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ARIA JAVIDAN:
Hello everyone my name is Aria Javidan and I am the manager for the TRC, welcome to the latest webinar today session is on 'Expanding Rural Access - Key Insights from Implementing Telehealth'. Today's session is hosted by the Heartland Telehealth Resource Center.

These webinars are designed to provide timely information and support to guide expanding telehealth programs. Just some background the consortium, located throughout the country are 12 resource centers and to national. One focused on policy and the other on technology. Each service focal point is around expanding telehealth services to 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 session. Please only use chat to communicate technology issues. Please refrain from using chat for comments. Please note that close captioning is available at the bottom of your screen. Today's and past webinars will be available on the and trc YouTube center website.

With that I will pass it over to Molly Brown, director for the heartland Resource Center.

MOLLY BROWN:
Think you are you. As aria mentioned, I am the director of the Heartland Telehealth Resource Center. We provide resources to Kansas, Missouri and Oklahoma. Today we are showcasing one of our regional experts as we explore key insights and graphical learnings as we explore in limiting telehealth access points across Oklahoma.

Now I would like to introduce our speaker. Samuel Karns is a passionate speaker for telehealth, rural health and library services. Currently he serves as a consultant with Oklahoma Complete Health. He leads initiatives to expand telehealth and rural healthcare. With prior experience in the Oklahoma broadband office he contributed to the states five-year action plan through extensive outreach and data collection.

Samuel also provided consulting services at the Oklahoma Department of libraries supporting 28 libraries into County systems. And worked with the Department of corrections to enhance library access for the incarcerated. I will turn it over to Sam.

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SAMUEL KARNS:
Awesome thank you. My name is Samuel Karns I am a rural and and Telehealth Specialist. I want to thank you all for attending to dig into a couple of things that I love the most which are library services and rural health.

The intersection of both. Just to begin, I work for Oklahoma Complete Health. We are a subsidiary of (Name) which is one of the nation's largest commercial healthcare programs. Essentially, we are in all 50 states. A big focus at our organization is on individual and whole health and also active local involvement. Which you would have gained from a large multistate conglomerate like us but we really try to have strong local focus in the communities.

We think that is the best way to give the members something they are familiar with and comfortable with. Most of our employees that serve in each of the states are going to be from those states.

I myself am from Oklahoma as well. I grew up in rural Oklahoma. Out in would Tonga a little bit, an hour or two hours out West. I am really intimately aware of all of the issues in rural US.

A snapshot of our members. We have 28 1/2 million members. Here in Oklahoma we have a little bit over 200,000 on Medicaid members that just came online. We are one of three providers there, the other two being (Name) and Aetna. One of the things that I like to highlight though is that we are the nation's leader in care for the foster care population. In Oklahoma we are the sole managed-care partner to our special contract.

We will start talking about services to rural communities. Having a focus on whole health an individual, it is usually in the context of social determinants of health like this.

There's only 50% that can be traced back to your jury -- ZIP Code. A lot of these issues are going to be compounded once we get into the rural communities as well.

When it comes to education, lower average job pay, significant gaps in care. Some members are having to drive an average of 30 minutes but we have quite a few members who have to drive upwards of an hour or more for basic care.

Most especially, specialty care. In the southeast region of the state we just had one of the only OBs actually close. If you want to stay in-state you have to drive two hours or maybe drive an hour to Arkansas or 45 minutes to an hour into Texas to get service.

And that is just one example. Depending on where you are in the state there is going to be significant

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gaps in care. One way that I like to look at it, obviously when it comes to access, these barriers overlap to create varying degrees of access or lack there of. Some people may not have transportation but, if they have connectivity we can get them telehealth.

They might not have connectivity but if they have transportation, we can pay for a ride to get to whatever their local provider is

Some don't have any of those options. They don't have connectivity or transportation, have no physical option. And I think that is where something like telehealth and other solutions as well come in. Mobile clinics

Just trying to get out to meet the member is very difficult in some of these areas.

It's coming up with strategies of how you can get into their communities and I guess can fit into their routine so that healthcare can become easy for them. As easy as it is for someone who lives in the city that has access all the time who may only live 10 minutes away from their doctor or less.

This is how I like to picture it is these overlapping barriers and when we come and we can either try to remove these barriers and that creates access naturally or we can come in with targeted solutions that essentially bypass these.

The one thing I do want to highlight is nuchal -- local knowledge. This is something that the more you get into rural communities, the more you see that you may think transportation is an issue but when you get into a community you realize that there is a community action agency that might have a transportation route that you did not know about. Or a local tribe might have some benefits for clothing that you might not know about.

Different things like that. This is all housed within local knowledge and affected by it. So how this looks in Oklahoma I kind of want to highlight

The state of Oklahoma health and equity map, as you can see the dark areas are high risk. Pretty much outside of our major city centers, Tulsa and Oklahoma, you are going to have some high risk areas. These are composite scores of life expectancy, opportunity index, and they will include healthcare and the job opportunities, different things like that.

I like to show that it really highlights that once you are outside of the city centers, there are significant care gaps in these areas. Also, some of these instances when we are talking about high-risk areas, they may be 10 to 15 years lower life expectancy.

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I just looked it up and we have some counties here in Oklahoma that have a life expectancy of 69 years old. And there are some counties in the US that are pushing 90. It is significant differences here.

Also to highlight the average drive time in these areas is also going to be 34 minutes to the nearest possible -- hospital. Again, that might be a local (unknown term) it might not be a high risk hospital able to serve everything. You may have to still get meta-flied to the city so they can take care of you there.

But this is something that I think telehealth has a great opportunity to assist with -- there we go, I lost video for second. With telehealth, we are able to keep members in the local areas and essentially bring the specialist to them.

Another map that tells the same story, is the connectivity map essentially. This is going to show where members have Internet and where they do not. Ideally, you want to be in the green. That's going to be 100/20. That's going to be reliable enough to have video, conferencing calls if the provider you can have back-and-forth information exchanges, no problem.

Anything less than that, you can still do it but it is not reliable. As you can see, it is kind of the same areas outside of the city centers. We still have some significant gaps in connectivity. I will say this is one of the areas that we are most poised to solve right now. There is a lot of funding coming through from the federal government, a lot of the broadband offices that have been set up around the country are doing great work and they are setting up these programs, CPF, digital equity programs that will help close these gaps.

And they have already start rolling out some project funds. So we are starting to see this change. Real time, right now. And hopefully, over the next 5 to 10 years these projects roll out and this will become a problem of the past and we will forget about that portion that is a barrier and it won't be anymore.

And then to the crux of the issue two, you will remember from those previous two maps were those high risk areas were located, the low connectivity also line up pretty nicely -- I don't know if Knisley is the right word, with these tribal jurisdictions.

The tribes have been underserved for years. And you are starting to see that in these Access maps essentially. But it creates another layer to work with in the sense that there is a lot of tribal knowledge and resources and just different processes that can be both beneficial and kind of a hindrance in the sense that it is a new process that you have to learn.

And then also try to figure out how to work with them directly. And this is something I firmly believe that,

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if you work with the tribes and you get them access all of them serve all of the people, all of the residents who live in those town ways.

Maybe not all services but they are not going to turn you away from their hospital. If they have an Internet provider they are going to service you if you are in their service area.

In so far as we can partner with tribes, not only are they trusted members of these communities here but since they have been underserved for so long it is a good way to fill these service gaps that have been around. And one of the things that we have done, these telehealth access points that we are here to talk about was a good way that we could get out into these communities.

It was a way to set up partnerships with them. And what they are is essentially just a booth or a room that we have made more private. We have pre-positioned equipment inside of them, diagnostic equipment.

Since these are all located in libraries they are going to have what we have a digital navigator, somebody who is there to help them either set it up or they can sit through with a patient and help them with using the diagnostic equipment as well.

I really think that's a vital part of having these is without these digital navigators then you are having to deal with a lot of digital literacy issues. But this was a way that we could go and we could physically put something in these communities.

And not only were they great, it was a way for members to go ahead and use these anytime they wanted. But what I think is the biggest selling point for them is the opportunities for ownerships with local providers. It was also a way that we could get private spaces.

None of these communities had any private spaces. And that was becoming a significant issue especially during COVID with people switching to Zoom. Nobody had any place to meet but this was a way we could get a private space out there immediately and then also it being clean and private and accessible

It was a true access point in a sense. These are the five that we placed. We have broken Bow, Hinton, Kemah, Tulsa and Atoka. These were the fried that we placed. We went into a partnership with Oklahoma State University and Oklahoma Department of libraries as well. Each one funding different portions of it and then Oklahoma Complete Health coming in and providing the medical expertise part for the partnerships.

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We are currently in the phase right now where we have these rolled out into all five locations. They have been live for four months and we are in the Data collection phase. We partnered with Oklahoma State University, that is a really robust data collection serving team.

They created a (unknown term) approved survey and they have rolled out to their locations. Now we are just waiting to get the data back. When we are rolling these out one of the things that we want to highlight for everyone is digital navigators were very important part of this and so when we were scoping out locations that was kind of the question of who was going to be our digital navigator.

A lot of our sites were chosen for, digital competencies. Most libraries are going to have some level of that. They all help people day in and day out with accessing stuff online or helping people with resumes. They help to create accounts online. The list is an list of things that they help with. I just wanted to make sure that people were a little bit more comfortable with it so they could actually help someone in the physicians visit. But these models are already out there, exist. If you are trying to roll this out then there are multiple to -- toolkits, trainings, there is everything that you could need from these. If you need any of it either reach out to your telehealth resource centers or you can reach out to me as well.

Just thinking about when rolling it out who is going to be your digital navigator and how are they going to be trained? Another big thing that we wanted was sanitization. While we wanted the libraries to help with these, we did not want it to dominate their workflow.

Some part of this was about automating the cleaning process to an extent. They are all going to have HEPA filters in them that passively clean the air. They will also have UBC lightning in them that will disinfect services between use. Between that and HEPA filters, the services and the air get cleaned. If you have equipment that needs to be cleaned or if you want to do a deeper cleaning with something, I always recommend electrostatic sprayers.

This is kind of ionizes the cleaning solution and makes it cling better to services. It is also very fun to use. I highly recommend it. You walk in and kind of blessed the room with it. But as I said there, it's much faster than a traditional white down. It's 20 seconds to clean a wheelchair versus 84 seconds.

This is something that every time somebody has to clean a surface I always recommend it. It just makes it so much faster. Another focus when we rolled it out was privacy, obviously. All of these are soundproof. Our individual booths that we rolled out came soundproof from the manufacturer. They are truly soundproof in the sense that you can't hear anyone talking in them. You would have to hear somebody yelling and even then, it is pretty faint. But just to be sure we also include a white noise machine to mask any other sounds and make sure nobody can hear anything. This is a big deal in rural communities.

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I always say that everybody's business is everybody's business there. So any time that we can encourage privacy and make them more soundproof, that is what we want to push it towards. I also want to highlight that privacy is a big concern for libraries across the board.

That also made them another natural partner in this. We don't have to worry about them talking about visits or something. They understand hippo laws -- HIPAA law exists. They deal with checkouts and they help people on the Internet day in and day out. This is very much in their wheelhouse.

When it comes to computers it is another question that we get. All of the computers are set up with see IPA compliant firewalls. Most of them are going to have some kind of firewall already on their computers. They also have to have them on staff computers as well.

It is very easy for us to get them put on. They are also set up to wipe all data between uses. I think most libraries will use something like Deep Freeze and there are some like Google admin which is another when you can set up to wipe it. Choose when it wipes either at the end of the day or between uses. There are a lot of those and if you need help you can reach out again and we will help you figure it out.

Just some examples of what these look like. The Benson media Center in Okemah. This was a church remodeled into a media center. They added an elevator to make it ADA compliant. There's going to be tons of the computer set up in there. And honestly, I don't know all of the resources they have in there now.

We partnered with local providers, many health departments and then my organization as well. We held a health fair there for the grand opening. And that worked out great. We had a mobile clinic come up and showed off the booth as well.

One of the things I like to highlight is kind of the growth that came from this was Cliff right there was the director of this at the time. And he did a lot of research for us on partnerships and best practices. He works with me now. Oklahoma Complete Health grabbed him up. But I just like to highlight it. Telehealth in these communities that did not have it before, it's more than just providing access it also provides opportunity. That is something that we all need.

Another example here is the Southern Oklahoma library system. We hunt -- we funded one in Atoka for them. They are looking for funding for 1/4 location. They have partnered with the Red Cross, FEMA, small business administration for disaster response they have been using their spaces. Atoka was just recently hit by a bad tornado that took a lot of damage.

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Luckily the library is one of the few things standing in the section. It was about one block away from being completely wiped out but because that was still open we were able to use their meeting spaces. But they have kind of gone all in in the health arena you could say, I guess. They hold vaccine clinics, exercise equipment, health literacy programs and all of that.

Hinton is another one to that we have just rolled out and I like to bring this one in just to highlight all of the equipment that we've put into all of these. These are very easy to use self-diagnostic equipment so that somebody can go in and do the diagnostic portion of their doctor's visit just with their physician talking them through it. So, an example is Tyco kids or med one something simple like an all-in-one scope and you have these detachable pieces that you take on and off.

Really easy to use. Again, your physician could walk you through it. This one is also exciting and I will jump back to this but it is located on the same grounds as a public school. So, there is a lot of opportunity there to use it for school telehealth partnerships. Some other use cases are again, school telehealth.

People use them for sensory rooms. I really like to think of it too is a supplement for mobile clinics. A mobile clinic is going to be very expensive. (Laughs) The Oklahoma just bought two meaty -- medium-size semi's that they repurposed as mobile units. They have a couple of rooms in them, a lobby, some diagnostic equipment. For two of them it was a little over $1 million.

I just think about the fact that for $1 million I could put one of these in almost every town in Oklahoma. When you are thinking about a rural response plan, I like to include these as a supplement in the sense that if you were to take your mobile clinic that has one room and you went to this community, if you stop at the library and could use these spaces then you have two meeting spaces instead of just the one. The nice thing to is that the mobile clinic goes away at the end of the day. You might not see it again until next year.

If that. And these stay in the community and can be used for multiple purposes. At least the ones that we implemented, are actually movable. They don't have to be fixed to a certain location. So, if we wanted to move it to another school or something like that that would utilize it more, that is something we could look into. We have senior centers that are looking at it.

As I said before, there is disaster response that is a good option to have for FEMA. And then vaccination clinics as well. I wanted to highlight to you that we partner with Oklahoma University that has a great telehealth program. I just wanted to show this quick video.

(Video plays)

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SPEAKER:
When your kids get sick at your school it can be stressful to know what to do. Thanks to a new partnership with Oklahoma telehealth, sick days are about to get a lot easier. They bring the expertise of our trusted doctors and nurses to your child's school. Here is how it works, when your child visit the school nurse the nurse has the option to start a video visit with the doctor at Oklahoma children's Hospital. To be eligible for a visit throughout the school year you will need to sign a permission form in advance. Through a secure link the doctor at Oklahoma Children's Hospital is able to evaluate your child's symptoms, make diagnosis and send electronic prescriptions to the pharmacy of your choice if needed. Some common conditions seen during school telehealth visits include sore throats, cold and flu symptoms, rashes, abrasions and pinkeye.

Using a camera, stethoscope, the school nurse can assist the doctor in looking into your child's ears and throat and listen to your child's heart and lungs. After the telehealth visit your doctor might recommend that the child returned to class or be picked up from school. If needed, they can help arrange in-person follow-up care. Parents are updated after the visit or they can choose to visit the -- join the visit virtually. Oklahoma Children's Hospital can help connect you with an primary care doctor if you do not have one. To sign your child up for OU health school-based telehealth program, ask your school nurse for an enrollment packet which includes forms about your child's health history and consent form.

The school-based telehealth program is available to any enrolled students regardless of insurance coverage status. No out-of-pocket payment is needed. If you have insurance it will cover the cost but if you do not have it then the visit will be covered for you. After you complete these forms, returned to the school nurse or front office.

SAMUEL KARNS:I just like to highlight their program. They do wonderful work. There are a lot of providers now that are expanding into that area. I just met with Oklahoma State University as well. They have been expanding quite a bit into the school telehealth arena.

There's a lot of opportunity for these to support that expansion as well. Some of the challenges to deployment that we are facing right now is the first one is visibility. Nobody knows that these are in there. Especially just being in five there were rural locations in Oklahoma. There have not been enough talk about using these but really talk about telehealth in general.

Nobody has that reflex right now of something might be wrong, let me see what my telehealth resources are available. If I call in first before driving an hour to an urgent care.

This is a tough issue because it's not just the patients that we are trying to educate it's the providers as

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well. The providers know their patients the best. The provider does not know about it then it's probably not going to be a suggestion ever. And so patients then, it trickles down in that way patients will not use it. It is really hard to get patients to ask to use something like this as well if the provider is not on board with it.

It is a big job on educating people what is available. What helps with visibility as well we are finding out is these alternate partnerships. School telehealth.

If a booth is not having very good traffic where it is located in the library but you can bring in a school telehealth program then suddenly it is used heavily at that point. Really being intentional with the program and the partnerships and the plan. Making sure that you have these use cases already lined up at the beginning and then just following through with those partnerships.

Also another thing is consider advertising the spaces for uses other than doctors visits or medical uses. Just any private meeting space is going to bring visibility to these. Word-of-mouth is huge in small communities. It is a great way if somebody goes into use it for a zoo meeting or job interview then they can talk about it with family members. It's a great way to get the word out.

Challenges to tribal. What I mentioned before is there are a lot of, what is the way to phrase it? Some of it is they just have different ways of doing business. It is just the difference in cultures. It is something that you have to really dig into ahead of time and learn and make sure that you are going to the right channels.

One of the mistakes I made at the beginning was trying to go too fast with these with one of the tribes and really I think you have to build that relationship first

But, when you do they are amazing -- partners. They have a lot of buy-in when it comes to telehealth because they really want to protect their elders who are some of the only people who know their language.

They can really see the value in something like this, it is just making sure that you go to the proper channels. Again, another example would be thinking that just trying to get approval from one tribe without knowing there history or maybe realizing that you have to go through a counsel. And then you would actually have to go through and get the approval of all three tribes that are on the Council.

That is obviously going to take much longer. It's a more involved process. I really recommend having a tribal liaison to help you with this and navigate the processes. Some of the regulatory challenges right now are the uncertain see in the prescription waivers. Not having great parity and other federal like --

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regulations. Just making providers cautious.

That just makes it harder to partner in a sense. Another issue is the affordable connectivity program. I think it was not going to get funded and then it was an now it is I think. But the issue is 300,000 Oklahomans would use -- lose access to Internet and that is a real problem when trying to roll out telehealth and make it ubiquitous across the state. And also provider compact status. Those make it much easier to roll out telehealth programs because we have such enormous issues with the worker shortages.

Across the board, nurses, physicians, we need help with all of those positions. Luckily, Oklahoma is one that has embraced these provider compacts. But it is still something that you have to work through at the time. And in some states it may be, they may not have embraced it this fast.

It becomes an issue trying to roll out a nationwide program. Just to tie it all back to this is just one facet of trying to solve this rural access issue.

Ideally we can go in and knock out some of these barriers like connectivity but, while we are still working that takes time and while we are still working on that, we can move in and come up with these targeted solutions to where these issues overlap.

And it doesn't create the same level of access but it does create some access and that is what we want. Giving some people some choice in the matter I think is always a good thing.

And really it's just an opportunity for us to go in and like I said before, meet them where they are at. And we try to come up with solutions that fit their needs and really the local knowledge again ties it all together in the sense that most of these programs can be taken out and put into another state but it may not work in that iteration. It has to be customized to fit that local community so that there is trust and buy-in.

That is just really what I wanted to highlight is that it is an opportunity for us to build trust and really to get healthier Oklahomans, healthier people in the sense the lack of access before is such a huge issue and compounds so much.

But if we can come in and even fix one small issue, it may have bigger outcomes, better outcomes later on and have a cascading effect as well. So with that, are there any questions?

MOLLY BROWN:
Thank you Sam for your time and what a great presentation. I actually have a couple of questions. Can

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you talk a little bit more about the digital navigators in terms of training? Did you and your team support that or was it already in place? Can you share a little bit about that.

SAMUEL KARNS:
Is going to be a little bit different for everyone. In our case, we partnered with individual libraries. Three of them were municipal libraries and too many -- two of them were system libraries. At least in Oklahoma, the municipal's have a lot of time. They are really the ones who own the staff in the sense that they are responsible for training and things like that.

What we did was we provided these materials to them and then they were responsible with either hiring, we provided funds for them to train and hire or hire and train a new person or to just train and add hours onto an existing employee.

So most of them I think actually ended up doing that. They had a part timer who they already had in mind and we provided the trainings for them and then they went in and basically became full-time employees for the duration of the project.

MOLLY BROWN:
OK thank you. We have a participant question and I will let them ask. Go ahead

SPEAKER:
Yes, I was just wondering is there any way that (audio issues)

(Multiple speakers)

SPEAKER:
-- With the system there. Can you hear me?

MOLLY BROWN:
You cut out a little bit. Are you able to put it into the Q&A option?

SPEAKER:
Yes.

MOLLY BROWN:
OK and if we do not get to it by the end of the presentation we will answer it off-line via email.

SPEAKER:

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OK.

MOLLY BROWN:
Were there any other questions? I will keep an eye out for Lula's question.

(Multiple speakers)

MOLLY BROWN:
There are some. Sorry, I closed it. Are you able to share more resources on the connectivity access or access equity?

SAMUEL KARNS:
Yes although I am not quite sure what you are asking about. Are you asking for members who don't have any Internet connectivity? Some resources for them.

If that is the case, we can definitely get you resources for that. It will all depend on what is available locally. Some states have additional programs that can help out. There are federal options as well.

One of the things we provide at least is we have a program called Connections Plus that supplements the lifeline. Anyone who does not qualify for Lifeline but we still want to get them a phone with a plan so that we can get them in contact with them, that is something that we just provide. We can submit that request and we can mail it to the members house within a couple of business days usually.

MOLLY BROWN:
The next question is I represent the combined telehealth and telemedicine technology that would provide greater services with the support of a local regional provider. What is your recommendation on how to link up with local organizations to trial and demonstrate?

SAMUEL KARNS:
If you are asking about partnering with someone like a local library that might have one of these booths, I would recommend going to the Department of libraries. They will have contacts for all of these locations.

Yeah, that would probably be the best way to go about that as well. If you are looking for more general partnerships, looking to demonstrate with more local providers, your office of rural health might have some insight into that as well. That is probably the route I would go.

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MOLLY BROWN:
We did have and I know that you talked a little bit about (unknown term) what is the actual cost for maybe one of those access points in a library.

SAMUEL KARNS:We have different options in a sense. We were with top box at the time. And that was after we checked multiple vendors. I tried to design my own at one point. (Laughs) And it was just going to be too expensive going those routes. And it wasn't really going to get us the quality that we wanted as well. We found one that was doing it already, top box and one of our libraries had already bought one outright. The Lawton public library.

And they were in talks with top box about the design and everything like that. It was at the time about 20,000 for each of those. That kind of comes with the soundproofing, hippo filters, UBC lights, the conduits and the air conditioning system and all of that kind of stuff.

It can be much cheaper as well. We just priced one out, for someone has an existing space and we can retrofit it in the same way and it is significantly cheaper. With all of the equipment it is like five grand probably. And that is kind of what I was referring to is if you were to give me $1 million, I could put one of those in every town.

For five grand it is pretty cheap. Cheap in the sense of if you are writing grants. If you are thinking about it in terms of grant funding and spending and trying to work into our rural access plan. It is relatively cheap in that sense.

MOLLY BROWN:
Another question. (Name) would you like to ask?

(Multiple speakers)

SPEAKER:
Molly, did you ask the question just then?

MOLLY BROWN:
I see that your hand is raised.

SPEAKER:

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Sam answered my question.

MOLLY BROWN:
One other question in the Q&A is how can clinicians in other states partner with you or the work that you are doing? Is that something that is available or open?

SAMUEL KARNS:
Yes. And that is something that wasn't a consideration at the time because working through the contacts and things like that, I would say in that case if you would reach out to me, yet if you can reach out to me or Oklahoma State University is another one. Or the Department of libraries. That something we can help facilitate. I'm trying to think if there's any other. Probably reaching out to me would be the best route.

I can connect you with whichever location or the Department of libraries.

MOLLY BROWN:
We will be sending out a follow-up email or at least the recordings will be available on the national consortium website and also we can provide Sam's contact information if you reach out to us directly.

We do have time for a last question. Are there outdoor options?

SAMUEL KARNS:
We don't really have an outdoor option right now. Most of these are going to be located in the library and it is a bookable space. It is enclosed.

The outdoor option I think becomes my concern then is thinking about privacy and how we are going to keep it private. Also at least in Oklahoma, it is so hot. It would be really uncomfortable. You could use it twice a year kind of thing (Laughs)

That is something I am open to thinking about, I just not have really thought through what an outdoor option would look like. But I do think that could be useful as well.

MOLLY BROWN:
I also think for us in the Midwest with the weather that is unpredictable

(Multiple speakers)

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SAMUEL KARNS:
It can be hard trying to keep the weather out of there.

MOLLY BROWN:
Were there any other questions before we begin a journey? I don't see any so thank you Sam. Are you, I can turn it over to you now.

ARIA JAVIDAN:
Thank you Molly. I'm going to bring up our closing slides here. Just a reminder that our next webinar will be held on Thursday, October 17. That will be hosted by the southeastern telehealth resource Center and it will be on improving specialty access and decreasing health -- hospital transfers with inpatient telehealth services. Information is available on the NCTRC page. Lastly, we ask that you take a diffuse 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 the Heartland Telehealth resource Center for hosting today's webinar and thank you to Samuel Karns. Thank you everyone.

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