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Thursday May 20 2021
2:00 p.m. – 3:00 p.m.
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>> BECKY SANDERS: I have the top of the hour. I want to thank everybody for joining us today. We are going to go ahead and get started.

My name is Becky Sanders, I'm the program director for the upper Midwest telehealth resource Center.

We cover the states of Indiana, Illinois, Michigan and Ohio, today we have Tony, from Diabetes Care Partners. Just a couple of housekeeping items before we turn everything over to him,

We always have to tell you about our national Consortium of telehealth resource centers.

So, we cannot have a national contortion of telehealth resource Center webinar,

without having the map of the 14 of us. There are 12 regional telehealth resource centers, there are two of the national health resource centers.

We are all federally funded through HRSA, to the federal office of health policy and the office for advancement of telehealth.

The program has been around since 2006, we are happy to be talking with you today.

Sharing information about diabetes.

Some tips and tricks,

everybody that has joined as has been put into a listen only mode. We ask you to put your questions in the Q&A button at the bottom of your screen.

I will not interrupt Tony unless there is a really specific question that everybody needs to know. We will save the questions until the end of the webinar.

If you have any technical issues, use the chat function to chat with Aria Javidan.

The slides and recording will be made available after the event.

We do have transcription going on today. We get to be the guinea pigs for the new transcription service. For the national construction of telehealth resource Center telehealth series.

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We will have a Q&A at the end. There are the links where things will be posted. How to get to all of the 14 telehealth resource centers.

Without further ado, I'm going to hand things over to Tony. I am so looking forward to this presentation.

I talked with Tony several times and hurt his presentation a couple of times, I always learn more. Being a parent of a type I diabetic teenager it means so much to me to have these resources.

Thank you, Tony for joining us today.

>> Thank you Becky. Thank you for the opportunity to present today on the importance of telehealth and diabetes education.

I also want to thank everybody for joining us today.

As many times as we do these webinars, it is always strange to talk into the void. I know you are there, I see that there are 65 people. But, I do not see you. If you would be so kind, to chat in the chat box, where you are connecting from. What city and state? I would love to know where you guys are. Awesome. Milwaukee. They are coming in way too fast. [laughing] Kimberly, from Austin. Wow, you guys are from everywhere. San Francisco, that is where we are at. Hi Brenda. I am actually located here in West Covina. It is about 10 miles east of Pasadena. Most people know it from the sitcom, my crazy ex-girlfriend. It is actually here in West Covina. I appreciate everybody chatting in. Everybody from everywhere. Pittsburgh, Carrie from Salt Lake City. Wendy from Louisiana. They are still coming in. Excellent, excellent today, we're going to talk about one of my favorite topics.

Mistakes, myths and misconceptions your telehealth diabetes programs needed to avoid to be successful.

A little bit about myself, and the CEO of Diabetes Care Partners. The most the most important title I have is PWG person living with diabetes. I have lived with diabetes for more than 10 years. I feel that personal connection to diabetes, is what makes our company and the direction that it goes to, the best way it can be.

It goes through a lens of a person that lives with diabetes.

You will see throughout the program here, we really concentrate on experience.

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What does the person that has a diabetes going through in their lives?

Two want to come to a diabetes program, especially a telehealth to get the help that they need. The two things that are the foundations of our program, the lens that we look through, the second, our mission and purpose on why we are here. You can see from the picture, that is made prediabetes, 230 pounds. I have definitely gone a long way.

I am hundred 65 pounds, currently. Our mission, is what we focus on every day.

To provide increased access to outcome driven, meaningful, innovative helpful education solutions and support for everyone. We would want to help every single person that has diabetes and prediabetes get empowered. In order to live a healthier life, that is our goal.

We are slowly getting there. A little bit about us, real quick.

We were founded in 2003.

We have been ADA recognized since 2006.

We started telehealth in about 2013.

Currently we manage over 36 remote sites, over 900 miles standing the states of Oregon, Nevada and the Mexican border.

Needless to say, we have seen a thing or two about diabetes and telehealth. I want to start this webinar, by asking you a really simple question.

It is kind of an experiment. Have a look at this. I want to know in the chat box, how many blocks do you see? Let me see in the chat box. How many blocks are you seeing in this picture? I'm going to make it bigger so you can see better. Too many to count, [laughing] I mean the bigger ones. I hear 20. Somebody says okay, great. I would say you are absolutely right. There is 20. Now, it will get a little bit harder.

Let me ask you, how many circles do you see here? How many circles do you see in that same picture? Okay, I see some zeros, I see some 16s. I see some, about 95 percent of the people cannot see the circles. You are not alone if you cannot see it. What if I told you that there are actually 16 circles. That they are in plain sight. I am a part of the 95 percent that did not see it.

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How can this be? You may ask, where are they?

Let me show you. There they are. Now, if that was interesting can you type in in the chat. This is an example of what you don't know is the hardest knowledge to come by. What you do not know, you do not know.

Once you know, your perspective will change forever. Once you see this experiment again, you will know where to look for the circles. At the very beginning, it is really hard to see.

What you do not know, you do not know.

I hope I can give you a different perspective about telehealth and diabetes programs,

just like this experiment here. When we first started the COVID pandemic, and we had to switch over to telehealth, most of us, that were not doing telehealth before, you were probably feeling, if you build it, they will come. Most of us were hoping that was true. Why not? Look at the value of telehealth, increased access, saves time, saves money,

the patient does not have to take any days off.

They do not need any childcare.

They can do it from the convenience of their home.

What more can you ask for? Right? I like to call this the cautionary tale of the shiny object syndrome. As great as the telehealth deliberately model is, it is not heaven itself the solution. Many programs thought that taking there in person programs and adjuster broadcasting through this new medium,

would translate the same, in most cases it did not.

In fact, what we see, is that any problems with an officious and sees,

engagement, and outcomes with your current program would be magnified when using telehealth to scale. What we saw, was low attendance and engagement. We saw a decrease in referrals for telehealth trainings. Because of that, we saw less people receiving diabetes education. Unfortunately because of that, programs were closed or downsized. Unfortunately, some diabetes educators lost their jobs. This did not have to be. When we asked a lot of the programs out there that were going through the struggles, not saying that everybody had the struggles,

there are a lot of programs that actually succeeded in telehealth.

During the COVID pandemic. I would say, the majority probably went through this cycle. When we asked them, what were the things that they thought contributed to this?

They told us at least four things that I am going to talk about today.

I want to call this section, myths and truths. So, the first thing that I heard, was,

my patients do not want to use telehealth.

In the chat box, if you believe this can you put yes, sir no? I would like to know what you guys think? Yes, sir no in the chat box. 50-50. 50-50. Depends on the patient, absolutely Wendy. Absolutely. I want to show you this chart. This is a chart of the health claims telehealth claims data during the public emergency.

From the healthcare coalition telehealth workgroup. You can see the spike. Almost 13 million telehealth claims per month at its peak.

Providers were offering telehealth, maybe not well enough. They were trying, people were responding.

Let's dive deeper into this data. I think it is very interesting on who was offering these telehealth services.

You see that blue line? That is the mental behavioral and mental health providers.

They accounted for almost half of these telehealth services.

Then, you can see the rest of them are pretty substantial as well compared to where they were.

That makes sense for behavioral and mental health,

people were going through very stressful times.

One thing to keep in mind, these providers were also experienced in telehealth for the emergency. As most telehealth were already being done in the space. Although, the others were doing it,

they actually started to do a lot more, because of the experience, that the behavioral and mental health workers had,

they were way above the curve. The fact remains, patients wanted and accepted telehealth when provided without must hesitation.

I want to point out, excuse me. I want to point out that the diabetes and character education specialist perform very similar services to the behavioral and mental health providers.

Most providers will tell you it feels like they are for emotional support than anything else. To help with diabetes, anxiety, denial, feelings of loneliness, burnout, frustration. That is why telehealth is so perfect for diabetes education support. I fear that most programs are missing the boat. Let me tell you what has happened with our program through the public health emergency as an example. Prior to COVID, we were seeing 32 new group cohorts of people living with diabetes each month,

I doctor's office, community centers and old facilities.

These are pictures of some of the places that we have done our program at.

Most of them are at physician's offices, Summit community centers,

during COVID, we were not able to do group sessions. We had to pivot two more one on ones and in-home group sessions. Meaning they were zooming in from home. Not getting together at a facility.

When we pivoted, we had an increase of 313 percent of our referral sources.

During that same time, we did over 6000 telehealth sessions. Currently, we have roughly about a four week waiting list.

For our members to participate. Essentially, we saw the same growth you saw from the previous slide for mental health providers in our own practice.

I believe it peak was because we were ready.

Just like for behavioral and mental health providers.

I am not showing this data to brag, I'm not showing you this to tell you what we have done.

I am showing you this because I want to make sure that you know, this is the potential for you. We are not special.

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We just acted and played the game for members by investing in a telehealth early on. The statement that my patients do not want to use telehealth, was not true for those programs and providers. Who were already ready to provide telehealth. So, some of the lessons learned, that we had,

first of all, telehealth is not for everyone.

Again, it is not the magic bullet.

It is the best we have today to increase access to our services.

It is remarkably scalable. First of all, we do have to find the value for the patient.

I do a whole talk on value, because it is so important.

Just like the experiment we did at the beginning of the webinar,

each patient's value can be hidden.

Sometimes, what they don't know they don't know, that is valuable. We do not convey the pile value as much as we should.

Once you figure that out with that patient, it gets so much easier for them to enroll in any program.

Let alone, telehealth programs. The next lesson we learned, was to become frictionless. Another reason for hesitation to telehealth, patients felt it was too difficult to learn. That is their preconceived notion, that is ours as well. We had many people say they did not want telehealth at the beginning.

Once we show them how easy it was, we made it easy by the way. They actually took part in a telehealth session.

They really took pride in their newly found knowledge.

They thanked us for helping them come into the 21st century. Many said by participating in a program,

they were also able to use the knowledge to attend their church via Zoom. If that is not empowerment, I do not know what is. You have to identify the main points of friction for the patients to participate in your program.

To help support them through it, that is the key. Here is another one.

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My patients do not have the equipment and Internet access for telehealth.

Please type yes or no in the chat. If you believe this. Ashley said, amen. Yes, Rebecca. True. Michelle says, true for many. Most don't says Heidi. Older patients do not have equipment. Absolutely. Most patients do not have smart phone access.

That is absolutely true.

Absolutely.

The digital divide Israel. 21 million Americans do not have Internet. Three in 10 people, 25 percent of rural places do not have Internet. 60 percent of healthcare facilities outside of metropolitan areas do not have broadband connections.

The digital divide is 100 percent real. For the ones that said that, that is what you are seeing. We see that too. We live in a metropolitan area, in Los Angeles.

We still have deserts of patients and members.

They just do not have these things.

What we do have, let's look at that. This may not to apply to everybody on this call.

This is what we do know.

97 percent of the people have cell phones. So, we are possibly able to do a phone consult. 85 percent of the people according to this, research have smart phones.

From 95 to 96 percent of age 18 through 49 have smart phones. We are talking about the younger crowd. For the older members, 61 percent age 65 have smart phones. Smartphone dependency is most common in younger adults and lower income Americans. You have to look at these numbers, you need to know where your opportunity is.

The lessons learned here, really are, build your strategy for mobile.

That is what we did. We implemented a lot of text messaging strategies.

To make sure we were able to connect with the majority of people that probably did not have in-home Wi-Fi. But, they definitely had smart phones. That was a big portion of the people that we took care of it. The other thing, have discussions with repairs. Your payer has the exact same goals as you. They want their members to be healthy.

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If you are able to provide that, they are on board. You have to have discussions with them and be creative.

I want to show you what we have done with some of our payers. What we have done, with some of our payers, one is called bright health were brand-new day, we started a pilot using something like this. An iPad. We implement did this iPad with a specific integration with a patient focused interface. It is very simple to use, we are piloting that. It was a suggestion that we came up with. We realized that there were so many members we could not connect with because they did not have Wi-Fi and a device. So, we asked, is there something we can do to take care of this? They said, yes, let us try this. That is a first step, talk to your partners.

Try to figure out if there is a way to do something.

Instead of just sitting back and saying, we're just going to see. If they do not have it, that is just too bad. We have to move forward.

The health plan was going to play for the connected portion of this iPad. So, they would pay the AT&T bill. I know that there is a new program with the FCC that I believe Becky will touch on. It provides a subsidy for broadband and devices that was just released about five days ago. That is definitely something coming in the queue. I am so happy that this is happening. Lessons learned, partner with local community resources. If your patients do not have devices or Internet in their homes, what about the local pharmacy?

A local summer center? Once things open back up, that might be an option. In order to partner with people and do that.

That is what we started doing.

The majority of our telehealth whereat doctors office and community centers. How about this one? Doctors do not want to refer to telehealth programs. How do you feel about that? I heard a lot of that when I was talking to other programs. Depends on the doctor. Absolutely.

So, as most of you probably already know, referrals before the PAG were low anyway. Less than five percent of Medicare beneficiaries received the training.

Lesson seven percent of private insurance members received the diabetes training as well. You would think these numbers would be at least in the 20s, if not the 70s and

80s. The fact of the matter is, doctors and all healthcare professionals are extremely busy.

They have probably been overwhelmed over the past year.

Diabetes education is not at the forefront of their mind. But, it should be. I'm going to show you some data.

We need to be there for our members. The thing that we have done, over the last 20 years,

we really create that strong relationship.

If they do not refer a member to you,

you do not get the opportunity to take care of them.

So, the more you can build those relationships.

I don't know a lot of programs have that in the forefront of their mind.

Regular and services are key. You would be amazed that physicians do not have time to train their staff. Their MAs know certain things, but they do not really know about diabetes. You guys are the experts, why not have regular in services to train them? By doing that, you become a part of their team. You start to build that relationship. Consistent follow-up. One of the things I heard a lot from physicians,

when I sent somebody to the education center I never hear back. I do not know what is happening with that patient.

A lot of the times, they say the patient comes back, and there is no difference in their blood sugar. They automatically blame the center. They say, they did not do a good job. That leads to the gradation of that relationship. Gradation of the relationship.

One of the truly best strategies we have used, and office telehealth services. The pictures I showed you earlier were at doctors offices,

we normally do them during the lunch break when nobody is in the waiting room,

or if they have a big enough conference room. Doctors love that. The service feels to the patient, that it is coming from the doctor. So, the doctor gets huge credit. That is awesome, I love that.

The second thing, they know exactly what is happening with that member. They are there at the office with you, via telehealth. So, they do not feel so disconnected to the patient. When they are sent to a center. Because of that, we feel that a lot of our doctors really embrace telehealth.

They see the results from it.

So, they say I am going to send all of my patients to you. And, a lot of them do. This is one of the doctors we work with. His name is Doctor girgis. We have been doing telehealth programs in his office before the pandemic a good solid six months.

He started seeing the results.

I want to share with you a video that I made.

He was gracious to do this for us. Let me share this with you really quickly.

>> I think that this program is a great success.

I really enjoyed it.

I can see the difference in their A1c, that is the whole idea.

Yes, two of my patients after the program, we did the A1c, they went down one point. So, that is a great success. I am doing it for all of my diabetic patients. They all are very impressed with the program. It is very invaluable. Valuable, they learn a lot.

They are very appreciative of this program. I hope this will continue.

We are very happy that our healthcare partner is doing a great job and patient education.

That is very important, most of the time, we do not have enough time to teach the patient everything. So, it is a very good program, I am very happy. What did you hear there?

>> I thought I got so much value out of that video.

Number one, he got praised by his patients. For doing this for them.

That is awesome, that is what I want.

I want him to get all of the credit, we do not want any of it.

That means, we get a chance to take care of more of his patients. It solidified our value with this practice. This video, gives us credibility amongst his fellow PCPs. At the end, he promoted us to the regional payer. Which is healthcare partners. You know, I sent this video to them. Ultimately, the value is not about us, the value is what I can do for them. What I can do for the doctor, 40 payer, for the patient. That is the key. So, always, always, always, try to create a better relationship with your PCPs in your refers. Here is another one, I can't get meaningful connection with my patient using telehealth. How do you guys feel about that? Yes, no? Is it hard, is it not? Somebody said, I feel the opposite, good. I disagree. Marianne says, is possibly more difficult to connect, but still possible. Absolutely, for sure. I have to tell you, telehealth is not easy. It is not easy because we are so use to being in front of somebody and actually seeing those nonverbal cues. Those make a huge difference. Over time you can definitely develop the skills online, you'll they are hard skills to learn there are other things like background noise. For those of you that do telehealth, you know they do not mute themselves. You hear the dog, you hear the road, it distracts the whole session. They are late for programs. There are tons of no-shows. The reason of that happening, telehealth is one of the best ways to increase access. It made it infinitely easy to join at the press of a button.

If you think about that, that easiness, also leads to people not wanting to do it because, it is so easy to leave her easy to not participate in. The friction part goes both ways. It can definitely be something that helps us,

at the same time, a lot of people just say,

it is easy enough for me to not connect some of the lessons we learned, be an active contributor versus a passive consumer. This has to be deliberate. Your program has to create that engagement.

To keep the interest of your patients.

I am hoping that I am doing this for you during this presentation as well.

Using the chat box, quite a bit. Right? Having a different way to present my screen. These are all different ways that we can interact with our members. In order to create more engagement.

Somebody said, you have to be creative, absolutely. We have to give virtual hugs. Somebody asked me a while back, how do you give a virtual hug?

One way is to make sure you let them know it is not their fault they have a diabetes. You have to take all of the blame and shame out of the program. A lot of you do, but there are some programs that do not do that. You would be amazed, just that one thing, could make a huge difference in a person's experience.

There experience on your program. Camera, lighting, sound and gestures, those are important,

more importantly, you have to make it fun. It is funny, when we were having the in person program, even through telehealth,

the thing that I knew that gauged the best experience for the member,

was that I heard laughing in the program. I knew that the program was a success when I heard that. Laughing is remarkable. How do you get laughing in a diabetes program?

For those of you that do well, you do. Everybody is on the same boat.

There will be a lot of things people do not want to talk about that come out.

Some of them are things that you can laugh at.

You were all together as a group of people that are living with diabetes. Be obsessed about the member experience. Everything we talked about enhances the positive experience.

You have to make sure the person is having the best experience that you could possibly give them. How do you know if you have done all these things? I would say two things, the light bulb, that is something you will see in their faces, in video or in person.

That aha moment. For those of you in the trenches, that do this, you know what I mean. When you get that aha moment, it makes you feel so great. You know they are starting to get engaged.

You know that they get it. The second thing, their data. Both engagement and clinical data is important to know if you do not know your data, you need to know your data, especially when going into telehealth. Let me show you some data examples from our program.

To kind of give you an idea. Here is engagement by attendance.

Our program is a three session program.

There's a reason for that.

Three sessions.

If they come to the first one, 89 percent of the time they will come to the second one.

Then, it drops to 76 percent. We feel that is a pretty good indicator that our engagement is there for our members.

We did see 6000 sessions last year. So, attendance is really key to engagement.

If you know your attendance, you know your engagement.

Your clinical outcomes, those are key.

Ultimately, your payers are interested in this. You are interested as well, the more you can decrease the A1c, the more different you will make in that person's life. This was the A1c for last year, 1.9 decrease in A1c for higher risk numbers. More importantly 6/10 members that were above nine were below nine after the program. These are key things that you have to know in your program. This is where your value is.

To be honest, this is how you tell your compelling story of your mission and your program.

You do this to the data. The last thing that we tracked, total cholesterol.

We decrease cholesterol by 21 points on the average.

70 percent of our patients decreased their A1c below 200 after completing the program. As a side note, I want you to look on the lower part of this slide. You notice that CMS measures citation. Our job is to know what our partners value is.

To provide those things through our services.

So, that is the CMS star measure, see 20, that is for diabetes. So, our payers are interested in those measures. So, our value to them, is to show them how we are affecting those metrics. That is their metrics, right? Again, I say the acronym, quite a bit and other talks.

Basically, that means, but is in it for me? What is in it for the payer, Doctor, member? That approach is what has made us successful. How about this last one? We will just wait until the PT is over and go back to normal? How many of you feel that way?

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Telehealth is difficult, we dabble in it, but everything will be done anyways. We will wait about another six months or so. There you go, no. [laughing] There is no going back. Absolutely. Telehealth may not be for everyone but the genie is out. The genie saying was actually said by the former CMS administrator. It is out, it is here to stay. Why should we do anything now that we are so close to reopening? What if I told you that providing the telehealth diabetes service is a matter of life and death? Would you believe me? Well, here is the data. Here is the proof.

This was a study that showed that in-hospital death rates, were significantly lower, 1.1 versus 11 percent in the well-controlled group,

relative to the poorly controlled cohort. Our goal in diabetes education support is to help and partner with people with people diabetes to live long healthy lives.

We take part in our success stories. Each of us that do this work I guarantee have many stories.

Many people have been saved from heart attacks, stroke amputation and kidney failure due to uncontrolled diabetes. You are therefore them for COVID, can you say you are there for them right now? When they need us the most? The difference between surviving COVID and seeing their grandchildren for the last time is determined by their blood sugar control. It matters more than ever that we provide services to people we serve in any way we can, even though the difficult road of understanding and understanding telehealth is in front of us. I challenge you not to be into the public health emergency is over to go back to normal.

This is our chance to ride as an industry.

To take a hard roll and do what is right for the patient. Something we promised we would serve them even in these very difficult times.

It matters, a life and death issue. Let's not miss these opportunities like these organizations. Let's embrace the long hard road, understand the customer experience instead of choosing to embrace complacency. So, let's always remember why we are doing this. We are doing it for them. Because, they are counting on us to always be there. This is the call to action. Be obsessed with their experience.

That is the number one thing that is going to keep them engaged.

It will get your results.

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You have to look at their experiences.

If they are having a bad experience figure out how to make it better.

Implement that into your process. Think mobile first, that is the lowest hanging fruit.

Know your data. Your data will lead you.

If you do not know your data, you do not know what your program is doing.

If you do not know what your program is doing, you are not showing people the value of your program.

Build relationships, continually do this.

Your referring sources need to know who you are, what you do and how will you do things. Plan for the long-term. The genie is out. We have to plan for the long-term.

We have to make an investment in telehealth. Nine whether you currently do telehealth or not it will catch up to. Do not wait, we have this opportunity right now. There are a lot of things that make it so much easier for us to do telehealth.

If you wait you will squander the opportunity. Go full board. Heads down. We are doing everything for our members. That is the reason we got into what we are doing.

Thank you so much for your time. If any of you have a smart phone you can use your phone for the QR code here you can scan this QR code and you can download my presentation. Instantly. Less friction. If you scan the QR code you can have my presentation. Thank you so much for your time.

>> BECKY SANDERS: Thank you, I always learn things. I appreciate you being here today.

We do have a couple of questions. People are already trying to QR code. It is working. Let me ask you a question.

How are programs handling patients who are driving?

Obviously dangerous and not encouraged,

or at the grocery store running errands during their telehealth visit?

>> TONY: That is a hazardous situation.

That is a liability for you. Upfront, on intake, it is always a great idea to lay out the ground rules.

This is a program for you, you need to be in a safe place.

You need to be in a private place. If they are not driving, they may be shopping. Maybe they are pushing their cart they are actually looking through the video on their mobile. You want to make sure you have those policies in place from the very beginning.

To make sure they understand the ground rules. If they ever show up on my telehealth program driving or doing anything else,

to be honest you have to let them know. Because, I want to make sure your privacy is secure, and you are safe, we have to reschedule the session. You have to do that.

>> BECKY SANDERS: Is it required by CMS to document patient and provider location? Do they only allow telehealth when patients are specifically in their home? How about work or a private office?

>> TONY: I think it is pretty open access to everything.

I will tell you, there is a thing about telehealth that you need to be cognizant of it.

If a member came to your practice,

and something happened to them,

you would have the ability to get emergency care for them.

In a telehealth system, you do not really have that option.

Other than calling 911. You have to know where they are. One of the policies that we have implemented, at the very beginning of the session, you should ask them, are you at your home location or someone else? Documented that, if something happens during the session, you want to make sure you have all of the information.

So, you can proceed forward. If you do not ask that question you will not know.

One of the challenges, we have had this, homeless. We have taken care of homeless people. They are not at any location. We do ask them, are you at a private area? Number two, can you tell me exactly where you are on the corner of what and what? Those are the only ways we can provide a service to them.

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We need to document that. No matter what, it is always a good practice to make sure you have that information.

>> BECKY SANDERS: Absolutely.

This one up when you were talking about payers and tablets, iPads in particular, did the payer actually pay for the iPad? Was it a private or a commercial payer? I am sorry, Medicaid or medic care.

>> TONY: Commercial.

>> BECKY SANDERS: That is good to hear. I have heard a lot of talk about that. I had not heard of one that actually did, that is good to know.

>> TONY: You never know until you have that discussion. Worst comes to worst, I would even recommend, tablets are not expensive. You can get an android tablet for less than 100 bucks. It means that much your program to reach out to people that do not have these things, by a couple. $200. Even if you want to get the broadband cellular connection, try it out.

Show the value. Once you that do that, go to your payers.

>> BECKY SANDERS: The other part of that was the broadband. I'm going to put into the chat box a link about the emergency broadband and if it program. I'm going to share my screen. Just really quickly. If you are not familiar with the lifeline program, what screen are you seeing? Are you seeing my email?

>> TONY: I see the FCC.

>> BECKY SANDERS: The emergency broadband benefit program is like the lifeline on steroids.

Lifeline has been around since the late 1990s.

It is under the Federal Communications Commission.

It is administered by a company called Universal service administrative company.

So, the normal lifeline program pays a subsidy of $9.25 toward Internet broadband in the home,

a landline phone or a cell phone. There are some qualifications.

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Usually 130 percent or less than the national poverty guidelines.

Or, that the eligible beneficiary is enrolled in a social security benefits,

were food stamps, something like that. Instead of the 925 provide a discount up to $50 a month on one of those things. Up to $75 per month of the beneficiary is on tribal lands. The other thing this program does provide is a device. The device has to have a retail value of $100. The participant might only pay $10 on the program, telecommunications vendor would pay the difference.

Whatever the beneficiary paid and that retail price. So, I put that link in the chat box.

This program opened on May 12.

It is available for those that have issues with broadband or obtaining devices.

So, I think we have time for just one more question. Does DS MES COVID telehealth ruling require the patient nevermind, we answer that.

During COVID they can be anywhere. Let me stop sharing my screen. How would you recommend they PowerPoint recitation when teaching?

>> TONY: PowerPoint is one of the best ways to do it. If you want to become a little bit more interactive you can do like what I did today.

From present presentation. Another good resource, can via you can actually create slides in their that have motion. That increases interaction with the person that is looking at it, it is not staying stagnant.

>> BECKY SANDERS: I want to thank you again, Tony. Thank you for being with us and sharing your wisdom and knowledge.

Aria Javidan, we have one closing slide. Can you put that in the chat as well? So people can hyperlink that. We do appreciate your feedback. On our webinar program. Would love to hear if there are any other topics you would like to hear about. For our next webinar, our series normally occurs every third Thursday of the month.

The next telehealth resource center hosting will be the Great Plains telehealth resource and assistance center. We do not have a topic yet, the date will be June 17 from 11 AM through 12 PM. Space Pacific standard Time. Thank you for joining us.

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Thank you Aria Javidan, and thank you for the transcription services. Have a great day, Tony.