Operator: Ladies and gentlemen, welcome **[00:00:01 inaudible]** for community based organizations, services, payments, and partners. Before we begin, please ensure you have opened to the WebEx chat panel by using the associated icon located at the bottom of your screen. Please note that all connections are muted at this time and you are in listen only mode. However, you may submit a written question at any time by selecting all panelists from the drop down menu in the chat panel and entering your question in the message box provided. If you require technical assistance, please make sure to send a chat to the event producer. With that being said, I'll go ahead and turn the call over to Cheryl Levine.

Cheryl: Hi. Good afternoon. Thanks, everyone, for joining the webinar. Today, we're focusing on Telehealth for community based organizations, services, payments, and partners. Today, I will be co-hosting this webinar. Welcome, everyone. My name is Cheryl Levine and I'm with HHS, with the office of the Secretary for Preparedness and Response. My co-lead on this is also with HHS, with Paulina Hall is from our Office of the National Coordinator for Health Information Technology and also Ben DeMarzo, the assistant secretary for Field Policy and Management with the US Department of Housing and Urban Development, and if you want to just say a quick welcome, Ben, we'd love to hear from you.

Ben: Thanks so much, Cheryl. Thanks to everybody over at the Department of Health and Human Services for co-hosting this with us today. My name's Ben DeMarzo. I'm the assistant deputy secretary for HUD's Office of Field Policy and Management, which oversees the department's place, based initiative, which includes the **[00:01:31 Admittance]** Center Demonstration. I personally thank everyone on the call for all your continued service, your hard work, everything you're doing to help our communities and partners during the ongoing pandemic.

We really appreciate everyone over at HHS for being available to help talk with all of you today about Telehealth 101. Because of the content of this webinar, we invited our Envision Center sites as well as HUD's other stakeholders and community partners, which includes a ConnectHome, Promise Zones, local state, federal partners, nonprofits, faith based and tribal organizations. As a result, we've got a record number of people on this call, over one thousand five hundred people. Welcome and thank you to you all.

I want to take just a brief moment to explain what the Envision Center Demonstration is to those of you who may be unfamiliar with

the concept, 2018 Secretary Carson launched the demonstration, which centralizes federal resources into a single brick and mortar location. Those locations would be called Envision Centers. At HUD, we initially identified 18 centers across the country to demonstrate this concept. We've now grown that to 49 locations, which are designated as Envision Centers and we continue to grow.

As an Envision Center site, HUD commits that we're going to help enhance the site's ability to deliver four pillars of self-sufficiency. Those pillars are Economic Empowerment, Educational Achievement, Health and Wellness and Character and Leadership. Today's webinar falls under that Health and Wellness pillar, and we're hoping the knowledge shared by the presenters will help enhance the Envision Centers serve their communities and the people we want to serve. If you would like more information, please visit www.hud.gov/envisioncenters, which is our website on the Envision Center demonstration. We're very excited to learn more from HHS today about Telehealth. Without further ado, I want to turn it back over to Cheryl Levine at HHS.

Cheryl: Thank you so much, Ben. The page here, just the welcome page at the bottom, there's a note. We do have a web page within HHS **[00:03:57 inaudible]** host, the information for this webinar, for this webinar's series on Telehealth. It will be, once we have that webinar recorded in the slide, we'll post it there. If you don't have it right now in front of you, it will be available later following our webinar.

With that, just a little bit of background, I'll start by king of telling you a little bit about the origins of this webinar. In my role leading our At-Risk Individuals program for my agency, HHS **[00:04:26 inaudible]**, I recognized early in the Covid-19 pandemic response, but it was important to coordinate with my federal partners in order to address the needs of At-Risk Individuals through the programs they serve every day. I believe there was an opportunity to create synergy across some of our federal programs and partners to address the needs of key populations we understood were at increased risk for severe illness related to Covid-19.

A resolve to call is to convene a coordination group and begin conducting weekly calls early March with federal partners from HUD, FEMA, and HHS Administration for Community Living. This became our Housing and Community Services Coordination Group for the Covid-19 response, with a focus on addressing the needs of older adults, people with disabilities and individuals with underlying health conditions during the public health emergency.

There was so much information coming out so quickly, I offered to help identify key resources for my federal partners. These became my so called curated list of resources that I selected and described to help inform my federal partners as they develop their own guidance and FAQs for their programs. I also teed up with subject matter experts to be speakers on certain topics. One of the interventions that HHS was engaged in promoting to help address what we'll need for access to health services, making sure people continue to receive their primary care, prescription refill, as well as behavioral health services was Telehealth.

Through our Housing and Services Coordination Group, we were sharing information on funding flexibility and access to Telehealth services. But we learned from our federal partners, however, that not everyone was familiar with what Telehealth was and wanted to learn more. Thank you so much to my federal housing and services partners, we have this opportunity today to provide you with additional background on services, payment, and partners, as well as promising practice to share with you, our stakeholders, and our community based organization partners through this webinar.

We hope the information will help you to leverage Telehealth services to implement social distancing and continue to address the needs of at risk individuals you serve every day through your program. With that, I'm going to hand this over to my colleague, Liz Linehan from ONC to facilitate our panel.

Liz: Thank you so much, Cheryl. It's my pleasure, really, to walk you through the agenda that we've prepared for you today. Just to reiterate, this is the first in a three part series and really meant to be an overview of Telehealth basics. We were going to kick it off with an overview of some of the fundamentals and opportunities around Telehealth to support the Covid-19 response. That will be followed by a little bit, more information on Medicaid and Telehealth, and some of the flexibilities that have evolved and the resources that are available through CMS, again, to support COVID.

Then we'll hear from our partners at the Administration for Community Living regarding resources that have been tailored for community based organizations that serve older adults and people with disabilities. Then finally, we're going to hear from some health centers in the field that are leveraging Telehealth with community based organizations in their public health emergency response. Just want to… in terms of housekeeping, just remind you that as we go along, we're going to run through the presentation sequentially and

if you have questions, we do invite you to put those in the chat and we hope at the end of the presentation to have some time for Q&A.

With that, I am going to introduce our panel of speakers we're delighted to have today. We're going to first start with Bill England, a senior adviser of Telehealth from the Federal Office of Rural Health at HRSA. He will be followed by Kirsten Jensen, director of Division of Benefits and Coverage in Disabled and Elderly Health Program Group at CMS, that will be followed by Laurie Gerhard, Director of the Office of Interagency Innovation at ACL, and then we'll hear from Kristen McGowan, quality manager of specialized health services at Congress of Health Center, and Judy Emmons, Director of primary care, also from Congreso Health Center.

With that, I'm going to kick it over to Bill England to start us off. Bill?

Bill: Thank you so much, Liz. HRSA and the Office **[00:09:06 inaudible]** Telehealth have been doing Telehealth for a long time, but we obviously, because of the pandemic, has a huge number of partners and we're really excited, particularly to have folks from HUD working with us on Telehealth. Just a brief introduction to HRSA, we are largely a grant funding organization. Our 12 billion dollar budget is, the majority of it, is focused on grants. We have about 5,000 grantees at any given moment. About 25% of our grantees typically are touching Telehealth, maybe not primarily Telehealth, but Telehealth as a technology that can be used as we deliver Telehealth services, as we deliver health care services.

Our largest program serving 28 million people is health centers, we'll have a couple speaking today. We have about 20%, or about 40% of our health centers historically, pre pandemic, were using Telehealth, but most of them, it was only a small fraction of the services they were delivering. As **[00:10:11 inaudible]** survey them and ask them, how are you doing with Telehealth? They have been giving us answers, mostly, reimbursement is the primary reason we are not using Telehealth or not able to use it effectively, along with lack of funding for equipment, lack of training and technology.

A relatively small number said the bandwidth was a problem. Only 8% in urban and 16% in rural, but that is related to the bricks and mortar facility not serving patients. Many of our rural frontier sites are now saying, yes, but the patients don't have good broadband so we can't get to them. That becomes a different issue as a result of the current crisis that we didn't have a lot of focus on before. At the height of the pandemic in early May, we are surveying each week

our health centers to say, how are you doing with a lot of things, including Telehealth.

We hit 51% of all their visits, were being delivered by Telehealth. Ranging from 18% to 88% **[00:11:17 inaudible]** not surprisingly 88% serviced by Telehealth. Many of these centers stood off by Telehealth program from zero or just a few patients a month to thousands of patients a month, practically overnight.

In the particular program where I'm housed, the offices using Telehealth, we have two types of programs that we run and have been running for almost 20 years. The Network programs where we are funding the delivery of Telehealth services and other things we're doing to advance Telehealth. The Telehealth Resource Center, that I will talk about in just a moment, license portability, how do we cross state lines with Telehealth? We have a couple of grantees that are working on multistate model for licensing. We have research, two research centers, actually, but we will about have to, we haven't announced them yet. That will be in a few weeks. We have couple of centers of excellence where we're prototyping in those centers, Telehealth delivery.

What I really want to focus on and leave with you is our Telehealth resource centers. This is our outreach to the world. These are all center, all groups of experts, that we're Telehealth programs for us, we put out and created a new program a number of years ago to say, we want to buy your expertise, we want to turn you into a consulting force to start new Telehealth programs. There are 12 resource centers that are regional to national centers, one on policy, one on technology. These are funded by HRSA for you to ask questions. Anything you need to know about starting a Telehealth program, they should be able to answer, or if they can't, they'll find the answer for you.

They put out lots of material. There are guides, there are fact sheets, there are hundreds of documents on their website. The website is www.telehealthresourcecenter.org. You can then drill down and find what you need or call them and start asking questions. The Telehealth Resource Centers put on webinars since Covid started. I believe we have, maybe, 15 webinars we've done on Telehealth, very similar to what we're doing today. They put on two to seven per month.

Also, they conduct at conferences. We're now doing all of our conferences virtually. We just finished the last one two weeks ago. I don't think there are any more conferences scheduled for the rest of

this year, but check their website for conferences starting next year. Conference is a very low registration fee. In fact, the virtual conferences we made free. But we don't know what we're doing next year with regard to conferences.

As I said, TRC can provide any information you need on starting a Telehealth program, like what's the workflow? One of the things people new to Telehealth may not recognize is you'll have much less, no shows when you are virtually doing visit. If you don't provide breaks for your clinicians, they may be seeing eight hours straight of video conferencing with patients, and we've had a few complaints about, oh, my gosh, this is really techy. Plan that into your workflow. Our policy center, in particular, has been in great demand as they try to help people with policy like reimbursement, like licensure.

Their website is a wealth of information, not only on the Medicare program and national policy, but on each individual state. You can drill down to what is required in a particular state and if it's not here, they will refer you to the TRC that covers that state, for more detail on state policies on Telehealth.

I want to also mention some one of our other very important partners in working with Telehealth, is the Federal Communications Commission and the Universal Service Lifeline program that they offer. We found during the pandemic, if people don't have phones, we can't reach them. We can't deliver health care, so the Lifeline program is essentially just what it says. It's a lifeline in the pandemic to reach people. We think about two thirds of people eligible for Lifeline are not currently participating in it. It's one phone per household, but it's a free phone if you need it and we think a lot of people need them.

We're working with our health centers to say, how do we make sure that our patients are taking advantage of this program? If not, how can we help them take advantage of it, get them enrolled in the program? If you have similar needs, check out the USEC website on what do you need to know about Lifeline to get your patients plugged in.

mHealth, we've been hearing for years that mHealth mobile devices are going to take over health care delivery, now we're starting to see that. What's the difference between doing mHealth through a cell phone and doing a video chat with your physician? The live video chats are certainly an important part of delivering health care, but the whole technology base is changing as we move into the home, people have smartphones, can they use it for health care?

Absolutely. How do we integrate that into the process? That's something we're working on very hard at HRSA and testing prototypes of how are we going to do this in 21st century technology.

Preparing for this webinar, I noticed the tech our program in Pennsylvania, we have a couple of speakers that may talk to that, offers as of July 1st, they began offering cell phones for people with disabilities to communicate, but those devices also may be useful for health care delivery, very exciting advance of technology.

Lastly, I want to mention something new we stood up as a result of the tremendous need for information on Telehealth. There's a new HHS web site, www.telehealthhhs.gov, divided into two sections, half for patients, half for providers. We are linking to everything we can find that may be relevant to Telehealth. A lot of links to the Telehealth resource centers that I mentioned, but also to professional organizations, the American Telemedicine Association. Anything we can find that's useful; we're posting on this website.

We also have it completely in Spanish on the consumer side, since many of our needs may be in Spanish. We haven't worked on other languages yet, but we're working on making sure that's available to anyone that needs information. We tell people, what do you need to know about starting a Telehealth visit? How do you prepare for it? What to expect? We also, on the provider side, we get questions about what technology should I buy? How do I get to find vendors?

The Telehealth Resource Centers, as I mentioned, have a technology center that you can go to, that will not tell you what vendor you should go to, but they will help you understand the questions you should be asking. That we also have these links on our www.telehealthhhs.gov website, to external directories that can help you find specific vendors for specific types of technology, software providers, whatever you may want to link to, and they control it. We are not making any recommendations, specific on that sort of thing.

I believe, here is my contact information. Please reach out to www.hrsa.gov if you have any questions. With that, I will turn it back, I think, over to Kirsten. Are you up next?

Kirsten: I am. Thank you, Bill. You can go to the next slide, please. Okay. Hi, this is Kirsten Jensen from CMS, from Medicaid, and I appreciate the opportunity to talk with you today. Today, I just wanted to provide an overview of coverage of services and Medicaid and how

Telehealth is incorporated into the program. Medicaid is a pair of health care and long term care services and supports for Medicaid beneficiaries, somewhere around 74 million Medicaid beneficiaries throughout the country. I wanted to… if you can go to the next slide.

I wanted to first start with a brief overview of the Medicaid program and how we cover services, because that'll give the foundation for how Telehealth is incorporated into the program. There are broad federal and Medicaid guidelines that provide a range of opportunities for states to cover services and pay for services in Medicaid, but states really have the flexibility to determine their own unique programs within those guidelines.

We do work with states to provide technical assistance on how to do that, if they ask, and each state must develop and operate something called a state plan. This is where they outline the nature and scope of the services that they will cover, how they will pay for them, and any amendments that they make to that state plan do need to come into CMS and we approve them. We are looking, again, for those broad federal guidelines and to the states proposals fit within those broad federal guidelines.

Medicaid does mandate some services and then states can elect to cover other services at their option. They also, similarly, have some mandated eligibility groups. Those are people who can receive the payment for Medicaid services and others that are optional, and then they have a lot of flexibility in how they pay for these services. States are the key points of contact with Medicaid providers, and this is important, I think, for this audience here because the relationship between Medicaid and providers of Medicaid services really do rest with the state Medicaid agency who have that relationship. They set the provider qualifications for the providers, the providers enroll in the Medicaid program as providers and then states pay for services. Go to the next slide, please.

This is just a quick view of the services that are covered in Medicaid. We have a set of mandatory optional services on the left, range from inpatient hospital services to physician free standing for centers. You'll see here the FQHC, the Federal Qualified Health Centers, Rural Health Centers HRSA community based organizations, family practitioners, freestanding per centers and such. Then on the optional side, you will also see a plethora of services. These are very broad categories. States have lots of flexibility with services they cover, even though prescription drugs is listed as an optional benefit

since most of states do cover the prescription drug benefit. Next slide, please.

Within that context of the services, that states must cover and can cover, states have a lot of flexibility regarding Telehealth. Telehealth is not incorporated into our statutes, into Medicaid statutes in any way. We view it as the use of technology to deliver a service. That's the simplest form in the way that we view it. Services that are covered in the Medicaid state plan that I mentioned before, the mandatory and optional services can be delivered using Telehealth. We do have examples, this is the very short list of examples of the store and forward, real time audio-visual communication, and we do allow telephonic visits as well. I'll talk about some of the intricacies of that in just a moment. Next slide, please.

The Telehealth rules… one thing that we've uncovered during this COVID experience, and as you're hearing, Medicaid is very flexible for states to determine what services to cover, which practitioners cover, what types of technology, what they're going to pay for it, and we defer to states to make those decisions. What we did uncover during the course of COVID is that many states had adopted rules where they were using the Medicare rules as the underpinnings to Medicaid, and then they were coming to Medicaid and saying, why is Medicaid being more flexible here?

We advised that the states needed to take a look at their own rules and figure out how they would like to proceed, because there isn't really anything in Medicaid that dictates or preclude the state from doing something in Telehealth. We did also find out, and this is new to us and this relates to the telephonic issue, is that the HIPAA requirements in Office of Civil Rights, did not allow for telephonic, for telephones to be used for delivery of services. They did during the period of the pandemic, lift that restriction so telephones are allowed, but from a Medicaid perspective, we don't have any limits of telephones.

Also, the services that the state elects to cover or to allow to be delivered via Telehealth does have to be within the provider's scope of practice. For example, if there's any Tele-dentistry going on, you would probably not have a Pharmacist providing that service for your Telehealth.

The services delivered via Telehealth; the state has discretion about how to provide that throughout their state. They may put some restrictions in place that say, for this area, we're allowing Telehealth, for this area, we're not. But underlying the service still needs to be

provided to the Medicaid beneficiary in a face to face manner. If that occurs during Covid, I think most states stepped back and allowed for very flexible Telehealth policies in their state and for services to be delivered.

Some states went from ground of doing no Telehealth in their state to basically opening it up to everything, and other states were a little bit more measured and built upon what they were already doing in their state. It really did vary across the country. Next slide, please.

States do not have to submit a state plan amendment to CMS for when they are delivering services via Telehealth, and this is from the service perspective. The only time they really do need to submit a state plan amendment to us is if they are paying for the Telehealth service differently than they would pay for it delivered via face to face. If there's a physician service being provided and the state pays one way when it's delivered face to face, and one way delivered via Telehealth, we would need to know about that. Again, this varies across states. Some states do indicate in their state plan with us exactly what they're doing with Telehealth and others do not. Next slide, please.

We have done some work during the course of this PHE, this Public Health Emergency, we put out something called a Telehealth toolkit. I believe it was in April or May. It is on our website at medicaid.gov, I'll provide the link a little bit later in the presentation. But we realized that states were really having to assess quickly what they were doing in their state, and because Medicaid is so flexible, we were trying to bring some useful information to states so that they could **[00:28:03 inaudible]**, we're going to cover Telehealth and how they were going to pay for it pretty quickly.

Our Telehealth toolkit, it was our first step at doing that, and it talks about different populations that might be eligible for Telehealth or they might want to look at coverage and reimbursement policies in Medicaid, to take a look at providers and practitioners, and how to approach telehealth among the providers and practitioners, some technology requirements, and some considerations for pediatrics. We are in the process of doing the next version of the Telehealth toolkit; look for publication of that sometime by the end of the year.

But we want to make sure… we want to take some time and talk with our states and figure out, where did you start? Where did you land with the PHE? What's coming next? We also want to provide some more tools. We had heard there were some challenges with communications, providers were having a hard time finding the

information they needed to know how to build for claims in their state. We're, again, we're building up the tools and some of the opportunities for states in this **[00:29:27 inaudible]**. More to come on that. Next slide, please.

These are some of our resources. You'll see here we have a website; it's called Telemedicine and Medicaid. One thing that has occurred is we've had our Telemedicine-Telehealth policies in place for a long time and the term Telehealth has, kind of, overtaken the term Telemedicine, and largely are used interchangeably now, although you heard Bill talk about some of the patient monitoring kinds of things. In Medicaid, we're using the word Telehealth, but on our website, you will see Telemedicine as our opening page. Here's the link to the Telehealth tool kit for states and another document that our payment colleagues put out about how to pay for services using Telehealth.

In summary, if you are a Medicaid provider or you are interested in becoming a Medicaid provider of these types of health care services and long term services and supports, you should contact your state Medicaid agency in your state and talk with them about what opportunities are available there for you. Then further, if you'd like to understand the Telehealth policies in that state, the state Medicaid agency is also the right contact point for you. I think that concludes my remarks, and I turn it over to Laurie.

Laurie: Thank you so much, Kirsten, and good afternoon, everyone. I'm Laurie Gerhard and I work at the US Administration for Community Living. The US Administration for community living, its mission is to serve older adults, people with disabilities and caregivers and help them to live full lives in the community. We do this work in partnership with states and community organizations and national organizations.

The Administration for Community Living, also known as ACL, funds and nationwide network, available in 56 states and has more than 1,322 access points that interact with over 20,000 service providers in local communities. These access points include Area agencies on Aging, Centers for Independent Living, University Centers for Excellence for People with Developmental Disabilities, Tribal Organizations and State Assistive Technology Act Program.

The State Assistive Technology Act programs are available in all 56 states and territories, and they provide information assistance about technology that is available. If people have any accessibility needs, they may need some assistance with vision or with hearing or

communication, any type of accessibility needs or functional needs. The State Assistive Technology Act programs are equipped to assist them and support them in finding technology that can help support them to live a full and independent life possible. Through the State Assistive Technology Act Program, then earlier, Bill English has also mentioned the Techout program in Philadelphia.

These programs actually provide people demonstrations of technology that is available. They have short term loans of technology that enable people to try the technology in their home, to see whether or not it actually does provide the support that they're seeking, and they will provide training. Many technology devices already have accessibility features built into them, but oftentimes people are unaware of these features, and State Assistive Technology Act Programs are equipped to be able to help people learn how to use the technology, as well as access and use accessibility features built into those technologies and, or introduce them to other technologies that can help support the technology they might be using with the accessibility needs they may have.

These programs also oftentimes get gently used devices and sometimes donated devices, or technologies that could be rolled out to individuals or actually given to individuals. I encourage you all to work with the State AT programs if you're seeking any types of technology, and particularly technologies for Telehealth. We have provided in the slide deck a list of resources for Telehealth communications platforms and applications. We're not necessarily recommending any of these particular resources, but just offering them as potential resources that you could check out for Telehealth.

In particular, we want to highlight Zoom. We've heard from people that rely on captioning services that Zoom has a very accessible platform, so we just want to mention that. But there's additional platforms that are available. StreamText is one of the resources on the slide and that provides real time captioning for any platform or device with Internet access. It's important to think about when you're doing Telehealth or Telemedicine. What are the needs of the individual that's engaging in the Telehealth or Telemedicine and how can we provide the technology that best equipped them to be able to fully engage in the Telehealth visit?

In addition, we provided some resources for training and technical assistance on the use of remote technologies, the Partnership on Employment and Accessible Technology has developed a website to guide organizations in selecting accessible platforms, and there's a

link to their website in the slide. Then, also, the Deaf and Hard of Hearing Technology Rehabilitation Center has developed a step by step guide on embedding interpreters in Zoom to help people that are deaf and hard of hearing engage in Telemedicine. We have a resource guide on how to prepare for a Telehealth visit on the eighty three site and the link for that is available on the slide deck.

We also have webinars that the AT3, which is the State Assistive Technology Act Technical Assistance Resource Center, has put together some webinars that specifically train on conducting some Telehealth visits and how to be thinking about the older adult, older person with disability or individual that is engaging in a Telehealth visit. This is a link, https://www.at3center.net/stateprograms, will take you to the Assistive Technology Act Program directory, so you can find your state assistive technology program. Also, Rob Groenendaal leads this program nationally and his contact information is available on the slide.

Then, I just wanted to quickly mention two initiatives that we have live right now, that we really love people's input. One is the strategic framework for action state opportunities to integrate services and improve outcomes for older adults and people with disabilities. There's a link to that framework on our website. It's posted and open for public comment and comments are due by August 31st, 2020. Then also, we wanted to mention a partnership we have going on with the Office of the Assistant Secretary for Health in HHS, the Federal Communications Commission, the US Department of Veterans Affairs, and the Consumer Technology Association Foundation called the Mental Health Prize Challenge. There's a link to that.

That challenge is to create a clearinghouse of social engagement, programming, and technology, to help people that might be socially isolated get connected. If you're interested in that challenge, please click on the link. Registrations and submissions are due September 8th. I'd like to turn things over to our colleague, Christine McGowan, to talk more about a local program. Christine?

Christine: Thank you, Laurie. Hi, my name is Christine McGowan. I am the quality manager for PHMC, Public Health Management Corporation. PHMC is a nonprofit public health institute that is located in the greater Philadelphia area. The mission of PHMC is to improve the health of the community by providing outreach, health promotion, education, research, planning, technical assistance, and direct

service. PHMC as a whole has about 350 programs. It is a very large organization.

Within those, one of those programs is the Health Network. The Health Network is made up of five highly qualified health centers. We have nurses out in the shelters. We have **[00:39:01 inaudible]** a house and we actually just opened a dental clinic as well. Who is in the health network? We have five health centers. You have Congresso, which has a large geriatric population. It also is primarily **[00:39:18 inaudible]** Latino population, then we have care clinic. They see a lot of our infectious disease management. A lot of our HIV, Hep C, they also provide M&T services.

Then we have health connections, which has a large pediatric population and also serves a large public health and population. Rising sun, it sees a large immigrant and refugee population and also has a large pediatric population. Then our last health center is Mary Howard. They have a large… they see a lot of our homeless population and they also have many connections to the shelters.

Telehealth is new to us. Prior to COVID, PHMC had never done Telehealth. This was definitely a learning experience. The way that we started this out, we had broken down to phases. Phase was, one was our rapid response. We really wanted to, get started, figure out how we were going to make this work. The first piece was advertising our telehealth services, which I'll speak more about in the next slide. We also want to make sure there was no gap in patient care. All of our existing appointments beginning in mid-March were converted to telehealth appointment, using either zoom or just from phone.

Majority of the visits in the beginning was done mainly just by a phone call. There was no video portion of it because in the first weeks we were just trying to get our feet wet and figure out how to implement telehealth. One of the major things we did in the beginning, which I think was really important, was creating a template and really providing that education to our providers in, when it comes to a Telehealth, what we need documented.

For example, we really needed to make sure that for documentation, we had in there the reason we were doing a Telehealth visit, and then tracking the time frame in terms of how long was the actual visit, when did it start, when did it end, and building those elements into a template that our providers could easily pull up and then document the rest of their notes.

Phase two was the integration of more of the video platforms. We used **[00:41:40 Docsity],** Talkto.me, and then Zoom was our main platform that we used, which I spoke about in the previous phase. The phase three was looking at our **[00:41:53 inaudible]** structure. As Philadelphia hit their peak on COVID, we wanted to make sure that we were going down to a skeleton crew at the health centers and really ensuring that we're allowing for social distancing, and then also to decrease the risk of exposure to our staff as well as our patients.

Phase four, which we're just starting to get into now, is really the new normal, as everyone seems to be calling it right now. This was really making sure that we could return staff to the site safely, and that also we could start to bring in patients for in-person appointment because a lot of our patients had done… we've done a lot of Telehealth and they really want to be seen in person. As we, kind of, have too steep in COVID cases, we wanted to make sure that you're getting patients in who need to be seen, like our high risk patients or patients with barriers before the potential for, maybe, another spike in COVID cases in the fall.

Marketing a Telehealth. This was a really big piece of our big push in the beginning. We really wanted our patients to know that we are here for you, that we are still available to provide all of our continuations of care to the community. The first thing we did was really creating flyers and disseminating that out to the communities, especially communities that we work really closely with. Community based organizations, the shelter system, and really making sure that they knew that we were there for them.

We also do, as I stated previously, any patient who already had an appointment, we will reach out to them and offer them a Telehealth visit. If they did not want to be seen by Telehealth, we have to move their appointment out depending on what it was for. We still kept some staff members at the health centers to ensure that they were still there for a walk in or urgent visits, or family planning visits, but we really did try to move everybody to Telehealth as quickly as possible.

The other thing that we had just started when this all started too, was using more of a comfort messaging talk-self system. We were able to text our patients about Telehealth appointments. If they had an upcoming appointment, we will send them a text, do you want to convert this to a Telehealth appointment? If they said yes, we will

then have a medical assistant reach out to them to schedule that appointment and get them kind of set up.

The other piece here that I did want to mention to with the marketing is one of the other pieces that my colleague, Judy, will speak to a little bit more later, is with the shelter system, we did identify a major barrier there with the homeless population in having access to a phone to do Telehealth. We did provide cell phones to the shelters so that patients were able to call in and have a Telehealth appointment without having to have increased exposure by coming on to the site or taking transportation to receive health care.

These are just kind of our outcomes. As you can see, starting in March is when we started Telehealth, and that is when we start to see the Telehealth numbers go up. The interesting piece that we did notice is we actually increased our number of medical visits. I think part of that is because a lot of patients were at home and not working, and I think a lot of it, too, was we realized how convenient Telehealth was for patients. They didn't have to worry about transportation and how to get there, they could really just pick up wherever they were and call us. Yes, we did see that, which was a good thing. It, also, we saw a decrease in our no show rate, which was extremely important.

We also saw an increase in behavioral health visits by 29%. I think that is largely due to the anxiety and everything surrounding the Covid pandemic. We really want to make sure that we were there to support our patients during this time of, really, transition and high anxiety. This is just an example of our staffing structure. When we took a look at our staffing structure, we, one, wanted to make sure that we were doing proper social distancing, but also want to make sure that we've had providers available at health centers to meet the immediate needs of our patients, while also allowing some people to do Telehealth.

We had a split model where we had provider one and two on site, and then provider three and four were offsite. We would do that for about two weeks and then we would rotate. This allowed us to, one, have a skeleton crew at the site during the peak time, but then it also allowed us if somebody within that group got COVID, we were then able to rotate them and we had people working from home who we could then call in. Luckily, during this time we only had two staff members who came positive for COVID, and neither of them

actually contracted it from being at the health center. It was due to other events.

We also, too, really encourage staff to work remotely, if they could. We identified within the site who really did not need to be there. One example is the referral coordinators. They did not need to be on site. They could do their job fully, remotely. They were sent home to work remotely. Now, I'm going to pass it off to my colleague, Judith Edelman.

Judith: Great, thank you, Christine. At the start of our Telehealth ramp up for PHMC, we had a lot of perceived barriers and I say perceived because these are things that we anticipated that we'd have challenges with, but actually, they ended up working out really well. One of those things was that we thought that our patients would have limited access to technology, specifically our elderly and homeless populations. What we found out was that our patients made it work.

We got really positive feedback and participation from our geriatric population. They were really grateful that we made the effort to make sure that they could stay safe at home and still connect with them while doing Telehealth. It turned out to be that people found ways around what some of the things that we had perceived as barriers. Like Christine said, we also distributed 30 phones to the city shelters across the city of Philadelphia. We did one per shelter, and that really helped our homeless patients to be able to access a phone at the shelter, and like Christine said, not have to take public transportation and not have to come into the health center and risk exposure.

Another perceived barrier was we thought there might be a little bit of a decreased quality of care by using Telehealth. You're not having that in-person experience. Our providers were a little bit reluctant and weren't quite sure that the quality would be there that they wanted for their patients. What we found out was that there was actually a high quality of care. Telehealth provided as a means to continue critical care for people with chronic conditions, especially while Philadelphia was in the height of the pandemic, and we really wanted to make sure that we were practicing social distance, make sure that we were keeping our patients safe.

But we had patients who really still needed medical care, and we found a way to blend our laboratory visits with a Telehealth consult so that we were still getting access to the data that we needed for these patients, but the, again, the risk was decreased for them. This

also decreased unnecessary exposure for those at high risk, as well as in the hospital system. We didn't want them to be accessing the ER for things that they could really access through their primary care provider. The video chat, actually, allowed for providers to perform physical exams for certain issues. We found that that was actually much more accessible than we thought it would be.

Then finally, we had thought that there would be challenges with billing, however, what we found was that payers were and continue to be extremely flexible and have just made this process really **[00:50:41 inaudible]** for us. It was an easier ramp up than we thought.

In terms of language services, language can often be a barrier for in-person medical services. Addressing language in Telehealth is an added challenge for our providers. These are just some ways that PHMC continues to address language barriers for both in-person and Telehealth visits, and maybe some tips that some folks can take from this. We always try to make sure that we have diverse staffing that meets the needs of our patient panel in each of our five clinics. We have staff who speak multiple languages, including Spanish, Hindi, Portuguese and French.

For those patients who speak a language other than what our providers and our staff might speak, we use live interpretation services, we do that through the language services associate interpretation line, as well as through in-person medical assistance and nurses providing some translation.

Finally, with the use of the interpretation line, we use LSA. With Telehealth, that was a little bit more complicated, but we did figure out a way to do a three way call with the LSA line and our provider, and connect to our patients. We were able to figure out a little bit of a way to take down that barrier to Telehealth while still use **[00:52:09 inaudible].**

Some of our successes. Some of these things are pretty obvious and then others just really came to us as a welcome surprise. Really, Telehealth allowed for innovative solutions to a challenging situation. One of those innovative solutions, like we said, was the distribution of the 30 cell phones. Also, we distributed electronic blood pressure cuffs to our hypertensive patients. That really allowed for people to have those Telehealth visits and take their blood pressure in the comfort and privacy of their own home, decreasing their exposure risk, but still being able to give that data to

the provider and the provider, still, feeling confident that they were managing their hypertensive patients well.

We would do a consult with a nurse who would walk them through how to use their new electronic blood pressure cuff, and then the patients would be able to report back to the provider in their Telehealth visit. We also had decreased patient risk and exposure for community transmission, this allows for continuous monitoring of our high risk patients, eliminates the need for public transportation, as well as communal waiting rooms. We have a significant decrease in the no show rate, like Christine said.

Patients who might not have come to an in-person visit due to anxiety, transportation issues, exposure, work challenges, were able to still have a consultation with their provider. This is something that we would look to continue past the pandemic, really integrating Telehealth in our normal systems, so that we can really break down those barriers where some of our patients might have no showed prior, now they might have the option for Telehealth.

It also diverted patients from inappropriate use of the ER. This supported our hospital systems during the peak, as well as decrease patient exposure. We really wanted to make sure that as the safety net health care system in the city of Philadelphia, we were really supporting our hospitals and making sure that our patients were taken care of so that the hospitals could really do that important work that they were doing.

Finally, it decreased the staff exposure and risk. Having that skeleton crew schedule really allowed us to be able to see patients in person, they'll see our walk in patients and our family planning patients, but it gave us the ability to decrease that risk of seeing so many in-person patients and really diversify the way that we were delivering care.

Some lessons learned, we wanted to share some things with you. For some agencies who might not have, yet, fully implemented Telehealth or are thinking about implementing Telehealth. What we've learned is that Telehealth decreases barriers present in vulnerable populations, such as mobility and transportation access. Telehealth remains a viable means of communication with patient who are at higher risk of severe outcomes. Even though we are past the peak of the pandemic here in Philadelphia, we want to continue this for folks who still might have risk of community contraction or transmission.

Telehealth can be integrated into regular in-person care, along with in-person visits to allow for a blended model of care. We did that a lot with lab visits. We did that a lot with our family planning visits, FCD pregnancy test, those types of visits. It was really a viable method of blending that and decreasing the risk, but still getting a little bit of in-person care. Then, Telehealth decrease a no show rate and allows for more provider flexibility. During this time, we did also have providers who had children who were not in school. Telehealth was a means for them to work in these two-week skeleton crew shifts while still being able to provide childcare at home for their kids who might have normally been in school during this time.

Finally, some recommendations, I'd like to start by saying utilize innovation strategy to think outside the box. Some things that we utilize within our network were human centered design strategies and lean methodology. There's a lot of information about these strategies on the Internet. I would highly recommend looking into them, really helpful, really simple common sense methods, but really helps put together a plan when you're trying to design something on the fly like this.

Seek funding specific to COVID-19 support. There is a lot of funding out there right now. Here's a link to just some of it. Communicate with your funders and payers. What we found is that funders and payers have been really willing to share their resources and they've been super flexible. Actually, those electronic blood pressure cuffs that I mentioned earlier were donated to us by the American Heart Association. Reach out and see what people are willing to do. Utilize a blended model. If a full Telehealth model doesn't work for you, see what you can do about blending in-person visits with laboratory visits or family planning visits.

Then, finally, just be flexible. I'm sure everyone on the call pretty much knows this, if COVID-19 has taught us anything, it's that flexibility is really just the key to success. Really being willing to pivot and change as needed. That is it for Public Health Management Corporation. Now, we're going to turn it over to the question portion of the presentation.

Cheryl: Hi, everyone. Thank you for the amazing panel and presentation. We are out of time for questions, although we've captured everything that you were able to put in the chat box. We'll be able to follow up with you on that. Just to let you know, the quick wrap up. Everything will be posted on this web page, the archives webinar, the slide

decks, we'll include the responses to the Q&A that we didn't get to today.

Just to let you know, there are two more webinars coming up in the series one month from now, focusing on accessibility and language access. Then two months out, we'll have one focusing on barriers **[00:58:22 inaudible]** individuals **[00:58:23 inaudible]** homelessness, and some of those issues related to broadband and connectivity.

Thank you so much for joining us today. We appreciate you joining our webinar. We hope you were able to find information to help with the work you're doing. Thanks, everyone.

Operator: That concludes our conference. Thank you for using AT&T Event Conferencing Enhanced. You may now disconnect.