Caitlin Hungate: (silence)

Hi, everyone. Thank you for joining. I know that there's going to be a few more folks trickling into our office hour event today and welcome. My name is Caitlin Hungate and I'm with the New York State Family Planning Training Center, she/her pronouns, and we'll keep letting folks in. So we'll just get going and we'll have plenty of time for Q&A. I am so honored to be with you all on this lunch hour, and a few housekeeping items before we begin. The event today is being recorded and will be posted on our website in the next few days, along with the slides from today's event. Everyone, you'll be on mute for now, but after our office hour experts provide some information and content, we'll have the rest of the hour with lots of questions. So you'll be invited to unmute yourself and join to the audio or use the chat to ask your questions. Whatever is best for you in our time together today.

I am joined by my colleague, Becky Milner at the training center as well. Becky, thank you so much for being with us and providing a tech support today. And we encourage you to participate as you are able today and we welcome your participation. So the next slide has our learning objectives for our time to get today. And we can just skip over these as you'll have this in the archive. The next slide is just more about our training center team. So our Project Director Katie Quimby, Chanel Richmond, myself, and Becky, we're so honored to continue to support you and the family planning providers across the state. And I'd love to turn it over to our office, our experts today, Emma and Danielle, to introduce themselves. And then Emma, to just give us some brief context and understanding around scheduling before we address some Q&A. Emma, I'll turn it to you.

Emma Ansara: Thanks so much. Hi, happy lunch break. My name is Emma Ansara, and I'm a family nurse practitioner by training, and I currently work at JSI as a clinical consultant. So supporting family planning folks, but also community health centers and thinking about telehealth, obviously, also behavioral health integration, thinking about integrating data and quality improvement and also thinking about equity and accessibility. So I'm really looking forward to our conversation and I'm really pleased to be collaborating with Danielle because we get to pop up on these opportunities sometimes together. Danielle, do you want to introduce yourself?

Danielle Louder: Yes. Thanks, Emma. Thanks, Caitlin and Becky, and everybody for being here with us today. I'm Danielle Louder and I serve as the director of the HRSA funded Northeast Telehealth Resource Center. We've been providing technical assistance and resources and training, evaluation, et cetera around telehealth for about a decade now. We're based out of a public health institute called Medical Care Development. We're based out of Maine, but we work all over the country and I also serve as co-director of our US-based programs for that. So excited to talk about this particular focus area and really dig into the weeds

depending on what kinds of questions folks have and look forward to the discussion as well. Thanks.

Emma Ansara: All right. Next slide, Becky. First of all, so I think I have about, I don't know, eight slides or so, but really the bulk of this office hours were really intending to be conversational. Certainly, were Danielle and Caitlin and Becky and I are available to answer questions, but really actually also brainstorming and learning from each other is really always the intent of office hours. But I did just want to start out by talking about why scheduling within the clinical environment is a complex operational process. It's really a site at which there's a lot of different decision making that's coming together. So absolutely making decisions that are related to clinical decision making triage, thinking about urgency, acuity. We have to also take into account patient needs and their comfort with different modalities with their schedule, with their time, with access, with... And we'll talk a little bit more about access.

It's certainly a time of thinking about what organizational resources are available, and fictional world we would be able to be endlessly available to our patients at the times and places and ways in which they needed us to be. But the truth is we're operating within a structure and constraints. So whether that's staffing, whether that's rooms, whether that's licenses for technology that we're operating under some real world constraints. It's also a time where people and process meet technology. So whether that thinking about scheduling through your health IT and how that works. And then as I mentioned before, I started taking into a consideration kind of available physical and virtual structures. There's also a really significant role that culture plays and I was on a call with someone yesterday who said culture eats strategy. So I think that always thinking about the ways in which how have we typically done things, what are the things that really matter to us? All of those things can influence scheduling as well. Next slide.

So just, I tried to break down elements of scheduling process and think about them particularly within the telehealth frame. So when we think about triage, we're making these decisions about what kind of a visit does patient need. So that's a consideration that's based on people's clinical complaints and also what are their exam, expectations of physical exams? Are there particular diagnostics? Those things will inform whether or not this can be a virtual or in person visit, whether it could be phone only or video. And so they're often tends to be the starting to split and think about what are visits that can, and can't be done as a telehealth visit.

As I mentioned in the previous slide, we also want to take into consideration patient's needs. And so some of that is about when would they prefer to be seen and does that time and that availability line up with your organization schedule, but a whole nother part when you're thinking about telehealth is thinking about digital access. So, right, we need to think about, are people connected? Do they have the broadband capabilities that are needed for a

virtual encounter, meaning a video encounter? Do they have the software? Are we engaging virtually in all of that pre-visit work in a language that is preferable for them?

There's also things about just individual's comfort and preference, given that complaint, given that moment. There's lovely resources and increasingly more and more resources, and we're going to show share them out about thinking about doing this on a systematic basis. So thinking about just in the way that when you do demographics annually for when you're doing demographics annually for patients that maybe that's a time where you routinely assess patients digital access needs, comfort preferences, but there's also a way that in that day of, in that particular moment for that particular complaint, the reason that folks called in, you also need to do a real-time assessment of what people's access, whether they're opportunities or barriers that they have around access. Next slide.

And then these are considerations that are absolutely true for when you're scheduling in person visits, but also for virtual. So just thinking about the structure of the schedule overall, how long does a patient need to be seen, when should this appointment, this virtual encounter be scheduled in the session or in the day. And then [inaudible 00:09:32] the staff that is comfortable, familiar, and wanting to engage with patients in this virtual or telephonic encounter? I'm going to spend a little less time, but I feel like I would be leaving a big gap if I didn't also mention that traditionally many sites, the folks that are involved with scheduling can also be involved with check-in, check-out and initiating the process that leads to rooming. And so even though those are in my operational workflow minds, separate elements of a telehealth encounter, they do integrate and intersect with scheduling.

So I just want to note that some of the decisions that are made at scheduling have implications, or sometimes the folks that are scheduling are also doing this check-in, check-out process. So I've included a little bit less about that, but I did just want it include that as part of a related workflow. Next slide. So we were just talking about this a little bit before the office hours, but what I tried to do on this slide, at the end, we have a very comprehensive and long list of resources, but I tried to do on this slide is offer very specific resources within some of the topics that I've mentioned so far. One of the things that we have observed is that generally there are less resources within the telehealth world that are particular to family planning providers.

Please, we do not think that it should be that way, but we want to acknowledge that. And so I think there's a lot of space to consider developing your own. And so what I've really tried to offer on this slide is specific resources that you might be able to tailor. So in this first bucket, this talking about triage. One example is from a kind of older arc resource that was a pediatric clinic that came up with a triage, just very basic tool to think about how to decide whether you should schedule something based on patient or family complaint or concern. Whether

you should schedule that in person or not. Danielle just shared with us this really terrific telehealth scheduling guide from CCI. It is for a primary care setting. However, these page numbers refer to specific guidelines that are much more related to family planning. And so that link is here as well.

So the example would be someone calls in and they're interested in starting birth control. And then this is like a very easy, relatively simple to read assessment of like, does this person need to be seen in person or not, and how you would make that decision? So that's just an example, vaginitis, well-woman care, and those are the page numbers that correspond. And then that last page is just a generic one that you could use. In terms of thinking about assessing patient needs and patient preferences, this first resource is a document from High Tech. And we'll talk a little bit about that later, the High Tech Center that is just helped you to think about accessing patient digital accessibility needs on a routine basis.

The next resources is I think, and anyways, it's again at the end, I just like to give credit and I'm having a brain fart, but this one is about specifically how to integrate interpreters into best practices for integrating interpreters into visit flows. The next is a general resource talking about how do we think about offering a virtual care or telehealth care to folks for whom English is not their first language. The next resource is from the American Academy of Family practice, really thinking about how to schedule days overall. So do we have a telehealth morning? Do we have, at the end of the session, laying out some different common options?

And then this last is a resource that you can tailor for your own use. That would be something that was sent to patients in advance of their visit that's prompting or giving guidelines about how to check in for their telehealth visit. So again you may not need to engage with all of these at the same time, but if you're feeling like there's a glitchy part of your scheduling process, I'm hopeful that maybe one of these could support you in working forward. Okay. Next slide.

And then in general, there's sort of a... When we were trying to get a sense of what people were interested in talking about and your questions that came in via registration is that both Danielle and I were talking about, if you think about the... Anyway, Danielle and I were talking before the session, but if we think about the fact that scheduling is this site of complexity, as I described in the beginning, we both advocate doing some workflow mapping, these are two different examples. And then Danielle shared another really terrific example from a California Telehealth Resource Center, but really thinking about whether it's taking paper to pencil, whether it's getting on PowerPoint, whether it's using a more sophisticated electronic support is just sketching out this process because it will help you think about here's scheduling, but what are things that are upstream that I need to consider? What are things that are downstream?

I'm a big advocate of thinking about workflow mapping based on both type of decision and site, but also thinking about depending upon what your role, how does this workflow impact the folks, the patient service representatives or the schedulers, how does it impact medical assistance or the rooming stuff? How does it affect the clinicians, the behavioral health providers, what are the health IT consequences and having differing lines. So the example that Danielle just chatted out is a little bit more specific about that. And then this second one, Danielle and I were saying is just nice, even though it does not follow the lines that I just described, it's just a very comprehensive and nice roadmap for a telehealth workflow.

Again, you look at these, they're way complicated. Maybe there's just one part that you want to focus on, but this can help you think about this as an integrated... These are workflows that integrate with other workflows. I think that is my talking at you section, and I think we're really interested in inviting conversations, seeing where you all want to take this. So I think we're going to go to the next slide and I'm going to pass it back to Caitlin who's just going to help to facilitate the question and answer, but I really look forward to continuing our conversation.

Caitlin Hungate: Thanks, Emma, so much for that information and context around scheduling. So this is the rest of the hour with you all in conversation, and we invite you, if you're able to come on camera, feel free to unmute your line as you're able. You're also able to... If you're unable to use your audio, please feel free to use the chat. We do have the questions that folks submitted in the registration, as well as other scheduling questions that have come up, but we first would love to center you and give you an opportunity since you were here with us to jump in and ask your questions of Emma, Danielle, the training center, just feel free to just unmute your line. And we welcome hearing from you at this time.

Danielle Louder: Caitlin, since we have a pretty small comfy group here, would it be okay if we just had everybody do at least tell us where they're from? I'm really interested to learn.

Caitlin Hungate: Absolutely, Danielle. That's a wonderful idea. And we can also, while people are thinking about questions, maybe I propose, I offer one of the questions that came through the registration just to give folks time to think about their questions. This was a question in the registration and I invite both Danielle and Emma to answer how you're able and other agencies to jump in as well. And we'd love to hear how you're doing this. This is a question was around what are some best scheduling flow for telehealth and in clinic visits in the same panel, and how to involve all members of the care team?

Danielle Louder: I think there are definitely some templates and oftentimes we would encourage, and again, we're talking specific use cases if you know one organization and their environment, and actually something that Emma was saying before we started the session here today was I think I'm going to get this right. So culture

eats strategy. And so I think if you know one person, one entity's culture like telehealth policy with the states. But while they're definitely are some very strong templates, and I would say try to link up with folks and we can help with this within telehealth resource center link up with folks who have successfully created strong workflows for scheduling, for example, and to make sure that you're utilizing or leveraging the skill sets of every team member in that for efficiencies, productivity. So nobody's duplicating efforts, et cetera. And everybody knows who's on first is really important.

And those are some of our most helpful technical assistance causes that we link you up with somebody who's done it, and they've made the mistakes and they've learned from them, and now they have, either a pretty graphical document, or maybe it's not so pretty, but it works for them and their culture and their environment in particular. I guess that's what I would say. Emma had noted that some folks because of the flow and because of the providers that they have, the team that they have, they tend to block things. Maybe mornings are telehealth, and that works for them. We've heard from some that they've been successful, particularly over these past couple years with COVID in alternating, they can go on the fly, but usually it's, they have one room that's committed to telehealth because then you're not having to move carts around.

And it's the technology doesn't have to get moved because we know things happen when technology has to get moved from room to room. So things like that in your workflow, but from a scheduling perspective, who's on first being proactive about figuring out who is appropriate for telehealth visits and maintaining knowledge on that. And if they have specific issues, whether it's connectivity or devices or just maybe they have what they need, but they're not all that sure how to use it. Maybe they don't know that they need an email to receive Zoom invites. So sometimes you have to go back to square one and who's responsible on your team for both identifying that information and to then troubleshoot with that, those patients or clients ahead of time, so that everybody's ready for the visit and it's successful and people aren't left frustrated. Emma, I don't know what you would add to that, but...

Emma Ansara: Yeah. What I was going to say is I think that the reality for so many folks within this telehealth space is that you're building the plane as you're flying it. And so some of it is I think you... Well, I don't know, but I think there's tremendous skill and creativity within the family planning realm. And so part of it is saying like, is the way that we're doing it, like the best way, because it feels really scrambly? So I would just say that in addition to what Danielle is talking about, which is thinking about how do you schedule days? And I did just link out this, I think this page 34 of this AAFP has just a nice graphic about time blocks, full days that are devoted to telehealth on-call scheduling and then open scheduling and some trade offs about each of those choices.

The other thing that we're starting to see, like the other staffing consideration that we're starting to see is two relatively new roles like Danielle probably

would be like, old hat, new to me, relatively new to me. So one is this idea of a telehealth coordinator. And so that is a person in depending upon the volume of telehealth that your organization is providing. I'm not necessarily suggesting that this is a new FTE that it's even an entire FTE or that it's new staff, it may be a reassignment for folks, but someone whose task is to really think about developing these workflows, testing out these workflows, communicating across different groups of staff. And really, we see that. So there's research that was done with community health centers in California, by the RAND incorporation. And this was the takeaway if you want telehealth to come and stick and you want it to be financially sustainable, that was really thinking about identifying a singular individual who is moving this forward.

So telehealth coordinator, the other thing that we're hearing a lot about is a telehealth navigator, which is much in the way that understanding that accessibility, which traditionally, when we talk about navigators has been around folks who are going to navigate insurance or pharmacy benefits or whatever that, or other kind of financial accessibility, but understanding that having a staff that is really committed to facilitating folks engagement virtually makes a huge difference. Makes a huge difference in, do people show up? Is it a successful encounter? And then do they feel committed to continuing to use and engage with their providers or their healthcare team virtually? And there's really interesting work out of there's a partnership with a foundation and a accountable care organization in Massachusetts. That's really doing some nice work.

So these are new roles, but I do want to say, I don't think that this is necessarily increasing to new staff. I mean, maybe if virtual care becomes results in a ramping up of your, or expansion of your services that may happen. But I think these are two new roles to think about as... And again, as Danielle's saying, you want to make this be a part of where you are and make this fit within your overall environment. But so those are just two things to chew. I mean, the sort of where we're seeing stuff coalescing, as we're all building these airplanes that we're flying. Any other questions?

Sarah Blust: Hi, everyone. This is Sarah Blust. Nice to see everybody. I think that was my question, possibly Caitlin, that was posed. And I'm joined here by my colleague, Renee Finley, we... And sorry, I have a little bit of a cold, but it's not COVID. I just have a cold. Two negative tests. So we're in New York City in Brooklyn. We manage the Public Health Solutions, sexual and reproductive health centers. And I think we've gotten of our flow down a bit, but it is still unpredictable sometimes and people... I mean, I think Renee can speak to this more than I, but we do try and have in the same morning or afternoon session televisits and in clinic visits and depending on how late someone is maybe to an in clinic that can impact the ability of the provider to be on time for the televisit.

And so it's just this day-to-day negotiation of folks coming in and then having it either it does work well or sometimes, you really can be stuck. And then you're

having folks wait for a long time to get into their televisit appointment. And your patience is really different when you are online. So if you're not there in like one or two minutes, probably people are going to be checking out and leaving. So the window of the room for error is a lot less, I think, when it comes to televisits or lateness. And so that's just something that we have been grappling with and it would be really nice to see... I was looking at the resources. Thank you very much. Those are really helpful.

I'm wondering if there are also just like screenshots of EHR panels where you can see how the visits, the actual visits that are scheduled and the actual in clinic versus televisits and what time. Those are put into the template, because we're constantly thinking, "Should we have televisits only in the top of the morning, the top of the afternoon? Should we do televisits at the end of the morning, the end of the afternoon?" We're just trying to figure out what is the ideal flow with that, given the fact that we're not just doing blocks, one, a televisit only morning or a televisit only afternoon. We are trying to do both in one time, because I think, again, Renee jumped in, but I think when we did that before, our providers were not as productive because people weren't showing up and then maybe there's someone coming in and so you just have to be responsive to what's going on.

So my other question was about the time, the length of time. We've been hearing from other kinds of... We've been getting some expertise from other folks out there and we've been hearing things like a visit as a visit is a visit where it's like, if you have a 20 minute televisit, you have a 20 minute in clinic visit. Are people syncing up their televisits and their in clinic visits? Are you considering those to be the same timeframe or are you thinking of those differently? So those are my questions. Thanks.

Danielle Louder: I think... Thanks, Sarah. Those are great questions. And I think to-

Sarah Blust: [crosstalk 00:29:31].

Danielle Louder: ... to that last question we've spent a lot of time and there's been a lot of discussion, particularly over the last couple of years about ensuring that a telehealth visit is of the same quality and standard of care. And I think the more we sync that up with in-person, whether it's the time expectations, that that's important to continue to see permanent policy expansions, for example, with at the federal level, there's over a hundred bills that Congress is looking at right now. For example, with talking about permanent expansions of telehealth that have just really blown the door wide open with respect to broad utilization during the COVID pandemic. And those things weren't necessarily allowed before. So like you're in a very urban area and in for Medicare that was not allowed for telehealth in the past because you had to be in a rural geographic area.

So I think the more we can sync up from a standard of care, obviously if there could be a piece cut out and you could still provide the same level of care and meet, check off all of the things from that visit that must be done in a shorter period for whatever reason, then that would be okay, but it... And then billing and I know family planning is a little bit like, but primary care, for example, we have lots of folks who work on, it gets to that like the no-show thing, even whether it's tele or in-person, it puts many different pressures on everybody throughout the day because it just discombobulates everything. But is there a way that you could do a plan B for either a billable service or a non-billable service?

Like we've had FQHCs that say, okay, we had a no-show in this time slot, so we're going to do, we're going to call a patient and do a screening that's billable so that your still able to be productive during that time. So we've had people work that kind of thing into their workflow as well. It's not always going to be possible, so you're not always going to catch somebody, but if you have a triage system of calling some patients that have a screening that needs to be done and that you can bill for that all the better, but... Emma, I don't know what you want to add to that.

Emma Ansara: Sarah, just, and Renee as well. I love these questions are like totally in the weeds. And I think to just be... Danielle was like appropriately thinking about this at this level. And I'm going to say, I think that telehealth visits, because they do not include [inaudible 00:32:02] physical exams and they don't include bad visits are shorter. However, the slots in which people are scheduling are still those, I don't know what your increment, 15, 20 minutes is the same because we understand that there has to be this time that we are getting people onto whatever platform that you're using. And so if we think about the visit, it used to be that...

I think the other thing, and I so appreciated this kind of observation, which is when we're in person because of our social skills and we have a little bit more flexibility that we can accordion, you know what I mean? Like I didn't want to keep anybody in the waiting room that long. So sometimes we'd room them, sometimes like if you'd want to keep them moving along, even if I was running behind, you're working with your staff to be like, we're still attending to you, and you're giving updates as you're right. Dead space on a virtual visit doesn't work. And so I do think that there's people... This question about time also builds in a little buffer for that to it's like you can't accordion through these other movements like you did in physical space. And so you have to buffer it a little bit.

So I think it ends up being the same size chunks, but that time is used in a portion differently. And that does have consequences for billing. I also think that we're... I mean, we can't in this moment, not talk about this, but the way that we are delivering telehealth at the height of the pandemic and we learned a ton through that process is actually probably not... I mean, there's lots to take

forward, but that's actually a different model and that we are seeing people and I really feel pushed and pulled into directions. I think there's tremendous opportunity around centering patience, access preferences, our responsiveness, like with these modalities. On the other hand, I appreciate that just from we're all in a marathon here and we need to support workflows that keep us sane.

And I do see people moving to... And I, again, whatever this process is, how it's going to be look at your site as different and financially, but I see people moving to a morning session of telehealth, and doing exactly what Danielle's thinking about. So there's like open access scheduling, which is of not related to telehealth, but as some, then there's lots of literature on it. I'm not going to bore you, but this idea that as no-shows appear, and we have these availability and slots in our schedule, we are calling patients. And a lot of this is around systems at your site, but then also education for patients to understand that you may be providing services on a much more day of basis. And so this work that you can do behind, say you're like, okay, I'm going to commit, we're going to commit to a morning session for one clinician to do telehealth, but you realize that you've got to hit your visit targets or your revenue targets, or however you guys talk about them. What are other things that we do in that, in between space to make sure that's used?

And I think trying to as Danielle saying, okay, there is a no no-show virtually, do I have a little list of people that we're working through? I mean, just thinking creatively about that, but... And so there are some lovely models in this open access scheduling. Is that something you guys have heard of? I don't want to... And some sites really like open access, but there is a process of figuring out how to keep all those lists and then working with patients so that they understand what open access means for them. Anyway, but I think that there could be some nice crossover in thinking about how to populate your telehealth schedule.

Sarah Blust: Thank you. I mean, open access, I haven't thought of open access before in terms of telehealth. I think of it's all, I am old school. I think of it completely in person as an-

Emma Ansara: Yeah. And it's not the same, right? But [crosstalk 00:36:24] could we maybe adapt something and thinking about how do we make use of that time? It's this push and pull, so I just throw it out there. It may not stick. I won't... I'll go back to the drawing board and think of something new.

Danielle Louder: Caitlin, I want to say that Evelyn Kieltyka and the Maine Family Planning program, they have some pretty cool stuff with respect to open access and texting, secure messaging, and that kind of stuff. So if you would like to connect with them, I'm sure we can get you linked up, share some of what they've experienced.

Caitlin Hungate: Great minds think alike, Danielle, because as Sarah was asking those questions, I was like, "Ooh! I'm going to ask Evelyn in Maine Family Planning." So Sarah and

we'll circle back with her and her team and maybe follow up with this whole group. So everyone has the benefit of hearing the update. We... And Tamara, I see you're on video. I don't know if you have a question and I welcome you to jump in as well, and I'm sorry if I mispronounced your name. So please jump in.

Tamara: Thank you. It is Tamara.

Caitlin Hungate: Tamara. Sorry about that.

Tamara: I'm from The Door. Hello, good morning, everybody. Nice to virtually see you all. And my question about telehealth. We, since the pandemic, it was new to the site at The Door and we've had it, it be our only source of visits and now be a dual source. But since we transitioned to be in person more days and off back full time since last year, we've seen a decrease in telehealth and we had issue using telehealth with patients. They, "Oh, you're opening. I want to be in person." So now we're trying that morning, afternoon scheduling thing with telehealth with a provider coming from three days a week, all day with one provider, having their own telehealth days to now having half days with different providers' availability in a week.

But struggling with management, like how do we maximize those telehealth slots? The timing for people should deal with technology, it's accounted for in those slots. So we do have a higher provider time with those slots. There are 30 minutes currently and now... Oh, my phone's... Okay. And now, I'm trying to figure out ways to maximize telehealth visits for those half afternoons or morning slots with our young people ages 12 to 24. And what can we do? Should we assessed to see what other visit types are needed in that besides the current offered and go from there? Have you tried to... What are some tips that worked for? Any of your other sites or suggestions you've had to help maximize those afternoons, mornings?

Danielle Louder: Yeah, I mean, I'm coming from a public health organization. It never hurts to do like needs assessments and preferences with your... And now you know, you want to focus on that particular age group. So there may be specific services that if they knew on a regular basis that those would be available to them like right after school, for example, that they would take advantage of that. So I think that would be a great idea. And I think that many sites have, whether they're family planning or not, taking that time to reach out to the end user, if you will, pays dividends, because I feel involved in the decision and then you're like, okay, we said we were interested in these services and that they would hopefully take advantage of them.

Tamara: Thank you.

Emma Ansara: I think also, maybe Tamara, you were hinting at this, but I think pre-visit before pandemic, we were like, oh, right. There's this theory of the pre-visit, what could we be doing in telephone or what could we be doing via... Whatever.

Okay, this is all like leapfrogged forward. But this idea of how can we connect with our clients beforehand and engage them and in helping us to identify. And some of that, I think, especially with adolescents, you may need to be as Danielle suggesting, offering that menu as opposed to with different ages that they may be more likely to come up with that. But whether that's text or other confidential and secure modes of communication, but it may be like, hey, look, here's all the... I think there's like a couple things going on with telehealth, right?

So I said before our experience of telehealth during the pandemic was different. I mean, that was, people need to get care and we're trying to be as remote as possible and we're doing the best that we can. Now, we're in this interesting space, which is how can we be really responsive to what patients or clients need, but also what role is telehealth playing within the services we provide? What do we do really well? What do we actually really need to do in person? And I think there's tremendous opportunity, especially with adolescents to do a lot of the counseling that we did in person. And in fact with adolescents, it may be that a virtual or remote encounter is preferable. That's not true for all of them, but it also may mean that there's certain things that they could get when they came in to see us.

So I always think about that basket of condoms that I had on the desk, but I don't know, but it emptied out every single week. So that's not happening in the virtual encounter, but... And so there may be other things that people were really coming to see me for that we weren't talking about as directly in the encounter. So I think there's like do it... What is the role that telehealth really has both for patients and healthcare teams? Is it additive? What can we do... What does it mean for this population? I think there's also a space in which clinicians and care teams are needing reassurance that they can provide quality services virtually. And so I think it's helpful to be reassuring care teams that this is, as Danielle is talking about, you can provide a high standard and quality of care in a virtual encounter.

And so one of the resources and I'll chat it out, I just can't talk and chat something out at the same time, but UCSF Beyond the Pill actually has just nice encouragement, I think for clinicians to feel comfortable about what they can do in terms of the quality of the care that they're providing. I think there's, you're just like marketing, rethinking the role of these services. And then also this work around providing support for care teams to say, this is worth doing in the ways that we're doing it. So you were like, how do we do it? I'm like, well, you could just pick any of those. I mean, you don't need to do all of those things at the same time, but I think any of those responses, pre-visit, supporting healthcare teams, marketing... And I actually would really encourage you to think about... Because this is we're moving out of the emergency context of the pandemic, but this is such a good time.

I don't know what avenues you have for hearing from clients about what these services are like, but this is a really good time to solicit feedback. You're marketing at the same time you're soliciting feedback, but it really to say like, we're trying this out, did it work for you? What did you like about it? What could we have done differently? What didn't work for you? I don't know what your processes are around that. And that may not be a thing that you can tackle right now, but that may be also something that you can dig into.

Danielle Louder: I know for particularly we talked about this during the learning collaborative that social media for that particular population, obviously you have to be careful with your protocols and what you put out there, but social media is huge, Insta, right? Like how can you leverage that? Anyway, another thought.

Sarah Blust: Are you all seeing some general go-to in terms of timeframe for the televisit? Because I think Tamara was saying 30 minutes. We are at 15. Is there like a gold standard for what your telehealth visit timeframe should be?

Danielle Louder: Yeah. I mean, I guess again, it depends on what you need to achieve during that time. And then Tamara was mentioning, they've built in time for tech issues, which is inevitably like probably less so for the younger population. We shouldn't assume that all of them are tech savvy, but the majority of them are, but building in time for that. And then you're not going to do a physical exam, but are there other components that you have to accommodate for? Because you do, you're adding in maybe an extra step or two with identifying where the patient's at. Like usually, that's part of your protocol. You want to know where they're located. If they're not in your clinic, say they're receiving care from home or some other site, then that's the first thing you ask them, where you located in case there's a crisis issue and da, da, da.

I mean, that doesn't take a lot of time, but it's just those types of little things could add up. So I would feel like if you feel like you could achieve it within the 15 minutes, and that's another opportunity for gathering feedback from your patients and clients too, did you feel like, and that maybe that's part of a global survey that you do, did you feel like you had adequate time? And if not, what would you suggest? Because I'm not sure there is necessarily a gold standard. It's what you feel like you need to achieve in those minutes.

Emma Ansara: I don't know if other people want to chime in just to let Sarah know what you're doing or how you guys have organized your schedules. If not, you're going to hear me talk more. I don't... I mean, I think Sarah, it's still a 15 minute visit, but I think, or, I mean, it's often a 15 minute visit or a 20. It depends, 30, 15, 15, 7. But I think the encounter with the clinician has reduced and there's like three minutes of it is like the pre-orientation and two minutes of it is the trans... Because I just think those transitions, I do think it's getting winnowed a little bit. I do. I've seen people come up with shorter templates if you're just me needing someone to say that.

But I think as Danielle suggesting there's ways that people are extending these encounters, but or maybe it's really a 12 minute visit, but you have a three minute buffer in there because of those timing issues that you brought up before. I do think it's a shorter FaceTime with a clinician. And so that... Anyway, that could have billing consequences, but I think that there's still for patients that actual encounter time is still that 15 to 20. I don't know what, did you have people come five minutes before? Everybody's a little bit different with that, but I think that the engagement time is the same for patients, but it's allotted differently. And so that clinicians scheduling time is getting a little shorter. Because part of when people were there that you were like, oh, can you go down the... I'm going to do this swab or I'm going to draw a lab or I'm going to all these things. I'm going to have yourself swab. There's just things that took up the actual exam room that you were scheduling for at the same time.

Danielle Louder: Yeah. And as part of that like, ooh, which team member is going to do, which part of it, which everybody contributing to the productivity? And so, yeah.

Tamara: I think the experience that I've had at my site with a telehealth encounter time increase or keeping it at 30 minutes was their gap in care. So we haven't seen them for over a year and some of it is still true to this day and they're... This relocated into another state or they're away at school and the gap in care, like we don't know what's been going on for the last two years for this patient. So just to help with the quality, they do more of the history that's done in physicals or annual exams that in some of these telehealth visits to help with that gap in case [crosstalk 00:49:37].

Danielle Louder: And you might be finding... It's probably finding the same in person too, right? Like it's not necessarily unique to telehealth, it's been like, oh my, I just saw my dermatologist for the first time since 2019 [inaudible 00:49:47] I think we're here to spend some extra time with me [inaudible 00:49:50]. Anyway.

Emma Ansara: Tamara, that's a great. There's been this tremendous deferment in care and it's really sobering to think about how many additional people will die related to cervical cancer or breast cancer. So I think it's a really lovely way of saying like, ah, maybe we'll schedule for the same and we'll use this time differently.

Sarah Blust: I'll keep asking questions if no one else.

Caitlin Hungate: Please do. This is the time for you.

Sarah Blust: I know there are other folks on the phone. So I mean, but one thing that I've been wondering about, and maybe this is related to the type of telehealth platform we use, but the medical assistance and the role of medical assistance within the televisit, because I don't really know for us what it is. We don't really have a clear role for our medical assistants in the televisit workflow. So certainly, I think with our providers, that's very clear. I mean, they really are leading that visit. It's really mostly them. They also do engage the LPNs, like

during the visit to support whatever it needs doing. But our medical assistants are kind of, for us, they're not really involved at all in the televisit.

And I have heard, I think it was Maine Family Planning talking about how is like a waiting room aspect with the app that they use. So therefore like a medical assistant, they can be seen or help before the patient gets to the provider in the televisit. We don't really have that as part of our capability, as far as I understand. I'm just wondering if other folks typically are utilizing medical assistance within the context of the televisit? How can we make sure that they're being used efficiently and productively to support telehealth?

Emma Ansara: Again, are there other folks that want to chime in?

Caitlin Hungate: And in case you didn't see it in the chat, Emma, Pascale had the same question about health educators. So I wonder, are there any other roles that... And Pascale, we invite you to, if you're able to unmute, feel free to add more context for some of these staffing positions that maybe we haven't figured out a role for in a televisit.

Pascale: Hi, it's literally just the same question of MA is being integrated for us, all of our family planning patients see the health educator and before they see the provider. So being able to integrate that, to reduce the time that the provider necessarily has to be there because of the fact that we're having a difficult time integrating telehealth. And I think this was mentioned earlier, just like in our schedule, because they're seeing in-person patients now heavily. So if we could reduce that 30 minutes where the health educator can maybe see them.

Emma Ansara: Are there other folks that want to add to this incredibly, timely, and appropriate question? So here's some stuff I'm just going to throw at you and then Danielle, absolutely chime in with her, with them. But so one is that a lot of teams have really... So I often talk about air traffic control. I'm sure Danielle has a more appropriate term, but I think that we saw and see a lot of healthcare teams utilizing additional software. So Microsoft Teams being probably the most common to really think about how these differing folks need to engage. I spent a tremendous amount of time thinking about integration of behavioral health services in primary care. And then part of my job was to think about that in a tele environment. So I would say that there has to be tremendous intentionality about it.

And we often see because even if someone's being seen virtually, they could still benefit from the work that the health educator was doing. And without of getting into the details, I don't know exactly what the MAs were doing as opposed to LPNs, but those things don't disappear or go away within the virtual environment. I think the challenging thing is how do we do air traffic control? How do we have differing folks come into this space? And so I talked at the beginning about a telehealth coordinator, but this is another thing that we see within complex healthcare teams is someone who's, so is either technology that

helps and facilitates people saying in a confidential way, hey, I'm going in to see patient or client A or, and I'm done and I'm going to pass the baton to Danielle who's now going to have the clinical encounter.

So thinking about Microsoft Teams, thinking about that being, how do people have visibility to their colleagues' schedules but often having a person who is actually has the 30,000 foot view on the schedules and patients and everybody going, it's air traffic control. I don't know what else to call it. That's a really helpful thing. And then I do think it's also... So I'll just say that. And then I think the other thing is how do... It becomes to me about like, how do we deploy this, but it may be how do we can see differently of the MA's role or the health educator's role. And so then I get back to that idea of telehealth navigators, which is really it can be at the same time as the visit or separate from that visit, but how are we supporting clients really maximally, engaging with the technology and really understanding that that benefits tremendously from facilitation? And so are there ways that these folks may be tapped in this context? I don't know what other thoughts do you all or Danielle have, and then just be mindful time.

Danielle Louder: Practice my echo, pause, see if others have some thoughts on that. I like the air traffic control analogy. Makes sense. Yeah. No, I think that seems to make a lot of sense in what you're saying, you might, Emma saying changing up the order of things, if that makes sense, based on everything else that you've got going on in your workflow, whether the education happens after the visit, or maybe the MA is reaching out pre-visit and doing some screenings, if they need to be done, or I don't think MAs can do things incident to a provider, that would be more of a nurse type role. But just identifying, I would be really curious in your current workflow, exactly what do your MAs do and how would we think about how that might be, some of that might be transitioned to the tele version of it.

Emma Ansara: It also may be that the MAs are now doing some of that behind the work to manage schedules. Like if we're talking about these concepts around the open access, right? I mean, it is a, I think skillset and confidence, but a reconception of what you can and could do and how to maximally support patients in the environment. And that may take that like drawing back and reflecting and then moving forward to implement it.

Caitlin Hungate: And I am sorry to jump in with final remarks, but we are near the end of the hour and there's a few must attend announcements that I think hopefully many of you will be excited about. The first thing is we will be continuing to have these office hour events. And so we invite you to think about, and then use the chat to let us know what other topics would be helpful and supportive for you in this work. So think about where other details around scheduling or workflow, provider buy-in, what other topics are supportive of you. Please feel free to use the chat in these next few minutes to think about what other topics would be supportive of you in thinking about telehealth in the long term as Emma and

Danielle talked about being beyond the emergence of the pandemic, beyond that emergency.

If you haven't already please subscribe and catch up on our past e-news and I'm going to put that link in the chat now. Another exciting announcement is that the training center is excited to be launching up to 10 technical assistant engagement opportunities to support family planning providers with their plans to implement, improve, dig into these quality improvement topics around telehealth and unlike trainings, which are offered for a broader audience, as some of you have engaged in our past TA initiatives know, it's tailored to support your agency and really dig in to some of the questions that maybe you asked today, but go even further into the detail else to address a challenge or particular need. And so if you're interested or your agency is interested in receiving telehealth TA, we'll put in a Google Form that you can complete, and it will be promoted in an upcoming e-news as well. So you'll be able to see that and register for TA in the upcoming e-newsletter. And we just ask that you complete this by June 10th.

Thank you for joining us today. I hope you'll join us in thanking Emma and Danielle. Thank you for your active participation and coming with your questions and challenges, and really to dig into scheduling issue. As a reminder, we will have the materials from today's hour together the next few days. So keep an eye on our website to get that PowerPoint, the slides and all of the resources. I skipped over the resource slide, which will be hyperlinked and you'll see in the archive, and you should have the slides already and we'll share them out afterwards. So you'll see those resources that Emma shared, some scholarship and publications that are referenced in the presentation as well. And our final ask in the last minute is to complete a brief evaluation of today's webinar. We really appreciate and welcome your feedback and use your feedback to improve our upcoming events. And we really appreciate your time and completing an evaluation. So please do take a minute to complete our evaluation, and thank you for joining us today. And this concludes our office hours, and we'll see you soon.

Pascale: Thank you.