Transcript for NC AHEC and CCNC Navigating COVID-19 Webinar Series

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Presenters:

Dr. Yun Boylston

Dr. Mark McNeill

Dr. Keith Mann

Dr. Libby Baxley

Dr. Tom Wroth

Hugh Tilson

Hugh Tilson

All right, everybody. Looks like it's time for us to get started. Good evening and thank everybody for joining us for this month's chapter of our navigating series. Tonight we're going to focus on navigating telehealth during COVID, while meeting board MOC requirements. Next slide. As always, the series is co sponsored by CCNC the North Carolina Pediatric Society, the NC psychiatric association, the NC Academy of Family Physicians and AHEC. Thanks, Tom, Elizabeth, Robin and Greg for their leadership and identifying relevant, timely issues for us to consider for their great partnership in putting on these webinars to respond to those issues. Next slide. Tonight we specifically want to thank the American Board of family medicine for their support for this webinar and the information we'll present. I'd also want to thank all of you who are making time to participate tonight for the great work you're doing for your patients, your staff and your communities every day. We hope the information you get tonight will help make navigating these times a little bit easier for you. Next slide.

My name is Hugh Tilson and Tom and I are going to moderate tonight. Next slide. Got some logistics for you. First is that you can adjust the proportion of speaker and slides by dragging the double gray lines between the slides and the speakers. You can also adjust your video settings to hide people who aren't speaking to do so you just click on that view button on the upper right hand corner of the screen you can select side by side: speaker. We'll put these instructions in the q&a For your convenience, in case you just weren't sitting around taking notes waiting for me to tell you how to do that. We're after you hear from our presenters you'll will turn to your questions or comments you can submit your questions using the q&a function on the black bar on the bottom of the screen. We'll probably hold most of our questions till the end of our presentations to make sure all of our presenters have enough time so if we don't get to your question right away just know we're doing that intentionally. We'll post the recording and a written transcript of our webinar on the CCNC AHEC website sometime tomorrow, and the slides

are already up on the website source, put a link to those in the q&a as well. Next slide. Zoom occasionally has some technical issues, we think that they've addressed them but just from an abundance of caution. If you have any problem hearing any of our speakers if you dial in to either these numbers, and use that webinar ID we think that that's a workaround, hopefully it won't be an issue, but just again out of an abundance of caution. That's a way to get around that and I'll post those in the q&a. For your convenience as well. So enough of the logistics. Next slide.

We have an amazing group of panelists for us tonight. And I'll let each of them introduce themselves to you as they get started with their presentations. Before I do, though, just thank you all for making the time to be with us tonight. A lot of preparation went into this and your information is going to be incredibly timely and important. We really appreciate you being with us tonight, and all that you've done to present to prepare for this. There's a lot of information on the slides so we'll post those give a link to those on our website, so you can follow along and we'll do that shortly. I think that's all that I have for logistics. So now I'll turn it over to Dr. Boylston to get us kicked off.

Dr. Yun Boylston

Great, thank you so much you I'm Yun Boylston with Burlington pediatrics and Mebane pediatrics and we are an independent pediatric practice located in Alamance County, and I feel like the band is back. You know I remember doing this, exactly 12 months ago it was May of 2020, and I believe the topic during that webinar was leadership and innovation, or, you know, innovation, elements of COVID, and we all need it so that's great. And it's a privilege and an honor to be invited back today. And this is really a story of our journey, and, you know, one of many many stories out there of successes and maybe some, you know, challenges and and I love the opportunity that I have to represent our practice and and show some of the work that we do day in, day out, to appreciate that, and let's get started so the, you know, in terms of the uniqueness of our practice and just to frame that we have three office locations and our practice panel is approximately 16,000 patients. So, next slide please. And this is a slide that I think resonates with everyone. If you have that queasy feeling in the pit of your stomach. I am right there with you because it's it's it's nice that we made it to the other side but you know if you think back to all the motivate, like all the motivators and kind of the urgency of the work that we were doing, you know, we'll set it up as March 2020. We saw this drastic margin compression revenue stream, you know, decline sharply, we experienced pretty abruptly about a 40 to 50% reduction in visits and at the same time we had this incredible increase in expenses while having to maintain payroll and you know for everybody out there. We recognize that payroll is the most significant expense that a practice has. And so we wanted to keep everyone employed gainfully employed, and at the same time we were having to pay for things like PPE, if we could get it, we were paying a premium for a lot of items that we didn't have experience doing previously. And then we also started to experience staffing challenges as well, how do we best deploy our talent, given all the uncertainties of, you know, individuals who may be experiencing quarantine events. How do we handle other situations where, you know, families had to make really tough, tough decisions as to whether they needed a parent to stay at home with the children who were remote learning and so a lot of this, we felt very acutely within our practice and within our work family as well. And all of these things I think just got churned together, and we really felt this very passionate, drive that we had to survive and we wanted to thrive. And so how do we use

our skill sets to the best of our capabilities in order to make all these things happen and so for us telehealth was definitely an essential necessity. I think there probably a lot of our audience members out there who probably view it the same way. And so that's kind of what what preceded all the work for us. Next slide please.

So, I know, today's discussion focuses primarily on the workflows. But contextually, I just wanted to recognize that there are so many other components to to utilizing telehealth and having it at your practice. And so recognizing that all the practices out there, I'm you're doing all of this work and these are only just on some of the broader framework on components of what it means to implement telehealth and so certainly, everyone who's done it appreciates this you know everything from, you know, very timely vendor selection and implementation, You know all the financial considerations that go into, you know, how do you how do you sustain telehealth in your practice, how do you cover all of IT costs, improved, you know, Wi Fi capabilities, extra iPads for nursing staff who, you know, require them, you know, to help some of the workflows happen, and also the liabilities of telehealth, were certainly ones that we had not had to consider before and so a lot of this, you know, how do you, you know what are the medical legal implications of providing a telehealth visit, you know, does it matter where the patient's located if they're at their grandma's house in South Carolina, you know, there were things that we really had not had to envision, but we're quickly starting to to adapt to like how we, how we would address those changes and kind of new situations that came up, and certainly the care delivery, you know, we wanted really high quality care at every touch point, but it was just really different and how do we standardize a telehealth visit to make sure that people are getting consistent experiences, and keeping in mind that nobody learned how to do this in residency I for one, certainly didn't and I don't think my colleagues at our practice did as well. And then also maintaining high on patient satisfaction and sustainability, you know that's something that I think we're all continuing to advocate for, you know payment parity has been incredible. You know it's been a lifeline, and for us to be able to carry on this work. And so how do we continue to get paid fairly for the work that we're doing, and certainly in the midst of all of this, you know, in terms of the coding changes that occurred, as well as creating good uses for to telehealth, but for today we're going to focus on the workflows, and the workflows for telehealth, you know, certainly, it encompasses all the operational efficiencies that you know really help you derive, you know, what's that secret sauce of the workflows that help you get everything that you want out of telehealth, you know, in the first place but I think a lot of that stems from what are the communication pipelines at your practice that enable these workflows to be developed quickly and efficiently. And so I'll be focusing on some of that in today's discussion.

And just to give some context again because I know the independent practice lens, you know, as we're, as we were urgently implementing all this, you know, paying for our platform which is Doxy for a lot of your organizations within the health system. You know if you have significant cash date you know days cash on hand if you have some of the deeper pockets, you know some of this, you can take on risk and and take on initiatives that may not work out right may not work out for the bottom line may not work out financially, but independent practices don't have that safety net, and essentially pretty much everything you implement really has to have return on investment, very quickly. And so that was a part of the increased risk I think for everybody here who is a part of an independent practice. Next slide.

And so part of our workflow development. You know there are certainly different ways to structure how we thought about this. I think for us it made sense to think about our team and the roles that they perform throughout our, you know, throughout the visit experience. And so there were a lot of things that a lot of different ways of thinking about, well what does it exactly mean to like check in, you know, like what is required for check in. Are there things that we could do without are there things that are absolutely required. And so just kind of go through each group so our front office staff or our receptionist, our receptionist our schedulers scheduling protocols were really significant part of how do we do telehealth well, right, because everyone knows if you have an inappropriate use case for telehealth. Well then, you're already setting yourself up for a dissatisfied patient higher risk for the provider, and really kind of toeing that line between, I know I'm not supposed to be doing this on telehealth this is highly inappropriate to do it through this medium. And so ensuring that we had some guidelines. And it's really hard because everybody here knows here if you call for a fever. By the time they see you, you know turns into constipation and not quite, you know, tied into the initial that happens to pediatrics anyway so maybe in the adult world you have some other, other things that happen. And then, you know, in terms of how do you efficiently perform registration for for patients who are not physically in the building, right I mean we're used to conventionally, giving somebody a clipboard of forms, having them fill it out in your presence, sending it back, you know, giving it back, and then they're taken to the exam room, but how do you do that when you're in a virtual space. And so a lot of this I feel like we learned we really, kind of, you know, curated best practices, and so I think that implementing telehealth, at least for the registration process for us actually improved our in person checking processes as as well. We recognize that a lot of this didn't have to be done synchronously, you know, you know check in, essentially getting information can be done the day prior to the visit. If it was a scheduled visit routine visit, or it could be done the morning of things could be, you know, sent by secure messaging, you know through secure email so there are a lot of different ways that we're able to do that.

And then the, this seems a little, you know, pretty intuitive but also we had this fear that we were going to risk that we were going to lose somebody in the virtual space you know this is the equivalent of leaving somebody out in the waiting room, and all the lights are turned off and and we forget that somebody is actually waiting for, for care and so there were situations that we knew, we really wanted to work through. And then for our clinical staff, you know some of the things, touch points, I think we became much more effective at the morning huddle, you know, typically across our three locations, a morning huddle is done before the first patient is seen, and it's a way for all of our team members providers clinical staff front staff to really get together and discuss the cadence of the day, potential challenges by patient by time. And so you know that was, I think we, we navigated that really well, And so I was really, I think it was a strength for us that we already have a morning huddle in place, and we utilize that to the best that we could. The other things that we recognize were that in a telehealth encounter, we could make this as lean as possible so once the patient was done checking in a provider was fairly, you know, autonomous in terms of the care delivery and could do a lot of the things that didn't require a clinical support. And so, you know, our current model right now is, you know we have a designated telehealth provider, each afternoon, and that that providers nurse actually runs our drive

thru COVID testing clinic. And so, a way to just optimize our, our staffing and to perform different tasks that need to be done while maintaining the same number of individuals so I think that's worked well.

Another positive outcome of telehealth visits, you know, we, when we kind of evolved through COVID It was, it was painfully obvious that you know we were used to maintain a fairly standard status quo with the ratio of well visit to sick visits, and, and, you know, roughly, pre COVID it was like 1 to 3 So one well visit every three sick visits, and so sick visits can be very straightforward, um, sometimes there's like minimal nursing input, but well visits are very nursing intensive, you know, to perform all the requirements that are recommended through Bright Futures you know the nurses are, you know, scoring all the screens performing all the, you know LED screens all the surveys, they're the ones giving vaccines, And so this was a way to help utilize our providers to the extent that we could while also giving the nurses buffer time to be able to give their shots and to catch up on some of their workflows. For our providers, I think we really learned what is lean care delivery, you know, this is when it's just me and my patient, you know how independent can I be and still deliver effective care. And so there are a lot of kind of tricks so that you know that we've we're just efficiencies that I think we've kind of been able to adopt because of this.

And then for we also piloted some things within our telehealth model. So, you know, on the weekends, we do have an urgent care clinic. But we also spent a good amount of time, a number of months where we were actually running a telehealth only provider and that person worked from home, and essentially we were just kind of doing a dry run of. In the event that a provider was caught during, you know, during a quarantine event or became sick. You know what were some ways that we can utilize that individual to still be a part of the workforce and yet, abide by quarantine and isolation guidelines. Fortunately, we never had to, you know, implement that. But it was a really good dry run and helped us meet some of the needs that we were seeing when telehealth was quite high, and the processes for communication, how do you convey to the front staff that you're finished with that patient and they need to be scheduled for COVID testing right I mean so there are definitely some workflows that that we have to work through. And then things like template development you know when you're writing a note that's part of the providers, you know, efficiency and, and, you know, in a workflows. And so how do you do that in the telehealth space.

And finally for billing we definitely had, this was, you know, all hands on deck. And our billing team was no different, you know, we had different protocols, you know insurance for verification differently. You know when somebody is not with you or in front of you, payment processing, you know, how do you get a copay. Prior to a telehealth visit, you know what if that patient has a high deductible plan, you know like how do you handle that, and then kind of early on, like what are the billing modifiers that you had to use in order to get payments. So a lot of different, you know, nuts and bolts of how to make this work. Next slide please.

So for us, you know, what was the ultimate outcome for a lot of this, I think, for us, the staffing optimization was a really, really critical piece of what telehealth was able to the value that telehealth has for us access to care. during lockdown I think that was an incredibly important piece for our patients. I think that it enabled us to really take part in the public health effort, especially when it came to helping to divert resources and staffing for testing and hopefully very soon for vaccinations. Behavioral Health has become a significant, you know, service that we provide via telehealth in really incredible ways that we had not, you know imagined. And you know, part of that, for example, you know, We deliver a lot of telehealth to instate on college students that maybe we would never have connected with or who thought that connecting with your pediatrician when you were in college was not, you know, was not feasible, but now we stay just as connected. And I think that's been a meaningful part of the care that we deliver through the continuum from birth to adulthood. And then, vulnerable populations, we certainly take this to heart that COVID is definitely, you know it's really revealed health inequities, and so how do you deliver care somebody who does not have a car is afraid to ride the bus, you know, many years ago we actually advocated to have a bus stop, literally placed in front of one of our offices because we recognized the need. And so you know how do we best provide care to to these vulnerable populations and so I think telehealth has been a really great success story.

And just to kind of give you some snippets in February of this past year, we were just curious about kind of how people had worked through COVID and just asking questions about patient panel. And so, this was just some caveats. We conducted a survey and this was just an hour of the Burlington pediatric patients in in our area. And you know, with over 600 responses. We had some really reassuring things come out from this data. So, you know, one question we asked was where have your children received health care since March of 2020? Essentially, you know the 12 months during COVID prior to the survey and close to 90% of parents surveyed said that their children had actively receive care at the doctor's office meeting our office, and that 40% had received telehealth services through our office. And this was in stark contrast to telehealth through another provider and that was 4%. This was especially meaningful because we've always argued as a medical home that given the choice, people will choose to connect with our medical home, and recognizing that you know for a lot of insurance companies or employers telehealth visits are free. You don't even have to pay a copay. But for most families, it was worth the premium to, to connect with our office, knowing that we knew their children so that was highly gratifying for all of our dentists colleagues out there this is also, you know, reassuring that the majority of these families also continued their connection with their dental on home, which was excellent. And then, you know only 4% had not received health care, I mean that's so meaningful, and we're still trying to catch up with those kids, you know, to make sure that everyone's getting their well visit, but all in all for us this data was highly reassuring. Next slide please.

And so where are we today. So for us, this is the little snapshot off to the left of the screen. This was our very first post that we made on Facebook marketing our telehealth services, and as you can see that was March 26 and the conditions that we treat are still essentially those, you know we still feel very comfortable and behavioral health if I could do this again it would probably be a much bigger icon. But today, or just rolling, you know 2021 telehealth comprises about 17% of our total visits, and at times, you know, very early on during the pandemic. You know it. Some months it was like, close to 25%. So,

you know, it's certainly decrease, but that I don't think that's really been because of decreased interest in telehealth it's much more of the the increase and kind of return, or the uptake of in person visits. So this is really reassuring. Next slide please.

And so in terms of, you know some of our as we kind of pilot things we always like to get feedback and, you know, I love our, you know, work, family, very supportive and always very helpful. You know mutually we love to ping ideas off each other and so I have a couple of testimonials that I thought we would share. And so we have um two providers, Trevor Downes and Dr Karen Winter, who provided some I thought these were really pretty representative, some of the other feelings, you know, Trevor says, When it all works well, and all providers know that's a big question mark. I get the feeling that the patients and their families like it a lot. To save time, I would absolutely agree with that. I think a big challenge. Currently, is that we still have connectivity issues. And I would say about one in four visits still has some sort of glitch or the you know the audio or the, you know, camera quality just is it is that you know still there's a lot to be desired. We have a lot of children who were in Caswell County other parts where you know broadband is still, still an issue. And so we're continuing to work through that. And Dr Winter, you know, we're both, you know, provide different services and, and certainly behavioral health is a big part of some of the services we provide, but she spoke to that, that mental health services are perhaps the most frequently used, my patients with ADHD depression and anxiety use these appointments for follow up, and that's absolutely true.

You'll notice that the providers comments are a little bit more tempered, our staff love this as you can see, Rhonda Fox is our lead care coordinator. She knows telehealth is not only the new norm but a new way for medical professionals to interact with patients without barriers. And I love that you know how do we meet you where you are, or how do we meet patients where they are and I think that this really speaks to that and Amber Davis one of our receptionists, um, she notes I feel that this is one of the best things we have done to promote immaculate patient care here at our practice, and I hope that you know Ambers pride and our collective pride in the work we do and the care we provide really shines through in her state, I really wanted to include her. Next slide please. So just on behalf of our entire practice Burlington pediatrics and Mebane pediatrics, we thank you for this opportunity just to share a glimpse of some of our journey. I also wanted to have a shameless plug for, let's, let's bring summer back, sponsored by the North Carolina DHHS to promote COVID vaccines through your channels where you are in your communities. And so this is some of our staff, you know, celebrating summer in our way. So, That's it. Great, thank you so much.

Dr. Mark McNeill

Great job. Dr. Boylston the new tough act to follow, but hopefully I can add to the discussion here. My name is Mark McNeill, I'm a solo family physician in Asheville the name my practice is Trillium family medicine, we get moved to the next slide. First is thanks to the CCNC NC AFP NC Peds society, American Board of family medicine for inviting me to be a part of this is pleasure to speak with you all this evening. Again, I'm an independent practice in Asheville. What has set my practice up and different has

been our since we opened up eight and a half years ago we really had a workflow based around our portal, and we train most of our patients to interact with us on the portal for scheduling their own appointment. Ask us about refills and questions rather than the telephone. So that's, we so engaging patients through technology has always been something very enthusiastic about so when the need came for telehealth. Last year, with the shutdowns and pay parity coming on we were, we're pretty, we're pretty excited to get started. And we can just jump two slides ahead.

When you're in small independent practice you can pivot pretty quickly. And that's what we did, I'm going to share just a little bit about our journey and then hopefully get into. Just some best practices that really helped us be successful at Trillium Family Medicine, and that hopefully might help your workflow and efficiencies out. So yeah and just like Dr. Boylston and in many of you in mid March I could feel the slowdown, I can see people not coming in. Come on practice manager and I sat down on Friday the thirteenth, actually I said hey, we got to do telehealth we're going to be in trouble came in on Sunday, the two hours, activating the telehealth module and my electronic health record. And on Monday started spreading the word blast this huge portal message to my patients saying, hey, telehealth sustainable for us. On to the next slide. My patients took to a quick and on day five of offering telehealth visits 13 of my 19 visits were telehealth, so we were just excited to death, to be still be available and be available safely. This continued. In April, 80% of my visits were telehealth. We thought about renaming to practice Trillium telemedicine, though. It really made a difference in keeping the practice open and healthy financially but also being available, safely to our patients. Obviously that's backed off a bit now but it's still 25% of what I do at this point, you're on to the next slide.

And I know I'm not the only one. And the minute, we're pivoting this well. This is a bit of a busy slide, but from my ACO showing about 100 practices in North Carolina were part of that ACO family physicians and internal medicine doctors, and we're going to focus on that dark blue line that represents the percent of claims, there'll be telehealth and on the right axis there that's right y axis its percentage. There you can see in mid February mid March, nobody's doing telehealth shut down happens, and payment kicks in and everybody just turns it off, and in 20 days telehealth use increases zero to 35%. At top of this year has been I think that's something we all be proud of those of us who have implemented telehealth, that was a lot of change in a short amount of time, of course. The downside is that we all just jumped into it, and just had to figure it out quickly and have had maybe some a lot of variation and how well we were doing it because, as Dr. Boylston and said we weren't really trained how to do this. Next slide please.

And I'm glad we're talking about your best practices because likely telehealth is here to stay, national surveys, 40% of patients and you telehealth at some point, consistent with Dr. Boylston survey, of those who use it for our five you have positively, three out of four say they're going to use it again. After the pandemic is done. But there's still work to do a lot of variation on how well it's been rolled out, and at this point only 58% patient can say with certainty that their primary care physician actually offers tele visit so we still have some work to do. We're going to the next slide please. So we want our patients, reaching out to us for telehealth because not reaching out to up telehealth they're going to be getting

recruited by other places. Tele doc and urgent cares. So, you know, how did we keep patients, reaching out to us and keep them coming back for telehealth well took page your business one on one, in business, one on one, you learn get clients, patients and our case patients with good salesmanship, and you keep them with good service. So we really, we can go to the next slide here, you're going to have, you have to keep marketing to patients and for us that's portal messages, we let them know early on, continue to remind them during the year that telehealth visits are available, and give them instructions on how to do it. We made sure our website was up to date with a whole page on telehealth, that gave people instructions and also some frequently asked questions. My staff was talking about, again, in the script and talking about when patients face to face on the portal on the phone. At the end of the day, nothing beats the doctor talking about it's that we're going to work, I told my staff, I mean patients will ignore yourself a lot, but they tend to ignore the doctor, less, so I made sure I was always reminding patients that this was an option for them. Over the past year, we hit the next slide.

But after you sell it, you got to follow up a good service to keep them coming back to you for it. But for my practice started out with good service was basically making it easy to access. For us, that meant, allowing patients to schedule it themselves. Self scheduling has been part of my workflow for eight half years as I started this practice. And we certainly folded telehealth into that unfortunate unfortunately for most practices, getting an appointment or getting a telehealth appointment still requires, or at least most primary care practices, still requires logging on. Excuse me calling the office, and having to wait on hold the phone tree, talk to receptions to get a telehealth visit. What's important to note, though, is that so scheduling is the standard at most urgent cares and Self Scheduling is the standard for a lot of the corporate telehealth companies. So if you're not offering Self Scheduling it may be something to consider to make it easier. So, because you may be losing some patients to an easier scheduling model. The other part of making it easy to access is just making sure there are plenty of same day appointments available for telehealth slots, nothing is going to discourage a patient, reaching out to you for telehealth than if they log on to your portal or call you in the net and they're feeling ill and the next telehealth visit is a few days away, they might just pick up that app for urgent care and head that way.

We also made a point just to minimize tech. Any other tech barriers. Unfortunately, when I first started with telehealth in March of 2020, my electronic health record vendor required everybody to log onto the portal or record download the app from the portal where they could access telehealth. That was a real barrier for patients who weren't tech savvy, push back on our electronic health record and thankfully they change that so now that once the patient gets to telehealth telehealth visit on the schedule, they just get a text with a link also an email with a link and all they have to do is click on it. So if your software isn't offering that at ease. you may want to consider some other vendor that makes it as easy as possible for the patient has to create an account or download an app that's just gonna create more steps where things can stumble. Next slide please.

Also make a point is to take the level of professionalism that we have in the room into the telehealth encounter first started with privacy, personal experience I did a telehealth visit with a clinician, last year, and really floored within the first minute I saw three people walking behindher, you imagine that

interfere with the privacy a bit so it's just important to still be respectful with that and making sure you're not having people walking behind you, disrupting that patient encounter, hopefully you're in a office in line. Support is still try to look like a clinician look professional, on this working from home. We're not all of us, but a lot of people working from home. Pandemic it's definitely I think more tangible. It's not a big challenge for me since I'm doing most of my telehealth visits at my office but for my, for some of my colleagues to do a lot of telehealth visits at home at least try to wear a hospital badge or a stethoscope or white coat just something that still says, I'm a clinician that's even more important for patients who don't have a relationship with also important for giving the patient a good experience. Just having a clean, uncluttered background, not too many distractions. We'll move to the next slide.

And I'm showing this screenshot, not, not as an example of what to do, it's really easy not to do. I was this was a telehealth visit I was doing in January. The patient I knew really well, and she was smirking though DOM eventually started to giggle and I had to say hey, time out, what am I missing. She said, Doctor, maybe you have a tiny hat on your head. And so I asked her to send me a screenshot and we both had a good laugh at that you see that tiny hat on my correct back there. But as you can imagine after that visit a mood that hat. Next slide please. Part of just giving good service. It was just trying to keep the visit as much like an in person visit as possible. We all have develop skills to make patients feel comfortable with us in our office, make them feel at home. You just want to take as much of that in, try to continue to use friendly body language, try to do well with eye contact and under eye contact with the camera, not necessarily the patient's image on your screen, or the next slide please.

Did a few thoughts on just making it easy on yourself. you know, I made a mistake early on, being the first person to jump on the telehealth visit or the only person to jump on the telehealth visit, I found myself having to do all the medical assistant duties of updating the med list, and getting the BIOS updating the chart. Change that pretty quickly and so our workflow includes just making sure you have another staff member, prepare the chart for you ahead of time, make sure getting contacting the patient ahead of time either on the tele visit or by phone. Also train my staff to make sure they're setting time expectations with the patient. I just don't think twice about waiting 15-30 minutes to see us. When they're in our office in an exam room, but they're not near as patient with tele visits and I've had a number of patients, cancel the appointment after waiting 15 minutes thinking I wasn't going to show up. Also, many patients after 10 minutes starts a new portal messages saying hey I thought I thought I had an appointment with a doctor. So then my patients, let them know if I'm running behind, I'm usually about 20-25 minutes behind. Thanks for waiting in the virtual waiting room I'll be there shortly. And that definitely helped improve satisfaction, patients from walking away from their smartphone. My staff also make sure to have a backup plan just like Dr. Boylston and we did I'm sure many of you on this webinar, about 20-25% of our visits have some type of technical difficulty connection so staff always kind of agreed with the patient agreed ahead of time that you're never going to convert to a phone call, FaceTime or Facebook Messenger, so we can just make that transition. Next slide please. Another a big difference. It just makes keeping it easy on yourself and improving the workflow in documentation is just having two screens, I've done plenty of tele visits with one screen and then I can do it but it is two screens it's three times easier right to have the patient's video on one

screen with the chart pulled up on the other. A great way to be able to chart easily go in and see everything. Doing that if you're the type of person who likes to chart a lot during the visit, right, it's probably a good idea to put the camera over the record, so that even though you're looking at the record look like you're looking at the patient. Also, also thought it was a good idea to let the patients know if I was looking away from the camera for whatever reason to say hey I'm examining your Ash now or a wonderful website so we didn't think I was checking my email or on my Twitter feed. Next slide please.

Just like Dr. Boylston said, it's important, it was very important to make sure I updated all these other things to help me get through my day efficiently, I use a lot of templates to help my charting but you know your template, we spent years, adapting those to our in person visits and they don't always translate exactly to a telehealth visit, so it's important just to sharpen that sword look at this templates, create one specific to televisits. Another barrier that makes that makes tele visits uncomfortable for a lot of doctors are just not feeling great about the physical exam. We all spend years in medical school and residency learning how to do good physical exams and nobody has really taught us how to do physical exams, through telehealth. But the good news is there's resources out there, one good one is Thomas Jefferson University School of Medicine has telehealth facilitator certificate customer $100 get to their series of webinars and go over what you can and cannot do on televisit well and work to documented. And the reality is you can do more of examine than you think. I'll go ahead and jump to the next slide here, and given the timeframe, this may be a good place for me to jump off just. We all because it's such a challenging year, and we've all been through a lot of change. But this is just, you know, this is just a reminder that when there's disruptive times there's also opportunity. Winston Churchill where he said never let a good crisis go to waste. This is a great time to innovate and try to take your practice to the next level. Our patients are online, more than ever now they want to service, they want to do self service online, they want to interact with you online, they're already doing it on telehealth. It's never been easier to say, hey, we've got to do things differently now. And this is how we're going to do it. Can you get more patients interacting with you online scheduling their own appointment rather than calling, reaching out for questions or concerns, rather than calling. It's a great time to innovate, move your workloads to the future. So I think that's probably a good place for me to stop again it's been a pleasure, presenting to you. I look forward to the questions.

Dr. Tom Wroth

Dr McNeil, Dr Boylston thank you so much, and we do have one question right before we go over to to Doctor man. So there's a question how are you navigating payment issues with insurances are you collecting co pays upfront or cash only. You only schedule for patients based on insurance that pays at the level of an office visit. How are y'all handling that.

Dr. Yun Boylston

I'm happy to answer that first, and then maybe Dr McNeil, would like to join in as well. I think I'm currently with in some of this might be just more temporary but we really have not had any issues with

receiving payment at the same level as you know like a typical 99213 or 99214 and so that's been a big plus for us. And, and I think there may be some changes coming down the way soon. But hopefully, you know the insurers will recognize the value of the service with the primary with primary medical home. In terms of payments. So the way that our current workflow is set up is that the, our front staff, contact the family. They make payment at that time and then they receive an email with the telehealth link for high deductible plans. And that's a little bit more challenging because sometimes it can be more, you don't quite know what the level of code is before you get there, but in general I think we target like a 99213, unless there's something exceptional about that visit. And we also, and we try not to do this but we also have the caveat that this may change but this is most likely what the what the cost will be.

Dr. Tom Wroth

That's great. I suppose and Dr McNeil. What about you, how do you all play in your workflow. How do you collect the co pays, and any other insurance issues you want to comment in.

Dr. Mark McNeill

Oh that's not too much different from Dr. Boylston, as far as getting paid payment, I mean, the insurances, have been paying at parity and we haven't had trouble up with this year. We're getting copays ahead of time either on the phone or when the patient logs on, for the tele visit my staffer in charge of that, you know, the picker, just a plug for the advocacy on pay parity, just couple days ago I was talking with legislature at the North Carolina General Assembly. 37 states have legislation legislative mandate a period he's working on, NC is not one of them but there is a bill in the House, working on it could be better. So, those of you who like to advocate, make sure you're talking to your, your legislators about this but in the days of pay parity right now and just getting the work that has to change. Super much.

Dr. Tom Wroth

Yeah, great. Well thank you both. All right, well, Doctor Mann, you're up.

Dr. Keith Mann

Great, thank you so much and those again are two hard acts to follow. Fantastic work doing COVID by both of the previous speakers. So my name is Keith Mann, I am a general pediatrician and vice president at the American Board of Pediatrics I oversee the continuing certification program. Prior to that I spent about 25 years in a couple of different children's hospitals, focusing my career on medical education, quality and safety and then your care of both ambulatory and hospitalized, general pediatric patients. Next slide please. So just a brief overview. Talk a slide about the American Board of Pediatrics, spend a little bit of time talking about our approach to COVID-19 and continuing certification, and then touch base on two parts of continuing certification, lifelong learning, which is, you know, we typically referred to as part two, and quality improvement, which we typically refer to as part four. Next slide please.

This is just a brief slide to share the vision and mission of the American Board of pediatrics and I wanted to highlight that improvement is part of the vision and the mission. And we want to inspire a lifetime pursuit of learning to improve child health, and then advanced child health by certifying pediatricians who are committed to continuous learning and improvement. And I think that was loud and clear. In the presentations that we heard today by Dr Boylston. So, this is a quick slide to share our initial approach to COVID-19. So in, in March or April when it was clear that pediatricians, were overwhelmed in different ways with COVID-19. Some were overwhelmed on the frontline of clinical care. Some were overwhelmed because financially there, they were concerned their practice wasn't going to make it, but everybody in some way shape and form was learning and adapting, and so the American Board of Pediatrics, thought that it was the right approach to recognize pediatricians for that work. And so in June of 2020 we awarded 25 Part Four points and 25 Part two points which is about half of what's needed for a cycle five year cycle for COVID learning and improvement to all pediatricians. Next slide please.

Sorry. Next slide please. So then to delve a little bit deeper into what what exists for ongoing COVID work. I'll start by just mentioning briefly some things related to part two are lifelong learning and self assessment. And just so for the pediatricians in the audience are aware we have a partnership where the with the ACCME, so any category one CME has the opportunity to count for MOC part two credit, there's two components that are important however one, there has to be an assessment of the person the learner, the physician engaged in that activity. And so for example if it's a grand rounds, or an hour of learning through a seminar or a lecture, there has to be some assessment either a multiple choice question or a self reflective statement that suggests the person engaged in learned. The second and, and I would say most category one CME already includes that. The second is that the activity has to be registered for MOC part two credit and what we're realizing is that a lot of CME providers aren't quite making this transition yet from registering an activity for Category One CME and also registering it for AVP MOC part two credit. The reason this is critical is because the information exchange where you subsequently get, get MOC part two credit happens in the background. You don't have to submit anything to the a BD, it happens through a data exchange that we have with the CME leaders at the ACCME. So the data exchange happens so if any of you work in CME departments or have CME providers that you're close with, Please be aware of this because, again, the goal would be for you to be able to get credit for any CME learning that you're doing on COVID to be able to get MOC part two credit as well. And I'll say this applies to using online resources, and the one that currently is up and running is up to date so you're learning about COVID and by reading about it in up to date or applying it to your patient care, real time by looking up things and up to date. You can get CME credit for that, but you could also get MOC part two credit for that. So we're trying to do things that make it seamless for you to get credit for learning, related to COVID and then, this obviously applies across other other content as well.

So the other two things I mentioned briefly, we have a decision skills activity that decision skills is case based learning. It's available on through your portfolio, go to adp.org log in and jump into your portfolio. And if you search, part two activities for decision skills it's there. We hope to release shortly, a 10 to 15

item decision skills question again case based, looking at physical exam findings and laboratory findings and X rays around COVID, so we hope to release that in the next six months or so. And then we did also, we have an activity called Question of the Week which by definition we released weekly. And next slide please. There, we released a question. In June of, 2020 on COVID there's more than one way that COVID-19 rears its ugly head, and then we release subsequently another one I Mis c and question of the week is essentially a question, followed by an abstract, followed by a 1250 word discussion of the topic, followed by a post test question which is the same as the pretest, followed by a medical pearl if you're so inclined to read a little bit further, we release it every week. It is a great way to stay on top of literature and a great way for general pediatricians to learn. And for each of these you can have an MOC point, which again seems like so small but you do these 20 weeks a year and the next thing you know you've completed your Part Two requirement and learned a tremendous amount along the way. Over 20,000 pediatricians are signed up for question of the week, and about 7000 do it with some regularity. Next slide please.

So switching over to part four now improvement in practice this on this slide are different ways that a physician could get credit for part four, and so many subspecialty physicians engage in multi institution or large scale QI projects, national collaboratives run by specialty societies or run out of the University of Cincinnati on very disease specific topics like inflammatory bowel disease. There are really not many multi institution or large scale QI projects available for general pediatricians, several state AAP chapters run really fantastic kind of QI network based projects, Tennessee and Alabama are two that come to mind but as a general pediatrician, it's a little harder to find a QI project that you can just join without implementing it yourself. So the second is around workplace based QI, and we would love for every pediatrician to get credit for work that's already being done in your practice. This can happen by submitting an application directly to us, we call it a ... or a small group qi application. One person submits the application and up to 10 others can get credit for it. So the application essentially is tries to meet the general minimal standards of a QI project. And so we do have a checklist on our website, and again I'm happy to share it afterwards if people are interested about what you might need to submit and so you don't do a lot of work and then don't have the critical elements that the application will be assessed against, but we have about 2000 people submit each year small group QI projects to us and about another 10,000 that get credit through their home organization sponsoring a small project like that, and that's by far the biggest way that pediatricians now get credit. You can also get credit if you're part of an NCQA patient center medical home, institutional, you're leading QI at an institution. And then lastly, we do have online performance improvement modules, but if you go back six or seven years about 24 to 25,000 pediatricians were getting submitting projects each year. Those online improvement projects, but, but we got feedback that there wasn't enough there wasn't enough for pediatricians to feel comfortable that they're doing meaningful work, it seemed to be a box check. And as we introduce more workplace based QI options that number has gone down to about 7000 So there's been a, you know, almost a 67% drop in the online performance improvement module submissions as people are shifting to getting credit for work that's done in their practice. Next slide please.

And so if you look at your portfolio, the box to the right of the red box that your QA project is where you would submit a small group QI project that you would like to do as part of your practice, but but during

COVID. It really we stole shamelessly from the American Board of Family Medicine who several months before us, implemented a small group QI application that was essentially based on COVID, and so you can actually click right on your COVID-19 improvement project and submit the work that you're doing as part of your practice for credit through the American Board of Pediatrics, and we've simplified the criteria, the small group project the most difficult criteria that we hear from pediatricians, is that we require three data points we require, not just pre posts we require some baseline data intervention post intervention data, and then either after a second intervention or some sustainability data. We've waived that for COVID and is only pre post because we know that so many people are rapidly implementing things and measurement is harder. So we did simplify the criteria for pre post for COVID improvement project. Next slide please. And then and then this is just a general format I didn't include the whole picture but again I want to thank Libby Baxley and her colleagues, the American Board of family medicine, we really copied this almost directly from them we tweaked it for for pediatricians, but for the most part it's it's almost the same application. And what you can do is check an area that you're, you are looking at and then fill in some general questions about what's the, what's the gap in knowledge, what did your project try to accomplish. How did you measure progress and what did it look like at the beginning, and then after your intervention. So it's a relatively straightforward application if you have the information it probably takes 10 to 15 minutes to fill out. We've had about 900 pediatricians applied through this pathway and about 93% had found their application accepted. Next slide please.

So that's it, that's a quick overview of what we're thinking about at the American Board of Pediatrics, both on a, on a bigger scale but also specifically related to COVID. I want to, you know, just briefly mentioned that and looking at the two presenters before that work is absolutely eligible for inclusion in the COVID pathway.You know, I think both presenters actually shared gaps that they identified in their practice interventions that were made, opportunities for measurement, both before the intervention and after the intervention, and really, both of those project did an outstanding job of describing improvement work even if maybe you don't call it that, and absolutely both should be eligible for COVID improvement pathway at least through the American Board of Pediatrics, so thank you so much for allowing me to be here. It's a pleasure. Thanks for all the work you're doing, taking care of kids and happy to answer any questions.

Dr. Libby Baxley

Hello, I will go ahead and pick up where Keith left off, I encourage Next slide please. I'm Libby Baxley, I'm the Executive Vice President of the American Board of family medicine. Prior to that I was at Brody School of Medicine as a senior, senior academic dean. And then previously at University of South Carolina before that. And as part of my role at ABFM I oversee our quality improvement and performance improvement activities and was really interested in sharing with you tonight some focus on that, more than even part two. And rather than using slides which would have really been a duplicate of what Keith did but with a different logo, because we do work so closely, our boards do and sharing information and ideas. I simply put up a for you to know that Brent has and the sponsors the program have a PDF that is multiple pages but you'll see the front page there, but in one sort of four page document describes all the different components of performance improvement and ABFM it, it has historically been one of the areas where we got the most complaints from people that you don't have

something that's relevant for me my practice is not traditional. This is too burdensome to do. Just, and I'm not sure what I should be doing. When I open the catalog, if you will and my physician portfolio. So starting several years ago we have made significant changes through our performance improvement efforts and I want to share some of those with you and I really focus on the more recent ones.

First is that along the lines of what he said, we really wanted to focus on credit for things that people already doing. But the goal of demonstrating that you're doing quality improvement for board certification is really to show that you can reflectively look at your practice or we can reflectively look at our practices, we can identify a gap in care we can develop an intervention with our team to try to close that gap and we can measure to answer the question, did this change result in an improvement. We don't require improvement to happen because we know that a single PDSA cycle doesn't always result in improvement, but it's, it's really demonstrating that you have the understanding and the capacity to do that. So there was no reason that we want any family physician to be going into their portfolio and picking up an activity that's in there just to do something extra for ABFM, that's, that's not the goal. And for that reason we developed a self directed pathway. About three years ago now, it was actually developed about five years ago but it only became functionally usable from a burden standpoint, about three years ago. And again, it's a very simple application you saw the sort of beginnings of it with what Keith showed, and we have found from talking to physicians who've submitted and measuring their time in the, in the portal to submit it that it really is around 10 to 15 minutes to simply tell us about something that you've done in your practice, or that you want to do in your practice. And you can start it and then come back and finish it. Once you've completed the cycle. The thing about the self directed activity is that it absolutely assures relevance, because the physicians doing that are picking what they want to do. It doesn't have to fit the other activities that are in the portfolio, it can be anything you want to do in your practice around care quality around processes of care around patient satisfaction. Any number of things. So relevance is there and we've really reduced the burden.

Beginning soon after March last year in April we quickly pivoted using the self directed activity because it had been successful, and developed a COVID specific self directed PI activity and have tried to promote this in a variety of ways and numerous ways, actually, but understanding that it's, you have to communicate 1000 times 1000 different ways but peculiarly when certification is a just in time sort of activity that people engage in, and then you're in the middle of a pandemic. But we've had over 11,000 submissions now that the COVID PI activity, and, and certainly are getting more and more every day. And we've said to people with this particular activity that we are less concerned about baseline data in fact from for most people the baseline was zero. In terms of, it's something like we've heard about tonight with pivoting to to virtual visits. Not everybody had already had virtual visits in place to begin with. And so, we just said, Look, we, what we want is for you to tell us what you did in your practice in response to the Pandemic. What did you need to do to provide high quality, safe care and to care for you and your staff at the same time, and, and they, there was follow up data requested and provided. And then we added a question about what they learned about in the process, which isn't normally in the performance improvement self directed activity, but since we weren't as heavy on the data side for self directed.

So we have, we're now looking at that data and seeing the, the plethora of times that people worked on it. Of course in the first months of this, the vast majority were virtualization of practice. And yet at the same time we have a physician hospitalist we had folks who were choosing to work at the community level, setting up testing sites setting up ways to screen patients, even for sick visits in the parking lot without having them come into the building. There were just a variety of creative ways that people chose to deal with this and some of it depended on their geography and the penetration of disease at that time. And the fascinating thing is looking at it over time. And we're, we're analyzing this data and what to ultimately report on what was the natural history of practice change among family physicians during the pandemic. So now we're seeing more about how do I incorporate virtual and in person visits, how do I go back to some in person visits which many have done and you all described tonight, very nicely. And, and keep some virtualization, goodness knows we wanted to have virtual visits I, I can remember for a decade now trying to advocate for virtual visits and all it took was one pandemic for everybody to realize that we could do it, we could do it effectively, and hopefully we'll continue to get support for that. So we're going to analyze that and and show what happened to the pandemic over time. This is, this remains open. Anybody can use it. Any of you who are here tonight and have not taken advantage of the COVID pi activity. You can submit one a year. We've had people submit last year for virtualization and this year for vaccines for example. And you can also submit within the same year if you have two different aspects you want to report on. Sorry. Using the COVID PI activity for one and the self directed for the, for the second.

Then finally, I'll mention that we also utilize the self directed to develop a health equity PI activity that's occurred. Soon after the murder of George Floyd, and a number of diplomats contact us, contacting us saying, I want to do something and I don't know what to do. I need help, and some direction on how I can do something, practice to help address this. So this was the first self directed activity where we actually provided references and resources. So links to screening tools for social determinants of health and your practice. Links to ways to assess implicit bias in your practice and do something to identify and address that and for the practice to come together around that issue, But, anything could be selected and we now have a couple 100 of those it's takes a little bit longer to do it wasn't the sort of automatic. We've all done this the way, COVID was. But we're really encouraging people to also think about that, it's, it's, it's become such an important part of what we need to do in our work as as physicians and have a lot of ideas that we can share with you we want to catalog some and get the news out there because a lot of people still say I'm not sure what I would do for that so that's that should be coming up soon. And I think this gives us more ideas about how to take contemporary issues that physicians are dealing with, and put those as specific PI activities for them to be able to submit for certification. And I'll stop there because I know we're getting late on time, but be happy to answer any questions as others have said,

Dr. Tom Wroth

Dr Baxley and Dr. Mann, thank you so much and is really what a great combination of presentations and I think one of the just a quick comment I think one of the really positive things come out of the last year, it's really the innovation and I think we've sort of heard it on all fronts. And it seems like the boards were starting to go in the direction of doing the PI on things that were relevant and practice and then COVID hit and as Dr Baxley said there's just a number of opportunities there. Dr Boylston and Dr. Neill I'd

love to just, you know put you on the spot a little bit but as you're doing your maintenance of certification activities are two part four. Have you all gone this route or has has tonight changed what you might do in the future.

Dr. Mark McNeill

Actually, before you logged on Tom Dr Baxley was asking me the same question and my answer was No, I haven't found that route but I think it was worth my time to learn that I can't, so like we will be shortly.

Dr. Yun Boylston

Yeah, great. I would echo Dr. McNeill's, answer as well, you know, unfortunately I haven't been staying completely on top of my MOC but I know that it's you know it's kind of getting to that point that Dr Mann's comments were very well received and appreciate your support, appreciate your support for recognizing and valuing the relevant work that we're doing, and the meaningful care that we're providing in our own way so to me that's very heartening.

Dr. Tom Wroth

Thank you. Right. Well, I'd love to take up a couple of questions from the, from the presentations, I'd love to ask you all few things and to Hugh, please jump in as well. One of the things that around telehealth I think there's a few things and, and we both touched on these. So one of the issues is around the digital divide, and Dr. Boylston and you talked about that a little bit and you know I was really fascinated to hear about Dr McNeil's practice and how it's really focused on the portal. Only and maybe Dr. McNeill if you could just comment on, you know, so you've got the 25% of people that have technical problems but what is your practice done to, to address this and what are your observations around this digital divide, concern. Sure.

Dr. Mark McNeill

Of course I'm very obviously led here my enthusiasm for getting patients on the portal but I wouldn't be naive, that still exists. I mean I will comment that a lot of folks, I don't think the digital divide, I think, maybe, most people, more of the patients will use portals to log on to telehealth than you may think. I mean I've got, I think, my oldest patient logging on for telehealth visit is 88, you know a lot of a lot of my grandparents have been emailing, their grandkids for years, the grandmas they figured this out, that's how they stay in touch with the grandchildren. It is adults Medicaid adults when our surveyor asked you when you get online if you can access your doctor they say they say they want to, and they will, and there's plenty of medical literature saying that, that if you give them an opportunity, they will so I guess I just want to push back a little bit I feel like some people use it as an excuse not to innovate. And I don't think it needs to be I think you can still reach a lot more populations, using this technology. That being said, the digital divide still exists, these systems aren't perfect. So you got to be aware of that in my office will be 15% of my patients still, I mean just, this is to me barriers, this is this is not going to

happen. So, either way, but in their, in their the way I look at it. I mean, I try to get those, those patients still benefit indirectly because I can get all these other patients online tele visits portals and otherwise, it allows me to be more efficient when those patients are in my office I can give them more time and I have more time for care management and case management. You know, we're trying to get those patients before it was really difficult. So, those patients, you can still make you may not necessarily be able to reach them but you can leverage what efficiencies you're getting from using the technology to them.

Dr. Tom Wroth

Great. Thank you. And Dr. Boylston, I know you're practicing a lot of work in the community a lot of, you know, focused on health equity and this there's this issue around the digital divide or how have you all approached approach this and what's been your experience.

Dr. Yun Boylston

You know that's um challenging because even in our area, you know we have children who unfortunately we're not able to even do remote learning, you know I have a little girl who in the evenings after she after her mom came home from work would drive her to the local ... station, so that she was able to get Wi Fi access. And we have a lot of parents who actually will drive to a location, and have the telehealth visit inside the car, because their signal is better. And so that's definitely something that we feel, I know statewide there's a tremendous support recognizing that that access to broad to broadband is a healthcare issue. And so I really hope that the momentum is there to continue to improve access, because I think that disparity is really going to become more, you know, more stark. Over the next decade.

Dr. Tom Wroth

Yeah, and especially, I think we're all of you are saying. This is here to stay, it's gonna be part of our workflow and so those issues are going to be here, here as well so, so just got a couple minutes I'd love to ask Dr Baxley and Dr. Mann if there any things kind of coming up for you or any kind of New Directions for the boards. I think you kind of articulated the approach around experiential learning and. And your response to the your diplomats and others but anything else you want to bring to the audience.

Dr. Keith Mann

Yeah, sure. All this is Keith, with the AVP, I'll just mention a couple things. So we're going to continue to find opportunities for physicians to get credit for work that's happening in their practice, but then we also want to help that work along, and one of the areas we're working on right now is in health equity. And so, people who have done a small group QI application recently will notice that we asked a question about whether or not you stratify your data by race or ethnicity. If you answer yes there's a series of

questions that asked you, what did you learn. And if you answer no, there's a series of questions that just try to understand why and what the barriers are. We're going to take that information and apply it, share it back with pediatricians and then make subsequent improvements that we hope can help pediatricians down this pathway. The over the next year, we'll have an application for part four, and instead of doing a QI project we'll be setting up the infrastructure to measure, race or ethnicity in your practice and then meaningfully utilize that data. So a lot of work to close the gap between the idea and the eventual implementation, but the hope is that if you have never measured race and ethnicity in a meaningful way before, we'll help you get from point 0 to point one. If you're, if you're measuring it but not confident about your data. We'll help you get from that that point to doing some data validity to make sure you feel good about the data you're collecting, and if you're already collecting the data. We want to be able to help you better analyze and meaningfully utilize that data. It's a, it's a long journey, but over the next year we hope to accomplish a lot in that arena. And then the last thing is around health equity as well. We will hopefully launch relatively soon a QI template which is a really low tech way it's a low tech QI application, around food insecurity, which we know is a problem throughout the country and if we can put some evidence based screening and resources out there, we'll have a food insecurity, QI template available for people as part of their part for work, hopefully people engage in that.

Dr. Tom Wroth

Great thanks Dr. Mann, and Dr Baxley anything you want to add here towards the end,

Dr. Libby Baxley

Just a couple quick things because I know we're at time, we will be over the course of the next six months, incorporating health equity into all of our PI activities are all that. That would make sense to do so, again, sort of riffing off how pediatrics is approach this. In addition to just the health directed in the health equity self directed PI focused. PI activity, we'll be incorporating that so that that people can start looking at their practices from that angle, regardless of what they're doing for improvement. We also will have a health equity KSA or self assessment activity that we hope will come online by the end of the year. To begin with, around what we used to call part two. And ABFM in the knowledge self assessment and lifelong learning. We chose to not jump in with COVID on that because things are changing so fast and by the time we'd get an item out there it would change. And we'd get feedback that from people may have said, you know you're not keeping up. It's already changed. So, we have now started to incorporate COVID COVID knowledge items into all of our activities KSA our continuous knowledge self assessment part two activity. Our, our longitudinal assessment so you'll start to see some of those more integrated fashion. The only other big thing is not about PI or part two but our longitudinal assessment as the option for avoiding the one day exam now has been formally approved by AVMS and we're no longer will be in a pilot, so that'll be an option for all family physicians going forward when it's time for their exam to engage in and FMCLA longitudinal assessment instead. And if anybody wants information about that there's a bunch on our website, I'm happy to follow up with you afterwards but it's been a game changer and the most common thing we're hearing from people is wow I'm learning as I'm being assessed, and that's been, that was really the intent, and so we're pretty excited about that.

Dr. Keith Mann

Great, thank you. I want to personally thank you for that mine is coming up. Thanks so much. Here we are at 7:03 What a great set of presentations, do you want to close this out.

Hugh Tilson

Thanks Tom for great job, asking those questions, Dr. McNeill Dr Boylston thanks for just wonderful presentation about the great work you're doing. Dr. Mann Dr Baxley thank you so much for making time to be with us and I just would be remiss if I didn't welcome Dr. Baxley back to North Carolina, and asked her to please give our warmest regards also to Warren Newton, who we miss, and I'll just leave it at that and thank everybody for their time this evening so thank you all so much. Take care everybody.