April:

Good afternoon, everyone. This is April Lewis, Director of Health Center Operations and HR training at NACHC. I want to thank you all and welcome you to our December telehealth office hours. If you're just joining in, please go put your phone on mute, if you are able to. That way we can minimize the background noise as we go throughout the call today. Before we get started, I want to thank my colleague Susan Sumrell who's on the line joining us from across the bridge in our Alexandria office. And also our other partners, which I'll get to momentarily that helped us to make this telehealth office hour a success.

April:

If you were on last month, you remember that this month we were planning to talk about telehealth etiquette and FTCA. What we've been sharing with you all throughout since we started in September, is that we want these office hours to be very responsive to what you need, the calls and questions that we get not only from big chat during the telehealth office hours but also that you send to telehealth@nachc.org. And with that, two things happen, we wanted to focus on spotlighting a community health center Finger Lakes that has been using telehealth and using it very successfully to reach patients in their rural areas, specifically the immigrant patient. And we were planning to talk about FTCA. Well, HRSA is preparing to release a publication that further explains FTCA and telemedicine, and so they requested to defer that talk until January once the publication is actually complete.

April:

We do have a little bit of information that we're going to share with you, to queue us up for what is forthcoming with that document. Mary's going to get to that at the end of her presentation. So for now, that's why we shift gears and then after we cover the FTCA, because we understand that you have a lot of questions around that, we'll go into the telehealth etiquette, then we have a very robust conversation being prepared on the return on investment for use of telehealth and also Telehealth Best Practices. So again, thank you for joining and continuing to communicate with us at telehealth@nachc.org on what it is that you would like to hear.

April:

A few logistics about our chat today, if on your screen, you see the dial in informatio nas always, it's sometimes easier to just be dialed in, versus connecting to your computer audio. The chat box to the right of your screen, please use that to ask questions, or leave any comments for the presenter, myself or the group. The email that I've mentioned is telehealth@nachc.org. You don't have to email back to receive copies of the slides anymore because to the right of your screen you see we have a page on nachc.org where you can download the recording of each office hour and also get the slide so we do as you recommended we do. If you if have colleagues that aren't able to make it forward them the recording so they can listen to it or either this side deck so they can see what was presented.

April:

We aren't using a slide deck in this call, Mary's going to talk through her presentation, but the full recording is made available within the next week to the week and a half. But if you have any questions or comments or not just specific to what you want to hear on the office hour but just in general about telehealth, please email us at telehealth@nachc.org. Today as I mentioned, we'll be going through how to reach those that need it most and then January the best practices and FTCA as I said to be

determined because in the event that get to January at the publication isn't ready, they will push it to February. So we'll just say keep that open as far as what we'll talk about FTCA related. Special thanks to the group of people that helped make this office hour a success every month, CCHP, Center for Connected Health Policy, HITEQ, HRSA, the Office for the Advancement of Telehealth here at NACHC and our Telehealth Resource Centers, and today in addition we want to thank Finger Lakes with Mary.

April:

With that, I want to say Mary, if you're on the line, please....Okay, perfect. I'm going go through and mute everyone out. So Mary, if both of you... I apologize for the back ground noise.. I will mute everybody out. Mary, the lady from Finger Lakes in New York, is now going to come in to share with us about how to reach those that need it most. So Mary, it's all yours.

Mary:

Thank you. April. Can you... can everybody hear me?

April:

All good.

Mary:

April asked me to come on and talk a little bit about Finger Lakes Community Health, some of the work we're doing with telehealth. And I'm going to just give a little bit, at the end of my discussion, a little bit of information that I have on FTCA through my discussions with some folks at her so because of my questions, so like just give you that update. But I just wanted to talk a little bit about... She was interested in me talking about our telehealth programme and particularly working with immigrant populations and how we've used technology to reach out. So, I'm just going to start and give you some overview of why we use telehealth and it's funny because our telehealth programme originated specifically to help farm workers reach out and so that we could provide more access to care for our farm worker populations. And that work started in about 2006, and then we've progressed from there and it's been a very long journey. Lots of things have happened, we've been through the mill and then we've tested everything and learned a lot. So we like to tell people just if you're interested in going down this road or in the middle of going down this road, the best advice I can give to you is to work with others that have done this work, telehealth technologies in their health centers because you don't want to repeat all our mistakes, because we all probably made a lot of them.

Mary:

So we are an FQHC migrant and Community Health Center programme in upstate New York in the western part of the state more...very rural area, we cover quite a bit of mileage between our health center sites, we have nine sites. They're not huge sites, but they're really important to the communities that we serve. One of the issues that we've had is, of course, between two of our furthermost sites, it's about an hour and 45 minute drive so it becomes a problem for us when we're trying to move our providers around because we all have works for ourselves with our community health workers that need to get patients from point A to point B, etc. And you are familiar at all with New York State we're in the Finger Lakes region and the Finger Lakes are all these lakes that were formed by glaciers that run north and south. The problem is there's no bridge across any of them. So you have to go around the waterways to get someplace. So it becomes a real barrier to patients.

Mary:

So why did we adopt telehealth technologies in the first place? The big thing was to eliminate geographic barriers, of course, because our patients just don't have the ability to get to where they need to go sometimes for primary care, specialty care, dental care, etc. A big reason for the use of technology in our health centers using virtual care is reduction of stigma, particularly when you have a person from ... potentially an HIV positive patient or maybe they have mental health issues or something else that they don't want to be going to one of the community sites or they're fearful of going up into one of the urban centers. So it's been a godsend for us to be able to use technology to reach out to those providers, so that our patients many who are immigrants, they're secure coming to this community health center where they get their normal care. If they know the staff, they're familiar, and so if I can bring them back to my health center and have them see their specialty care provider, it's a real boon to them because it really saves them time, money, worry, etc.

Mary:

Additionally, when we talk about the integration of primary care and behavioral health for our patients, it's really convenient when I can say to my patient, here you are, you're seeing the primary care provider and we want to have to see the behavioral health counselor but I'm sorry she's not at this site today, but we're going to zoom you into her via video so you can do a virtual call, and not have to come back, not have to leave the health center where you're comfortable, and there's a real team approach there.

Mary:

And then finally, one of the big reasons of course, to adopt telehealth in our health centers was to address the workforce problem we have, which is we can't keep providers with us, because the hospital systems come in and we get them all trained really well. And then the hospital comes in and says, "Thank you," and they pay him some more money and take our providers and I know that's a national problem for community health centers. We're no different. Now I'm able to, with technology, be able to have... A couple things have happened. If I have a site, what we've done our model that we set up because of technology now, we have an RN at every one of our sites at all times. We might not have an MD or a mid level provider at that site, but with technology if a patient walks into the health center where there's only the RN there, she can then create a virtual visit with one of our other providers and they can do a visit so that I can still see that patient. I don't have to say to that patient, "I'm really sorry, we have no provider here today, you're on your own or go to the emergency room or go to the urgent care." I can have them see one of my providers, the nurse, we've trained our RNs to be able to tele present and be the hands of the provider. And so they can palpate, they can use all the peripheral equipment we have to see the patient on behalf of the provider, so that we can eliminate probably 80% of the problems that the patient has come in for virtually because a lot of those... If there's some weird thing that the patient comes in for that they have to see somebody in person, then we can have them come back. But we're in a lot of cases, we've been able to mitigate them having to go to the emergency room and of course as FQHCs as we all move into a value based world, this is going to become more and more important for us to really keep our patients in our primary care settings.

Mary:

And why is that? Of course, is because the healthcare system is changing. And now, one of the things that we're all being faced with, additionally, on top of all the other issues that we face every day, is that our insurance carriers are starting to get into the business of telehealth. So for me here in upstate New York, we have a big plan, it's the big mothership here of health insurance for most of the region. And

now what they start to do is offer for $40 any patient that has their plan they can call into their telehealth platform that they have and request a visit. Well, what that's done for me, unfortunately, and has impacted us because now my providers, all the easy visits that they normally would see in between all the chronic visits are getting cherry picked by my insurance carrier. So they're taken the easy patients--ears, eye infections, sore throat, flu. And so what's happening to FQHC is, our own insurers that are paying us to see patients are also getting into the business of seeing patients via telemedicine. And so, what we get left with is all these patients that have some really difficult challenging chronic diseases, so we have to compete with that.

Mary:

And so I say to my peer of FQHC, that we have to get into that same business, we have to offer that same modality to our patients because that's how they want to get their health care. And in order to survive, we have to play the game based on what our patient asked for and what they want, and what kind of a patient experience do they want to have. I would just suggest that we really have to pay attention to that as a sustainability issue. Another thing that we have found, particularly with our immigrant population, all of our pharmacare patients in particular, and most of the other folks that are in some of the immigrant communities we serve, they have a smartphones. And on smartphone, they may have minutes on them, designated minutes where they buy minutes every month, but they still have a smartphone because that's mainly the way that they communicate with their families back home. And so we've taken that knowledge and said, "If you have a smartphone, we can provide you with access to a provider or a mental health counselor via your smartphone and our HIPAA compliant platform that we have."

Mary:

What we've been working on is some ways to build pilot programs and testing it with our patients, particularly our farm worker patients, because they have some real access issues. There's a whole lot of fear...and just the political atmosphere and they're just afraid to go to the grocery store. So to come into the health center, they got to be in pretty rough shape in a lot of cases. What we're trying to do is say, "Okay, well, how can we use technology to reach out to our patients because they won't come to us We need to go to them." Telehealth technologies offer us a huge opportunity for those populations. But I would offer to all of our patients because as we think about millennials, I mean, this will pertain to everybody if they have a smartphone, you can do so much now that we just haven't had those tools at our fingertips before and we do now.

Mary:

Why are we doing that? The big reason is that we can build partnerships with our provider, other providers in our community, as we look at value based contracting, a lot of FQHC are independent provider associations, IPAs, or Accountable Care Organizations. And so if I have a behavioral health partner that I work with a lot, and we're trying to all manage your total cost of care, particularly maybe in a value based contract, I want to keep all those patients coming to my partners and telehealth technologies really gives us that ability to do that. I can just call up my partner, "Hey, I want to have a visit with this patient, he wants to see a substance use provider or a peer counselor to talk about some of his issues. Can you guys accommodate us with that?" So that's really helped us and it also helps to build partnerships because you can go out and look for people that are like you or people that work with your patient base and say, "Hey, do you want to consider working on a project together where we can

build telehealth technologies between our two organizations to benefit our patients, can I have that access to you virtually."

Mary:

It's really helped us here Finger Lakes, we have some great partnerships now with people that in organizations that we never worked with traditionally in the past and now, technology has really allowed us to do that. We have found that we have a lot better patient outcomes with the introduction of technology, telehealth technology into our practice, because the bottom line is if we offer more access to care to our patients, they probably will have better health outcomes and better quality care, because they're going to get things that they need, when they need it, how they want it. They're also going to be kept more in the primary care setting that the FQHC offers rather than sending them off to all these distant providers and urgent cares and emergency rooms. When you can keep them in house, maybe virtually, but you can keep them in house.

Mary:

It's really helped us here, as well, to expand our workforce. So an example of that, is I have a bilingual nutritionist and I have a nine sites, and there's a lot of drive time between those sites. So now, I can schedule my nutritionist, she might see some patients in person and she might see some patients virtually, but she can sit in one location and see a lot of patients. For our behavioral health, we have a very limited number of behavioral health providers, it's growing, but still we have a lot of patient demand. For instance, we hired a licensed clinical social worker who's bilingual. He's providing services at three of our sites because they have large Spanish speaking population. He's able to see a good chunk of his patients are seen virtually because it provides them access to him. He sees them in person when he can about every fourth visit, but he sees a lot of his patients virtually. What's been interesting about the whole issue around behavioral health. We have about 50% of our patients based on our data, want to see their behavioral health partner virtually, they don't want to be in the same room. They'll actually ask to go to a different health center and see that behavioral health provider virtually rather than be in the same room.

Mary:

There's been some really interesting outcomes with our telehealth technologies, I've heard others in the crowd across the country are seeing the same thing. But we're able to expand I can have a provider see a patient in the health center where there may not be a provider there, so I'm allowing access to care for my patients. I now have my providers, they'll call other sites if they have a no show, they'll call another site and say, "Hey, I have a no show, is there any patients that need to be seen. Did you get any walk ins or anything?" So that's really helped my providers and it's really helped our patients. And of course, it helps reduce costs because we keep people in primary care and that's the name of the game, really got to get people into the primary care setting and not in hospitals.

Mary:

Quickly, I just want to bullet where for us we did a cost benefit analysis for telehealth in our community health center programme. And I would argue that you would probably all see something similar. We've seen decreased transportation issues because we've crossed those geographical barriers. We've seen a decrease in lost work and unpaid time with our patients because a lot of times our patients, particularly foreign workers, if they lose work, they don't get paid. They don't want to go maybe five hours off for a day to go into the city and see a cardiologist when they don't have to. We've seen a decrease in our

emergency room and urgent care visits. We've seen a quicker time to get people treatment. And we've seen a reduction of stigma for our patients, because they can come back into the health center system, particularly with behavioral health, they can come back in and see their substance use peer counselor via video or they can see the psychiatrist via video. They don't have to go to a community mental health clinic where nobody wants to be seen walking in that building.

Mary:

We've seen an increase in the continuity of care because we're keeping track of them because we're keeping in primary care, much greater access to behavioral health services across the board for both mental health and substance use disorder treatment. We do a lot of MIT. We're doing prep via video, we're doing a lot of those things have seek treatment, it's been really great. We can also... One of the things it's been a great learning tool for our providers because what we're able to do is, when we start out a new provider maybe working with a pediatric neurologist, for instance, particularly mid levels they may be uncomfortable with working with kids and ADHD medications or ADHD behavior or Other behavioral diagnoses that kids might have.

Mary:

When we started our pediatric neurology programme with really great neurology programme, it's about an hour and a half from here. What happened is we asked the primary care provider to come into the visit with the pediatric neurologist at our site with the patient and the parents with a guardian. In that visit, the pediatric neurologist would come in virtually, but you have the primary care providing a parent, guardian and the child in the room together, but everybody's hearing the same thing and the primary care provider is learning from the pediatric neurologist and they're able to talk back and forth and say, "Well, do you see how this happens? I'm not sure how I should deal with that. Or do you suspect that maybe I should be thinking about this, whatever." And so what we found is we've been doing that programme now with pediatric neurology for about six years and my mid levels where we used to refer about 40% of our kids up to the urban center for pediatric neurology evaluations, we rarely send kids up there now because our providers have become much more comfortable with seeing a lot of these kids themselves.

Mary:

Now the only kid that really get referred out for that kind of a service are those kids that have huge need, and they're really complicated cases. So we've been able to really see better outcomes in those children and at school and at home as reported by the school and the parents. And we've also been able to educate our providers. So if we look at our workforce when you introduce technology and telehealth technologies into your health center setting, what you're really being able to do is to offer your providers the opportunity to use cutting edge medicine all they'll have all these great tools and really be up and be able to communicate with a lot of the specialists and others docs in other areas. That if you work in a big urban center, you might have more contact with them, but particularly in suburban and rural health center programmes, we don't get access to those people very often. So when you have virtual visits or you can just call them up because you developed a relationship, it really helps our providers out here at the FQHC to feel connected, if you will.

Mary:

So that's really important, but it also my providers skill sets have increased greatly. For instance, with my HIV population, I have two of my mid level providers because of the experiences they gained by working

with the specialist up in the urban center with their HIV patients and given them time to work alongside with the specialist virtually, I have two more providers now, that went out become HIV specialists. So we don't have to send so many people out of our own system to get care because my providers have that expertise now. We only have to send out the more difficult cases.

Mary:

There's a lot of benefits that we see that don't always come with the payment of a claim when we talk about telehealth technology, so it's really something to keep in mind. Also, there's high patient satisfaction, our patients we do satisfaction surveys to our providers and our patients and they really like it. I just want to just mention two models that we're doing and then just briefly touch on FTCA, and then I'll take any questions that you might have.

Mary:

We're working on two models right now. One is our community health workers are set up with a laptop and they have general exam camera, a stethoscope, otoscope for your ears, nose, throat, and oral camera. Those all can plug into a laptop, and so when they go out, they can go out to a patient house, let's say, one of your patients gets out of the emergency or out of the hospital, they're patient, they're diabetic or whatever.

Mary:

And so our community health worker can go out and they can do an evaluation with the patient within 30 hours of the hospital, because what we're also trying to do is prevent those readmissions, right? Because we get dinged for that if we have too many of our patients end up back in the hospital. So my community health worker can go out they can have a laptop and they can do check on the patient. "Hey, how you doing? Is everything okay? That wound doesn't look very good. Hang on, let me get in touch with one of our providers or our RN. I want to show them this and see what we should do. Can they just give you some medicine for it? Or do you need to come in and see them?" That's really been really helpful in that model is great because we can go out a community health center go out, they can tele present back to a provider. The multiple people stay in a migrant labor camp, we can see one patient after another virtually to get them care, especially if they can't get into one of the health centers.

Mary:

The other is we're working on moving our patients to our patient portal. And within our patient portal and our EMR system, we use the clinical works. But within that patient portal system, we have a provider on staff that will be available in evening hours, particularly for our farm worker patients, so that a patient can go into the portal as if they're registered in our portal and they can can request a visit with the provider, and then they do a virtual visit with the provider from their smartphone, and we use a HIPAA compliant video bridge if you will programme so that all that safe and we always make sure that the patient's in a good place where their privacy is protected.

Mary:

That's how we're using telehealth just in a nutshell, we're doing a whole bunch of telehealth with a whole bunch of different modalities, because we just keep finding more ways that we can use a technology. There's just so much opportunity out there. I would highly encourage you to talk to other people that are doing it or reach out to find out how your health center can really benefit from this. Because it will really change how you practice medicine to the better, I believe, and it also will give you a

good road to sustainability because the problem is for all of us is that all of our competitors are already starting to do this. So we have to compete and this is one of the ways that our patients are going to want to get care particularly millennials and the Z generation.

Mary:

In terms of FTCA, I just want to say one of the things that HRSA they're trying to figure out how FTCA is impacted with telehealth because it's pretty complicated, because of the nature of using technology. But telehealth technologies are only a tool. They're not a service they're a tool. You just have to keep in mind that some of the same promises will hold with your FTCA coverage. What we do know is we're pretty confident that based on HRSA answers to me that if you're serving a patient and the patient comes into one of your sites that's on your federal scope, and that the provider might be at another one of your sites that's on your federal scope, then that visit that takes place should be covered by your FTCA.

Mary:

The problem comes in is when the patient comes into your health center, and your tele presenting that patient and they're seeing, say, a psychiatrists that belong just to some hospital system, that visit is probably not covered under your FTCA. Just like we sent a patient out to another specialist, it wouldn't be covered. One of the things that HRSA recommended that I suggest to others when they start asking these questions, is if you have a scenario and you want to find out if there's telehealth or if there's FTCA coverage, two things. Number one, keep in mind that this is a very grey area, and that and HERSA is trying to figure it out, because everything's moving really fast. They're trying desperately to make sure that they give us all the right information, but there's so much that's changing in terms of technology, and now we're looking at artificial intelligence and all this stuff.

Mary:

They're really trying to wrap their heads around what this could and couldn't encompass. So just keep that in mind that it's a little bit of a grey area still. Sounds like there's some guidance coming out in the beginning and the first quarter of 2020. But their recommendation is that you call the FTCA hotline, and if you go on to HERSA you can find that number, it's a toll free number. Give them your scenario and make sure you have it down, you know exactly where the patient's sitting and where the provider would be sitting, and what does that look like. Is the patient in the health center and is the provider at home? And so you need to have those things and you need to understand your federal scope when you call FTCA, because they might ask you, "Well, is this on your scope of services? Is this one of your sites?" Make sure you have that with you or understand it.

Mary:

The other recommendation is that we should all... If you're going to involve yourself in telehealth technologies, you should get gap coverage. We are in the process of looking at that now because we've been challenged, try to find some that'll actually give us telehealth get coverage. We have gap coverage, but when you specifically talk about telehealth people kind of get glassy eyed. So I have already told folks as soon as I find someone that really can offer us all accurate fees, those kinds of plans, I'm going to let the right people know, so they can get the word out that there's a place for us to go. But you really should try to get gap coverage for your telehealth.

Mary:

With that, I will just leave it at that, and if there's any questions, I'd be happy to answer.

April:

Mary, thank you so much for that great information. You guys are absolutely leading the charge in the telehealth space. There was a question that came through the chat. I'll just say it out loud in case others missed it. There are no slide for today, this will just be the audio recording which will be uploaded on the NACHC website. I will pop that link back up. But the easiest thing to do to the right of your screen is to go to net.org and just search telehealth, scroll all the way to the bottom and that's where the telehealth office hours recordings and slides will live. So give us about a week to get everything compressed and we'll have it uploaded for your use.

April:

We did get a question, Mary for you, is the video HIPAA compliant because you're using the tele visit through the eCW (eClinicalWorks) software.

Mary:

So the easy W software is Hilo and that is HIPAA compliant. But when we do... There's two things you can do. So we have two ways of doing a clinical visit. Both are HIPAA compliant. We have a video a hard like actual computer, if you will, server that's a video bridge. And it's through a very prominent company that I need to bring up here but that offers total HIPAA compliant communication between up to, I think, you can have a lot of people on a call, but for a clinical trial, you can have four people on a call potentially if you want because oftentimes we might have two people talking, but we might have to bring in a third person as an interpreter and they're all using a HIPAA compliant bridge, if you will. It's just like a teleconference when you do a conference call phone calls, same thing, but it's for video and it's all HIPAA compliant.

Mary:

Secondly, there's programmes out there like Zoom, that it you can request a HIPAA, you can request a BAA from them, and you have to make sure that you get a BAA. You should get that from any video company that you want to buy services for. But they've really stepped up to the plate. A lot of these video companies such as Zoom, Blue Jean, I'm trying to think, WebEx, there's a bunch of them that offer services and you just have to make sure you ask them for a business associate agreement, a BAA, that states that that those visits are HIPAA protected.

April:

Perfect, thank you. The next question came in, one of our favorites about reimbursement. Is telehealth available if you're seeing the patient via telehealth when the provider is the FQHC and the patient is in their own home?

Mary:

That depends on your state. Many of the states, and I don't have a stent front to this, a lot of states now are allowing accurate fees if the providers in our house center and the patients at home. For instance, in New York State, we can bill for that visit now and we can build Medicaid for that visit and our commercial providers and etc. Medicare's very tricky and there's not a lot you can bail as an FQ if your patient has Medicare. I'm not sure if it's good or bad, I think it's bad but we don't see as many Medicare

patients as we do Medicaid, and in a lot of states now Medicaid will pay for that. If your state doesn't allow for that, my recommendation to you is to reach out to those of us that have gotten that put in place, and we can certainly give you our two sense on how we got that through our legislature. Because I will tell you that in a lot of states FAHCs have led the charge to get reimbursement more robust for telehealth, and it just comes from, a lot of it is just educating our folks to make sure that they understand that this is really no different than a regular visit.

Mary:

Reach out to any of us, the telehealth resource centers are a fantastic resource. They're national they have free services, so look them up. They're HRSA funded to find out what your state allows for that. That's a state thing now, not federal.

April:

Absolutely. Thank you, Mary. And also I just put a link in the website, do the CCH, Center for Connected Health Pharmacy, one of our partners with this call, you can go in and see what the current by-state reimbursement policies are. It's one of... We'll constantly hear because that's just the question of the day, the hour, the month and the week, how can we get paid for it? So that fight is absolutely the trusted source for you to go in and see what's happening at your state. But to echo what Mary said, it is different per state.

April:

Mary, we did have another question. What did you find were important areas to cover when creating your organization's telehealth policy and procedure?

Mary:

So one of the things that you want to make sure you do when you think about introducing telehealth technologies to provide better access to care for your patients. What you want to look at is where are your trouble spots? Where are there gaps in care that your patients really struggle? So the first thing you always want to do when you start thinking about introducing telehealth into your organization, you want to do a complete needs assessment to really look at, who, how, what, where, when, why. All those things, and do an assessment. That's what we did and we said, "You know what, we just can't get access to psychiatry and to mental health counselors who speak Spanish." So we really focused on that as one of our first programmes and we actually reached out to other FQHCs out in another big urban center, because they had extra capacity.

Mary:

For me, I say, for all FQs this is a great way to share and resources and keep it in the family if you will, between FQHCs, but that's what we did. We did a nice assessment, we came up with a vision of what we wanted to try to address and we stuck with that and we planned. We always talk about this four buckets you have to address when you're building telehealth into your programme. Number one is broadband, you got to make sure you have enough and that it's dedicated. You want to then deal with your equipment, what kind of equipment you need to have programme development? That's where you should spend most of your time.

Mary:

And then of course, your regulatory and legal stuff. But with your clinical processes, no matter what modality you pick to build telehealth into... What you want to do with your clinical processes is you don't want to go in and all of a sudden say to your clinical team, "We're all going to start doing tele psychiatry now we're going to change the way we do everything so it fit." You can't do that because your whole team will quit or they'll be really angry at you. What you want to do instead, is say we know that there's a huge need for tele psychiatry with our patients, we're going to find a partner, we're going to work with that partner. But what we're going to do is we're going to weave that telehealth capability into our current clinical process because we don't want to change the world because staff can't take all that on at once. It's too hard in our health centers to ask our staff to take that many changes on at once, you won't succeed.

Mary:

The problem with tele health technologies is when you first get started, you have to have some wins, so that staff adopted it cheerfully. Otherwise, they'll just back off and say, "You know what? This isn't work and I don't want to deal with it" And we don't want that. We want to have a successful engagement with telehealth technologies. You really want to be careful of how you just don't try to change everything at once. You got to do it really systematically.

April:

Thank you for that Mary. That was actually one of the notes that I was going to make for you to see how did your staff embrace the change for this process, I appreciate that.

April:

There was a question, I asked if you use the particular needs assessment form as you were getting that information?

Mary:

We sort of developed our own, but I think if you go on the web, you'll find. I know some of the telehealth resource centers have those kinds of things on their website. Just Google it.

April:

Gotcha. And Kathy, thank you so much. If you are looking to chat about Kathy, for an example memo or Medicaid memo explicitly allowing FQHCs to serve as the distance provider, there's a Dropbox link there if you want to view what she shared. So thank you so much, Kathy.

April:

And I don't see any other questions coming through the chat though. I'll pause and see is my colleague Susan or if any of the partners from the TRC, HRSA or CCHP have anything that you want to share at this time. Feel free to unmute your line. I'm not sure if my other colleague Colleen is gone. But if anyone else has anything to share, feel free to unmute it this time.

Mary:

Jonathan, I see you on thank you so much for joining.

Susan:

Hi, April it Susan. I don't have anything to share. Just a big thank you to Mary. I always learn a lot from your presentations and this was wonderful today. Lots of great information. I just want to echo though, Mary's comment about the question on, can this be covered... Telehealth be covered if your patient is in the home? You really do need to check with your state and the telehealth resource centers are an excellent resource. We are also happy to work with you here at NACHC if that's something that you're interested in pursuing. So we can sort of work together with folks if that is a challenging policy in your state. But we've seen a lot of improvement over the last year and this, especially in the state of Virginia. So we're happy to work with you on that, if you have any further questions. Thank you, Mary.

Mary:

Oh, thank you.

April:

We did have another question Mary, I know you said that you're working on your gap insurance, but the question is, who did you acquire your gap insurance coverage from, and what situations are you thinking to cover with this insurance?

Mary:

Well, I don't want to give out the name of the company until I find out for sure if they're going to do gap coverage, like we think they're going to do it. But and I will let someone know it NACHC, as soon as we get names of companies that you can reach out to as FQHCs. But what we want coverage for is exactly that whole issue of, if my providers in my health center and I want to see my patient at home, because they can't get to me, I don't want to not see them. So I need to gap coverage for those kind of visits, in case something happens. It's those kind of scenarios when my provider or when the patient comes into my site, but they see the pediatric neurologist up in the urban center, I need to have some gap coverage for that.

April:

Got it.

Mary:

Because I'm not the provider.

April:

Let's see. I don't know I have something pop in, not I've spotted. Anyone else?

April:

Mary, do have anything you want to say or jump in or any one from our partners?

May:

This is May from CCHP - my apologies for for joining late... I don't know if this was covered, but I heard the word gap insurance. I have heard and I think, may be NACHC has already said this at some point but that the HRSA is looking at having clear guidelines on exactly how FCTA works with telehealth. It's very big right now because it's not addressed, the coverage is not addressed. So they are working on guidelines. Unfortunately from a recent discussion I had, they gave the word soon. So there's not like a

definite time of when that would be released, but it is something they are aware of as an issue that can cause confusion for FQCHs and community health centers on like exactly what type of coverage they have. They use telehealth and they are trying to like clarify that. So hopefully that will, again come out soon, but they did not give me like a specific date on when those guidelines would be issued.

May:

I did come in the middle of Mary's answer to a question, about it varies from state to state on like what to tell how policies I'm going to get like on Medicaid, on what is the reimbursement and how that could be done. It is very confusing and it can get very complicated. The PHP is more than happy to try to help you as much as possible. However, there are some intricacies there in the policies that vary from state to state that we have not had the resources to do a deep dive on for some states, or the majority of states. We did get a grant to do a deeper dive on a couple of days, but we had to, for the grant, tailor to the use of telehealth to address substance use disorders. But that will at least provide like more information specifically for FQHCs and like what the policy barriers might be, what some of like the issues are on utilization of telehealth, at least for a couple of states and hopefully we can interest other funders to where we can expand that more.

May:

So we just got that graph. But we will hopefully have that completed within the next couple of months. So that information again, it's coming soon, but a little bit more definite than the HRSA information on FCTA.

April:

Got it, thank you May. Anyone else from the team?

April:

And also, since we have a few minutes in the chat, if there's anyone from the field who's on the line, if you prefer to ask the question versus type it in, now we'll be your opportunity if you want to.

April:

Wonderful. Well, Mary, thank you so very much for that very practical overview of how you all are being successful with telehealth in the Upstate, and thank you for hearing your theme for just reaching those spaces that are absolutely needed.

April:

Susan, May, HRSA, thank you all as always for supporting this office hour. To our participants, thank you for taking the time out of your day to join in and be engaged, you see the email address on the screen. If you have any lingering questions or comments, feel free to reach out to us at telehealth@nachc.org. Again, the recording will be up soon. And we will be back on next Thursday, not next Thursday, but next month, January the 9th, at two o'clock. Remember we huddle the second Thursday of each month.

April:

Thank you all in the field for the continued work that you do. From me personally and here at NACHC, I wish you all very happy holidays and safe happy and blessed travels to wherever you go, or if you're at

home doing nothing like me, have fun. So we will be back on January, will talk to you. Thank you all so much.

Mary:

Thanks

April:

Bye, bye.