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ARIA JAVIDAN:
Hello, my name is Aria Javidan, welcome to the latest presentation in the NTSC webinar series, 'Breaking Down Barriers to Telehealth: How the Digital Health Readiness Screener'. Today's webinar is hosted by (unknown name), decide to provide timely interventions to guides that the other telehealth programs.

Just to provide a little bit of background on the Consortium. Located across the country that 12 regional TSEs and one national. Each himself at focal points for advancing the effective use of telehealth and advancing access to telehealth services in rural and underserved communities.

If you kept get started today. The author has deviated. Review the Q&A of the draft questions. Questions will be answered at the end of the question. Please only use the chat for communicating issues for technology or communication access it. Please offend them here to get to make comments.

** Audio issues, please stand by **

KRISTIN RISING:
Thank you for that love the introduction. I am an emergency medical physician at Jefferson, I have been here for just over seven years and I spend most of my time these days and seven of the Executive Director for Jeff's incentive for connective care.

I have no conflicts to disclose related to this topic or presentation.

Just a little bit on the centre foot collective care over all. This is a community-based research Centre at Jefferson, formally absent 2021. Home this is home to our valve a diverse set of portfolios of highly unlined on centres of responsive care delivery system designed for...

We also have very extensive topics for developing effective approaches to food -related needs of patients, the ever-expanding work on harm reduction and how people use drugs, and working with the emergency department on how patient uncertainty can affect acute care seeking need. A restructuring to look at decentralized care, and research model. How can we bring the care needed and bring researchers to patients in their homes, as opposed always acting them to come to us. And to various other work.

We have three Court faculty, 22 staff at a lot of students working with us. We have a lot of public health

digits, medical help students would be working with today, postdoctoral fellows, and significant cross department and college collaborations at Jefferson and outside of institutions as well.

This is Jefferson's telehealth solution. I started at Jefferson in 2014 and was recruited as part of a team by the then plastered to develop and launch a telehealth program here at Jefferson. As he said in our group interview "I am convinced that we are going to be telehealth someday and I want to be ready when we do." In 2014 we launched JeffConnect, and this is how we conceptualize thinking about telehealth and what would the build out from the beginning. Again thinking about it from the patient lens and the patient experience, that your needs vary depending on where you are in the wheel of health as we think about it. Then you get a little bit sick, moderately sick, and maybe end up in the acute care setting of the post care setting.

You really get back to a new baseline, and you get back to some sort of baseline, so we built programs over time based on fig about this, and this wheel shows you most of these programs are really in for existence here. Some are still in development, but it is what we have been strong toward ineffability.

When the covert pandemic hit, we were fortunate compared to many health systems in terms of how readily were for telehealth, again this being from some patient years prior. And so we really saw an immediate surge in telehealth use overnight. As you can see from the numbers on our platform. From when I was system lost until now our on-demand platform which is where we see people 24/7, emergency medical physicians and our nurse practitioner staff, we were seeing 10 to 15 people a day for 2015 to 2019. From March 2020 we saw 200 people per day, scheduled visits, same kind of thing, 40 to 60, up to 3000 per day.

The overall visits, we had 100,000 visits, March 2020 we had 100,050. So really an immense surge.

With discharge we said the health system was ready, we could do that surge overnight including many of our patient web ready. Because we did have that surge in patient attending those visits. But we were also really aware that in this we needed to start to think about who was getting that behind it went. And just kind of some key concepts to talk for and some of the weapons we have done within that we used in addressing this.

The first big thing to think about if the telehealth can help increase access and decrease healthcare disparities. But only if we addressed the digital divide. This is a term that a lot of people have talked about and affect as a lot of discussion about how to do that. There has been minimal movement to really advancing the fault of how to do that and that really has been what we are focusing on.

So when I think about the digital divide, and we talk about that we look at literature. Most people talk

about the digital divide as being an issue of access and knowledge. Do people have access to a device, with a camera and audio abilities? Do they know how to use that device to engage? That is digital literacy. And so we have done some work in the space, and in early Covid-19 did work to address access and knowledge. We got funding from the federal communications division, as many as you may have been involved in early in COVID 19, and we disputed iPads and what about care items to patients.

We said we know that knowledge and this nativity piece is important as well. So we layered on having a whole bunch of students who are primarily in matters of public health leaders who called patients that we disputed these devices to, and offered them health in setting up and using the devices. What we saw was that really access to knowledge was not really enough. So out of 855 patients who got the one or more of these devices, when we look to many months out, 72% of them had an active (unknown term) account which is important because you need to have one to have remote patient monitoring devices, and you need want to have any kind of a scheduled visit. And so over one quarter of patients were not able to actually engage of any of that stuff.

51% of them, so just over half had had at least one health visit anytime. So despite the main goal of this work singlets get you connected what telehealth is (indiscernible), about half of them were not able to connect at only 32% of those who received the monitoring device had any readings transmitted from these at all. So there still were significant gaps that we needed well beyond this level of support. So understanding that really address the access and knowledge is not enough. That is really as far as most of the discussion and any sort of measures that I could find to kind of be assessing people Digital Health need to went, what this digital literacy piece. But what we realize in some percent work and engaging with patients and working with teams about various barriers is that the of a vaguely imported bevy is that we needed to talk about and start to quantify, and ultimately work to address. One of the big ones are most with this issue of trust. We engage with some of our research patient over that time to look into Bevier's amount telehealth, cultivar not about trust that had emerged, and often that you do decide to come out with highlighting trust.

Another was acceptability. Some patients that saying I didn't want to give technology to engage in healthcare. I do not think it is appropriate, I didn't want to get my personal information, I do not trust my device. Which was different to the trust in the healthcare system. And another said people talk about relevance. I have gotten healthcare in person all my life, why would I start doing it difficult now? Yes, there was a pandemic, but this is how I get my care.

So the town we took on which is important for moving forward is this time of Digital Health prejudice. Are you ready, both in your abilities and in your kind of mental and positive state, to engage in telehealth? And then a really important point to take about this is that all throughout this, we talk about Digital Health letting us and we talk about getting patients to sufficient Digital Health readiness, with the caveat to say

that everybody ultimately is going to decide to use telehealth in different amounts. And for one person, it may make sense to do 95% of their visit still in person. They may have a lot of person it touched needs, different exams and such, and it is really just an occasional telehealth visit is going to be imported. For someone else it may be appropriate and desirable to get 95% of deficits for telehealth. I will goal is not to shift all of kata telehealth, it is to make sure that patients feel ready to engage with it and able to assess when it is an appropriate tool for them to use.

So, telehealth can increase access. But we need to address the digital divide, addressing access to knowledge is not enough. The other underlying barriers. The next one, and this really emerged from kind of existing work, but then really importantly from a funded consensus conference we posted last year, it is really important to focus on understanding and addressing individual and patient barriers. It is not enough to just say OK, trust is a barrier, we are going with trust and addressing trust for everyone. Or access is about the ad we are addressing barriers. If you want has differed above you said it is important to address them differently.

So that was where we really shifted with this next work, in which a colleague of mine put together this work to develop and to validate its clean-up for Digital Health readiness. We said if we need to talk at the individual level and we need to address at the individual level do we need a means of actually being able to identify individual level areas. And so this Digital Health readiness screen (developed as a process to screen and identify barriers across individuals. It is intended to be an approach to excess with efficient deployment of interventions in the clinical and also FICA ultimately community settings, with those interventions designed to address specific different Digital Health readiness barriers. The funding for this work was given to us by the HTML foundation.

The goal of this ultimately is that when we identified people with access problems, the next time we get funding for devices we can target that funding to the people who have said that access is a primary or even decile barrier. When we identified people with knowledge problems we can deploy navigators, educators, students who are available to help support them in getting some further digital literacy skills. Trust and acceptability might be addressed well in a lot of systems bifocal community health workers, and the benefits piece is probably imported to identify two conditions and P educators to talk about when and why might tell health be a beneficial add on to the care that you are kind of accustomed to receiving in the past and how is a hybrid care model may be beneficial to you as an individual?

So to develop this clean-up, we went through a vigorous process. That kind of first approach that is needed for developing a kind of assessment tool, is to explore the conceptual domain of what the concept is that you are measuring. So in this instance it was digital health readiness. So we engaged across a whole set of patients and clinicians to law what the content would even be of Digital Health prejudice. What are all of the factors we need to improve in our ultimate talk? And then at Weaver find

these content valid items that we developed, with a process called cognitive interviewing. And you work with individuals to whom detail would ultimately apply, so we engage with patients in the hospital and outpatient settings, to go through every single item in the screen and review with them what this is measuring, is this content important to you, is it understandable, and we've offended the wording and the items were entitled for dispositive interviewing.

We also tested for of 300 patients, and ultimately, what emerged at this final screener is a screener with 24 items close to primary domains that emerged. The majority of the items, 18 out of the 24, apply in technical readiness to made and we will go for that in the next few slides. The remaining six items really applied in the quality of care already desperate domain. That trust and acceptability concept.

So the areas of the most in technical readiness were 18 items. There were some topics that were covered in their, and general questions about videogame visits, general visits about technology access, questions about technology access, and then a bit of a specific focus on the patient quarter. The quality of care might enough the questions were around quality, concerns, and questions as well as trust.

These are the questions here. So the video visits general, intent is actually a big want to look at that was important to understand is have you ever completed a telehealth is a with a provider? People who have completed one hour at a whole different level of readiness to start with. Have you completed a telehealth visit and are you confident in your technical ability to do a telehealth visit? Something may have completed a visit but no matter been entirely assisted by somebody else and they may have no confidence in the ability to do so again.

Technology access, some of these are going to be once everybody is fading about. Do you have access to the internet? Do you have access to a phone and computer with a camera. Some of the of one's unmerged however are really important for people but not once I think that we think about all the time. Do you have a place where you are comfortable talking about your health needs? That is really important. Some people might say I had internet access in my computer in my one-room apartment that I share with four other people, in no way am I talking about my healthcare there.

Do you know what to do with issues with sound or picture quality? Can you troubleshoot? Then another important one that we had for multiple patients was about data limits. Are you willing to use your data omitted for telehealth visits? Which people thought was really important for us to look at.

Technology access, you can see technology knowledge, you can see confidence in using computer, comfort with accessing the internet, looking for health information on the internet, so some very basic questions which it is important to get to this level of granular when you are trying to deploy specific intervention to people and say where is the point in which you need your education or intervention?

The quality of trust once, I 50s want our imported because they have not been addressed as much, these other questions ultimately emerged. Are you concerned that you will not get high quality care telehealth visit? Are you concerned that your doctor will not spend enough time with you? That was one we heard from people. They get nervous that the doctor could just click the button, and ended the visit at any point and that they have no ability to eat even control that and at all which for some people was really uncomfortable about having a telehealth visit. Are you presenting wanted have a personal connection with your doctor? Are you concerned about the privacy of the information provided technology for your healthcare? But all your information in there. All the information is up here on your device. It is scary for people. They do not know whether to assess how it is safe. And along to that one, are you concerned about security of the healthcare information when using a portal?

So, to talk through, as we are focusing on now, what we have been doing about these things, the video visits in general, the main intervention that we have, which many systems have to different degrees, is that we have telehealth navigators. And these are always, the job has changed over the years, somewhere in the central team, participate a centralized resource that we have had with our team, in which providers can I must specifically refer patients, maybe a patient does not feel comfortable, they have not used the technology, or a patient you had trouble who can get referred to navigate and get some individual support, but these navigators also have been using workflows to try to identify all the people who are having first time telehealth visits to do outreach for them before those visits to make sure that they know how to access the veg it, to even potentially do a test visit, and either be really helping people into porting the basic onboarding.

The tech access, we always look for those targeted funding opportunities. The Federal Communications Commission was the biggest one we have had for this. But looking at funding to be able to bring and kind of clothes that divide for people with the technology access.

For the patient portal part, a kind of novel program that we have developed which has been really successful in kind of taking some interesting times over time if the Jefferson digital onboarding task force. This task force started as a project which we had funding from a few years ago, to try to address kind of digital equity needs within the Philadelphia community. It started to really with a very much community focus. We hired two community health workers on our team, we trained as digital navigators, trained in the basics of understanding digital use, what is digital healthcare, what is the portal, how do you sign onto and use the portal, and they were based at kind of an academic community partnership sites that we have here in Philadelphia.

The main focus of them was to attend community events to do Digital Health outreach, to offer assistance specifically will portal set up and not necessarily in the portal specific to Jefferson but they

knew how to do the portals across the different main healthcare systems here.

We found with this work that we had really low engagement numbers. At these community events, individual's overall were not interested in taking the time to talk about the Digital Health. We reached a lot of challenges the people who were engaged not have a primary care doctor, need to tell provincial words, or actually many steps before that step of being able to talk about and use a Digital Health course and up the portal. And so we kind of stepped back and really had two more from the support.

These were some of our key learnings that we took in fitting about this. The first one was thinking about the site of engagement is really critical when we are doing this work. And that we needed to find people, when they were in the mindset and when it was relevant to them. This community events, again, people outside of not having primaries or some other challenges, even though she did have access to healthcare, it was not the time that most of them wanted to figure about digital healthcare. When would I use my portal? It just was not benefited them at the moment.

The second one we found was that when it is possible to best evaporate into other services. We did have better success in the community when we backed our outreach into providing blood pressure screenings or other direct service, when people wanted to engage. And started to seek other places to do that work. And one of the places that really emerged was partnering with organizations in the city who are giving digital literacy training essay and can we come at can we do some tailored education, looking at the Digital Health tools, and helping people with patient portal signed up? And that was a good way to kind of wrap it into other services.

The photos that trust building is essential and takes time. Again, we just meet them in the community, we are doing this, it was not as if this ugly what it is signed onto the port with us. We needed a place will be doing more trust building. And we also did find that despite this important of focusing on the vessel the Digital Health readiness needs of populations, that many people do still enact sufficient digital literacy support in general, and many people identified being just so stuck on using the phone or the computer that they did not feel ready to engage in these events but they needed more help.

So the current state, we really pivoted a lot from this work in the community, is that we said well, let's find people at that time with a much more relevant mindset and really look at giving support while they are currently patient. And so the covered state and goal is to provide support to hospitalized patients in signing up for and using the patient portal. The team that we now use is primarily medical students, who are volunteering to do this with oversight from two of the staff members for my setup. And the process for this, students can sign up for as many or as a few shifts as they feel they have time for in a week. When they started their shift they run a report in an exotic health record, that identifies all of the hospitalized patients, sortable across all of our hospitals, although they mostly updated the hospital here

in Center City Philadelphia. It is a report of all hospitalized patients who do not have an active portal account. This report can be searched and sorted based on language, ZIP Code, location, we do not go to patients in intensive care units for instance, and to consult this up advertised as the we have a set of students who are Spanish who sold it by language and they prioritize Spanish-speaking patients, and also, as kind of possible and available on the report we prioritize going to patients live in ZIP Codes that are (indiscernible).

And then the students, as much as they have time – it's approach patient and kind of go from room to room, offering patient assistance with portal set up and use. The patients have been filled by this. They have gotten multiple reactions that are versions of "I just spent all morning trying to do this with my family member and could not figure it out and now you just walk in and 15 minutes later I am set up. We are really filled with the support for this.

And this is kind of an example of a basic workflow. So the initial question, would you be interested in involving been the portal today? And patient say no, and that is fine, they say focus on much comedy document the reason for the client and the encounter. If patients are interacted, to go through the process of involving the patient in the portal, and then they show them basic use of the portal. Where is the menu, how can you message your provider and see your results, fight, and if a bit of functionality on that.

And then the kind of document the encounter, and a few demographics we are collecting on the patients. If patients tell them that they are already involved in the portal down the offer them help you to get. When was the last time you used to? Do you have any question about using it? And answer questions as they are able. And of a waste document that encounter.

The next option is some patients say I am interested but not right now. I am tired, I have to go to a test. And he put them in a queue for follow-up from our team.

We have taken some exciting steps forward. We started with a few medical students, they really enjoyed it, and these were mostly second-year medical students who started with us and the students said you know, this is so meaningful and valuable to us that we really wish that we had been offered this as an opportunity for fast yes and we really think this is supper that should be an ongoing expanding opportunity. And so they went through the process to establish this as a medical group at Jefferson really of their own accord. Is it OK for us to establish this? And now they have a whole structure here. They have got presidents, if I expected, and event Director, they are required to have at least one event every quarter. And so they are doing education outreach to student about issues related to this. They have got 12 comments members, and it is really filling a need on both sides. Medical students only on a really looking for morning for opportunities to contact parents, directly engaging patients, to be introduced to

the hospital setting, so it'd be wonderful for them it has been a wonderful opportunity for patient.

So here is what we have today, just looking at some numbers. Kind of the curiosity. So they have opposed 1400 patient since 2023. And they have involved 393 to date. The over quota have been involved, quite a few not, many of these have contact precautions, they have obviously cannot go in the room, some of them the patients have access, some do not have wireless, the avenger of reasons. But 1/4+ uptake.

It is interesting to me to look at some of the demographics. The age distribution is actually pretty homogenous across tickets. We have got almost 38% you are at 18 to 45 years, which is actually really surprising to me. I fought we would be in higher intergroup. And about 1/4 in the 66+ years. This is our visual breakdown. We got 22.1% who identify as phallic Latinx, and then a range of other visual background.

And then some further demographics are only connected through August of last year, we really significantly pared down the data collection sheet after that point to allow for increased bandwidth on patient support. But just that sample, which was 343 patients, showed you a couple of additional things. Over half a male, close to 20% reported speaking Spanish at home, the vast majority of them have access to internet. And that is something that we saw. The patients he did not have access to incidental much less interested in getting support. But 94% of access to internet, and about 20% of that list of people actually do not feel comfortable using the internet so there was some additional need there.

Also, we asked them for August of last year, we did ask health literacy questions and I think this is actually interesting to look at. Overall, the health literacy of the population that we ultimately ended up supporting was pretty high. We had close to three quarters of patients reporting being quite a bit of extremely confident filling out medical forms. Only 15.7% reported that they often are always had problems understanding written information. And 12% reported problems understanding what was told to them about medical information, often always.

And so it did not correlate as closely as I fought it might, as affect many people do, they would think it is low health literacy, they are not necessarily hand in hand.

And for the trust and quality questions we asked them to of these questions. We asked them if they were consenting with target high-quality care, and 24.7% of those said that they were concerned about that. And 38.2% reported concerns about privacy of information using technology. For those trust and quality concerns really are people that equity prevailant here, and these were among the ones that agreed and allowed us to help sign up for the portal. So it may well have been much higher in the proportion who ultimately declined assistance.

The NAFTA to think that we asked, trying to kind of come up with some of that measure of what is impacting people, we ask this question about empowerment. So under question of 1 to 5, when one is not empowered in five is very empowered, how empowered to do you feel in managing your health after talking with our team today? The average score was 4.4, and 64% of them reported five. So at least from this one a measure, feeling good at the end of the encounter.

And then we asked them about the need for general digital literacy support. So on a scale of 1 to 5, if Jeff the must offer a class of basic computer skills and how to use smartphones, how interested would you be in taking the class? In this one, the average was in the middle of 2.5, but 1/3 of patients reported a very strong interest. So not everyone. That is not going to be any intervention that is one-size-fits-all. But of your proportion of patient was saying yes, I could use more digital literacy support.

And so to this technological peace, and additional literacy support, we decided we really whether to dive into this. There are many community programs that exist in Philadelphia, and nationally, in person, online, that are kind of developed to help people with digital literacy needs. They are still more need outstand be connoted for many of the people who have these needs life is complicated and busy at home. It is hard to carve out the time to go to a community program, especially if it is a multiple session class. And so we wanted to really explore kind of using this hospitalized time as having people as a captive audience, and using this time in a useful manner.

And so we developed this program that we called Jefferson bedside IT training. And the goal of this was to provide basic digital literacy education to hospitalized patients. Again, this team, it is a small team, we are really in the very initial pilot phase, but this team is primarily medical student and is being overseen by two Centre staff. And the process is really essentially the same at this point. We do not have a standard measure in our system for who has a digital literacy needs. And so right now, we are still doing the same process of learning that electronic music report method approach of hospitalized patients who do not have an active portal account and approaching patients to offer assistance with digital literacy skills and giving that assistance I've on a computer or on a phone.

My team is taking a laptop with him so if patients want to learn on the computer they can say "Micah is a laptop let's get down to it." And on a phone, it is (indiscernible).

These other topics and items that are covered. This curriculum overall is continuing to be refined and optimized by our team, but have been developed based on published work in the space, talking with various folks who are providing this service in the community here, to really kind open together best practices and most focused on every guest. The topic of basic navigation really does start with the most basic. Turning on your computer or phone, typing, copy and paste, using the shift and Lock, using a

mouse, that kind of stuff.

With where on that kind of continuum we start being driven by patients. They just kind of go through and demonstrate these things and when patients get stuck they pick of the curriculum.

Web browsing is enough wood. How do you use the web? What is a search engine? How do you use different ones? How did bookmark a webpage, how do you find a bookmark page?

Apps is specific to iPhones, but what does it mean to do those things? I remember looking at my parents for quite some time ago affecting "Oh my gosh, every app in your phone is open!" And they did not even realize there was a way to close and app. So those kind of imported fix.

So email is looking at basic email functions, how you send and reply to emails, what are attachments, how do you find them, and forwarding of emails.

Patient portal use is that patient use. How do you log onto the portal and few menu items? That is Moby could develop out in that space, and we will over time.

And that of advanced topics, learning about Zoom, issues of safety, upgrading def passwords, updating your password.

We have involved 22 patients. This is a low uptake. About 10%. We have had very few jitters and will be anticipated for to five shifts per week, the few who have worked wonders of only had capacity for one or two shifts per week so this is still very much in his building sites. To date this shows us the topic that patients have selected. First of all notably, I really fought there would be many more he wanted to work on the computer and were excited about this, we bring the laptop to the bedside. Almost all patients wanted this to be on the smart phone and enjoyed using the smart phone better.

So the number one topic they wanted was help with the patient portal. After that it was app you said basic navigation. These are skills that many of the people were asking for.

And then evaluation, we do not really have a lot of data on evaluation, but we are evaluating this at a very basic level, skills we are looking at with the patient reported confidence survey, the answering this confidence across those same domains of basic navigation, my chart applications, but awaiting their confidence on each of the domains and specific questions within them on a scale of 1 to 5. And then we are following up with patients we to six weeks after our engagement and teaching session with them to again ask them these comforters questions.

And then we are also doing program evaluation which is asking them 6 to 8 questions looking at satisfaction with the program, the utility of it to them, after they had been out in the community.

So those are the things we are doing apostate technical readiness and quality of care is kind of the other place it is really important. And this largely is driven by just our overall Jeffersons work focusing on community outreach and really, developing and infusing community health workers throughout our practice here at Jefferson as well as out in the community. We have a community health work Academy who we have worked very closely with overtime but he we have been co-creating a conviction on web specifically Amanda Digital Health readiness so that while community health workers may not feel comfortable in all of the nuances of kind of the technology used, they are comfortable with the concept, with the wide, with addressing some of those issues of trust and acceptability.

One example of this is a partnership to be had with Estevan to Health Center, which is a health centre based on North Philadelphia which solves almost entirely a Latino population and they had really struggled early in the pandemic to use the patient portal. And whether some help with this. So we parted with them and did some research work in which we trained members of their community to do qualitative interviews, to engage in the research process with us. They engaged community members to discuss what the main barriers were and to identify what some helpful interventions might be.

In this partnership it turned out to be a bunch of very basic videos, we partnered with the community and they did the voiceovers and it was very much truly from this voice and these are things which we can now put on in the waiting room for patients to watch while they are waiting for deficit. They are covering very specific chunks. How to request an appointment in the patient portal or showing them how to get on the portal page, or how to reset a password. A very short basic video back attacking out to some of the main skills the people thought that they needed.

And then we have had partnerships ongoing and continuing to kind of develop new partnerships with community organizations to provide digital health education to their communities. So have been looking for organizations is somebodies for example have been community health centres, or the library, that are providing digital education for their populations at a single become and give a presentation that focuses on Digital Health and how they can use Digital Health to improve their life? And then as part of that I was staff offer direct assistance to the individuals that in setting up their patient portals, regardless of what those portals are.

So our priorities moving forward, my main priority in the space of most immediate is to develop a short form of Abba Digital Health readiness clean-up. I think many of you on here my to be "24 questions, how is it ever useful in daily life?" And I think it is useful when someone is getting in the weeks with patients to say "OK, where exactly I'll be going tail some more intensive interventions?" It is not useful when we are

going to increment a screen as part of everyday life for people amidst every other screener that they are getting in a healthcare encounter. And so we are working on identifying what potential funding opportunities may be and developing that short form. And then alongside that, that means to come with developing that short form, we have been working with leadership to look at where and how can we integrate most key elements of this screener into routine healthcare screening so we understand an individual patient level whatever you need to be addressed, and at our population levels what bevy is a most salient in different parts of our population for us to be focusing on putting the majority of our resources to growing interventions focused in that area.

That is what I have for you today. I will look out for any questions or, that people have, on any portion of this or other related topics.

SPEAKER:
We have one question, and I encourage everybody else if you have questions or comments go ahead and put them in the Q&A. So the first question, and we addressed a little bit of it at the end here, love the screener, how do you use? How is it administered and by whom? Do you do initial screens and then (indiscernible)?

ARIA JAVIDAN:
Great question. Probably in the majority of that question was addressed in the end. So to date we have used a few of the questions in part for instance in doing (unknown term), in thinking about how we tailor it, I'll be covering salient parts on the screen, but as a health system more broadly, we have not, in any scale, use the screen I get.

Most health systems over the past year have started to routinely screen for most related (indiscernible) recent CMS changes, and leadership have been asking Digital Health readiness, this really is a social determinant, do we have a question or two that we really should be adding into this? My answer is yes, which question, two of we talked, but really working to get to that short form and making this something that is on the standard. We are always focusing on this when we are faking about any of the other health-related needs of impacting care. That is something I am really hoping to make some headway in the next year.

ARIA JAVIDAN:
What kind of data software are you using and what advice do you have an organization in permitting something similar with (indiscernible)?

KRISTIN RISING:
That is an interesting question. The research from and to critical them are different. We mostly use

(indiscernible). We used epic medical record system as building this in as part of our documentation within epic. So we have areas for documenting social needs, healthy planet, but developing this I think really, it is important to have this in a place that is able to be accessed and seen by the different types of healthcare staff and providers and also to be something really integrated and whatever your medical record is. So I think developing that is a system of in the medical backward is an important kind of goal of this.

KATHY WIBBERLY:
How have the devices been paid for, and how to get them? Kristin Rising: Bike to Books Installation 2020, there was specific funding from the (indiscernible) to fund devices to get to patients. So that was the majority, a large chunk of those, as I said, community health workers will based out of partner academic centres in all Philadelphia and I know that site for itself doing some literacy classes and is part of the education classes, people who complete those have been receiving a laptop. That was based on a donor find that they had received, but I think it is hard to find things like devices, and I think it ends up being limited, you know, a foundation grant, a philanthropist in the area he was interested in supporting something like that is usually where it is possible. But I figure that is a hard challenge and is no kind of sustainable answer. --

KATHY WIBBERLY:
Is the screen a publicly available, and if so, where is the best place to access it?

Audio lost

Audio restored Kristin Rising: I will go back and find it for you guys. We do note here, the screener we initially tested 29 questions, we do not in here the 5 to 12 move. But do note that there were some removed. We also do have a formative page that is taking some out, so I am happy to send that along. I can even send that to Kathy and you can circulated out if you want. Yes it is free and open use, please use it, please send ideas if you ever want to collaborate on things, this is an area that is important for us all to make some headway in.

KATHY WIBBERLY:
I'll be happy to send it out to everybody to get it handed out. (indiscernible) via telehealth?

KRISTIN RISING:
We have found that it has been a challenge, the digital literacy and the ability to use technology is not something that is limited to being a challenge of the patients we are engaging with. We do have limitations in terms of the people that are coming in, many of our community health workers, they have not received any digital literacy training, and using technology has not been a main part of their life prior

and they are maybe not effective on the communities they are working with realizing that and making sure that there is kind of underlying baseline training for staff or assessments, who is comfortable and what (they are in, they do not have to be comfortable with technology, and...

KATHY WIBBERLY:
What about including family with patients? Kristin Rising: we do have a lot of family who get involved. (indiscernible)

We do this as well for patients who are hospitalized, as well as patients who are involved in primary care, this volatile specialty services as well as your, and with that we will follow that same approach on really focusing on inpatient and outpatient in terms of administrative discreteness.

KATHY WIBBERLY:
Are you developing any companion cheat sheets for patients once they have gotten assistance while inpatient? Great topic, thank you for sharing.

KRISTIN RISING:
We do have some basic sheets we give to people in terms of how did they log on, how to use fix, I think we probably have some work we could do in this area especially around the digital literacy training that we are doing. That is a great question, shipping the top of my team next to look at the current state of exactly what we are and get because I do think it is hard. You learn in the moment, you leave a negative "Oh god, what to tell me about that? "So if you have something we can reach out and share it with you if you reach out, be happy to share it, but is public it is more focused.

KATHY WIBBERLY:
But cannot What is any advice you would give?

KRISTIN RISING:
We be considering from the beginning staff technology use, and their own digital literacy and be in confidence with the use of telehealth more before kind of assuming. We as a whole did not think about that too much at the beginning, it just became apparent over time that we needed to be more kind of aware and it acquiring in the beginning about needs. So I think acknowledging that, we bring you folks in and some of them are needing training.

KATHY WIBBERLY:
Unless anybody else has more to at this is a comment more than a question. We have got involved in community tech work, and has been very positive feedback about that base level of training. And I love that. And I think we are seeing more and more of this as we go. Engaged in community health markers,

really involved in that digital literacy piece. It is exciting work, and I think over the next year or two we are going to see a huge explosion of this type of work being done. Thank you for all the work that you are doing. It is just excited to have some data back in some of this information.

KRISTIN RISING:
Absolutely, thank you for having me today.

ARIA JAVIDAN:
Thank you again. Just a reminder our next webinar be held on Wednesday, February 20, information about that is on our website. Also, we hope that you are willing to fill in the survey that will pop up at the end of our webinar.

Thank again for taking part.

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