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ARIA JAVIDAN:

Hello everyone my name is aria Javidan I am the project measure for the national Consortium of telehealth resource centers was up welcome to the most recent presentation in the webinar series, today's session is on TAB into telehealth innovative models of telehealth access points, today's webinar is hosted by the North Wells regional (dialogue missed due to speaker's pace) and these revelers are designed to provide timely information and demonstrations to support and guide the development of your telehealth programs.

To provide a little bit of background on the consortium located through the country there (indiscernible) (dialogue missed due to speaker's pace) policy and one on telehealth technology. Each service focal points for advancing the use of telehealth and supporting access to telehealth services in rural and underserved communities.

Today marks the end of the public health emergency and we want to quickly highlight that we do have an an end of the PAG collection on our website that collection includes the resources that you see listed here a post PAG fact sheet that looks at various policies impacting different provider types including clinicians and hospitals and the end of the PAT telehealth compliance checklist for northward (dialogue missed due to speaker's pace)

That is all on our website the telehealth resource sensor.org. Just a few tips before we get started today. Your audio has been muted. Use the Q&A function of the zoom platform to ask questions. Questions will be answered at the end of the presentation.

Note that close captioning is available and that is at the bottom of your screen full stop today's webinar is also being recorded and you will be able to access today's and past webinars on the NCT RC YouTube channel.

With that I will pass it to Jolene Johnson the manager of the Northwestern telehealth resource Center.

JALEEN JOHNSON:

Thank you so much, are you. Good afternoon everybody. Thank you so much for joining today for that my name is Jolene Johnson. I am the program manager of the Northwest regional telehealth resource Center. I pronounce or she/her/hers. For those who might be visually impaired I am a 36-year-old white female with long brown hair, blue eyes, and I am wearing a button up white and brown shirt.

Welcome to our webinar, tap into how telehealth: innovative models of telehealth access points unofficially branded by us by TAPs and joining me is Nikki Perisho our director who will be putting some

links in the chat.

The NR TRC is funded by the health resources and services administration. Otherwise known as HD RSA and the office of advancement of telehealth also known as OA T. We serve the seven state region of Alaska, Idaho, Montana, Oregon, Utah, Washington, and Wyoming.

We work to advance the development, implementation, and integration of telehealth by creating a synergistic telehealth community.

Our purpose is to assist patients, healthcare providers, organizations, and networks and implementing cost-effective telehealth programs into their practice.

The NR TRC collaborates with the NCT RC and regional telehealth stakeholders to serve the Northwest by providing technical assistance, free telehealth training, resources and research related to telehealth and by fostering statewide regional and national collaborations to share knowledge and best practices.

On the slides you will see our highlighted resources including the critical access hospital telehealth guide, our free online telehealth training catalog, our recently released end of the PhD telehealth compliance checklist which is super timely for today and also the NR TRC find telehealth map which includes a mapping of telehealth facilities in the Northwest as well as a mapping of telehealth access points or TAPs.

But speaking of TAPs I want to take a quick minute to define exactly what ATAPI is. A telehealth access point or a T AP is a place for individuals to access a telehealth appointment. The spaces consist of adequate internet, a device with working cameras, speakers, and microphone, as well as privacy considerations in the form of a dedicated room or kiosk where the visit can be conducted.

TAPs also have support staff to assist individuals through telehealth appointments if needed. TAPs are increasingly seen across the nation at community institutions like libraries and community health centers.

TAPs are scalable at many levels. The NR TRC is excited to highlight three of these models today as we see these spaces as a very important tool for filling the gaps in patient access to telehealth.

And that will bring me to our wonderful speakers today. Please join me in welcoming Doctor Amanda Diego, associate professor of the University of Wyoming, Didgette McCracken open canvas and agriculture faculty at Oregon State University, and Leslie Roos programming manager the Department of Veterans Affairs.

Let us get started with Doctor D Diego and the paths program. Over to you!

DR AMANDA DeDIEGO:

Thank you so much! I would like to take a moment to offer thanks to the NR TRC for the invitation to be with you today and I would like to share a bit about what we are doing in Wyoming.

I am excited to share with you the paths program. This is a program out of Wyoming. So outside of this work I am an associate professor of counseling at the University of Wyoming and my background is in mental health. I am a licensed professional counselor and I work and see clients using telehealth in my predominantly rural community of Casper, Wyoming and integrate a lot of telehealth into my training in the use -- work that I do at my university.

The program I am going to talk about today is about how all of these pieces of our very rural were -- world came together to create new ways to grant access to health. Next slide?

So this story begins with a group of researchers and community stakeholders getting together during the pandemic to talk about how we address key barriers to rural healthcare issues.

As many of you probably experienced the pandemic happened and we had to get creative about using things like telehealth to get services to people who needed them. Because in person services were not feasible or a safe option to use at the time. So we, in Wyoming, already faced huge barriers to rural healthcare access thinking about things like geography. In my state we have a common phrase that Wyoming is a big town with long roads.

It is not uncommon to drive 200 miles to get to the next community and so we have these pockets of tightknit communities with limited resources distributed through our state. That geographical barrier became a huge issue in terms of addressing rural healthcare needs in our state.

It look like if you are in a community with a good hospital or a good patient behavioral health hospital or providers local to you things were going OK.

But if you are in the community without those things, particularly in the wintertime, which lasts about eight months of the year you are in a bit of a bind in terms of seeking care. That does not account for the needs of specialty care options or options in terms of healthcare providers so that was a huge issue to address.

There is the common issue of stigma and a safety particularly in the mental health realm which tends to be my focus. We, in the state of

Wyoming have one of the highest suicide rate in the nation and have historically for the last 10 years or so so there is a stigma against seeking health and talking to mental health providers will stop there is a sense of privacy and a sense of shame associated with seeking help.

So, imagine yourself in a rural community that is tightknit and there is one therapist in town. Maybe one counselor or social worker. Everyone knows who they are owned by their offices and everyone knows what everyone's vehicle looks like.

If you are parked outside of the counselor's office and someone sees your truck they know where you are and why you are there and what you are doing. That can be a big deterrent for folks in our communities to seek health and care. There is also an element of safety.

Talking about individuals with domestic violence situations that they are struggling with or issues related to our LGBT population that might not be out or comfortable sharing their identities or even things like substance use struggles where individuals are not feeling comfortable with being open about the struggles and their families.

In the pandemics we switch to telehealth and asked the question of Intel health resources who is being left out and why? We found often these individuals who needed to address stigma and safety were often uncomfortable using telehealth in their home to connect with providers because of these deterrents.

Further there are technology limitations. It is common in pockets of Wyoming to not have access to cell phone service, not have access to broadband internet, to not even have access to reliable satellite internet.

In these pockets doing telehealth from home is not necessarily feasible either because we do not have adequate technology to connect with providers for reliable video connection.

Or even telephone connection if there is no cell phone service where you live. Our indigenous communities this is a big issue because they are highly underserved in terms of broadband internet and cell phone service, etc. In our senior and veteran populations do not have the adequate devices that they need to connect with providers.

The pandemic was a struggling time for most of us but huge advances in terms of telehealth really highlighted the need to find the equivalent of 1/3 space.

So the pandemic highlighted the need for creative solutions to address these barriers to healthcare even in the telehealth room. So our team at the University of Wyoming sat down and tried to find ways to

address these barriers using telehealth with fidelity to make sure that the services being provided really addressed community needs but did so in a way that did not compromise the quality of service provided.

We found this evaluation guide for the Center for disease control that became our guideline. It became our roadmap for how we want to put our path together. That is my pun for the day. I get one and that is it. So these key elements included being innovative in our approach, looking at synergistic and goal focused approaches to addressing these needs, and making sure there was good, solid management and monitoring and feedback and evaluation and communication going on between all parties as things progress.

Particularly looking at meaningful partnership between public and private organizations to ensure that we are working together to address gaps and making sure we have political buy-in from stakeholders and policymakers so they know what we are doing and are backing it up to.

This became the formula or the secret sauce that we use. We wanted to seek a solution in the community to address barriers to telehealth.

A lot of this ended up looking like a counselor, like me, and a librarian, like Lisa Scroggins the detect -- director at the Wyoming berry sitting at a conference table in 2022 and having this conversation of "hey, so as a public library I see you are working hard to connect with communities and ensure that they are aware that libraries are not just buildings that housed books but community centers that has resources. And I am a healthcare provider figuring out ways to address stigma and safety in the community so we can make healthcare feel accessible at a number of levels."

We figured out we were working towards the same goals. This project was born from that conversation of figuring out how to connect with community entities that represent Sais spaces -- safe spaces to or third spaces ? to borrow a library term ? for providers to use when they connect with clients or patients.

So, from that came PATHS that is allowed access to telehealth spaces. That is our official clever branding. Our goal is here are three things: to work in communities to address healthcare equity issues by creating new originating sites or TAPs to create access to healthcare particularly in stigma free environment.

If your home is not an option and provider offices are unsafe or not an option we need another space. We need a stigma free environment to connect. The second goal that we have is to enhance an inclusive provider network for coordinating care, communication between organizations and an awareness of resources for community members.

Part of this involves talking to different entities in the state which had a vested interest in telehealth and doing live information gathering. We had a lot of meetings and a lot of conversations and a lot of informal interviews to learn from our different communities what they have tried before and what was successful and what was not and what you encountered along the way.

We wanted to learn from the experience from those who traveled this road before us. From that we gained a lot of partners because they said "we have tried this and it was not the right time, not enough by in the provider community about telehealth or they do not have the right infrastructure or people were not paying as much attention to healthcare as they are now."

We learned there is a fundamental shift in our communities towards an openness in engaging in telehealth as healthcare providers because of the pandemic. Out of necessity comes innovation. From the communities because of more conversations about healthcare in these communities through the pandemic people are more open to seeking care than they were in the past.

And then the piece of this it that kept coming up in rural communities, people do not know what the resources are. They do not know how to find them. That became a part of what we are trying to do. We wanted to support partners and implement telehealth and different communities.

How we are doing this is focusing on three areas of intervention in different communities. The first was education. I am working with the Wyoming telehealth network to the University of Wyoming and their mission is to provide provider education support and technical training when it comes to telehealth and telehealth use. They also provide a lot of support for community members who want to engage in telehealth that maybe do not know how or have concerns about that.

They have been really important in this endeavor because they are coming in and offering things like technical support, training, and consultation opportunities for providers that want to get involved but do not feel as confident in using telehealth.

There is a lot of education in happening for providers but also education happening on the community level about healthcare resources that are available and how you can access them. We also wanted to focus on prevention and not just intervention. We talked to library partners about how to bring prevention into the picture. What we landed on was piloting a couple of things in our locations.

Looking at things like boosting healthcare fairs in libraries or other accessible spaces. So that we can highlight the availability of

resources in a stigma free space. Looking at integrating health and prevention programming into library calendars so individuals who are interested in attending programming will have options for things like nutrition support or chronic illness management or even bystanders suicide prevention training.

Also a couple of library partners created health information resource centers so in specific areas of the library dedicated to accessing health information and part of our implementation plan is doing suicide prevention training for all library staff. That way they feel they have the tools they need to attend to the populations that might be coming in to use the supports.

Although, what we learned is these patrons are in the library already because it is a safe space and they felt grateful to have the additional level of training to interact regardless. We also looked at things like policy and procedure manuals to see if staff had guidance on how to address emergencies in the library space.

In another intervention which I will talk about on the next slide. So our intervention is working with public libraries around the state and they are providing broadband internet access and providing a secure location for individuals to come out and seek health information and healthcare.

They have built in IT support for our senior populations who maybe do not feel as confident using technology. They are offering opportunities for online scheduling for use of the spaces that we are building in these public libraries. And also data reporting for usage so we can ensure that we are using a data driven approach to our health outreach efforts.

And then we, as a team, are providing awareness and support for marketing in these areas and we are doing all of the nerdy numbercrunching when it comes to outcomes and evaluations for library partners and we are doing a lot of education on the ground both in communities and with providers across the state around telehealth and suicide prevention and the nitty-gritty technical grant writing and management.

When this comes together this looks like building out ADA compliance, private spaces, in libraries dedicated to healthcare usage. So in most of our library partners those will look like these tricked out cubicles that we are having built so there are spaces with computer equipment that is ideal for telehealth usage and so we are doing that currently in three locations and we have grants pending for another eight locations around the state.

Our goal is to work with every county in the state to have these I -- resources available. In some of our more world locations we are

looking at repurchasing our multiple use spaces but in this case it is for telehealth and tracking usage to ensure we are targeting populations that needed the most.

Beyond this we have grown and are working with university extension sites which is more Didgette's domain and working with one juvenile detention center to see what this might look like in a correction setting.

So this started out with a librarian and a counselor sitting in a conference room sharing ideas about how to improve access to healthcare. It has grown so much in the last year. From that we now have an innovative network of partners who are looking at ways to contribute and we have grown even since this slide was made.

How can we contribute what we do to our efforts of addressing healthcare equity and access? We have at connections to USDA and we are working with Montana and Idaho libraries on an interstate connection of public resources and our extension offices here at EW at the office of rural health, we have private foundations who have invested in what we are doing including the (indiscernible) County health trust and the (indiscernible) community foundation and we would be nowhere without the support of the Wyoming State Library and our individual library branch partners.

They are incredible and so dedicated to improving the communities that they work with.

Then of course the telehealth network that has been a huge part of our team. What is exciting is it keeps growing full stop we talked with the AARP and the BA and other stakeholders in the hope for the future is that we continue to partially connect entities together to talk about ways that we can work in the best interest of communities and provide education as needed and provide accessible telehealth spaces in the community with stigma free environments for individuals to access care.

I believe I have expired all of my time. But I am very happy to connect with you outside of this venue or answer questions that you might have if you would love to talk to us about collaborating or our methods or evaluation, all of the things that we are using, we are pretty open book.

We would love to talk with you about how to work in your own communities in the future. Our contact information is available here and I would love to chat with you. With that, I will hand things over to my dear colleague Didgette over at Oregon who is going to talk about cyber mom.

DIDGETTE McCracken:

Thank you Amanda, I appreciate that. Appreciate following Amanda as I will point to some things that she has brought to our attention. My name is Didgette McCracken and I work for Oregon State University. My program area is open campus. And a tiny sliver of agriculture.

I am tasked with filling community needs within three buckets. College and career access, degree completion, and then community development.

Through those three buckets where we landed on some different project work that I have done within our communities is this idea of a cyber mill. I will talk a bit about that today. Amanda led us down the road to this really well because this is a current practice and a solution that we found within our community.

I wanted to echo what Amanda had said. She set it up well for me. My community is very similar to what she described in Wyoming.

We are frontier. We have few people per square mile. And we have quite a large area. The highlighted area is my county. Where I work in the people I serve we are mostly public lands with in our county and our big population centers has hundred and 14 people. Within that area it is 70 miles to any population larger than that.

We are quite remote. As Amanda talked about two it is not unusual to not have cell service and certainly not have connectivity within our area because of terrain or just not having those resources so equity is a real issue that we strive to overcome and in doing so we know that whether it is jobs, education, healthcare, being able to access Wi-Fi internet, broadband, is not equitable in our area.

That is the problem we tried to tackle. To do that we looked at the idea of a cyber mill and created it. Those are the founders and myself. We worked together since 2019 to create something that provided our residents with free and accessible broadband and technology.

A little bit on the creation of that: Amanda talked about multiple things that overlap. We did surveys and talked with partners and look at what our mission should be and a business plan for such a location and then we branded that and that is how we came up with the cyber mill idea.

We started this idea in a small isolated town, Seneca Oregon, its population 180. It is a place in a 70 mile stretch that has the only cell service between our population center in our county and the population center to our south. It is a 900 square-foot building that we created a space for community to access technology and broadband that the community itself has no internet aside from satellite.

I am talking about USENET and some of you might be familiar with Starling. We had to do a lot of fundraising to create this opportunity and once we had it operational there were operations pieces that needed to go into that.

So, what does this space provide? I synthesized this down because we are talking what telehealth access to look at that in particular. It serves many needs but I will talk about those key services that we have seen utilized in the space since 2021 October is when we opened that site.

We have folks who utilized it for mental health services and meeting with providers or providers meeting with their clients. Also accessing providers online in appointments. We created community meeting spaces that did not exist prior and we are talking about small towns that just do not have that space to meet or work particularly when you have clientele and are working with things as sensitive as mental health and health concerns.

Some key partnerships that we created when we created these spaces was of course working with our local providers and local and regional hospitals that we have in the area. We also have a local nonprofit that provides mental health and behavioral health and multiple services, community counseling services and we work closely with our County Senior services and veteran services as we know those folks are often accessing health and medical needs.

In Oregon we have the local health authority which is a state agency and then we also have a local community health partnerships that is where some local money funnels down into County or regional levels for different health projects.

The*denotes some of those folks that have not only supported this or partnered on this but also have provided funding as well and we have multiple partnerships but I want to look at the health side of things today.

So this is an example of what I am talking about. This is the inside of the Seneca cyber mill. We opened in 2021 and what you were looking at on the left is a space with a sort of lounge space and a bar space there where people can come in and work or bring a laptop and on the left-hand side of the photo is some desks where there are three desktop computers and there is a printer/scanner/copier available for folks to print or make copies. You can scan materials. The photo on the right is what we call our conference room which is eight ? 10 person space but it is set up with all of the technology you need for an appointment and privacy.

We have a video camera, speakers, microphone, a computer in there, and

it is a space that you can book online, totally free, you can have an appointment on site there. You can also access anywhere on the web that you need to as far as a telehealth appointment.

The space in a town of 180 I will show you statistics in a minute but I want you to see what I am talking about. Next slide? This is an exterior, it is very simple, we renovated a building that was not in use and it is about 900 ft.? and it is centrally and easily located in a town of 180.

We have a system that we have for entrance into the building and there are instructions on how to become a member. You receive a six digit code and you enter the facility and again, this is free. This leads us to our data collection because when you come in the front door you receive data on who is using it and why.

It is self reported but it is a simple site, we created a community space to make these access points happen. This is some of the data that we collect. Seneca is a population of hundred and 80 and this is as of last month we have had 232 users to our Seneca site.

This is more than 100% of the population which is exciting for us and that demonstrates the need that I think we are filling. You can see the total bookings of 93, that is how many times people have booked that conference room. It has been well utilized and then the charges are therefore the copy machine and you can make 10 free copies a month and beyond that is it is a charge and you can pay online.

This is a sample of some data and we have more data on the next slide. We capture things like age, why you are utilizing the site, and this is all self-reported when you become a member, which is free. You can see different uses whether that is for business and entrepreneurs, medical, work, and a lot of people what I have found is personal is also possibly medical or therapeutic uses as well.

This gives us an idea of who we are serving and why. Again, this is more about our demographics but on the left I wanted to share that we have in Oregon and Oregon health plan which is for folks at a certain income level, I should say below a certain income level, and this is not completely accurate. It should be larger because we did not realize when we first created this the health impact that we created.

This question on the survey came later and I will show you on the other site a more accurate view of how many folks are utilizing the Oregon health plan and our site but this gives you an idea of our demographics as far as poverty level.

We opened this site on October of last year so it is our newest place and it is similar in look and feel. It is a location in our community of 825 that did not have any value to the main street and this

community had more access than the last that you saw but we crated a space where people could utilize technology and had access to a room where they could seek health appointments.

That room is booked as well. Just since our opening we had 43 people book that room. The copy machine is well used, as you can see, and we are already approaching ? actually we are beyond as of yesterday 1/4 of the population.

Quite a bit of usage for the site and this site was a proof of concept on a different level. Seneca did not have access other than satellite. The city has access, it has broadband lines through the city but what we learned is cost is a barrier. Particularly with senior citizens on a fixed income. Those folks have to choose. One gentleman has to choose between his medications or the price of Wi-Fi into his home.

These are decisions that people make and creating a space for folks to utilize and meet and receive health options is real and needed and we are seeing the use and much like Amanda said most folks go up to three hours out of our area for appointments and any specialists.

We have a local hospital but many travel out of the area which is a day of work and sometimes overnight. And sometimes not great driving conditions.

Again, similar demographics as far as uses. With medical and the work. A little more education use because we have a larger population of students in the Prairie city area.

Now you will see a more accurate view of the Oregon health plan because from the beginning of Prairie city we had this question on our survey and it is basically 1/3 of the population that is a member at that level of income to receive Oregon health plan.

This is our website. I would invite any of you to check this out if you have the interest. This is my email and just like Amanda I am happy to share and talk about this project. I love it. We can talk but the impact and how our community is using it but happy to share it today with all of you and our next presenter is Leslie Roos and we will kick it over to her!

LESLY ROOSE:

Thank you for having me to today. I am here to present VA's Atlas program for top ATLAS is an acronym my name is Leslie Roos I am a registered nurse by trade and I have been with the VA over 15 years and a majority of that time has been in various roles in telehealth.

So, we will go into the program overview. Our goal is to enhance the accessibility of the care for veterans and communities and bridge the digital divide. This goes hand-in-hand with what Didgette and Amanda

talked about. There are digital deserts where veterans live where there is no connectivity or options and even if they had technology they might not be able to connect to a provider via telehealth.

So what we did is we look to create an alternative experience to have telehealth at home or routine care at the local VA facility by providing a space free of distractions that is also comfortable and affords a living room like setting to receive free care.

To do that we partnered with public and private organizations to establish comfortable locations for veterans to connect with their VA care team using video telehealth in communities where veterans live far from a care facility or cannot afford it at home.

Future enhancement is we are looking to stand up a grant program to provide organizations funding to create community access points and partnership with their local VA facilities. The picture on the right is our Springfield Virginia. It is not a site not located in a rural area but is a site OK did where there is traffic and congestion.

This is what the space looks like. They use it for their telehealth appointments with their VA and we work closely with the Phillips who donated this agreement to the American Legion. So you can see we have two chairs for both the veteran and a caregiver and there is vanity lighting above the monitor to help with illumination and give a better visual for the providers on the other end and Phillips also has a lighting piece and it does have several different modes where it is bright.

There is a consult mode a cleaning mode and also a relaxation mode where it cycles through different colors. If the patient is waiting for the provider or things like that or to join the appointment they can turn that lighting to their needs.

We have a quote from one of our veteran -- veterans who said "it is so much easier to see my doctor." We have Atlas iced across the country. This is a map of where they are located. You can see some of these icons show a pod like structure similar to Amanda's presentation of those tricked out cubicles and then we also have our Walmart locations where they use their existing health services rooms.

Through our partnership we have five VFW locations, three American lesions, and five Walmart sites and we also have local Atlas sites developed outside of the national pilot that the VA has worked with County libraries and veteran service offices and Montana State University and University of Montana and some health centers in Hawaii.

So, when we think about where to place these sites we think about the broadband and connectivity and we look at the number of veterans

eligible for care and what number of veterans are already taking advantage of these services and we look at the drivetime distance to get to the nearest VA medical center or outpatient clinic, you can see that in the acronym, we look at the market.

Are there outpatient clinics that are going to be decommissioned? Or could we stand up and Atlas site until the facility is able to stand up and outpatient clinic in order to give inner rim coverage? We looked at the non-VA site itself will stop is their support and enthusiasm? How much and how often is the space available for scheduling?

Is the space conducive for telehealth? Is it private? Are there modifications that need to be made? Is it ADA compliant? Things like that nature. We also look at nature -- leadership opportunities was up is there leadership and enthusiasm and engagement among the facility staff?

So when we look at space we were very blessed to have had these pods donated by Phillips. They are not necessary and you can see from previous examples that there are different options and we really look for private and closed spaces.

We like the footprint of 8' x 10' and what we actually did is the pod like structure that you see we took it to the VFW convention as well as the American Legion convention and got a lot of foot traffic from veterans to get feedback of what they liked and did not like and so just about every component of that we have insight from others.

You can see that credenza is carved out of the bottom and we have feedback that veterans with service animals need a place to lay down during the visit and that is why it does not go down to the floor.

You can see there is also frosted glass there beside the door and that helps to feel like the space is not as claustrophobic. And of course the lighting, we have feedback from the providers about the illumination needed to see the nonverbal expressions or if the patient is trying to show them a lesion or a rash they can see that as well as the color.

You can see it in other photos but we work to make sure that we picked a color that did not distort the images of the veterans skin and things of that nature.

We also looked to make sure that the sites are accessible. We are looking at routes that are 36 inches wide and the ADA compliance. If there are doors and windows that they can either be covered, frosted, or have blinds installed to provide privacy.

Sufficient lighting bright enough to navigate and conduct a video

visit and soundproofing and verification that speaking at conversational volume cannot be heard outside of the room.

Seating for the veteran and the caregiver. What we also found is that seating is -- geriatric seating is recommend a full top during our visits dietitians got back to us and said they needed more sturdy seating at those sites.

Having a phone available for technical support that would be needed. If the internet connection goes down or if there are problems or if a veteran shows up at the wrong day or time they can coordinate with the local VA to get scheduled or see if they can be fit in for that day.

Just making sure that all of their equipment is secured, PC, WebCam, electrical cords, things like that. Next slide? So, technology requirements, we look to have an internet connection with the required bandwidth of 25 ? three download and upload speeds and those are the minimum that is recommended for video visits. And then eight Windows 10 computer with a Google Chrome internet browser.

We also recommend a computer monitor to have a minimum display of 27 inches. We got feedback on that as well and 27 and inches and up seems to really work well with the feedback that the veterans felt like they were sitting across the desk with their provider.

They could see and read if they did a screen share of their chart and things of that nature. WebCam and microphone can already be in degraded into the computer or tablet device and then speakers and a wired keyboard and mouse. We had wireless keyboards in the beginning but the batteries went dead when they were not shut off so moving forward we recommend a wired keyboard.

So, clinical services. The selection of clinical services will be determined by the VA sites providing the care. Services must be appropriate for telehealth including services from hubs and so we have clinical resource hubs and telehealth hubs and other specialized services like tele-genomics which provide telehealth care to some of our Atlas site and so we are making sure we have the necessary needs being achieved from the non-VA site.

A demonstrated need in the catchment area and familiarity with service lines in telehealth, that is a good thing about the pandemic, we were able to get a lot of proprietors quickly on board with telehealth and train. Just taking in the lessons learned from other sites.

We request that a minimum of two services be provided at each location and I think Amanda also refer to this in her presentation as well. A lot of these smaller rural towns it is like cheers for everyone knows your name but if you are only offering mental health care it would be easy to determine by process of elimination what the veteran is

therefore.

That is why we recommend a minimum of two. We have been providing services since 2019 and some of the services that we provide the most are primary care, mental health, pharmacy, nutrition, social work, rehab, we have recently had a sleep visit.

We are not limited to any particular specialty. We have been expanding and sometimes veterans themselves request because they have seen their primary care provider at a site and they have an oncoming appointment and they requested they can be seen at the Atlas site for that as well.

So at these sites we do have site attendance. These are donated by the non-VA site. Their responsibilities are to provide veterans who call or visit the site with information about Atlas including contact information and handouts which are provided by the VA and they introduce the veteran to the telehealth room and ensure they know how to utilize the technology and access their video appointment.

We also have guidance provided by the VA as well as some posters. They maintain the telehealth room and clean the space prior to and following the appointment ensuring that equipment is operational and they also contact other parties for assistance as needed.

If, for some reason, there was a power outage and they wanted to test equipment to ensure things were functioning properly or they want to change providers they serve as the point of contact to reach out to let us know and get it set up.

They do not enter the telehealth room during the appointment unless it is in the event of an emergency and they do not access veterans information or provide any medical advice or care.

So, moving forward we are working to establish the telehealth grant program as we mentioned earlier and that is through the John Scott mental health improvement act section 701. As part of those legislative requirements we completed an assessment of barriers faced by veterans in accessing telehealth services and that has been submitted to the house veterans affair committee and the central Veterans Affairs committee and we are also working on developing the regulations to grant awards to external organizations to expand and provide telehealth services to veterans.

On the right, they are, that is a picture of the technology that is actually installed in Springfield Virginia that was taken to the capital building for demonstrations in the Russell rotunda.

Just to give you some additional visuals of what the hardware looks like, on the left this is the pod. It is a place in Eureka, Montana,

and you can see the frosted glass door and the lighting as well as the phone on the counter.

This is Springfield American legion. You probably remember this from other slides. This was not a pod like environment. This space was actually a conference room within the American legion that they offered up to veterans to connect with the VA but they did not want a pod taking up space in the room because they wanted to use that room.

So, Phillips took one wall of that pod and applied it to their existing wall structure there. And so, as I mentioned we also worked with Walmart and their health services room which is adjacent to the pharmacy in most instances and this is a room they used for vaccines and pharmacy medication counseling and things of that nature.

This is what their space looks like. Other community partners, for organizations beyond those supported by the Atlas program team, so veteran service offices, libraries, assisted-living facilities, local VA teams are welcome to pursue those partnerships with permission from their site and their leadership in the partnership and all efforts are managed at the local level by the facility telehealth core Nader designee.

So in the references I have included that we have multiple Atlas videos on our YouTube channel so, in the upper left-hand corner that is the co-create session and you can see the pod like structure behind in the background there. That is the reinforced posterboard that was cut. That way we could get patient feedback and in Eureka Montana the use it after the co-create session on a float to promote the site.

Then we have other Atlas site promotional's that show the pod and include veteran testimonials as well. I will leave those for your own personal review. We also have additional information and health resources. We have a public facing Atlas website and we do update that frequently. If you want to take a look at that and we also have a VA app store pin eight page for the video connect.

Alright, with that I will turn it back over to Jaleen unless there are other questions.

JALEEN JOHNSON:

Alright! Thank you so much, Leslie! That was great. I enjoyed you outlining the specs of the Atlas program that it has for these pieces. That is super helpful. All of that being said, you guys have it! Before we get to the question and answer portion of today the NR TRC would like to take time to spotlight a few TAPs resources that are available. First is the training of national libraries of medicine called telehealth 101. What libraries need to know.

This is geared towards libraries but provides a great framework for

anyone interested in developing their own in their own institution and the second is training we developed in partnership with our parent organization that we taught communication and telehealth network as well as a digital inclusion fellowship with the nonprofit technology Enterprise network out of Oregon.

Navigating the telehealth neighborhood is a guide for digital navigators. Like the NL at Atul and training this is used with digital navigators in mind but it is a great starting point for care navigators, community health workers, or any support staff assisting another person in accessing telehealth.

All courses are open to the public and you can register for either using the QR codes on the slide and last but not least I mentioned previously the NR TRC fine telehealth map and we are pleased to announce that the new layer of public facing telehealth access points is currently live for all 50 US states, territories, and minor islands.

Our facility and telehealth facility mapping remains within the Northwest but this is exciting because we can now map telehealth access points across the nation on this map. If you, or any other organizations you know are providing ATAPI in your community I encourage you to fill out the form on the slide get it on the map.

We hope these efforts create awareness of these spaces that are available for telehealth appointments and also help navigators, providers, and telehealth participants to find the resources they need to participate in telehealth access.

So, that concludes our presentation, a big thanks once more to our presenters. Also to you all for joining us today. For further inquiries you can reach out to us via our contact form and a link will be provided and chat for that.

Now I want to get to the great questions that everybody had within the chat. I think we have only a couple of minutes. If we do not get to all of these we will save the questions and try to answer them afterwards. I know Doctor Diego spent some time answering a few of those but I think one of the best questions that came up that I think people would like to know about if we dive into more detail is funding for telehealth access points.

As well as what the cost is for implementing. I think Leslie mentioned some funding coming through the VA but if you want to dive into any of your processes I think that would be helpful for the audience.

LESLY ROOSE:

Currently right now the VA has worked exclusively through donations. VFW American Legion and Walmart have donated their time, space, and

resources for this as well as Phillips came alongside and donated equipment to the VS so sites, the veteran service organization sites.

And then the telehealth grant program we expected that probably in fiscal year 2025 we can award that first branch.

JALEEN JOHNSON:

I think we are at the hour so we need to wrap up. Again, thank you for joining us and we will try to backtrack on those questions and make sure they get answered for you. Thank you for joining us!

ARIA JAVIDAN:

Thank you, a reminder that our next webinar will be held on Thursday, June 15 on how health equity among Medicare beneficiaries registration for that is available in the consortium website. Lastly we ask that you take a few minutes to complete the survey that will pop up at the conclusion of the webinar and your feedback is valuable to us. Thank you again to the Northwest regional telehealth center for hosting today's webinar and to Leslie, Amanda, and digit for their presentations today.