Center for Connected Health Policy.

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ARIA JAVIDAN: Hello. My name is Aria Javidan and I'm the program coordinator for the National Consortium Of Telehealth Resource Centers. Welcome to the latest presentation in the NCTRC monthly webinar sear ease. Today's session is at Telehealth Development and Expansion at Specialty Pediatric Health System. Hosted by the Southwest Telehealth Resource Centers. These webinars are designed to provide timely information and demonstrations to support and guide the development of your telehealth programs. Just to provide some background on the consortium there are 12 regional resource centers and two national, one focused on tele telehealth policy and the other on technology. Each serve as focal points for advancing the effective use of telehealth in rural and underserved communities. Just a few tips before we get started. Your audio has been muted. Please use the Q & A function at the bottom of the Zoom platform to ask questions. Questions will be answered at the end of the presentation. Please note that closed-captioning is available and it is located at the bottom of your screen. Today's webinar is also being recorded and you will be able to access today's today's webinar on the NCTRC YouTube channel. With that I will pass it over to the director of the Southwest Telehealth Resource Centers, Elizabeth Krupinski.
ELIZABETH KRUPINSKI: Thank you so much. Good afternoon -- still good morning to a few of you. It is my pleasure to introduce today's speaker, Gigi Sorenson Sorenson. She's the Corporate Director of telehealth for Shriners hospitals for children, responsible for strategy development, operational oversight in the virtual care program across the facilities nationally and internationally. Prior to this she was chief clinical officer VP of operations for a vertically inte integrated telehealth company applicability of hardware and software developed for customers. She's developed remote patient monitoring, director to consumer, outpatient specialty clinic, all while working in a health care system space. Most of her work has been done in partnership with delivering care to multiple Native American reservation sites primarily in the state of Arizona Telemedicine Program. She's published on the partnerships required for success which I think is important. She's been PEI at a number of federal grants to support her telemedicine efforts. Her clinical expertise is in cardiology where she was an advanced nurse and transitioned into her administrative activities. She developed a comprehensive cardiovascular service line for the northern Arizona health care system. She graduated from northern Illinois University with a master's of science in nursing degree and holds a green belt, big fan of all that. She's an active member of the ATA, past chair of the business and finance and industry council. She is currently an active member and past advisory board member. She's a true air zonean, loves to hike, ride her horse and volunteer on short-term international medical missions. Today we're going to hear her expertise and wise thoughts about expanding pediatric specialty health system.
GIGI SORENSON: Thank you, Elizabeth. Very kind. Welcome, everyone. Thank you for taking time out of your day to spend with us. I want to first straight up apologize for my voice. I'm recovering from COVID and so this is left over. I usually don't sound this Mickey Mousey or gangster, depending on the

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flow. I just wanted to go through things and spend some time describing Shriners Hospitals and our telehealth program as it relates to what has happened in the past and where we are going. The exciting thing here is that Shriners has taken on a huge marketing campaign. Instead of Shriners Hospitals, it has been shortened to Shriners children to show our main focus is children. The most significant thing is we are now celebrating our 100th year anniversary at Shriners. It is an amazing milestone, where things were started and how it moved through the system. I want to spend some time describing this because it is critical to understand how we function as a hospital system, which is very different than what people think of in the norm. We've been having a number of major milestones for celebration. Our first hospital started in Shreveport. Shriners first started in 1922 in Louisiana and it was born out of the temple of Shriners in sleeve port that wanted to focus on caring for children affected by polio. That was the focus of the first hospital that got stood up and started our track down the full line of orthopedic care. Through that time, the Shriners at different temples across the United States, Mexico and Canada and then internationally have now taken on causes of this. The next big service line they opened up was burn in 1962. 1980, spinal cord injury and rehab opened up at the new hospital in Philadelphia. 2005, cleft lip and palate services were started and then in 2020, we've just started to expand and grow internationally with our services. Shriners functions in a very specific core group of diagnosis or treatment areas. As it was described, we started in orthopedics. That still is our main driver. A number of our facilities you'll see specialize in one or potentially two of these. Burn is our other major site site. We have four major burn hospitals across the states that care for children with acute burns. Spinal cord injury is another one. Off of that has come a very large and very active physical medicine and rehab component attached between our spinal cord injury and our orthopedic care. Then cleft lip and palate. We have specialized surgeons at a number of different facilities to care for this. For example, in Portland, Oregon. We don't care for all children; we care for this group of children with these four main specialty diagnoses. In that also know that Shriners Hospitals care for children irrespective of their ability to pay. It was actually a new phenomenon to Shriners just in a relatively short period of time, 20 years ago, to even start billing precise insurances. We work off an en enendowment that comes in from the different Shriners temples across the world to fund this activity. So it is a very special thing where children are looked at for do they fit coming into our system for this very specialized care. They can enter our system through any one of our 21 locations between the US, Canada, which is in Montreal, and Mexico City, our hospital there. But as you see, we have facilities that stretch from coast to coast, and they've all been opened by Shriners temples that have founded resources and have been able to do this. You can see each site is color coordinated for what services they provide. For example, in Chicago we have orthopedics, cleft lip and palate and spine care delivery and have those experiments there. It's the same in Texas and in northern California, which also cares for burn. What we are starting to do now is regionalize our care. In the past when these were opened, these were all hospitals that were opened. Now, as you know, being in health care, the switch from in-patient care is moving to the outpatient. A number of these facilities have now moved either into an ambulatory systemic center and/or full-blown cling. For example, Twin Cities is a clinic only. Canada, Montreal, is a full hospital. Greenville is a mix of hospital and clinic. Tijuana is a clinic

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only. Our models are changing. Salt Lake City within the past 18 months moved from a hospital to an ambulatory center. All our sites we have are partnered with another major children's hospital in the city. This allows us to not only capitalize on the orates other expertise of a rounded or integrated pediatric hospital but also sharing the expertise of our specialty surgeons with those children's hospitals in the area. So many of our providers have multiple places where they practice, with Shriners being their primary. It is a lovely symbiotic relationship and also with the advent of our telehealth program, which I'll get into, we are now load sharing a number of relationships across the system. In fact, today we have a clinic with patients out of the Twin Cities area being seen by providers from northern California and Honolulu at the same time. This makes it fantastic. These are a mix of post-op patients for follow-up so they don't have to travel, and pre-op patients to see if they're eligible for surgery. Again they wouldn't have to travel. Nor are our providers having to travel in order to hold these clinics and see these children. That makes it a lovely mix of where we're going. As you see, we are spread. It makes it quite exciting to move from there. We also have a huge effort in our main guiding, you hear it every day, more kids and more places, and now starting to add at less cost, to be able to use the telemedicine piece. We have a huge global community where we are seeing children in the -- way beyond the borders of what we call our three home countries: Canada, US and Mexico. Yesterday we held a huge clinic in Cyprus, where we saw 25 children and we will see 30 more next week in Cyprus. We had a clinic in Panama last week where we saw 35 children. Just all of this. Our international look and our global community pull is extreme. We have a number of affiliate relationships. We're pushing 100 formal affiliate relationships with multiple clinics across the globe, where children come to a centralized location and a provider at that location presents those children to our providers in the US. Those international visits are growing exponentially every day and we get requests from all over the world. That also then pushes us in regard to knowing what countries we can safely practice in for cybersecurity, what type of guidelines are in place in regard to licensure and privacy, just wonderful things to help us move through, and we're doing it. Our US clinics, what we're seeing a lot now happening is load sharing. We'll talk about that as we go on. But the other component of this is that Shriners is known for holding very large outreach clinics so that children can go to a more near and localized clinic in their area and our Shriners teams in the past had sent huge teams down to evaluate these children to see if they were candidates for the Shriners programs that were offered and available. Now we're doing many of these via telehealth so that we either have to send no team to travel or a very limited team that can help get the children ready for evaluation and processed and things like this. So telehealth has come into a huge effort into our outreach clin, that are out there. Another huge component that is built in deeply into our mission and vision of Shriners is research. This has become quite a very heavy talking point or a very heavy activity for us, where there is a number of very active research projects going on at a number of our sites across the country. Very exciting what we're doing, and we'd be happy to share some of that later. Just where we've come, like many others, Shriners had dipped their toes into telemedicine starting in about 2015. In -- as you see, 2017, 2018, 2019, very small numbers that their programs. We'll get into this in regard to some of our challenges that were there. Then of course the pandemic hit and all the clinics closed, so everything was forced

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into telehealth. I joined Shriners in June of 2020, so we've had very busy number of program developments that we can -- that we will describe and talk about. What I want to show on this slide is that from 2020, when Shriners was forced into using telemedicine as really the only way to see children was to do it virtually, we've been able to sustain this program, which is remarkable because there are many programs that are out that after the pandemic saw a very large dip in their numbers and volume. For us, we continue to sustain these volumes across our systems. We got our numbers in for October just last night, and so we're at 15,700 and some visits now. We should end very close to where -- or maybe potentially even exceed our numbers from last year, which is exciting for us to know that the programs we are developing have staying power, our patients, families and providers are trusting this as an excellent and an additional form of care delivery that can be beneficial to them. So we're excited about the numbers. Granted, if you go to other facilities and health systems, these numbers are huge. But for Shriners, this is a really big number and we're really proud of it. Especially knowing where we were and where we have come and we are going to stay. I'm one -- those of you who know me know that I'm a pretty practical kind of person person. I think it's always good in webinars when talking about education is just to be open and share what are our challenges. I have found in talking to colleagues over these many, many years being involved in telehealth, that no-one is ever out there alone. You might as well just admit when there are struggles and where your challenges are and what you have to do to get past them. That way, then I feel maybe if there's something that Shriners has challenged and over overcome, we can share and help each other move and grow. One of the things with challenges is we have 21 sites. There are 21 sites of different types of facilities, with different staffing models and different staffing modes. The telehealth coordinators do not report up through me at the sites at this time, and so what you're dealing with are the needs and demands of each individual site. So you have 21 different efforts going after telehealth. Sometimes that can be challenging. But what we do with these sites is that we meet monthly with these teams and at the team meetings we have the site administrator, the chief of staff, their director of nursing and then multiple people who are the telehealth coordinator and other people involved in telehealth, typically the director of radiology, someone from the business office office, finance, head of the schedulers, et cetera, business development people. This has helped us now coordinate not only messaging but efforts and share success stories from one site to another that is a comparable site so that sites can lift each other up and boost each other up. That's how we're handling that. Also this program, when it was first envisioned, was strictly set up as a video conferencing system and there was very little integration into the electronic health record. It was very hardware-centric, where carts were bought for each site and put in a locked room down the hall where the providers had to leave their offices or clinics and go to. A number of those things have been changing, and rapidly changing on them them. Where we are knew clinically focused, outcome outcome-driven, work progress, improved focused, et cetera. So changing that culture of the program over the past few years. Sometimes it feels like you're turning the titanic, but we've turned and gaining steam and momentum. Others have been challenges for adoption adoption. Of course, changing the mindsets of -- when the pandemic first hit, when COVID first hit, we had to do it, otherwise we couldn't see our patients. Now I can see my patients in person, so why

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would I do it virtually? What we've seen now is families essentially demanding demanding it. Now as we've faced this tridemic thing between flu and RSV and COVID resurgence, and to top that off in some of our areas we'll start to face winter weather issues, such as our hospital in Montreal Montreal, travel and wanting to be out with people is almost forcing those scenarios to maintain an adoption. Maintaining a continued support for this, we have that at the upper levels. We have now started focusing on more so on our patients and families, where we did not do a very good job, and pulling them more in to say what can we do to better support you in virtual care delivery so that you feel comfortable in moving this forward? That has been a main source of us that we have taken on to face that challenge. As we look, like I said, we're very proud of the numbers that we have, but we're always looking for those growth strategies. Where we could expand the program, where should it be, where to we want it to be, and this is just very, very exciting for us as we move forward. A number of it is working with each individual site, starting out with some corporate guidance from our medical affairs department, our hospital operations department, and looking forward to then where do we need to go. We've been really focusing on improving those metrics that show the number of our participating providers. Getting more docs. And also not only just docs but ancillary services, which is our second bullet point. Major focus in virtual care delivery from PT, O OT, speech, nutrition is huge for us, and now getting into child life, behavior health and social worker through our care management program. So building up not only just the volume of cases done but the number of people doing the virtual, so that we can approach it from two different angles. For us, this has seemed to work well. Then each site now we've been working with each site, saying in your facility, based on what type of care is your folks for focus for delivery, what could be potential volume indicators that you would like to hit? What are potential percentage of providers that you would like to see participating in virtual care delivery? And working with each group of providers and each site has its own board, and that board, what they would like to see, and administration, what they would like to see. This has become very exciting for us in order to grow the volume and then also grow the use case scenarios. How many different disciplines are using virtual care? That's another metric that we track so that we know how many different experiments are growing and where are we moving into this. We recently brought on our research team so that they're using telehealth now to educate families and get consent and move them through that system. Our care management program has grown from a pilot now to sustainability. We also have a team we call -- from our prosthetics and orthotics program, POPS team, and they've just now taken off, also doing visits, post-deployment of an orthootic or prosthetic. Families and children come in. It's very overwhelming to these moms who might have multiple kids. OK, here's the new brakes here's how you put it on. Then they go home and it's like is this upside down, is this right, left, is it too tight, too loose as soon as so our POPS team is following up 24 hours post-deployment of a new device, and then weekly for a number of weeks to make sure that mom understands or kiddo understands, are they putting it on right, are there any skin issues, irritation issues, fit issues, so that we can do that. Also then, before a child comes in for what would potentially be an upgrade because they've grown or it's worn out or whatever, our POPS team meets with these children and their families ahead of time to make sure when they hit the door, everything is ready for them, which makes the visit

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go much smoother and much more beneficial. So use of those types of things. And of course the standard things of any type of bundled payment arrange arrangement where you can see children for their post-op visits virtually. Of course, we do that. And then looking also at those evaluation cases. You would hate for a child, especially the international children children, to go through all of the visa work and very long plane rides and travel, being out of their home country for weeks on end, only to find out that they really aren't a candidate or a fit for the Shriners program. All of that is being done virtually now. As we grow those types of international cases, along with the follow-up, you would hate to see someone who came in, had their surgery, they went home after those first couple of weeks of healing, they just needed to be followed up. You can't expect someone to come all the way back into country for a 20-minute post-op visit. All of those cases are now being done virtually and that is helping us to grow that quality program, quality side of our program, so that we know then when children are going home and we're turning them back over to their own primary care provider, their own specialist provider in-country, there aren't any question, concerns. And then as the child grows, and maybe their needs change, they need longer rods put in or it's a multiplestep surgery for that condition to be deemed then functional for the child, that we can either know when to bring them back in-country or our providers can walk those in-country surgeons through what has to be done and how to do it. So a huge educational component, and that is also helping us to grow those volumes and expertise in where we're going. We have a number of sites who have set very specific goals in regard to what type of cases they want to see virtually, what providers they want virtually. We had one site where their speech-language pathologist at COVID had COVID, went home, and they have never come back on site into the clinic. They do all their care virtually -- I take that back. Not all. They rotate where they have one SLP come into the clinic in case there is a child that needs something immediate, hands-on. About 90 percent of their care is now delivered virtually, which is a huge staff satisfaction. Where we see that, we have been able to retain staff this way, knowing that they have that flexibility to work from home and meet their quality guidelines and their care guidelines guidelines. So that's also quite -- it's really good for the staff, it's really good for the providers. Patients feel that extra effort that's being done for them. Those families feel that extra effort. Sometimes these children are very complicated medically medically, surgically, and so being able to stay in their own home. One of the other programs we did is we had a halo traction, very active halo traction program in Philadelphia and those patients typically have to stay in the hospital for almost six weeks. Now they're discharged within 48 hours. We follow them at home. The care managers and the PT's are being able to see them in their homes to make sure all is going well. Huge satisfaction for the families. We're not disrupt disrupting their lives like they had in the past. Huge satisfaction for the providers because they're not having to physically go and round on a patient. They can see these kiddos, back to back virtually in their office. It makes everything much smoother in where we're going. A number of different variables. Each site is different, like I said, based on the type, if it's a hospital or clinic. We work with each site to set specific goals that
are reviewed monthly and then set them annually. As we go for growth, not only do we have growth but we have those other sustainability-type issues. You have to feed and nurture in order to sustain.

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For us, for sustainability, we're working deeper and deeper electronic health integration. We are actually in the process of switching over our EHR to a new EHR, which goes live December 1, just a couple of weeks away, and have been extremely busy,working to make sure that the virtual health program is transitioned into the new AHR AHR. But how can we make it easier and easier on our providers and our families to give and receive medical information back and forth and benefit even more from their telehealth visit. This has allowed us to expand the types of telehealth visits that we do because information is available to the providers and they feel comfortable doing it. We've also worked diligently on work flow process simplicity. I'm not a fancy kind of person, putting mascara on in the morning, like I did for y'all, is a big deal for me. I think I even put on lip gloss. As simple as we can make it, that's what we want to do. We have gotten rid of almost all of our carts and encouraged our providers to work either from their office for simplicity and flow, or some of our sites have developed a telemedicine room inside their clinic. If a provider has a mixed day of seeing kiddos in person and virtually, they can still do it in the same space. Also, we've made a diligent effort over the past couple of years to make it as efficient as possible, so we're very into clicks, how many clicks does a provider have to do in order to get done what they need to get done. This has been very exciting for us. It's also been one of our challenges that, if you remember, we talked about at the very beginning, each site being different and doing that. We've made these work flow processes standard across the system. Every site follows the same work flow. We have built our software responses on this work flow. That way, then, we only have one work flow to teach. If we have sites sharing patients, we might have a provider in green Greenville seeing a kiddo from Lexington. Those telehealth coordinators between Lexington and green Greenville know they're following the exact same process to have that visit done. This is improved satisfaction, after that initial hurdle of we can all do it the same as made it easier. When we're load sharing back and forth, it isn't, well, how do you do it? It makes life much easier. Because of this, we've also become very satisfaction oriented. We want our providers to be happy to see this as just another way to see their kiddos, not, oh, it's another thing to learn. No, that it's much more a normal process for them, that it's not unique, it's not force, it gives them the ability to stretch beyond the physical boundaries of their clinic or town in order to see their children. Because many of our sites, especially our hospital sites, see children from all over the country and all over the world. By using the virtual care sessions sessions that we've put into place, it makes their life easier for trying to figure out that post-op care for that continuity of care until the next step that's needed. Also, with our sustainability, any time we have the opportunity to educate our providers, our patients, we just did a series of four professionally done videos for our patients and families and our providers to walk them through how to get their best experience out of a virtual care session. And how a mom can prepare their kiddo. We still, like others, you still have those sessions where mom is driving down Highway 5 in California with the kiddo in the back seat trying to hold the phone. It really doesn't work well. But it's gotten better and better. For moms showing up to the visit and the child is not there. Yes, you need your child. It's a learning curve, but we take every opportunity we can. And then also working with our providers, that if you are going to do it, here are the benefits, here's how you can set up your home office. When we had providers working from home during the pandemic and their children were also at

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home, and so every available electronic device was turned on, either streaming school, movies, games and then you were trying to have a virtual visit and we would have providers going, well well, the connection is horrible. Well, maybe you've maxed out your routeer. Let's talk about turning things off or boosting your routeer so we have a better connection, working through those things. Any time we can educate, actually working with a team out of gal Galston today to review how they can better utilize the room they have set up for telehealth to make it easier on their providers to share screens so that their motion analysis work can be shared along with their PAX images, et cetera. Any opportunity we get, we love it and we welcome that to be in there. For us, working at these types of things will -- that and setting those goals and objectives we talked about before is our hope for that continued just normalcy of virtual care delivery in where we're going with Shriners. We always love to hear from docs going, "Could I do this?" Or hearing from some of our ancillary services, "I would like to do this." One light I would like to show in this is that with our -- it came from a satisfaction and work flow simplicity, we had a site lose their nutritionist and they were going out and looking for contract nutritionists. Well, another site in the area said knew transitionist said, "I have bandwidth. I could help out." So now we have one of our nutrition nutritionists out of Chicago provides care delivery to our kiddos from the Twin Cities clinic and the St St Louis not only outpatient arena but their in-patient hospital stay too, where they didn't have these resources before and now they do. She's doing about 50 visits a month to these two different sites so that we can then load share and balance what she's doing. She loves it and she feels great community and connection now with these other two sites. We have the same from our northern Ca Cal to Pasadena hospital with our nutritionists and Boston to spring field facilities with our nutritionist nutritionist. This has allowed us to be mindful also then about what type of HR needs do we have, can we snare we're going to be sharing social workers across a couple of clinics because we don't really need a full-time one at either one but we have a full-time social worker who is willing to try it. She's going to be offing her services to another system. This is all just part and parcel of what we're doing and how we're sharing. One of the benefits of meeting with our sites is that we hear these ideas or they say, "Here's our struggle we're facing right now. Is there anything in telehealth that can help us with our struggle?" We love those types of problem solving activities and look forward to it. We are continuing to look forward to the growth of our program and the steadiness of our program. It will be an exciting time switching over EH EHR's and we'll see what happens with that prospect. But always looking forward how we can grow. And then with our international team, it's fun to see how many new countries we went into this month. Look forward to that continued growth of being able to provide the expert care that exists at Shriners to children across the world. I'd like to thank you all for your time today and happy to answer any questions that may have come up. Here's how you can find me. Any time I can offer any guidance or assistance or an ear, always willing to do that. Thank you very much, Elizabeth and the team from the southwest TRC, and it's been my privilege to spend this amount of time with you today.

ELIZABETH KRUPINSKI: That was awesome purchase thank you so much. I'll give you a chance to take a swig of water or something to wet your throat there.

GIGI SORENSON: Thank you.

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ELIZABETH KRUPINSKI: A lot of great stuff. Thanks for the summary. I think a lot of people know the Shriners, but I don't think they always appreciate the extent of what the Shriners do and how much telemedicine they've actually been involved with. I had two questions. The first one is you do international, you go into a lot of local communities in the United States, tribal areas, border areas, kind of everywhere. What's your approach in the telemedicine arena to dealing with the language and cultural differences that you encounter?
GIGI SORENSON: Those are two things that are near and dear to my heart, spending time here in air zonea on the reservation. Culture is extremely important. Any time we have a team going into a new country, we try to make sure that they have considered nuances in regard to who potentially might be in the room with that patient. It might just not be mom or dad. It may be an extended family, and how can they deal with that, and what are appropriate questions to ask or ways to get things done? Now, the lovely thing in regard to language, we have built in on demand interpretation in our virtual care platform that we use. So it's essentially a click of a button. We can pick from 65 different languages, including ASL, and have that come up. If it's more discreet language, for example, from some of our Polynesian islands, we call ahead of time because our visits are scheduled and we can say we need this type of interpretation, so that they're ready and available when we have our thing. The longest we've had to wait for an interpreter to come on is five minutes. We can handle that. It's the culture piece that sometimes takes a little bit of research on the back end.
ELIZABETH KRUPINSKI: That can always be a challenge. Most of what you talked about seemed to be in the telemedicine arena, video conferencing. Do you guys do any audio-only? If so, what circumstances? When you're dealing with all these folks in the rural areas and so on, they don't have often access. Do you do audio-only? Under what circumstances do you guys see it as appropriate?
GIGI SORENSON: We do audio-only. Actually, the first eight months of the pandemic, Montreal was strict strictly audio-only for all of their visits, because the Canadian government has very, very strict regulations and guidelines as to what types of video conferencing programs can be used in country to see patients. It took us a while to stand up a program in Canada. What we use that for, a lot of times, are the pre-op evaluations because the provider ahead of time already has the imaging that they need, they have all the referrals from the primary care and they can speak through with the family, saying, "I see your films, I see this, tell me about this, tell me about that." The other places and some of those quick follow-up visits postsurgical or those quick check-ins, where you don't have to see the kiddo walk across the room or measure angle in a hand that's been operated on. So you don't have to put a protractor on a kid. Things like this. Those are the frequent audios. A number of our ancillary services, so dietary can use this, our care managers can use audio-only also. We prefer video connections, but it doesn't always work. Like you said said, broadband isn't what it needs to be consistently across the world.
ELIZABETH KRUPINSKI: You guys don't deal with insurance. This is all provided to the patients outside the context of their insurance?
GIGI SORENSON: We are now -- if a patient does have insurance, we will bill the insurance company. If a patient does not have insurance or insurance that doesn't cover to the extent of what the costs

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would be, we deal with what insurance will pay and then Shriners picks up the rest.
ELIZABETH KRUPINSKI: Do you have relationships with rural US hospitals throughout the country? How is it received? And do you have much success in working directly with their leadership, especially with the concern with limited staff and resources?
GIGI SORENSON: We do with a number of rural clinics, because that is usually where our outreach clinics end up being held, in the smaller rural hospitals, so that kiddos can congregate within a 50-mile radius versus having to travel hours and hours to get care. So we do have relationships in that manner for those evaluations or group follow-up sessions. Leadership has been -- what we find, we're actually working now up -- going into the Cherokee nation where Shriners have been providing outreach clinics for five or six years now and we're going to be adding a virtual component to it, so a couple more times a year these kiddos can be seen versus maybe just once or twice. There's where we've seen the excellent relationship building. If you throw a telemedicine component into the in-person care you're giving, more children can be seen, they can be seen faster, and their follow-up care can be done easier.
ELIZABETH KRUPINSKI: Nice. How much does the Shriners publish on all this stuff? And where?
GIGI SORENSON: Very little.
ELIZABETH KRUPINSKI: That's what I thought.
GIGI SORENSON: Our providers are individual providers, publish their research. We have a couple of very prolific writers in regard to their research. But what Shriners does, because of the uniqueness of our funding and the Shriners relationships, it's not a super public -- we just don't -- not something you go out and go, "Whoa, look at us." It's more behind the scenes and plodding away, taking care of kiddos.
ELIZABETH KRUPINSKI: That's a great model too. I'm sure you have a ton of data hiding in there somewhere.
GIGI SORENSON: Yes, ma'am.
ELIZABETH KRUPINSKI: Does anybody else online very well any other questions for Gigi? You can just type them into the Q & A box. If not, then I'm going to hand it back over to Aria.
ARIA JAVIDAN: Thank you, Elizabeth, and thank you you, Gigi, for your presentation. I'm going to bring up the closing slides. Just a reminder that our next webinar will be held on Thursday, January 19 of next year. We do not hold a webinar in the month of December for the holidays. That will be on our update hosted by the Center for Connected Health Policy. Please check the consortium website for more information on the upcoming webinar. We do ask that you take a few short minutes to complete the survey that will pop up at the conclusion of this webinar. Your feedback is valuable to us. Thank you again to Gigi for her presentation today and to the Southwest Telehealth Resource Centers for hosting today's webinar webinar. Have a great day, everyone.
ELIZABETH KRUPINSKI: We have additional questions if we have time.
ARIA JAVIDAN: Of course.
ELIZABETH KRUPINSKI: When you have a monthly meeting, do you have all 21 sites present?
GIGI SORENSON: We do a biannual town hall where we have all sites present at the same time.

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Otherwise, it's each site individual, so that we can address those specific questions and needs of that team and share their specific metrics with them, so that it's a more intimate type of discussion.
ELIZABETH KRUPINSKI: Alright. How does an SLP speech-language pathologist find out how to work with you. Volunteer here.
GIGI SORENSON: Hotdog. Email me directly.
ELIZABETH KRUPINSKI: Her email is on the last line. Excellent. How are risk scores tied to international coding and billing via telehealth?
GIGI SORENSON: I will have to get back to you. I don't know. I'm sorry.
ELIZABETH KRUPINSKI: Alright. I think that might be all of it now. Wait a minute. Let me double-check. Do you have SLP internship opportunities?
GIGI SORENSON: Yes, they do. All of our sites that have SLP's do take on interns, and so does our behavioral health providers. Yes, that is an opportunity through Shriners. You can contact either the site closest to you directly or Shriners' HR department.
ELIZABETH KRUPINSKI: Do you guys use remote patient monitoring in any of your activities?
GIGI SORENSON: We do not at this time, because really -- you know, since that's my near and dear baby thing. It is something that we are chatting about, especially with our complex kids who may come in and then land up with other medical conditions or the flu or RSV or something afterwards and could use some targeted monitoring at home post-surgery.
ELIZABETH KRUPINSKI: When people are like, wait, let me ask this. We do have seven minutes left. Are there any other thoughts or questions?
GIGI SORENSON: As soon as I hang up, you think of the most fantastic question or thing to say.
ELIZABETH KRUPINSKI: Exactly. Does anybody have more fantastic questions for Gigi? Alright, maybe not this time. I think we got them all. Again, on behalf of the NCTRC and the Southwest Telehealth Resource Centers, Gigi, thank you so much. That was a wonderful presentation.
GIGI SORENSON: Thank you, everyone. It was great spending time with you.

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