Using Telehealth to Improve Quality Measures

November 16, 2018

Thank you, Karen. Good afternoon to everyone and welcome to this atom Alliance Quality Innovation Network Learning in Action Event entitled Using Telehealth to Improve Quality Measures. My name is Don Gettinger. I'm the Quality Data Reporting Manager here in Indiana. I've been working with the quality improvement organization for almost 15 years now. I wanted to let you know a little bit about the atom alliance. It is a five-year and five-state initiative to ignite powerful change in healthcare quality. We welcome people from Indiana, Kentucky, Tennessee, Mississippi and Alabama and we appreciate all that you do to achieve quality and better outcomes in healthcare for lower cost to the patients and communities that we serve.

Today we are going to be talking about a few things, and we will have some housekeeping comments that I have here, then we will do a few polling questions, and there will be some polling questions throughout. There will be a brief presentation and some opportunities for sharing. Like Karen mentioned, your phones are on mute, and that is because we are recording the call, and we want to make sure that we keep any background noise out of the recording. However, your participation is very important, so if at any time you have something you would like to share or to ask a question, please press star nine, and we will get the line unmuted. We don't have you muted because we don't want to hear from you, we just don't want to hear everything in the background during the whole call.

In addition to pressing star nine to open up your line, you can type questions and comments in the chat box. We will be having some polling questions, and when those do pop up, please participate in those as it will help us to know who is on the call and help us to tailor the presentation to that. Remember, you do have to click submit for that polling answer to be tallied.

So, with that, I'm going to go to our first polling question, asking about what stage of telehealth is your organization in? The options are: Not using it yet at all or Will be implementing Telehealth soon. You can see the polling just opened up on the right side of your screen. The third option is: Have you been providing it for less than a year or for more than a year? So, we will wait just a few minutes until the responses come in. Then we will see the results on the screen. I want to, again, give a few moments and for those that did answer, it was spread out. One more chance at the answer even if you didn't answer the first one. In which areas are you using Telehealth? If you are using more than one, pick the one that you use it for the most. Unfortunate, we don't have any multi-answer answers. Again, you need to press submit so that the question will be response will be measured.

We will give everybody a few more seconds to hit submit.

We do have a response here and it looks like telepsychiatry is the most common use, and that matches what we hear anecdotally. And there will be a few more polling questions throughout the course of this, Learning in Action Network Event. But now, I am going to turn over our call to the first speaker, Cathie Moore who is going to talk about some of the quality measures associated with Telehealth. Cathie is a

Quality Improvement Advisor. She has worked with the QIO for more than 20 years and worked on hospital quality reporting and other facility quality reporting projects, providing direct technical assistance. I am going to pass the ball to Cathie and let you take it away.

Thank you, Don. Don has asked me to talk about the quality measures that are tied to Telehealth, and there really isn't any measures that are directly tied to Telehealth, but a couple of the measures that I think is important, as the first one being the emergency department throughput measure. This is the medium time of the emergency department arrival until departure until the discharge from the emergency department. This actual measure changes at the end of 2019 for those patients that are admitted to the hospital, but the ones that we are talking about are the ones that are discharged from the emergency department. Empirical evidence demonstrates that the emergency department throughput is an indicator of hospital quality of care and shows that the shorter length of stay in the emergency department leads to improved clinical outcomes. Significant emergency department overcrowding has numerous downstream effects, as we all know, including prolonged patient waiting time, increased suffering for those who are waiting, rushed and unpleasant treatment environments, and potentially poor patient outcome. Quality improvement efforts aimed at reducing the ED overcrowding and length of stay have been associated with increased ED patient buy-in and a decrease in the number of patients that have left without being seen, reduction in costs, and an increase in patient satisfaction. Between the opiate epidemic and increase in suicidal attempts, fewer inpatient psychiatric beds, there are more behavioral health patients seen in the emergency department. And recent peer review studies demonstrate the need for dedicated emergency mental health services, supplying evidence that the clinical needs for these patients to be substantially differ from the non-psychiatric population. Doctor Scott Zeller, the Vice President of Acute Psychiatry, stated that most patients can be treated successfully in the ED without hospitalization through better collaboration with highly trained psychiatric and emergency care professionals. A couple of the measures that are tied to this median time, is the arrival time. That is the earliest documented time the patient arrives at the outpatient emergency department. The medical record must be abstracted, as documented and taken at face value. When the time document is obviously in error or is not a valid time and no other documentation is found in the medical records, and the abstractor needs to abstract the unable to determine. These are one of the indicators that you have to abstract from the only acceptable sources to determine the earliest time the patient arrived, at the ED or observation and then like any documentation, which reflects the process that occurred after the arrival at the ED, or after the arrival for observation. The arrival time should not be abstracted as simply the earliest time, and one of the only acceptable sources without regards to other substantiating documentation. When you are looking at the only acceptable sources, if the earliest time documented appears to be an obvious error, this time should not be abstracted.

The other one that is tied to the median time is the ED departure time. This is the military time that the patient physically left the emergency department. The intent is to capture the latest time at which the patient was receiving care in the emergency department under the care of the emergency department services. The medical record to get must be abstracted, as documented or taken at face value and when the time documented is in obvious error, like out of the range, and no other documentation is found that provides the information, the abstractor should select the unable to determine. Do not use the time the

discharge order was written because it may not represent the actual time of departure. If there is a discharge time listed on the disposition sheet, this may be used for the ED departure time. On the observation status, those are for patients placed into observation services, use the time for the physician, APN or physician assistant order for observation for the ED departure time. The intent of this guideline is to abstract the time the patient is no longer under the care of the ED services.

I wanted to bring up the Agency for Healthcare Research and Quality National Resource for Health Information Technology, this article, they were awarded the $260 million in funding for health IT. It was published in December 2008, and it talks about the access to care, and that is really an issue in regions where physician to patient ratio is inadequate or where there are not enough medical specialists available to meet the population need. Telehealth has a great potential to expand access and improve the quality of rural healthcare. It can reduce burdens for patients, such as travel to receive specialty care and improve monitoring and timeliness and communication with healthcare systems. In the rural areas, healthcare delivery systems struggle to maintain adequate numbers of clinical staff to serve their patient population. Medical specialists are in particularly short supply. Although 20% of the U.S. population reside in the rural area, only 9% of physicians and 10% of the specialists practice in these areas. Telehealth offers tremendous potential to transform the healthcare delivery system by overcoming geographical distance and enhancing the access to care.

At this time, I am going to turn it over to Becky Sanders. Becky is the Director of Operations for the Indiana Rural Health Association. She works with a wide variety of healthcare providers throughout the state of Indiana. She also develops and maintains relationships with other state organizations to foster public/private partnerships on behalf of IRHA. Becky also serves as the Program Director for the Upper Midwest Telehealth Resource Center, or the UNTRC. In this role, she works with UNTRC Consortium partners to provide a single point of contact for telehealth resources throughout the state of Indiana, Illinois, Ohio, and Michigan. The resource center provides educational presentations, individual technical assistance, facilitation, and connections to telehealth information via the website and program staff. At this time, I will turn it over to Becky.

Thank you so much, Cathie, and I appreciate that. Again, what we will be talking about today is how telemedicine can be used to help you improve your quality measures and specifically those measures that we have talked about today, throughput in the ED and we did see in our second polling question that of those using telehealth, most chose the telepsychiatry option, which is really a very good measure to track when you are using Telehealth in the emergency department Because often times if you don't have an option to get a psychiatrist or psychologist in to do a behavioral health study on someone who is presenting in the ED, that patient could be there for a couple of days before you get someone physically on-site to do that study for you.

So, what I want to talk about, one of the things that we have done, and again, this information is for the regions, the states in the region that I cover, which is Illinois, Michigan, Indiana, and Ohio. Some of the states are not represented in this call today, but I think you would find similar numbers. This study was done in late 2017 and early 2018 by Reach, and they are a telemedicine vendor. They surveyed folks in our region using telehealth, and you can see that 48% of the respondents indicated that telemedicine was

a high priority in their organization. You can also see here that many things are increasing in regards to reimbursements and insecurity in the telehealth arena. Many of the respondents are working to influence telemedicine policy, and we saw a lot of changes in 2017 and 2018, and state policy for telemedicine, specifically around reimbursing of controlled substances to do with the opioid crisis. Also, increases in what Medicaid would cover in the state Medicaid programs for reimbursement.

So, I mentioned, the four states that I covered are the lilac (color on slide) states here as we have Indiana and Kentucky, along with Tennessee, Mississippi and Alabama on the call today. You see of the Telehealth Regional Resource Centers, the states on the atom call today actually fall into four different regions for the Telehealth Resource Centers. Regardless, each one of these Telehealth Resource Centers is federally funded through HRSA, the Office of Rural Health Policy, and the Office of Advancement for Telehealth. We all work as virtual librarians helping to answer questions about regulatory and reimbursement and how to start Telehealth programs and jointly as a consortium of the 12 regional and the two national Telehealth centers. We have jointly put together a website and we do have monthly webinars, and there is a lot information and facts sheets through this main website. You can reach out to any Telehealth Resource Center and ask a question, and it gets routed to us by email, and we can respond and start to talk about and helping answer what ever issue you are working on.

Our Telehealth Resource Center for Indiana and our surrounding states is this UMTRC.org. We also have different events, and we have free webinars on a regular basis. I mentioned that I consider ourselves virtual librarians, this is one of the things as we started rebranding ourselves as a national consortium, that we really thought is what is it that we really do? What is our elevator pitch? Similar to those on the call who are old enough to remember the Dewey decimal system in the library and the card catalog that you look through. That is very much what we do. We have a lot of white papers and resources that we send people to and make a lot of connections. For programs that are just starting out, to successful programs that can share best practices.

So, we talk about definitions, I have used both the words Telehealth and Telemedicine. Telehealth being the overarching technology field where anything that is an app or an activity, sensor, that data can be used and considered Telehealth. Telemedicine is that billable clinical encounter between the patient and a provider, who is at a distance.

I would like to talk about the various types of telehealth as flavors of ice cream. The hospitals and specialties, and here again, behavioral health and emergency department is one of the top ones, but you see specialist that are brought in remotely to help treat patients, so the patient can stay local, to their local community and emergency department where they end up. You see behavioral health, tele-stroke, trauma, tele-ICU, and that instance meds, this is really where telehealth or telemedicine started. We are also seeing behavioral health integration into primary care medical homes. There are some examples as recently we were talking with an organization that actually brought a psychologist, a clinical psychologist on site in a Federally Qualified Health Center, and so, if the primary care provider was talking with the patient, and they seemed to have some issues going on that they really needed help dealing with. Maybe they just had an onset diagnosis of hypertension or diabetes or a death in the family. Those types of things, they could bring in behavioral health specialists just to talk with the patient in that same room

where they had been seeing their primary care provider. That could be done with a behavioral health specialist in person, coming into a primary care office, or it can be done via telemedicine. Both things work really well, because the patient is able to be seen at the time they are in crisis, and not being given just a card and say here, call this place to get another appointment or an appointment being made for them, and then they just don't show up because of transportation issues or any host of other things.

The other thing that we are seeing a lot of movement on, and we are going to talk a little bit about what is going to happen in 2019, around the 2019 physician fee schedule, reimbursement, some new CTP codes that have come out for that. This area of transitions and monitoring, this is all about chronic care management, and also, I did not put on the slide, it is about remote patient monitoring. And we are seeing new codes coming out for remote patient monitoring where we are able to actually track a person's data, wirelessly via Bluetooth or interactive voice response systems around some of those chronic care conditions. Tracking their weight if they have COPD, tracking their blood sugar if they are diabetic. All of these things, these vital data that can be gathered and transmitted to a care manager or a coach to help maintain that data in the primary care office for that patient. And, then whenever they go outside of their range when there is an alert, somebody is looking at that data and can work with that patient to figure out what is going on, and if it is a false alert or a real alert, and maybe they need to go to the emergency room. But what if all they need is a change in medication or their script has run out, and they help getting that filled, and then you can keep that patient from going to the emergency room unnecessarily and avoiding that high cost on the healthcare system.

Another area where we talk about this is community para-medicine. We are seeing a lot of programs around community para-medicine sending EMS personnel out to do home checks, to check up on patients. You can pull data from your electronic medical records and find out who are your frequent flyers, if you will, in the emergency department, and why are they coming in so often? Is it something in the home environment that is causing them to continually keep showing up at the emergency department.

Lastly, primary care in schools. Here, we are able to reach out to school-age children and provide them with medical care so that the parent doesn't have to leave work, or the guardian doesn't have to leave work and the children don't have to leave school, they can get cared for by a remote provider. If it is an earache that is diagnosed as an ear infection or a sore throat that is diagnosed as strep, the script can be written, and the parent or guardian can pick it up on the way home and get the kids on that medication overnight, and then they can go back to school the next day.

Any questions, and are we holding questions until the end? I know I am throwing out a lot of information. If there is something that is coming up in the chat that we need to address, just let me know.

No questions at this time.

Thank you. I mentioned the 2019 physician fee schedule earlier. The proposed rules were released in July of this year and the final rule was released on November 1st of this year. There are four major areas that I want to touch on today. This brief communication is a technology-based service or a virtual check-in between a patient and provider. This is a provider that there is already that patient-provider relationship,

and your co-pay does apply, and it does require informed consent. RHC's and FQHC's are going to get their own code, a code that has been released so far for hospitals and providers is the G 2012, and that is reimbursed at $14. We think that is around a 15-minute check-in or less.

The next one is an asynchronous remote evaluation. So those familiar with the Telehealth and Telemedicine language are going to recognize this is what we have previously been called storing forward Telemedicine. This is an established patient relationship, maybe the patient has a rash or a burn or some type of an open wound. They send a picture to their primary care provider to help triage, and is this just bad enough for me to go to the ER, or can I go get something over the counter for this? Again, informed consent is required, and RHC's and FQHC's will be getting their own code for that.

The next two that I want to talk about and this one is very interesting. This interprofessional internet consultation between providers. There's been a lot of talk and I mentioned primary care medical homes and in the case of accountable care organizations and a lot of the things that we are seeing in MACRA and MIPS, and APM's, all moving toward patient-centered care so that different care providers caring for the same patient can talk and actually get reimbursed based on the amount of time they spend working together consulting on a single patient. These codes are limited to practitioners who can independently bill Medicare for E and M codes and evaluation and maintenance codes. And this is not allowed to be used in FQHC's and RHC's because their PPS rates already includes this component in it.

The last section that I want to talk about of new changes in the 2019 physician fee schedule are these HCPCS codes and CPT codes here. These are all coming out of the bipartisan budget act of 2018 that was passed in February 2018, and this adds remote psychiatric monitoring codes and codes for CCM or chronic care management.

Electronic copies of the slides are being made available and there are two places, two different things, a couple of information graphics and policy sheet on the National Telehealth Resource Center policy page that you can access these URL's. They have really good information, typically we see the new version of the Medicare Learning Network Telehealth fact sheet come out at the end of December of the first couple of weeks of January. Once those sheets come out, we'll have a full listing and one location of all of these codes for Medicare Telehealth reimbursement.

When we talk to people who want to start Telemedicine programs and what kind of barriers they have or what they need to overcome, often broadband is brought up. There is a new bill at the federal level to increase broadband construction throughout the United States. I have seen many efforts at the state level to build more broadband access and to make it as ubiquitous as having what we talk about as basic telephone service in the home. The other barrier that is brought up a lot is the cost of equipment, again, especially for psychiatry, the equipment cost, the equipment itself keeps getting smaller and the costs get lower as technology improves. To do any kind of behavioral health assessment, all you need is a HIPAA compliant video conferencing platform, and it can be done with a WebCam and a computer or a laptop and access to HIPAA compliant software over the web.

Then, providers, we know that provider shortages exist and will continue as states work on workforce shortage issues, it will take time to generate additional practitioners. By reducing the amount of travel

that providers have to do to go and reach out to rural areas, you can reduce windshield time for providers and they can become more efficient in their time by seeing patients remotely.

Opportunities, when you start to think what can I do within my facility to increase or adopt telemedicine? Think about who you refer to now. What are those existing relationships, and can you add a Telehealth technology component to that relationship? Because you are not providing a new service, what you are doing is using technology to help bring the patient and provider closer and provide more timely care for your patient.

Also, when you start thinking about these types of things, often your next step will be doing a needs assessment. Hospitals have a requirement to do a Community Health Needs Assessment every three years. You could also do a market analysis or focus groups, use data from patients or provider satisfaction and even employee satisfaction. All of this data can help you figure out what the low hanging fruit is for you to start a telemedicine program.

Just the basics of starting a telemedicine program, a lot of it is a plan, do, check, act cycle. You are going to assess and define what it is that you are going to do and develop a work plan and project timeline and figure out what your plan is to attack this need. Overcome those barriers, and then you will implement your plan and continuously monitor every month or every quarter, what is happening with your new program, and then you are going to go back and tweak it to where you see changes and other efficiencies that you can introduce into the program. With that, that is my contact information, and I am going to pass the ball back to Don.

Thank you, Becky and Cathie!

This time in the call is for the people that are here, and we are trying to share a little bit of information, but also provide a forum for you, the facilities and hospitals that are in our region, to learn from each other, and to share with each other what is working and what is not. Also, will ask questions of any of our speakers or other participants in the calls. We will open up the line and if you do have a question or would like to share something, please press star 9, and that will open up the line.

We do have a caller with their hand raised. I am taking your line off mute.

Hello.

It is a call from an 812-area code, possibly Jasper.

This is Adrian. Thank you for the opportunity and is the first time I have done anything like this, so if I talk too fast, or if you have questions, please stop me. Adrian Lehman, I am the Practice Manager of the hospital's telemedicine center at Memorial Hospital in Jasper, Indiana. We have been down a long road to get here, but I am happy where we're at, and we will be applying for our primary stroke certification through the Joint Commission in the winter, and hopefully, we'll have our site visit in early spring, or late spring. But, to kind of give you background of how we got to where we are today, it started about three years ago. We are a community hospital servicing about a nine-county area, and we knew very many years ago that we were losing market share when it came to neurology, primarily with our stroke

patients. We had a phone consultation service with the University of Louisville, and it worked well, but if you are on a phone call with physician at a University, they are going to say to transfer the patients because they cannot see them. By the time we did our financial impact analysis, we were transferring around 84% of our stroke patients. Now I am happy to report that we are now down to 12%. We use a 90-day approach to implement our stroke program, and it actually ended up being 180 days. We had never actually kept a stroke patient in-house that was post TPA. So, staff education, processes, policies, procedures, we had to start from the ground. That is kind of why we did a systematic approach to implementation plans. There were about 40 departments that we had represented as stakeholders. So again, we started at the point where a patient starts in EMS and goes from discharge and beyond. And that is how we built our team, and that is how we built our process and all of our process maps. The one thing that I can say is to have your telemedicine partners, whoever is providing your telemedicine, to have them as part of your active medical staff. All of our U of L physicians are fully credentialed and privileged within our hospital. We were actually awarded the Malcolm Baldrige National Quality Award this morning, and we held our press conference. I actually had a U of L physician in our press conference audience, on our robot. Which again, speaks volumes to our partnership with them. That is the only way I feel like this has been successful. Our patients love it. The technology, we actually chose a robot that would be fully interactive with the patient. Because when you are coming from a community like ours, we're very Germanic. We didn't know how our population would take the technology, but everybody has loved it. Most patients say they don't even realize that at the end of the assessment that they are talking to a robot. And they are not, because we say they are talking to the University of Louisville physicians, and our robot has a name that we did as a house-wide contest so that people would be engaged with where we were with our stroke program, and then it is not a robot that is walking around, it is Ace. That is his name, it stands for Always Committed to Excellence, which we were on our Baldrige journey at the time. So, that is basically all that I have. We do use Get with the Guidelines, the HA SASA Get with the Guidelines for Stroke, we actually were awarded the Get with Guideline Targets for Stroke Honor Elite Silver Plus for 2017, which was our first year with the stroke program, so I am very proud of where we are at, but will always have opportunities for improvement. Thinks like this webinar, I very much appreciate the opportunity to still have the resources out there that we will definitely need as we continue on our journey. Any questions?

Adrian, thank you for sharing. I want to remind people that they want to ask questions they can post them in chat and we will read them out, or they can press star 9, and their phone will be taken off of mute. Congratulations on your award this morning.

Thank you.

I see a couple who have their hand raised in the chat.

Since audio today is provided by the phone line, if you can press the*9 on your touch tone pad of your phone, we can unmute your line. I will unmute you now.

Hello. This Dr. Amanda Bulliver, I am the Chief Transformation Officer for Deaconess Health System in Evansville, Indiana. I have Allison Flowers with me. She is our Telehealth Coordinator and both of us are

going to talk about a couple of our programs real briefly, and I will start off with our Deaconess Clinic Live. We have been live with that for a year and a half now, and it is our direct to consumer minor acute illness service that we provide state-wide to Indiana and Kentucky. Right now, we are seeing a lot of benefits from our hospital we are one of the 18 next-generation ACO's. We are really focused on our population health and decreasing cost, and so offering this service, we are getting the patients at the right level of care instead of arriving in our emergency room. As far as our patients, an increase in access and value to those who would lose time at work or transportation or otherwise would not have access to care. For our physicians, it is very helpful when they have an overflow of access, so they can redirect those patients to use Deaconess Clinic Live, so then, they are avoiding the emergency department. As far as benefits to our quality measures, we currently use Deaconess Clinic Live within our EMR, and it is fully embedded and integrated into our physician workflow, and every one of our quality metrics, that fires as far as health maintenance or best practice is also followed by our Deconess Clinic Live providers. Because our Deaconess Clinic Live doctors are in our own urgent care, so, we use our own providers for this service. And being connected to our EMR, it drives all of our quality connectivity with our patients and providers. As far as the challenges along the way when we started, it was hit or miss with physicians as to whether or not they wanted to do the service. But now a year and a half in, everybody wants to do it because they have seen the rapid adoption by patients and they have been won over by the service. Getting the patient used to the technology is probably one of the hardest challenges, and I would say as a best practice to recommend that you don't underestimate how simple you need to keep it for the patients, because you don't want to get on a video visit to be challenging, because it will end up being its own deterrent. As far as best practices to the positive of putting it in our EMR workflow and using our own providers, has been a huge success. Many of the patients who use Deaconess Clinic Live have also been offered video visits through their own health insurance or other third parties that were reluctant to use it because it is not a Deaconess doctor, and with this, we have had rapid adoption and we continue to see it excel and grow. With that, I will turn it over to Allie to talk about our tele-psych program.

And so, with tele-psych, we have been live with our emergent site consult actually within our own health system for a little over five years. We would have our care team and provider in one location, and then we could actually provide consults to three different locations. Since we have been doing that, we actually were brought on under a grant that just ended this last summer, and we were able to maintain a program where we're serving other facilities. Benefits for that with these emergent site consults is that we are at critical access hospitals, so the patient can seek treatment close to home, and get dispositions and recommendation from their local facility. A lot of these patients would have to drive over an hour for an evaluation and most of the time, they don't really meet inpatient criteria, and they're driving an hour back or having to get them transportation. Decreased travel times and decreased length of stay in the ED, we have heard stories where patients sat for almost 24 hours, and at one facility it's down to, they are in and out within 3-4 hours now. Just a more efficient use of resources also for our care team. Right now, we are serving five different locations, which include two critical access hospitals, and we are getting ready to extend that to our MFN, the Maternal-Fetal Medicine, location at the women's hospital and to our women's hospitals. We have definitely identified a need for that patient population. So, challenges along the way for us, if it is not a Deaconess facility, the other locations that we are serving, they are not on our medical record. So, just figuring out a way to route a note back to them, which is basically faxing it

back to their ED and they are having to scan it into their own medical record. Which is a little cumbersome, but they are able to get the service that way. We did have some connectivity issues at one location that during high uses of their Wi-Fi, we were not able to get a connection on the iPad. We did have to use, now and we use a hardwired laptop, and that is how we are providing that evaluation. Some best practices that we have learned along the way, one location noticed they were contacting the care team, and then having to go back and do different drug screens and things like that. We got together some common labs that would be ordered with different diagnoses and things that patients were presenting with, and they have standing orders now and do all of that before they ever contact the care team. The care team calls the emergency room back to talk to either the nurse or the physician about the patient before we're actually connecting to get a little bit of background on the patient. Then again, we are faxing the note once the evaluation is complete.

That summarizes the two services that we offer that we wanted to highlight today for this call.

Thank you. Karen, do we have anyone else with their hand raised?

No hands are raised at this time.

Are there any questions or comments in the chat?

No questions in the chat or the question and answer.

Again, I want to remind you it is a great opportunity to talk to other facilities in our five-state region that are either using telemedicine or thinking about it. If you have any questions for any of the presenters, Cathie or Becky, the hospitals that if shared so far, please feel free to speak up or if you have a general question that you want to ask anyone on the call, we will share that response. Again, just press*9 on your phone to speak up or you can type into chat.

This is Cathie, and I wanted to ask Becky, do we have schools participating in the state that you are working with as far as using the technology that you were talking about?

Yes. I know of programs in Michigan and Indiana, and not in Ohio, and I think there are some programs starting around the Chicago public schools in Illinois. I am thinking Tennessee, probably some in the other states too. I would have to track them down, but I could do that and get back to you if you would like?

I think it is a great program and wondered how many were taking advantage of the opportunity.

It is a long process for a school, and they have to get by and really from the community at large. It has to be approved by the superintendent of the school, and what we have done in Indiana is try and work with local providers, sometimes a pediatrician in the community or a Federally Qualified Health Center has been a good match. It is for the kids to be seen for behavioral health so that they are not driving long distances to appointments, and then there is so many other opportunities once you start doing that, to bring in classes on nutrition and cooking and all kinds of other things that set the kids up for a healthier lifestyle.

I do have another question for Allison, I know on the critical access hospital visits that I go to here in Indiana, one of the biggest things that I hear is the availability of space when that patient needs to be admitted somewhere. Do you guys find that as an issue if you determine that the patient needs acute care services, is that an issue on your end as far as finding placement?

So far, that has not been an issue for us, and if somebody requires inpatient, they have gone to Crosspoint, which is our local inpatient.

Okay.

We do recognize that is definitely a concern and even in the northern part of the state, which Becky might be able to speak to that a little more than I can, there have been some major issues. One issue that we have is that we only take pediatric patients, 12 years old and older, at Crosspoint. So, if it is a younger pediatric patient that we would have to find someplace for them to go outside of our service area.

I know in the central part of Indiana, a star program that has just opened in Connersville was full almost immediately. They keep notes and books and they just start making the rounds of calls when they have a patient needs to go to inpatient service, and they keep calling until they can find a bed.

I think this problem is not just Indiana, and it is a pretty national problem, the availability of inpatient beds. Karen, are there other questions or with any attendees with their hand raised?

No hands raised and no more questions.

I will give one last call if there are any questions for our speaker, and this is the time to do that.

We do have a hand raised.

Wonderful.

I am going to unmute the caller from the 901-area code.

Hello.

Hello, this is Dr. Hugh in family practice, we are just in the process of starting Telehealth services and trying to figure out implementation of the process into the workflow and really the various opportunities of utilization and was just curious if some of the other attendees and their utilization of Telehealth in a primary care outpatient setting, and the success and challenges of that.

We may need to unmute Doctor Bolivar, again if we could.

Can you hear me? Our direct to consumer is more of an extension of our urgent care versus primary care. However, we have really just solidified getting it into our EMR workflow and using our own providers. On our roadmap is to then extend this out to our primary care so our primary care can identify patients who would be good candidates for a follow-up visit by video. So, we have some physicians who are very interested and kind of audited their schedule thinking probably half of what they saw in their office, they could have completed by video. I think the challenge is, of course, the reimbursement, and then we

would go on from there. It is definitely on our roadmap, and the physicians are very interested. I think it was our challenge to get it built into our EMR, so they could go from the first row of their schedule, seeing the patient in the exam room, then come back to their office open the next encounter, click one button and be connected with the patient. We have met that goal, and the next step is figuring out the logistics and identify the right patients and assuring that the reimbursement is present. We also serve several counties to the south in our Western Kentucky area, and I know it is not part of this call group, but part of our service area and they are pretty progressive, and their Telehealth laws will make reimbursement parity for Medicaid and all commercial payers as of July 1 in 2019. We are really looking forward to that. We may be able to share some more experience with this group once that barrier comes down in our Kentucky area.

Thank you.

Thank you, Doctor. Are there any other questions and comments?

No hands are raised right now.

Looking at the clock, we are coming to the top of the hour. So, I want to thank everyone for being on this call and for my speakers for presenting, and the facilities that both shared and participated in this question and answer session, and the time that we had here. I want to thank you for your interest and for your participation.

We have one more slide with some additional contact information. You can engage with us at the atom Alliance, which is our five-state region through this web link below. We will have a post-event survey, and I will ask you to take a few minutes, and your feedback is very valuable to us, it helps us shape our future Learning and Action Network events, and as a reminder, this call was recorded, and the recording and the transcript will be available on our atomAlliance.org website. Thank you all for joining us and have a great afternoon.