>> Testing the captioning.
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>> ARIA JAVIDAN: Hello, my name is Aria Javidan, and I'm the project manager for the National Consortium of Telehealth Resource Centers. Today's session is on Optimizing Virtual Care and is hosted by the Pacific Basin Telehealth Resource Center. Just to provide a little bit of background on the consortium located throughout the country. There are 12 regional centers and two national. Each serve as focal points for advancing the effective use of telehealth and supporting access to telehealth services in rural and underserved communities. A few tips before we get started today, your audio has been muted. Please use the Q&A function of the Zoom platform to ask questions. Questions will be answered at the end of the presentation. Please also note that closed captioning is available and that is located at the bottom of your screen. Today's webinar is also being recorded and you'll be able to access today's and past webinars on the NTRTC Youtube channel.
>> CHRISTINA HIGA: Thank you, Aria. Aloha, everyone. It's my pleasure to introduce our speaker today, Chrissy Kuahine is the director. And Leina Kanana is the chief community health services officer. It's one of our largest federally qualified health centers in the state of Hawaii and we are so happy today to share with you their story and highlight their innovation and fantastic work over the years with telehealth and health information. I know they have a very full agenda today, so, I'm going to turn it over to I believe Chrisy, who will be starting it off. Thank you.
>> CHRISSY KUAHINE: Aloha and good morning. This is Chrissy Kuahine and Oahu, Hawaii. I like to put this up in the background. This is really me standing on one of our buildings taking a photo of our coastline. I'm sharing my screen now, so, that's the building on the left-hand side of the slide. It's always just a real reminder for me of how blessed we are to be where we're at, our community, and being able to serve our population with all the wonderful services, including telehealth. I am the director of clinical and patient informatics. My role is I oversee our electronic medical record department, and of course our data and telehealth. That came up in 2020 with all of you. And I've been here for 33 years in different roles. And I am very excited and grateful for the opportunity for allowing us to share what we're doing here out in the middle of the Pacific. I'll turn it over to Leina Kanana to introduce herself.
>> LEINA KANANA: Aloha, everyone. Flower I'm the I'm the chief community health officer. Chrissy and I both started when we were in high school. (Laughing) I've been heavily involved in the social services and enabling services here at the center. And I'm excite to just share with you how we use technology and we integrate that into our care here.
>> CHRISSY KUAHINE: Oh, Leina. Sorry, I didn't see that. I'll switch now.
>> LEINA KANANA: Let's see. We were established in 1972 as a community response to the lack of healthcare providers available here on the leeward coast of Oahu. Back in the '70s when the sugar mills shut down, there was no healthcare. The healthcare offered to our community members were provided by the sugar mill companies. When that shut down, many of our community members had to travel an hour and a half on a bumpy road down to downtown Honolulu to receive healthcare. With some investigation of community leaders back in the '70s they put together a plan to build a

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community health center here that's centrally located on the leeward coast. We've groan from a one-doctor office to being the second largest and oldest of the 15, FQHCs in Hawaii. We employ over 600 employees and most of them are residents of our community.
And so when I talk about leeward coast, this here is a picture of the picture of Oahu. Leeward coast is everything you see on the left side here on that pink shaded area of Waianae. These little dots are most of our service sites that we have operational. We have our main center and then we also have several satellite clinics in neighboring communities. Then we also are operating school-based health clinics in three schools, two high schools and two middle schools, sorry, so that's four. And then we're also branching out to elementary schools in the new school year. Next slide.
Our services are really comprehensive, thus Waianae Coast Comprehensive Health Center. Adolescent health, all the way down to WIC. Most services are offered at the main center and some services are at the satellite clinics. They operate as little mini clinics, but they're fashioned like the main center here. We also provide telehealth visits. The COVID pandemic has really pushed us into the telehealth world where we just were starting to get our footing on telehealth and our training providers. But with the pandemic, we did a fast run into the telehealth realm and we're now full fledged. We have many of our behavioral health and medical visits are done via telehealth here. We also have what we call The Comp at Tamure SuperMarket. We put up a kiosk here in Waianae. It's one of the most major supermarkets here. What a better place to set up a kiosk. We're right in your local grocery store where you can pick up your groceries, pick up your medication, and stop in to see your provider all at the same time.
So, the population we serve, and last year, in 2022, the Health Center serviced just over 35,000 patients through just over 120,000 in-person visits and just over 78,000 virtual visits. So, lots going on here at the center. Our demographics consist of a mix of native Hawaiian, Asian and Pacific islanders, and Caucasians. We do have other ethnicities, but these are the three major groups. The socioeconomic status, about 70% are below the federal poverty level. 3% are uninsured. And we pride ourself in that low number there. And about 10% are receiving coverage under Medicare and are dual eligible. And about 60% of our patients are Medicaid or QUEST. The coverage we call it here in Hawaii is QUEST coverage. We're at about 65% that are receiving Medicaid coverage. Some indicators of the population that we serve. This here just gives you a snapshot of the area, and then our county, which is the whole island of Oahu, and then the state of Hawaii, which are all the major islands. For those living 100% below poverty level, for our community we're at 22.4%, whereas the Honolulu County, our island is at 8, and the state is about 10%. For households receiving SNAP, our community is about 34%, the island is about 10%, and the state is about 11%. Our income for community is averaging around $21,000. Our county for our island is about $35,000, and the state is about $32,000. You can kind of begin to see the socioeconomic indicators and the risk of the community and the population that we serve. For our households, for children receiving assistance for Waianae, we're at 55%, whereas the state and county are in the 20s. For those with no high school degree or diploma, Waianae is around 7%, and the county and the state are averaging around 4%.
This here, we recently gave a presentation to individuals in New York just discussing about the cost of living. And I'm sure some of you who are here from Hawaii can relate to this. Others on the mainland I can just indulge you of the cost of living here in Hawaii. That picture there in the middle is a legitimate picture of a home that was for sale here at Waianae. $500,000. Two bedrooms, one bath, 644 square foot. Whereas you can get something much larger and more spacious and much more beautiful in Arizona. That depicts to you the struggle of the cost of living here in Hawaii. For groceries, you can get

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so much more on the mainland considering what you can get here in Hawaii. The picture on the right of the family there, we wanted to just share with you the multigenerational living that we have here in Hawaii. Because the cost of living, many families, mine, as well as Chrissy's, we live multigenerational. We have our parents and then ourselves, our children, and even grandchildren are all living under the same roof. And it's for many reasons. One, like I mentioned, the cost of living. But it's that aloha spirit that keeps us going and drives us. It's also helps when there are children in the home, as well. You'll find many homes here in Hawaii where people live like this, multigenerational. It's not unheard of on the mainland, but this is our style of living here in Hawaii. The picture on the bottom right where you see those in wheelchairs holding up signs, this was a protest of native Hawaiians on the big island of Hawaii. This is to show you the resilience and the strong culture here in Hawaii. No matter where if the cost of living is hi, people are struggling socially or economically, there's still that resilience, there's still that ohana and our strong cultural ties to our native land and our culture. Next slide.
I'll turn it over to Chrissy.

>> CHRISSY KUAHINE: All righty. Thank you, Leina for setting the stage in terms of the population we serve and our community. The two things that really stand out are how unique we are in terms of our Native Hawaiian population, but also to the challenges that we face for living in Hawaii, the cost of living, and all the other socioeconomic indicators that Leina presented. Now despite all of that, our adoption of emerging technologies really we have not let that stop us in helping our community advance in terms of improving health outcomes using technology. And I didn't have it in this presentation, but usually I have a really great slide that shows what our mission is. And I think it's really telling in what our vision, our mission, our passion, in terms of technology and being able to improve the quality of life for our community. And that is besides being a healing and teaching health center, we are innovators. And this mission was created years ago. And making sure that we use emerging technology to help improve our community's health. And that goes even beyond their health. But also all the other social determinants of health that we know impact our patients and our community's health. So, first thing was we adopted an electronic health record system. We actually purchased next-gen EMR we purchased back in 2000. We've had an EMR system for 20 years. And for a community health center to do that, not using grant money, using our own money, I think that is really telling in terms of what kind of vision our CEO, Rich Batinni, and our executive healthcare team had in knowing the importance of technology and the importance of data capture. And of course, being able to access patients' information regardless of what location they showed up at.
One of the reasons we went with Next Gen is we're able to customize our EMR templates. We have a little over 1,000 either customized or so created from scratch or out-of-the-box templates we were able to modify. And why that's important for us, and we didn't really emphasize this, but we not only provide here at the center Western medicine, but we also provide Native Hawaiian healing. We provide traditional cultural practices, such as massage therapy, but also using medicinal herbs and then a non-traditional way of, not risk, sorry, Leina, help me out here. I can't think of the word.
>> LEINA KANANA: Conflict resolution.
>> CHRISSY KUAHINE: So sorry. Yes, thank you, thank you. Certainly out of the box you're not going to have any of those templates to document any of those services that are provided. We also we're a lead agency in developing the first social determinants of health instrument tool that is now being used all over the country. I want to say this was about 7-9 years ago. Or 7 years ago.
>> LEINA KANANA: Seven years ago, yes.

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>> CHRISSY KUAHINE: What we've done on our end is we modified the SDOH tool we used quite a bit and we're now at version seven. The reason why we modified it is so we can track and collect most appropriately based on our community's needs and how we are able to better serve them. We talked about poverty in our community. When we talk about implementing telehealth, there are certainly challenges when it comes to broadband access. So, internet access when we talk about affordability, and even digital literacy. We'll talk about that in the next few slides. We've seen that the average family income for our Native Hawaiian population is $18,000 per year. So, thinking about whether or not you're going to pay for internet access versus putting food on the table for your family or even gas in your car to get to work, those are the kind of challenges that our community is facing. And despite that, we were able to rapidly transform our in-person visits into telehealth visits at the start of the pandemic. Before I go into that, I think one of the things that really, and this is not just for us, but this is something that all organizations have come to realize and has really been highlighted at the height, the peak of the pandemic in 2021, I think we all realize that there was a digital divide that existed between the haves and, you know, have notes. But really what has come, I think, to light is the fact that one of the social determinants of health is really digital inclusion. So, if you think about all the things that are now exclusively and probably solely only accessible online, you start to think about those that don't have either the ability because of affordability or even geographical. So, really they are unserved because they just don't have the connection. Or if they do, they really don't have the digital literacy to use the internet in a meaningful way that can contribute to all of the social indicators that we know at the end of the day are also contribute to healthcare outcomes.
So, in 2019, we had no virtual visits; it was all in-person. But that wasn't to say we weren't thinking about it. It was fortuitous for us that in 2019 we had already selected a telehealth platform, MEND, and had purchased licenses. Of course, we were planning to roll it out as we do any other project with six months, and then you have an implementation. Well, 2020 pushed all of us off of a cliff and we either had to fly or speed quickly to the ground. So, lucky for us, we did not have a day where we weren't able to service our patients. So, although we closed our physical doors, we were up and running with telehealth as soon as our stay-at-home order was officially announced. Just very quickly, we were able to use ad hoc function, which was just starting a televideo visit either texting or emailing to our patients. We were able to train over 100 providers in 10 days. We had all of our providers. So, these are specialists, not including our emergency room. We do have an emergency room here, but all of our primary care, behavioral health, and our specialty providers all trained by August. And then we had an integrated with Next Gen appointment scheduling in September. We had rolled out to all of our providers and locations. Just some of the things I think if folks are still trying to roll out a particular vendor or you're still trying to expand on your telehealth platform in terms of adoption, these are some of the techniques we used. We set up Zoom sessions just like this one. We left them open three days in a row for eight hours. This was open to everyone. So, not only our clinical staff, but every single employee in our health centers: HR, billing, whoever wanted to experience MEND as a patient, they'd log in, we'd send them a televideo link and we'd send them a session. More than 50% of our employees are from the community. So, what better way to get the word out than hey, this is telehealth, this is how you get connected, than going through your employees who are your community members. And quite a few of our employees are also our patients. So, that was super successful getting people to experience it when they were available. We also had for the in-person visits where folks had to come in, if time allowed and the patient had their cell phone, the MA or clinical assistant would go ahead and demo where an ad hoc function so they would get that training in person for their

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follow-up telehealth visit. We also created a position or I want to say repurposed a position into a telehealth patient education specialist at that time who would contact patients ahead of time to make sure that they had a device, did they know how to use it, and then run through a test if they needed to. The other thing that we looked to was our CEO, Rich, who was excited when HRSA came out with the Optimizing Virtual Care Grant. We had applied. We were one of 29 health centers who were awarded the grant. The other community health center on Oahu was KKV. And really the purpose of the OVC grant was to use telehealth digital tools to open up, and in our case, our goal is to increase access to care. Because at the end of the day, if your patients are receiving care, whether it's in-person or via some telehealth modality, whether it's televideo or telephonic, they're receiving care. We want to make sure we're reducing barriers whether they're technological or in some cases digital literacy. We want to make sure we're able to offer that as a service, an additional service, because we know any time that we can provide care it's going to help our patients in terms of healthcare outcomes.

One of the great things about this grant is you had to make sure you wrote in sustainability. So, that's a little bit different, I think, from some of the grants that we typically apply for. So, that was one of the criteria. You had to show that you had some idea of how you were going to sustain whatever it is that you were going to put in place.

Some of the OVC, these are the strategies that we had determined that we were going to focus on for our grants. So, telehealth service kiosks. Leina one mentioned in the store. We're going to be looking at a very cool news video that was done recently on the kiosk. Telehealth services, this involved also providing digital literacy. We'll see that in the upcoming slides how we offered free kapuna, in Hawaii, that's our seniors, free kapuna, very basic, 101 computer classes. And they walked away with a free refurbished laptop. We're also looking at remote patient monitoring. So, for those at-risk patients. And then we're also developing a mobile app. So, this is something we're currently developing and hoping that this will be one portal for our community to go to for not only their patient portal information, but also for community-based social services and resources. And then the last thing that we had looked at and we are super excited about is our HIT innovations in terms of integrated advanced augmented intelligence, analytics, and machine learning, and NLPs, natural language processing, you'll see in the next few slides.

Just to give you a snapshot of where we are in terms of telehealth adoption and I think really on the right-hand side is what folks are interested in is why it is that our patients, and probably in most cases, why many patients are not able to conduct a full televideo visit and have to opt for a telephonic or audio only. On the right-hand side, this snapshot was about a month ago. We were at 75% in-person on the telehealth side. We're at the 25%. I just looked at our last statistics yesterday. So, we're at about 85% in-person and then the rest are televideo and telephonic. So, as you can see, our telephonic has decreased. Some of those have gone into in-person. The others in terms of televideo, we've been able to address the things like digital literacy and then with the ACP program, which Leina will talk about, affordability. Being able to address affordability. These numbers are from last year, but they've stayed pretty consistent. Again, over half of our patients have either poor or unstable internet connectivity. It's one of those things when we talk about broadbrand access, we have to talk about what's meaningful. You might have access to the internet, but is it strong enough for you to maintain a telehealth visit? Is it strong enough for you, and as Leina talked about, a multigenerational family, if everyone is on the internet, can anyone really do work? Can you engage in distance learning activities? Or even work from home? We have a certain amount of folks that don't have camera-enabled devices. We also have those that don't have any internet access. And that can be due to

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affordability and/or geographic barriers. So, they just don't have fiber to their home or any other means of accessing. And then we also have patients who just don't know how to use, and that's the digital literacy. That's really declined. What I have found just in my own personal assistance with patients is how quite a few patients who have phones and they typically, if they're older, their children or family members are purchasing a phone for them so they can stay connected. But usually if it's a brand new iPhone or Android, besides picking up the phone and answering it and maybe texting, there's not a whole lot they know about their phones. That's where the digital literacy part comes. It's how do I even use the device that I have?

So, one of the things we also incorporated into identifying the challenges that our population faces, so of course not only finding out what the barriers are, but how do we track the services and resources that we're providing them in terms of, in this case, telehealth? So, as was mentioned we've been tracking service codes for about 30 years now. Talk about data rich. We definitely have a lot of information on care-enabling. So, again, these are these services that we provide that we typically typically are not reimbursed for. For the CHCs on this call right now, you totally understand where I'm coming from. Providing transportation, helping family members with their mom or dad to get to a specialist in town or explaining their medication list and why they have to take it. In this case, we created our own telehealth care enabling code. That is all tracked in our EMR and so we're able to systematically track, monitor, and then report on how these types of services impact our patient outcome.

Looking at our telehealth patient assistance kiosk, we have two as I mentioned. On the left-hand side, that's just a visual of what that space looks like. It's about 100 square feet. It's not very big, but it's adjacent to our community pharmacy that we also have in that grocery store. One of the cool things is we have two video platforms that we use. One is MEND and we also use Title Care. For folks who are not familiar with Title Care, it's a really cool device that allows for a physical exam with a remote provider. So, what you're seeing here in the picture is a tool that, it can be anyone. It doesn't have to be a certified medical assistant. In our case, the kiosks are manned with outreach navigators that can help use the tool so the remote provider can visualize the patient's eardrums. They can listen to the patient's heartbeat.

And you'll see that in the next slide with the news report that was just filmed a little bit ago. On the right-hand side is just if anyone is interested, there are different ways that you can set this up. So, besides something on the left that we have, you know, an actual room dedicated to a telehealth kiosk. If you're looking to set up a mobile, flexible way to use any of your exam rooms, or for behavioral health, for that matter, you could use office. We put iPads on rolling cart that we could move them to whatever location the provider needs to connect with when their patients are being seen via televideo. So, this is a news story that we're going to take a look at in just a sec. I'm going to stop sharing my screen for just a moment because I realize I didn't include share sound. Let me do that.

Okay.

>> Telehealth has been a lifeline for many patients, especially during the pandemic.

>> As KITV reports, a community health center is taking it a step further to make it even easier for people to get proper medical care.

>> In Waianae's biggest store she bought her groceries and got a quick check-up, too.

>> How are you doing today?

>> I have an ear problem going on.

>> Tip it up a little bit.

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>> From his office about a mile away, Dr. Steven bradly examined her while she sat in a small kiosk in Tamura's super market.
>> He could see everything as if he were there in front of me doing it himself.

>> With this tool, a community health center has found an innovative way to give patients the care they need.
>> After monitoring her lungs and heart, the doctor called in her medication to the pharmacy in the next room.

>> Okay, I called it in so, you'll be able to pick it up in a few minutes.

>> Okay, thank you very much.
>> The kiosk is part of a strategy by the Waianae Coast Comprehensive Health Center to bring medical care to patients plagued by chronic health problems.
>> Finally, it's coming to places like Waianae, where to me the need is the greatest. This is where the pathology is the most serious.
>> Patients can also get other services including help signing up for health insurance, food benefits, and even housing assistance.
>> Not only your healthcare needs, the cough or the runny nose, but also those things that really impact a person's healthcare outcomes.
>> They also run a center in Ewa. And for Eva, it's a lifesaver.
>> This is the best thing that actually happened in our community.
>> Christine, KITV 4, Island News.
>> CHRISSY KUAHINE: So, talk about one-stop-shop. Because this is a HRSA service location, we do offer transportation to this location. So, our patients are picked up at their home, they can see their provider, pick up their medication in the very next room, and then as you saw here, for our patient Eva was able to do her grocery shopping, and then she can get back on transportation and go home. So, we're very excited about that kiosk. We also have another kiosk that is located in Ewa, one of our service sites. That one was funded by Aloha Care, our QUEST payer. We appreciate their help in supporting that site. That one we use for behavioral health, as well as primary care. So acute-types of visits, as well as patient assistance services. One of the things I'm going to gloss over just very quickly, one of our projects in addressing the need for access to internet, as well as access to meaningful broadband. So, where a patient can either access in their home, outside of their home, and of course maintain something that is strong enough for a telehealth visit or other resources. So, what we have currently set up is a wi-fi, long-range wi-fi infrastructure. On the right-hand side of the picture here, you'll see what is the current coverage. That is our entire campus. We're looking at expanding our community wi-fi initiative beyond our health center down to the coast. And what's starred there, naps – that's an affordable housing complex that we hope to incorporate wi-fi and incorporate the outreach activities and funding to that location. This is the Kapuna Computer Training Courses, which we talked about. Obviously our kapuna were super excited. Our eldest on our top left, 91 years young. On the right-hand side, our kapuna first time ever turning on a laptop, first time owning a laptop, and first time joining a Zoom. Talk about being so excited to connect to the outside world, something that all of us on here probably take for granted. The other thing I really want to emphasize is really partnerships. Really the key is looking at who your partners are, who they could be potentially who are out there with the

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same passion, mission, and goals, that you have in terms of digital access, digital literacy, closing that digital divide. One of our partnerships has even expanded. We are now a partner on their community activities event calendar. This is island wide. Super exciting. Who you see here is Virna Cheung, the director of the Decision Support. She volunteers twice a year her time as a yoga instructor for chair yoga. You have those Kapuna who are accessing from home, as well as at an assisted living facility, where the staff get those folks connected. I'm going to turn it over now to Leina to talk a little bit about our ACP program outreach.
>> LEINA KANANA: Yeah, I'm sure you're all familiar with the affordable connectivity program offered by the federal government. Our LLC that we just formed maybe about two years ago was one of two awardees here in Hawaii. As was mentioned earlier in the slides, the socioeconomic status factors, risk of our patients really have a huge impact on their lives. When this grant came out, we knew that it was something that we really needed to get on. Because this really promotes the affordability of the internet connection. So, the goal here of the grant of our program is really just to increase the awareness of ACP in our population and increase the number of people enrolled across our community. So, we've begun promoting ACP at various community events and we're gearing up for more. We're really reaching out to our community partners, our community social service partners, and trying to see what we can piggy back on each other in promoting this service. And our plan is really to reach those unconventional events, such as bingo nights in our community, where a lot of our Polynesian member congregate at weekly. Sporting events. We have a lot of events on the coast for our kids, parrot clubs, as well as the four homesteads that we have here on the leeward coast. So, homestead is something that you would compare to a tribal land on the mainland, where these are parcels of land for those who are 50% Native Hawaiians. They can take part of this and receive up to $75 towards their broadband service. We're excited about supporting the ACP in our community. Another initiative that we are taking part in is our remote patient monitoring program. We've linked up with a vendor to begin providing these kits that you see here to a cohort, a small cohort of patients. So, each day in their homes these patients will be able to use the tablet and device to transmit symptoms and vital signs over to our vendor. And then it's submitted securely to the clinical team within seconds and then the patient's data is then analyzed and provided, the information is provided to their care team. And then if there is any adverse vital signs or adverse symptoms, then the information is brought over to us immediately. And then our team of nurses are providing round-the-clock, not round-the-clock care, but are on call round-the-clock will be able to adjust their care plan under the supervision of our providers or do any kind of education or referral to the emergency room.
So, with that, these patients have a multitude of useful features right at their fingertips such as educational videos and quizzes, nutrition information. They can hopefully eventually maybe video chat with their nurse, care plan reminders, and medication reminders.
So, we're excited to begin this cohort year. Chrissy?
>> CHRISSY KUAHINE: So, Comp Health Connect. This is something that is in development, I mentioned in our strategies. Just to give you an idea of what we're working towards, our initial implementation will really focus on our Aharo services. One portal where our – Elepaio services. One portal where our community can go to find whatever resources they need, as well as for our patients' medical care portal. Then we look at expanding to community partners, news events. For us in Hawaii, you know, it's the Surf Up. Surf report. And then high school football, what is the schedule. So, really a wide variety of information in one portal.
This is really the exciting part. I know we're winding down our time. I want to make sure we get through

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this. I want to turn it over to Leina to highlight what we're doing in the AI world.
>> LEINA KANANA: Yeah, we're taking a lot of steps in the AI world. To manage our cohorts and population we have at the health center. I was really difficult in those early days, but the early days is not so long ago. As you know, we have complex patients. Multiple comorbidities, health conditions, SDOH factors. We started looking at our high utilizers, repeat admissions. We really focused on our most costly patients. We had adopted ADT fees. We were using that. We also noticed there is a lag with claims-based data. And we've been noticing that we've been reactive versus being responsive. And ultimately, we were just really chasing our tail with these most costly patients. So, we came across this company called Forsight Health Solutions, who their model really is to predict the risk and promote that optimal health interventions for our vulnerable populations. And they really do this by collecting data from diverse sources. So, that could be from our EMR and case management notes where really people don't tend to take note of, our SDOH surveys. Claims data, prescription information, inpatient transitions information. And what they do is they take all of that, they use their proprietary models, their AI analytics machine we like to say, and what they can do is accurately predict their health risks, the costs, the adverse outcomes, and the health disparities of our patients. But most importantly, is that they identify the most effective actions that we can take as case managers to mitigate and reverse those health outcomes and even produce cost savings.
I'm so sorry for the noise. I am underneath our cafeteria and it sounds like a party is going on upstairs. So, studies have shown that 20% of a patient's health and well-being is really driven by the access and the quality of medical services. The remaining 80% is really driven by their social determinants of health. This includes behavior, where they live, and their environment and so forth. So, Foresight, they take these factors as a starting point to evaluate the patient's comprehensive risk and their health status risk. And they give us the most accurate prediction of their risk for their patients by synthesizing all of these data points. And so they're able to pinpoint the individuals that require various levels of care. They're looking for those high-risk patients who would most benefit from a specific service or a specific intervention. And identify that most impactable care services at both the population level and the individual level. So, in other words, giving us that prescriptive analytics. So, this type of precision care for our care coordinators and our community health workers have really been shown to kind of enhance that effectiveness of our program's overall experience. So, in March of 2021, we entered a value-based contract with two health clients here in Hawaii where we identified and agreed upon cohorts with both plans. So, roughly almost 2,000 members. Baseline risk levels and cost measures were measured for both of the cohorts (coughing). Sorry, excuse me. And monthly claims were combined with that EMR data and it was analyzed to kind of give our care team guidance along with the Foresight tool and just to kind of help us monitor our progress. So, our experience in that first year was first of all we saw an extreme amount of SDOH risk contributors. The workflow, just to give you a small detail, was our care team would reach autoto the patient, complete the SDOH or the prepare tool that Chrissy had mentioned. Along with all that rich data and all of those service codes that we captured that Chrissy captured earlier is embedded into our EHR. Foresight is pulling all of this rich data to help us put together these risk factor models for us. These are SDOH risk factor contributors we found. Rates of unemployment, homelessness, those living alone, those with food issues. Next slide. And these are medical risk contributors that Foresight had found in their analysis, those with depressive disorders, obesity, COPD, schizophrenia. So, lots of stuff that they're pulling from our EMR. The next slide goes over natural language processing. So, one of the key features of Foresight is they were able to go into our case management notes. A lot of it is just free texting. Our EMR is not

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designed ultimately for a case manager like our staff. So, what Foresight did is they're able to go into our case management notes and kind of looked at those locked-away EMR notes. So, for this slide here, our codes are our data from our SDOH surveys, would show us what you see here in the blue. That came straight from the surveys or the codes that our staff used. But what you see there in the green is information that came from the system reading our staff's notes. For instance, if staff put in their notes living in a tent or sleeping at the beach, the tool was able to pick out keywords in the staff's notes and say you know what? This patient might be homeless. Because note after note, there was talk about a blue tarp or living in a car or on the sidewalk. So, the tool was able to expand or show us that there's so much more people who are experiencing homeless than just what the survey provides. And we use that natural language processing had pulled out language for other social risks, as well. This here showed us the savings due to our enabling services. So, let's go to crisis stabilization. If we had performed a crisis stabilization on a patient, the costs annually for that patient would be about $1100. So, the Foresight model was able to pull out what kinds of particular interventions and what is the predicted cost savings for that patient annually, monthly, and premonthly. Next slide. Our work with both plans consisted of work for one year, a one-year project. We worked our care coordinators, which are nurses, and community health coordinators at the center to do work with our two cohorts. For the health plan A, the cost savings for this cohort was about $1.7 million, which is an extreme amount in an annual amount of cost savings. So, when we look at cost savings, I should back up a little bit. We look at the baseline period and then the study period and what was the cost of this cohort in those two time periods. So, from 13 we went down to $11 million. Next slide. And then the same thing for Health Plan B. It was about $1.7 million. We're really proud of the services that our staff have been able to provide with the assistance of the AI-based formularies, where Foresight is able to give us prescriptive analytics. And our team takes that and every month we're looking at claims, cost levels, we're looking at all these unconventional data sets that helped guide our care management teams into the work that they're doing today.
>> CHRISSY KUAHINE: Mahalo, Leina. We're really looking at our own value-based care model. This is something that Leina and others on our executive team are presenting, really, all over the nation, because we know, we've known this all along. But now with AI, we're able to prove that what we do in terms of enabling care services, all those integrated services really do contribute to not only improving healthcare outcomes, but also a cost savings. Thanks, Leina. This is our last slide. I know we're at the end. But I think this is really telling in terms of our patients' experience and their perspective of the quality of care when it comes to telehealth. This was our result of our Q1 for this year. Since 2020, we incorporated telehealth connectivity in our patient surveys. So, these surveys are conducted by a third-party vendor that we use and they call patients and ask about their experience. This is the first time , if you look on the left-hand side, the blue line represents our televideo visits. So, our telehealth visits are separated out into telephonic, televideo, and then the in-person is the black line that you see there on the graph. This is the first time that televideo has in terms of satisfaction when you look at overall satisfaction in courtesy and helpfulness, provider listening, provider explanation, provider knowledge or list of patient perspective, provider knowledge of health history, and quality of care, televideo scored higher than the two other modalities. And then on the left-hand side, just down at the bottom, when wee look at ease of connecting with a care team, this was the first time that our televideo experience ended up being better than telephonic in terms of connecting. So, I think we feel happy with our efforts. We know it's making a difference. But we also know that our patients who can connect and who have connected expect that that service line or access to care will continue even in this post-pandemic era.

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We thank everyone for your time. I tell you we could go on forever, but I see that we're at the end. I hope we have some time for questions.
>> CHRISTINA HIGA: Mahalo so much Chrissy and Leina. That was fabulous. I have people texting me how impressed they are. Every section of their presentation could have been split up into an hour in itself. We do have a question from Dan Smith in asking how would you quantify the benefits of telehealth both outcomes and cost reduction? I want to just kind of talk about this question a little bit, because you presented so much on how Waianae is using data to improve care. You talked about telehealth adoption data. A lot of our providers don't actually collect that level. You talked about here the satisfaction. That piece, as well. I wanted to know do you collect data or how do you measure, I guess, it's what Dan's question is. How do you measure it in terms of the benefits in cost reduction, and specifically for telehealth? Leina, you covered the social services and taking that high-risk population. And maybe it's not easy to break out. Because it seems from your presentation that improving health and care is what Waianae does. Maybe you don't break it out that way. I'll turn it over to you to address Dan's question. >> CHRISSY KUAHINE: Thanks, Dan. I appreciate the question. It's very timely. Thanks to Christina, we have been in discussion with UMMC, so, University of Mississippi Medical Center. They are a HRSA telehealth center of excellence designated site. So, with their help and wealth of knowledge and expertise in the research realm, we actually did a study with Foresight Health Solutions between 2021 and 2022, Leina, if I'm not mistaken. It was a yearlong study. They looked at over 14,000 visits. But really what that study was was a hybrid care model. And so we looked at three different modalities. So, in-person only, in-person with a telehealth visit follow-up, and it can be multiple. We broke those telehealth visits into televideo and telephonic. So, if you think back at the slides of why patients would end up being telephonic, then you'll know why we had that modality. But I think the very exciting thing is the outcome that we knew that telehealth benefits, but really what this shows and we actually submitted an abstracted on it, so hopefully we'll be selected, was that the hybrid model in terms of in-person with a telehealth visit follow-up for both whether it's telephonic or televideo experienced all improvements in the health quality measures that we had selected. So, if you're familiar with HQNs, that could be for preventive or disease monitoring. All except cervical cancer screening, which requires, obviously, that a female goes in and sees her provider. We also not experienced better healthcare outcomes for that cohort, but cost savings. We're very excited about that study and hope to share that with others.
>> CHRISTINA HIGA: Thank you so much, Chrissy. I see that Aria's video came on. I don't know if that's an indication that we have to take the last three questions. We will take the last three questions and respond. Leina is trying to respond live right now. I want to thank all of you for attending, especially to our speakers, Chrissy and Leina. What a wonderful presentation. Very exciting. Generating a lot of questions and comments. So, with that, I'm going to thank everyone and turn it back to Aria for closing discussion.
>> ARIA JAVIDAN: Thank you, Christina. Just a reminder that our next webinar will be held on Thursday, August 17th. That will be hosted by TTAC. Registration is available on the website. Lastly, we 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 very valuable to us. Thank you, again, to Chrissy and Leina for their presentation, and to the Pacific Basin Resource Center for their presentation.
>> Aloha, mahalo!

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