April Lewis (00:00):
See partners that you see on our screen. We are in communication now to determine what we should roll out for February, but we're keeping track of all the topics. Because we keep this open, I don't have a direct listserv to email everyone and say, "This is what we're going to talk about," because I wanted to minimize just the administrative burden on you.

April Lewis (00:20):
You can come to the same link every month and get on the call. Just stay tuned in and doing the calls to see what we're going to discuss, or feel free at any time to email telemedicine, I'm sorry, telehealth@nachc.org to see what the topic is going to be, and, again, to make recommendations. As you see on the screen, like I said, these are the partners that make these telehealth office hours happen. Special thanks to CCHP, HITEQ, HRSA, specifically the office for the Advancement of Telehealth, us here at NACHC, our colleagues over in the policy department and the Telehealth Resource Center.

April Lewis (00:56):
Today we're going to hear from Elizabeth. It came with rave reviews from May at CCHP, this presentation that she did on telemedicine, on the ROI. I figured this would be a good, especially since the health centers are across the spectrum on where you are with telehealth, having started, not considering it, all the way to have been doing it for quite some time regardless of reimbursement situations or not. With that, I'm going to hand it over to Elizabeth to take the wheel.

April Lewis (01:25):
Again, if you have any questions, you can upload them or enter them in the chat to the right of your screen, or you can send emails to the inbox, and I'll be checking it periodically. Elizabeth, it's on you.

Elizabeth Krupinski (01:37):
Great. Thank you.

April Lewis (01:37):
You're unmuted.

Elizabeth Krupinski (01:45):
Good afternoon or morning everyone, depending on where you are. How this talk ... Sorry. There's some feedback. This talk may be a little high level for some, but hopefully it will resonate with a lot of you. Next slide. Telemedicine, is it worth it? Is there a return on investment? Well, clearly I think it is...for a long time. I think sometimes when we're starting out with our telemedicine programs or trying to convince others to implement telehealth, telemedicine, that we might need to think of return on investment in different ways than what traditionally people might think of.

Elizabeth Krupinski (02:34):
Traditionally I mean your CFO basically, who's going to say, "What's the bottom line? Are we making any money?" Next slide. I think as you're going through and developing your telehealth plan, and business in parentheses, because in the end a lot of it really is ending up being business, I think you need to go through a variety of stages. This isn't only in your early stages, this is even when you want to expand your program perhaps, or take it to that next level.
Elizabeth Krupinski (03:05):
Without doing some of this, I think sometimes you get lost in the overwhelming aspects of telehealth and lose sight of really why you're doing it sometimes. I see the process really as going through a variety of stages. One of the ones that really sets the tone for everything is really to define your goals. A lot of times I find that this is the hardest part for people, because when you ask them, "Why do you want to do telemedicine?" Like, "Well, because it's cool. Because everybody else is doing it. Because we want to help our patients." All sorts of reasons.

Elizabeth Krupinski (03:47):
Those are really swell reasons, but they're not very specific. If you don't have specific goals in mind, you can't measure whether or not you're achieving those goals. Without that you won't have return on investment. Part of the first let of figuring out what your goals are is to review what's going on now. Why do you think telemedicine is going to be useful? Where is it going to be useful and so on? Review the existing conditions.

Elizabeth Krupinski (04:17):
We've been to a number of sites. I've been involved with a couple of telemedicine programs. We start out asking them, "Well, where do you think you're going to need telehealth?" It's like, "All our patients will benefit. Well, maybe it's just our neuro patients," and go down the line to figure out what's going on. Then you want to figure out if, why, and how those goals that you decide to do are actually going to be attainable and how you're going to do that. That's where the plan for reaching those goals is going to come in to play. Next slide.

Elizabeth Krupinski (04:53):
You can actually break down what I just talked about into a little more specifics. When you're identifying your goals, determine the basics. I'm going to go through a slide later on that shows you what that means. For example, don't let technology drive what you're doing. You have to develop your goals, and then decide on what technology you use. A SWOT analysis can also be very useful, in terms of figuring out, again, if you're very strong already in providing stroke services, maybe stroke is not the area where you want to first develop your telehealth.

Elizabeth Krupinski (05:36):
Perhaps where you're lacking is in tele behavioral health, or behavioral health in general. That's where telemedicine may help. Determining it or carrying out a SWOT analysis can help. Telehealth conditions, there's two approaches there. One is a readiness assessment, figuring out what's going on, because surprisingly at a lot of institutions people are doing telemedicine but nobody else really knows about it. You'll find these pockets of people who are already out there doing it, sometimes not even thinking they're doing telemedicine, just reaching their patients through technology. A lot goes on.

Elizabeth Krupinski (06:13):
You want to see if people are ready for this. By people, I mean your entire staff, your physicians, all the providers, your tech, billing, everybody, as well as your patients. Again, what services? Sometimes one of your services may need telehealth, sometimes it may not. When you're thinking about if, when, and how to attain those goals, a market analysis is also very useful. Figuring out what everybody else is town is doing in terms of telehealth or offering services.
Elizabeth Krupinski (06:53):
If there's a world-renowned stroke hospital two miles down the road, getting into the stroke business is probably not a viable idea. Find out what everybody else is doing. Also, assess the regulatory environment. Unfortunately this does change I don't want to say at a fast pace, but it does change, so you want to keep up on both federal and state regulations in respect of telehealth. Those barriers are coming down and it is getting a lot easier, but you still have to keep track of what's going on.

Elizabeth Krupinski (07:27):
Then in terms of reaching your goals, you need a strategy. In my opinion, integration is one of the hardest things to do. I think it's the most valuable thing to do. I don't just mean integrating, say, a telehealth platform with your EMR. I mean integrating telehealth into your daily workflow throughout your enterprise, to figure out how you're really going to make it happen. Plus, this clearly is important for return on investment, but, again, as I said, you may have to look at it in a slightly different way than just costs and benefits. Then having a solid business plan to move ahead with is always going to be useful.

Elizabeth Krupinski (08:07):
Next slide. In terms of what are your goals, like I said, the goal is simply not to provide telemedicine. There's a lot of different areas where goals come into play. These are just some of the them, the more popular ones. I mean reducing readmissions, reducing costs, patient education, improving outcomes, and so on. There's actually a really nice document from the American Telemedicine Association on a variety of metrics that can be used to create goals for telehealth and then measure them.

Elizabeth Krupinski (08:43):
If you're interested in that document, just let me know and I can send it to you. Because it really does a nice job of describing metrics, what to measure, and various methods to do so. Devising in advance what your goals really are is going to help you define that return on investment, because the return on investment from reducing readmissions is going to be a very different type of return on investment than, say, physician satisfaction or improving outcomes. Those don't necessarily have a dollar value attached to them.

Elizabeth Krupinski (09:20):
Next slide. Now, I promised that a couple of slides ago that I was going to show you a flowchart to help you decide what you're going to do. As you can see, what I've split out is what do you want to do versus the technology that you want to use to do it. Sometimes it is very easy to get sucked up into the coolness of the technology. You go to meetings and you go to the exhibition floors. They're showing you all sorts of wonderful technologies that can measure this, monitor this, send this information, do great video sessions and so on. That should not be what leads your program. You don't buy the platform first and then figure out what are we going to use it for.

Elizabeth Krupinski (10:13):
What I think you really need to do is figure out first what it is you want to do. Because what you want to do is going to drive what technology you choose. You have a lot of choices, and these are just some of them. Are you going to be doing emergency evaluations? Are you going to be doing treatment, whether that's behavioral health, whether that's a primary or urgent care, dermatology, ophthalmology,
whatever? Are you only going to be doing consultations, for example, with primary care providers, doing specialty consults? Are you going to be doing correctional services, or something else?

Elizabeth Krupinski (10:49):
Then decide to whom? Who are you marketing this to, in a sense? Are you marketing this to your physicians? Is telehealth supposed to make their life easier, increase their patient base? Or are you marketing this to patients? Are you doing in-home telehealth? Are you going to non-physician providers? For example, perhaps therapy, speech therapy or physical therapy or something. Once you go down this path and decide in a sense what are your use cases, then you can go and figure out what the technology is to do it.

Elizabeth Krupinski (11:29):
Are you simply going to do phone or email? Are you going to be doing video conferencing, remote patient monitoring and so on? Each one of the case scenarios or use cases that you pick may end up having a very different type of technology, and then that's going to guide your choices in that direction. Once you go down that technology route, is it through a facility or an established program? Who's going to be responsible for the technology choice? Are you going to go with just a piece of technology or are you going to go with a full platform that some of these companies are offering that integrates everything from the electronic health record, through the video conferencing system, through the peripherals that they can provide, and so on?

Elizabeth Krupinski (12:17):
At the very least, I think it's critically important to separate out, like I said, the technology from your use cases. Next slide. Now, once you get in to figuring out what you want to do and where you want to target, it's important to build your team. This is going to differ depending on every institution, depending on your specialties, who you're reaching out to, and so on. At the very least, you're going to have a core team, and those are usually a relatively small group of people, typically a clinician, someone who's informed about billing, somebody who understands the regulatory landscape, IT, and usually somebody who really has some experience in the telehealth arena overall, and possibly someone with an administrative background.

Elizabeth Krupinski (13:13):
That core team is going to really run the operations of your program. You're probably going to want other people involved, but they may be more on an ad hoc basis. For example, your folks in the various clinical departments. Somebody from government affairs. You don't need somebody from government affairs at a 1.0 FTE in your telehealth program, but you might want to put them on at .05 or .1 and you periodically may want to interact with them. Same thing with legal counsel. Financial services, you probably want somebody at maybe a .5 or .6, and so on.

Elizabeth Krupinski (13:55):
Then as you branch out, you're going to bring in the various providers, whether those are clinicians or ancillary health providers from the various clinical departments. Then at that very upper level, you're going to have your executive sponsors or basically who writes the checks for all of this, your C suite of whoever's at your health care enterprise who makes these decisions. It's a flexible model, and it really involves, like I said, people coming in and out as needed. You're going to have that one core team that really ends up running everything.
Elizabeth Krupinski (14:33):
Next slide. The business case, like I said, really depends on what it is you want to do, your goals. I think it's incredibly important when you're starting out to realize that telemedicine really has about a three to five year average time to ramp up to the point of return on investment. I think it's incredibly important to tell that C suite or the sponsor of your program that you're probably going to have very heavy cost in the beginning to get things going, because you're going to have to focus on infrastructure development and integration, and that you're really not going to see the types of return on investments that they're expecting usually straight off. It takes time.

Elizabeth Krupinski (15:26):
You really need to strategically prioritize what you're doing and to operationalize what you're doing. Our telehealth program in Arizona, we took about three to five years for us to ramp up. I've been here at Emory just over four years, and it's taken that much time to get to the point where we're purchasing a platform and implementing clinical instances of telemedicine. It really does take time. It's not an overnight process.

Elizabeth Krupinski (16:02):
Again, I go back to it in point number three here, the technology needs to be seamless. We need to integrate. You have to invest in a technology that's going to work for you. You have to figure out in advance what you want it to do. Does it have to integrate with your electronic health records? Does it need to be licensed from multiple sites, or do you just want one overall license? The use cases are going to drive the revenue and business case.

Elizabeth Krupinski (16:40):
For example, these are just different examples, but you might have an outpatient surgical follow-up, where an RN and their APP is the one providing the services. This, for example, would be used to increase the NPV per surgeon. Behavioral health outreach might have a very different model. You could use a flat fee per session. Specialty endpoint and inpatient consultations. That would be hospital follow-up or hospital NPV. Cash-based video business is something to explore.

Elizabeth Krupinski (17:16):
Do you want patients just to log on to a portal and provide their credit card information, and that's how you're going to do your video business. There's a lot of health care enterprises that are adopting that model. It's not just companies that are only online that are doing this. The e-visit model. Again, is it via cash or CPT? There's tons of models that you can do. The key point here is that whatever your use case is, it's going to drive the business model. Not everything gets reimbursed by insurance.

Elizabeth Krupinski (17:56):
You may have to adopt a cash model, or you may have to adopt something slightly different, a contract with an outside organization, perhaps. That use case really determines, some extent, the business model, and therefore the return on investment. Next slide. Now this is a document that was created not that long ago, September of 2019. I highly recommend it. If you want a copy of it, I can email you a copy of it. It was developed by Manatt Health Strategies, the folks are listed there.
It's a framework for evaluating ROI in telehealth. It's a really wonderful document that really provides you with almost a one step to follow type process. Next slide. These are just some of the tables in that document. This one provides and shows how the ROI considerations are going to be different for different types of providers. As you look, are you a community hospital, are you an academic medical center, your considerations, your goals are going to be very different depending on where you're starting from. What kind of provider are you?

Elizabeth Krupinski (19:20):
A primary care clinic is going to be very different from an academic medical center. I mean an academic medical center is probably going to want to provide specialty consultations out to some of their rural sites. The primary care clinic is going to want to perhaps utilize telehealth, the services of that academic medical center. The goals and the return on investment for each one of those is going to be very different, again, depending on what your organization is. Next slide.

Elizabeth Krupinski (19:51):
This table talks about some of the things that you should consider when you're setting up your goals, and then as you're actually implementing your program, what goes into calculating your return on investment. Your patient acuity mix is certainly going to impact your bottom line and your return on investment. As you change from, say, just following up patients where the acuity is perhaps less acute, to go to, again, just say a tele stroke or a tele cardiology program where the acuity is very different, that's going to change how you run your program and the types of patients you're going to get, and the type of reimbursement possibly that you're going to get.

Elizabeth Krupinski (20:41):
How you define your cost savings. Again, is it a redistribution of services? Are you saving on readmissions? Where are those cost savings actually going to happen? Is it simply reduction in travel? All of those are legitimate, but you have to know in advance where you expect to see those savings. Patient volume. Are you going to increase your patient volume? At a academic medical center, that's important, and it's important in a primary care clinic as well.

Elizabeth Krupinski (21:14):
Depending on what you're doing, can you really expect to see an increase in patient volume? Same thing, patient retention, reimbursement versus contracts, the technology, the staffing, and so on. All of these are considerations when you're thinking about return on investment. Like I said, for some of these, especially these bottom three here, technology, program management, and staffing, a lot of these are going to be upfront costs in that first year, sometimes up to three years, where you're not going to really see a return on investment. It will be after that once you've got all of this in place.

Elizabeth Krupinski (21:53):
Next slide. This one really shows the ways of looking at the financial impact. This was an example that they created looking at a tele cardiology program at a rural community hospital, and just the pre versus post-telehealth implementation. This is really where that baseline, figuring out where you are now comes in place. You can't show the impact of telehealth if you don't have that baseline estimate of what you've been doing for the past few years.

Elizabeth Krupinski (22:31):
That's why that first critical step of doing that SWOT analysis and looking at what your current situation is, is critically important to being able to create diagrams like this that will show these increases, either in revenues or costs. It's interesting, this is just a...but it really shows how you need to look at various aspects of revenue. It's not just going to be reimbursement, for example. You may have to look at more than one aspect of revenue or increases, and same thing with cost. What are your costs? It's not just the technology. You got to account for the personnel cost, and so on.

Elizabeth Krupinski (23:18):
Then from both of these diagrams, you can calculate your margins and your... Next slide. This one really, again, goes back to that other slide that talked about the acuity mix, the cost savings, and so on. Then it starts to provide the rationale and an estimated impact. This is a document or a template that you can use. Again, it's going along with that same example that they created, a use case of a rural community hospital looking at tele cardiology.

Elizabeth Krupinski (23:55):
This is something, an exercise, I think, that you really need to go through on your own, utilizing a chart like this. What are these main drivers that are going to drive your return on investment? Then spell out what's the rationale? Why are you looking at this? Then look at the estimated impact. As you're starting, even if you're expanding programs, sometimes it's hard to get at exactly what the impact is going to be. Again, it's an estimate, and you have to do a good faith estimate of what that might be. Because if you don't, the impact could really turn on you.

Elizabeth Krupinski (24:34):
If it ends up being more cost than revenue, that's bad news for your program, which is why you really need to set out in advance, like I said, using a template like this to really figure out what it is you want to do, what your goals are, and so on. Next slide. Now, as you're developing your budget, you can look at a variety of things. Again, they're templates and it provides you, again, with what you might want to do. Patients, right now you have 5,000 cardiology patients. What you expect with tele cardiology, you expect 5,300, as you can see. They estimated we're going to get some new patients. Plus we're going to have 200 of our existing patients utilize tele cardiology.

Elizabeth Krupinski (25:27):
They then look at the potential increases in revenue, whether that was because of a contract or because of reimbursement, or whatever. Then it looks at the costs, staffing, technology, program cost, et cetera, and looks at your margins, your directs and your indirects and your impact. As you can see, the change here is the difference between current and future state. If your enterprise happened to be this big, this particular example they were estimating a $1.6 million future state as opposed to what they had before. They created a model where they expect to see an increase in revenues, or a positive ROI.

Elizabeth Krupinski (26:18):
Now, those numbers would change. Is it realistic to expect 100 new patients, for example, in one year into your practice, whether it's cardiology, dermatology, or whatever? Would you expect 200 patients to be retained? That's where, again, the initial analysis of what you're doing now and deciding on what your goal is ends up being critically important. Again, is it reasonable to expect, say, 16,000 average revenue per case? It all depends on your use case.
Elizabeth Krupinski (26:53):
Again, this type of exercise and going through in advance what you think would be that future state is critically important. Next slide. Now, as you're going through this exercise of figuring out what you would expect to see, and especially when you're in your early stages, I think it's critically important to benchmark yourself and go out and compare yourself to other programs. Here at Emory, what we did is we went to a variety of other academic medical centers.

Elizabeth Krupinski (27:25):
We went to UPMC, UMMC, UVA, Jefferson, Dartmouth and so on. We asked them, "What are you doing? How are you doing it? If we were to do X, what do you think would happen?" We benchmarked ourselves. If you're a private practitioner, you certainly don't want to compare yourself to an academic medical center, but you can go out and find other private practice clinics who are doing telemedicine and find out what they're doing, how are they doing it. Use them as a model.

Elizabeth Krupinski (27:59):
I really encourage everybody to reach out to, for example, the TRCs, because they can help, one, put you in contact with folks they know that are equivalent to you, or at least the same model of operations. They can also help you with some of these benchmarks. Again, these are just some of the things that I think you need when you're starting out, the use cases, the core team, looking at who you need to have on your program, and so on.

Elizabeth Krupinski (28:31):
Next slide. Again, for your business case, you have to be able to measure what you're doing. Again, you really want to, when you're talking about revenue and costs, you really have to define them in a very specific way. We started out in our program looking at four main boxes that we said were important to our mission. We wanted efficiency gains. Our clinicians are pretty much slammed all the time, and their days are just getting longer. The expectations are getting more, for the number of patients, for example, that they've got to see. We want to increase our efficiency.

Elizabeth Krupinski (29:17):
Cost management is always important to everyone. We also want to expand our reach out to different new patients, and we want to increase access for our existing patients. Those are great umbrella goals. Then within each one of them, we got more specific. What do we mean by efficiency? Well, we want to directly impact the patient and provider efficiency. We want to make it easier for people to see each other and to get more done in less time, perhaps.

Elizabeth Krupinski (29:53):
Cost management, our goal there was reduced admissions. When we expanded our reach, we want to reach out to rural areas here in Georgia and provide more specialty consults. Again, being an academic medical center, that made sense to us. If you're a community health center expanding your reach, may not be that. It may simply be reaching out to patients who are not receiving services, that they already exist. Access is expanded coverage with your existing providers and partners.

Elizabeth Krupinski (30:26):
Again, what you decide here is your overall goals, and then as the specific things you want to measure are going to be different than what we did here. Again, this is an example of how you can plot things out and think about things. Next slide. We also then, like I said, got even more specific, in terms of what are our strategy areas. Where are we looking to implement and utilize telehealth to help? We created these strategic areas, and then possible program or case samples.

Elizabeth Krupinski (31:06):
Again, our goals over there on the left, cost reduction, revenue, access, and so on. Then again, we got a little bit more specific. For cost reductions, for example, using something called like an e-sitter for patients who require ongoing monitor, so like a babysitter almost, and what would that cost? Revenue generation. Can e-visits using messaging to care teams work? Would patients pay to be able to contact their care team on a random basis, rather than just during their regular visits?

Elizabeth Krupinski (31:42):
Access increasing to some of our rural locations, or even accessing, have patients on the other side of Atlanta, given the traffic flow here. Operational flow, video triage, and treatment for ED for low acuity cases. We provided, again, what is our strategic area? What are our goals? What is our mission within each one of those? Cost avoidance or cost reduction. Then we provided a different use case.

Elizabeth Krupinski (32:13):
What we then did for each one of these is start to build enthusiasm in our test cases. Next slide. We developed and we talked to a variety of clinical areas, and this is just some of the ones that are here at Emory. For example, cardiology, dermatology, our travel clinic, general surgery, and so on. We went to them and said, "Here's our mission. Here are our goals. Here's what we're going to think about. What is your specific use case?"

Elizabeth Krupinski (32:45):
For example, TravelWell, our travel clinic was looking for new and follow-up patient consultations. Endocrinology was looking for remote patient monitoring, and so on. We said, great, these are the use cases. We had clinical champions and administrators, but I blocked that out, because that's irrelevant. Then we asked them, "What's the revenue model?" What's important is not necessarily the fact that dermatology wants to do it by cash as does Travel. The fact that each one of these has a different revenue model.

Elizabeth Krupinski (33:21):
The key point being that as you go into different services, again, your revenue model is going to change depending on what your use case is. That's going to change your return on investment. Then that last column is expense coverage. How are you going to cover any expenses associated with implementing telemedicine? For example, cardiology said, "We have an existing FTE. We're just going to make them .5 telemedicine," and they don't have to worry about expenses.

Elizabeth Krupinski (33:56):
With in-clinic sessions for plastic surgery and TravelWell. Those would be reimbursed, for example. Again, it's a lot of careful planning and figuring out the use cases and the exact revenue model that's going to drive your return on investment. Next slide. Again, part of the exercise is to use, for example, a
template like this. What this one does is look at who's involved in your program, so, for example, medical director, your IT people, your project manager and so on.

Elizabeth Krupinski (34:31):
Then plot out, as you grow your program from, say, 10 patients, to 20 patients, to 30, to more than 30 patients in a particular use case, how does that change their FTE or their time on the program? In other words, the time that you're going to have to invest in them and cover their FTE. We plotted it out and got a total amount saying to our administration basically, "Look, we're going to probably start out here in this range of 10 patients. Let's be conservative. We expect our program to grow and create a return on investment, but notice that if we do that, time has to increase, the FTEs." That's going to cause some expense that has to be covered.

Elizabeth Krupinski (35:27):
Plotting out that it's a balance, and that as you grow, you have to take into account that you can't do things at the same FTEs as you used to. You may actually have to hire another IS network engineer. That's what we put at three. Between 10 and 20 we could do it with one engineer. We started to go 30 and more cases, we're going to need two. That's dramatically going to impact your expenses and therefore your return on investment. Next slide.

Elizabeth Krupinski (35:57):
Again, we completed the spreadsheet there, and looked at all the various expenses that are going to be incurred. Then for year one of our program, we said, "We simply cannot project what revenue might happen. It may very well be that there is no revenue." Again, it takes three to five years to turn a program on and get to that point of where there's a good solid return on investment.

Elizabeth Krupinski (36:26):
I think it's important to acknowledge upfront that that year one, maybe even year two and year three the return on investment or the revenue itself simply cannot often be estimated accurately. Unfortunately you can estimate what your costs are going to be, but that's the upfront investment in the infrastructure of the program that people have to be aware of. Next slide.

Elizabeth Krupinski (36:53):
Again, we put that previous slide into numbers, and talked about if for the 15 to 20 use case, which we expected would be in year one, maybe year two, this is what the program would cost in terms of simply getting the infrastructure up and running. That was just personnel. That doesn't talk about the platform or the technology that we used. That was a whole different aspect. Again, there's templates that you can utilize to figure that out too.

Elizabeth Krupinski (37:27):
In summary here, next slide. I hopefully stressed that I think it's incredibly important to define your mission and your goals really quite carefully, and really be as specific as you can in terms of your use cases, in terms of what you expect that revenue model to be, noting that it's not one size fits all. That expecting insurance to cover each different use case scenario may not be the best way to look at it. Looking at cash models. Looking at perhaps just working it into your traditional workflow and maybe not
even getting some revenue from a particular service. If there's no revenue but in the long run you prevent readmissions, that's your return on investment.

Elizabeth Krupinski (38:20):
Then you have to carry out your due diligence again. Really assessing your landscape in terms of what you're doing now and then what it is you expect to do in the future. Again, part of that is that market analysis, looking at what everybody else is doing. What's your competition? Can you expect to get 30 new patients per year if the shop down the street has all of your patients. What's going to draw them to you? Is telemedicine enough of an option?

Elizabeth Krupinski (38:49):
Develop those case scenarios, but not just clinical. Think about the operations. There's a whole nother presentation that I had that talks about how do you plot out what's going on. We literally have gone in and observed clinical operations now, and we create these diagrams of what happens. X does this, and the surgeon comes in and does that. Then the patient does this. Where does billing and everything come in?

Elizabeth Krupinski (39:19):
Then if you were to implement telemedicine, how does that change that flow diagram? Look at the operations, because it's the key thing, from my perspective really, is how well you integrate telemedicine into your existing operation. That involves personnel. That involves your budget, and so on. I, again, strongly encourage you to reach out to other programs who are doing telemedicine, similar to what you're doing, or planning on doing. Reach out to the telehealth resource centers in your area, and always, always remember, this is a process.

Elizabeth Krupinski (39:58):
Telemedicine and doing telehealth is not something that happens overnight. You pop the equipment in and all of a sudden you can do telemedicine. It doesn't work that way. You have to really integrate. You have to train people. You have to prepare people, your entire staff, your providers, and the patients, and return on investment takes time. It's not typically going to happen in your first year of operation. Going to take time to ramp up, get everything in place, recoup on that initial investment, and then you're going to start to see that return on investment.

Elizabeth Krupinski (40:36):
Again, it will be in a context of what you defined that ROI as, whether it's revenue, whether it's new patients, whether it saved time, whatever. You will have defined it in the beginning, and you will be able to measure it if you've done it properly. Next slide. Again, if you want some of those documents that I talked about, some of these templates, please feel free to reach out to me. Again, reach out to your telehealth resource centers and folks in your area specifically for more regional information. Thank you.

April Lewis (41:16):
Elizabeth, thank you so much for that presentation. Great, great, great information to look at it holistically before you even consider looking at technology, who to speak with. This was very useful. For everyone on the call, the recording and the slides will be updated. I put a comment in the chat. It takes a few minutes or a few days to get the recording sent. We can stick the slides up there fairly quickly, so
definitely before this time tomorrow if not by the end of the day today the slides will be made available. As Elizabeth so graciously offered, you can email her for a direct request.

April Lewis (41:54):
Elizabeth, I did have just one question. I was looking at the slide of the tables that are on there. Were those the tables that your team crafted internally, or are they pulled from somewhere else?

Elizabeth Krupinski (42:08):
Those are pretty much what we crafted internally.

April Lewis (42:11):
Got you. I didn't get any questions from the comments. I was sitting here. The information you shared is so thorough and so detailed, I didn't think that we would get any questions, because you covered everything. The breakdown of the tables is really good. I'm also going to share it with NACHC internally, just because I feel like a lot of the internal staff could be brought up to speed on what the big picture of telehealth looks like. Thank you so much for this useful information.

April Lewis (42:41):
Again, if you have questions, stick them in, or click raise hand and I'll unmute you. Before we depart, I wanted to just check in with our partners, May, Cathy Webberly, see if you all had any additional questions or comments from your end. I probably have to ...

May (43:03):
This is May. Can you hear me okay?

April Lewis (43:05):
I can. Thank you. Hi May.

May (43:07):
Hi. Just to echo, too, what Elizabeth said. Like I told you, she's a great presenter and lots of information there. Definitely if you guys have questions to reach out to the telehealth resource centers that covers your region, and they'll be more than happy to help you.

April Lewis (43:25):
Wonderful. Cathy, I don't know if you had anything to add. I just unmuted you. Sorry to put you on the spot. Well, Elizabeth, you truly covered it all, so thank you so much. We'll get these slides out to you all. Just as I was sitting here and thinking about the request for topics that have come in, and Cathy and I were chatting about the telehealth best practices that we may roll out in April and on our planning call, May and the team, we had several topics to be considered.

April Lewis (44:07):
I'm going to look at an online community to develop for us that's in this team telehealth. That's a space where we use a platform called Noddlepod here at NACHC. It's really where you can, of course, you could upload these topics, but I can communicate with you all in between the office hours, myself or
someone else from the team. It's not to add another email to you or something else to do, but it will be a place that as we confirm the next month's topic, I can put it in the queue there and it'll just be a consolidated location for you to ask questions and also afford the opportunity for a bidirectional conversation.

April Lewis (44:45):

If you have a question, one of your peers can chime in and speak to it. If any of you here participate in our 340b pharmacy office hours, we do use that platform. That being said, as we get it set up, I will push it out in the PPA updates that come from NACHC. Also, when we reconvene in February, I'll have a link set up for everybody to get registered for it, but you can join the telehealth office hours online community. That's forthcoming. I think it'll serve this group well.

April Lewis (45:20):

With that, Elizabeth, again, thank you so much. Happy New Year to everyone. I didn't even start with that. I'm so sorry. Happy New Year to everyone, and we will be back on next month the same time. That's going to be, as I look at my calendar, because I don't know offhand. That's going to be February the 13th at 2:00 PM Eastern. Thank you all, and have a great rest of your day.