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SPEAKER:

Welcome to this presentation and the national telehealth resource webinar series. These webinars are designed to provide timely information and demonstrations... These webinars are presented on the third Thursday of each month. I guess I should go to the first slide. Sorry about that. Let's try that again.

We are located are the country, there are 12 regional teleported -- telehealth centers. And... Each serve as focal points for dancing the effective use of telehealth and supporting access to telehealth services and -- in rural and underserved communities. We have a few tips before we get started.

First, your phone and/or computer microphones are being muted during the time of the presentation. Time will be reserved at the end for Q&A. Please fill out the post webinar survey, we definitely appreciate that. This webinar is being recorded, as you are just reminded. Recordings will be posted to our YouTube channel.

Which is @youtube.com/C/NT CRC. This webinar is hosted by telehealth resource Center. As presented by my colleagues, Michael Kerlin from Wilde health Institute, Laurie Archbald-Pannone he coming from the University of Virginia. David Fletcher from the guys in her health system. And Rebecca Harless with the Charleston area Medical Center. Without further ado, I will put this to Michael Kurliand.

MICHAEL KURLIAND:

Thank you, Kathy. Pleasure to be here with you and my esteemed colleagues. I want to thank everyone for bearing through another zoom webinar. Really, really appreciate it. I told a joke over zoom once. It was not remotely funny. I wanted to see if you guys were paying attention. Anyone personally just drop me an (indiscernible) in the chat.

But, some of the stuff you may already know. You may already know about the shipping grant -- demographics. In about seven years, older adults, folks age 65 and older, will be about 20% of the population. If you can believe this, boomers are already to starting to turn 75. If anything, these last two years really opened up our eyes to the health system -- that the health system is truly unprepared in many ways for the aging demographic.

It really meaningful and sustaining ways when it comes to healthcare delivery. The labor shortage really intensified the access and care coordination challenges that exist for many years. It really brought them to light. And healthcare system already disproportionately impacted over adults.... It is obvious our health systems to continue to evolve and adapt to the needs of older adults.

Quite frankly, all the populations. And all of us that are on this call are big telehealth advocates who

are already believers. Many of us already believe telehealth is inevitable. It is not really so -- silver bullet, right? It is just one tool that could help, in particular, this population.

Back in 2020 when, I say that because these last few years have been blunt for me. It feels like 2021 was maybe a decade ago. When was held convened, (indiscernible) from all over the country. From all -- other hospitals, health systems, number organizations, nonprofits. A few examples are Dartmouth, UC's, University of Virginia. Milken Institute, the list goes on and on. All of the (indiscernible) who advanced telehealth of older adults, we noticed there was a lot of great, great material out there.

That was specific for being too telehealth. But, it got very, very sparse when it was advancing telehealth for older adults. But this group decided on was, maybe we can help this work by putting together some form of guidelines or best practices.

If there are tons of consensus, you can only imagine what a lot of smart people trying to decide on one thing. The collaborative developed set of key principles and guidelines for delivering care to older adults. That is the same -- the saying in front of you. These Ps... are really targeted to clinicians and administrators to help guide tangible changes to workflows and practices. The folks we have today starting with David from Geisinger are going to share some examples of what they are living there and some of the best practices and some of the lessons learned.

If you can, hang in there for the next three presenters. Send in your questions and let's get started with David.

DAVID FLETCHER:

Thank you very much, Michael. I appreciate it... I oversee our synchronous episodic telemedicine and then also some of our monitoring programs, like EICU and (unknown term). I have been here for just under four years before that I was at... I've been at it for a while. Of course, as you mentioned, a huge C change in the last few years. It has given us a lot of insight into across a wide swath of our demographics.

It is particularly important for us at Geisinger, this older population is (indiscernible). Because we have 11 hospitals. We are really mostly central and northeast part of Pennsylvania. So, this area is very rural. A lot of agricultural work. There was a lot of coal mining.

You know, naturally that industry has gotten much smaller. there is not a lot of (indiscernible) area. Our population is aging. At a faster rate than the nation at large. Our older patients are very important to us. And that we understand how we can best serve them.

So, I think this initiative has been very important to us. I think it was very interested in these principles. The first principal I will talk about is kind of keeping the patient at the center for how you design the program. I think that is important for telehealth because there is kind of this built-in assumption. Whenever I go anywhere, talk about telehealth. And evidently Billy, people will say, "that is to be great, like the Genovese, the general wise, the millennial's." I do not know about the order so much, folks. There is a certain intuitive sense of logic to that.

They will say all the things you do not know that get you in trouble is the things you know for sure that just ain't so (Laughs). I think this is a great example of that. And I think, you know, we have really tried to look at and really talk to our patients and find out, "what do you really want?" We have some of our built in assumptions. Is telehealth something you are not interested in?

Do you have technical challenges? What are your feelings about using this technology? You know, to some degree, we jumped into the deep end of the pool with COVID. Our clinics were closed. We did not really have a choice. So, we had a little bit of a run rate.

We were able to do surveys and ask all of our patients across a wide range of demographics, "what did you think of using telemedicine?" We found really high satisfaction across all of our demographic groups. You know, that is not just us, really across the country, you see that. We looked at breaking it off by age. Our older patients also liked it.

There was a grain of truth. Their satisfaction scores were just a little bit lower than the younger patients. But, barely. You could barely notice it. In fact, what was interesting to me was, when we compare our group of 65 to 79-year-olds to other 65 and 79-year-old across the country, we have higher satisfaction of telemedicine.

I think the reason for that is, we really a confit -- a conscious effort. Because we know so much of our population is older, do not have downloading apps and cumbersome enrollment processes like an EMR portal and stuff like that. We send a link to a patient. Either through their text or email. They click on that link and they -- it gets them into the secure network and right into the (indiscernible).

I think that has really helped why we see a little higher satisfaction for our older patients. You can see that the even over the age 80 age group had higher satisfaction. Trying to boggle that initial assumption around patients, older patients.

Next slide. So, some of the comments that I took hold of. These comments were some of our patients who had telemedicine (indiscernible). you can see, one of them is disabled.

Cannot drive very well and felt safer doing the video visit. In some cases, our older population, it is even more important for them that are younger. It is not just a matter of convenience in this case, it is a matter of safety.

You can see, it is a super simple set up. Much easier than having to try to get in person somewhere. (Laughs) Especially in the first six months or so, it is amazing how many -- how so many of our responses started with the words, "I actually" (Laughs) You can see there is little bit of a surprise and how much land up liking this!

There was a little bit of, "what is this all about?" We see it a lot. "I actually really like this. It is super easy. Relax. Easy to talk to my doctor in a way that's maybe I would not in the clinic." So, we were very happy to see this. Okay, great. Satisfaction high. Is there any difference for our older patients?

Here is where we saw - we did see somewhat of a difference.

This question is specifically asking, "this is great, you have been doing telemedicine." Let's say we get beyond COVID someday, how you feel about doing telemedicine going forward? I expect pretty high result, because they love it, right? What we see here is, yeah, kinda. (Laughs) You see that first group is medication questions and kind of follow-up after visit.

Pretty broad consensus. There, that makes sense for telemedicine. The next one is like follow-up after procedure, surgery, something like that. Fairly high. But, that later color on the far right is the age group 65 and older. So, a bit of a disparity there. A little bit more hesitation.

You know, the next one is for the chronic care. You see a really big disparity therebetween the younger population into the older population. This puzzled us a little bit. "Okay, you loved it, but you're not so sure about doing it going forward."

I do not have this on a slide. Our next question was, "what concerns, if any, do you have that telemedicine?" And they responded, "I worry that it may not be as thorough of a visit as in person." That was very lightening. It shows you the importance of having the patient at the center of what you are doing and communicating with them. Because it really had nothing to do with, "I am scared of technology."

"I am older, I cannot see my phone." All of these things people assume. It was, "I do not know what technology you are using when doing a telehealth visit and I do not know when it is appropriate to do so... That really shone a light for us that we have to be transparent with our patients about what method we use to determine what visits we differ telemedicine.

We put a nice video together with one of our pulmonologist talking about when he likes to telemedicine. Equally important, when he does not like to telemedicine. And when we do not schedule those visits for telemedicine when we do not think they are clinically appropriate. So, that has been a key that we have really needed to understand about our patients and push out.

You know, we took all of this feedback. And really try to design our programs around that. For instance, our older population, you know sometimes they have other caregivers. They have other folks who help them get to their payments when they cannot drive, and stuff like that. How do we help them incorporate those, the whole team come into the visit?

One program we put together was called the Geisinger at home program. The basic idea is, Geisinger also has its own health plan. This is a key component of this. So, the health plan sponsors this program. We sent out a nurse or a (indiscernible) into the patient's home... Handheld camera, (indiscernible), that they can plug into that tablet. The dial in the doctor right from the patient's home. In a help to navigate the visit.

The team is therefore something in here with the doctor is saying directly. Patients feel comfortable that this is a full visit. They have a nurse helping to direct it. They have the tools. It is not just sitting

there on the iPhone. So, you can see that is actually one of our patients and that is our nurse educator there on the screen.

We have a short video so you can get a sense of what the program is about.

(Video plays)

(Music plays)

SPEAKER:

By being watched more carefully, I feel like someone is there for me. If I ever need to, all I have to do is pick up the phone.

SPEAKER:

I live with commune -- communicating with the patient and caring for the patients full sub

SPEAKER:

Geisinger at home is really a new model that actually pulls off a lot of things that we used to do in healthcare, maybe 50 years ago. So, what we have really done is identified those individuals who have complex medical conditions. Who may have a hard time getting out of their home to get into the doctor. Whether it be their primary care specialist. We take clinicians outside of the home and really try to manage their medical conditions inside the home.

SPEAKER:

Hi!

SPEAKER:

How are you doing?

SPEAKER:

I am doing fine.

SPEAKER:

Long time no see.

SPEAKER:

I know, I know!

SPEAKER:

Often times, we see patients where they feel they need to see a doctor. But, they are too sick to go to the doctor. So, with Geisinger at home, they were down 911 and have their spouse or children bring them to the emergency room.

So, we are able to bring that access to them.

SPEAKER:

It is wonderful. I mean, it really is. To have those. Especially when the weather is so hot. Then it is the winter and it is too cold.

SPEAKER:

We have seen a pretty significant drop in both hospital admissions and ED visits as a result of the program. We still have work to do. We are continuously enrolling. We have identify, believe it or not, about 10,000 patients. Who probably need some of the services, or at least need to be evaluated for the services.

SPEAKER:

I think it is a privilege to be able to go into someone's home. I think that it brings down some barriers on the patient's eye to let us come into their home. To really see all of the different things that made the driving -- may be driving some of those medical issues.

SPEAKER:

(away from mic)

SPEAKER:

If it is a weekly drive on her, I can set it up with them and they can complete it for you, okay? I will say that for up -- up for you tomorrow.

SPEAKER:

To have a patient ask you for a hug because you're able to keep them out of the hospital, as challenging as this work is, it drives you to get up and do the next day.

SPEAKER:

There is no one better that have been taking care of me.

SPEAKER:

What we look for is to try to take patients in their home, with their left once, in the best physical condition -- loved ones. That is our mission that we are about. Hoping seniors make good decisions about their health.

SPEAKER:

I will give you a video visit...

(Laughter)

SPEAKER:

There, we will do that. Next time I see you in person, I will get a real hug.

SPEAKER:

Okay, good.

SPEAKER:

Not to make your husband jealous. But, hopefully we will see you soon, okay?

SPEAKER:

Okay, thank you.

DAVID FLETCHER:

You can see how much the patients really love that program. Being able to stay in the comfort of their home. The best thing is, they love it, and our program would be able to save -- save the health plan \$2 million in its first year of operation. Very resource intensive. But, to save all of those images and ED visits, save the program enormous amounts of money. Like I said, the patient love it.

I think it is so important to build a program around your patient's needs and you can see the benefits from it. I will turn it down to Becky.

REBECCA HARLESS:

Hi everyone, I am Rebecca Harless. Thank you for that introduction. One of the things I really like, I always meet with David every month or so. I always learn so much from having these collisions with him. This is what I love about these webinars and different events we attend over the course of the year.

So, I am Rebecca Harless. I am the AA trustee Medical Center for the ambulatory division and telemedicine. That is in West Virginia. Not Charleston, South Carolina (Laughs). That is always a big line of contention. We are currently a four hospital system as of September 1. We have acquired(unknown term), so we will grow to about eight or nine. And we have about 10% of our total MB literary visits on telemedicine at this point.

I've been working at the... My boss came to me and said, "we have some grant I need to take care of and telemedicine." And I was like, "okay, what is it?" (Laughs) I have progressed to this journey through the years to where we are today.

But, I will talk to you today about principal two. Which is equitable and accessible. I would really like to talk to about how CAMC has applied this principle to real-world offerings that we apply in South Virginia. This is a lot of work that went into full something you heard Mike say that. A lot of work that went into building these principles and guidelines and what specifically they said.

All along this was going on, I was thinking, "I think we can meet some of these. I know for some of these, there will be a gap that we will have to build an action plan around to get to." So, I always like to say and show when I am having a speaking engagement to show, "here is what we are doing really well, and here is where we have some opportunities." I would like to explain what the Medical Center does.

We created telemedicine hubs. What the definition of that hub is, is somewhere in the neighborhood of two hours away from Charleston full so we are centrally located. Most of our specialists are adulatory division is, somewhere in the neighborhood of over 200 employed providers, mostly specialists. Over 150+ APP's. But, we provide a area for all of southern West Virginia.

Princeton is almost 2 1/2, three hours away. Lewisburg is two hours away. We see a lot of patients from these areas. The telemedicine hub really started as an experiment. Thinking through the PhD really allowed us to do this, to move into these areas and kind of get a low cost lease to provide what is an person, but telemedicine visit.

We took all of the (indiscernible) of what is an in person visit, and created that in the hub. There is a nurse there. He saw the same triage. You would expect them to have your blood pressure, get your weight. All of those things. All of that still happens and goes into the chart. But, the provider connects from Charleston to whatever rural location to that patient is in. So, the -- some thoughts through West Virginia.

In West Virginia, we're looking at over 20% in the nation of 60 years old and older. West Virginia is on the track for 30% by about 2030. And we are somewhere in the neighborhood of over 47 to 50 on broadband access in states across the US. So, depend on what pulled you look at. So, there are some difficulties with patients having technology and access from their home. Regardless if they are an older population.

West Virginia is a CON state. Back to this idea that this is an experiment. The CON state, when we found is, it is really hard to move the specialists from Charleston to Lewisburg. Or to Princeton. But, there is a loophole in the CON telemedicine does not fall within the CON. So, we are able to move it from telemedicine.

What I like to think about telemedicine hub... You may be in line to get a phone. The person in front of you may be looking at, "how do I work my email?" How do I do that? Certificate of need state. So, you have to get a certificate of need to move a service line. It can be contested from other parties in the state.

So, the ATM T story for telemedicine is, you can go there and receive some help. So, where we are meeting the principal and some of the standards, I would like to group those top four together. So, thinking through accounts for whether it is physical and cognitive differences, cultural linguistic differences, technology, literacy, and access. And technology. I consider that the shallow end of the pool. Right?

So, the patient can come into this and really we remove those barriers for them. If they are able to get the few miles to telemedicine hub, then we are able to help them through whatever cognitive help they need, linguistic, literacy, technology. Because we have hardwired all of this.

The same (indiscernible) that I use for eight... The physician can listen to your heart and lungs from two and half hours away. And then thinking through, you know, access from the homes. The next

guideline is accessed from the home. I think that is moving more into the deep end. Maybe once the patient comes to the telemedicine hub and they are like, "thanks for showing me. Now I can go back home and I think I can try this from home."

So, the patient have options. I really like to look at it, we do not have options to access before. The action -- option was, you drove to Charleston to see the provider. We have multiple options for patients now for access. I think that is the way we are going. I like that.

And kind of where we are not meeting the standard is, being able to engage in ongoing education, best practices. It is not that we do not want to. That is on our roadmap. We just do not have the further provider adoption to get to that point. And to be honest, I attended a session at matrix back in the spring.

It was fantastic. There was a physician who sat up there and talked about how to do an efficient telemedicine exam. Sometimes, never thought of. For belly pains. He said, "would you stand up and jump for me?" When that was painful. And I was like, "that is genius." If we can take those kinds of things and we are not there yet. That is on the roadmap. We want to get there. As we continue to see it as an option, we will get there.

Next slide. So, looking at some of the challenges and successes, lessons, opportunities are for telemedicine hub. We did this in a couple different ways. We started with a stand-alone clinic and we also have embedded clinics. So, embedded clinics are in rural health centers or if UHC's. That partnership seems to work a lot more. To be honest, with the standalone, it has not been as successful as that embedded clinic.

Looking through provider practice patterns. So, virtual first verses, "I need to see you in person for your first visit." Those kind of things. Working through that... There is additional coordination or to be able to work through. Some of the successes are, we have turned this into a destination filter almost a field trip destination. Not too long ago, the department of health and services of Secretary wanted to see what we are doing that is innovative and how we are providing this access and how great it is.

And the patients just want to tell you, you walk in and they just want to tell their story about how thankful they are to have this opportunity to see the provider. And not have to drive, you know, their social determinants of health there to get to Charleston one way is \$8.50. With tools. So, you are look at \$17, you have to eat lunch, those kinds of things. The nurse navigators has been a huge success for us. When you are looking at hiring this person, you have to find the utility players.

You can find the best nurse, but if she only wants to be clinical, that will not be - this is not the right role for that person. Because they will be in marketing. they are going out and talking to other physicians, patients, attending farmer market, kind of getting the word out there. To say, "you can come see us here and see your provider." That is a big thing to think about if you're moving in this direction. The success is embedded in the clinic. The nurse navigator, although we pay for that FTE, we place them in this embedded clinic, it really becomes an extension of the staff there.

They invite them to picnics, they invite them to their events. And they become that person that is like, "hey, can you help me get Ms. Smith into see a rheumatologist." "Yeah, I will get you in." That ends up working really well. The partner relationships - when you go through thinking there is a lot of hospitals closing and what can we do for your community and take care of their instead of bringing care to Charleston. So, that has been a big help.

The nonthreatening approach to provider practice changes. That is a partner. So, back is one-on-one with the partner relationships. Thinking through, "I do not want to upset my cardiologist, don't use it." We provide all of our specialists on the platform. Your doctor is referring ended out of there and use the pieces they want. If you want to refer to in person cardiology, we recommend it. You know, that is fine. Just refer to us both up if they want to use (indiscernible), or rheumatology, or something else.

Again, we have heard while the connectivity. It is hardwired into that connectivity. We talked about the tolls. Interpretive services. The downstream revenue. When it comes down to it, the mission is here. With no money, there is no mission.

So, when we went and looked at an audit of these patients, all of them ended up new to our system. All but to burn into our system when we did the audit. With that included was new cardiology care, new (indiscernible) care for these patients they had not had. When we looked at what is coming to Charleston to see appropriate things, is a nuclear stress test.

It is a six test any... Those are the things that are coming to Charleston while all the ancillaries and PTO labs are all staying in their community. And then moving into lessons learned. Reviewing referrals. I think this goes into adoption. Your provider adoption. I was able to come early on, go and say, "why are we saying no? I do not understand." Providing that as a question to your providers, "why did you say we cannot see this patient in the hub?"

Is some care -- having some care there is better than no care. That helps because it is not the administered are coming and saying, "you have to do this, you have to see telemedicine." It is a patient who has a specific need. It is referred to them for help that cannot get there. So, it is really kind of transforming practice matters for us. Competitive partners both of this is a lesson we learned not too long ago. Two weeks ago, maybe. I was visiting one of the hubs.

They said, "this other RHC does not want to refer." They want to, but they do not want to walk in the doors here to see us (Laughs)... Coming soon, we will have a mobile unit. In addition to or in person telemedicine hubs, we'll be able to do telemedicine on this mobile unit.

We are setting up partnerships with these, you know, we do not think about it. Like David said, we did not know what we did not know on that piece of, "they do not want their patients walking into another..." I understand it, I probably would have thought the same thing. We are looking for a solution on that. We think the mobile unit will be that. And then the next slide.

It is an example of a roadmap of where we have started and where you will go with the telehealth hubs. We found this to be a useful diagram for the population... This patient gave us a testimonial.

One of the things that I think really kind of shows patient satisfaction is, she says she has the same attention and quality care that she felt like she would have gotten in an in person visit. Action, maybe even better. -- actually

She is a couple of marketing pieces for us. She has moved all of her care to the help. Even her primary care and she has moved her mother in there, as well...

LAURIE ARCHBALD-PANNONE:

Thank you very much. I am Laurie. I am here for the University of Virginia. I will talk about our program and how we try to incorporate some of the principal, guidelines, or with principal three of. Having integrated and coordinate services. I am a geriatric physician, I have been here at UVA since 2002. I work exclusively with older adults.

So, I will often have my older adults, they are 65 and their parents coming with them, as well. We see multigenerational families, and we see a variety of families... What I will talk about specifically today is, programming put into place at the beginning of March 20.

Kind of preparing as much is because. And responding to the COVID pandemic, ones that hit. In our long-term care facilities in our nursing homes. So, thinking about the third principal. Some of the guidelines associated with that, that is really that ideally, telehealth will facilitate access to older adult health records for the providers. But they will be -- there will be safe and coordinate a transitions of care.

That care is integrated over the whole care continuum. That crucial stakeholders are connected throughout the process. And that that staff aren't really truly working to drive efficiency. Those are the guidelines with the principal. I will walk for our program and how we attempted to work within - you know, strive for success.

In some of these areas. And in other areas, we still have opportunity for improvement there. And what has just been, you know, we have not quite gotten there yet and there is a lot more that needs to be done. So, that is what I will talk about today. Next slide, please.

So, our program we started... It stands for geriatric engagement and resource engagement for care facilities. At its core, the purpose of our program was to try to integrate our community of care as we are looking at this pandemic coming in front of us. We collaborated with her hospital, health system, our local helped apartment, REMS, or laboratory. To really try to bring people together who are going to be critically important to have open communication so our patients can have the best care.

We had multiple different components of our program. We started with educational discussion series. The project ECHO series, where he worked with our regional staff in long-term care facilities. It was really a listen first approach. No one had ever had COVID before. What were people prepared for? What were people not prepared for? Where was COVID? That was the first piece of this. We worked with our nursing liaison, who was a person who is both part of this virtual discussion series, but also connecting directly with facilities to have those same discussions at a more personal level.

To say, you know, what is it that you need? Do you have gloves? Do you have gowns? What can we do to help? Sometimes, we could provide those resources. Sometimes, we can connect facilities with other resources that provide those resources. Sometimes we were just there to help think creatively in terms of how can we get done what we need done.

We had Telemann -- telehealth consultation. I'll talk about that as we go forward. We also did... To help prepare for COVID and working with medical students for both remote and social connections with our residents who were, you know, isolated really in the facilities, especially the beginning of COVID. Those are our components of the program. Go to the next slide.

If the clinical will, as I was sitting there with our goal -- team at the end of February 2020 looking at March... Knowing something was coming, but not quite knowing what it would be. Our goal overall was, "how can we have the best outcome for our patients? Was what happened me optimize the clinical outcome for patients into this unknown world of COVID that we are walking into at the time. So with that goal in mind, we really wanted to focus on, how can we get people to where they need to be to get the best care?

How can we facilitate transportation from the hospital to long-term care facilities... And how can we facilitate transportation back to the facilities. Some were trying -- requiring to the hospital and needed to go to the hospital, our team would work with the transfer of imprint -- information. What we learned very early on, which is better now. But early in the COVID, you know, we are talking about March 17.

Patients were getting sent over to the hospital from the long-term care facility where there may be an outbreak going on. The paperwork that they were coming with, which was critically important to the transition of care, was getting kind of put to the side as (indiscernible). Right? We do not know how to deal with that at the time.

Ultimately, we have been able to get through that information. It was not sitting on the stretcher, so to speak. When the next team came in. So, what RT was able to do in working with the facility and working with the hospital, was able to say, "what electronically can be transferred to you from facility?" again, our electronic medical records are not fully integrated. That is the peace we really need to work on moving forward.

How can we help the transfer of information... Especially if there is a do not resuscitate order. How can we enter the... We also work with our emergency services to help transfer the patient. Which, you know, for those of us who are working clinically at the time, at the beginning of COVID, was hard. It was hard to find a facility.

To find transport. There were able to go inside the facilities during an outbreak, transfer patients. Bring them to the hospital full so that was not as simple as calling 911 and getting them over. Working to know who was able to do that and help coordinate that. We were then able to work directly with our hospital-based colleagues to let them know of the patient's that were on the way. To let them know, directly, through our health system, that one of our UVA physicians has the economist and observe the

patient and consulted on the patient through the facility.

And teams as important for them to be transferred for care, to be escalated for careful thought there was a time when we are able to directly admit that person to the floor. To kind of facilitate them getting the care that they need. To leave the emergency department reserve for patients who had not yet been evaluated. And that triage line. And get -- patients to where they needed. That had unseen challenges there, specifically, the transport.

There is a system in place already. From transferring patients to emergency room and from EMS to continue with the rest of their responsibly. There is not a procedure in place for transferring the patients directly to the floor and having to wait for a bed, for example. That is not something we were able to -- something we had to wait a while to do. Hopefully moving forward... Moving this back on the other side, as patients were in the hospital and getting ready to go back to the facility, ideally, this is all the bees the case.

That the facility is well aware and prepared to accept patients back. Especially in those early days of COVID, to enter the facility new patient was coming back. As soon as they could and to make sure that they were staffed properly. Setting was so important. Our team, in coordination with the hospital team, were able to relay with the facility team. "So-and-so is being laid off the ventilator today falls at the next day she is on 2 L of oxygen." Maybe we are thinking two or three days down the road. That she would be transferring back, so they can start to get prepared for that.

That was the integration pieces we are working with the transfer. For patients in long-term care, this is their home. Ideally, if it is medically safe, we want to be able to treat people in place and not to have to come to the emergency department or the hospital unnecessarily.

Some of the components of our program that we put into place were working come again, directly with our health apartment. Directly with the facility. To help identify and test people in place both up to sound like a simple thing to do in 2022, to get someone tested for COVID. In March 2020, it was really impossible.

So, we were able to coordinate with our lab to directly get the supplies to the facilities test and then bring them back and help with the resulting there. We were also able to assess with what we call the COVID kit, which was our telemedicine deployed kit that has a full examination there to bring that to the facility, and ensure that our pulmonary critical care consultant had the appropriate tools they needed to fully assess the patient in the facility.

And determine if they are sick to be cared for there, if they needed to be transferred. The other component we had when we were dealing with an outbreak, when working with facility that had multiple patients with COVID infection was, we were told daily rants. Virtual daily rounds, I will go into a little bit more on the next slide.

The goal of our virtual daily rounds was to have a systematic approach to how to manage communication, clinical care, and management of these very complex patients. So, we strives to

develop an efficient communication that involves all of our clinical decision-makers, that we would have our nursing staff facility. The primary care clinicians that were taking care of the patients with the facility, as well as our consultant team. We would have this time were coming 30 minute or less, we would work to identify anyone who was in clinical decline and may need a consult.

Hope to escalate care and help identify bidirectional transfers. I will talk a little bit more about virtual rounds in terms of the details. But, when we were able to see in the facilities and what we were able to implement this, we had less patient being able to treat in place with (indiscernible) careful so they wanted to stay in the hospital...

We were able to help to support that. Next slide. We will talk a bit more about the virtual daily rounds. The key with the virtual daily rounds, we were able to have all of the physicians there, the same time, the same call. Making those decisions at the same time. Which really increase the deficiency of the staff so they do not have to try to track down all of the different providers they were working with.

So, we had our primary care providers. Our hospital-based team, facility nursing, all of those together. Virtually. We had a systematic process we become through. So, first we would go to any acute issues of (indiscernible) might have. Anything that happened overnight. We would then have reviewed all of the vital signs for each of the residents, whether they were infected or under investigation. The kind of see if there any set-asides of people who are clinically declining.

We work to identify patients that might be appropriate for consultation for telemedicine, be our primary critical care consultation. Or -- are applied in geriatric care consultation for supper then do inpatient updates. To help and display discharge and facility that need. And then kind of a what else. We were able to really have a systematic approach where we had all of the participant there.

We were able to do this in 30 minutes or less. Because again, facility staff was both very, very busy. Staffing was a concern. So, with that, in terms of thinking back to the principal and guidelines, I will go to the next slide. We were able to work to help to facilitate care.

With coordinated transitions of care. We were able to work together to bring crucial stakeholders together to have that discussion process.

It was kind of integrated care continuum. We work to have that done. It was not really done in a sustainable way. And in large part, because we were not really having all of our staff working and is driving efficiently, it would often be our pulmonary care special consultant he would be directly calling the nursing staff to coordinate the scheduling of the important -- appointment time.

It was getting done. Perhaps, there may have been a better way that we could have done that to distribute it across the team. And then an area that we would like to focus on, is to really have better access to health records. For the telehealth providers. Again, having different EMR's, made it challenging to talk directly. And to get transfer of information. We did our best to kind of do's workarounds. Ideally, we can work towards a system where we do not have to do workarounds in the system just works to help do the work.

So, that is somewhere we still have to go. With that, just a brief summary of what we learn from this program. We learned a lot about COVID, that is for sure. We learned that telemedicine is helpful. It can be helpful, but not alone. Within the construct of the rest of our program, it can be most helpful. Of course we had click -- quick assessments was that we had shared decision-making for sub specially when we had limited availability for people on sites. One of the major challenges we had when we are talking about facility-based nursing staff and staffing concerns is that, with our patient population, there had to be someone there at the Tele presenters.

The staff had the -- had to be there to help with the visit. That was a challenge in terms of stopping. We were able to really focus on working together as a care community. To integrate the communication into (indiscernible)'s appealing daily rounds to help facilitate that in an efficient manner. So with that, that is some of our examples of the program we had. I think I will kick it back to Mike now.

MICHAEL KURLIAND:

Think you, Laurie. Thank you to the rest of the panelist. Hearing everyone's lessons learned, best practices, and thinking about the principles and guidelines, P and G's is what I like to call them.

Also putting my operational hat on. It is really helpful for me to hear kind of where you are already kind of doing is. An alien as you are building your workflows and systems out. Also, the honesty. Like, thanks for identifying these. We really do need to work on these particular guidelines here.

I think as a leader in operations, it would help guide just how I build my programs and the communications around the programs. To that, I just want to ask David to kick off. Maybe everyone else can weigh in. You're learning a lot. David, you share some survey data.

Laurie and Rebecca, you have some lessons learned. How are you sharing that with your providers that might be on the fence, or just kind of your team? What response are you getting now after you shared this new information?

DAVID FLETCHER:

It is a great question. I would say, we have been mediocre at best at it, honestly. It is a challenge for some it is getting that feedback loop to the providers, I think, is absolutely key.

The reason I know we are not doing a great job of it is because, I still see very wide variation within a single service line. So, like some of our primary care providers are doing enormous amount of telemedicine in the patient's homes. We know from the survey data, the patient's get a lot of value out of that. It is much more convenient.

Some of her other providers, especially seeing the same sets of patients, are rarely doing any. I think it is because, the telehealth side, we, have a long way to go to try to explain to providers. Really, they had the same concerns as the patient did, that we saw in the surveys (Laughs). In many cases, there is a perception that it was an emergency measure, tie this over until we kind of get through the initial

hurdles of COVID. And then we can go back to operation normal.

There is still a lot to go. I would say the biggest thing we are focusing on right now is, getting through all of this data.

And really understanding, is it an even swap? Is her advantages to a downstream? We have indications that there are. Other instances where it is actually that we can do it, but we really should not, because they does my we will have to have them come in and bled dry anyway, do not bother. We have to be really transport with both our providers and patients about what the answer to the questions are.

I am hoping to have a lot of data to be able to publish it in the next few years. Working with some of our physicians.

REBECCA HARLESS:

From our perception, we are good at providing data in some instances... That on the back end of our telemedicine visits that say, "We have saved this many ER visits." That is a big number... I do not think it is just bad in West Virginia, then the budget is bad across the nation in healthcare this year. It is a number we have to make really visible.

It is something like \$6 million since 2020. That we saved in your urgent care at PCP visits for just our urgent care piece. Right? When you extrapolate that out there. That is a member we are really good at sharing and we are really good at going in saying this is the downstream revenue.

I think we're in the same place, with David, as far as the providers. And quite frankly, we called it an experiment in the beginning facet that was probably a mistake. Because that gives the assumption of, "I will catch it next time. I will skip." Really, we need that engagement.

I think what helps us, we have marketing out of these locations driving it straight to the patient saying, "you can use telemedicine, you can use it here." Which is creating a pull from the patient instead of the administration. Which is helping change, we are up to a 10% (indiscernible). It also is - the conversations are changing over time to say, in strategic planning of, this is real and this is here. At 10%, to consider that. This is not an experiment anymore. This is real, it will continue to grow.

MICHAEL KURLIAND:

There are a few questions in the QA section. We have a few minutes. Does anyone on the panel want to address any empty questions? I apologize. If we do not get to your question, one of us will answer those questions in an email. We will figure out how to get in touch with you (Laughs).

DAVID FLETCHER:

I see there is one directed specifically to me for some so, I will jump in on that. We are hit and miss on it. In the beginning, I would say in terms of getting the patient engagement, making sure they are confirmed for their appointment, in the early days, we had nothing.

Basically, the first prisoners went talk about patients was the provider themselves. Which was a challenge. You know (Laughs) The provider is doing technical support. So, we built some infrastructure around that now. So, we check in. We have some scheduling type employees who will call the patient ahead of time. Particularly for someone would run a report it to see if they had done a telemedicine visit previously most of if not, we would call them into a check check with them.

And walk them through it. It's make sure they are fully prepared for it. Of course, we have a lot on our website about what to expect with the video visit and things like that for something and, we try to keep it really, really simple. We had a lot of patients who were like, I can handle this. So, that is great. And it has definitely been an illusion that we have had to go through both of our providers do not like being technical support, for sure.

MICHAEL KURLIAND:

Thank you, David... All of this great information around older adults and telehealth, have no fear. West health and resource Center and UVA are working together and creating a center about -- excellent for telehealth engaging. All you have to do is text CE4TA... Stop what you're doing right now and hop on that mailing list. Kathy, I think we have two minutes for wrapup.

I do not know if we have any more time for the questions. We will get to your questions, folks. You will get an email or one of us will call.

KATHY WIBBERLY:

We are getting ready to enter website with all of the principles and guidelines. So, if you do this texting and get on the mailing list, you'll get notified when the website goes live. As well as any new content when it is added. So, I encourage you to do that. I want to thank you for joining us and the webinar series, as you know, from the beginning, is monthly.

The next one coming up is on the topic of reimagining reimbursements, planning first to sustainability for telehealth practices hosted by telehealth resource Center. And looking forward to that on September 15.

So, the registration for that is already up on the national telehealth - the telehealth resource centers.org website. And last but not least, we would love to get your opinion on this particular webinar. So, we would love for you to take a few minutes to complete the online survey. Which I am hoping will pop up for you.

And we will definitely try to get back to you if you had some questions that were unanswered. Thank you for your time, and thank you for joining us.

DAVID FLETCHER:

Thank you, everybody.

SPEAKER:

Recording stopped.

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