SPEAKER:
Hello, I am the program coordinator for the national Consortium of telehealth resource centers. Sorry about that, looks like my screen went down. One check. There we go. Welcome to the latest presentation of the webinar series of Pandemic Response Action Plan and the Opportunity to Use its Lessons to Improve Healthcare. Today's webinar is hosted by the Telehealth Technology Assessment Center. They are presented on the third Thursday of every month. Just to provide background on the consortium located throughout the country. There are 12 resource centers and two national resource centers. Each serve as focal points in supporting telehealth and services in rural and underserved communities. A few tips before you get started. Your audio has been muted. Please use the Q&A function to submit your questions. And with that, I will pass it over to Patricia who will be introducing our speaker for today.

SPEAKER:
Hello everyone, I would like to introduce to you Mark Vanderwerf. His title says telehealth and advisory consultant. But I highly recommend you read his bio. What I will say is that Mark's ability to recognize and communicate the challenges and opportunities of telehealth technology has made him a great asset to the telehealth technology assessment center. With that, I'd like to turn it over to Mark.

MARK VANDERWERF:
Good morning and good afternoon everybody. As I've already been announced, I am Mark Vanderwerf. I've been in telemedicine for a long time. I'd like to say hello to all my friends out there, thank you for coming. The purpose of this or that tactic of the day is this pandemic response action plan. Let me get into details around that. We were asked in 2020 two construct a Pandemic Response Action Plan. And as part of that was to look at the critical challenges that were facing providers during the pandemic. COVID-19 hasn't left us yet so many of the things in this plan are focused on this. There were three major deliverables and I will get into more detail. But it was to create an action plan for telehealth to address each of those critical challenges. Really step back and find out what can we really do to solve some of these problems. Not just throwing more people at it for, but technology. It was completed in the beginning of last year and was published in the journal. What are the regulatory policies in place? After - - as part of that, make recommendations to policymakers as to what we could do going forw
rd. As the slide says, it was published in the journal. One of the things that came out of this in January of last year, there was a lot of talk of ending the labors or figuring out when the labor should be ended. We joined with the ETA ATA, AHA and CTA and others to recommend the continuation of waivers for 2-3 years from last January. I will dig into that more as we go. What we are in the middle of now is to look at basically the impact of using the elements of this plan in hospital networks in the United States. We looked at eight

programs identified by the TRC's and we interviewed them and in depth. What was implemented and what was the result. The final report is being written today. It will be finished at the end of March and will then be submitted for publication. A big part of that is conclusions and recommendations against all three of the sections of the Pandemic Response Action Plan. The team, we tried to really not have any concerted bias as we wrote these programs. Bias is a hard thing. But to give as much as we could we tried to go for a broad scheme. The and TRC's were represented, nursing, physicians. Technologists to infection control in a rural area and one in a denser area on the East Coast. Public health and emergency response. That was the primary core of the team. For the interviewing of what happened, we had the leaders of the providers that implemented the tools. So the output of project is three phases and a report for each one. The first is the Pandemic Response Action Plan itself, and that has been published. In the Journal or you can go to the website. Regulatory and reimbursement, it's been published. You can go to the Journal or phase 3 is where we are today. In some ways it was an interesting report because we spent a year on the first one and then another year digging into what happens. Unlike a lot of reporting in this area, we decided we would submit all the reports to the reader peer-reviewed. It doesn't focus on answers at all, it focuses on the problem and questions. To a great degree in this technique, it's assumed the answers will build themselves. It's more easier to get to the answer. So, what did we find? These were the critical challenges that we identified. There's a lot of them, there's some overlap and that is intended. Some of them are really basic. Keeping protocols up to date obviously. Keeping the hospital open. How do you keep the functions going in a crisis? Especially in a crisis that impacts directly your revenue. There rest of these are pretty self-explanatory. Protect the potentially infected, answer staffing needs that has gotten a lot of press. Trying to contain the infection within your hospital. Providing access to care even though a crisis is going on. Even though clinics were closed and even though there was a moratorium on elective surgeries and procedures. Here at home, challenges rated related related to them. And the ability to rotate patients in and out of the hospital to allow better capacity. Etc. supporting remote work and staff, behavior health is a critical area. Transportation was an interesting challenge especially in rural areas. Transporting people and supplies, etc. Last but not least, public health. If you open the front pages of the plan, you will see that each one of those 11 areas has their own section. In each section, the problems are described in the paragraph format. This presentation will have - - already so I didn't leave it in paragraph. But again, the problems are discussed first. The solutions and ideas are presented in bullet format. The reason we did that is because we are focusing on the problem. We want it almost to look like a checklist. Rather than going through each solution in depth, this identifies what the solutions are and what the ideas are to address them and puts them in a format where you can cut through. I'm not going into all of 11.

I will give you samples of what we saw. I have chosen at random section number two and section number six. Keeping the hospital clinic open and access to urgent care. Actually, access to care. Keep the hospital, clinic open. What are the obstacles? The freezing of elective surgeries in the closing of clinics, etc. Some of the most profitable or best margin services in the hospital ended or were suspended. And at the same time the revenue is going down, the costs are going up. No
going to read through that because you can. But also, these are not, these are pretty logical. Notice the piece we looked at, the continuity of care for patients. Really a serious issue, loss of staff due to infection. Fear of infection, family, etc. Keeping staff healthy both physically and mentally. So those are examples of the bullets of the problem. These are samples of the solutions. One of the ways is to work with the potentially infected, before they arrive. Don't bring them into the hospital. Most people did this. There was still resistance to it. This is the part that works. Allowing people to work at home, which also may reduce some staff stresses. Because people can quarantine in their home if they're not ill, they can do some work at home. (Inaudible) Using this technology should be part of the normal operation of a healthcare provider. And connectivity is a key part in making sure that at least your employees all have connections is critical. This should be examined, the survey should be created and it should be done every year. Keep it up to date. When crisis hits, is not th
time to do this. Close down/get rid of physical waiting rooms. In the later parts of the report, we began to realize just how much overhead is in waiting room space. 20-25 percent of clinics are waiting rooms. That's a terrible waste of time. Or waste of space. Keeping infected people out as much as possible. All of the sections of the report cross reference. It says twice in section 3 directly on infection control, will be connected into more detail. Simple stuff like using a pad on a pole. Allows physicians to have access. This was a major savings. Let's say you have a nurse and they have 12 patients. They round those patients every hour. That's 12 sets of PPE every hour. Eight hours who are lucky enough to only work eight hours. That's 96 per day for that nurse. You have 10 nurses, that's 960 sets of PPE. That doesn't include physicians, food-service visitors, etc. It's a countrymen does consumer for many parts of the pandemic tremendous. Provide access to urgent care. When we talk about consumers here as a broader term than just patients. Consumer is a bigger - - the bottom line is consumers and patients still needed the service. They still need urgent questions answered, they still need diagnoses, given guidance by their healthcare provider. It didn't go away. Both sides how to avoid exposure. At the same time, providers are critically impacted. A good provider wants to provide care for the patients. And there was a major interruption in this. Infection exposure for them was a daily concern and remains a daily concern. We identified significant impact to the isolation from care. Some of the things coming out in literature is a lot of traumatic

disease patients, their was an excess death rate increased death rate. Mostly blamed on the continuity of care being interrupted. Another problem is it's hard to set this up during a crisis. Go ahead and direct consumer services. Make it part of creating a digital front door. It changes the way you can deal with your patience in the future in a critical way. You have to choose a video platform, make sure when you choose the video platform, you take into consideration usability by the patient or consumer. Don't have a separate scheduling system for remote and in person. Same scheduling system and adapt. Whenever possible, conduct follow-up visits remotely. Make that the rule. Next one kind of repeats but implement direct to consumer urgent care as the course of business and in preparing for a crisis situation. Let's not wait until a crisis. It really helps the flexibility of an organization when a crisis occurs. And to go direct to consumer is a telemedicine assessment toolkit on the TTAC site. We continue to go through all of these. So every one of the 11 problems were constructed the same way. Heavy emphasis on the problem. And then identifying solutions. So the last piece of the project, the phase 3 was to look again at what happened within eight different healthcare providers. All of them were hospitals and most of them were small hospitals. A couple of them were medium-sized. So let me go into that last section. I'm not going to dive into the lessons learned in that section because that's an unpublished document. I'm basically using bait to get you to read the document. But let's go into some of the conclusions and recommendations. These are aimed at the three phases. These are: Emory, they haven't been peer-reviewed, so these are just samples. Preliminary a big thing is looking at these tools during a crisis is difficult. You're in a crisis and now you want to do many things you have to do to set up virtual. The hospitals that we talked to, many of them had a fragment of digital of these tools implemented. If they didn't, it was desperately difficult to do what they had to do and try to stand up a virtual environment. We complain about a lot of problems. All almost all the weaknesses during COVID-19 exacerbated as this pandemic proceeds, already existed prior to the pandemic. None of these things are new. We just haven't addressed them properly. The pandemic is not really addressing it either. We have work to do after the pandemic. Staff shortages, old-fashioned work clothes, yada yada. One of the things that the pandemic should have told us is that it's time for change. There is a risk of rebounding back to the old workflows. Part of our recommendation to CMS along with other organizations, yes, you have to properly know the value and cost of telemedicine in order to set reimbursement rates. But look at this as a unique opportunity. Understanding the value and cost to put a much more appropriate reimbursement policy. Conclusions are curl — in person visits when in person was not necessary. Physical waiting rooms and physical check in, where else do you go in any other industry where you don't fill out your registration online before you go? It's about time we start using them. Virtual cueing is a completely accessible acceptable and developed area. Focusing on registration online. To look at how more

accurate registration online or at a kiosk was then registering at the front desk. The accuracy of letting a patient register online was almost 50 percent more accurate. We are teasing everyone about the clipboard. You have access to resources outside your facility. That can go for any other expertise area. It didn't - - patient references need to be, patient practices haven't been in completely engaged as a conclusion. A source of medical truth is critically needed. The fact we don't have a single source of truth is a critical issue. Moving care to the home is critical, technology is not a panacea. Every one of these things as backup to it well within the final plan. And these are recommendations. These are samples again. Biggest thing is preserve the advancements achieved during covert COVID. Maintain the incentives to motivate and sustain behavior. Now that we know more about the pandemic, the labor should be waivers should be maintained at least two years past COVID-19. Restructure incentives and so forth. Step back and look out how the workflow continues. Figure out how to use efficient technology and workflows. I will get into more detail in the next slide. A more expansive relationship basically will help us to not acquire in person encounters. Some of the ways you can increase that is through integration of the various RPM, CCM and care coordination into your normal course of business. And really look toward the patient and what happens around them after they leave. Integrate mental health into care practice. The critical impact of mental health especially during the COVID, was a real reflection of what was going on beneath the surface even before COVID arrived. We are recommending that as hospitals move forward, that instead of using virtual as something you do only if you can, really really look at healthcare delivery and consider virtual first. What can we do with virtual upfront before we bring a patient in to make both the care convenient for the patient. We go through these recommendations and make these directly linked back to the problems. So that's a lock everybody. I encourage you to go in the Journal or TTAC and read the plan. I'd love to have your feedback. I recommend that you go to the same sources and look at the policies issues, reimbursement issues and the recommendations. Then when this last section is published next month, that you go to this as a source. It will be published in a peer-reviewed - - but there's no guarantee it will be published by the Journal. It will be published on TTAC, regardless. So, are there any questions?

SPEAKER:
Sorry about that. (Laughs) We don't have any questions so please submit your questions into the chat box and Mark would be happy to answer those for you.

MARK VANDERWERF:
I will be surprised if no one has any questions on the pandemic.

SPEAKER:
We have a couple comments. Great presentation and informative.

Thorough review.

MARK VANDERWERF:
You can even say you disagree with us, that's accepted too.

SPEAKER:
Not a single question.

MARK VANDERWERF:
Darn. Where is the link to TTAC?

SPEAKER:
I will get that for you.

MARK VANDERWERF:
Okay. Patricia will distribute that. But basically, go to the national Telemedicine Technology Assessment Center. It will take you directly to their website. And within their website, look into toolkits and you should be able to find it fairly quickly. – – will help you find it no matter what.

SPEAKER:
Since we don't have any questions, thank you, Mark.

SPEAKER:
Thank you again for your presentation. I'm just bringing up the closing slides. Our next webinar will happen March 17 hosted by the Great Plains Telehealth Resource and Assistance Center. Registration information is available on the NCTRC website. And lastly, there will be a short survey that will pop up at the end of this webinar. Take a few minutes to complete that survey. Thank you again to the Telehealth Technology Assessment Center and have a great day everyone.