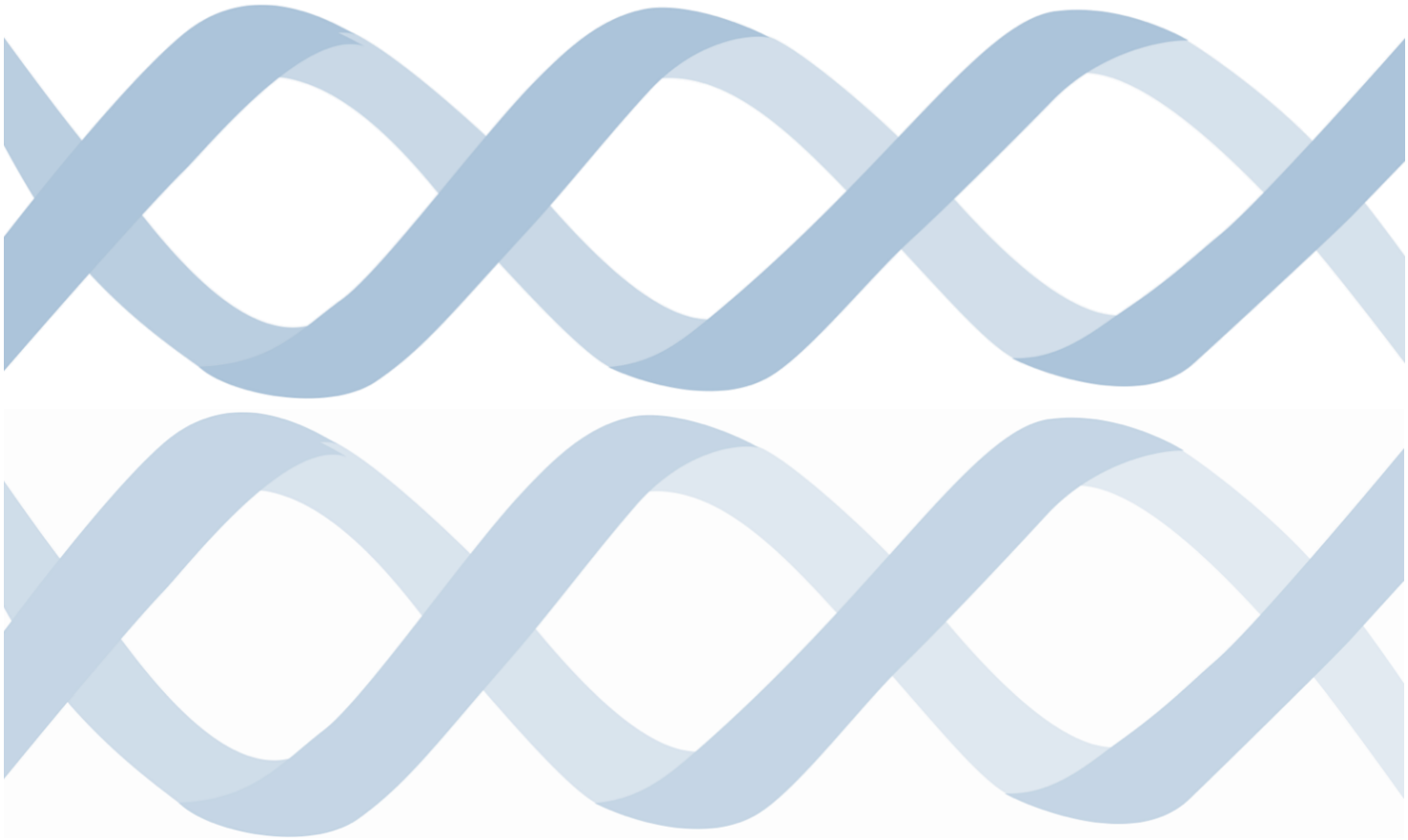
ROCKELIS PARTNERS



REVISE, ADJUST, ADAPT... REPEAT

11 STEPS TO TRANSITION A SMALL MEDICAL PRACTICE TO TELEHEALTH

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Introduction

This document's purpose is to map changing a psychiatry clinical practice from completely face-to-face to telehealth in a short timeframe. Most of these changes were implemented in three to four days, due to COVID-19 Worldwide Pandemic.

We run an outpatient mental health clinical practice, in San Juan, Puerto Rico. The clinic operates with one psychiatrist, three psychologists, two secretaries, billing companies and administrative personnel. Each clinician runs their practice independently but share office space, office equipment and pool resources to contract administrative personnel (admin team).

Facing the threat of the COVID-19 pandemic, we found ourselves with the challenge to eliminate almost all face-to-face interactions between patients, providers (doctors), suppliers and admin team.

In the beginning, we were uncertain about the design and implementation of a telehealth workflow. However, the process we implemented (described in this reading), yielded positive results relatively quick. Within two weeks, the clinic was operating at its target patient volume.

This document is organized in the sequential steps we followed to complete the transition, from initial assessment and planning to actual implementation. There are also some ideas that we did not implement but can be useful in different circumstances.

Despite having some overlap between steps, we found excellent value by following the sequence and avoid jumping steps. In other words, finishing step 1 before starting step 2. That discipline helped us to stay organized and to use our resources effectively.

Step 1: Understand the Tools Already in Place

Before rushing to buy a telehealth software or subscription, we took a close look at our practice. First, we identified the agents that were fundamental for the clinic's day-to day operation and classified them as internal or external.

Internal agents are our co-workers, such as: admin personnel, psychiatrists, and psychologists. For the internal agents, we identified the role of every person working at the clinic and listed each persons' detailed tasks.

To create this list, it was essential to involve our admin team.

External agents include patients, suppliers (for example: materials suppliers, electronic billing intermediary, billing company, electronic health record company), health insurance companies, and everyone else that interacts with the clinic daily. Our goal was to understand how our interaction with each of these agents was, and how it would change, due to our transition to telehealth.

Step 2: Identify What Needs Adaptation

Once listed, each person's task was classified into three categories:

a) Electronic Processes – no modification required

These are tasks or processes that should not change either in an in-person practice or using telehealth. In the clinic, some processes involving Electronic Health Records (EHR) and data transfers to the billing agency did not change. Everything else changed somehow.

b) Electronic Processes –modification required

These processes are already done with some form of telecommunication tool, such as email, fax, and telephone. Those tasks or processes may only require slight modifications in order to transition to a telehealth practice. For example, re-routing phone calls, assigning email accounts to administrative personnel, making the email available on their mobile phones, and receiving fax communications electronically. Some providers using electronic health records (EHR) offer HIPAA compliant email services for their clients. So, if you have electronic health records, you might opt to receive fax communications through their messaging systems.

Tip: Be sure to notify changes in communication medium (e.g. from fax to secure email) to the people that usually reach out to you in such way.

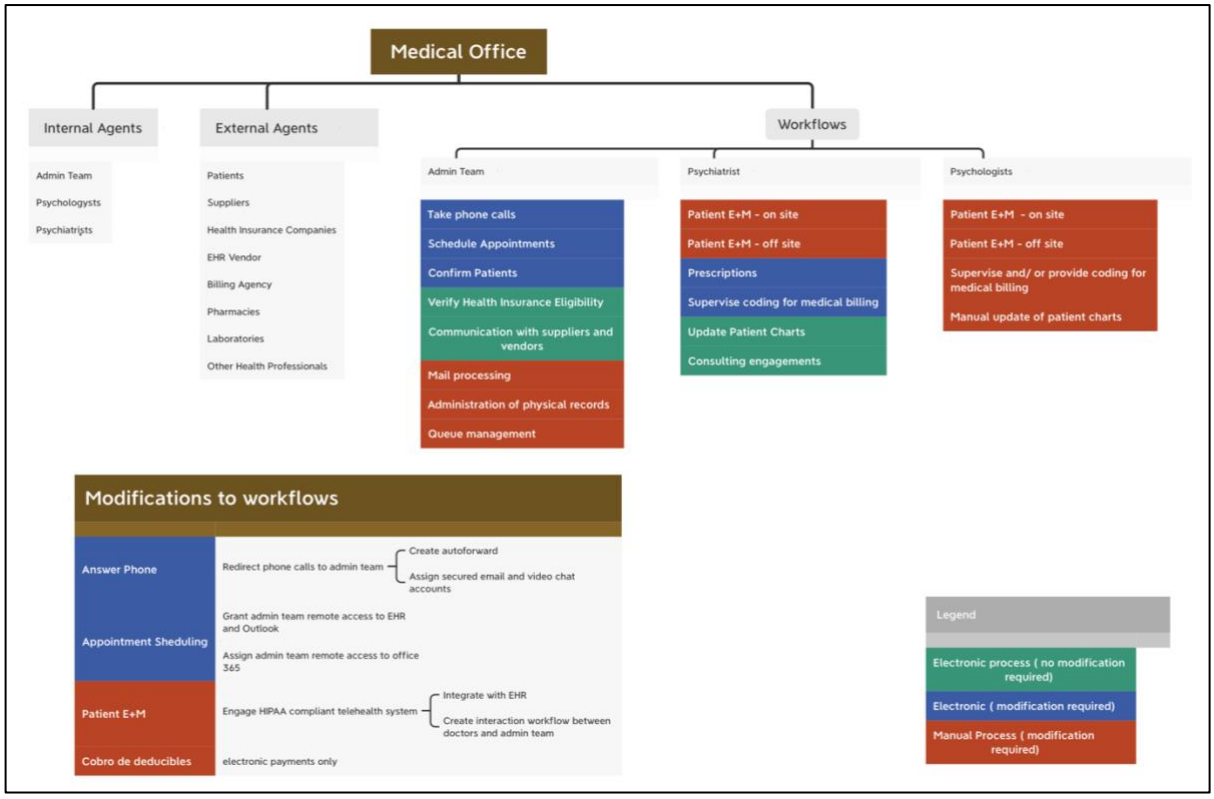
c) Manual Processes- modifications required

These were the processes we aimed to minimize or eliminate. In our case, most modifications revolved around what happens during a patient's visit to the clinic. From the exchange of documents with admin personnel to the presential meeting with the doctor.

Mind Map

To make this exercise easier, we developed a diagram with the agents (internal and external), workflows, and target modifications. The diagram helped us visualize the concept from a broad perspective. You can use the image below as a reference.

FIGURE 1.



STEP 3: MAKING AN INVENTORY OF EQUIPMENT

Then we made an inventory of the computers and telecommunications equipment we had at hand. We were as specific as we could. From quantity of telephones, printers, computers, fax and the like. Next step was inquiring what equipment was adaptable to a remote workflow. For example, we learned how to forward patient calls to admin personnel, enabled remote printing, and looked for alternatives to receive faxes electronically.

We also made sure that people working from home had the right equipment. That is, making sure everyone working remote had a functioning computer or tablet with internet access with adequate speed for both telehealth and EHR, mobile phone reception, and a private place at home for proper interaction with patients, suppliers and between coworkers.

STEP 4: BUDGET

The budget is like an inventory of monetary resources available to implement the project.

We expected that the transition to telehealth was going to increase expenses while receiving less income, at least temporarily. Expenses included then engagement of telehealth vendor, software licenses, legal expenses, and purchase of computer equipment. In addition, patient flow in the office started to dwindle for some weeks

before the lockdown, which meant less revenues. Also, we made the decision to shut down the office and start the telehealth transition a week before quarantine became mandatory (zero revenues for 4 days).

We kept in mind that the clinic was going to receive less income at least during the transition period and made it clear since the beginning, not to make any reductions in payroll, especially to our admin team.

Budgeting the increase in expenses was relatively simple. For instance, we decided a maximum amount to spend in telehealth subscriptions ($100/ month), software licenses ($100/ month) and equipment ($2,000). Then we asked our billing agent to walk us through the revised codes for telehealth to project how the income was going to be affected.

Tip: That simplified budget also helped to simplify decision making, especially when shopping for EHR, electronic equipment and telehealth systems. For instance, HIPAA compliant telehealth systems are not THAT different (almost all consist a secure video chat with secure file transfer capabilities). By simply cutting options that fall outside the budget, you can save time and simplify choices.

a) Cutting down expenses

To cut some cash outflows, we contacted the banks and suppliers to apply for any possible moratory, deferral, stand-still or payment forgiveness (both personal and business related).

We took an extra-protective approach and were extremely aggressive by reducing expenses to keep a cash reservoir during the crisis. As we are facing a health crisis not seen before during our lifetime; we also are uncertain of how long it will last, we prepared for the worst.

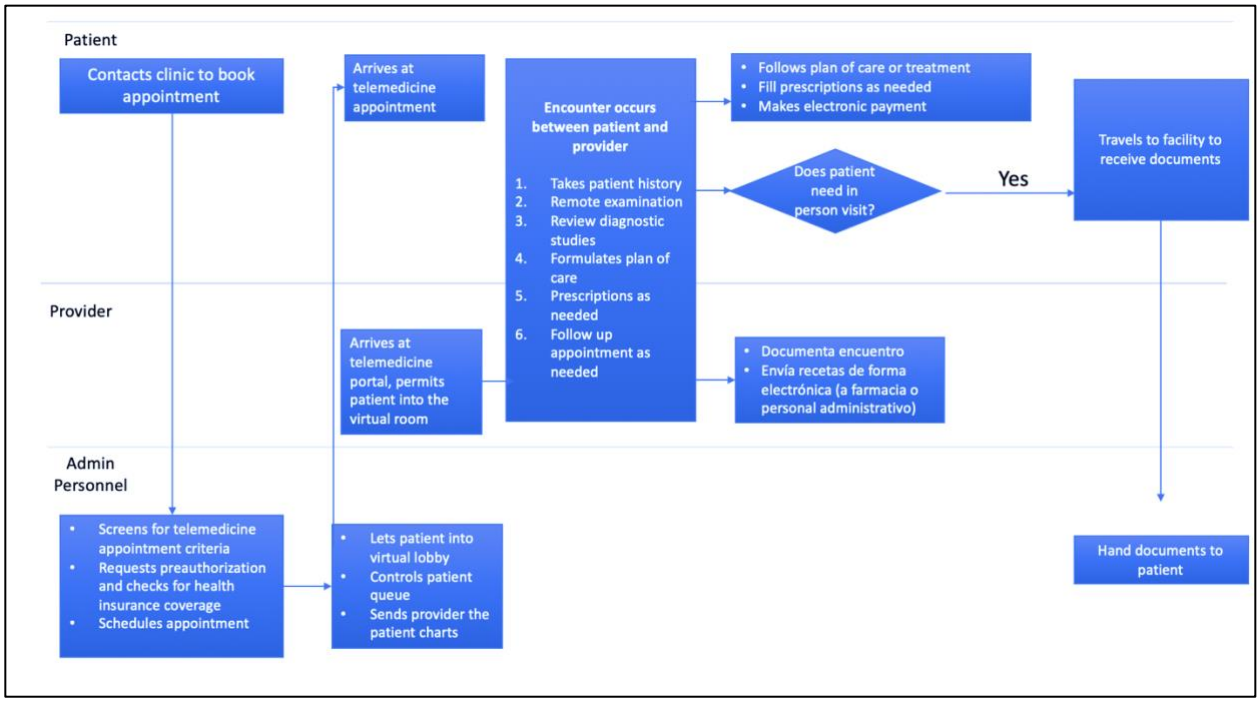
Step 5: Create Telehealth Workflow

A visual map of the office's workflow simplified our understanding of some processes, especially the sequence of events that makes up the patient's experience. It also helped us identify what interactions needed to change in the transition to telehealth.

We did not reinvent the wheel here. A Google search of "telehealth workflow maps" prompted us many examples to use for refence. We used a template published by the American Academy of Pediatrics[1] and adapted it to make it work for our practice. (See Figure 2)

[1] https://www.aap.org/en-us/_layouts/15/WopiFrame.aspx?sourcedoc=/en-us/Documents/telehealth_template_swimlane_workflows.docx&action=default

FIGURE 2.



a) ELECTRONIC HEALTH RECORDS (EHR)

Operating with EHR before the transition to telehealth was the most powerful at our disposal, and certainly eased the process. EHR systems not only store patient's medical information. Many EHR vendors also have the ability to integrate important parts of the clinic's workflow, such as billing, prescriptions[2], laboratories, imaging, and most important of all, patient visit scheduling.

Tip: An essential step in transitioning to telehealth is to understand the capabilities of your EHR system and reap benefits to the fullest. Look for video tutorials in your vendors webpage, blogs of other users of the same systems, or just call your vendor's customer service department. Understanding your EHR capabilities will shorten your learning curve significantly. Also, it will help you take the most of your EHR and what you are already paying for.

b) PATIENT APPOINTMENTS

We were using our EHR's schedule capabilities to book patients before the transition to telehealth and saw no need to do major changes to the process. We made sure administrative personnel had access to book appointments and make changes on doctor's schedule.

[2] Except for some DEA regulated medications.

Tip: Some EHRs also have automatic confirmations or schedule reminders by email or text messaging, and some allow patients to book appointments by themselves. This may save you and your personnel some precious time and effort. Also note that you may be already paying for the service.

Tip: If you don't run your practice with EHR, at least make sure you use an electronic scheduling tool, such as Microsoft Outlook or Google Calendar, that not only helps you to organize, but also lets you give access to your administrative personnel or nurses to your schedule. Be sure to grant permission to authorize personnel for them to book appointments and make changes in your calendar.

c) Patient visits to the clinic

We defined patient visits as the sequence of events that involve face-to-face interaction between patients, providers, and administrative personnel. The list below has examples of some interactions. Note that the list excludes interactions that cannot be replicated with telehealth, such as physical exams and medical/dental procedures.

Patient interactions with administrative personnel	**Patient interactions with provider**
– Handing health insurance cards – Handing cash, checks or credit cards – Exchange of forms such as informed consents, insurance claim forms and patient agreements – Handing prescriptions and medical certificates	– Patient evaluation, diagnosis, and treatment – Medication management – Analysis and discussion of laboratories and imaging results

d) Interaction Between Provider and Administrative Personnel

Theses interactions change dramatically, especially if both the doctors and admin team used to be in the same office and now will be in separate locations. We underestimated how important this was, and it brought us challenges, especially during the implementation of the telehealth workflow.

The main challenge was (still is) to replace face-to-face interactions and at the same time avoid message clutter or not communicating important things between coworkers. The importance of coworker interactions became very notable when coordinating the patient queue during virtual visits.

We recommend that, to the extent possible, coordinate how to use the available communication mediums and for what. For instance, sometimes email is effective to communicate a message, but a text, chat or phone call can be better in some situations, depending on message length, timeliness of required response, and sensitivity of information.

Step 6: Integration with Electronic Ecosystem

a) Cash Billing

Cash billing is one of the areas that looks radically different after our transition to telehealth. we were a bit reluctant to stop accepting any form of physical payment, but the COVID-19 crisis forced us to migrate cash billing entirely to electronic methods. Our goal then became to cut interactions such as having cash exchanging hands, or physically processing a check or credit card.

There are options to continue to collect payments with the same methods as with an in-person practice, such as cash, debt cards, credit cards, or checks. Systems such as Stripe, PayPal, ATH Móvil and Venmo provide easy to implement solutions, but may involve some transactions fees. Some EHRs and telehealth systems that also integrate payment collection capabilities.

Some patients were hesitant to make payments in such forms, either because they don't understand how to use these services or don't have a bank account. For now, we are only accepting ATH Movil (Puerto Rican version of Venmo) and, on limited circumstances, PayPal.

For patients that have credit cards or checking accounts, we considered to collect payments by phone and processing them with vendors such as Square and Paysimple.com, but we are not doing so at the moment. If the patient does not have a bank account, a possibility for him or her is to buy a prepaid debit that can be processed either by phone or online.

b) Insurance Billing

Billing insurance companies was somewhat easy to adapt because we used EHR before the transition to telehealth. With electronic records, there is usually a way to grant access to some areas of the patient's charts. Using the access, the billing personnel can gather the information needed to fill out claim forms, such as type of treatment, therapy time and billing codes. Our personnel were able to bill as usual, sending claims to insurance companies through an electronic medium accepted by the insurance company.

In case of manual records, the provider may create an excel spreadsheet with the information needed by the billing personnel and send it using a secure messaging system. If the providers fill the insurance forms manually and by themselves, he or she may complete the forms and scan them using a household printer/scanner or a mobile device.

Note: The changes and additions in billing codes, modifiers, etc., arising from the COVID-19 Pandemic, lead to a significant increase in the administrative and bureaucratic burden. Several insurance companies denied us payments and billing codes that would translate in receiving the same fees for telehealth that were paid in one-to-one encounters. Both, the increased administrative burden, and the decreased payments for telehealth services, made the office's financial and administrative

operation awfully hard to carry on. We opted to cease accepting most health plans in the shortest period possible. Otherwise, we most likely would be insolvent (and possibly in bankruptcy) within a short period of time.

c) Prescriptions, Laboratories, and Imaging

Our EHR system makes it relatively easy to integrate with laboratories and imaging (radiology centers) so we can order laboratories or imaging studies (MRI, CT Scan, X-Ray, etc.) electronically. If the EHR vendor and laboratory have the capabilities, the test results can be transmitted directly to a provider so the patient would not need to physically pick up the results.

The same applies to medication prescriptions, except when prescribing controlled substances. While allowed at Federal level, many jurisdictions (including Puerto Rico) do not allow for electronic prescription of controlled medications.

If you do not use EHR, you still can send order of laboratories, imaging studies and prescriptions either using fax, email, or even a mobile phone photo. Be sure that the laboratory or testing center accepts medical orders by electronic means. Also, it is recommended to receive confirmation by phone that the prescription or doctor's orders were received at the correct fax or email address.

Step 7: Choosing a Telehealth System

The criteria points we used to choose the telehealth vendor included: cost, ease of use, ability for integration with our EHR, and implementation time and ease. Some vendors insisted in scheduling a demo session before talking about pricing. Since we were on a short timetable, we chose one that had pricing information available and was ready to use. Since we were not sure if it was going to work, I scheduled calls with several other vendors to compare pricing and features. In case we found a better and cheaper Telehealth System or if we were not satisfied with the service, we considered the possibility of asking for a refund or negotiate a prorated charge in order to migrate to the better Telehealth System.

At the end of the day, I found some options with lower prices and some other with features that our vendor did not have. But neither in pricing nor features were enticing enough to go through the hassle of changing vendors. The main feature of most systems is a secured channel in which providers can video chat with their patients. During the Covid-19 emergency doctors may use non-HIPAA[3] compliant channels such as WhatsApp video chat, Google Hangouts or Apple Face Time[4]. We saw those options as a quick fix during the emergency but noted we would have missed some key features important to run the practice as we intend to. For instance, some vendors have the capability to

[3] https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf

[4] Facebook Live, Twitch, Tik Tok, or a chat room like Slack are not acceptable forms of communications, even during the emergency

create virtual waiting rooms, in which administrative personnel can access to send and receive consent forms, check insurance eligibility, and even collect payments. Providers can have the patient visits using video chat, manage patient queue, take screen shots and send/receive documents.

a) Patient disclosures and informed consents- This is important

We engaged in constant communication with our lawyer to ensure we follow patient disclosure requirements. We still pay special attention in how to incorporate patient disclosures into the telehealth platform and make the process as fluid as possible. At the time of this publication, we are still developing electronic forms to integrate fluidly with our telehealth workflow

Step 8: Dress Rehearsal

Once we set up the subscription for the telehealth system and had our computer equipment in place, we were ready to run some tests.

1. Enlisted our assistants, the doctor, and a mock patient.
2. Initiated a video call -simulation- between the doctor and the mock patient.
   - On the first try we were not even able to talk to each other.
   - After adjusting some privacy settings in both the phone and computer, we were able to run a successful test. One important setting is the device's microphone and camera.
3. Running more tests that included our admin team, the doctor, and a mock patient.
   - In this round, the main goal was understanding the experience. This was important in order to explain patients how this new virtual experience will be like.
   - It also was a good opportunity to play with some of the features, such as photo capture and file transfer. We also began to figure out ways to integrate the features within the workflow.

During the first three days we ran about fifteen to twenty test calls. We used them to familiarize with the system, stress testing (e.g. getting a bunch of mock patients in queue, taking calls from different devices, comparing mock sessions using Wi-Fi vs. cell phone data), and tried things we learned from blog posts and the instruction manual.

Tip: This is an iterative process. As we keep gaining more experience and learn how to work with the systems, we keep adjusting the workflow or change system settings.

Step 9: Communicating with Patients

Our admin team started to schedule telehealth appointments. They told patients that from now on, the doctor would be evaluating patients by telehealth, and explained them, how the process would look like.

To our surprise, most patients agreed with the changes in both virtual visits and electronic payments. A small number of patients were not willing or able to be treated using telehealth, but we were able to accommodate for most of them. Accommodations usually consisted in making phone calls instead of video calls.

We told our admin team to book few patients in the first days of implementation and increase the number of appointments gradually, as employers and patients became familiarized with the new technology. In our case, we booked five patients on day 1 and doubled the amount each following day until reaching our target patient volume.

a) Overbooking

So far, our patient not-shows declined significantly since using telehealth. Thus, we have not needed to overbook the doctor's schedule. Our strategy may change should the amount and frequency of not-shows increase.

Step 10: Going Live

The first day we received patients for telehealth appointments was like the dress rehearsal, but with more problems.

We had a Murphy's law kind of day. There was slow internet either with the doctor or the patient, confronted problems with video and audio quality, and the server crashed for 30 minutes (no kidding). There also was the stress that comes natural with every-day work at the clinic, plus the frustration of having so much troubleshooting on after having run several successful simulations. There was a point in which the doctor just switched to Facetime to finish seeing patients, while the admin team spent the day figuring out what went wrong, and what to do about it.

Tip: Have proper backup in case your telehealth system crashes, or telecommunications stop working.

After running updates on all devices, checking that privacy settings were set properly, running troubleshooting with the telehealth system vendor, and upgrading the system to the paid version (free versions are free for a reason), we saw light at the end of the road and were able to fix most of the problems we encountered.

The next couple of days went by much better. The devices were correctly set, we had a better idea of how to manage basic troubleshooting, and were more fluid explaining patients how to use the tool. Once the system was working smoothly, we paid more attention to interactions between admin personnel and providers, improving patient experience, and streamlining inefficient processes. It has been an iterative process, we are still revising, adjusting, and adapting.

Step 11: Revise, Adjust, Adapt ... Repeat

Every day that passes we find new opportunities, make new mistakes and bump into situations that call for adjustments in the telehealth workflow. As time passes, adjustments to workflow have been smaller and less frequent. Yet, it has been accretive for us to stay aware of how things can improve. Sometimes, minor changes can make a substantial difference in how a clinic runs. We have found opportunities to ease workflows, work more comfortably, and improve the experience of patients.

We meet with our staff, especially the admin team, at least twice a week to evaluate how things are flowing. We are focusing in fixing things that are either annoying or too difficult to do. In our experience with telehealth, there is usually a work around (so far).

Many of us are learning together how to work with telehealth, as the situation with COVID-19 forced us to embrace the change. The process of going digital might seem daunting and intimidating. It was for us. But at the end of the day, it enabled us to provide quality healthcare service to our patients and keeping them distantly safe.

We wish your health and success.

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