Phillip Stringfield (00:00):

All right. I have two o'clock on my end on the East Coast. So I want to go ahead and get things kicked off as everyone is joining in. And I want to welcome you to the October session of NACHCs Telehealth Office Hour. My name is Phillip Stringfield and I serve as the manager of health center operations training within NACHCs training and technical assistance division. So I'm glad to have everyone joining us in today. So as we get started today, I just wanted to go ahead and put in a quick reminder of the upcoming finance operations management and IT conference that we have coming up next week. It's going to be October 19th through 20th and we are going to be in Las Vegas. So we're definitely looking forward to having everyone there, whether it's going to be in person or virtual. So if you would like to find out more information, registration is still open. You can visit nachc.org to find out more about the upcoming sessions that we have in addition to the keynote speakers that we have [inaudible 00:01:00] as well.

And the last reminder, I just wanted to put in a quick plug for the EHR user groups that NACHC hosts. So if you're not familiar, NACHC does host five independent EHR user groups that meet on a monthly or quarterly basis. And these groups are also led by steering committees comprised of PCA health center and HCCN leaders. So if you're interested in joining either the group or the leadership team of either of these groups you can see my email at the bottom and I'll make sure to put it in the chat as well, but feel free to send me your email with your interest of which group you like to join, and I'll make sure to get you all prepared and connected to the right group.

So let's go ahead and dive into some housekeeping to help navigate throughout today's call. So we will be accepting questions towards the end of today's presentation, but if you would like to verbalize your question, feel free to raise your hand and we'll make sure to unmute you when the time is right, so that way you can ask your question and get it answered and have the direct engagement with today's presenters. And then also just putting a quick plug in for the Q&A feature, so we'll be looking at the Q&A feature and keeping track of all those questions that come in and we'll make sure at the end to get those questions answered for you, and making sure that all of that do come in are able to get answered [inaudible 00:02:26] as much time that we have left there.

So let's go ahead and dive right into today's session. I am joined by Amanda Laramie and Adrienne Mann of Coleman Associates. And we'll be talking about optimizing Telehealth workflows. And really we're going to be looking at how to strategically work in telehealth visits to your operational workflows. So I'm definitely looking forward to all the great nuggets that they have to share with us today. And without further ado, we're going to go ahead and hand things over to the team. So thank you.

Amanda Laramie (02:56):

Thank you so much Philip and Olivia for having us. We're really excited to be here for the office hours today and talk about telehealth and virtual care. My name is Amanda Laramie. I'm the COO of Coleman Associates. And joining me is Adrienne Mann. She is the chief innovation officer for Coleman Associates. I know a lot of you have heard Melissa Stratman, our CEO, speak in the past. Like so many other Coleman Associates, Adrienne and I both started in the front lines of healthcare. I hail from a women's health center in Rhode Island. Now, I'm in Boulder, Colorado, but I've been working with Coleman for the last 10 years. I started as a medical assistant, I dabbled at the front desk, but poorly, and then became the assistant manager and manager of my health center. And then, joining me, Adrienne Mann is a nurse.

She started in Chicago as a nurse and care coordinator in her health center. And she's been with Coleman Associates for about four years, and recently the chief innovation officer. And Adrienne

everything's... You can hear me okay on my end, right? I always want to do a double check that everything sounds okay.

Adrienne Mann (04:02):

Yep. I can hear you.

Amanda Laramie (04:03):

Okay. Awesome. So here's what we're going to cover today in about the next 40 minutes before we stop for questions so that we can respond to exactly what you wanted to get answered today in these office hours. So we're going to start by talking about some scheduling strategies for telehealth. We know in talking to Philip and some of the folks from the community health centers to weigh in on this session, that scheduling was a hot topic. So we wanted to share with you what we are seeing in terms of best practices for scheduling. Second, we're going to talk about what we're seeing in terms of workflows. So beyond scheduling, but like how telehealth is working, how the visits are connecting, how patients... are they do doing phone? Are they doing video? What's the best connection for those? I'm going to share with you a case study of what I saw from Northern California and share with you how we're recommending people, reorient the workflow to give a better patient experience, but also a better staff experience as well.

Third, we're going to cover some strategies to increase the number of video visits you're doing. Even though we're all operating under current reimbursement guidelines and I know they differ by state in terms of what we're getting paid on for phone versus video, we are thinking that telehealth is around to stay. However, we think we want to bank on video visits more than phone. And so I want to share with you some best practices we've seen for getting more of your visits, video versus phone. And then lastly, for the last 15 minutes, we will do a Q&A. So feel free to put them into the Q&A box and we will either answer them as we go. Adrienne's going to alert me when they come in the Q&A box. And if we can't answer them as we go, we'll save them till the end of the last 15 minutes.

All right. So in terms of talking about scheduling, we do want to start here chronologically. Let's start here in terms of the patient's visit, what is their experience making an appointment for telehealth, and how do you prevent some issues with telehealth from the beginning at that stage of scheduling? So this graphic right here, you'll notice, this is something we've done a telehealth training program and for you, we wanted to pull out some of the best components and give them to you here. I'm not going to cover the entirety of this slide. You have these for your reference. You can look through them afterwards. What I want to cover is this pink box on the left, which is talking about how the appointment is scheduled, and then that blue longer box on the right of the pink one, which is about pre-visit workflows, because what we're seeing in telehealth workflows and what we've been coaching teams to do across the country is really think about what you can do in advance of the telehealth visit, including scheduling and at what point your preregistering patients.

So if I look at the pink box, we're going to start there with scheduling, but then if I go to the blue, we're going to talk about polishing the schedule today, we're going to talk about preregistration, and we're going to talk about this really important component, which is not a component of our in-person visits, which is providing some important technology support so that the connection works, so that the patient has a good experience, because in the preliminary research we've been seeing about telehealth and whether patients would opt for it again, is whether or not it's a smooth connection? Whether they were able to connect to their provider? Whether they had issues with audio, sound? Those are the things that are preventing people from doing video visits, are just saying, "Yeah, just schedule the patient to come in." And so those are the elements today we're going to focus on. And

then the day of the visit, and after visit workflow, we're not going to spend so much time on today, but you can absolutely refer back to these slides for those elements.

Adrienne Mann (07:50):

Yeah. Thanks, Amanda. And I would just say whenever... if we're zooming in on the pink box that was on that slide and going into telehealth scheduling, the first step in scheduling for telehealth is really deciding what visits are appropriate for telehealth. And at this point, I think a lot of you have already figured out what patients and visits work better for telehealth versus in person visits. But this is a graphic depending on where you are in that journey that might help you to think outside of the box about what could be provided via telehealth and even in extended or hybrid visits, which can be really helpful especially as we go into cold and flu season and if there are additional spikes of COVID-19. You can also see this in the dark pink box.

But what we see in most organizations is even amongst an organizations' providers, there's different varying levels of comfort with telehealth. And so my guess is that you have some providers internally who have really figured it out and then some who are still adjusting. So what we would definitely recommend to what we see people doing now is using your internal resources to come up with training materials, to do your brown-bag lunch trainings, to get everybody so that they're comfortable with telehealth, so that, that isn't a barrier to getting patients scheduled for telehealth regardless of what the... or the reason for visit is. So-

Amanda Laramie (09:11):

And if I could share in that Adrienne, before you move on, I mean, the reason I put that in there is from teams I've been coaching. Everyone's been saying to me, "Some providers love it and they don't want it to go away, and they appreciate all the comforts of providing telehealth when they get to work from home, and they're the ones who are pushing for it." And then you have providers who are on this other end, who are just like, "I don't know. It's not as effective as in person." And all of that is true, but I think the most important thing we can recommend is capitalizing on those providers who've really figured out great ways to do visits and utilize virtual to provide exam for a patient and go through symptoms and say like, "This was actually awesome." And then share that learning with other providers on site, who may not be as interested in providing it, if you want to have it as an option for your patients when they call in to schedule.

That's what we're looking to do, is make sure that patients get to choose what they prefer versus us say, "You know what? We're going to allow 5% of our visits to be telehealth." So long as reimbursement stays the same, why not give patients that patient-centered option of saying, "Do you want to drive in for the visit, or can we do this visit over video?"

Adrienne Mann (10:23):

Yep. I would second all of that, Amanda, and I would say that it gets into it here, is because there are... I think about it from a care coordination perspective of course is, it's always good to be able to provide patients who have a hard time getting out of their house or who have difficulty with transportation, or just want a telehealth visit, that option, which I think is great. I want to talk about some specific examples of schedules. And so, I have to start off by saying no schedule is a magic wand that fixes every operational problem. So I cannot promise that at all. Because they are really just tools that work in tandem with other operational improvements, which is why this is one part of what we're going to be talking about today.

But in terms of the mechanics of scheduling, there are basically two common methods that we're seeing. So one is to intersperse telehealth visits with in-person visits in the same session, and that's what this slide depicts. And then the other, which is going to be my next slide in a moment, is to have a dedicated session for telehealth versus in-person session. And Amanda, if you don't mind going back also. So this graphic here depicts an intersperse schedule, like I mentioned. So to orient you, the schedule that we see work the best regardless of if it's in-person or telehealth care is a simplified patient schedule. So you'll see in both examples, all of the visits are the same length. You can also see that the light green huddle spots are built in at the beginning of the session, and that's a practice that we use for all of our schedules that we recommend.

So you can certainly engineer a certain number of telehealth slots like it shows here. But what we find is that if you have specific times that are telehealth or specific times that are in-person, it tends to increase the number of slots that go by unused. What tends to work better is making each slot flexible and able to turn into either a telehealth or an in-person visit, and then often your schedule still ends up looking like this with an interspersed amount of telehealth and in-person. That in particular helps a lot if you're trying to implement a strategy like tele-jockeying that Amanda is going to cover in just a couple of slides. So then, in this other graphic, you can see the two schedules and Amanda, do you mind showing them the other graphic? The next one?

Amanda Laramie (12:48):

Yep.

Adrienne Mann (12:49):

Great. So this is the depiction of if you decide to do all telehealth for a session or all in-person for a session. So the downside of this is that in some cases, and we see this in some organizations, they just cannot fill their telehealth spots, or they can't fill their in-person schedule, and you're stuck with more unused slots. If you have really high telehealth demand, or in some cases, if you have really high in-person demand in addition to that telehealth demand, this can certainly work. And it's a good option if you want to be able to provide remote working options for staff and providers, or if you're limited in clinic space and you're trying to expand your capacity in that way.

Generally, a simplified schedule includes some of those. I want to just show you the pink patient care team blocks. You didn't see them in the other schedule, but they often include this in those. Just to orient you a little bit, the patient care team blocks are either used for catch up time or they can be used by the patient care team to schedule another patient. And you determine how many of those you have based off of the length of your simple visits and then your productivity goals. So I just wanted to mention that part. Speaking of-

Amanda Laramie (14:05):

[crosstalk 00:14:05].

Adrienne Mann (14:04):

Yeah.

Amanda Laramie (14:07):

If I can bring something up, and I know you're going to give it over to me to talk about tele-jockeying, we had a comment in the chat from John who is talking about how it can be difficult to switch back and

forth between in-person and telehealth, and we've certainly heard that and seen that, and I think that is a challenge. Most people have said is an issue with the graphic we showed you where it's interspersed.

It is a challenge and it's one of the things that I think is a risk of going to a schedule like this with all the same visit lengths without doing any workflow improvements in your in-person flow, because what you'll tend to see, and I'll show you this example later, is a provider being very late for their telehealth appointment and the patient possibly thinking that they were forgotten about, or that maybe it wasn't happening, because it's not like they're sitting in-person in a waiting room. And so I agree with you, John, that it can be difficult to switch back and forth. And this only works if there's smooth workflows that allow you to start relatively on time with each visits that's in the schedule. Otherwise the interspersed can be very challenging.

Adrienne Mann (15:15):

I would absolutely second that. Usually probably the easiest place to start is with having sessions that are blocked off for telehealth versus in-person, and then moving to more of a certain time, and then moving into true interspersed to make it a total voice that... You're absolutely right. It requires those other workflow changes to make both processes really smooth.

Amanda Laramie (15:39):

Yeah. This concept of tele-jockeying though, that Adrienne was just handing over to me to share, is something that can work well in either schedule formats we showed you. So whether it's a full telehealth session, or whether it's an interspersed one, or whether it's a session where it was planning to be all in-person, but you have some late cancellations or no shows happening. And it's this concept called tele-jockeying, which is flipping visits that were previously... flipping conversations when you're on the phone scheduling with patients. I was in Upstate New York, two weeks ago, and they had 40 minute slots for new patients. And they had this pattern of those had higher rate of no shows than their other appointments because they had been booked quite a bit ago. And so what they did when they found that it was like 9:00 AM and the 40 minute appointment hadn't shown up yet, and then it's becoming 9:02, they would look at Wendy, who was on the phone answering calls, and say, "We're flipping these visits to be [2:20s 00:16:46]. Next person who calls see if they can come in. We'll see them."

Slash, if they can't come in, because that was like 20 minutes away, the best thing they could do was turn it to a telehealth visit and say that provider doc there, Dr. S, he's about to have this no-show. You want to be seen right now, let's make you a virtual visit. We're going to get you all logged in and he can see you right now. And that tele-jockeying flips the scheduling conversation into a visit. So we can recoup the visit, service a patient who would otherwise be scheduled weeks out, and work that patient in the schedule. So that's a concept that takes a little coordination on behalf of whoever's answering the phone and the team in the back, but it's really effective at reducing missed opportunities and giving patients the satisfaction of getting their visit right then and especially...

We used to do this in the olden days before telehealth, anyway in that first example I gave of being like, "Well, could you just come in?" But now, we don't have to do that. The advantage of having telehealth is to really maximize and say, "You don't even have to drive. Don't worry about the commute. Are you available right now?" And do to visit. I will say this little pink box in the top right, I also was working with a dental team in Los Angeles and they were finding this was really helping them prevent missed opportunities for those longer dental visits. And obviously not every dental visit would work in this scenario, but for someone experiencing pain or someone who said, "Gee, I had this treatment a few

weeks ago and now this is happening." If the patient couldn't come in, they try to flip it to a teledental visit and connect with that patient right there and evaluate them for pain and figure out next steps.

The other scheduling practice that I mentioned earlier is this one called polishing the schedule. For anyone who has heard Coleman Associates speak before, or worked with us, you've heard of scrubbing, which is a tactic we use to teach health centers how to get the schedule cleaned up, meaning every appointment is a necessary visit and we know patients are going to show up for those. This polishing concept is basically like scrubbing 2.0, which is a practice. Say you have your appointments scheduled, you're ready for your day, and you're looking at tomorrow's schedule, and you want to make sure it's all set to go for your telehealth, for your in-person. These are the three questions that I would encourage you to ask if you're doing like a visit prep or looking at your schedule the day in advance, which are, does the patient want the appointment in-person or can it be telehealth? Do they need the visit in-person or could it be done on telehealth? And then, K, will they keep this appointment? Period. So that you can anticipate whether you can use this slot for someone else.

Now, this wink... I mean, that's the acronym I'm sharing. We didn't come up with it. It was a trainee that I was working with in Southern California, [inaudible 00:19:52] said, "No, that's wink." And so now we've been referring to it as wink. The want it, need it, keep it questions for telehealth, the intention of this is to prevent the team from saying on the day of the visit, "oh, shoot. That patient, they came in for that. We really could have just gone over those results over telehealth and I could have gotten that referral started for them. They didn't need to come in. Shoot, I could have saved them that drive."

It also prevents the question or the comment that a care team would have of like, when they get on telehealth saying, "Oh shoot, I couldn't do much on this telehealth visit. I needed to see them. Oh, I feel bad that they wasted their copay or they're sliding scale fee payment on this because really they just need to come in." So this polishing allows the team to look at the schedule in advance and say, "Could this be telehealth? Could this be in person? And what would the patient prefer?" And asking those questions. So that's polishing.

Adrienne Mann (20:51):

Yeah. Thanks, Amanda. Some of the next steps, just to summarize where you go next in terms of scheduling, is that thinking about that telehealth might require different scheduling, a really improved scheduling, like thinking about what visit types are appropriate for telehealth and maybe doing training around that, and thinking about that balance, which we talked about between having flexibility so that you prevent unused slots and what you can handle internally in terms of keeping things running on time, we see that in most cases, simplified scheduling definitely improves patient access and decreases staff time in scheduling appointments. So that can have a positive impact on the third next available, and especially the call abandonment rate. You do have to be really data driven about how you approach your schedule though.

So for example, if your cycle time for telehealth and, or in-person provider time are closer to 18 minutes, then you really need closer to a 20 minute simple schedule, versus if that time is closer to 12 minutes, then a 15 minute schedule might be more appropriate. And so, the way that you move from what that old schedule looks like to what the new schedule looks like is you shouldn't decrease or increase the number of patients that you schedule unless you also need to schedule more patients to hit your productivity goals. So if the examples that we show have more or less patient scheduled than you do, you don't want to change that number that should be based off of your productivity. The key here is moving everything into one length of appointment, getting rid of any double books, getting rid of any multiple, longer appointment lengths.

And really a simple schedule is just more realistic in the sense that we know all visits are not the same length, right? But in practice, we're not very good at predicting it, which ones are going to be long or short. And you can see that because rarely our patient care team's like, "Yes, our schedule is working perfect." And if they are saying that, please let me know because I want to steal your schedule. What simplified scheduling has the assumption of is that, most of the time, all those different lengths of appointments are going to come out in the wash. So we just make it as easy as possible to schedule an appointment so that, that's not where we're spending our time. It's really just about getting the patient on the schedule.

So if you've mastered those basic scheduling techniques for telehealth, then the next step in where you go is really focusing on creating a multidisciplinary team that can provide telehealth care. So for example, making sure that you're providing warm handoffs to behavioral health, to dental, to care coordination, or whatever other services that you have for patients. And this is definitely that next level piece, because this requires a lot of coordination between staff across departments. But definitely you want to make sure that you're not losing out on some of that high quality care that we know that community health centers provide. And part of that is having multiple services on site or being able to provide that in a telehealth capacity. Amanda, do you want to take over and tell us what we're seeing?

Amanda Laramie (24:11):

Yeah. Absolutely. I mean, I think getting into even number six, what you were just talking about, Adrienne, in terms of needing broader roles for support staff to handle this. And I saw some interesting chat between some folks talking about when you would go through polishing and asking those, want it, need it, keep it questions. And so, I just want to respond to the chat briefly, which was... I don't know if it's always something someone at the call center or clerk could do. I love the suggestion provided in the chat that it's something you look at over huddle or you do during visit prep because sometimes it needs the care team to weigh in on the want it, need it, keep it questions. But I will say that the more you're bringing in your front care team or call center... For example, I was coaching a dental team who had their call center person join huddle every morning, [they 00:25:00] just virtual into the huddle, is they started to learn, based on the huddle of conversations, what was more appropriate for telehealth versus in-person. And so they got better and better at it.

Is it going to be perfect every time? No. But I do think you could look at how to make that cross-functional team really strong and how to bring them into huddle so that you could do less of fixing the schedule the day before and more fixing it upstream at the time patients are scheduled. So in terms of just switching gears to broad work roles and what we're seeing in the workflows of telehealth, I just first want to orient you before I share with you this visit tracking. Some of the terms we use when we go into health centers and start tracking visit and seeing what it's like from start to finish from the patient's shoes.

And so what we're looking at, what is non-value added time? What is all that time that the patient is spending without a staff member in front of them, in a waiting room, in an exam room? In the course of telehealth, that would be waiting before provider joins the call, waiting before they get the text, the call is ready, even though they were told to be ready at three o'clock. That would be non-value added time. Value-added time is just the reverse of that. It's any time they're spending with a staff member, whereas PPT is patient provider time. It's literally just when the provider is with the patient. And then handoffs is just how many times patients are switching hands, which is really important in telehealth to look at, is how many touches and points of contact is that patient making with members of the care team?

And so here's what we're commonly seeing. So this tracking came in from a team I'm coaching in California, and Luana did this tracking. One reason I put it into this office hours is because it's very representative of what we're seeing across the country, which is this patient had a 3:20 appointment and at 2:37, someone at the pod in reception called the patient to check them in. So they checked them in at 2:37 for 3:20 appointment and hung up, and then the patient was waiting for 31 minutes before they got a call back that they were ready to be seen. So then at 3:08, the MA, so another handoff, calls the patient to get their chart and appointment ready for their provider. Then they hang up, and then 45 more minutes go by before the provider calls the patient to start the appointment at 3:56, even though the appointment was at 3:20.

So then they had the appointment. And if you look from 3:56 to 4:01 was the appointment, that patient provider time, or PPT, was five minutes of that total time. Now, was the patient at home? Yes. Thank goodness they weren't waiting in the clinic for that. But it still was waiting. I don't know if that patient was able to work in between, I don't know what they were able to do. So here's what we see with that, which is, we tend to measure cycle time. Coleman Associates thinks that for telehealth cycle time, it's the amount of time the patient had reserved for that visit. So in this case, they had planned on 3:20 to whenever, for their appointment. So we would track cycle time as 41 minutes. However, the cycle time below is from the first contact the staff member made with the patient.

That non-value added time for the patient was 76 minutes or 90%, if we're looking at the full 84, and their value added time was eight minutes talking to registration, MA, and the provider. And like I said, that PPT was five minutes. So this is just an example. I don't know what it's like at your health centers. I'm sure some of you are seeing this and are like, "That's similar to our workflow," and some of you may not be, but the issues with this is that... I think it was John saying in the beginning of this was, this can be a real issue if you're doing an interspersed schedule. And I will tell you this organization where this tracking comes from was doing an interspersed schedule. It's why the provider was so late for the visit. Now, what I've seen is the consequences of this is sometimes the patient's no longer available or sometimes they are like, "Okay, I guess they forgot about me." And then they're not as apt to want to do telehealth again.

So what we can look at in order to improve this is to look at how the day can run smoothly around telehealth and that takes a lot of steps we won't go into today in a lot of detail, because frankly, we would need more time to go through all the ways to make an in-person day run smoothly so telehealth is on time. But what we can tell you today is that smooth handoffs, virtual waiting rooms, and keeping the patient on the line so long as it's not like 40 minutes on the line, but especially in a virtual waiting room, can improve the success rates of making sure you don't disconnect with the patient and can't reconnect with them.

So for example, in New York where we were doing this work in this health center, we texted the patient, we used two-way texting that was HIPAA compliant to let the patient know, "Hey, we're about to be ready for you. Get ready." And then we connected with the patient. The MA did their intake and then kept the patient on the line in the virtual waiting room before the provider walked in, pulled the patient out of the virtual waiting room and began their visit. And what that did is it prevented the patient from getting lost and it meant the patient didn't have to keep reconnecting and have those overly high number of handoffs.

So if we're thinking about going back to this workflow that I shared earlier, the tenets to keep in mind are prepping for the patient ahead of time, which I'm going to go into next about video visits and patient satisfaction of making sure the patient can connect, making sure the technology is tested. That's what we're going to cover next, as well as this, keeping the patient on the line and making sure that the patient has very clear instructions before their visit starts about what they should be expecting. Like, is it

a text? Is it a phone call? And I would emphasize if it is a phone call, but you're doing a video visit, why couldn't you connect with a patient through video for that first part of the visit and not do phone, then video, then hang up and do phone, right? It's just a lot of connect, reconnect, and chances to lose someone. I don't know, Adrienne, if you'd weigh in on anything there, but that's what we're seeing, is like the common, "We lost someone."

Adrienne Mann (32:00):

Yeah. I would agree. And there were actually a couple of questions too in the chat about people thinking about how do you not lose patients. And one of the things I was mentioning is in addition to the keeping folks on the line part and everything that you mentioned is, I believe you're about to get to the part about doing tech checks with patients and I think that's another critical part. I did just want to mention real quick if that's okay, Amanda, is there's two questions I wanted to just go ahead and answer real quick, because I bet they're not only ones. One is the name of the HIPAA compliant two-way texting platform. I just mentioned, there are quite a few of them. Some EMRs have been built in. There are other add-ons that you can do. Really, we're agnostic about which one you choose. Just definitely having that two-way texting is really critical for getting that patient engagement. And then, there's another question about a sample workflow about how to smooth out processes. I'm going to send a couple of resources in the chat, just so that folks have those. Thanks, Amanda.

Amanda Laramie (32:59):

Great. Thanks for that. And yeah, I echo that some of the... a lot of the telehealth platforms we're seeing have the capability and some health centers weren't using them. I was coaching a team out of New Hampshire that was using RingCentral and they didn't know that they could text through that, and so that's what they started to do to get the patient ready, and so that they could just connect one time virtual after the text. But I know not every platform is RingCentral, but that was the one they were using and they figured out text on it, which was great. And honestly, some people use texting without it being connected, but just make sure no PHI is ever on it too, right? But that's trickier to keep. Obviously you want the HIPAA compliant. You don't want to get into hot water there.

Adrienne Mann (33:42):

I'll put a couple of examples in the chat of other softwares that people use.

Amanda Laramie (33:47):

Yeah. Great. But yes, we are agnostic, we've worked with them all, and it's just how you capitalize on them that really makes a difference. So in terms of increasing video visits, so there's been some questions coming in about, how do we make sure the video is smooth and how do we increase... How do we do technology checks? So this comes from Community Health Center, Inc. This was through another webinar. So this is totally their content that I'm sharing with you here, where they talked about how in the beginning of the pandemic, they started really high on phone and they worked hard throughout the pandemic to move to more video. And so some of the best practices they were sharing to increase the number of video visits was to do a technology check at the time the appointment was made.

And one of the reasons they wanted to do this was so that the video visit was smooth and everyone felt like it was a fabulous experience. One of the reasons before I tell you exactly what is covered in a technology support that either a call center could do, or in this case, routing to a group of tech savvy people who could take those calls and test the technology with the patients is some barriers

to the technology that mean less people use video and more people use phone. And I was actually in a call yesterday with someone who said, they've been actually pulling data out of this data California through all their health centers and finding that in the very best cases, the really savvy community health centers and hospital groups, they were at like 40% video rate out of all their virtual visits.

So out of all virtual visits, 40% were video and that was on the very high end. And typically they were seeing something around six where still folks are doing a lot of telephone visits versus video. And we get a little concerned about that just thinking about where reimbursement is likely to go and the risk of not getting as high of reimbursement on phone as you would video. The reasons for that are staff discomfort with the technology. I was in a health center where the provider kept it getting disconnected because the wifi was going out. And so they were like, "Well, why am I going to do this? This is pain. Why don't I just call the patient?" So really getting technology set up, more wifi hotspots connectivity, getting your IT in there and really making sure you could have five providers doing a virtual visit at the same time. You should test that to make sure it's going to work.

But then also the patient discomfort with the technology is a factor. And so I think throughout the pandemic, obviously more and more people have become comfortable as they're FaceTiming, or they're using Zoom, or they're connecting with family members. And actually that's one of the best tips that I heard throughout the pandemic, was one health center was... when they asked the patient, "Can you do telehealth?" Often the answer would be no. But then if you asked the patient differently and said, "Have you used FaceTime before?" Then you'd find more patients who said, "Well, yeah, I've done FaceTime before." And then they said, "Great. So you have a camera. Let's talk about how to get this app on there." And then they basically use... It's like a form of motivational interviewing of, "Here's what you're already comfortable with. Let's expand on it," and just ask the question differently.

So technology support can be in the form of these questions on the slide. Can the patient log in? Who would they call if they have issues? Just having this system built behind the patient so that they know who to reach out to, and they're getting some assistance from the staff members before the visit on getting on and getting on safely. That's how I would suggest MA's perform [misfunction 00:37:48]. Some places it's like the front desk or a pod receptionist, like that example I showed you earlier of them making sure the patient can connect, but in advance of that, at the time the patient is scheduled, asking those questions like, "Well, have you ever used FaceTime?" We use Zoom for healthcare or we use doxy.me. It's a link. Here's a simple link. You could test getting on in advance."

Doing some of that with the patient in advance of the day of the visit so that the last check is the MA getting the patient on and saying, "Stay on the line. The provider will be right there." I know not all telehealth platforms have virtual waiting rooms. I'm a big fan of them, but not all of them have them. So if you don't, you just have to think of a different workflow to make sure you're not connecting with the patient until everyone's ready to take over and you don't connect, disconnect, reconnect, et cetera.

So build in some tech support before the visit, making sure they can log in. And then this is an example borrowed from CHC, Inc. in Connecticut, where I showed that slide earlier of the phone and video visits, and phone getting lower and video getting higher, is they shared this idea. So I'm just borrowing this from them. This is absolutely an idea they tested, which is any patient after they'd had two video appointments, they marked them with alert in their EHR to say like, digitally competent. Basically they were like, once we know this patient's been successful, they're a prime candidate. Should they opt to have this visit be a telehealth one? Because we already know they can connect. It worked well. They like it. And then helps the call center staff when they answer the phone, see like, "This is a great option for the patient. If they don't bring it up themselves, we could offer it to them." And that's another way to keep the video visits going with your patients.

So here's those questions I mentioned. How do you plan to join your visit? Have you ever used FaceTime or Skype before? Do you have a smartphone or tablet? Will you have reliable internet? That's the other question. And I will tell you health centers, we've coached on this. Just make a script and add it to anyone who's scheduling visits. Can you test it with me right now? I know for those of you, because we work in community health, who have high abandonment rates and really high call volumes, you're sitting here looking at these questions and you're like, "There is no way I am adding five more questions to the call center staff when they're scheduling these appointments." Because it can take a little while, right? So I've worked with some health centers who've taken these appointments and made it part of the visit prep questions they've done, where if an MA or someone on the care team is already doing visit prep, they would go through checking with the patient before the visit and say, "This is telehealth. Let me just make sure you're ready for tomorrow and done it there."

It really depends on what's happening in your health center. And I know we're going to get into Q&A in just a second where we could... if you have a question about that, Adrienne and I could answer because I don't think any place... there's not one specific way. I wish I was here to tell you there is the one way we have seen from all these health centers we've been to, it depends on where your staff is located? What your call abandonment rate is? What your current visit volume is? Et cetera, for us to weigh in. So we can answer some of those in the Q&A. So the last thing I'll say before the Q&A is that here are some of the... just as takeaways from what we covered in the slides.

Consider tele-jockeying, if you're not already doing that, to fill slots that would otherwise go unused, consider that tool of tele-jockeying where you could take a patient who's calling for an appointment and say, "Do you want a telehealth visit right now?" And put them in. Consider polishing the schedule and how to clean it up. Would you do that in huddle? Would you do it as part of visit prep? Would it be something the care team builds in the day before? Ask the patient in polishing, whether they would want, if they asked the care team, if they really need the visit and if they will keep the visits? And then evaluate your team communication with virtual care, how do you prevent errors duplication in a number of handoffs? Do you lessen the amount of context you have with the patient before they connect? Do you use a virtual waiting room? Do you get more video versus telephone? And who's going to connect over video? Those are just some takeaways as we go into the Q&A. And Adrienne, I see them coming in. So let's absolutely move there next.

Adrienne Mann (42:37):

So the first one that I want to make sure that we answer is the questions you were showing about telehealth competence. There was a question about response rate to those questions. I was wondering if you want to take that one Amanda, or I'm happy to?

Amanda Laramie (42:52):

And I'm assuming they're asking the question like response rates from, when you ask that, what do people say? Is that what you're gathering is the question? How-

Adrienne Mann (43:00):

Yeah. Well, and I think like how responsive people are to those questions is my... And feel free... Let me see who asked that. El Doro, if you want to clarify that, please do. But I would say in general it depends on your patient population and it also depends on who asks the questions. And so, what we usually recommend is any question that you're going to ask of patients is track some data on how often those questions are getting answered. And my guess is that you have somebody in your organization that has a really high response rate, and then you just watch them to figure out what they do differently entering

to that is usually my recommendation. We see this a lot whenever we talk about confirmation calls, or jockeying calls, or any of those types of calls, is there's just some people in the organization who are probably really good at it and have them train folks, and that's how you get your response rate up really high.

Amanda Laramie (43:55):

Mm-hmm (affirmative).

Adrienne Mann (43:57):

And then I see a question from Tracey, about what is an acceptable abandoned call rate for a call center. Amanda, I know you have a lot of thoughts on this, but I'm also happy to take it. You tell me.

Amanda Laramie (44:15):

Okay. So honestly this is a hard one to answer because I think any abandonment rate above like 2% is really difficult. I would say as a benchmark... I mean, I don't know. People have asked us this as like, "What is the benchmark?" And I would say, well, I think you're trying to get 5% or lower. Honestly 3% or lower is better. 1% is usually the fluke of the patient who calls and hangs up even before they hear anything, and I can see the data on the out of like, they were literally on for less than 20 seconds and they weren't waiting that long. So I would always encourage you to look at the combination of hold times and a call abandonment rate because generally hold times they are short and they still abandon, are that 1 to 2% range. But when you start to get at 5% or over, that's when you're seeing hold times that are longer and where I would encourage some different workflows to lessen those. I don't know, Adrienne, if you'd add anything to that.

Adrienne Mann (45:08):

I agree wholeheartedly. Yes. I think getting them down really low like that is really where you see your best results and have the best patient experience. And then I just wanted to take care of a couple of these real quick is, is there a good platform for telehealth that you would recommend? We don't recommend a specific platform because we've seen them all work and we don't use them as front end users. But I have not seen a single client who was not successful because of their telehealth platform. I don't know if you would agree with that statement, Amanda.

Amanda Laramie (45:42):

Yeah. I was even coaching a team who was contemplating switching theirs because they thought one was better over the other. And when I saw them using the one they were switching from, I was just like, "This one's perfectly fine. You're just not utilizing all the bells and whistles." They just needed to figure out all the nuances of it. And because they, like so many health centers, had to set it up overnight to see any patients. It was just set up really quickly, which I think most people were in that boat. And now, if they can spend a little more time to figure out how to use it, it could work great. So I agree. I wouldn't recommend one of the other, I would just recommend really figuring out how to use all of its features.

Adrienne Mann (46:23):

Yeah. And then Amanda, do you mind going on to the next slide real quick just while I answer a couple of these questions? And then, I did just want to mention because I know we've got 13 minutes left and we're going to answer as many questions as you have, but I just want to make sure that folks have our

contact information. And in particular, I wanted to mention that we try and practice what we preach. And so we do offer two-way texting if anybody has questions after this. And our number is 888-403-3764, in case you want to test out our two-way texting capabilities. But then a couple of other questions. So in terms of the specific legal requirements, because it varies a lot by state, we don't answer those questions because we're not experts in every state's law.

So with the telehealth visit scheduling and the patients on vacation in other state, I would strongly encourage you to talk to your own internal experts on that and look at your own state's regulations, just because it varies so much, that would be my recommendation. And then in terms of having two patient care teams... Amanda, do you want to take that one while I look through the chat a little bit more?

Amanda Laramie (47:31):

So the question is, do you recommend having two patient care teams of oh, a telehealth and a face to face? And I'm assuming that means for the same provider. Is that how you're interpreting it? Or do you mean one provider is telehealth and one provider is seen as face to face?

Adrienne Mann (47:48):

That's how I understood it.

Amanda Laramie (47:49):

Yeah. Okay. Angelita is responding. Same provider. That's a really loaded question Angelita because I think whenever I see a question about, should we increase any number of bodies to have two teams, one for telehealth and one to face to face, are you also meaning... I think you mean in the same session. If you are-

Adrienne Mann (48:16):

Yeah, go ahead and we can unmute you if you raise your hand, Angelita.

Amanda Laramie (48:19):

In the same session, I think is what she's saying.

Adrienne Mann (48:25):

Okay. Yeah.

Amanda Laramie (48:26):

So if it's in the same session, I think it's hard to answer that because we never advocate for adding more staff without the visit numbers to back it up. So I can't answer that without saying, "Well, are you seeing X number of telehealth visits that would justify the cost of having the medical assistant be the person who's going to queue them up for telehealth?" If you already have a patient care team where it's two MAs and a provider, and you're doing enough telehealth or maybe one is queuing up the telehealth and one is queuing up the patients in-person, yes, that could work. But if you're talking about adding one, I really can't weigh in on that without knowing your visit numbers. I think it's something I would encourage you to test.

If you already have those staff members say, "Okay, here's how much telehealth we have. Are they like every other patient?" And then that's what we would do anyway, is one MA gets one patient, one gets the other, does the whole visit, does the intake, make sure they checks them out, or does their follow up visit in the back. And then the next MA is getting the next visit. And if that happens to be telehealth, they're taking that one. So anyway, I hope that's helpful.

Adrienne Mann (49:44):

Yeah. And then if anybody else has asked a question, I either did not see it in the chat or if you want to raise your hand, let me know. I think we're up to date on answering questions. So let us know. Can you share call center benchmarks for wait time, abandonment averages, average time to queue? I mean, yeah. Amanda, do you want to talk about that or do you want me to answer it?

Amanda Laramie (50:12):

Wait time, so I guess, the short answer is the benchmarks. I haven't seen a ton of benchmarks. What I know from my experiences when we've worked with teams on this, they're getting to less than a minute, is what improves call abandonment rate. So I think that's really helpful and I would encourage you to just look at your data to see if that is in fact to the case, if your average hold times, once they get below a certain threshold, means the abandonment rate also goes down? Average time to queue, that also depends on factors because I know from calling a bunch of health centers, some people have a really long phone tree and some don't, and it's like, at which point does the patient get to the phone tree?

And then that's already factored into a minute they've been on the call to then a minute of waiting. So it's based on some different factors and I can't say I have like, here's what from the country is the benchmark. I just know getting under a minute for hold time, getting abandonment rate under 5%, and then getting the patient a person to answer their call in a minute or less is ideal. I mean, that's what patients want.

Adrienne Mann (51:29):

Yeah. I think we're really hesitant to talk about what national benchmarks is because to us it's like, I don't know, what would you want if you were a patient? And you want somebody to answer the phone basically right away.

Amanda Laramie (51:38):

Yeah.

Adrienne Mann (51:39):

That's how I don't abandon my calls is that kind of a thing which is not that's easy to get there. Yeah, go ahead.

Amanda Laramie (51:48):

Well, Christie's question is good. I'll read it Adrienne, if you want to take the first stab at it. So collecting co-pays or balances using telehealth, that is our challenge, is getting the patient to answer the phone when we call to take care of that portion. Are there best practices for this?

Adrienne Mann (52:04):

Yeah. I mean, basically it's that keeping them on the line thing and, or being able to preregister, having options for [inaudible 00:52:13] pay online, being able to do things like texting out bills or texting out... Or sorry. Let me state that differently. So that you can text the patient to ask them, to see if they can call you or if there's a good time for you to call them. But the more that you can, one, get as much information up front as possible, preferably in an online option, is definitely better. And then being able to do it in real time instead of doing it anytime later. Basically the longer you wait to ask the patient, the bigger the drop off is going to be, particularly if it's trying to get them on the phone after the visit.

Amanda Laramie (52:53):

Mm-hmm (affirmative).

Adrienne Mann (52:54):

I had-

Amanda Laramie (52:55):

And I wanted-

Adrienne Mann (52:56):

Oh, go ahead.

Amanda Laramie (52:56):

Oh, go ahead [crosstalk 00:52:57].

Adrienne Mann (52:57):

I was going to say I had this issue with my... I went to the chiropractor and I lost my debit card and had to update it. And so, they usually just charged my card on file, which I know you can't do in a community health center, but they were calling me like, "Hey, we need this information." I'm going to be honest, I didn't call them back because I knew I was going to go back in and I was just going to give them the money at that time. And if they had asked me in real time, I would've given it to them versus trying to answer the phone for something that isn't that important to the patient, is tricky. And I'm a bad patient. I think most of us are.

Amanda Laramie (53:27):

I would just emphasize that like getting the same information to the patient that everyone's saying the same thing. When the appointment is scheduled, it's, "Here's the deal." The day of the appointment, you're going to talk to front desk first. They're going to collect your sliding scale fee payment. After that, we're going to route you to the MA. The MA is going to ask you a few questions about your visit and then you're going to be with the provider. If you had a workflow like that you were saying at the time they were scheduled, at the time of the confirmation call, and then that's what happened in person, it's like it's set up to be more successful. And what I often see is people having bits of information and not all communicating the same thing. And that's when you tend to have lower collection rates and things like that.

Adrienne Mann (54:13):

Yeah. It's really hard to understand the process from a patient perspective, if the staff doesn't understand the whole process, because it's hard to... If people aren't explaining it to them, they're not going to understand.

Amanda Laramie (54:13):

Mm-hmm (affirmative).

Adrienne Mann (54:29):

Great. What other questions do y'all have? Oh, and hi Phillip.

Phillip Stringfield (54:33):

Oh, hello. Thank you so much. I was just checking in. It looks like you did a great job of answering everyone's question. Even the ones that were submitted prior to we've received mostly an answer to all of them. The only one that I would just bring up as we close this out is, if you had any strategies similar to copay collection, we just had some questions around making registration a little bit more seamless in how to handle patients who don't complete registration prior to their appointment. And if you had any insights around that, that you wanted to share.

Adrienne Mann (55:06):

Yeah. So pre-registration is the way of the future for everything. The biggest barrier... And I know Amanda has strong feelings about this too, so feel free to jump in Amanda. The biggest issue that I see in preregistration and folks not preregistering is that it's hard. What I have seen... I'm thinking of one organization I worked without in Oklahoma. They were really early adapters. I mean they did this well before COVID. They had their Frisian tablets, but they did the naughty thing that lots of health centers do, is they just uploaded their current paperwork to Frisian and it was like 80 pages long on Frisian. And so nobody preregistered. I would not preregister. So the key thing, and I know it's hard but is getting in there and reducing your paperwork, reducing what you asked before. And I know I'm trying to remember who asked this question in the actual chat. I think I responded to them directly.

Savannah had that exceptional question is, really to be able to reduce paperwork, the way that we start is we grab all the paperwork that is in your organization, or you can start with just the registration paperwork, and get all of the right people in the room that have the authority and the knowledge to be able to actually say, "Yes, we need this question," or "No, we don't need this question," and go through line by line and cross things out. And that's the most effective way that we see to reduce your paperwork, and it's really important to do that before you move to an online scheduling system or online registration, because the shorter and easier that you can make it, the more compliance you're going to get from patients. Anything you'd add Amanda?

Amanda Laramie (56:47):

Just that I did a visit tracking with someone who worked the front desk two weeks ago and she usually works the front desk and she was shadowing. It was in the back and she's like, "Oh, that's funny." And when the MA does their really long intake, they ask two of the same questions we ask at the front. And so, just by her seeing that, they eliminated one of them and it was Preferred Pharmacy. It's like they were asking it multiple times, but no one saw what the other hand was doing. And so they eliminated it from the front desk and put it in the back when the MA did their thing. And I know that question fill up

about like getting patients registered before their appointment is the big one. But I love that Adrienne went upstream because I do think some of the problem is just how long it takes.

And you have to do that first before saying, "Okay, if we can get it shorter... And now we've gotten shorter and now they're still not doing it," then there's the question of, do you get the patient on the line before their visit and say, "Great, your MA said she was ready for you in five minutes. So I'm just going to get you registered right now." And I'm doing this as phone, but it could also just be video like this, because you would just connect with them once over the virtual visit and do it right there.

Adrienne Mann (57:57):

I would second all of that.

Phillip Stringfield (58:00):

Thank you so much. I mean it looks like that is going to wrap up our question and answer segment of our telehealth office hours. So of course, I want to say a big thank you to Amanda and Adrienne for sharing this wealth of knowledge with us. I'd love to see the engagement that was going on in the chat and people really connecting and making different pieces connect as well. So with that, I also want to just say big thank you to a colleague, Olivia, for helping on the back end and getting us set up for today's presentation. And just putting a last plug to just hold on at the end of this webinar, once we close out, you will be forwarded over to the webinar evaluation. If you're able to complete that for us, we would greatly appreciate it. And also there's an option for you to include future topics.

We would love to keep the conversations going and we can't do that without your feedback. So feel free to take a moment to complete the evaluation. We'll definitely be grateful for it. But you have our emails right at the bottom, if there's any other questions or any connections that need to be made. So with that, I want to thank you all. I mean, enjoy the rest of your week and we hope to see you at [inaudible 00:59:08].

Adrienne Mann (59:09):

Thank you so much, Philip and Olivia and to Adrienne. Thank you so much for having us. We appreciate being here with Mark. Thank you.