April Lewis:

Good afternoon everyone, and thank you so much for joining part two of our business intelligence webinar series. This segment is called Business Intelligence and Disruptive Technology: Telehealth and Other Patient Engagement Strategies Powered by Population Health Tools. I am April Lewis, the Director of Hospital Operations and HR Training with NACHC. I hope you all had a wonderful extended weekend. If you had to work, on behalf of all of us that did nothing, we say we are sorry, but welcome back to reality.

April Lewis:

We have a dynamic set of speakers today that's going to talk all things business intelligence technology, health information technology, and population health. I do want to remind you that this webinar is recorded, and you'll be able to access it in your MyNACHC account. Within no more than two weeks, you'll surely get a notice from our end at NACHC saying that the webinar has now archived into your portal. If for whatever reason you can't access it or don't have a MyNACHC account, if you go to nachc.org, that's N-A-C-H-C.org, to the top right corner to the log in button, you'll be able to set up an account there.

April Lewis:

And also, once this webinar ends, you will be prompted to complete a brief, brief survey. We do ask that you do take the time to give us your feedback so we can prepare future webinars, education sessions, and all things that we do from this end to help you all excel in your efforts back at your health center.

April Lewis:

Without further ado, I'm going to bring up our first presenter, our lead presenter Heather Budd. She's the VP of Clinical Transformation with Azara Healthcare. And then the other panelist will introduce themselves as well, and we'll go right into the webinar. Thank you all again for joining.

Heather Budd:

Thank you so much, April. My name is Heather Budd and I'm the VP of Clinical Transformation for Azara Healthcare. And what that really means is that I have a history of working with health centers. I was a quality director and later a COO of a health center in Rhode Island. And I did a lot of work in terms of practice redesign, care team transformation, and I'm really passionate about making data work for health centers. So, that is what I do.

Heather Budd:

And I'm going to also ask LuAnn Kimker to introduce herself. She is my colleague at Azara Healthcare. LuAnn? LuAnn, you might be muted.

LuAnn Kimker:

Okay, can you hear me now? I'm sorry.

Heather Budd:

Yeah, no problem.

LuAnn Kimker:

I'm LuAnn Kimker, I'm the Director of Clinical Innovation, as Heather said. And my background, I'm a nurse by background, and have worked in the healthcare setting for many years working on transformation projects, patients in our medical home, and really focus on quality and data to help make quality better and the care and outcomes that you provide. I'm excited to talk about this topic today around innovation and telehealth. I'm going to hand it over now to our colleagues Jose and Ellen. They're going to be joining us from Finger Lakes Health Center in New York. Jose and Ellen, do you want to introduce yourselves?

Jose Canario:

Hi, can you hear me?

LuAnn Kimker:

Yes.

Jose Canario:

Okay. This is Jose Canario. I'm the Medical Director for Finger Lakes Community Health, which is a fairly qualified health center here in the Finger Lakes region of New York, which if you don't know, is located basically between Rochester, New York and Syracuse, New York. We have clinics all the way across the north coast of Lake Ontario down to the Pennsylvania border almost. And I've been here for about a year and a half. One of the things that attracted me to Finger Lakes Community Health was their necessitating and innovation, especially with telehealth. And then I'll let Ellen introduce herself.

Ellen Hey:

Hi, I'm Ellen Hey, I'm a family nurse practitioner and I'm the Director of Clinical Services at Finger Lakes Community Health. And again, enjoy taking opportunities to think outside the box and figure out how we can do visits in a way that meets our clients' needs. So thank you, and back to you Heather.

Heather Budd:

Okay great. So, LuAnn if you want to just move the slide to the agenda, we'll just give you a brief intro to what we're planning on covering today. So, obviously we've already accomplished the introductions, we are going to talk a little bit about how are we defining disruptive technology and telehealth, and what is some of the background related to all of those things. Then we're going to have kind of an interview style section with Jose and Ellen, who are going to grace us with their incredible experience with this program developing over time. And then we'll show you some slides where the data is actually being used to show some of the accomplishments that they've been able to achieve, and that's kind of part of their interview, and then a few other things towards the end as we bring it to a conclusion. So LuAnn I'll, let you take it away from here for now.

LuAnn Kimker:

Great, thanks Heather. So, the first thing I want to talk about is just about disruptive innovation in general. What does that really mean? And over time, a lot of you have done a lot of different things in your practices that would be probably considered innovative, and so there's this trajectory of innovation versus disruption. Sometimes we're doing what's innovation because we're just doing things that are the same but they make it a little bit better, that's when I think about some of our PDSA cycles that you might do in your practice. We change a little bit about the work flow here or there for a lot of things. So,

we're doing new things. But when we talk about disruption in healthcare, we're really talking about doing things that make what we used to do, obsolete. And this in the healthcare industry, this is based off some of the work that was done by Clayton Christensen at the Harvard Business School in the 1990's.

LuAnn Kimker:

But it's caught really caught on in the healthcare industry to think about, how do we do things differently? And in this environment for those who we're on the call last week, we talked about having your foot in two canoes. Seek for service in value based care. Some of the things that we're going to talk about today around telehealth are not just doing things a little bit better. They're really innovative and if you had thought about doing them ... even though some people were starting a few years ago, most of us in the last five to ten years would never have thought that some of the stuff that you're going to hear about today, would actually come to fruition and be able to happen.

LuAnn Kimker:

So, disruptive technology. Just to get a core definition is really about products, services that are cheaper, simpler, more convenient, and they make it possible to do things in a less expensive way in different settings, different services. Even that could mean patients caring for themselves. Now, the patients caring for themselves is really easy. We've talked about that more recently and had more of a focus on that as we think about self care, shared cared, shared decision making. Then there is patients in a medical home, which if you think about it, has been out since the 70s and actually not until the last ten years, have we seen a lot of advances in terms of it actually being adopted.

LuAnn Kimker:

And I don't think that it actually made us throw something out, but it definitely has had us redesign and really think about the model in which we provide care. And I don't know about you folks but when I read this for the first time and when you think about making healthcare cheaper, simpler, more convenient and having different people do different things, that becomes a challenge. When we start to mess with people's roles and what they do, it makes people nervous.

LuAnn Kimker:

So, The New England Journal of Medicine catalyst group has a group of individuals that they work with. Executives, clinical leaders, that are in involved in healthcare delivery and they surveyed 519 of those folks. And basically what they said was that the healthcare sectors that were most in need of disruptive innovation were hospitals and health systems, healthcare IT, and primary care. And we know, even as we've talked about changes in care and reducing hospitalizations. When you think about reducing hospitalizations, that made people nervous because it meant that hospitals were going to need less beds. Potentially than they had before, so it changed their whole model and the approach to keeping people in the hospital longer, now we need to get them out sooner and we need to do different things. But I think there's a lot of opportunity in primary care to also make those changes, and if you looked at this data also by the organization types that needed to have the most disruption, it was in provider organizations. And I think that CHCs, although a different structure, fit into that category also.

LuAnn Kimker:

So, what do they specifically say? These were some of the free text comments that came out of that survey, just to highlight them because I think it talks a little bit about where we're going. So breaking down barriers for referrals, drugs and services. A better way for clinicians and patients to talk to each

other. Looking at minimizing social factors like food, housing and transportation. Social determinants of health are a huge focus right now. Distributing healthcare and quality healthcare, so how do we make sure that people in rural areas, as well as those in urban areas, have access to the services that they need?

LuAnn Kimker:

And really making that relationship and connecting the patient and their primary care around evidence based medicine. These are the types of things that you're going to hear, some about as Ellen and Jose talked about, telehealth. And so, telehealth like many things in healthcare, has a couple of different definitions. The Center for Connected Health describes it as a collection or means and methods for enhancing the care that's provided by using telecommunications technology.

LuAnn Kimker:

HRSA, which is what the health centers are primarily guided by, describes it a little bit differently but I would say it's the same concept, it's just being a little bit more concrete and specific about the types of things that they're looking for. So, it's electronic information and telecommunications to support long distance clinical healthcare and I think what Finger Lakes has learned, and others, is sometimes that amount of distance can vary but it's really about how important that is to the patient. Because ten miles might not seem like a very far distance, but for some it could be very huge or a huge barrier for what they're faced with.

LuAnn Kimker:

And before I start a transition over, I think the one thing that I just wanted to point out is that you're going to hear them talk about some different options in terms of how telehealth is provided. Live video, store and forward, remote patient monitoring. That's more like your blood pressure, machines, your holter monitors, and then mobile health. How are we using smartphone apps that are really designed to be able to foster health and well being. And all of these are different approaches to telehealth. You will also, either just as a reference point, there's telemedicine and there's telehealth. A lot of times you think those things are being morphed into one and less distinction being made between them. You'll also see where does virtual visits fall into this and some of that may actually be more around remote patient monitoring and asynchronous communications that are happening by email. There was just a thing on the news this morning around virtual visits and how that's changed care around back pain at some practices at the Mass General and Brigham and Women's Hospital. So, you'll hear a lot more about this and with that, I'm going to hand it over to Heather to talk to Ellen and Jose a little bit about how they're actually implementing telehealth in their studies.

Heather Budd:

Thanks, LuAnn. Before we actually jump into the chat with Jose and Ellen, I just want to use the capacity for pulling technology that we have here with Webex, just to kind of take the temperature on those of you who are with us today, to find out where you are on the spectrum of telehealth. So April, would you cue our audience how to do this?

April Lewis:

Yes, if you look to the right of you screen, all of you have started. It asks, "how many of you are currently using telehealth?" Yes, no but we want to, no, and it's not yet on our strategic plan, or no answer, or you do not know for sure.

Heather Budd:

Mm-hmm (affirmative).

April Lewis:

And we have about 42 seconds left to answer.

Heather Budd:

Great.

April Lewis:

Okay, and the last ten seconds for those who've not started.

April Lewis:

All right and that concludes it. Heather, we have 16% say yes, 32% no but want to, 10% no and it's not on their strategic plan, and 42 did not answer or either they may not know.

Heather Budd:

Okay. Great, so that's pretty much what I imagined, that many of you are interested in pursuing this and some of you are already pursuing it in some form, so that's great to know. And at this point, we'll continue on with our chat. There's just one extra slide here that's talking about the speed of disruptive technology, which can be a little bit scary. I think when you think about some of the different disruptive technologies that we've experienced in our lifetime, I think about Uber and Lyft and the way that they have changed what we used to think of as taxi services and providing much quicker, faster and easier, more personalized service on demand. I think that's the kind of thing we need to be keeping in mind as we approach all of this work with our patients.

Heather Budd:

The beautiful thing is that you as health centers have these incredibly cultivated relationships with your patients and they know that you care about them and care about their well being as a whole. Whereas some of the newer companies who are coming into the space, I think about CVS Caremark and it's rendition of Aetna and some of the other partnerships that are forming out there. Amazon for example, purchasing Whole Foods and just some of the access that some of these companies that are famous for some of their disruption. Have to some of our patients potentially, if not now, in the near future. Just kind of wanting to create a bit of a platform for why this is valuable now and that there is some need for speed as we approach this. And of course, hopefully we're doing it with some thoughtfulness as well.

Heather Budd:

So as we said already, we're so grateful to both Jose Canario, as well as Ellen Hey from the Finger Lakes Community Health Organization, for being here with us. Finger Lakes is just an incredible leader in the space and many of you may have heard their CEO, Mary Zelazny, interviewed on NPR and probably in other places that I am not aware of, but she's doing a lot to really get this message out there in terms of the work they've done. So, we are fortunate to have two of their lead staff with us today. We've got a little bit of thinking around what we'd like to speak to them about and I just want to encourage all of you because I'm guessing that many of you will have questions about some of things that they've done. Please feel free to put those questions in either the chat or the Q and A box. We're going to probably

hold them until the end and address them at that point, but don't let that keep you from asking your questions because we will return to them and make sure that you get your answers.

Heather Budd:

So, Jose and Ellen. I'm curious to hear a little bit about some of the history. I know that neither of you has been Finger Lakes Community Health for the entirety of this process, but I know you're aware of the history and I feel like that's an important part of why Finger Lakes was particularly uniquely positioned to pursue a lot of the telehealth work you've done and it's not just telehealth but it's also community health workers and they have played a particular role at Finger Lakes.

Heather Budd:

So, I'm curious if either one or both of you would like to just talk to us about what you know and what you think our audience would benefit from hearing about.

Jose Canario:

Thanks, Heather. This is Jose Canario. I know that Finger Lakes Community Health after we started off with Finger Lakes migrant outreach. Here in upstate New York, we have a lot of dairy farms, and orchards and farms in general in terms of migrant, or agriculture workers that were coming into the area and they noticed there was a need for outreach to these individuals on their farms and at the dairys. And so that's the way they could be paid to be, is that they would have community health workers with a provider go out and do screenings, and do some healthcare, medications and that eventually evolved into having a clinic, or an office, in which they were able to come. It was opened up to the community and we've expanded, like I said, from soda switches up north on Lake Ontario, down to Bath which is about 30 minutes away from Pennsylvania border, maybe even more.

Jose Canario:

And anywhere between, it's because of the need of seeing these agriculture workers and getting them screenings and healthcare. And like I said, we opened up to the community once we got through qualified healthcare. And as you can imagine, it takes three, maybe three and half hours to go from one side to the other - top to bottom. It's a lot distance to cover and so, we put a lot of outreach with our community health workers, trying to get them into the offices and that kind of involvement into some of the telehealth things that we talked about a little bit.

Ellen Hey:

Yes, I think another part of that, Heather this is Ellen, is that we could get patients in for primary care but often times had to talk them into getting specialty care and by the time it took for one community health worker to go pick up a medication, whether it was a new patient or an agricultural worker, take them another two hours a day and then bring them back. We actually were able to reach more individuals and fill a specialist schedule better with the use of technology. So, technology allows us to bring the patient to the health center and we're now reaching out and trying to reach the patient at their facility at their home or wherever they happen to be. To be able to have them come in by technology for a visit so that we can decrease our transportation time. We kind of live in an area that does not have mass transit. We don't have the ability to have-

Heather Budd:

Right.

Ellen Hey:

Buses and taxi cabs. Uber and Lyft are coming in our zone but again, still the number of people that we can transport to us, to a higher level of care. So, that's - that's when we started providing it to specialty care and that have branched out to do the primary care by this technology.

Heather Budd:

Right, and I just want to highlight too, part of what you're sharing it's almost like you guys are so fortunate that you've had these community health workers who were willing to actually drive to a patient and transport them to a specialty provider. I don't think that's happening in all communities and certainly not in all community health centers. It's an incredible gift that you've offered your patients historically and what I'm hearing is you saw the opportunity to really get greater economies of scale and reaching more patients by providing this service using technology rather than having to drive all those hours that Jose actually spoke about.

Heather Budd:

So, just wanted to put that out there because it's like, that piece almost got glossed over and I think it's really important to state because so many health centers are thinking about care management, and the use of community health workers and there's so many different ways that we can apply these incredible resources in our communities.

Ellen Hey:

Absolutely.

Heather Budd:

Yeah. So, great that gives us a little bit of an idea of why you guys were positioned to do this and I'm curious if you can talk to us too about some of the goals that your practice had in pursuing telehealth, and I know some of them you've already spoken about. But anything you haven't yet spoken to, please feel free to elaborate on.

Ellen Hey:

Yeah, I think the only other key in reviewing the slides here is that you definitely got to access the specialist. We are a rural, federally qualified health center. We do struggle with recruiting and sustaining healthcare providers, whether it's primary care or even behavioral health specialists. So I do think technology is a lot of of the internally, increased our bandwidth in covering all seven of our physical sites. And the fact that we have the ability to have our, for example, a community health or excuse me, a licensed clinical social worker, worked out of one facility and actually can filter daily patients from any of our other six facilities or even from home as we're trying to reach that virtual component to it.

Ellen Hey:

So this individual will be able to come where she lives and work out of a building closer to her home that actually touched patients across the span of our footprint. So, it started with specialists, it helps us to guarantee key time with psychiatrists all the way from New York City to Rochester and Syracuse. But also, it gives us guaranteed OR time as we deal with our dental program. So, our success with our data

has allowed us to show that by contracting with us or working with us, we can A, get the children specifically in for care, get them assessed. Have them only go to the cities for their OR time to get to their community health worker and then actually do a follow up at our health center. So, it actually helped that family. They actively engaged in their work environment so they don't have to miss time out of work, but actually get them the completion of care, which is one of our goals with that.

Ellen Hey:

The patients actually get what they need and are actually maintaining and either manage their chronic disease, or take care or resolve their disease that the child may carry.

Heather Budd:

Great. Jose, do you want to add anything to that because I know some of what you had spoken to me about, has me prepared for this, had to do with the maternal fetal health program and also some of the younger generations' technology hunger.

Jose Canario:

With our maternal fetal health program, we have community health worker going out with the provider. We're identifying, though, those who may need some follow up, trying to get some ... GYS. Maybe like things like that. If they have any kind of issues or social work, if they have any issues at home. We can have a community health worker go to the house and instead of the provider having to travel from here to there, or have them in house and be able to do some of the things via the virtual visit.

Jose Canario:

All our community health workers have the ability, if you have internet access in the places you're going, to login to their computer and do a telehealth visit with the provider so you can kind of do that same day if an issue comes up and then the provider could update to move on and go to their OB, that can happen as well.

Jose Canario:

And then as things go, I have two teenage girls and they're always telling me how to do my phone thing so, I trapped our younger generation with someone's technology that they're using as we move forward. We're going to have kiosks, I know that there is some offices out there that already have kiosks for checking in and doing that. We're using our portals to see what we can do with the mobile phones. Obviously, we could send texts from our EHR about lab results, about the coming in for a visit, things like that, but we're also seeing what we can do in these virtual visits component that we're piloting here pretty soon and that we can actually do a virtual visit on their phone with the providers back at the office. Either we're going to start off with maybe health worker first, but then the goal is to eventually open it up so that we could talk to a patient securely on their phone and talk to them.

Jose Canario:

Or I'll call or something like that and obviously...

Heather Budd:

Right.

Jose Canario:

Things like that but also that use that as an opportunity to quote, "see and hear" with patients on their phone from your phone or your office computer.

Heather Budd:

Okay. Excellent. All right. So, we took a little bit of time to build out a basic timeline of what happened in the journey with telehealth at Finger Lakes, but I want to just see if either of you wants to just speak to this a little bit just so that people can understand how you walked before you ran, basically. And how things have evolved overtime. Some of this you've spoken to a little bit, but I think just showing them how it fits together in terms of the chronology is helpful.

Jose Canario:

It is. And can I just interrupt real quick and go back to the last slide, just one or two.

Heather Budd:

Oh.

Jose Canario:

One more thing I've got ...

Heather Budd:

Sure.

Jose Canario:

Whereas I feel like something that one of the advantages doing this telehealth with psychiatrists or neurologists or even dental is that the primary care provider now has direct access as well to the specialist, so they can get some additional information. It's like having the patient, either the primary care provider or the RN in the room was all patient - Everybody's on board with the same care plan. It's a good way of educating everybody involved and it's also, I think, a good way for the specialist to see someone with barriers of care that the patient's experiencing if the RN or the primary care provider is able to bring that to light as well where they're all sitting in the same room. I just wanted to cover that because I think it's an excellent opportunity for folks ... Our sized primary care and their sized specialist to be on the same page and have the patient know that we have one goal in common and we can handle that all.

Heather Budd:

Yeah, no, that's so important. It's facilitating greater understanding on all three legs of the stool. So I think that's got to help, so thanks for advocating for that, yeah.

Heather Budd:

All right, which one of you wants to start with the timeline?

Ellen Hey:

I'll take on this challenge. So, we have teledental again is the key thing we noticed in our data. Our numbers showed that we had known children that had severe dental caries that actually needed to go to the OR for dental work. We do not live in a tertiary area, or an area where our local hospitals actually take pediatrics and do gyniatrics anesthesia. So, these children had to go about an hour to three hours up to go into the OR ... or to go to the dentist to have an evaluation and then go back again for the OR time and claim and go back to the in-shop visit. So over time, we're actually able to put this program together, where the patient actually meets right here in our health center versus a health center where they're located and getting their care, meetstt the dentist from Rochester to do an assessment and does the pre-op visit, and then goes to Rochester for just their surgery and then does their post-op visit. That's in the health centers.

Ellen Hey:

So with this program, we're actually able to increase a 15 ... or the low teens rate of completion, up to a 90 plus percentile of completion from identification of need to completion of surgical intervention. They're the nice, big things that's helped to build with that program is A, not only is the completion of care done and are guaranteed OR time if a child identified today, the chances of them getting into the OR could very well be this month, or next month. They don't have to wait six months out for OR time.

Ellen Hey:

It is also more importantly allows us to have completion of care. That also is a great teaching tool because as we're doing any of this from a phone, the patient and the family should get to see exactly what the specialists are seeing when we do a dental exam or you're doing a derm exam. The patient should get to see that on the screen too, so it's a great training tool.

Ellen Hey:

So, we did start with... I refer it to cows, the computers on wheels that you would typically see in the hospitals. We had telehealth carts. We had dedicated monitors, computers, and they'd follow...additional devices like your stethoscope, your otoscope, your oral cameras that were dedicated for each site. So, each site has one. We actually started with block schedules, meaning that telehealth only took place potentially two days, from one to three for that specialist. Maybe Wednesday from 8:00 to noon for this specialist and something that dedicated specific times on a schedule in block. We have now expanded from that have gone to where we're doing a wall mouth in every single one of our dam rooms, so that telehealth equipment won't be the issue, it'll be in every room. We'll have the capacity to use telehealth.

Ellen Hey:

We've also expanded schedules now, so that they're actually going to be telehealth visits at any times during the day. What works in the patient's schedule and in the specialist's schedule, or in our schedule. So, it's more going to when is the patient available and that we make that telehealth visit take place.

Ellen Hey:

Initially, we started with 30 telehealth parts. There was a dental one, a counseling one, and medical one and now that'll be available in each on of our rooms. We've also now just expanded to virtual visits, where we're actually taking the technology through say, on the roads. We actually do our computer and our hotspots, or whatever device we can have to develop internet or internet access. Have our community health workers out in the field with a computer, they'd be waiting to be screening or they're

doing outreach, and they identified that a person might need to have a visit or reschedule a follow up visit, and send a community health worker out to a home, they have the ability to do our telehealth visits from that patient's home or work or business, around the farm. Therefore, again, decreasing their time away from work or working into their schedule versus making them lose time and finances to the visit right from their home back to the provider that is at a different location.

Ellen Hey:

So if we look at this, it's having me develop telehealth in our health centers, then we have, we are working on the develop. How do we do a virtual visit when there isn't a building to come through at.

Heather Budd:

Right, it seems like the biggest extension of your CHW program when you think about the history of where you guys started. That this is just the techno ... I don't know what the right word is, but making that program "technologized" and making it possible for more and more people to receive that kind of care.

Ellen Hey:

Yeah.

Heather Budd:

Yeah. All right, thanks Ellen.

Heather Budd:

All right, so you referred to some of the pieces of this that I think our audience probably would love to hear even more about the different devices that are really needed for telehealth and obviously this has evolved overtime but, particularly the role of some of what you refer to as "peripheral devices." But how do they differ for the rooms, the specialists, and then out in the fields if you could speak to that.

Jose Canario:

So devices for in the rooms at the clinic, like Ellen had mentioned we're trying to get all our clinical rooms out outfitted with the equipment so that you can do telehealth right from inside the room. And what we're doing now is we have a touch screen computer screen, it's like a big TV that is a basic computer. On top of that, with a remote control camera that you can zoom in, zoom out, move around the room.

Jose Canario:

In addition, there's a speaker device, microphone so that you just have to speak in a normal voice and it'll pick up and you can hear the other side of specialists as well. To enhance these visits, we also have what is they call these peripherals. They include an ... dental, what dentists use for the in mouth examination but we have found that it's an excellent tool for dermatology issues. So, if a provider at another site has a rash that is very interesting and want some advice on, they can call somebody at another office here within Finger Lakes Community Health and get a curb-side consult. We have a dermatologist on the line just to show what the rash is and it's high definition. It's really nice actually.

Jose Canario:

In addition, we have an otoscope that can be attached as one of the peripherals to the screen via USB. This otoscope is just like a regular old otoscope. You can see what's going on inside the ear, as well, but the specialists on the others side can also see. So, you go inside the ears, nose, inside the throat, so you can really do a good physical exam. HE and ENT can with that.

Jose Canario:

You also have a stethoscope that can be attached via Bluetooth and basically it looks like the sides of the 50 cent coin. It has a little bit of substance to it that you can just hold it in your hand, put it up to the chest, and you can hear breath sounds. You can hear it, the specialists can hear it, breath sounds, heart sounds, murmurs, rogues, palps, all those things that go along with the clinical, physical exam.

Jose Canario:

Trying to think of any other peripherals we use at the moment. Other than that, either the provider or the RN can do the actual, physical exam like palpating the abdomen, doing the neurological exam. The provider on the other side can do the whole physical exam provided to them and they're able to participate as well.

Jose Canario:

As far as for the specialists, they just need to have the monitor, a speaker, and a camera, and they can do it on their laptop. Since they're really not with the patient, they don't any of the peripherals, so it's pretty simple on their end. And then as far as the community health workers out in the field, they have their laptops, they can have the peripherals as well. They're all portable, it's all USB driven. They put it into their laptop and then I can hear it on this side of the primary care person who is seeing this patient work through it.

Heather Budd:

So, I'm curious about a couple of things. One, how did you get specialists to actually start to agree to work with you? My guess is that cultivating those relationships was a big part of the building of the momentum of this program.

Ellen Hey:

Yes, absolutely. And so far, it is again is, not working with you, now working with any of your providers, it's more reaching out to them and offering them as an option, we start discussing it with them. You know, building a contract and sometimes it's just showing-

Heather Budd:

Right.

Ellen Hey:

Them what the system can do, and how the system can work and what were the best fits there.

Heather Budd:

Yeah, I'm sure it must be so helpful that they don't really have to commit much in terms of investment on their end, give that they can use a webcam and a laptop and basically have all that stuff. They don't have to buy a specific device to participate, Ellen.

Ellen Hey:

Correct, absolutely. Yep.

Heather Budd:

Yeah. And actually related to that, I'm guessing that you're no-show rate is much lower on these kinds of visits than it might be for a patient showing up physically to a specialty visit. Is that true?

Ellen Hey:

So, I think we still struggle with no-show rate and we still are a population that-

Heather Budd:

Right.

Ellen Hey:

Still has no-show issues and maybe try to do a little bit more outreach with somebody you know who's had a telehealth visit to ensure that they can come or work around it. I think our expansion not having specific times has helped to decrease our no-show time.

Heather Budd:

Mm, got it. Okay, that makes sense, so you're building in more of the flexibility to meet the patients not only where they are, but also in terms of what they need.

Ellen Hey:

Exactly.

Heather Budd:

That's amazing. Yeah, okay. Then along with that, one of the other components that I heard both of you speak about at different times regarding the community health workers in the field, is really the internet. I know you're predominately in a very rural area where internet is not a given and I would just love to hear you speak about the multiple ways that you addressed this for your community health workers because I think this is pretty important.

Ellen Hey:

Yes. Again, it's still a challenge so we're tracking right now and mapping our area to see who are the better providers in the area. So, that's some of our bigger stoppers is that the infrastructure in our communities is not always there to support the newest of the technology. So, we are just currently now changing different hotspots. Satellite's a little bit more of a challenge because of the security network's going through, so satellite we really haven't had that much luck with our technology at this current point.

Heather Budd:

Mm-hmm (affirmative).

Ellen Hey:

But we're just mapping it and knowing that we're trying to track on a more frequent basis of what works where and what part of the state that they have to go to in making sure the devices are available to our community health workers to flip, whether it's AT&T going to Verizon or going to to find another provider in that area.

Ellen Hey:

And then even too, they can share that our health centers have the bandwidth that they need-

Heather Budd:

Right.

Ellen Hey:

Since you are doing videos, so sometimes video versus voice. Then if we have to, we nip out some of it so that when one device is doing one, and another device is doing the other. Part of it's not waiting for perfection to do good.

Heather Budd:

Yeah.

Ellen Hey:

So we put it out there and we just keep working out the bumps as we go.

Heather Budd:

Right, access is the key.

Ellen Hey:

Yeah.

Heather Budd:

Okay, that makes sense. All right, thank you so much.

Heather Budd:

So, I think a natural corollary to all of those questions has to be, how does reimbursement work for these visits? And I know it's a little bit different for some of these three different areas and of course feel free to add to this if you want to. I know you guys are really interested in furthering the work around reimbursement, that you're building a platform for proving the relevance, the use, the incredible improvements that you're seeing in patient care as results of this and it's still not perfect.

Ellen Hey:

Yeah. So, right now currently there's reimbursement for telepresenting and it's kind of a flat fee. It doesn't really fall into a role about what has evolved and all the different types of visits, so we're trying to build a platform right now where we can provide some data about the different types of visits. So, we have our basic visits which we call level one, so we kind of just mirrored it, nothing too creative, mirrored it right over what we do typically for our provider visits. So, level one visit is that nothing is

really needed on the staffing side. You just put the patient in front of the device, you turn it on, you make sure that there's a HIPPA secured connection between the patient and whomever is on the other end.

Ellen Hey:

So, for example we do a lot of this with our counseling services or our diabetic educator. We don't really need to present anything to the first one, you just need to take your snippets here, she has a secure connection with whoever the provider is, and then when the visit is completed, the patient's good to go. So that's our level one visit.

Ellen Hey:

A level two visit really where we have nursing go in and they go in and make a secure connection, whether it's with a specialist or one of the primary care providers of a different type and it gives a report of what's happened over the past month or so, what lab results are or any concerns that are identified. We work a lot with behavioral health and our infectious disease. Then we bring the patient in. The patient, and the nurse, and the provider, the specialist at the other end, have the visit together. They sometimes, the nurses there or if we are with our virtual visit, the community health worker out in the home, is doing some assessment for that provider.

Ellen Hey:

So, they're using a stethoscope, the otoscope, putting in for a neuro scan. Some of our specialist visits, combining with our primary care, we'll actually have a primary care provider in the visit with the specialist and the patient. So almost like a collaborative visit.

Ellen Hey:

That's kind of our level three, where they're having a more extensive evaluation, discussing, and then establishment of a plan of care. So, a level three is a collaborative visit where we would actually have one our primary care providers involved with the specialist. And we initially started our HIV and our Hep-C care visits this way and we are transitioning them to nurse visits, and actually we're transitioning them to be completed in-house by our primary care providers and then only referring specific cases to the specialist.

Ellen Hey:

So, that's our three levels, but currently right now our reimbursement works on the flat fee. There's a telehealth fee that you get from insurances for presenting, so we're going with that right now as we continue to build and advocate for different levels of reimbursement with telehealth.

Heather Budd:

Great and I think it's probably important that folks know as well, that the specialist can bill for his or her visit in a standard way.

Ellen Hey:

Right.

Heather Budd:

So they're getting complete coverage for their participation, which is probably really key for them being willing to be part of this.

Ellen Hey:

Correct.

Heather Budd:

Yeah, so in this case, the CHC is really shouldering the burden of making this available and I think the other, next piece of this is how did ... let me switch to the, how did you fund this piece because ... well, actually let's just talk about it here.

Heather Budd:

So, how did you fund some of this, or are you still funding some of this work given the complexity of reimbursement as it stands right now?

Ellen Hey:

So, let's talk about technology and that thing first. So, a lot of our technology utilized grants, whether it's the USDA or other additional grants we have available. Also for our visits in our programs, have researched out different grant fundings to assist with getting it started as we are working our way through the reimbursements with insurances and getting coverage for that. We initiated a lot with grant funding. Both say to skip the technology and get things going, but we know with some of our visits we had to get them started and then go back and relate to challenging and advocate for reimbursement, which is already ... that Pandora's Box has already been open or that the door has been open and we're just now seeing things just aren't going to hopefully completely snowball with increasing coverage and bandwidth service telehealth presentation.

Heather Budd:

Okay, great. Thank you.

Heather Budd:

So, I'm curious for either of you or both of you, some of this has been mentioned already but what benefits do you see providers and staff receiving from this process?

Ellen Hey:

So, yeah-

Heather Budd:

We know it's good for patients.

Ellen Hey:

Absolutely, absolutely. I think the biggest thing is that we are a federally qualified health center, so we tend to recruit people for a short period of time and then they migrate off after they complete The National Health Service Form, we get a lot of scholars for low retainment. So, we tend to have a higher turnover rate meaning that they don't tend to come for a lifetime, they come for three to five years.

Ellen Hey:

So part of it is that it's definitely a great way to connect with the patient and the primary care team, whether it's the community health worker, the patient navigator, the nursing staff or even the provider on the care team. And know the specialist get comfortable with the care, learn the disease process in different treatments, it's definitely a way to keep everybody up to date on different changes and connected. Also helping them to become part of a more collaborative care for completion. We're aware of what's happening and the message that's being given and actually can reinforce that message when we're seeing them with phone calls through the follow up checks after the visit.

Heather Budd:

Right. And I'm guessing too that this last point about higher rates of completion of care, we obviously know that that's the case for you in the dental realm in particular, but I'm sure this is true across the board that that's got to be a relief to all of the different roles you've talked about. The nurse, the community health worker, providers and other support staff who are delivering are to patients, to know that they're actually getting what they need has to be huge.

Ellen Hey:

Oh, absolutely. Absolutely.

Heather Budd:

Yeah, okay.

Ellen Hey:

Thank you.

Heather Budd:

Yeah, thanks for sharing that.

Heather Budd:

So, I know the answer to this question. We've shared already some of the information particularly around the teledental program, but I'm curious if you could talk to us about other measures, well that measure and also other measures, that improved related to these programs. The reason I'm saying these programs is this is a combination of various disruptive technology, I think, that you've employed which is your community health worker programs, different kinds of visits with patients, more frequent follow ups, less the telehealth and teledental all together as a package. So just wanted to name that all of those pieces are a part of this.

Ellen Hey:

Absolutely. I think it's a team approach. And so, I think our continued push for the use of technology, you're trying to think outside the box of how we can do it better so that you haven't missed a slide here. Our Hep-C patients have actually been able to get their care initiated if their vital remission in 99% of our patients. We're working very hard now with our blood pressure and our hypertensive patients, are creating methods for us to get their numbers outside of the health center to modify their treatment and get them under control.

Ellen Hey:

and a quicker turnaround, so we've actually been able to implement at one of our sites and now we're just transitioning it out to another site where we're using home monitoring devices and actually touching base at three, seven, and fourteen days. And having the opportunity to initiate or modify treatment along any one of those touches that happens, so that that way we're not, have a reading and then it falls through it reinforces to patients that this is important for us and this is important for your health and this is a key area, not just waiting for three to six months and seeing results because of that.

Heather Budd:

Yeah, absolutely. Okay, so I think having people see some of the data that backs up what you guys have been talking about is really helpful. LuAnn actually put together some dashboards showing Finger Lakes data, in particular around BP control in this case. Looking at the Penn Yann site in particular and I'm just walking you through this and LuAnn, you're welcome to jump in here and say something and, of course, Ellen and Jose as well.

Heather Budd:

Just to orient everybody, it's the upper left hand corner. This is for the overall population in Finger Lakes, their hypertension control rate, so it's at 57%. And they've obviously set targets here and you can see those targets are higher than 57, so the yellow would be their interim target, the green is their ultimate goal.

Heather Budd:

And then you can see, if we skip over to the other side looking at the similar looking gauge but where it's yellow, this is the hypertension blood pressure control rate for the Penn Yann site which is where that new way of seeing hypertensive patients really was piloted. You can see they've got a pretty significant jump on the control level for their hypertensive patients, all the way up to 71%.

Heather Budd:

The two timeline graphs that you see in the middle, the one at the top is Penn Yann overtime and then you can also see the timeline for Finger Lakes as a whole overtime. You could see all the different month periods where the control rate is shifting overtime.

Heather Budd:

And then there's a couple of other things here as well, I'm just watching the time and knowing that we've got more things to cover, but these are really around things like people with essential hypertension, potentially undiagnosed hypertension, so the whole population then again over on the other side. Potentially undiagnosed hypertension and those who are hypertensive at the site, so obviously there's a difference in the number of people being seen at that site but it also looks like they're missing fewer patients with two readings of blood pressure that's greater than 140 over 90, and not necessarily diagnosing them with hypertension.

Heather Budd:

So, all of those things are great. Anything anybody else wants to say about that?

Ellen Hey:

Yeah, so Heather, I think the important thing that's in your two statements and a great addition to this with having the ability to have this dashboard and have this at the care team's fingertips. So, our team is actually now not waiting for patients to come in, they're actually reaching out to patients, calling them and saying this is the last time you were here. You take that 39 that are on diagnosed with hypertension, you had an elevated reading, we'd really like you to come in and get this pop and take it home and then let's talk about your readings that you're acquiring at home.

Ellen Hey:

So, we've actually had the team now enabled to start work this dashboard and outreach to patients and persuading them to come in the door because they actually have this data at their fingertips now which is key, and they don't have to wait for me to run a report to send it to them or anyone from our IT team. The care team themselves can pull up this report and know I as provider A know what my hypertension control is and what are my patients that I need to reach out to that aren't under control.

Ellen Hey:

And then my team can go ahead and address that they don't have to wait for me.

Heather Budd:

Absolutely. And then this slide is really looking at RNA control levels for patients with HIV and you can see there's been a study increase overtime with looking at this data. We've got an anomaly member over here back in May of 17'. My guess is that starting at ten and staying down here is more consistent with what you've typically seen. And it's pretty impressive that you've been able to improve to this degree with this population. Anything you want to say about this?

Ellen Hey:

Yeah, I'm actually working with a project right now, with our virtual visits, is some of these individuals are migratory, so then they're not here consistently year around.

Heather Budd:

Mm-hmm (affirmative).

Ellen Hey:

So that we're trying to now use our virtual visits to help to stay connected with them throughout the years, so that we're not having them come back in, and just like we are with our diabetics, have them come back in with season and then starting from scratch again because I haven't had care throughout the year. So, try to think outside our current borders to think about how can we provide care for somebody year around and they might not have access to us year around. And technology-

Heather Budd:

Great.

Ellen Hey:

Is going to help us close that door.

Heather Budd:

Yeah, great point. So this could be that this agricultural worker is following the picking opportunities where the season moves depending on what's in season, what's not, or it could be that they're going to another place depend on what their circumstances might be.

Heather Budd:

And then this is data on the child dental sealants measure, you can see that there's been a nice uptick on this. This is not the stat that we were giving you before, which is around the completion of the dental treatment plan, this is specifically child dental sealant which is a measure that all of you are, I'm sure, working on improving but this is a pretty great number from my perspective having seen quite a bit of data.

Heather Budd:

Again, I'm aware of the time and I know we've got several questions as well. So, I want to point out that you are tracking all of this information for the most part with the exception of some of your integrated behavioral health in ACW, so that you can actually have your referral clerks close the loop of something that HRSA is looking much more closely at in the coming year and it's part of patient center medical home which is big reason why I know you're doing it.

Heather Budd:

But it's so important so that you actually know what needs follow up or what might be completed. We've talked quite a bit about the business intelligence having shown you some of the slides, is there anything else you want to say about this, Ellen or Jose? Before we get too close-

Ellen Hey:

Yes, again it's just an additional advantage, it's great. It's at the staffs fingertips, so once we have gotten it in, each of the teams can take ownership of what belongs to them, of course just waiting for reports to come from a central location.

Heather Budd:

Right and I think the key is that the teams can take ownership, rather than that burden resting on the provider's shoulders in particular. So, I want to hear the answer to this question and I'm also aware that we've got some questions out there and I'm going to ask April to cue us, so if you've got things that you're dreaming of for telehealth and CHWs, maybe you can work them into your answers. But I want to turn things over, I want to just do some Q and A for a moment here and we've got some slides after this that we're going to skip just in the interest of time. The interview with Jose and Ellen is just too valuable, so I didn't want to cut any of that off.

Heather Budd:

But April, would you let us know what questions we've got?

April Lewis:

I sure can. The first one asks, "what software do you use for video conferencing capabilities?"

Heather Budd:

Okay, great.

Ellen Hey:

Yeah, I use Jabber. Yeah, I think it's a Jabber based line. I'm sorry, I'm not part of the... the big slide, but we use Jabber as most of our video, HIPPA compliant base line. We had Zoom actually, also that they have a HIPPA compliance and all that.

Heather Budd:

Nice. Let me just interrupt again for one second here just because I know we're reaching the end of time. April, do you want to make your end announcement and let people know that we might go over a minute or two, but just to fill out their evaluations when they get that pop-up and whatever else you want to say?

April Lewis:

Absolutely. Thank you all again for joining. We will keep the line open and answer any outstanding questions, so if you did submit them, we're going to answer them. If you have to jump off, just ping me in the chatroom or shoot me an email, and I will get you connected on the tether and the ping where your questions may be answered. But for those of you that do have to leave, again thank you so much for joining. Sorry we ran over but to echo Heather's point on the interview was valuable information. The recording will be available and made via your myNACHC account. Please, please, please complete the survey and have a wonderful week ahead and reach out if there's anything that we can do from our end. And we'll go onto the next question, Heather. It asks, "how do you go about training your staff and physicians to quote, do, end quote telehealth?"

Heather Budd:

Mm-hmm (affirmative).

Ellen Hey:

So yeah, we actually conduct training at least once a month for not only individuals, but it's actually part of doing business, so we include it as part of doing business. It's not an optional choice. It is something that we include right from the day that they start, and then reinforce it at the three month mark and the six month mark, and then we just identify any issues or concerns as we go along. So, myself and the telehealth team and the IT team meet once a month minimally, twice if we have issues because one of it's just based on what are the current issues and then one of them is vision focus. So, we just included it. Everybody learns how to use it. And we actually have been doing a lot of our staff meetings this way, so people get comfortable with using the equipment, because if you don't use it, you lose it so we try to make it a component of our everyday life.

Heather Budd:

Makes sense. Next question.

April Lewis:

The next question reads, "what type of staff are on-site with the patient during the telehealth visit? Like community health workers, dental students etc. and are there every telehealth visits where the patient is by themselves and all the contact with the other health center is virtual?"

Ellen Hey:

So, depending on the statistic visit that takes place, where in the health center there's usually a provider in the building. Although, we have modified that over the last three months that we have an RN in the building just so that if there's an issue, especially if it's a behavioral health component. We are working and our goal is to get to the part where the patient's by themselves and the providers in the health center, that's our ultimate goal. In the next six months we'll see that happening. I can be used in that platform, especially when we're on call to actually come in on their app and be able to see a rash or direct care if you can actually see the patient.

Ellen Hey:

But right now, typically minimally it could be community health workers they're off-site. The on-site, it's usually used by nursing staff within the building and RN.

April Lewis:

Perfect. All righty, and the next question if you're able to answer is, "is the reimbursement for Medicaid and Medicare ... sorry for my chuckle ... so that's the next question, "does Medicaid and Medicare reimburse telehealth visits?"

Ellen Hey:

So, they're two separate entities. For us, we have special payment. So, our telehealth discovered if they cross the threshold, for straight Medicaid, the managed Medicaids are yes, they do cover it. Each on is a different component. Medicare is based on specific locations and some of our sites have Medicare reimbursement and some of our sites do not. So again, that's an avenue that we keep researching and try to challenge out, and get change.

April Lewis:

Okay, and I'll just echo back, even at the national level, I always redirect people when they come to Medicaid and get with your state and just closely watch the decisions that are being made at the political level because there are some nuances with the reimbursement.

Ellen Hey:

Yep.

Heather Budd:

Absolutely.

Ellen Hey:

We also meet monthly on that and track that just like we do with all of our programs, just to say, okay what's changing. How do we modify it? How do we keep knocking at the door to get it better?

Jose Canario:

Mm-hmm (affirmative).

April Lewis:

And that is all the questions that are in the chat box.

Heather Budd:

Okay. Great. So, as April said, these slides will be available to you along with the recording in myNACHC.com and I just want to say a special thank you to Jose and Ellen from Finger Lakes Community Health for being here with us today. We're so fortunate to have your expertise and obviously, the audience had lots of questions for you so yeah, we really appreciate it.

April Lewis:

Alrighty. Thank you all. Thanks Heather. Thanks Jose. Thanks LuAnn. Thank you all very much, you all have a great day and to all of our attendees, thank you again for joining and sticking around. Please reach out if you need anything from our end and have a wonderful rest of the week.