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**SPEAKER:**

Hello, I'm already a job done, welcome to the latest presentation in the NCTRC monthly revenue in our series, today's webinar is 'Utilizing Innovations in Telehealth to Advance the Care of Patients in Congregate Settings'. Today's webinar is being hosted by the mid-Atlantic telehealth resource Center, these are designed to provide timely information and resources to support and guide the growth of your telehealth program.

To provide a bit of background on the consortium, there are 12 regional telehealth resource centers of the country, each serve as a focal point for advancing the effective use of telehealth and supporting health -- access to telehealth services in under supported in rural communities.

Just a few housekeeping tips for get started. Your audio has been viewed for today's webinar, please use the Q&A function at the bottom of your screen to ask questions. Questions will be answered at the end of the presentation. Please note that close captioning is also available, that is located at the bottom of your screen. Today's webinar is also being recorded, and you will be able to access today's empath webinars on the NCTRC U2 channel.

I will pass this over to Kathy Wibberly, from the mid-Atlantic telehealth resource Center.

**KATHY WIBBERLY:**

Good afternoon, good morning, wherever you are, we are excited to be sending this webinar. It comes from a history of the pandemic, and two of our presenters are both former retired University of Virginia telemedicine office key staff.

They are now consulting for (unknown name), as well as on their own. I am thrilled to have both David and Mike with you, they will do a little bit of an introduction of their backgrounds so I will save you from that and go directly to them.

**DAVID C. GORDON:**

Greetings to everyone across the time zone! On behalf of Mike and myself, we appreciate this opportunity to share our COVID story of reaching out to provide care and -- in Concord settings. -- In it congregate settings.

I have to say, right out of the gate, this is therapeutic for us to do. It's important to tell this story. It's as much about the technical and policy aspects of telemedicine, it is much about just the experiential aspect of what we did during COVID, to tell our story with the hope that within these stories, that you will have some ideas about things to do to prepare for patients and congregate settings.

I am very concerned and I promise, while I tend to be hyperbolic, this is not hyperbolic. We are not still prepared for how we care for patients in these settings through telehealth, and hopefully, our story today can help guide some advances both from technology providers, as well as clinical programs, as well as bigger telehealth programs. Next slide.

So this is who we are. This is Mike and Dave's most chaotic adventure, I'm David Gordon, I was the director of operations for many years at the Karen S. Rheuban Center for Telehealth, as Kathy mentioned. I decided to retire right in the middle of COVID, saying "I told you so," On the way out.

I'm still a part of efforts to provide telehealth and throughout COVID was working in development services for congregate settings. Why?

MICHAEL PATTERSON:

Thank you all for having us today. I Mike Patterson with totter technologies, been around healthcare technology for many years starting with radiology and engineering. In 1909, -- in 1999, started working with the Karen S. Rheuban Center for Telehealth, several decades of telehealth experience. Ironically, as many systems as we have implemented and trained on, I've never been on the receiving end of a telemedicine counter until this past Christmas, when also ironically, I tested positive for COVID.

It was a textbook encounter, I'm saying that at this stage -- to set the stage for what you're going to hear. I logged into my chart to send a quick message to my provider. Within an hour, a nurse called me and interviewed me, set me up on appointment a couple of hours later with my provider.

Provider was on time, video and audio was beautiful, 10 to 15 minute consult. Two hours later, or maybe even less, I had my meds called into the pharmacy. I had been picked up, Saul had to do was suffer through COVID. This was a beautiful encounter.

Totier Technologies, this is what we brought to the crisis. It's a wide bubble from engineering to training to building federal relationships, security, grant development, data analysis, and vulnerable populations. Our partners represent over 75 years of telehealth program development, we had also worked together so we knew each other real well and we developed this for prison settings. These are the skills we thought we needed.

We are also the partnership with University of Virginia Center for telehealth and the UVA health system. There is one bubble missing that we learned later and we will mention later, and that's the bubble of the nurse innovator. Next slide, please.

So our aim for today is to share our COVID telehealth experience in congregate care facilities to detail problems we had in reaching most vulnerable populations, I will tell you a little bit about what worked, what didn't work, and what lessons we learned and the charge of those telehealth communities, how do we advances congregant care telehealth moving forward. We all have our COVID stories, this is ours.

DAVID C. GORDON:

On March 10, as our story goes, we felt pretty good about the work we had done over decades to establish relationship with congregate settings. We had done nursing home telehealth, we had been doing some substantial work in prisons over the years, in fact, the prisons were in large part where we began to provide telehealth. When the flag went up on the public health emergency on March 11, and we were watching the march of COVID across the country, we were starting to feel under some very intense pressure to make sure that we had available in the most vulnerable of settings, for the most vulnerable of people, capabilities.

There was palpable fear among the settings, we weren't sure we were ready, we didn't have a clear plan to turn to. When we had begun, our leaders had told us long ago in telehealth, that in five years time, telehealth will be on every doctors desktop. We weren't there, nor were our partner facilities there. We had fixed endpoints out and about in the world, but we had a lot of untested and uneven capability, uncertain broadband allotment.

We had been operating under public health policies, the insanity of the Medicare rules that said, "Hey, you conserve a rural nursing home, but if it's a rural nursing home that's near a Starbucks, it must be urban." We can't provide services under Medicare, which led to us being woefully underprepared to be an environment where the disease was spreading and uncertainty as to how it was spreading, then to move forward.

Not to mention, there was such worry of personal protective gear, ventilators, the lack of iPads, they were uncertain as to the telehealth technology. You guys all know this, we experienced it as an existential crisis, and that's where we began.

We thought we were more prepared, we had said frequently, "Just wait until there is an airborne epidemic, this will really show itself," But here we were. We were seeing the stories out of New York in March and out of Italy, as this New York City ED physician said, "We are trying to keep our heads above water without drowning, we are scared. We are trying to fight for everyone else's life, but we are trying to fight for our own lives as well." That were restarted. Next slide.

The places we start are very important to note. When you read this definition that we got on their, congregate care and Conger get setting, it's a broad definition. It's an environment where a number of people reside, meet, or gather in close proximity for either a limited or extended period of time. That's the easiest definition.

Well, that's everywhere. With schools, with programs, with work, which are congregants settings, people could go home, but when we looked at our most vulnerable patients, those with significant comorbidities, those who were frail elderly, they were living in long-term care facilities, assisted living, they were in regional jail, statewide correctional facilities, we have right out of the gate with people in homeless shelters, problems with them, there was a whole untouched area where we had really not thought enough about prior to this moment in March, and that was the developmentally disabled. People in group homes.

We started in thinking through how we were going to move into these settings. And of course, who we

found in the settings were captured, we hope, in part by this image that you see here. There is the sense of people who were being isolated into a facility who were frail and scared. Alone, looking out the window at their family members, uncertain, unclear about what was happening. People with mental status issues, both rural and urban.

Not to mention all the people that surrounded them, who were taking care of them. Again, this is what we all remember from the news and from the images we saw, it was particular to the charge that we received at the beginning of the epidemic, how do we reach these patients? We quickly started calling our VIPs, vulnerable isolated populations.

MICHAEL PATTERSON:

I was also keeping up the news and thinking this is getting real in our communities. March 25, 2020, I sent an email to Dr. Karen Rubin, medical director at the University for telehealth, and said, "If there's any way I can help or be of service, just let me know, I'm around." I also sent one to my colleague David here as well. That was the night of March 25.

March 26, midday, I was fully engaged with the University of Virginia health system and crisis. We had kind of a unique charge, or at least I thought so at the time. We couldn't go insights to University of Virginia, we needed to acquire the equipment for the University of Virginia, test the equipment, assemble the equipment, deliver the equipment, set it up, and train and the training all had to be done remotely as well.

It was like picking up that pizza, driving across town as fast as you can, and getting it to the home while still hot. That's why we coined the phrase "GrubHub telehealth," In the pictures, I hope it gives you an idea of what we're doing. You see the nice pelican cases in the upper left, the first few sites we went to were in bags and cardboard boxes. We had to get out quickly.

You may have noticed in one of the slides, you can go to the next one, please. The surroundings may look familiar, this is where we are today, this was in my home, my den, my foyer, my living room, my dining room. We were building it here. Testing, making sure it works in a very controlled environment, I have a good broadband connection, so once it was up and running, we get a call to go to the nursing home.

Actually, what we were putting in the kits were iPads, pulse oximeter's, blood pressure cups, thermometers, packing materials with consent forms, all the other forms that were needed by the University of Virginia's telemedicine. We also had a good team in place for technical people, Program Manager, and nurse innovator. We also were using that as a sandbox as we returned to build these kits and put them together, make them work and test.

We were also looking at what else was out there. Once the system was ready to go out the front door, we get a call, we pick up the kit, take it to the site wherein we were in full PPE, sanitized, and at every step, we would place the kit may be at the front door of the location. Contact the person in there that we were meeting, they would come out, put the kit down maybe back up 10 feet or so, then go back and sanitize hands. Then head back and do it all over again.

Once again, GrubHub telehealth. Since we are telling stories today, I realize that March 25, I sent an email. April 13, there are a number of stories before then and after then, but April 13, it was about 230 in the afternoon, either watching an email trail by got a call that we had a skilled nursing facility that had an outbreak, 41/48 patients were testing positive for COVID. Seven staff members, including the major staff members. It took us about 45 minutes, 315, 330 in the afternoon. We dropped it off. I put up in the parking lot, there are a of cars in the parking lot, I don't know if I was going through a crisis, but it was very eerie feeling.

I contacted the person I was talking to, the executive director, I think. She contacted several people and their PPE, which looks like hazmat gear, drop off the equipment pick it up, we set up the test. We go back to our office, we start testing that night, I think around eight or 9 o'clock, meeting with a nurse manager that had been brought in from another facility. They had people out sick at that facility, and there were patients on gurneys in the hallways, trying to take care of patients as we get it done. It worked fine, everything was going well, we got on the network, didn't take very long, I can indicated that back to the University of Virginia.

The next morning, I think it was on 630 or 7:30 AM, maybe a little early, the UTA team was rounding with that site.

DAVID C. GORDON:

Virtually rounding.

MICHAEL PATTERSON:

Virtually rounding with that site. We couldn't go into any of the prisons. We had another rural prison about 45 minutes to an hour from here. The prisons, they had fixed in points so we were taken back to the telemedicine unit at the University of Virginia or Virginia Commonwealth University or any of the others. That would work well.

All of a sudden, we are not able to bring the patient over to medical because we had quarantine areas of the prison. We are testing with cellular iPads because there is no Wi-Fi in administration and most of the prisons. Where the wardens and officers meet.

Fortunately, the cell signals worked where the COVID positive patients were. We were able to work back to UVA, and assisting patients. You will see it in the lower right corner, that's a picture of one that we had at the La Quinta Inn, the local homeless shelter had moved some of the homeless folks into the liquid to him, with set up equipment there, and that was easy, they had good broadband, good Wi-Fi, and it worked well. UVA sent med students over to operate the equipment, and operate the equipment.

One thing we did learn about nursing homes and other facilities, COVID was equal opportunity it didn't matter if you were for-profit or in the jails, COVID was there, and the cases were going up.

DAVID C. GORDON:

I think it is important to note that by quickly delivering our GrubHub delivery to major facilities, and being able to have strong pulmonologist, geriatricians, nursing staff, to triage patients, that deep commitment to caring for patients save lives.

We got patients to ICU more quickly, we were able to stay there, we were able to give to staff at the facility's confidence. It was working. We had a team that was ready to go it made all the difference, having a pulmonologist and geriatrician tell that you made all the difference, to be able to consult with developmental pediatrics made all the difference, have psychiatry, that quick team was really one of the major threads.

Then, to get the technology out as Mike described, to make a call in the afternoon, have the technology delivered, have all the instructions and quick training, having tested, knowing the passwords, going all the kinds of things that we had to have, simple and easy ready to go, right out-of-the-box to test right then at the doorstep, such that by less than 24 hours later, to be rounding on these patients making positions about their care made all the difference.

We were able to do this because we broke rules, we were able to use whatever connectivity work, and thank goodness for the rule changes that were heard on the national level, whether we used (unknown term) or Zoom, whatever we had to use to be able to connect while protecting what is important. Number one, being able to see these patients, getting them to Charis quickly as possibly, which we need to be able to do because their fear in this process. One of the big pieces that we saw early on was the need to finally change this paradigm. It's not that fixing points, it's extremely important in a group home or in a prison environment to have a fixed endpoint where people can get care, but the nature of the pandemic was such that we needed to get to the patient.

The change of paradigm in the middle of a crisis is never easy. We recognize, by needing to reach the patient, we also had to change the system. We had to do both things at the same time with technologies that work. Mike is going to discuss this sum, the symbol of the technology, the more complex we got in that technology, the more we added on peripherals, the more difficult things became for us.

Then finally, the thing that made it work was our good fortune to have nurse innovators, in particular nurse innovators, who new technology, new the clinical issues, but also could speak the language of the front and staff to know how those folks, how anxious they were, how, if technology didn't work quickly, how quickly would be pushed to the side.

So as Mike Ryan, an epidemiologist at WHO said, you have to live fast, have no regrets. If you need to be right before you move, you will never win.

**MICHAEL PATTERSON:**

What didn't work well? There are a lot of points of failure in telemedicine, or there can be a lot of points of failure. Moving forward, we have the technology, so we tried to pair them with iPads, if they were Bluetooth stethoscopes, which we could do no problem.

Understand that on the iPads, we had several video chat program. We had WebEx and Zoom and Polycom and (unknown term), just for example, with a stethoscope, you may have to have another stethoscope program on the iPad in order for the stethoscope to work, because it wouldn't communicate down the channels, the audio channels of the video programs.

You can imagine the workflow where you are looking at video chat and you want to go to stethoscope, you have to minimize the video chat to bring up the stethoscope but you can't hear the video chat. Those are some of the things we were thinking, so in the prisons for example, a couple of those sites went to two iPads for video, or two iPads for the telehealth encounter, one for the stethoscope and one for the video chat.

That works well on that end, sort of well, it's kind of klutzy moving iPads around. On the provider side, it is very clumsy try to move around. That's just one end, and with other stethoscopes, they had to communicate over... An example was connecting to the broadband. Not only a nursing home but inside the prisons, one technology we were using only work at 2.4 GHz. If you know anything about your home networks, you may have two broadband networks in your home, 2.4 GHz and 5 GHz.

The generation of technology reusing only work in two point -- on 2.4. A lot of nursing homes only had 2.5. We were moving through learning, testing, we attested in a controlled environment and work fine, and then we would move out and it didn't work or didn't work well.

We were going to cellular, we didn't have too many problems with firewalls, but some areas, we did have trouble with firewalls like the prisons and some of the nursing homes, we had to work with IT staff behind-the-scenes to get the technologies not only on the network, but to move through the firewalls.

Broadband, I mentioned cellular iPads, we are using consumer, cellular iPads at a few sites. Testing the prisons and testing the nursing homes. We all know about dead zones and we weren't always, many of the prisons in rural areas, you are getting good cell signal even in the parking lot.

Even when we did, it didn't work well, so we were able to work with AT&T and Verizon has a same sort of deal, we're able to get on that first surface -- service which they have for EMS and police and emergency folks, prioritize the traffic so we were able to prioritize telehealth traffic, which helped a lot. Still, like in the prisons, your behind concrete and steel.

We are trying to burp -- boosted those signals because there was no Wi-Fi beyond administration, there were no cell signals back in the cell, so we tried several boosters, some worked better, but we still couldn't adapt the signal to do telehealth.

We found a company, there are several them out there, we found a company that doesn't amazing job with boosting cell signals and can work with several carriers at once and can bond the two carriers together, or three carriers, pick the best signal and it's kind of seamless. It also sets up a wireless footprint for your devices, so you can do your 2.4 GHz or 5 GHz with your iPads or your stethoscopes or whatever you're using.

That works well, we tested at a number of places, there was one prison we went to, we could hardly get a cell signal in the parking lot. We took it back in a population, we were in the common area of the mental health ward of the prison, we got a cell signal but I was optimistic it would work with this device all the way back into the cell area. The prison cell area, not the cellular...

We tested it, we went through the corridor to the pod, walked all the way back to the very end the cells, prison cells, inside the cell with the steel door closed, only through the opening in the food tray opening of the prison door. We still had a beautiful signal, and that worked very well. We thought, "Now we have it, we have a solution, this will be awesome."

You move down and see security unless, you may think HIPAA security which is very important in prisons, but the security we were meeting the prisons was HEPA but we were meeting security, because everything you bring into prison is potentially contraband. An iPad can be used as a weapon. The one we used to boost the cell signal had not been vetted by the state Department of Corrections.

We had permission to go in and test all these devices, when it came to finding what worked, we had our hurdle so we were back at square one. Training, we had multiple shifts, and in the prisons especially, we were moving healthcare staff from one center to another. It became a challenge to train.

When we collected data, we could have done a much better job.

DAVID C. GORDON:

There were quite a few lessons learned through this, and we hope for today, these lessons have value for you guys out there. Knowing that we are at a moment where we are getting ready to end the public health emergency, we had an incredible webinar last week, I encourage everyone to look at it, what the end of the public health emergency means to telehealth, very important to know.

We are facing that, there's some clear lessons learned that I think we need to apply to telehealth going forward in our planning. It is extraordinary, from GrubHub telehealth, that we could do a high addition telehealth encounter through the food slot of a steel door at the back of a mental health ward in a prison. Such that we can provide care to a person that hadn't gotten character in this process. -- Care to in this process.

We can reach this but only if we are prepared, and we take this lesson and use them. That first again is using simple technologies, we need to continue to work hard for technologies that are interoperable and that are simple to use. Use those networks, those emergency networks, cellular networks that might describe it telehealth programs, programs can use those and it helped us to find ways to reach places that we couldn't otherwise reach.

Seeking through the nursing role in particular, and as a communication bridge for this work, because that then leads to partnerships in the community, I cannot emphasize enough how important the fire marshal in our community was to our success and to all these facilities by knowing the first responders, by knowing the maps of these facilities, by having the context -- contacts, by having the



rings, we were able to base our plans to the fire marshal.

What we brought together with GrubHub telehealth programs need to think how they do that, how they deliver technology in these extraordinary moments. FedEx ain't the solution, we had to get ourselves there with technology that was ready to go. So ask yourself, do you have a plan for the next pandemic?

We've done a great job, I share the fact that Mike and I had our first telehealth encounters for our own lives. We've been able to see our physicians that way. We've come a long way, for me as a patient, as a health system. But do we have a plan for nursing facilities? Do we have good solid plans for regional jails, prisons? I know some do not.

Knowing how to prepare for the future is important. Simplifying contracts and contract process is very important. And then in that context, which we've learned and relearned in GrubHub telehealth, to test, test, test, train, train, train. There are so many staff to turn over in these environments, such that we have to prepare both people and systems.

93% of the people who died during the pandemic by February 2022 were over the age of 50 and had comorbidities. They were people with disabilities of all kinds, the most vulnerable people with complex medical conditions in these settings, and they account for the highest portion of COVID-19 -related deaths.

So what do we do? We continue to develop the role of clinical nurse innovator, I think that's a role we need to talk about. We need to find solutions to some significant technology challenges. None of this is to say that places didn't do it extremely well, and at moments, we did it extremely well. Those article citations you saw under GrubHub telehealth, those are our story about the way that we save lives. By using these capabilities. There are technology challenges like stethoscopes and other peripherals, we need to keep working on.

There are great things on the market, but they are also complex when you take them out to these kinds of settings. Programs ahead of time, designed and present. Having boots on the ground, capability, is important, advocating for policy change, the work that we have done through the telehealth resource centers to increase awareness of telehealth, I would point you to our webpage where there is an extraordinary variety of data based on lessons learned from COVID best practice examples, things to think about as we not only build telehealth and electronic medical record and take care of our existing patients and our facilities, but also think about how we reach those who are true VIPs so that we have systematic responses to telehealth in Congo get settings. That way, we can party like a 2020 rather than 1999.

The flags coming down, the national emergency is ending, but we are getting and must be prepared for another emergency because they are likely. Last slide, please.

Everybody can see that but we can't. It's a charge for telehealth workers and that we all have to see if this can serve as a wake-up call for us. We are now in the start of the third year, we should have the

care of individuals in congregant settings as a major goal to see how we can measurably improve that care. Questions?

KATHY WIBBERLY:

Awesome, we have a couple of questions in the chat. One is, does anyone in the organization speak the jargon of the inmates?

DAVID C. GORDON:

I can't tell you how important that is. The person was not in our organization, but the person was the nurse innovator with in the Correctional facilities and had done correctional healthcare for many years.

Mike and I were not thinking, "You can make a shiver out of the cart you put an iPad on," She was able to understand what needed to get approved to move into those facilities.

MICHAEL PATTERSON:

We were also working with the wardens and the lead security officers, and all the medical staff in every prison.

KATHY WIBBERLY:

Next question, is the only HIPAA security available in the cloud encryption?

MICHAEL PATTERSON:

Repeat that question, Kathy?

KATHY WIBBERLY:

The question is, is the only HIPAA security available in the cloud encryption? I guess the question is cloud encryption the only way to ensure HIPAA security? For cloud based services?

MICHAEL PATTERSON:

You can create VPNs and virtual circuits and things in the old school way of configuring circuits, but with today's technologies, in point in point encryption through the cloud is a best practice.

DAVID C. GORDON:

We did have a nightmare because of security just shifting passwords. It made our head hurt every day. We all have that in our personal lives, and if we are going to have to move quickly in crisis environments, while the same time protecting confidentiality and safety encryption, especially in places like prisons, we are going to need new technology, we see stuff out there like people working with pass keys, those things are going to become vital as we prepare for things down the road.

We can't lose two days time because we can't figure out how to work with password changes. We get password changes and downloads from the companies right in the middle of providing care.

MICHAEL PATTERSON:

For some of the apps, you had to have an account set up through the servers or through the company

or through UVA. One thing that was important to note that I did not say, and this happened to one of our first nursing homes, we were told that the only place we are doing encounters will be in the medical clinic, or in the medical rooms outside of the clinic. They are the only places we will do it.

We had tested, it worked well, we explained to the physicians, everyone was on board. I think this was before we had a nurse innovator by the way. The very next day we get an email or call that the technology didn't work. It wasn't only the prisons, if you're going into the individual residents of assisted living, and some of the nursing homes, they are responsible for their own Internet connection, which would also be kind of a nightmare, you have to set up on each individual. Each individual residents network. And cellular. We had similar problems at some of the nursing homes, we may have great cell coverage, and even without the boosters we were talking about, who have great cell coverage, and we invariably want to use it in a place that didn't have great cell coverage.

Our mindset has already -- always been, it's easier to move technology than is to move people. This was certainly true during COVID, so we were scrambling just to do whatever we could to make it work.

KATHY WIBBERLY:

Another question, how can technologies be leveraged to prevent infections in hospitals and institutions?

DAVID C. GORDON:

I think that's the place where we were most prepared. Fortunately, at UVA, we were able to rule out hospital, Ebola got us prepared for using video competent capabilities in a room at a nursing station, and from a physician or caregiver at home for other professions, social work, nutrition, other people who did not need to go through a door, but who could talk to the patient.

In an environment, mind you, where that could be turned off so the patient could have privacy. There is a way to actually measure that, you can measure the amount of door clicks to a room. If you put telehealth capability into rooms in the hospitals, where you can measure that door click and you can reduce it by having basic questions answered, concerns, family connections, etc., through telehealth, you can reduce infection.

In the moments of infection, where we will face things like the avian flu and H1 N1, in hospitals, our genuine hope and desire is that this will be the standard for entire hospitals.

KATHY WIBBERLY:

Absolutely. Another question, what regulatory limits do you still encounter at this point? Our nurse and physician licensing a difficulty that you frequently encounter as it is determined by the majority of states?

DAVID C. GORDON:

Amen, compact licensing sure would help. We have staffing issues, in our system. We look at this as a whole, and then you look at a small rural nursing home or the surrounding of that community or the

need for a pulmonologist, complex health needs to be addressed and it also bolsters the workforce it aids us in a crisis to be able to rely on that.

Yes, there is no question, the biggest problem we face in the most immediate ways is that telehealth licensure because those regulations are still so damn hard. We talked in the last webinar, the redline goes back to the other one you're in, and then to a clinician, and then to an administrator. We have got to develop a simpler template contract that we employ nationwide, especially in the light of emergencies in a pandemic, so that that is not a roadblock for the immediate use of telehealth.

KATHY WIBBERLY:

The whole contracting issue, I don't think anyone has addressed nationally at all. That has been one of the major roadblocks, how do you quickly create contracts between entities that don't originally have contracts and do that in the midst of an emergency where lawyers are trying to. I's and cross T's, change simple words. It's a crazy roadblock that should be there.

DAVID C. GORDON:

We ended up breaking the rules, we use language like "Now that patient is a patient of Dr. Smith from the health system," We were treating it like the sacred relationship that is and not as telehealth as a contractual service for nursing home, we were just ducking and dodging considerations because it was life-and-death. We have to, in this interim period, which could end at any time, time spent on contracting and civil affrication is worthwhile.

KATHY WIBBERLY:

For those of you who don't know the Stark Laws, there was during the pandemic a relaxation of that. As the public health emergency ends, that is going to come black -- come back, the laws were put in place to prevent hospitals from inducing referrals. Meaning that if I give you a bunch of great supplies for telehealth, I give you carts and all this, it will be the appearance that since I received all these freebies, I am bound or obligated to send my patients to you via the telehealth fidgets -- visits and to you in person.

That's with the federal government tried to stop happening, it required you to have these contracts in place and required these hospital health systems, even vendors, to not be able to giveaway product. You had have contracts where you had the entity that you were sending equipment to, let's say a nursing home or whatever, they are actually having to pay for anything that they receive and the only exceptional work around is if you apply for a federal grant and got that grant for that entity. Then you could purpose -- purchase equipment on the ground and give it to that nursing ground -- nursing home or prison.

That was definitely a challenge and it will be a challenge after the public health organization.

DAVID C. GORDON:

There's a lot of difference between giving a small hospital an MRI to reduce referrals for neurosurgical care, and giving somebody an iPad (Laughs)

KATHY WIBBERLY:

Coladas recognize the differences, that's the thing that a lot of policymakers are at least trying to address but has not quite gotten there yet. We have a few comments in the chat, one is, have any of you listen to Tupac to speak the inmates jargon?

MICHAEL PATTERSON:

Yeah (Laughs)

KATHY WIBBERLY:

I think those are all the questions we have. The only comment was, great application of all these revolutionary technologies. All right.

SPEAKER:

Thank you, Kathy, and thank you Mike and David for your presentation today. Just a reminder that our next webinar will be held on Thursday, March 16, that will be on leveraging telemedicine to eliminate outcome disparities for world war newborns, that will be note -- hosted by the Northeast telehealth resource Center. More information is available on our website.

Lastly, we do ask you to complete the survey that will pop up at the conclusion of this webinar, your feedback is valuable to us. Thank you again to the Mid-Atlantic Telehealth Resource Center for hosting this webinar, have a great day, everyone.

DAVID C. GORDON:

Take you, folks.

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