Brandon (00:00):

All right. Thank you so much, Olivia. And welcome again everyone to today's telehealth office hour session. Today's session's going to dive into a telehealth risk assessment tool developed by Unity Health Center. So this comprehensive approach of this tool allows for really a complete assessment of the dimensions that allow organizations to develop a telehealth work plan, and strategies for continuous quality improvement of telehealth services. So as Olivia mentioned earlier, I will be moderating the chat during the presentation. So if you have any questions, pop those into the Q and A box. And if you happen to put them in the chat box, I will be moderating that and pulling those out accordingly. So again, we will try to address those questions, many questions as possible near the tail end of today's session. So again, our presenters today are, Ms. Angela Diop, who's the VP of information systems at Unity Health Center, as well as Ms. Adriana Anderson, who is the AP of... I'm sorry, VP of corporate compliance and risk management, a privacy officer also at Unity Health Center. So I'm going to hand it over to the Unity team now. Enjoy. Thank you.

Adriana Anderson (01:09):

Thank you, Brandon. And thank you NACHC leadership for inviting us to share our experience with our colleagues. As Brandon mentioned, I am Adriana Anderson, VP of corporate compliance and risk management at Unity Healthcare in the District of Columbia. And I am also the privacy officer. And it is my pleasure to introduce my colleague, Angela Diop.

Angela Diop (01:39):

Yes. Thank you, Adriana. My name is Angela Diop, and I am the VP of information systems here at Unity.

Adriana Anderson (01:52):

We will be happy to provide a background of Unity so you can assess what kind of thoroughly qualified healthcare center we are.

Angela Diop (02:01):

Next slide please. So Unity has been serving the District of Columbia since 1985. Like many of you, we have a range of services that we offer. These services include primary, specialty, dental and behavioral healthcare. We actually care for special populations of people, such as people experiencing homelessness, people with HIV, returning citizens, and Title X. We actually have a big Title X program. And we are located throughout the District of Columbia and all eight wards. We have 25 plus sites. It goes in and out of fluctuation all the time. And these are community health centers, homeless shelters, our medical sites and homeless shelters, school-based health centers. And we provide services in the D.C. jail. Our mission really is to promote healthier communities through compassion and comprehensive health and human services. And I actually like to share this picture because this is our largest site in upper Northwest D.C. And that is a beautiful mural that we had painted on our site that kind of represents the diversity of our communities. Next slide, please.

Angela Diop (03:24):

The other kind of highlights of our patient population and who we are, nearly three quarters of our patients are African Americans. Almost 20% are Hispanic. And 60% of patients have incomes below 100% of the federal poverty level. We see 450,000 patients a year. That was actually in 2020. And then

as I mentioned before, that's actually a nice little map of the District of Columbia there, and how dispersed our services are throughout the district. Next slide, please.

Adriana Anderson (04:07):

And here before we dive into the substance of a telehealth risk assessment, is always very good to have clarity on the terminology. So in some environments, telehealth and telemedicine are used in the same way, but they are actually different concepts. Telehealth is the use of electronic information and telecommunication technologies to support and promote long distance clinical care. And that includes all kind of care. Public health, health administration, health related information, patient monitoring. Telemedicine is more strictly considered clinical services. The remote diagnosis, treatment of patients by means of telecommunications technology. So telemedicine in a way is one of the chapters of telehealth.

Adriana Anderson (05:07):

And very important for purposes of billing payment and considering what is a legal encounter, is the concept of the originating site. In most the regulations in our country, the originating site is where the patient is receiving the health services. So the location of the patient is very important when we consider telehealth services. And this location could be with the patient's physician, in other qualified healthcare professional, or when the patient is self initiating the encounter with the provider. And how the originating site is being considered during the COVID two years of experience, has been a very important concept as we assess the risk. Next one, please.

Adriana Anderson (06:00):

So telehealth at unity prior to COVID-19, was still a futuristic project. We had some experience with telehealth, mostly driven by grants and pilot projects, with some futuristic mindset of expanding the services at some time. At that time, D.C. telehealth regulations did not recognize the patient home as an originating site. So as I mentioned, where the patient is located is a very important key. Audio and video visits were not reimbursed at the same rate as in person visits, which also impacted the expansion and ability to provide more services. And then many patients with lack of access to devices and connectivity and limited literacy were not very like to participate in telehealth services. So that was the environment we came until March of 2020. Next to slide, please.

Adriana Anderson (07:10):

And then we know what happened in March 2020. The reality of COVID-19 came to all of us. And on Wednesday, March 11, 2020, Mayor Muriel Bowser, the mayor of the District of Columbia declared emergency rule. And that had a huge impact for telehealth services. The Medicaid authority in D.C. in recognition for the need to enhance access to care in a time in which people were asked to shelter at home, and in the time in which people were asked to maintain social distance, had to consider how this emergency rule needed to expand the way to reach out to needed populations.

Adriana Anderson (07:58):

This emergency rule recognized for first time, the patient home or location as a reimbursable site, originating site for telehealth services. And the D.C. Medicaid parity law also allowed for audio and video telehealth visits to be reimbursed at the same rate as in person visits. This changes of the emergency rule really allowed organizations like Unity, to provide for the large number of services that we need to provide to our community. As you saw in the second slide, we provide services for... we do about half a million encounters a year with our target population. So reaching out to them in a time of crisis was

very, very important. So these changes in the regulation allowed us to expand and to provide very much needed services at the time. Next is slide please.

Adriana Anderson (08:58):

So here is how fast this expanded. We had nearly zero telehealth visits, which were most pilot projects, experimental. And then we jump into 800 visits a day within a space of 30 days. It was pretty rapid, and we deployed very, very fast. At the peak, Unity saw nearly 1,000 patients a day virtually. And those were all kind of things, because there was a fair amount of information related to COVID-19, but people had all kind of health issues that were still happening. And we also discovered the value of telehealth for population health management and for patients who suffer from chronic disease, who were populations most at risk, and who needed to have constant monitoring. Next is slide, please. So at this point, we will ask a little bit about your experience.

Angela Diop (10:06):

Yeah. So we're going to get started with some polling. We thought we'd have some fun and ask you guys, what has been your experience with telehealth? Have you implemented telehealth services at your health center? Yes, fully. Yes, partially. Or no, we have not. There's a poll up right now. You can go ahead and click. We're going to have the poll stay open for a few seconds or so. And we'd like to see where you're at and we're happy to share that with the audience here. So give it a little bit more time. Here.

Angela Diop (10:53):

All righty. Okay. So that's pretty exciting. So what our poll is showing is that 70% of us say, "Yes, we have fully implemented telehealth services." Which makes a lot of sense why you would be on this call today. Or 27%, partially, and 3%, no. So that's pretty good. I think the pandemic has shifted the landscape quite a bit for us and how we're providing care. We have a second poll we're going to ask you to respond to before we get into the nuts and bolts of a telehealth risk assessment, because it seems like a lot of us are pretty ready for this. So the question is, have you performed a telehealth risk assessment? Yes, you've performed one, or maybe you've partially performed one, or no, we have not performed a telehealth risk assessment.

Angela Diop (11:53):

I feel like I should sing that song. (singing) give you guys some background music. Right? (singing) Olivia, you're going to have to do that next one next time. Alrighty. All right. Results. Okay. It's kind of equal to 21% says they have performed a risk assessment. Adriana and I will also love any sort of feedback you all have about the work that Unity has done as we go along here. Yes, we have partially performed one or 60%... almost 60% say, "No, we have not performed the telehealth risk assessment." So we hope that today's talk can maybe give you the tools or give you a little head start on addressing that.

Adriana Anderson (13:00):

So here it is how we did our telehealth risk assessment. Next slide, please. So really the expansion of telehealth continues, but when we experienced this fast growth, it felt quite scary. I think as executives in our organizations, we are always trying to protect the assets and we want to protect our patients, and we want to make sure that we are providing for all the considerations and all the risks that expansion of a new service implies. We knew at the time telehealth was there to stay, and we know that now is here to stay. So we were looking for tools that could help us assess all the areas that could be important for

us to look into. And that's when we came across the tool from the Emergency Care Research Institute, ECRI. They developed a guidance that provided for a good overview of all the areas that an organization, particularly a community health center needed to look into to provide for a full risk assessment. So we took the tool. Next slide please.

Adriana Anderson (14:38):

And here is the reference. That tool was issued in the summer of 2020. Here is the reference. And I also would like to make a pitch for all of our colleagues to join the resources of the Emergency Care Research Institute. If you have not done that already, they have a wealth of information in their library. And we found this tool they issued in the summer of 2020, guiding community health centers and ambulatory centers about all the areas we needed to focus on to really assess all the risk. Next slide, please.

Adriana Anderson (15:22):

And what we did, we took that tool. And the tool contains seven dimensions that prevent, identify and manage clinical risks associated with developing, implementing and maintaining a telehealth program. So we took each dimension. And each dimension was in the tool organized with strategies to assess the content of this dimension. And each strategy we assess if we have complete the task, if we were in progress, or if we were in need to develop that strategy. And the conclusion of this assessment gave us our work plan to work and improve in our telehealth services. So we propose action items to address at the completion of each strategy. Next slide.

Adriana Anderson (16:24):

So here are the seven dimensions. The first one is telehealth program development, privacy, security and confidentiality, patient education and informed consent. A huge one that has been in constant flux during the past two years, credentialing and privileging, particularly in some of us that work in areas in which there is reciprocity with our states. Equipment and technology, which is the most intuitive issue of concern when we go into something that requires so much technology. Provider and staff education, and then the risks and assessment of how is the actual conduct of the telehealth visit. So we are going to present the different strategies for each one of seven dimensions and discuss a little bit what we found on our own self-assessment. Next slide, please.

Adriana Anderson (17:27):

Here is again, another way to present these seven dimensions, but this slide really indicates that this is a more progressive process. So we need to make sure that we are in compliance with credentialing and privileging before we actually have an encounter with a patient. We need to have the technology. So this slide also shows that the development of a telehealth program is somehow a progression of different aspects that we need to take into consideration. Next slide.

Adriana Anderson (18:06):

So here is the first aspect, and is the multidisciplinary team. So developing really a concept of all the people that need to be included when you are developing the program. And I cannot emphasize the team approach enough. I think many organizations have look at telehealth only and exclusively as a technological issue of getting one of the providers on board, so we can communicate with our patients via our phone. However, once the system is deployed, that's when all these other considerations come into play. So I think it's very important that we realize, all these members of the team need to be involved. So what we did is we took each dimension and we identify a leader in our organization, that

could lead that particular dimension. So we tap our leader in clinical operations to help us with the telehealth program development. How we do the appointments, how we make sure the patient has the information to connect.

Adriana Anderson (19:19):

How do we make sure that we have the infrastructure to really roll with the appointments. Privacy, security and confidentiality. This has privacy and IT security issues involve, and involve a heavy assessment of technology. Patient education and informed consent. For that, we tap again, our leader of operations. Credentialing and privileging is an activity that at Unity is advanced by our human resources department, and we team up with them to make sure that we were in compliance with the regional regulations that cover our geographic area. Equipment and technology, provider staff and education again, operations, and then the conduct of the telehealth visits. So I am certain at your health centers, do have leaders in each one of these dimensions, that could be representing the development and in depth analysis of each one of them? Next slide. Then privacy, security and confidentiality. So Angela, if you could help me a little bit here, but really the software, the vendor vetting, is a very important step for an organization.

Angela Diop (20:40):

Certainly. Actually, I wanted to just add one other thing to your previous slide, Adriana. And that is, so it might look like a lot of people and a lot of disciplines, but the other thing that we did with organizing it is we actually... or a lot of work, but we actually brought these teams together for a series of, I think, two or three meetings, to work through these questions. So the amount of time to do it was maybe about four to six hours, and organizing in that way and just bringing that group together really helped to break it down and get it done. Was a little work in between, but really helped to... because I think sometimes health centers were overwhelmed by the amount of work when we see something like that.

Adriana Anderson (21:26):

Yeah. And I think, just the terminology risk assessment, sounds pretty scary.

Angela Diop (21:35):

Yeah.

Adriana Anderson (21:35):

And really, I think we need to demystify risk assessment, and understand is really about thinking through different areas and doing a self-assessment, which is really what we are sharing with our colleagues today.

Angela Diop (21:50):

Yes. So more on privacy and security and then the strategies there under the risk assessment, really making sure that we are only having authorized users having access to EPHI, only those who need access. Another strategy is to monitor secure communication systems, so that we are making sure that we're preventing any sort of accidental or malicious breaches. And then as a security reminder, this is a different way of providing care. So just reminding people that it is something that needs to be held in private, and there's other ways over here, because you're not maybe in an exam room like normal, and just to make sure we're avoiding being overheard.

Adriana Anderson (22:41):

And of course, the same considerations you would have for HIPAA compliance in your office visit, you will have as a well in a telehealth encounter. Even more because if it's happening in the home of the patient or in the home of the provider. There may be other people who may overhear information and that's a very important consideration. Next slide.

Adriana Anderson (23:12):

Third dimension, patient education and informed consent. Is very important to educate the patients about telehealth, and too is spelt out that it includes risk and benefits. And if there are alternatives that are available and the limitations that equipment and technology give for a clinical encounter as opposed to an in person encounter. So it's important to prepare the patients for the virtual visits. Some patients get confused when we have applications that have a virtual waiting area. And some patients need a better explanation of what is a virtual visit, particularly generations that were not accustomed to interact regularly by cellular phones.

Adriana Anderson (24:02):

So it's important if you can afford it, to do a trial run at the health center, with the patients. Or virtually, in which you explain how to log in, how to wait in the virtual waiting area, and how to make contact with the provider. Provide the patients with greeting telehealth. Preparation checklist is a great tool that helps them to assess their equipment, to have it fully charged. The worst thing that could happen is that you are in the middle of the presentation, of your interaction, and then the phone of your patient goes out of battery. So little details for a checklist will help the patient be better prepared for the visit. To review the state requirements for informed consent. In some states, there are additional requirements when the encounter is via telehealth. And of course, we need to obtain the patient inform consent. So this is the third dimension. We walk through that and we make sure that we develop elements of compliance for all of these just to have a better program. Next slide.

Adriana Anderson (25:16):

Four dimension. This four dimension has been one of the most dynamic during the COVID period. We need to verify if the remote practitioners are qualified to practice telehealth medicine in the jurisdiction when they are requesting privileges. There have been numerous regulations in which a state's creative reciprocity agreements during the pandemic, but these reciprocity agreements were very much tied to the emergency emergency regulations and emergency rules. And those have been expanded. Some have been terminated, and it has been a constant influx of these reciprocity agreements. So we need to really always be on the outlook for tracking a state laws that may affect the practice of telehealth, and consult with local legal counsel and ensure that the legal telehealth requirements are met.

Adriana Anderson (26:19):

And many of us work in environments in which we do a lot of interstate and we have multi-state areas of service. So this is really, really important. Here I added in the slide, a tool that has been very helpful for Unity, is issued by the Center for Connected Health Policy. And the link includes a list of all telehealth policies per a state, and is very well updated. So I will recommend this one to all our colleagues. Incorporate selected clinical telehealth performance measures into your health centers privileging process.

Adriana Anderson (26:59):

I think we have figured out very well how to assess the quality of our providers in in-person visits, but this is a new territory. How we are measuring how the provider performs in this new environment. And one that I think we will all be discussing in the years to come. How we monitor for adverse outcomes and discrepancies in diagnosis, treatment and follow up, as compared with a face to face visit. New territory, but we also were very careful to figure out how we could monitor for that, because how risky those discrepancies are, are still to be seen as this telehealth environment continues to evolve. Next one. And here is one in which Angela is the expert, which is, equipment and technology.

Angela Diop (28:02):

Yes. So the dimension of equipment and technology, that might be kind of our knee-jerk reaction when we think of telehealth, but like Adriana said, it's just one of seven dimensions. Really determining what the needs are in order to conduct, or to figure that out, conduct a technology assessment. Before you purchase new equipment, you can buy small quantity samples, and have providers and staff try out the equipment and the applications, verify that the hardware and software is compatible with the EHR. I think this is something we had quite a bit of workaround in the beginning. Really trying to make sure that it fit our care model and our existing applications. Conduct routine equipment testing and maintenance to address any potential problems. Also, I would say, address problems as quickly as you can when they do come up, because they can affect patient care.

Angela Diop (29:05):

So it's really important to do ongoing quality checks of audio, video and any sort of transmission of data. Perform equipment calibration before every telehealth visit and document results. That's pretty tall order, but it's definitely something we aspire to do. Ensure that future technology costs... And I think this is a pretty important one as Adriana mentioned. Telehealth is here to stay, but how are we planning for that in the future? Have we thought about what it will cost, what will software cost? And putting it together in our business plan. Next slide, please.

Angela Diop (29:45):

And then the next dimension here is provider and staff education. And there was a lot of training that we had to do. We wanted to make sure that providers and staff were trained on telehealth topics, including even the use of the technology itself, what the goals of the programs are, key roles and responsibilities, who's doing what, policies and procedures, and metrics. Identify super users. This was another real key. Super users and champions who can assist with other users with the telehealth process and help communicate processes change. I think pretty important in that is to make sure you have a provider champion that can really get you a long way in showing up your telehealth program.

Angela Diop (30:38):

Develop instructions for staff on what to do in the event of equipment malfunction, or have ways for them to be able to communicate those to you through help desk or self help. Train staff regularly on ways an organization may be hacked. We have new ways of gaining entrance to our systems and our applications, and cyber crime has been on the rise throughout this pandemic. And it's really important to make sure that we are training our staff on how to recognize and prevent things that could cause security breaches. Next slide.

Adriana Anderson (31:17):

So the conduct of the telehealth visit. And really, we have tried to equate a telehealth visit to the same quality of an in person clinical visit, but we need to recognize that telehealth requires meeting the same standard of care as to a face to face encounter. So if during the visit, it is determined that the telehealth is not the appropriate venue for the patient's individual situation, we need to prepare our providers to arrange for alternative evaluation and treatment. That is really an area in which the input of our clinical teams is fundamental and they need to start developing protocols and SOPs that could help our providers indicate when to cut or when to move a telehealth visit into an in depth, much deeper evaluation. We need to ensure that a lawful patient provider relationship exists. We had several instances of patients that were not established patients.

Adriana Anderson (32:18):

They reach out to us for the first time. Depending on the jurisdiction, that was not available visit or even allowed. We were allowed to continue know remotely with our existing patients, but in some state laws, that will not be allowed. So it's important to know when according to your state law, you can establish a new patient via telehealth. Another strategy is to use a preparation telehealth etiquette checklist, to ensure that professional standards are upheld during the visit.

Adriana Anderson (32:55):

And this is very important to provide some disclaimers to reassess with the participant, with the patient, if they understand what the consensus, if they understand the limitations of the virtual encounter. Again, follow federal and state laws. This has been very, very dynamic. And particularly when it comes to online prescribing. And document any provider patient encounter in your electronic health record. And one of the things we have found is that not all the applications in the market interact very well with all the electronic health systems that our type of organizations use. So this is a very important aspect, because we need to have the same standards of documentation as we would have with an in person encounter at one of our clinics. Next slide.

Adriana Anderson (34:01):

So here is the risk assessment tool. And I've seen in the chat, some of our colleagues are asking for the tool, and the tool has been sent already to people who registered, or will be sent again with the materials of this presentation. And next slide, please.

Adriana Anderson (34:23):

Is very simple. This is what we did. We created a tab for each one of the dimensions, and then we listed each strategy in that tab. Then we created a dropdown menu to indicate if that particular strategy has been completed, if it is in progress, or if we needed to start developing the strategy. And then we provided a description and provided an action to respond to this strategy. And the column that is entitled proposed actions, was the foundation for our plan to make sure we had a robust program in which we were controlling for our risks.

Adriana Anderson (35:19):

So is not a complicated tool. We basically adapted what ECRI released for the use of our organizations into a useful Excel tool. It didn't take as many meetings to complete it. As Angela mentioned, we had an initial meeting to strategize. We had one to really go in depth, tab per tab. And then we had one to conclude of our action items and to develop our work plan. So the conduct of risk assessment is not [inaudible 00:35:55] process when we have the conceptual framework. As we share this tool, we are

very interested in your feedback. We want to learn from you too. A number of you indicated you have done telehealth risk assessments. We also want to learn from you. So we welcome, and we appreciate all your feedback, comments, and your ideas to improve how we continue doing these risk assessments. There are some things that we know we have to continue monitoring, and we know telehealth is here to stay. So we hope this tool can only get better with the input of all in the field. Next slide.

Adriana Anderson (36:39):

So these are the results of our risk assessment. Next slide. We had a happy surprise. 11 strategies as enumerated previously, we were completed. So our program was not as immature as we were afraid of. We were in a very good place to begin with. There are 32 strategies listed in the tool, and 11 were already completed. 16 were already in progress. We had some idea how to go about that. Some strategies actually will remain in progress. We will never be able to complete, because of the dynamics of the emergency declarations. And as I mentioned, credentialing, privileging, changes on prescription, regulations for telehealth, depending on the state. So some of the strategies will be a matter of constant monitoring.

Adriana Anderson (37:41):

Three strategies were in need of development. And two strategies we realized we actually didn't have to think about at Unity. For example, equipment calibration, because we were not providing equipment to our patient population. Some of you may be distributing equipment, but that was not our case. So we even found tour strategies were not a direct concern at this time. So I am certain that as you go through this exercise, you may find also that you are better prepared than you think, and you may find other thing which probably it will be a matter of putting in place continuing monitoring. And maybe as you can see in our case, only three strategies were in need of full development. Next slide. Okay. And now many of you are thinking, "Okay. All this effort, but what about the patient? What about evaluation of how these services have impacted the community?" And Unity had a great opportunity to do this exercise. So here is a little bit of what we have learned.

Angela Diop (38:55):

Yeah, but first a commercial break. Want to add two more polls for you guys. So how much of your services do you envision will continue being at telehealth? 75% or more? 50%. 25% or none, or very little, will continue with telehealth. Please take a moment and submit your poll responses. I know you guys don't want me to sing every time. Do you? Okay. I'm going to guess. I'm going to guess it's going to be 25%. Let's see. Ooh, I'm good. Huh?

Adriana Anderson (39:53):

Wow.

Angela Diop (39:54):

So we have about 7% saying 75%. 31% saying 50% will continue. Whopping 56% saying about 25% of our services will continue as telehealth. Very few. 6% saying none or very little. One last poll, if you guys will indulge us. And that is, what kind of services do you envision will continue to expand because of telehealth and primary care, mental health, behavioral health, dental specialties, other. If you put others, you can drop in the chat what you think that other might be. So we're again, interested in learning from you as well. What's happening out there with our colleagues. Nutritionist, that's a great one. Thank you, Linda.

Adriana Anderson (40:51):

And this is really select all that apply.

Angela Diop (40:55):

Yes. School health services, MTM breastfeeding peer counseling, MHGPS, case management, dermatology. Excellent. Health coaching.

Adriana Anderson (41:15):

I'm realizing our list is just too limited. What we are learning from our colleagues.

Angela Diop (41:21):

Yes. Nutrition. Very good. Excellent. All right. Remote monitoring. 93% of people say mental and behavioral health, and then 66%, primary care. Very interesting. Excellent. So, thank you. Thanks for the polls, and hopefully, that... peer recovery support, SUD. Hopefully that information was as interesting to you as it is to us in planning for the future. I'm going to just take a few... next slide please. A few minutes, just to round out our talk here, just to talk about kind of what this all means. We talked about how we got here, how we assess ourselves, but kind of what are the benefits and what have we seen from it? So we realized many benefits and opportunities over the past several years. It seems like several years now, but two years of our experience. And that includes, we were able to reduce our patient's exposure to disease.

Angela Diop (42:27):

We found it to be cost effective, convenient for both staff and patients at time, because it reduced travel time and work time. We were working a lot of hours then. And so just being able to kind of shave those things off and redirect it into patient care was great. We were able to engage family and care team members in the visit that maybe might not have been available if they had an in office visit. We actually had more scheduling flexibility. And that flexibility not only extended to patients, but also our staff who were dealing with many of the issues and concerns of the pandemic and trying to keep their children in school and on Zoom and all of that. We were able to reduce wait times and we saw reductions in no show rates. And I'm going to show a couple of slides on some of those. Next slide, please.

Angela Diop (43:24):

The patient experiences were great as well. Besides this telehealth assessment we did, there were a couple of other activities that we have done that have helped us to round out our information and knowledge about telehealth. One is that we did add to our patient experience surveys that we do with our patients, questions about telehealth. As well as we actually conducted a study with simply hospital to look at how seniors in a couple of economically depressed wards in our city were able to connect with telehealth. And this actually helped to provide additional qualitative and qualitative information about the experiences that patients had. So what we found was that some were able to connect with relative, ease. A lot of people have smartphones. And so I think more people had equipment than what we thought. Few needed help, but felt more comfortable over time.

Angela Diop (44:40):

A lot of our patients appreciated being able to stay home. It was pretty scary in the beginning of the pandemic, and that actually helped to limit their exposure to COVID, and many of our patients are in the high risk groups. And so that was really important to us. And our patients, they saved time by eliminating wait times in the clinic. And then some patients did have audio issues, and they were turned off by using video. And so that is some work with that we had to work on and deal with. Next slide please.

Angela Diop (45:15):

So here's just a couple of examples of... I mentioned we modified our patient experience survey, where we asked patients, were you able to see a care team within 15 minutes of your appointment? On the left is in person appointment, on the right is a telehealth video appointment. And as you can see from that, in person visits, about maybe 80 to 85% of patients saw their care team within 15 minutes of their appointment time. Whereas with telehealth, greater than 95% of patients are being seen within that 15 minute time. So that's a bonus to the patient. Next slide, please.

Angela Diop (46:00):

Well, and to everyone, to staff and improving access. We did see some significant reductions in no shows comparing in person visits to telehealth video and telehealth audio visits, where we run 30 to 40% no show rate at Unity, typically. But with telehealth, we were able to see no show rates much lower. We're seeing rates closer to 15% with those patients. Next slide please. And then the last one. We have more, but we just wanted to share a few. But patient's perception of quality. And then here again, patients were asked their overall perception of the quality of care of the providers. And what we saw is that having a telehealth visit, a video visit, the quality did not suffer. As a matter of fact, they were pretty pleased with the quality and slightly more pleased than an in person visit. Next slide please.

Adriana Anderson (47:12):

So just as we wrap up our tool and the presentation of our experience, we want to share also some recommendations and lessons learned of our experience. Next slide please. So the first thing is perfect is the enemy of the good. We knew we needed to assess our risk. We didn't know if there was a tool out there that has been already embraced by the community as a good tool, but we decided to go with the ECRI Institute, who is a great resource of quality source of information in clinical risk. And we decided to go with it. So begin somewhere to assess your telehealth risk, try to be comprehensive, try to create your team, but don't be afraid if it's not perfect. Just begin somewhere because this is very dynamic, and as we have experienced, is a moving target. Look and use your regional resources. We have a fantastic primary care association in the District of Columbia, and they gather a lot of their members for issues like telehealth and technology and other areas of concerns.

Adriana Anderson (48:31):

So please look at regional resources that you may be overlooking, and team up with them. Collaborate with all your internal stakeholders. Again, telehealth is not just a technical issue. It involves the whole provision of services and most of your areas. The adoption by providers is key. And finally, we know telehealth is a very dynamic process that is in the growing phase. So we are already planning to reassess our risk, or please reassess your risk regularly. We are seeing that in some areas like mental health, probably services are going to continue at a similar volume than during COVID. And other practices in primary care may go more into the in person clinic, but we are also doing pilot projects in areas of week

nutrition, dental, and other families support services. So is still a moving target. We know the risk in particular specialties will have to be assessed at some point. Next is slide.

Angela Diop (49:57):

And here [crosstalk 00:49:57].

Adriana Anderson (49:59):

Go ahead, Angela.

Angela Diop (50:00):

Oh, okay. Sorry. So one of the outcomes... I talked about other sources of information. We pulled together some recommendations that we wanted to do at Unity Healthcare. And this was a lot of this came out of, was really directed at how do we continue to advocate in advance telehealth and grow telehealth? We thought we need to refine the workflows. The first workflows were really provider heavy and relied on the providers having to do a lot of work, but really better building out the care model so that there is a multidisciplinary team that's working to support the patient. Our recommendation was explore and pilot adding perhaps applications to TVs or patient portals that would actually help to demonstrate to our patients digital options for them. And that's telemedicine, patient portal, contactless check-in. There were a number of things that came out of the whole pandemic that we thought could be added.

Angela Diop (51:08):

We also recommended that we evaluate if we should continue using our current technology platform. We started a certain way because it was easy and we needed to get started, but we continue to evaluate that as more and more tools and functionality become available in our need of EHR as well as and other applications. We also agreed that to refresh the telehealth risk assessment and update the action plan annually. And then we have a thought of expanding recidivism services. Oh, sorry. So one of the things popped up here while I'm reading. To include training and implementation of telemedicine visits. Next slide. And I think that's the last slide we have, which is references. And we want to thank you for your time. We managed to end and have five minutes left for questions. So thank you very much. It was an honor to be able to talk with you all and thank you all for your feedback. That was great. We learned as well.

Brandon (52:24):

All right, great. Thank you so much, Angela and Adriana. I was getting so many questions. I had to take a second to pull those all together. We have about 11 or 12 questions I've been compiling, and I'll just kind of go through the list. You're getting a lot of thank yous in the chat. I'll go through the list of some of the questions that we have. And I'll just kind of start at the top here. So one was, did you include your CPMHQ or quality professional in this assessment, I guess earlier when you were presenting?

Adriana Anderson (52:57):

We had the fortune to have our leader in clinical. IT is also heavily involving our quality team, our quality efforts. So he played that dual role. I think as we continue involving the services and trying to measure how they compare with our in person visits, we may have to expand the input from clinical experts, and

quality experts. I think this is also a territory in which much development is expected within the next few years.

Brandon (53:34):

Great. And we did get a few questions via the Q and A chat box, and I do want to check some of those first. The first question in there was, can you share any best practices to compliantly support patients when they travel out of state temporarily, for example, visit Texas for a month to care for a loved one?

Adriana Anderson (53:55):

Yeah. We had numerous people that left the state during the COVID period, and they wanted to keep engagement with their providers. So I think because this has been such a moving target, my recommendation would be, look at your estate regulations and what your payers allow. Medicaid, Medicare, CMS rules, and your insurance payers guidance, are key in this areas. And it needs to be a constant monitoring. As emergency declarations are expected to finish this year, we may envision a period of stability in 2022, but it all depends. So really it's a question of your payers and making sure your licensure and regulatory requirements are also in compliance.

Brandon (54:48):

Great. Thank you, Adriana. Another question is how are you monitoring at Unity? How are you monitoring your telehealth program for quality of visits?

Adriana Anderson (54:59):

Yeah. Again, we are measuring patient satisfaction. We added a questionnaire about patient satisfaction, basically in April, the month after we roll out our program. We are also incorporating an evaluation of the telehealth visits with our quality target goals, but we don't have the sophistication yet to do the comparison how the quality of what we provided during COVID compares with the quality of what we provided before COVID. So if anyone of you knows of any resource, we can tap funds for that study. We are interested. We are very, very anxious to get funding for that.

Brandon (55:46):

Great. Two more questions. Well, there's several more questions, but I want to hear these first two. What is your organization's percentage to total visits that are currently telehealth visits? So what percentage of telehealth visits out of your total visits are telehealth.

Adriana Anderson (56:04):

I guess, Angela, I may be wrong. I think we are probably at 25 to 30%.

Angela Diop (56:07):

Yeah. About 25% right now. Maybe about 30, but... and I think we have a goal to kind of settle out at about 25, is kind of the goal. It might have bumped up a little bit because of Omicron, but prior to Omicron, it was about 25%.

Adriana Anderson (56:25):

But if you look at the specialties, then it looks different. For example, mental health has a larger proportion of-

Brandon (56:32):

Much higher.

Adriana Anderson (56:33):

Much higher than as compared with other specialties. So I do envision a moving target in the percentage depending on the specialty.

Brandon (56:42):

Great. Yeah. That's actually very... almost becoming standard around the 25 to 30% of telehealth visits [inaudible 00:56:48] amongst health centers. So that's really good to know. Another-

Angela Diop (56:51):

I mean, I think also with that though, we're also envisioning some new ways of providing care. We actually have a virtual care team that we're standing up this year. So just kind of expanding where we're using telehealth is another piece, not just for our primary care but augmenting care as well.

Brandon (57:12):

Very good point. It's like a two part question here. One, easy. What EHR is Unity health using? That's the first question. And then, how was the process to integrate telehealth visit information to flow back to the EHR, our patients' chart?

Angela Diop (57:29):

Yeah. So we use eClinical works. And one of the things that happened early on, which is why we were able to go from zero to 800, is we had an excellent provider champion CMIO. He actually surveyed our providers for tools that they could use easily. And so we use another third party tool with actually Doxy me, with it. And so they're using Doxy me for the video, and then they're documenting an ECW. I think that longer term we'd look at being able to... as ECW builds functionality, to be able do it all in the same platform, that would be the goal. And that's why we actually have in there reevaluating our technology platform.

Brandon (58:11):

Great. Thank you, Angela. One last question and we literally have one minute left. So try to keep us at time. How did you deal with patients that do not have email? Sign in and connecting for services, ask a question. A good portion of our patients do not have email, but do have cell phones. So generally from operational perspective.

Angela Diop (58:32):

So one of the reasons we used the technology we did, Doxy me, was because it allowed us to connect with the patients without email. We can send an SMS, text message to them, and get them. And that actually was at the time why we didn't use our native EMR for that. So that was our solution at the time. It might not be in the future, but yeah, that's how we addressed it.

Brandon (58:59):

Great. Well, once again, thank you, Adriana and Angela, from Unity Health, right here in town in D.C. Really appreciate it. Some really valuable information around your approaches to your telehealth assessment. And to everyone, there's several more questions that have come in while we were having this conversation. So we'll be sure to get these questions over to our speakers, and they'll be able to provide some responses and we'll have that disseminated to everyone as an FAQ as soon as we can. All right. Thanks again for your participation. Thanks again for a wonderful presentation, Angela and Adriana. And everyone, enjoy your afternoon. Thank you.

Adriana Anderson (59:34):

Thank you.

Angela Diop (59:34):

Thank you.