Transcript for ORH Telehealth Webinar
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Presenters:
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Dr. John E Jenkins, Greensboro AHEC
Stan Kachnowski, PhD, Director of HIT Lab, Columbia Business School
Jordan Berg, Telehealth Technology Assessment Center

Lakeisha Moore:

We have very special guests. George Berg will join us with the telehealth technology assessment center (TTAC) and both will be joining us today to talk about digital health strategy and some of the technology trends we are seeing out there in the telehealth field. Just a reminder, if you'd like to ask a question today during the webinar, please type in your question by clicking on the Q&A icon in Zoom, you'll see it located towards the bottom of your screen, and we will work to answer as many questions as we can, time permitting. Also, if you need technical assistance during this webinar, you can email technical assistance COVID-19@gmail.com, as you see that on the screen and someone will be happy to assist you. A very special welcome to our safety net sites across this date: the Federally Qualified Health Centers, local health departments, critical access and small and rural hospitals, all that are out there providing care to patients amid the COVID-19 pandemic.

During today's webinar we will share some Telehealth best practices specific to implementing a digital strategy and also share some other Telehealth resources. We hope you will be able to incorporate and adopt some of these best practices that we've been sharing over the last few weeks into your organization and workflow. We'll also have Lisa Renfrow, from AHEC, join us by talking about how you can receive continuing medical education (or CME) for this webinar. And then Dr. Jenkins and Stan Kachnowski, the director of HITLAB at Columbia University will join us to dig into it deeper conversation about digital health strategy and best practices facing. Dr. Jenkins will also share some very special pearls from one of his colleagues, Dr. Sylvia Romm, from Atlantic health system. Jordan is with us today and he's going to talk about some of the wonderful technical assistants available through TTAC, the telehealth technology assessment center. And they will also some of their share best practices that they've seen when it comes to technology and implementation. Robyn is with us also and she's with the office of rural health, one of our telehealth specialists, and she'll be monitoring the Q&A to go through your questions—we are going to try to leave time for question-and-answer at the end. Lastly, some other housekeeping tips I want go over before we dig into the content today: just a reminder this webinar is being recorded and the slides will be available on the office of rural health and AHEC website with the slides. If you do ask a question during the webinar, please include your name and email address, I think the system should prompt you to do that, but if it doesn't, if you can please include your name and email address that is very helpful for us, especially for the billing and coding questions. Many times we found it easier to follow up with you directly to make sure that we're getting the information you need back to you and to have one of our certified billers and coders actually work with you. So, without any further ado, we will go ahead and get started with Lisa who will share some of the CME information so you can get CME credit for today's presentation. Lisa, I'll turn it over to you.

Lisa Renfrow:

Thank you Lakeisha. To obtain CME credit for contact hours for participation in the webinar, you must have MyAHEC account up with an up-to-date cellphone number listed. If you do not have an account or a cell phone number associated with your existing account you will be prompted to create or update this information once registration is completed. To register your attendance for

today's webinar, please text 7F98F to (336) 793-9317. Both the phone and code numbers are listed on the current slide. For additional instructions for how to use the text registration system visit www.nwAHEC.org/textray, as shown on the slide. The registration code and phone number will be shown again at the end of the webinar. Next slide.

The Continuing education for this program is being provided by area L AHEC in partnership with the office of rural health, NW AHEC and Greensboro AHEC. Specific credit information is listed on the slide. I will turn it over to Dr. John Jenkins.

Dr. John Jenkins:

Thanks. So I can't believe we've been together for seven weeks for telehealth implementation and best practices, where we started, where you started in your practices where you are today. Abraham Lincoln said you can't escape the responsibility of tomorrow by evading it today and you guys have embraced that responsibility. The why today revolves around the future of telehealth and access to health and well-being and some pearls around digital health strategy and practice strategy as well as understanding some of the peripherals that are available to help us in our digital health work. I'm going to have two conversations today: part one with Stan Kachnowski of Columbia business school, Columbia University in New York right at the epicenter of COVID-19; and another practitioner from the center of COVID-19, Sylvia Romm in New Jersey whom I spoke with earlier this morning and she shared some pearls that I will condense and share with you guys. Before we get started, let's review some of the things of the why we are doing this. We are doing this because we want to create superior access. That includes the four rights, the right care, at the right time, in the right place, for the right value. We want our care to be reliable, it's a very important concept in healthcare. And the three bests of reliable are: best practices, best coordination of care, resulting in best outcomes possible. We want a leaner cost structure because we're moving towards value-based care. We want to create customer loyalty, experiences that create lasting relationships. The four pillars of care delivery that keep and gain our patients are: superior access, reliable care, leaner cost structures and customer loyalty. Today we are joined by Stan Kachnowski, he is the director of the digital health program at Columbia University's business school. And he is the chair of the H I.T. of the health information technology lab, there at Columbia. Welcome Stan. I'd like you to tell our listeners today a little bit about the HIT lab and your digital strategy program for executives.

Stan Kachnowski:

Yeah, thank you very much. Again, thank you for everyone, all the attendees, North of 100, a very impressive group and I'm glad to be talking with everyone here today. First of all, the program is certified for 22 CME credits. For those of you who are trying to find an interesting way to fill in some extra credits on the CME side, the digital health strategy program at Columbia is running again starting tomorrow and going tomorrow Wednesday, Thursday remotely obviously. We will be afforded, traditionally it goes for about $4300 for physicians, it's $1500. It will cover a lot of the agenda if you want to contact me information there on LinkedIn, I can send you a regular hard copy or a regular soft copy. The agenda goes through day one, the who, and gives you perspective then terminologies about digital health and what physicians are facing with COVID-19 and how to respond with digital health technologies. Day one you have the leaders of digital health care system, so the person who's the head of the COVID response center down state, a distinguished professor and the head of the non-invasive cardiology program down state, Jason Lazar, a former student of mine, at Columbia School of Public Health. You have Professor Frank Lichtenberg talking about medical technology why it's been hard to get reimbursement for using digital help. And you have folks like Bill Toronto, the president of globalization the billion-dollar digital health investment fund. That's the who, the different perspectives of patients in hospitals and digital help what they are facing not just before COVID but now during COVID. Day 2 gets into the methods and the technology, the techniques that people are using to not just develop a digital health strategy for the

COVID era, but also beyond COVID era. So folks are going to understand what is it to receive reimbursement for telemedicine. If you look at Livongo, the founder and CEO, Glen Tullman, and the CFO Lee Shapiro they will be talking about that. We will go into details around digital therapeutic approvals, getting expedited use authorization from the FDA. Day two will be the methods people are deploying in their organizations to develop these strategies. The day three will be the how. So we've got McKinsey, the head of the global healthcare practice, Peter Pfeiffer, we've got Professor of strategy of Columbia business school. We have folks telling you how to do this we will break you into teams and you'll actually develop an organizational strategy for your organization. And the second half of day three we go into the case studies of how people of done it successfully and you'll hear from everyone from Google, as well as an innovation lab. And Matt Holt who is the head of Health2.0 and develop the phrase Health2.0. That's for the program.

It's an exceptional program. We,ve been in trial by fire for the past seven weeks, deploying virtual health visits in our practices. There's a broader concept that you talk about which is digital help. Can you take us down the road of understanding what digital health encompasses?

The definition of digital health is a combination of everything from the human body, bioinformatics and everything outside of the body, so biomedical informatics, that can turned into data. That is an entirely new mindset and frame of reference that was created by Dr. Erik Topol's 2012 book, which I will encourage you to read this book, called "The Creative Structure of Medicine." He was the first person to think about creating a digital human (i.e. tissue, blood, saliva) anything from that human body that can be turned into data. Again Dr. Topol is a bioinformaticist, so this is something he's done for a long time. He's also a cardiologist. And then by medical informatics, which he was exposed to substantially, when he went from the Cleveland Clinic down to UCSD in San Diego in about 2008. And he started seeing what QUALCOMM was doing and wireless medicine in healthcare. How QUALCOMM was trying to take everything in healthcare and create data around it by using wireless chips embedding wireless chips into anything, from your surgical kit to putting wireless chips in patients until you name it, QUALCOMM was trying to find a way to put a wireless chip in. They were the first ones to develop, the U.S.-based, Company Cardionet which is the first noninvasive, remote telemetry unit, developed in 2004, and validated by the FDA. He had this exposure and he realized we created digital humans in digital medicine. So he coined the term 'digital medicine' and digital health came out of that. This is a combination first time someone thought about not just doing that on a per patient basis but what's the population base of that. If you go to the next slide, I can go through some of the components of digital medicine and digital healthcare. A huge one we are all seeing, everyone on this current call is able to see the telemedicine is a key component here. And certainly digital medical devices in wearables and remote patient tracking, those are currently growing at a historically unprecedented rate in our society. The fastest diffusion of digital help we've seen prior to this was the adoption of electronic health record from roughly 10 to 15% of physician practices volume to almost 90% in a five-year period in 2015 because of the ACA and it's reimbursement. That was astounding. We are seeing now for telemedicine and for remote patient monitoring is roughly 400 percent growth rate per month if not more. With that kind of growth is a lot of pain. When you look at these 12 vectors and categories of digital healthcare, they are all growing in various shapes ways and forms and they're all showing various efficacy economically, technically, and clinically. If we look at the 12 right now, we have the point that telemedicine and telehealth is one that is without precedent blown any kinds of fusion scales out of the water, with what's happening now.

If you go the next slide I can walk a little more through some of the key concepts and strategies that we will be teaching the program. We've generally built my own dissertation and worked on over the last 30 years, first is the diffusion, this is a model and theory developed by Rogers the professor of Minnesota, who studied in 1961, 1962 and 1963, the diffusion of the polio vaccine. Effectively going from 0 to 100 in a very rapid diffusion area and adoption curve in 1950s and Rogers the sociologist and he deployed methodology called trace method to understand what led

to the diffusion of these innovations. It was the communications model. In healthcare and digital health, it's a combination of communication amongst others as well that we are seeing the diffusion of telemedicine at the marketplace and ecosystem where the regulatory infrastructure has been obliterated to make way for pragmatic necessity of being able to treat patients in a non-site based, whether inpatient or outpatient manner. This is an important methodology to look at when looking at the use of telemedicine and telehealth care, and certainly we'll be discussing that a lot in the program the next few days. The other methodology that I really want to emphasize, even if you just go and plug in the word "Sense Making" on Google images, sometimes the picture can be worth of thousand years and save you a few hours. If you type in "Sense Making" in Google images you'll see models and frameworks and strategies around sense making. This is Carl White, he's a professor out of the University of Michigan, just has put together phenomenal methodological framework. I've used a lot of them in my research around understanding how rapidly make micro decisions in order to better understand what your organization needs to do to adapt to rapidly changing environments. And "Sense Making" was what Goldman Sachs utilized as a framework of methodology to ensure they didn't give away to Lehman Brothers during the economic crash of 2008. So I would highly recommend those two frameworks, and again if you just go online and type in those words Google images, you'll find a treasure trove of information on how to help you and your organization make it through this extraordinarily difficult time. What we are seeing today is everyone's talking about telemedicine, there's a lot of excitement about telemedicine telehealth. And we are seeing some paucity of reimbursement even when it's implemented properly. New York Presbyterian, the sister hospital Columbia University they've been using Telemedicine for five years. Their reimbursements are nowhere near what they were pre-COVID. Implementing tele medicine is a critical infrastructure component to utilize and utilize well. And receive any kind of full reimbursement, it's an entirely different story and it's got to be something that going into it and setting expectations. The strategic frameworks we are utilized today are absolutely critical for tomorrow because of what we've seen with the second wave of COVID outbreaks around the country, a lot was predicted by some of the folks from the CDC. Certainly other areas of study around the predominant epidemiology, and again I'm a technologist, I'm not an epidemiologist, I read voluminous amount of what's happening on the progression of the disease since it started in December and now that it's spreading in other parts of the world, research ties in west Africa and the EU and India. I'm also a visiting professor in the institute of technology at New Delhi. Future of digital health within your practice revolves around the rapid diffusion of technology we're going to see as a measure of pragmatism and necessity. The sense making you and your practice is do not just around telemedicine but also around remote patient monitoring, so looking at the figure on the right-hand side, the kind of the cartoon of George Jetson or whoever that is, the idea is that he's got he's got a lot of reimbursable points with the organizations that did not exist 60 days ago. And working with your partners to lobby various state policymakers to make sure reimbursement is not just inevitable but also expedient because that's one of the things that we are seeing in New York State where a lot of reimbursement has been promised, but we are lagging now, 60 to 90 days for the reimbursement to actually become a receivable. So these sorts of various digital health tools on a sensor basis, certainly imaging radiology and many others, there's just an enormous future that's going to occur at an accelerated rate because of the efficiencies that are going to be achieved and the patient centricities, and the patient general gravitation towards these new models that will be more efficient for them in terms of travel time, in terms of in office wait time etc. This is a model that the new normal will become more permanent, we will have this new digital embedded in it on an ongoing basis after this. As physicians, it's critical to understand what the future could look like with these sorts of reimbursements, and how to prepare a strategy for today that will also work for tomorrow.

Yeah I love this, so when I look at this, I think back and think about Google and Facebook and all of our social media. It's not about the tools in the platforms, it's about the data that gets extracted from those tools and platforms, that is marketable that's being able to be monetized and

turn into reimbursement. So, as we look at this, there's is a real threat here. If we don't, as the medical community, look at embracing these tools and using these data to advance health and wellbeing, somebody is going to create a healthcare marketplace around these data.

Without a doubt. And I think that's something people are realizing today when they are building their digital platforms. Generally speaking, these digital technology companies, they will have 1 or 2 small sentences at the end of paragraph 25 of contract of 55 paragraphs that will effectively own your data. As physicians, there is no legal course in your background to look for that sentence, it generally will say the third-party vendor has the right to use the data for marketing and research purposes or something like that and de-identified of course. That is something that can be negotiated. As physicians those contracts are definitely negotiable, it's not like a term of service when you buy an Apple iPod or something like that. Their data has a value and in generally what we're seeing this physicians are not able to extract that value simply because of training and lack of legal infrastructure, more sophisticated health systems and people working in larger groups will tend to negotiate those contracts in terms of service nicely to leverage their data and monetize that and make sure that something they are either going to keep in their own house and of accessible through a report function not through a direct extract function. There are lot of ways of being able to monetize and longitudinal, aggregated data. You are absolutely right, it's a huge opportunity for physicians to do something beyond just having that reimbursable event but actually create some long-term value with that.

Dr. Jenkins:
Stan this is been great. I hope many of our leaders will take advantage of this opportunity to learn to be leaders in this area because we have got to take the bull by the horns for the future for our patients and also for the value of the practices. So thanks, Stan so much.

Stan Kachnowski:
Thank you John everyone involving putting it together and the attendees as well. Again, feel very if anyone has additional questions either email or contact me via Linkedin if you want to stay in touch in terms of ongoing digital health development updates, I update almost daily with digital health evens and news particularly around reimbursement. Thank you again everybody, have a good day. Perfect, thank you.

Dr. Jenkins:
So we are able to talk with Sylvia Romm, a physician at Atlantic health system. Sylvia is a chief innovation officer and she's been a practicing digital health physician for many years. Sylvia shared her experiences around the third-largest health system in New Jersey. How right there in the epicenter to COVID-19, they dealt with this pandemic and virtual health. Sylvia said it was amazing to her having been a champion of digital health for years, to see how quickly the infrastructure went into place and people adopted telemedicine. Zoom, Doxy, FaceTime ,all of these, were put in place in a matter of days. The volume there New Jersey went from very little telehealth to 80% virtual and 20% inpatient. So I asked Sylvia, what's can happen in the next several months? She said they are planning for a rebalancing of healthcare visits. That rebalancing, they think might eventually look like 80% in person and 20% virtual. But they don't know. And there are several things that influence that. Sylvia said one was the need to reestablish rapport with our patient's. That report has been busted because our patients have been afraid to come to our office. Our staff is afraid of our patients. And we have this atmosphere of fear and uncertainty around COVID-19. If you listen to the media is changing daily in terms of the amount of fear that we have. So reestablishing rapport by creating safe places for patients to come back to, and educating patients about that is going to be really critical. The second thing Sylvia told me was site preparation. Making sure the sites themselves convey both safety as well as actually provided safety. There was clear communication about social distancing

about registrations. Sylvia said their health system was moving towards complete preregistration and no longer having the registration at a window at least for the foreseeable future. So that means you register online or telephonically, when you get to the office you either wait into the car or you go right into the exam space rather than having a waiting room. Sylvia told me in her mind, waiting rooms would become extinct. And finally understanding preferences. The cat is out of the bad. And Sylvia shared that many of our patients have experienced virtual visits and they like it. And they don't want to get in the car and drive out just to be told they are doing okay or to have a routine visit or that required visit every 90 days for a refill. So hopefully, we are going to see some of these exemptions and waivers stay in place. That was one of the three thing Sylvia says will influence the future of telemedicine. One, some of our waivers and rules stay in place, waivers for patients to receive certain prescriptions that are in the low controlled substance range, such as ADHD medications, medications for neuropathies. These visits could be virtual. The law would be permanently changed to allow the prescriptions to be virtually put in place. As well as, what's going to happen with COVID-19. Stan talked about are we going to experience a second wave or a wave with the flu in the fall/winters. How this influences what our delivery will be like. And finally, reimbursement. Currently we have a lot of parity. We have to lobby to keep parity in place at least to keep strong reimbursement models in place for telemedicine, so that telemedicine can be part of the way that we deliver care to our patients. It was a great conversation and I hope to bring Sylvia back to a podcast that we will start doing for digital health in the future. We are ready to listen to one of our speakers from Alaska. Lakeisha, will you introduce our true virtual distance speaker?

Lakeisha Moore:
Will do. Thank you Dr. Jenkins. And thanks Dan I hope you can stick around for us a little while. I saw some questions coming in that we love to get back to at the end. And also Dr. Romm also. Great thanks Stan, thanks for sticking around. We are excited to have Jordan Berg with us. He is with the telehealth technology investment center. We call him TTAC for short. And Jordon is joining us from Alaska. Is it sunny there or not? I was trying to figure out what the weather is like in Alaska. Thanks Jordon for telling us the wonderful resources that are available through TTAC and some of the technical assistance you can provide. Welcome Jordon.

Jordan Berg:
Thank you Lakeisha, for that introduction. I want to talk a little bit about who TTAC is we like to joke we are one of the best kept secrets of telehealth medicine but we have become more active and more people are aware of us. We want to make sure as a resource, you understand who we are. Next slide please.

First of all, we want to point out we are a federally funded resource through the office of advancement of telehealth. We are free informational resource for people wanting to learn more about telemedicine more about telehealth and particularly more about telemedicine technology. We work with the 12 regional telehealth resource centers and the other national telehealth resource centers, that’s focused on policy, to help educate the organizational and individual population across the United States about what telemedicine can do and how to get started and how to get up to speed as quickly as possible. TTAC has three staff members that engaged with them. We have Steve looking me in the eye and then Doris. Between the three of us, we have more than 50 years of experience. Next slide.

This quick graphic here explains a little bit about who the telehealth resource centers are and how they are distributed across the country. Your telehealth resource center, your regional telehealth resource center in this case purple mid Atlantic telehealth resource Center on the right, is a really great resource for you, they are up to speed on the things that are happening in your area, what the regional policy looks like, some of the local pitfalls that you need to be aware. So these are all across the country. Alaska's part of the Northwest Center, so we are in the upper left there in blue. Your

local, your regional telehealth resource center is a great resource for you to be plugged into and engaged in what's happening in telemedicine in your area. At the bottom of the screen you see the two national resource centers. One is focus on policy, Center for Connected Health Policy located in California. And we've got the telehealth technology assessment center. We are located in Anchorage Alaska. We are the national resource center focused on telemedicine technology and making sure people understand how to choose technology, what kind of technologies are out there and really what is possible. Next slide.

We want to talk to you guys about a few things here. First is, we want to talk about the current data technology particularly in relation to COVID-19. We're going to talk about trends and video-based platforms, we're going to talk about security and privacy, we're going to talk about remote monitoring at a pretty high level. And we are going to leave you with some really practical key thoughts about how to make technology decisions during COVID-19. We want to obviously leave time for some questions and answers.

We can't really talk about telemedicine technology without talking about the trends we've seen with COVID-19. It's been interesting that it's both disrupting and reinforcing force in the telemedicine market. So no one's surprise there's been a lot more interest in using telemedicine and the growth that we've seen is really unprecedented. We've been talking to a lot of different organizations who are concerned with how to get telemedicine functionality set up just as quickly as it can. Most of these organizations are looking to some sort of web based, cloud video platform to provide additionally functionality quickly. Is not a new trend, we've been tracking the last couple of years. But it's been really accelerated in the growth and speed that organizations are moving to these platforms. Probably one of the biggest changes we've seen is the rapid use of the patient home as the care location. So with practice what is this look like? This looks like connecting the patients with tablets and connecting patients with smart phones and connecting the patients over consumer-grade Wi-Fi and mobile networks. It also means we have to use platforms that are simple to connect and that require the minimum amount of effort for the patient to engage with. Things that connect over a link, things that connect with minimum amount of downloads or app installs. Applications and products that consider those are really important in the current landscape. When we're talking about the different types of platforms, we try to point out a key platform dimensions that people will be aware of. We will talk about these a little bit. The key first platform that we need to consider is how deployable these solutions are. So when we talk about deploy ability, what we talk about is how quickly and how efficiently can we get these systems out into the patients hands. So if you make a purchase decision today if you buy platform today, how long is it going to be before that platform is with your patients, in their hands able to deliver the care that you need. So there's a lot of systems out there to be honest the whole telehealth medicine system is stressed right now. If you approach a vendor or if you approach platform and you asked them how to get their solution out, it may be more challenging for them to deploy more than it was before the crisis. Keeping that in mind we are looking at how quickly these solution can get out is important. The second dimension we want to consider is scalability. How can we go from seeing a couple dozen presentations a week via telemedicine to 100 patients a week. Is your network robust enough to maintain in light of the spike in traffic. Do you have the software licenses that you need to cover additional demands? And then when you are scaling out at that large size, how reliable is the platform that you are using. If you get this new system, how will it perform in the actual patient environment over time? And then, another dimension we want to consider is ease of use. We talked about this a little bit. It's not just the patient aspect we have to consider. We're looking at the new solutions, it's not just that we have new patients who are experiencing this but we have a lot of providers, a lot of new staff that is never used telemedicine before to deliver care, but are now having to use it because that's how we are delivering care in this new environment. So we want to make sure whatever products we select are simple to use, they're easy to train on. And that does not get bogged down in the technology issues. When we are choosing telemedicine technology and we're choosing any technology, one thing we try to

emphasize is how easy is it to make it to make the technology invisible? We are trying to deliver care and if the technology is getting in the way of that, if it's making it more convoluted and it's really visible and it becomes the center of attention, then that's a problem. Good telemedicine solutions and good technology will disappear in the background and make it easier to deliver the care you need to. The last key platform to mention we want to talk about is on the next slide. We kind of dedicated a whole slide to this because it is a pressing concern that we talked to folks a lot about. So security and privacy. We see two forces with security and privacy conversations with COVID-19. One is, there's been relaxation of compliance and regulations around what platform and what locations we used to deliver care. And the second, what that means is we have had a lot of folks connecting over platforms that have not been traditionally telemedicine platforms. So connecting on face time or connecting over different social media platforms. This is likely to be a temporary measure. It is one of the forces that is moving the security conversation. We can expect as the crisis is beginning to wind down and we reengaging with how will it look in the long-term, those rules will be changing, we can expect to move to a more secure and more regulated required platform. The second thing we are seen as we also see a lot of concern rates over some high-value not high-value, high-volume video providers in relation to what they are doing in terms of security and privacy. Some of these issues are related to users not understanding the controls and not having adequate training about the systems they are using. It's also related to organizations not having and establishing effective procedures and controls around telemedicine technology. There's other issues around deeper problems in the ways that vendors and providers have been handling their data. It has been a little more concerning. Regardless, we are seeing growing pains as organizations and vendors and consumers deal with new ways of seeking care. We want to talk a little more about the next slide of remote monitoring. We've seen a trend over the years interested in monitoring technologies, but again we've seen a spike in interest of how we get remote monitoring into the tools into patients' hands quickly. There's a lot of organizations interested in getting these devices that can connect and relay patient data, getting these integrated into their telemedicine solutions. Some of the interest is around biometrics and COVID-19, specifically temperature and blood oxygen readings, but there's also a growing question is how do we continue to provide care to our chronic patients who it's no longer safe to see in person? When we are looking at these sorts of solutions, we want to also consider, like we did with the video platforms, some key consideration. One is, right now, some these devices are fairly hard to get their hands on. lot of about technology and devices and thermometers, they are manufactured in China and there have been severe disruptions to the supply lines. Even if the devices themselves are not necessarily manufactured in China, a lot of components are. So it can be harder to source some of these devices. When you are looking at vendors that offer these sorts of devices and you're looking at platforms that support them, one of the things that you can consider is do they support multiple devices? So do they have multiple thermometers they can support, multiple pulse oximeters they can support, or blood pressure or that sort of thing. Second, when you actually have these devices, how are you integrating that information into your use case? How are you getting that information in putting that in your system you can use it? So most the devices are not designed for biometric data, and most will use their own proprietary platform, everyone wants to use their own platform on their system, collecting data in ways that they kind of control and give you access to. When you're looking at these source of technologies, you want to take a close look at how readily and easily you can get access to your data and how you can integrate that into your care system. Finally, like with the video platforms, these solutions need to be easy to use, particularly if they need are going to deployed into the patient homes. We need make sure patients can set up, connect, and use these devices, without needing physical help at the location. That needs to be a key consideration. The next slide, the next talking points that we want to raise with you, these are key thoughts we bring up almost every time we talk to anyone. And these are general ideas about telemedicine technology, things you need to keep in mind. We really like to emphasize that it's always important that whatever technology we pick have a really well-understood

case and workflow, that our organizations are very motivated to support. We've seen this so many times, that any time we picked technology because it's shiny or interesting, that technology for the sake of technology will just end up in a drawer, it's not going to be used, it's going to hinder care more than it's going to enhance care. The second is the importance of spending hands on time with any piece of technology we engage with before we make purchase decisions. You can save yourself a whole lot of heartache and you can gain a whole lot of understanding by trying before you buy, even if it's just for a short period of time. You can learn more from 30 seconds of handling a handling technology than you can from all kinds of vendor demonstrations and things like that. Finally, when we select a piece of technology, we have the whole team buying into whatever piece of technology that is. When you presented technology to group, you're going to get different perspectives. You're going to get clinical staff, administrative staff, your ID department, will have different views of what makes it a good component of the technology. If we can collect that input and make sure the decisions we make are thoroughly considered and documented and we're able to communicate throughout our organizations, those are vital considerations to make telemedicine technology go. The last set of slides here, is we want to talk a little bit about COVID-19 specific thoughts we will leave with you. So right now, we need to consider how we make our COVID-19 response both flexible and robust? Telemedicine is and has been a proven tool for reaching existing patients. This is more true now when we can't see as many patients as we would like in person or is affected by symptoms or diagnosis of COVID-19. What this is going to mean is we have to reach out to patients in their home, we have to engage with their existing devices and with their existing networks. We need to be flexible. We need to be understanding and we need to really reengage with the patients. I really like what was said earlier how it's important we reestablish our rapport with patients, we do whatever we can to get rid of the atmosphere of fear and uncertainty. And a lot of that is just convincing our patients that we have a plan, and that if that plan fails and that we have a backup plan. And if that plan fails, then we know what we are going to do; and being able to be confident and calm with our patients that we navigate technology, that they are probably not super familiar with and that we are also getting up to speed with as well. The second point that we want to leave you with is if we are going to expand healthcare to patients using telemedicine technology, then we will expand our risk. We can't get around risk. And we can't completely avoid it, we can mitigate it and we can understand it. But we have to be able to understand that as we move further into this crisis it will highlight the challenges of getting these new technologies to new users and new patients. It's also important to understand how our partners are defining and managing risk on their end. So if you're engaging with a new telemedicine partner or a new telemedicine provider, understanding exactly what they're willing to do with the data and understanding exactly how they're going to engage with you about risk is really important. We also need to understand the controls and the policies that we have in place in our organization. So I like to use an analogy: telemedicine technology is power tool, it can be to use to enhance and to multiply what we are doing in telemedicine. But it also has the ability to cause damage if people don't understand the tools that they're being handed, and if they don't understand the rules around using those tools when we hand them to them. So we want to make sure that when we are using and deploying the technology we are smart about knowing what our rules are and that we are all involved in the protecting the security and privacy of our patients. And then the final point we want to leave people with, one that's been made a couple times already, as we are in a solution and environment, it's worthwhile to take a little breath and think about what are these solutions going to look like in a year? What are they going to look like five years? Because whatever technologies we choose, whatever solutions we engage with, they are not going away. We've heard before as well people are getting used to getting their care at home and getting used to working at home. Were not going to be able to go back to the way we delivered care before. We want to plan past the current crisis and we need to plan into the future, so that whatever we build has some lasting and staying power, so that we're able to deliver care well into the future over the next five years. On the next slide we want to make sure we have questions about a

specific telemedicine technology, we've got toolkits. We have resources for you on our website. One of the most valuable resources is if you go to telehealth technology.org and you click that large grey button, you can ask us specific questions and we will respond. We will respond to a lot of these technical assistance requests every single day and we are eager to answer your questions as best we can. With that I will turn it back over to Lakeisha and thank you for letting us come and speak with you today.

Lakeisha Moore:

Great thanks so much Jordan. Great information. And I see some questions came in. So I'm hoping you can stick around with us to discuss some of the questions we've covered today, the things specific to some of the telehealth technology assessment center resources.

For everyone, a couple of reminders. If you could submit your questions using the Q&A functions, which I see many of you have done that. A reminder we don't have the audio option available so any questions will need to have come in through the Q&A is through the Q&A function. Also a reminder about CME credit for today's webinar. You will need a MyAHEC account in order to get CME credit. The information is on your screen there, and then for full instructions you can visit www.nwahec.org/textreg. website if you need additional instructions. So Robyn has been standing by and getting your questions together. We like to leave the slide appear around additional telehealth technical assistance is available through the office of rural health. We focus on safety net healthcare providers and through the North Carolina Area Health Education Center and CCNC, and that information is on your screen. I'm going to turn it over to Robyn to go through Q&A for the last few minutes here. Robyn. I was going to say you might be on mute.

Robyn McArdle
Can you hear me okay?

Lakeisha Moore:
Yeah We've got you now.

Robyn McArdle:

Okay Great Thank you. Thank you all, the first question we have is coming from Gary Mattson. Gary asked, and I believe this will be best for Stan from the original part of the presentation. So Gary says, **"Are there any national healthcare agencies that have made recommendations about what is appropriate and not appropriate to be addressed clinically versus telehealth? I'm sorry via telemedicine. I have concerns that some things are being addressed via telemedicine and should not such be addressed such as ear infections or sore throats and treating with antibiotics when there should be testing or visualization."**

Stan Kachnowski:

There are a number of guidances on this, both from a federal and state standpoint. Again, if you want to email me Gary, or catch me through LinkedIn, I'm happy to send over some reference links for you to follow up on those questions. You are asking the exact appropriate question and that is when it comes to the details of these sorts of reimbursements, it can sometimes be very localized and a depending on where your reimbursement sources coming from, it it's a county social welfare Association, or if it's a state reimbursement fund or if it's a federal reimbursement fun. Right now we're seeing in New York State these guidances are extraordinary liberal. But again, as I mentioned late earlier, it's not so much the reimbursement promises that are being made, if this is a new practice, it takes time for the funding pathway to actually be set and then start actually receiving funds through these sorts of mechanisms. It's a little bit more complicated than other reimbursement

but it's also are you going to get paid in 60, 90 or 120 days or whatever it might be. And those are some things to keep an eye on.

Dr. Jenkins:

And Stan, I'd add, there are at least three resources that you can look at today. One is the AMA's toolkit for telehealth. It gives guidelines as to what is the scope of practice that the AMA supports. Another one is the American Academy of Pediatrics and they have a telemedicine toolkit that gives pediatricians guidelines as to what they feel is appropriate for telemedicine. And then the third is your local medical board. So our North Carolina medical board has a position telemedicine statement online as to what is appropriate for telemedicine. And realize also the technology is changing as we get new tools that allow us to actually do a urinalysis remotely to do a throat examination remotely or an ear examination remotely, just as we would do in our office. These new tools are going to change that scope of practice.

Robyn McArdle:

Thank you so much we appreciate the responses. So the next question that we have, well we have a comment from Kim Schwartz, and she did just want to mention that it is essential for the RPM, the remote patient monitoring data, to be linked to a PCP. So if anybody has questions or comments about that we can provide you with Kim's information at the end of this session.

So the next question, I believe this will probably be for Dr. Jenkins, comes and says, **"our discussions have been focused on how to responsibly serve remote patients through telehealth. Is there a similar discussion taking place about how to responsibly handle administrative support for remote providers, who through telehealth become increasingly untethered from office settings that have traditionally housed features like patient intake, discharge, access to EMRs, claims billing and adjudication?"**

Dr. Jenkins:

Ah surely. So it's interesting that person must have been in my emails today because I got several questions from practice administrators who are looking at developing protocols for providers who are doing remote work. Previous to this, that was most common by the big telehealth companies like AmWell and MDLive and TeleDoc and others who had policies and procedures for their particular practitioners. As we integrate telehealth into what we do in our practices, like Sylvia says it becomes 20% or more of what we do every day, then we are going to have to incorporate what is the scope of practice, how do we govern that scope of practice, what does peer review look like in that scope of practice, chart review, coding, quality and compliance issues are all going to have to be built into that. So I think we have to ban together as a state, we have a lot of help on the technology part. I think AHEC, DHHS, and the work we're hoping to do will start to create a rulebook, a guidebook for administrators as to how they will engage practitioners in telemedicine.

Dr. Jenkins:

Thank you so much. So our next question comes from Deborah Grammer, and she asked, "do you have examples of workflow incorporating language interpretation in the telehealth visit?" So Dr. Jenkins I don't know if you have a good answer for that.

Dr. Jenkins:

So we do. So our serve for children does that right now here in Greensboro because they have a majority of their population or a significant portion of their population are immigrants. And many of those do not have English as a first language or don't have English as a language at all. And so this is incorporated telephonically at this point, all though you can actually triangulate video visits by having just like we do Microsoft teams, having an interpreter in one window, having the patient and

the patient's caregiver in one window and the physician in a third window. Most of us now use telephonic interpretation, we don't have on site interpretation, or we use services, and so those services are more than willing to be linked into the conversation by using a telephonic link, which Medicare and Medicaid are currently allowing us to do during the crisis. And in the future, we have to plan for how we can triangulate those as a part of the technology we use. So to earlier points mentioned by our speakers, you need to be careful about what technologies you choose when you think about all the problems you'll have to address with that technology.

Robyn McArdle:

Great thank you so much. So we'll just do one more question. And for those who have asked questions that we have not been able to address we will follow up with you after the webinar. So Jordan this came up during your session. I'm not sure if this would be best for you. If not we could possibly loop in Dr. Jenkins. But the question says, **"how expensive are scales that can give us accurate weights in ounces, such as for infants and newborns, where we are worried about weight loss? We know it is best to see them in person, but there may be needs for these type of scales. I have heard they are expensive, but was not sure if they could be rented."**

Jordan Berg:

Yeah It's a great question to, you know it's kind of interesting that they mentioned scales. There are a few technologies in medicine that are highly diffusive throughout the last century or so, and one is a scale. You know, they're digital now, and they weren't maybe 20 years ago. And so digital scales have become much more accurate over the last 10 years and much easier to install from a user experience perspective. And so we do like them both in terms of accuracy. Now I think one thing maybe to remember from our inaccuracy grade is the term that we use. There's accurate from a consumer standpoint where we say okay it's generally pretty close to what we would expect and maybe you know it matches up exactly, or we don't really know but it's not entirely accurate. And then there's clinical accuracy, which is a different term and it really is something that we expect a higher grade from. And then there's an FDA-validated accuracy and that kind of accuracy and validation is a capital and carries a lot more weight to it from the standpoint of the marketplace there are only a couple of those. Phillips is a big one. If you're trying to have something that is extremely accurate and there are a few other's out there. And again I have no financial ties to Phillips. Full disclosure. But in general we love the scale not so much the perfect accuracy but more they are all generally within 5% or so, but more for the longitudinal data they provide as to the delta that is occurring with the subject and the patients from week to week, month to month and year over year. They are much easier to install than they were 5 to 10 years ago. I've been using one now again no financial tie to it at all from fitbit, but I've been using it for seven years. Obviously the news is not good when I look at my longitudinal data. I've been going uphill I've been going downhill. And I just stopped looking at the longitudinal data because it's depressing. I can say that COVID has hit me, I've got the "COVID-15" going right now. Yeah I would recommend doing due diligence again just contact me on LinkedIn I'd be happy to help you with some of the data we have in my lab that we've been looking at.

Dr. Jenkins:

Sure, and I would add on to that we have experience developing a digital app for diabetes in which a weight scale was part of it, and the weight scale was digitally integrated into the app so the data was being piped back to us in real time. The cost of those scales were anywhere from $50-$100 pre-COVID. I think the technology will go down once the use case is built for them, because it certainly does not cost that much to manufacture the scale. Again, I have no interest in a scale company as well. I think there are some modifications to scales babies to be measured as well in that area. FDA approval is the key issue if that is going to be data that goes directly into the EHR.

Therefore it has to be accurate data or if it's going to be patient recorded data and to our speaker's point, then that can be actual patient data can come from other devices and be used to assess trends such as weight loss or weight gain. And know when a person has to be brought in face-to-face. A lot of movement in this area.

Robyn McArdle:
Thank you Jordan and Dr. Jenkins both, we appreciate the feedback. We gone a few minutes over. I apologize.

Lakeisha Moore:
Thanks everybody. I think it's use case great for TTAC I don't know if you're looking at specific scales and you just want to say, "hey I just want to make sure, this is something that came on our radar," or even if you're not really sure, I think that's a great use case when you're looking at different technologies. TTAC, that is exactly what they are there for. So thanks everyone for chiming in on that one. We want to thank all of you for taking the time to join us today. We hope the information shared has been helpful. Next we will take it deeper dive into telehealth implementation, looking at a longer term digital health strategy we've been down the road, so we'll continue that conversation. And next week is our last live webinar session. We have appreciated a lot of the conversation and the feed back we've received from you, that helps us understand other questions you may have out there for us. We look forward to seeing you next Monday, same time same place and hope everybody stay safe and enjoy the sunshine, Jordan I hope it's sunny in Alaska also. Here in North Carolina it's nice and sunny. At least everyone can get out and get fresh air and we look forward to seeing you next week. Stay safe everyone. Goodbye.
Goodbye.