Preparing for the New Normal in Telehealth: Transitioning from Surviving to Thriving

Webinar Transcript

Krista Davis: Good afternoon all and welcome to today's webinar, Preparing for the New Normal in Telehealth: Transitioning from Surviving to Thriving. My name is Krista Davis and I'm a communication specialist here at Quality Insights and I'll be your host for today's presentation. We'll get started with that in just a few moments, but first I wanted to go over a few housekeeping items. All participants entered today's program in a listen only mode. Should you have a question or a comment during today's call, we ask that you please type it into either the chat or the Q and A box, which you'll find on the right side of your screen. If you're unable to locate your chat box, hover over the bottom of your screen and click on the circle with the speech bubble.

The slides you see today were emailed to everyone who had registered. They will be sent again to everyone who attends along with your CE information after the presentation is over, so keep an eye on your email. At the end of today's program, you'll be directed to an evaluation and a post test. Once completed, you will be presented with a certificate for you to fill out and print as proof of your course completion. Even if you don't need the CEs, we hope that you still complete the evaluation as it does help tell us how we did and how we can shape future programming. To complete the course you must watch the 60 minute webinar either live or recorded and complete the post test questions and evaluation.

1.25 contact hours have been approved for nursing, Quality Insights is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation. There are no identified conflicts of interest. After learning this course, you all will be able to identify at least three tele-health best practices, describe key components of telehealth etiquette, and explain how a physical exam can be conducted using tele-health technologies. I would now like to introduce today's guest speaker, Kathy Wibberly. Kathy is director of the Mid-Atlantic Telehealth Resource Center, one of 12 regional telehealth resource centers serving the country. Kathy's public service career reflects close to 30 years of experience in public health, public policy, program development, program evaluation and strategic planning.

Kathy received her BA in psychology with minors in pre-medicine and youth services from Gordon College in Wenham, Massachusetts. She went on to receive her MS and PhD in counseling psychology from Virginia Commonwealth

University in Richmond, Virginia. Kathy also has a certificate from the Management Academy for Public Health at the University of North Carolina Chapel Hill. It is my pleasure to now turn the program over to Dr. Kathy Wibberly. Kathy, the floor is yours.

Kathy Wibberly: Great, thank you very much. And, I'm thrilled to join you guys all today and just wanted to get started with the whole reason why we're probably all on this webinar. So I think we have all been hit with this digital transformation of our company's practices, organizations and who would have thunk. It happened overnight. And so what I have heard over and over again is that tele-health has just become an overnight success after 20 years. So literally tele-health has been around for more than 20 years, close to 30 years now, but I think the last three or four months has seen this skyrocketing use and for a variety of reasons, beyond just exposure and fear of exposure, but this whole issue of changing the policy landscape to enable tele-health in a way that we've never seen before. And I think because all of this has kind of been automatically like flipped the switch overnight success kind of thing, we are now facing some issues.

And so the genie is out of the bottle and we cannot expect business as usual when the pandemic is over whenever that will be. But we also need to start thinking very much on how we prepare for one, a tsunami of patients who have literally delayed care because they didn't want to use telehealth technologies or, their care needs to be in person. And I'm not a proponent that tele-health is the cure all and be all and end all for all things, because there are certainly some things that need to be done in person. But we also need to deal with the, how do we fix sloppy tele-health because we have seen in the last four or five months, because we have flipped the switch so quickly, people have not had time to really prepare.

They've just been in panic mode and we need to see our patients, we need to see our clients. We need to figure out how to keep a revenue stream coming into our practice. We need to stay open. And so what we have seen is a lot of sloppiness in tele-health and not a lot of, paying attention to best practices. So that's really part of what this webinar's going to be is to help people now that the panic is slightly over, somewhat over, we are resuming a little bit of normalcy, we're starting to see patients or clients in the office. How do we start thinking about best practices? And now that we've all gotten a taste of tele-health, some of us a good taste, some of us probably are still not sure about this. But we're not going to be able to go back to our pre-existing policies. And we're probably going to be living with a hybrid world for a while. So how do we then make these transitions and make them work?

So I think what I'm going to do is really just run through, fairly quickly, some of the things that you really need to think about, and some of the things that you should be learning as you make this transition from tele-health back to normal, back to how do I integrate tele-health into my normal or the new normal, which everyone hates that term now, but that really is where we're going. So the

starting point for me is that tele-health technology is just simply a tool in a clinician's toolbox. It's not a separate service. So you don't ... your patient does not get care using tele-health or through tele-health. Your patient is still getting their care through you, the clinician, if you are the clinician or your practice. So don't let people use the term, I'm getting my care through tele-medicine. That's just a tool. You don't get your care through a telescope, you're getting care through the clinician. And so that needs to be really clear.

So the first thing you really need to think about as you resume "Normal," or the new normal is what is the problem that I'm trying to solve or fix. And oftentimes what happens is people go out and like, certainly just go by technology because they're like, we need to make something work. And that's great if you have technology, but technology should not be the driver of what you're doing. Technology should actually be probably the last thing you do. The first thing you do is really figure out what is the problem you're trying to solve, and so for some of you, it's going to be access to care. I have rural patients who can't possibly drive an hour or right now during this pandemic. I have patients who are high risk and should not be risking exposure. Or I have providers who are at high risk and should not be risking exposure. And so being in the office is kind of unnecessary exposure, and I can try to mitigate those risks, but you need to really think about what the problem is you're trying to solve.

So for some people it's we have high rates of missed appointments. Patients call it the last minute and they can't get in because whatever the reason is, they can't find childcare, they can't find transportation, they didn't get their paycheck this week and they can't take the bus. I mean, whatever it is that could be a problem you're trying to solve. Or it could be, I have patients with chronic disease and they schedule appointments and I'm supposed to see them regularly and they just don't show up, but I need to manage their condition better. And for some of you it's access to specialty care services. I make referrals and they don't go because it's too far away or it's inconvenient. So whatever those issues are, define your problem first.

Once you've defined your problem, you really need to think about your organization and your practice, who in my organization sees this problem, really understands the problem and is actually motivated and willing to do the work to find a solution. And that is what we often call a clinical champion. Usually it is a clinician, it's a nurse, it's a nurse manager, it's a physician, it's a auntie, it's a PA, whoever it is in your organization that says, I am not happy with the way things are. I feel like we're not giving the best quality care to our patients, we can do better, that person is usually the person that will make your tele-health program work and not just survive, but thrive because that's the person who sees a problem, wants a solution and is willing to put in the hard work. And it is hard work to make it really work well, to do it. And so take that person and let them be the driver. The person who actually sees the problem and wants to fix it.

So the starting point for any program is look at what has been done successfully. There are lots and lots of program models, and I can point you to a lot of those. So you can reach out to me if you don't see them. There are so many toolkits out there, evidence based practice documents, there are all sorts of program model documents that you can look at. And so take a look at what has been done in similar settings with similar patient demographics, because that's a great place to start and then adapt from there. You might say, well, that's great for their patients because they're all rural, but I'm in an urban setting. Or that's great for the urban setting, but I'm in rural, so how can I adapt this to make it work? But there are all sorts of ways that you can be creative and then try some things out.

So your technology selection should always be the ending point of after you've defined your program model. And I know some of you have quickly found a technology solution and that's great if you have, but if you're just piloting things or if you're just using Zoom for healthcare for now, and you think, in my ideal world, we're going to have peripheral devices and we're going to have other tech integration into the EMR, whatever it is, your technology requirements and how they're defined should really be defined by the program model and not the other way around. A lot of the frustrations that I find providers have is they go out and they go, this technology looks really cool, and then they purchase it. And then they realize that their program model doesn't fit. Their workflows, the technology solution is not flexible and providers want a different workflow. And so really be thinking about all these other things I'm going to talk to you about before you go back and go, these are my technology requirements.

So another couple things to just mention before we get into best practices is this whole starting point of quality and safety. So we all often get the question, well, what's appropriate for tele-health or what can I do to make sure that things are safe for my patients? And I think that's a great question. And quality and safety is definitely the piece where we need to start, and there are some model policies that really look at that. The FSMB has one that really gives you some best practices. But what I want to say is that the standard of care really should not change whether you're using telehealth or in-person care. And so what is the standard of care? The standard of care is not the gold standard. I don't think many of our practices and in-person care use the gold standard because we just don't have the infrastructure to do that.

The standard of care is the type and level of care an ordinary, prudent health care professional with the same training and experience that you have would provide under similar circumstances in the same community. And that is actually the standard of care that's used in the legal courts of law when there's a malpractice suit, would someone with your type of training, living in your community, working in your community have done the same thing you did. And if they said, no, that would be negligence, or that would be a malpractice, then you have a problem. But if that other person says yeah, that's pretty much what I would do as well, you're pretty safe. And so really think about like the standard

of care, and make sure that, that doesn't really change whether you're using technology or not.

So that leads us into then establishing a protocol. And that's really the point where we really think about what is the clinical protocol that we need to have. And I encourage people, especially if you're in a primary care or acute care setting. But even if you're in a specialty care setting, you should be able to think about each of these visit types and whether you're going to use these visit types. So there's acute care on demand visits, they're scheduled follow-up visits, they're scheduled wellness visits. And then there're differences between adult and children. And then there's scheduled specialty care consult, whether that's dental health, behavioral health, cardiology, whatever it is. When I say establish a protocol, what I want you to do is think through, what are the most frequently seen conditions with their corresponding ICD codes that you see in your office, in your regular in-person practice?

What would you do to assess that patient if they were in your office and highlight those things that you feel like are a must have to meet the standard of care. And I don't need you to do this for every condition you see, but just the top couple, four or five. Because once you have thought through that, the rest will typically come pretty naturally. Identify what documentation is required for that condition or ICD code, identify when you would treat and when you would refer and then identify when you would, or wouldn't be able to prescribe if needed. Okay? So think through those and then when you think about the technology setting and using technology, how much are you able to do with technology? It could be 70%, it could be 80%. It could be a hundred percent. Typically, we can do a lot more with technology than people think you can. And so I'm going to talk a little bit about this whole clinical assessment piece and how you would use technology for it.

So most people will tell you, and I think every clinician I've talked to says, we can do a clinical assessment by observing the patient. In that first 10 seconds when I walk into that exam room, I'm already doing a ton of assessment and you can do that same assessment by video if you have a good, clear picture. And that is going to be part of the challenge right now, because we have a lot of sloppy tele-health going on because we have patients who have very poor bandwidth. We've not trained our patients to be good tele-health patients, so that's part of this whole fixing sloppy, we have to figure out how to train our patients to be good patients. But if you have a good video image, you can do a lot of what you would do in the exam room. You're looking at general appearance, you're looking at skin tone. You can ask them to walk across the room and look at their gait. You're looking at clarity of speech and posture.

You're looking at their breathing and whether their chest is moving up and down, whether they're having trouble breathing, and all of those things can be done just by observing the patient. And so think about that when you think about your protocols, what am I looking for? Listen to the patient, he's telling

you the diagnosis and so I think what we have often lost in our in-person clinic practices is that as that time in the patient room gets shorter and shorter because of our business models and our revenue models, we have oftentimes lost that time to really talk through complaints and history. And so if you don't have that patient's full history and record when you're doing a tele-health consult, that's going to be really important to gather in advance of that consult. And that could be done by phone by somebody else in your office. It doesn't have to be done by you in a tele-health call or tele-health visit.

But you really should gather that history, the chief complaints, the associated signs and symptoms, personal, social family history, medication review allergies, all of that stuff can be gathered as part of the clinical assessment. And it's really important to know. So what is the unique part of doing a clinical exam or a physical exam by tele-health? I think the keywords are, it has to be provider directed. So because you don't have hands on and you often don't have peripheral devices, you're going to have to help the patient help you or have a family member help you. And that's okay, it's okay to do. So a couple of things that you really need to get good at and I always advise clinicians, if you're doing a tele-health visit for the first time or the first couple of times, plan of a longer block of time than you would for an in-person visit. And that's just the reality of it because you have a learning curve, the patient has a learning curve, you're using technology differently, and you're going to have to figure out and master how to give your patient directions.

So it is perfectly okay to say to your patient, you know what? I need to look at your pupils, but I need you to get your camera to focus on your eyes. So can you look into the camera or can you get a little bit closer and hold still? Or if they're using, let's say a phone or a device, they may be handholding it and it could be shaky. And you might want to say, can you prop your phone up and then just like move in closer, but it is perfectly okay to ask your patient to readjust what they're looking at, how they're looking. It's perfectly okay to say, it's really dark, can you get a flashlight or can you just turn on the flashlight on your phone so I can see better. Have them open their mouth, stick out their tongue, say aah into the camera. Ask your patient to be your hands.

So you can, if you're on video, show them where to touch. So you can feel your sinuses this way, check your lymph nodes here, show them where to tap, where to feel and then ask them their level of pain or tenderness as you would in an office. So a huge part of that physical exam is you learning how to communicate to your patient what they need to do, to do the physical exam. And the language that you use is going to differ based on the age of your patient obviously. If you're looking at a 10 or 12 year old, you may have to have very different terminology than a 50, 60 year old educated person. And so really be thinking about how you would do this. And I always advise clinicians, if you have like children at home, eight year olds, 10 year olds, practice this on them, because if you can communicate in a way that they can do exactly what you're asking, you could probably do this by video with just about any level of patient.

All right. The next thing that I advise people to do is, oftentimes clinicians will say, I don't have peripheral devices when I'm doing this with patients at home, and you have permission to use whatever peripheral devices that patient might have in the home and oftentimes they have it. So right now, if you are one of those people who have just flipped to tele-health like last minute, and you just had to do it, you can be thinking forward and thinking if I'm going to be doing this as part of my practice, there are peripheral devices that I can actually make available to my patients at home. Or I can advise my patients to purchase certain things if they have the money and if they don't have the money ... Many practices are just providing chronic condition patients with some peripheral devices to the home so that you can do the annual, not just the annual exam, but the follow up visits from home.

And so this is the time when you can really start forward thinking about which set of patients might I want to have peripheral devices cause this group of patients rarely come into the office even though they should be there, and how can I do these visits from home? And there are lots of technologies out there that work very well, that are affordable to patients. But if you don't have that, you've not gotten to that point yet, it is perfectly fine to use consumer devices when peripherals are not available. And so you may need to guide your patient on how to use their devices appropriately. So most people don't know how to take their blood pressure correctly, and actually many clinicians don't know how to follow the standards for taking a blood pressure, with feet not dangling and with arms not crossed and all those things, but you may need to guide your patient in how to do that.

So you could say, do you have a blood pressure cuff at home? If you do, could you go get it? Can I watch you take your blood pressure reading? And they may need to enlist somebody to help to put that cuff on correctly. If they have a glucometer, if they're diabetic, you can watch them do a test strip and show you their readings. You can do, if they have a Fitbit, it will capture their heart rate. And so you can say if you're wearing a Fitbit, what's your heart rate look like right now? But it's also fine to have them take their pulse, so you can actually do the timing for them and just have them count out loud each time they feel a beat, and get their pulse. Most people have thermometers at home. Most people have scales, so you may need to watch them get on a scale and look at the weight, but that's perfectly okay to do as well.

And if you can do all those things, you can do the vast majority of a wellness checkup or a wellness visit for most of your patients. And so you often say, well, how am I going to do the annual wellness exam? Well, there you go. You've got most of that information right here. So the other thing that, and there are a lot of videos and things that I can direct you to, we have them on our website on conducting the physical exam and really looking at every part of the anatomy and every component of the physical exam. I'm not going to go through that now just because we don't have the time, but I do want to think about then telemedicine success linked to workflow rather than technology. And this is a

true statement. If you don't have a good workflow, you, as a clinician are going to be frustrated and the rest of your staff are going to be frustrated if you're working in a practice. And oftentimes your patients are going to be frustrated as well.

So what is the workflow when it comes to tele-health? It's really a sequence of physical and cognitive tasks performed by different people within and between organizations. I think one of the things that I have heard a lot when I talk to providers who have flipped to tele-health during the pandemic is, I'm doing everything myself. Like I'm not engaging anyone on my team, I am like my provider. I am the provider, I am sitting at home trying to figure out how to do these telehealth visits with my patients. And that has probably been the most frequent complaint of this is like, why am I doing everything and I can't do it all? And the reason why you're frustrated is because you shouldn't be doing it all. And so this is the time now when you're making that transition to really think about those workflows.

So a workflow can make things really smooth or a bad workflow can just make it like treacherous for you and for your practice. So really let's think about workflow mapping and what it really entails. The first thing is inclusive planning. And I really mean this when I say inclusive planning. And for some of you that may mean bringing your home or office staff into a room, if you're actually literally in a practice site right now, but it could be a Zoom call where you just have everyone together and you say, we're not going to see patients for these two hours, we're going to sit down and hammer this out. Don't work in silos because everyone needs to be involved and everyone is impacted by the workflow. Everything from your front desk person who's answering the phone calls, what do they tell the patient who is trying to cancel appointment or schedule appointment? Do they offer a tele-health visit?

I've had some practices who say, anytime a patient calls to cancel an appointment, they are immediately offered a tele-health visit and that converts canceled appointments to actual billable appointments like 50 or 60% of the time. Because oftentimes the cancellation is because I can't find transportation. Nobody's taking care of my kids, my sitter didn't show up. My husband or wife had to go to work suddenly, and now I'm stuck home and I have no car. I mean, all of these things happen to patients and a billable kind of encounter goes away. And if you train your front desk staff person to, hey, we can offer you a tele-health visit right away during your regular appointment time, would you like to do that? That is part of your workflow and you should build that in if that's what you want to have happen.

Your billing team needs to be involved, because they need to understand coding and billing and how the documentation leads to that. But believe it or not, your housekeeping staff might need to be involved as well. Because if you are doing tele-health visits from your office while the patient is at home, I don't know how many times I've said, I've heard people say, oh my gosh, my patient came on

and my camera wouldn't turn on because whoever was cleaning unplugged something or they moved my camera or they set something aside. So you really need to have those conversations. What things need to be left on, what things can be turned off, what things need to be moved. I mean, it's always good practice to test everything before you turn it on and see a patient or a client. But sometimes that doesn't happen because you're running from one to another, and so everyone needs to be involved in this discussion, in this conversation.

So one thing that a workflow does, it helps to clarify roles and responsibilities and it helps to identify potential issues. And I always say, think about both the patient experience and the provider experience. Sometimes we often think about one without the other and when people are talking about workflows and developing workflows, I often say like do a little bit of role assignment. So you can have one staff member and say, hey, you're going to come at this as a patient. You can have your clinician say, you be yourself, come at it as a provider. And then you can say to your other staff, give them some roles. You're a family member, you are ... But whatever that is, assign some roles and think through the workflow based on who they are and how this impacts them.

So these are some of the things that you want to ask yourself and think through when you're thinking about workflows. So one is how will my patient be informed about the availability of tele-health services? Who's going to tell them, what will they be told? Because that's very important, how will they be told and when will they be told? And you can think through all of the various scenarios. So part of tele-health is marketing that you actually have this service. Part of marketing is actually helping your patient understand how to be a good telehealth patient. So there's a training component for your patient as well. You wish that you wouldn't have to tell patients that they shouldn't be doing their tele-health visit in the middle of a coffee shop at Starbucks, or while driving a car. But believe it or not, we hear horror stories from providers saying, my patient like joined my visit and they were in the back of a car with like 10 other family members.

These things happen and patients don't realize that there are this etiquette, that they should be involved, there's privacy issues, there's all sorts of issues, but there's also bandwidth issues. If you're in a moving vehicle, your bandwidth is relying on your mobile service and if you're driving through mountains, that's probably pretty inconsistent. So somebody needs to be able to engage the patient and explain this to them. Who's that going to be? And it could be multiple people at multiple points, but that needs to be thought out. How will tele-health visits be scheduled and who will do the scheduling? So your practice needs to think through will tele-health visits be available only during specific blocks of time? And there are some providers who say I'm only going to do tele-health visits between 2:00 and 5:00 PM, that's when I'm going to be in an environment where I have a stable, good internet connection and that's where I'm going to sit.

Others say, I'll just take them just like an office visit, so schedule them anytime I have an open block of time, it could be tele-health or it could be in-person. Some people just say I'm always available by tele-health. So if a patient comes in and they need an acute care visit, here I am. If I'm in my office, connect them. So you really need to think through and different providers have different preferences. So some of your providers may say one thing and another provider may say another, and you're going to need to think through how you're going to schedule in that way. So how will the patient be prepared? I think I went through that a little bit, but what information does the provider need before the visit and who's going to prepare it?

So somebody needs to do the paperwork and oftentimes it shouldn't be the provider if you have office staff, right? If there are consent forms that need to be filled out, if there's a history that needs to be done, who's going to gather this information, how are you going to get the information? How are you going to get the information to the provider before the visit? Will someone be sending the patient a reminder about the tele-health visit? When will that happen? Will it be an hour before the visit or 10 minutes before the visit or both of those? Who's going to send that reminder, will it go by text message or will it go by email or a patient portal? All those things need to be thought through. Where will the provider be during the tele-health visit? And this could really change, based on the pandemic and where things are.

So where the provider is, is going to also impact their ability and their own bandwidth issues. Some providers are working from home and some providers have three or four kids who are doing education from home and streaming on Zoom and/or watching movies on Netflix. And all of a sudden when everyone in the family is using the internet, everything gets really slow and the video gets jittery and things go out. So the provider really needs to think through where am I going to be during this visit? Can I actually legitimately see a patient by tele-health in this context? Maybe there are certain hours that will be better than others. How will the patient, or how will the provider know when the patient's ready to be seen? Are you going to have a waiting room feature? So this is, again, goes back to your, what platform that you select.

Some providers say, I would like to take my time with my patients. And so if their visit is at 11:00 AM and I'm with another patient, I'm going to wrap up that patient first. And so the patient who's in the waiting room needs to understand and know that I might be a few minutes late, well guess what? They're sitting in a waiting room and they're expecting you to come on at 11:00 and who's going to communicate with that patient in the waiting room? Hey, doctor so and so, or nurse so and so is running a few minutes behind, because if I'm on in the waiting room for more than a few minutes, I'm going to think I did something wrong and log off and then you log on and the patient's not there. So all of these things need to be thought through, how are you going to message? Are you going to just put on a generic message in your waiting room space, kind of a

generic background that just says, the provider will be with you shortly, please wait. All that messaging needs to be very well thought through.

How will you, the provider interface with your EMR? And this is one complaint that I have heard a lot from providers. So a lot of times some EMRs will build in a virtual visit platform within the EMR, but it's in a tab. So now in order to see the patient by video, you're in this video tab, but in order to see the medical record, you have to flip to another tab. But then if you're in that medical record tab, you can't see the video. And so then you're frustrated because you're trying to be able to look at both at the same time. Now your patient's looking at your eyes and you're like looking all over the monitor trying to figure out which tab you're on and how do you get back to the video. And so that does not lend to a good provider or a patient experience. So you really need to think through, is this interface what I want? Is this the ideal situation? Can I do dual monitors?

Am I able to log into my EMR using two dual monitors and be able to have one tab on another and one on one? So all those things, like think about that from both the provider and patient experience piece. So this next section is really about etiquette and how do I look and sound professional in a visit? And I think this is something we don't pay attention to, but need to much more than we do. And so this is part of that fixing sloppy piece. So have I actually tested the audio and video, always encourage you to do that self-check before you connect with the patient. How is my lighting, and what does my self-view look like? What am I wearing and what's in my background? How do I introduce myself? So remember if this is a new patient or someone that maybe you've only seen once, and it's been three years, and now they're coming back to you, you may want to introduce yourself and verify some credentials, your own identity, but how are you going to verify the identity of the patient as well?

You need to be thinking through that, because sometimes for those of you who are doing acute care, you may have someone you've never seen before. They might've submitted some paperwork online and for your safety and for the safety of the patient, you probably want to have them hold up a driver's license or a photo ID just to verify that it is who you're talking to. So think about that. If that patient, if you're seeing patients from some other location, whether it's their home, their work place, wherever they happen to be, it's always good practice to verify where their location is. There's a couple reasons for that. One is, if they are actually having an emergency, they're complaining about chest pains and you go, I need to call 911, they shouldn't be talking to me, they need to be going to the hospital. Well, you're calling 911 is not going to help because 911 is going to be directed to wherever your location is, not the patient's location.

So finding out where that patient is, their physical address is always an important piece of information to have. If it's in your EMR, their home address, you can basically just say, are you at home right now and is this your address? And they can just say yes, and that's done. We can move on. But sometimes you

do have patients who say, oh, well, I'm using my grandmother's house because there's an internet connection. Well, you better find out grandmother's house's address. And this is particularly important if you think that this patient may need a 911 call. But another reason is because of licensure. So right now there's some relaxation of that licensure requirement, but I have literally had providers contact me and go, my patient was in a moving car and they were telling me they were on their visit to cousin whatever's house in another state, and they just crossed the state border. What am I supposed to do now? And that's a legit question, but your patient could be vacationing in Florida, who knows where they are?

And so it's always good to ask where they happen to be, and you really need to know ... you have a procedure and protocol for if something goes wrong. So the power can go out, you can have a storm, you could drop the internet connection, the call drops. What is your process for reconnecting with the patient? And what typically happens is there's no process in place, nothing is verbalized. So the call drops out and now you're trying to call the patient and the patient's trying to call you and both of you are getting a busy signal, so you really should have a process defined for your patient. And this is part of that patient education. If the call drops off, I want you to try to reconnect the same way that you connected before so that we can have the video consult. And if I don't see you in three or four minutes, I'm going to call you, call your phone, which also means you need to have their phone number somewhere in your records.

Or you can say, if you're unable to connect, I want you to call my phone and provide some phone number, preferably not your personal cell phone number, but some way to direct the call so that you can answer it. So I also recommend that people have a little kind of, create your own etiquette checklist. And there are a lot of them out there right now, so I can direct you to things that are on our website toolkit. But if you are really doing tele-health for the first time, or this is your first couple months doing it, it doesn't hurt to have a checklist in front of you. And some of you are going to need more of these items, some of you do these things naturally because you're just, you've been on Zoom or on video calls all your life and they just happen naturally.

But thinking through these things in a systematic way will help you look more professional and more prepared. And this is just one example of a checklist that can be out there, and some of you need these reminders, some of you don't, but it doesn't hurt to have that stuff available and kind of paste it up on the wall next to your computer. So another thing to ask yourself as you're thinking about workflow is what happens at the end of the visit. So unlike an in-person, in-office visit, typically you will guide that patient out and there'll be like a checkout procedure. And at that time there'll be asked about coordinating care and follow up visits and all of those things on billing and paying their bill. Well, in a tele-health visit, you sign off, you sign off and that's the end. So you really need to think through what happens after the visit is over.

So who is going to reconnect with them if there needs to be further billing questions, or if they need to get different insurance information or they need to coordinate a followup visit, who's going to do that follow up and how is that going to be communicated and coordinated? So those are things that need to be thought through when you're thinking about workflow. So oftentimes people will actually develop a workflow diagram, and this is what it would kind of look like. So how do I initiate a visit? Who calls the patient? Who does the registration, the check-in, who's responsible for what? So the provider might be doing these things. This is another example of a workflow. Some of it is kind of a combination of a diagram and then some instructions. So the day before the patient's environment, the clinic identifies the appointment. Then the clinic identifies the patient, calls them, schedules. So think about that and how that best works within your practice setting, how you put that workflow diagram together.

So another thing that I encourage people to think about is this quality improvement and program evaluation piece. So oftentimes, many of you are involved in, let's say Medicare programs that have quality improvement pieces, or you're involved in accreditation standards that have quality improvement pieces and metrics. Some of those things are going to change with tele-health, but a lot of things are going to remain the same. You really should be thinking through like, what do I need to really understand in terms of our program metrics? How does tele-health impact that or should it impact that? Do I want to take a look at whether patients are doing as well, or perhaps better with tele-health visits or if there's an issue that I need to identify. And many times you need to think that through before the bus has left the station, because once it's gone, you've missed your baseline and you really can't answer some of those questions.

So the last couple of things I wanted to say is test everything. If you've developed a new workflow, that's great. You might've gotten your whole team together and you go, this is the workflow that we'd like to see happen. Pilot test the workflow and get feedback at every step of the way, because oftentimes what looks good on paper when everyone's around the table talking about it, does not look real great in real life in practice. And so I often say like, test something out like three or four times, run through the entire workflow. You can even get mock patients, get a relative, get a friend to be a mock patient and just run through the entire workflow a couple of times as your pilot test before you go live with real patients, because you want to get it right, and you'd like to get it right before the first time trying it out.

And so update your protocols, your workflows as your pilot testing, and then go live with it and then you can scale. So scaling up has to do with training, and this is the piece that many practices fail to do because you go, okay, we just spent like three days sitting down working on the workflow and the protocols, we've got it down now. And then you have somebody leave the practice. Somebody gets a new job, you have new person coming in and they have not been trained

and they're just thrown into this and they don't know the workflow, the protocols. And so they're just learning trial by fire. That's not a good way to introduce people to tele-health number one, and two, it's a great way to create bad experiences and get people mad at each other. So really think about where do I build in training when I'm onboarding new staff, where do I build in recurring training, like annual refresher training or even every six months.

Part of that training piece is how often do I use tele-health? If it's something that you use every single day and everyone is used to it, you may not need to do much, but like once a year in your staff meeting, you go, hey, let's review this protocol. Is it still working for everyone? Do we need to make any changes, and kind of run through it. But if you are getting a lot of turnover in staff, what training do they need? What training do your clinicians need? So, do they need to learn how to do a physical exam using tele-health? Should that be a part of your training for every new clinician that comes on board, then add that to your training and your onboarding protocol. If you have front desk person that oftentimes turns over, how is that person going to learn? What is the spiel that they give to patients when they call? How are they going to learn?

And oftentimes it helps if your person who's answering the phone actually understands what it means to have a tele-health visit. So you may want to have them run through a mock visit so that they understand so they can explain it to the patient, because they're oftentimes your frontline communications person. Or it could be your nurse manager, your nurse is doing this, but really think through who needs to be trained, how often do they need to be trained and how are they going to be trained? And then I'm going to wrap up with just a couple of slides about who we are and what resources we have available. But before I do that, I just want to make sure that you all understand, I'm going through a lot of things. There are a lot of good practices. There are a lot of best practices, but at some point you're going to say, you need to take some risks. So don't let the perfect be the enemy of the good.

You could, if you're one of those people that has to work through every single detail of your protocol and make sure it's working perfectly before you even attempt something, you may be frustrating your patients, and unnecessarily frustrating your staff, because you may need to eventually just say, hey, I'm going to take a risk and just do this and see if it works. And if there are things that need to get fixed along the way, we're going to fix it and we have a process for fixing that and identifying those issues. So don't be afraid at some point to just go let's just do it. So who am I? I am Kathy Wibberly and I am the director of the Mid-Atlantic Telehealth Resource Center. So the Telehealth Resource Center program is federally funded by HRSA. There are 14 resource centers throughout the country. We cover the entire United States and some affiliated Pacific islands as well.

The dark purple States are a part of the Mid-Atlantic, so that's my footprint. There are 12 regional centers and I'm one of those regional centers. We also

have a national center. The Center for Connected Health Policy deals with telehealth policy and the Telehealth Technology and Assessment Resource Center really looks at telehealth technologies and guides people through that. Our services are entirely free of charge, and we are really here to answer questions, to help guide you through this whole workflow process, to do training, basically whatever you need to help you implement tele-health programs successfully. In terms of by center, our website is M-A-T-R-C.org, and you can access that and there's all sorts of things on our website, but right front and center is our COVID-19 toolkit link. And if you click there, it will take you to a bunch of resources, and I'll talk a little bit more about what's available there.

But in terms of our resource center and each regional resource center is slightly different, we have a group of what we call consultative service partners that we have engaged and they're on retainer with us through the grant. They have a variety of specialties. So typically if you reach out and you request technical assistance, and we have a link for get technical assistance, we also have links to virtual office hours, several times a month and the virtual office hours are open to anyone. You can just join whenever they are at any point in time, you don't have to make an appointment and you can get your questions answered. But if you have a specific technical assistance need, like you say, I really need to find out good peripheral devices that I can send to my patients at home. And don't forget some of you who are not in very rural areas, you have Uber and you have Lyft and you have other services that you can use to get peripheral devices to your patient's home.

We have a group of people with all sorts of specialties from technology to tele-stroke, to remote patient monitoring. And so if it's not something that I can answer for you, it's like a quick question on billing or reimbursement or policy, I will refer you to one of our consultative service partners who can then spend some more concerted time with you to really work through some of your needs. So we do have that whole network there. We have a lot of web based resources, so we have Hot Topics. Our COVID-19 toolkit is one of our most hit on resources right now. We have a tele-behavioral health center of excellence. We have remote patient monitoring toolkit. We're getting ready to bring up our school based tele-health toolkit. We have a toolkit on tele-genetics, on vendor selection, on tele-MAT. We have a page on HIPAA. We also do an annual conference and we have a lot of those materials, up and online, accessible to you.

But our COVID-19 toolkit is really the place to start if you're just getting started with tele-health. And we have just whole topic areas on best practices for conducting a tele-health visit, this is where you will actually find those videos. So we have sub-sections under the sub-sections. So when you open a section, it may look like everything is right there, but if you scroll down to the bottom page, there are links to sub-sections. So in the best practices, there are sections on documenting a visit, tele-health etiquette. And if you click on that link, it'll drop down and a whole host of other materials. So don't miss out on some of

that information. And that's my contact information, and I think we can just leave a few minutes for questions.

Krista Davis: Thank you very much, Kathy. And at this point we would like to invite you all to type in your questions that you may have into the chat box or the Q and A box that you'll find on the right side of your screen. We have about nine minutes or so, so we do have some time. I also wanted to direct you to the chat box, I put the link to the Mid-Atlantic Telehealth Resource Center website and to Kathy's email address in the chat box, so that you all have that. As I know, you are not able to click on it in the WebEx player. So our first question is regarding what you had just mentioned, Kathy, regarding your virtual office hours, the first Tuesday of each month, is it 12:00 to 1:00 Eastern time, or is it another time standard? Can you give more detail on that?

Kathy Wibberly: We are all on Eastern time, because every state that we serve is on the East coast. So all our times are Eastern time. So we have tele-health basics and tele-mental health, that's one, and that happens twice a month. And that's the second and fourth Friday of each month between 12:00 and 2:00, and you can join any time between 12:00 and 2:00. And then we have one on that's focused on tele-health technology, our vendors, and that's the first Tuesday of each month between 12:00 and 1:00. We're getting ready to add a virtual [inaudible 00:52:12] on remote patient monitoring as well as one on school based tele-health, and hopefully that'll be added before the end of the month or starting of September.

Krista Davis: Thank you. And our next question is, do you have any best practices for a nursing home tele-health visit?

Kathy Wibberly: We do. So we are actually as part of our COVID funding, getting ready to put together a whole toolkit on that. But in the meantime, if you go to our COVID-19 toolkit, there is a section called resources for specialty providers and settings. And if you go under there, it opens up to tele-dentistry, but again, if you scroll down, there'll be links to other sub-sections and there is a section on tele-health and post-acute long-term care settings.

Krista Davis: Thank you. And our next question is how do we go about finding the best vendor for our practice?

Kathy Wibberly: Yeah. So I'm not sure what kind of vendor, whether it's a service provider or a technology vendor, but we actually do have a tele-health technology selection toolkit that you can use on our website, but part of our virtual office hours are the vendor selection. And so that would be a great time to talk through your needs. So again, I think the best vendor is going to depend on what your requirements are, which again, as I mentioned in the talk, your requirements are going to be based on what your needs are and what you want to do in your workflow.

Krista Davis: Thank you. And our next question is, do you know whether they will be increasing the payments providers receive for tele-health since the need for tele-health has increased?

Kathy Wibberly: So I think what we're seeing nationally is definitely a movement toward parody in payment for in-person versus virtual visits. What we're also seeing is a debate about telephone visits and whether there should be parody and payment for phone visits. I think my personal position is that a phone visit is necessary because people don't have broadband, don't have devices. But if quality of care and the amount of information that you get in the phone visit really does not compare to a video visit if you're given the options. So I think it's going to be a tough call.

You don't want to dis-incentivize people from getting care, and so phone visits need to be built in such a way that people can provide that care and not feel like they're getting $10 an hour for their time, yet at the same time, you also don't want to create an incentive for people to "Get lazy," both on the patient and provider side and say, well, it's much more convenient to do a phone visit, so I'm just going to do it that way. So I think that's the challenge that we're all faced with at this point.

Krista Davis: Thank you. And while we are waiting to see if there are more questions coming in, I did just want to put some contact information on the screen for those of us here at Quality Insights. At the top you'll find email addresses for the three members of our community coalition team. Also, our 1-800 number at which you can reach any of our staff and also our website. The link that you see on the screen is the link that you need to click if you're interested in participating in our learning and action network, which will be commencing later on this fall.

So if there are any further questions we invite you to please type them into the chat box now. And it does not appear that there are any further questions. So once again, I want to thank all of you for attending today's program. I want to give a special thanks to Dr. Wibberly for taking time out of her very busy day to spend an hour with us sharing her knowledge. So thank you Kathy for your time.

Kathy Wibberly: Yeah, it's great to be with you and definitely reach out if you need any assistance.

Krista Davis: Thank you very much and thank you again. We hope you will join us for our next webinar, until then we hope you have a great afternoon and stay safe. Thanks again, everyone. Bye.

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