cover all Medicaid fee for service services and the MMC benefits package may have specialized coding. So watch out for that. And then the same rate as face-to-face. They cover it at the same rate as face-to-face with that payment parity.

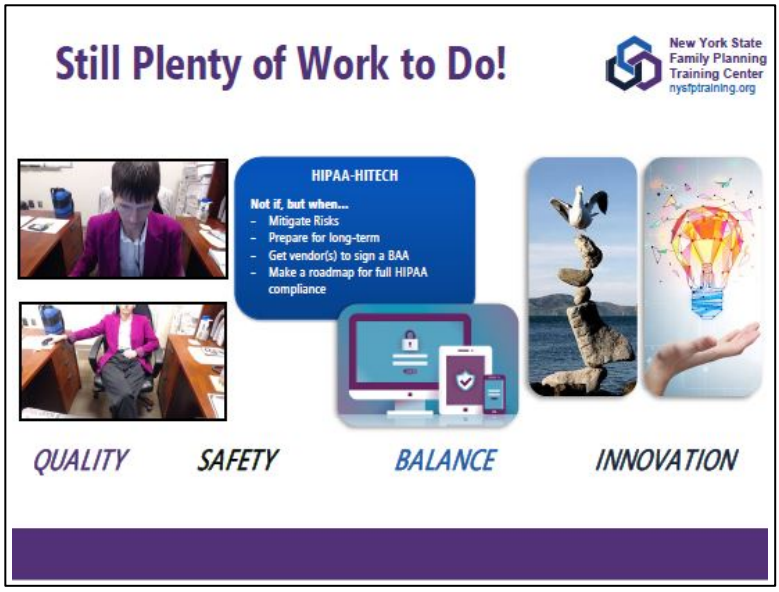


Danielle Louder: Telephonic services, and I just want to call out this great resource. This was a presentation by Ron Bass and Kendra Muckle and there's a link to the recording there. These are that table of the six payment pathways that are specific to telephonic right here. So if you just click on that, then you can access that table.



Danielle Louder: Private payers, they're different. They're all different. So I will just call out that our colleagues at the Adirondack Health Institute have a resource page, and they have been keeping up with the changes as some private payers are starting to pull back on some of the expansion. So you want to be looking at that, or call them up and figure out that there has been consistency among payers with that waived cost-sharing. There's a lot of diversity around eligible services, modality requirements, audio only coverage. So check into that or you can give us a shout and we'll help you check into it. Check individual payer websites for current status of their policy expansions.

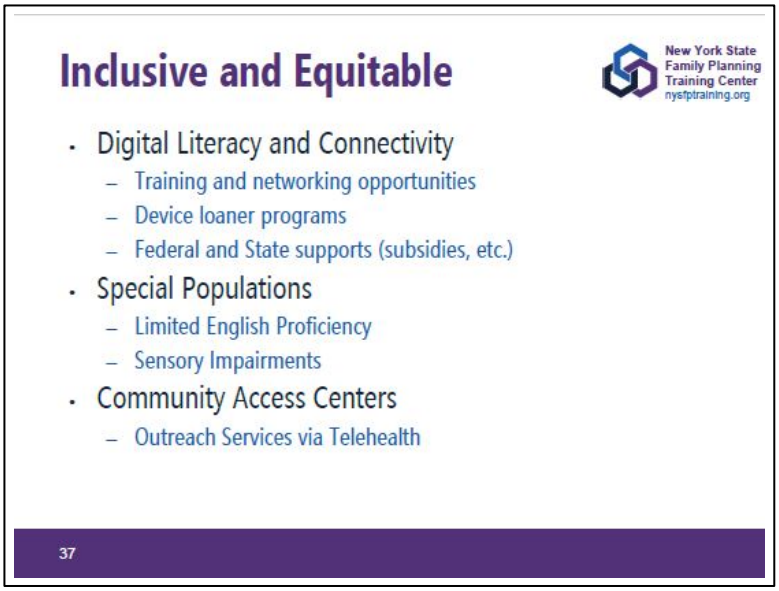
Danielle Louder: Do you want me to kind of blow through this question? So again, if you have challenges, please reach out to us.



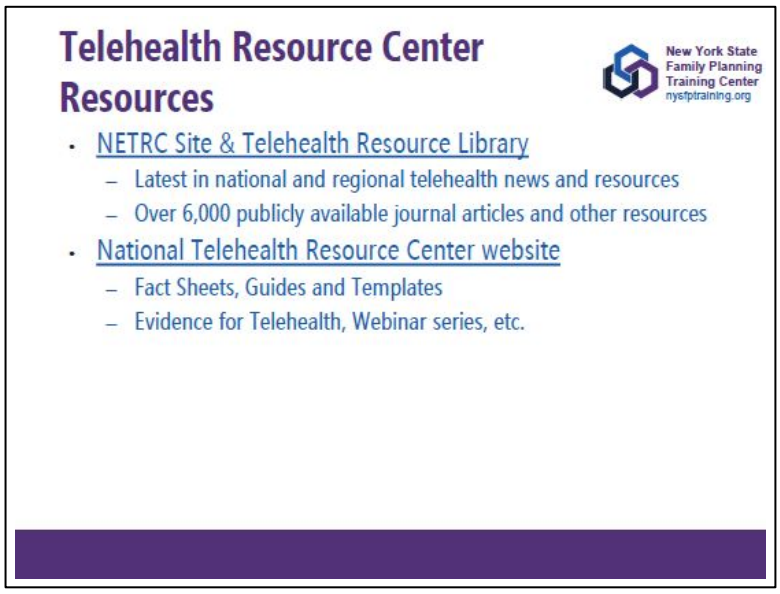
Danielle Louder: Just kind of a reminder, there's still work to be done, and that's what we're here for to help out with. This is our colleague, Elizabeth Krupinski, the pictures of what not to do. I just think those are fun. So just a reminder that we always have improvements that we can be making with respect to our "webside" manner, if you will. HIPAA and HITECH, really start thinking on that if you're in a spot that you've been using a non-HIPAA compliant solution. And then innovation, kind of thinking, balancing it, going back to the office. Whether it's doing block scheduling so you're not driving your providers crazy. And what just works efficiency wise within your setting to get patient preference. Whether they want to be seen via telehealth, telemedicine, or they don't. So kind of balancing all that. And then innovation, thinking outside the box.

Danielle Louder: These are just a cadre of articles, and there are many, many more than I thought I'd pulled together, but there are hyperlinks here if you'd like to dig into any of these in a little bit more detail. The proposed 2021 Physician Fee Schedule is out. It's already been through the public comment phase. But it does extend permanently several of the policy expansions, the ones that can be addressed via regulatory. So it's got some of the additional services, eligible services, et cetera, that will be continued beyond. And it actually gets into the audio only as well, but encourage you to check that out if you have a chance.

Danielle Louder: Tips and strategies, and there were several great ones mentioned in the previous session. But securing that leadership support for sustainability and growth. Know your data, show the return on investment and how additional needs can be met via telehealth. Say you start small and you want to grow. Whether it's different use cases or to a larger population, make sure you have data to back that up because you might need funds to purchase additional equipment, et cetera. Focus your time, effort, and money on program development and a sustainable business model. And we have templates for that if folks are interested. Choosing technology that meets stakeholder needs and fits the budget. Simple is usually better. All kinds of bells and whistles are not usually the right answer. Providers have EHRs to deal with and all these other things. And so if you can keep it simple, that's the best for both patients and providers. Integration is key. We talked a little bit about that earlier, the organizational strategic plan. It's not just like a one-off. It's got to really be thought about from the strategic organizational perspective. And then day-to-day operations. Making an expectation and building it into new employee orientation and enrolled skills and all of those different things. Address issues quickly and communicate successes and challenges both internally and externally as appropriate. Advocate for policy change that helps you and your program grow. If there's a big barrier sitting there in front of you in reimbursement or whatever, if you can't carry the water or advocate for policy change, there are people who can. So I would encourage you to connect with them and move forward.



Danielle Louder: Inclusive and equitable, we talked about this. Just some resources around digital literacy and connectivity, training and networking opportunities. There are device loaner programs and some of those are state-specific. But TeleHealth for Seniors is a great website and I should have put it on here. But you can write that down, TeleHealth for Seniors, they're new and they do device lending. And then federal and state supports. The FCC had a huge grant opportunity, $200 million, a lot of that went to New York State because it was really for hotspots to purchase equipment. And they also have the lifeline program, which is for devices and subsidies for consumers who are low income. And so that's another great resource that I would highly recommend you check into. Special populations, if they need interpretive services, there are many options out there. Some folks say, "Well, we can have a family member do the interpretation." And while many families might feel comfortable with that, it can be inappropriate at times. Family planning services should be thinking about the privacy there or if there may potentially be domestic violence issues and they would be afraid to share all the information that they need to now. So just thinking through those types of things. Sensory impairments, whether deaf and hard of hearing, there are resources out there to make sure that the telehealth services can be provided at the same quality of care. Community access centers, outreach services via telehealth. Again, doing some of those social determinants of health tech screenings and helping to address some of those. And ensuring those services are provided via telehealth.



Danielle Louder: I think we are ready to transfer back to Meg. These are just some live resources, guys, but I don't need to go through them in detail. It's more just so that you know that they're there so that you're not having to recreate any wheels.

Danielle Louder: We had a virtual conference this June and there are, gosh, I think 30 different presentations. But I did want to call out our colleagues, Leah Coplon and Terri-Ann Thompson did a specific presentation on reproductive healthcare and findings from a network of clinics in Maine. You can access all of that for free. You just have to click on this link and do a quick registration.

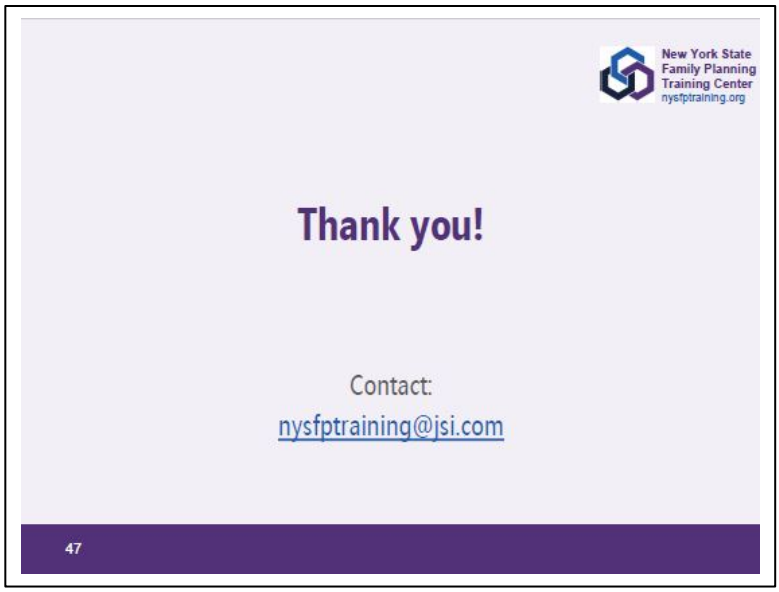
Danielle Louder: Additional policy and reimbursement.

Danielle Louder: Patient and client resources, again, so you don't have to recreate wheels.Specific family planning resources. And then I'm going to go ahead and turn it over to Meg.

Meg Sheahan: Thank you. Okay. So I would like if possible to just back up to the previous slide because I'd like to highlight... Yes, thank you. The Family Planning National Training Center offers some great resources, including a toolkit that offers suggestions to help family planning providers continue to meet clients' needs while keeping themselves and their clients safe during COVID-19. And a telehealth etiquette job aid that can help agencies provide a positive client experience when conducting telehealth visits because they're very useful.

Meg Sheahan: The New York State Family Planning Training Center offers a webinar on family planning billing for telehealth during COVID-19. I was having a little trouble with this link earlier this morning. So just in case, we'll post the link in the chat, but telehealth training... Sorry, the Training Center also offers technical assistance. The second link here will take you to a form that the training center will use to connect organizations with free technical assistance in adapting coding and billing practices to telehealth services. The Training Center will support up to seven TA engagements and applications will be accepted on a first come first serve basis. But this is important, people. The deadline to apply is tomorrow, Friday October 23rd. So definitely check that out if you are interested.

Meg Sheahan: Please join us for our upcoming session on November 18th from 10:30 AM until noon. The focus of this session is safely providing in-person services with a strong focus on innovations in family planning. Our December session will focus on collective trauma and moral distress. We will soon finalize the date and time and we'll make that information available as soon as possible.



Meg Sheahan: And finally, thank you all so much for joining us today. A very heartfelt thank you to Sarah, Renee, and Daniel from Public Health Solutions, and to Danielle from the Northeast Telehealth Resource Center who put a lot of work into making this session so rich. There is so much to it. An hour and a half is just not enough. Thank you. We hope to see you all for our upcoming session in November. Until then, stay safe. Thank you for your important work. We appreciate you.