NCTRC Webinar - Transforming H...Risk OB Care With Telemedicine

Thu, Sep 11, 2025 10:30AM • 1:09:23

SUMMARY KEYWORDS

Telemedicine, high-risk OB, maternal fetal medicine, telehealth technologies, rural health, telehealth policy, telehealth reimbursement, patient compliance, remote monitoring, virtual interpreters, telehealth platforms, patient outcomes, telehealth implementation, stakeholder engagement.

SPEAKERS

Dr. Anne Patterson, Aria Javidan, Tanya Mack, Lloyd Sirmons

Aria Javidan 08:20

Aria, hello everyone. My name is Aria Javidan, and I'm the project manager for the National Consortium of telehealth resource centers. Welcome to today's webinar transforming high risk OB care with telemedicine. Today's webinar is hosted by the southeastern telehealth Resource Center, and these sessions are designed to provide timely information and demonstrations to support and guide the development of your telehealth programs. To write a little bit of background on the consortium located throughout the country, there are 12 regional telehealth resource centers and two national one focused on telehealth policy and the other on telehealth technology assessment. 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, your audio has been muted. Please use the Q and A function of the Zoom platform to ask questions. Questions will be answered at the end of the presentation. Please only use the chat for communicating issues with technology or communication access issues, please refrain using chat to ask questions or make comments. 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 will be able to access today's and past webinars on the nctrc YouTube channel and the nctrc website@telehealthresourcecenter.org with that, I will pass it over to Lloyd sermons, director of the southeastern telehealth Resource Center.

Lloyd Sirmons 09:47

Yeah, thank you for that, Aria. We commented earlier on that ARIA really makes these webinars go smoother. So ARIA, we appreciate all you do. And I know all the TRCs, you know, they feel the same. So we're excited to be hosting this month's webinar. We always try to choose the fall, and so this is this is our month, and we're delighted today to have what I would consider to be two friends. I've known both of these ladies for a long time. I've been in the telehealth space for 15 years now with the Global Partnership for telehealth. And I believe these might be two of the, some of the first people that I met when I started doing telemedicine and telehealth. So they have definitely been in the field for a long time, and have been at the forefront in, you know, in what they do. And so today we have Tonya Mack, who is the president of women's telehealth, and then Dr Anne Patterson, who is the CEO and Medical Director for women's telehealth. And so I'm just going to turn it over to you, Tanya, and we'll let you start driving the train, and we look forward to the information you're going to be sharing with us today.

Tanya Mack 11:06

Sounds great. Thank you, Lloyd, and we appreciate the opportunity to meet with everyone today, and hopefully, let's see, I think we got going. Can everybody see that? I think yes. Looks good. Okay, sounds good. So welcome. Welcome. We're here today to talk about what is happening with high risk pregnancies across the United States and how we have used telehealth technologies in an evolutionary state over the past 15 years. Actually, Lloyd, you were mentioning we were one of the first people you met. And that's true. We actually had Lloyd and his crew at GPT here in the southeast, teach us how to do our very first encounter. So boy, we now have come a long way. We've completed over 200,000 tele maternal fetal medicine encounters through the years. We're one of the nation's largest, I think, and one of the few that cross state lines. So women's telehealth operates. We're licensed to do telemedicine in almost 22 states. We provide maternal fetal medicine physicians and mid level providers. I'd like to introduce my partner, Dr Anne Patterson. She's going to focus on clinical and technical. I'm going to focus on business and operations and how we do things. But let's start by talking about why we're even talking in the United States. The state of us maternal health care is not in a good place here in the Deep South, where I am, we are actually and have been for a while, 50 out of 50 states for maternal death, and probably 42nd or 43rd for infant mortality as well. So we are living it here. Sometimes Ann and I drive around and we think we're in the United States, and there's great health care in big cities, maybe usually, but a lot of states have one or two big cities and then medical deserts. So we have been very successful in filling the urban and rural. We're 50% urban now and 50% rural, but filling the gaps using telehealth technologies. And we're going to talk about who, what, when, where, why today, but some of the reasons we're in crisis. One is that compared to other industrialized nations, we spend a lot of money on high risk OB pregnancies with not a lot of good outcome returns. So we're going to be talking about that. We also have widening disparities. So you'll be getting a lot of statistics in just a moment, but we have widening disparities in African American in rural and in poverty areas, which are these medical deserts that we see in almost every state in between, the cities patients have to drive a long way, and access is a big issue. And then, of course, we have two patients. When we see our patients, we see the mom as the maternal, which may have chronic conditions or specific pregnancy problems, and then we also see the fetus as it's growing and developing over the pregnancy. And certainly they're intertwined. So what happens to mom? Happens to baby? And they're related in some way, of course. So I just want to plant an early seed for those of you that are on here, that I think when we started this company 15 years ago, we felt that it would be a gap filler. We felt that it would be a way that we felt drawn to help people in underserved areas. We still do. We still feel that way. However, over time, we have learned in urban centers that you think there are enough resources for high risk pregnancy, but there are not just to kind of give you a flavor. Dr Patterson here is probably one of two or 3000 physicians in the United States that do the extra three year fellowship beyond OBGYN residency to be able to handle high risk pregnancy problems. So tele MFM has become not only kind of a supplement, but kind of a transformative solution. We're using it for running outpatient clinics. In total, we're using it in acute care settings. We're using it in government clinics. We're using it in OB offices, and we're using it as extra staff where hands on maternal fetal medicine doctors provide the hands on care, and telemedicine is really set up to handle about 80 to 90% of diagnosing, treating and monitoring high risk pregnancy problems. So with that, I'm going to turn it over to Dr to Dr Patterson to talk a little bit about the specifics of what we're actually seeing in the field.

Dr. Anne Patterson 15:49
Okay, advance there. Okay, so obviously we started this practice to try to really help patients who otherwise would not have this type of care. And so we are acutely aware that where there's not obstetricians, there isn't someone to provide MFM care, but if we can locate in an area that's regional to the places where the patient could travel to and get to to be seen, then that has been our goal so that ladies who might not have the money to go across the county, much less two hours away, can they sometimes use the Medicaid vans, which are available, sometimes to bring them to us, and that we can see them and we can do high resolution scans. We can look at these images in real time, if we need to. We can help guide the sonographers as needed for studies, we can do anything with ultrasound that

you could do in a brick and mortar location standing there due to the technology. And so we have been able to bring this kind of care to women who otherwise would not have had it or not have had it in that region.

Tanya Mack 17:03
So I kind of want to go over the statistics that you're seeing on the slide. We actually had al help us create this heat map that you're seeing that kind of shows poor maternity care. Now, what you see in blue is not so bad. What you see in a peachy color is middle of the road, and what you see in orange and red are our medical deserts for high risk care. So about 50,000 women in the United States experience severe maternity problems that would be high risk, and they're disproportionately African American, rural and low income women, kind of shocking a little bit in the United States is 35% of US counties and 50% of rural hospitals lack OB services. So you heard Dr Patterson talk about sometimes our patients don't have the funds to travel across the county and there's no services in their county. So it is a big problem. For every one maternal death, it is estimated that there are 70 to 80 more cases that would be considered near misses. So it is a big problem in the United States. So we just wanted to talk a little bit about there's not enough of these providers around. They're scattered around. Also not on the slide, but I'll just tell you that about 68% of maternal fetal medicine physicians are based in cities, not in rural and mostly in academic centers. So with that, let's talk about why is this? What are some of our barriers that we see? We just talked about rural and urban or geographic disparities. So it's typical that in a city, it would not be unusual for the two or three major cities in a state to be two to four hours apart, and patients that live in the middle have to travel, you know, quite a distance to go, and just for a frame of reference, when they go these appointments, in person and with telemedicine, actually are long. So they will have an ultrasound scan, they'll have a doctor visit, they may have genetic testing, but for the rural woman that has to get up, take her kids, maybe take a day off work, drive two hours, sit in a waiting room, spend two to three hours and then drive home while she's pregnant. It's very problematic to try to access care in person in many of these cases, and it's even complicated more if it's going to be repetitive visits, like a closely monitored diabetic or a fetal anomaly that we're watching grow and then we'll ultimately need surgery, so it is a big burden for the patients to drive to access care. Then we talked about the limited MFM workforce and facilities. So I want to talk about both. We talked about the MFM workforce. There's just not a lot of Dr Patterson's in the world. That's number one. But also too, even post covid, we are finding that a lot of facilities are not enabled for connected telehealth. So in covid, I think one thing that happened was we all got used to zoom health, but it's not connected to Bluetooth technologies. We're trusting what the patient says on the other side, I also do walk throughs of a lot of facilities, hospital facilities and outpatient also. And I'll frequently find, yes, we do telemedicine. Great. Show me what you do. And I'm led to a cart in the closet in the emergency room that somebody, only a few people know how to use. So we are headed, I think, from zoom telehealth days where we all could access, at least talking to a provider to now that the waivers are down and we're going back to HIPAA compliance and back to reimbursement that requires medically evidence, a lot of facilities are now having to make investments to enable connected telehealth. For us, it's very hard to do maternal fetal medicine without looking at ultrasound for the baby, because we're always going to look at the baby plus the mom, so we have to be connected. But we're finding, still today, not enough doctors and not enough places for high risk OB and still many, many facilities not advanced in telehealth technologies. We also continue to see as a barrier labor and delivery closures, and these are most frequently found in rural areas I know here in Georgia, which is the state we're sitting in, and you can probably comment van's the past president of the OB GYN society, but I can think of five or six over the past couple years that have closed their doors in our county, and they were the only labor and delivery for the counties around them. Do you have any comments on that?

Dr. Anne Patterson 21:47
Yeah, I think if you could advance the slide here a minute,

Tanya Mack 21:52
it's hard to go back, so we'll just wait a minute and bring you back in. Then how about that? What? Okay, I think it's the next slide. Okay, and I want to talk a little bit about barriers for patients. We talked about their transportation. They may not have the means. It may be too expensive, they may not have PTO to take a day off, to come and go. The distance may be longer than they can do. Child Care is an issue. They're frequently rolling into a large academic center. They have to find parking, they have to find someone to take care of their kids, and they may not be able to bring their kids to some of the ultrasound procedures, depending on that facility's policy. So getting support for child care for a lot of them is an issue. We also have a barrier with financial means, both in terms of carriers lack of coverage. We still have state by state reimbursement for maternal fetal telehealth. Some states are more progressive. Some are not very progressive. So we're dealing with what is that state's requirements? And you heard earlier about the resource centers have one center that is policy, and if you haven't ever logged into that, you should it's a center for connected policy, and they can tell you, state by state, at the at the click of a fingertip, what their coverage is for the insurance carriers and government payers in your state. But we're looking for not only cut payer coverage, but also co pays and specialist visits, especially if they're going to be over and over through a nine month pregnancy, there's an affordability issue for the patients. And then culturally, we have had one of our centers in an agriculture area where we have maybe 80 or 90% Spanish speakers. Big cities have other language requirements. There may be fear around seeing a specialist and just the beliefs and practices of different cultures to go see a high risk specialist. So between getting there, getting childcare, making sure that there's financial coverage, and getting the patient seen in a way that they understand. We remain having quite a few barriers. We've made quite a few inroads in the 15 years, but there are also quite a few barriers. Okay. Ann, back to you, right.

Dr. Anne Patterson 24:11
So what we try to do, and we reach out to these people, is to be in a facility where we can do ultrasound, and so we arrive in a small community. People are not necessarily trained, so we have tried to address that and being able to work with them, train them up to be MFM sonographers, and by doing that, we also can scan with them, to help them as they grow. Then once we know they're capable and can scan. We are on a bi directional HIPAA compliant, medically encrypted network, very important, because not only do we get to see the scans pretty close to real time when they send over, but we can scan with them live, as I have said, and that way we can see real time what is the heart look like? What is the heart study? What is the blood flow in the brain? We can check the MCA Dopplers, all of that can be very important, depending on the diagnosis. And so all those modalities are available to us. Truly, We can almost do anything, any MFM can do, other than hands on. We certainly can't do an amniocentesis. We certainly can't do an interfetal transfusion. However, we have an enabled stethoscope where we can have the patient have the bell on her chest directed on screen, but I can put it in my ears and I can hear mom's heart and lungs just like I was at bedside. So all of that's very important. So we can not only see and take care of the patient, we then sit down with the patient and go over all their problems, all their concerns. We have a roadmap for them to follow, for their OB to follow. And obviously always in obstetrics, I think I say everything always changes, and so certainly it does, but within reason, we have a plan of care so that they know what to expect as best we can. And we also have the capability, once the reporting is done, to send that directly into anybody's EMR, to anybody's s facts, or however the physician likes to get the records, so that way we are able to provide really excellent care. There are also technologies available so patients can have kits at home. We worked with New Mexico to help provide the right kit. So a lot of these ladies who are high risk live in a very remote area, but need some type of monitoring, have that that can be read remotely and then provided the right information about care as needed. So all of those things we do and utilize every day, I think Tanya mentioned earlier, we've seen about 200,000 patients this way, and I think we've made a huge

impact in the small or underserved communities that we have been in, as I say, not as you said earlier, not all of them are small communities. Yeah.

Tanya Mack 27:11
So one thing I just want to make sure everybody's noticing on this slide is that there is in telemedicine. Could be education, could be a phone call could be very advanced technology. We use a variety of telehealth technologies. We use texting, we use Bluetooth, we use live scanning, we use integration with EMRs. We've used remote patient monitoring, just as Dr Patterson said, there it's what is the need. We pretty much have tools to fill most of the needs, whether they're rural or urban. And this New Mexico study was very interesting because it wired six hospitals in the northeast corner of New Mexico to be able to talk to each other, get patients to the right level of care, and to access patients where they had never had it the patients there were up in the mountains and would not come down and drive into New Mexico to be seen in person. So they were one of our first success stories with RPM up in the mountains, where patients actually did antepartum visits and tracking and monitoring at home, and then they came down for key visits during their pregnancy. So I think we we tend to think mostly in maternal fetal as still using patients show up to a clinical setting where there is a trained sonographer, and in a setting where there's a lot of clinical support, which is still the majority of ours, but growing is the use of remote technologies in monitoring at home. And I think we'll talk a little bit more about some of the other ones that we think we'll see coming. So we're all evolving in telemedicine. That is the news there. So we next want to talk to you about so that's great. There's a need. There's some tools. What can we do? But we want to give you some examples of impact so that you saw some real world studies and kind of open your thinking about the possibility of what might apply to you. So I'll talk about one case, and then Anne will talk about another case. So I want to kind of present to you this idea of multiple multiple stakeholders working together. So for about nine years in the State of Georgia, we had had horrible statistics for preterm labor. You heard me talk about 50 out of 50 for maternal death and infant mortality, not much better than that. So at the time, about eight years ago, our commissioner for the Department of Public Health here in Georgia came to us and said, I know you guys know how to use this technology. We have a centering program. Our worst statistics are in this one area. Excuse me, in Georgia, would you work with us to actually partner with a vendor with you with the Department of Public Health to put this into an 18 county area in our Department of Public Health District office there. So we, and there was no existing program in the country at the time that we found that did included centering so we got the partners together. Global Partnership for telehealth was the vendor partner state of Georgia. DPH was the government entity. Women's telehealth was the medical service provider, and we targeted a 15 County area. We implemented tele MFM into the facility in two ways. One way was that we actually were part of the centering program. So about three times in the pregnancy, we had the telehealth medical providers log into the Centering Pregnancy visits. It was during the antepartum testing for labs. So if we had an abnormal lab, we would know about that very early in the pregnancy. It was also when they had their glucose testing for diabetes, so if they fell over into gestational diabetics, we'd be able to capture and monitor and treat them. And it was also around when we did their 18 to 20 week ultrasound, so if we found a structural abnormality, we could identify them, and also about the seventh month, so we'd start talking to them about complications of pregnancy. So we were actually one part of this program was working in coordination with the Centering Pregnancy group to put information and direct access to providers through telemedicine education into the centering visits, if for any reason, they were abnormal the findings. Then we went to part two. And part two was we actually enabled in that office, them to have a maternal fetal medicine encounter, so we could not only educate them, but then we can also see, diagnose, treat and monitor them, so we're able to have early intervention and capture them. The statistics. When we started that we measured the metric was preterm labor. So typically, preterm labor difficult outcomes, sometimes with NICU hospitalizations, if they actually deliver early. We started this program, and in our first 18 months, we treated over 500 we saw over 500 pregnancies, and we were able to drop the preterm labor rate from 18.8% to 8.8% and at the time, the national average, according to the March of Dimes,

was around 11% so we not only went from the highest, but we actually beat what is the national average in a very rural area. It was kind of astounding. I want to talk a little bit about the financial impact of that. Medicaid in the State and the Department of Public Health actually helped fund getting the equipment and the program up and running. March of Dimes gave them the Centering Pregnancy grant as their side of the stakeholder, and it cost less than 50,000 to train the techs, put in the equipment, do everything and get the program up and running. Medicaid saved an average of 5 million a year by avoiding early delivery costs and NICU days, this program continued for eight years, until they lost the OB that was there locally in the Department of Public Health. So in our first year, this was actually published by the American Telemedicine Association, but it just gives you an example of what partners can do together to get better outcomes and to improve the services in an area, and also to have the payers in a state benefit greatly. So this is one example on the business side, and turn it over to Anne to talk about a pretty astounding patient outcome, to give you an example on the patient side.

Dr. Anne Patterson 34:04
So this is about a patient who is a monochorionic, monochorionic, amniotic twin gestation. And everybody knows that, those in obstetrics knows that that can be a pretty complicated situation. And this lady lived a distance from the hospital and two hours from an inpatient center. So we saw her with her OB on a regular basis, and we elected to put her in the hospital early. And we did start monitoring her daily, and we watched these cords as these twins continue to bounce around. And as you can see, on this cord, amazingly braided the cord anyway, we were able to keep her pregnant, make sure the baby stayed stable, which they did, until 34 weeks, when we elected to deliver. And pretty astounding at the delivery what you see, but it's an example of what you can do with MFM telemedicine in house, seeing a patient daily and getting to a really decent gestational age where both babies survived, and not only survived, but they did quite well. And fortunately, we have a NICU in this facility that's very robust, but the babies really didn't need much, but a little time to feed and grow,

Tanya Mack 35:26
and she was able to be maintained in her home community, not be transferred to a major academic center, right, Dr Patterson, right.

Dr. Anne Patterson 35:33
She was at home with her family nearby, with her local obstetrician, and that's really good, because if you end up with babies in one place and you're another and you have to travel a lot to see them, that is that can be not only costly, time consuming, but very difficult emotionally.

Tanya Mack 35:50
Yeah, so these are two examples of gains that we've had, but I want Dr Patterson to walk you through some more, especially clinical gains that we've had in the field.

Dr. Anne Patterson 36:00
So one of the things that we see a lot of, and I'm sure in anybody in obstetrics does, is a lot of diabetics, not only due to obesity in this country, which is, I think, at a epidemic level, but because the placenta can make a hormone that will make you more diabetic in pregnancy, so we have the ability to do virtual teaching, also in a HIPAA compliant setting, through telemedicine. Can be done through a platform, another platform we use, and it we are able to provide in home diabetic education and help the patient with that, with CGMS and that sort of thing. So we try to keep them as close to good control as possible by using these modalities. And that's been very, very helpful. We can also coordinate care with a multidisciplinary team, in other words, using telehealth, we can access the NICU at times, we have also utilized cardiology, also online with us at the same time, all of those things really help integrate really good care. In addition, when you can able have are that enabled you get really good

patient compliance. Patients appreciate being able to do this and not have to travel. But more importantly, really, this is a generation of women who have grown up with technology very, very rarely, not, not impossible. We do, usually do not see patients look like a deer in headlights when you start telemedicine. They're very comfortable with it. We do satisfaction surveys to make sure that we are delivering the kind of information and help to them that they understand and appreciate. And so far, that has certainly been the case, and I think that's very important. We have the ability to use a virtual interpreter where the person who does not speak English actually can see the interpreter. They're very engaging that way, and so it's not just a language line, and that's been very helpful, especially in different cross cultural situations. And often the interpreters can help us understand some of the nuances of the patient's background, of what they expect or need or whatever. Because even though there are various places that people come that are Spanish speaking, often culturally, it's very different from Central America or from places in South America, and we try to be very conscious of what someone's background is, so that they not only understand what's going on, which truly very, very important, but that we understand what their needs are and what their concerns are. Because if you do, you get a better engagement with the patient, and they're much more willing to work with you, especially if there are issues they have to work through.

Tanya Mack 39:07
Okay, thank you for that. So what are our implementation challenges that we have as we try to expand telemfm across the country, and we work in many states, and have been in many states, so I want to address some challenges that are still out there. We talked a minute ago about reimbursement coverage, and it really varies from state to state. Still, we have had to bring payers into our site and have them see what we do, to see if they're even going to cover tele, MFM. We have worked with private payers. We've worked with government entities. Each state still defines telemedicine a little bit differently from what kind of things are covered, what providers are covered, what you can use, store and forward only. It's just variable. So we still look at reimbursement coverage every time that we look at where we're going to be providing services in a new state. I also just want to mention parity law. We have been very fortunate, and part of the reasons we started our company in Georgia is we were one of the first states in the country that actually had parity law, which basically means if we can listen to your vital signs and your heart sounds and lung sounds. If we can scan your baby and see in real time what's happening, if we can make a plan, if you can sue us for all that stuff, and we provide the care, you're going to pay us the same as if we're in person. And so in Georgia, for example, we do have parity law. We really don't worry about, am I going to get paid if I see this patient in this state, but in a lot of states, we don't. So we have made a lot of progress over the 15 years from when we started, when we started, there were only eight states in the nation that covered tele MFM. There are now all of them. I think all of them cover some things. So you just have to check in your state as to what the coverage issues are and how they define things in your state. But that still remains a challenge. There is no federal telehealth mandate for reimbursement. It's still very much state to state. Second challenge that we still see is broadband access. So again, this kind of follows rural and city, where, if we go into some of these medical deserts, we still provide our tele MFM encounters, mostly through broadband network, a little bit cellular, but mostly broadband network, which means we need to have a great internet speed. But as we found out in New Mexico, sometimes in the mountains you don't. Sometimes in a rural area, you don't. Sometimes you're in a dip in the away from the cell tower. So we do do testing when we go into a facility to make sure that we're able to do live scanning, doing up down testing, and making sure that the speed is okay to transmit images and have our consults. But you think sometimes in the United States that, you know, we just automatically take it for granted, and we just don't have it everywhere that we would like to provide services. That's for sure. Women's telehealth has also visited about eight countries to provide services. In the Congo in Guatemala, we spent time in India and learning about how people do things in other areas. We don't all do things the same across the world, but certainly in the United States, broadband is our number one way to connect for tele MFM, and we need to make sure, when we go in and see about expanding services that that we have good

connectivity to start with licensure barriers. We have made progress, but we again have a compact. So I think many years ago, pre covid, we had about 13 states in a compact. It is not reciprocity, where it automatically goes from state to state, but it certainly is a beginning point in pulling out your application in the state board to kind of be advanced more quickly if you are providing a service that there's low services in that area. So we continue to get more states participating. Just to kind of give you a flavor, the earliest that we've been getting, the easiest we've been able to get a license in another state to provide and bring in services to a state has been about six to eight weeks, and the longest has been three years. So there is quite a bit of variability in each state. And how many licenses do you hold down? 20 some a lot, a lot. I have a lot. And she has to sometimes take special classes or do what's required in each state to be able to provide telemedicine services. So in the US, you have to be licensed where the patient sits, not where the providers sit. Many of our providers work in pods or geographic regions where they will hold somewhere between two and six licenses to be able to provide tele MFM services in the states around them, where it makes sense to so licensure is sometimes easy, sometimes very difficult, and you have to follow the rules again of each state hospital facilities. We talked about that before. Again, we're seeing a lot of movement in hospitals. Our biggest growth right now is in hospital systems that are coming off zoom based telehealth and actually plugging into Bluetooth and connected modalities so that we get medically evidence visits and not just patient history type visits. So we are seeing movements, but there's still just as many I walk into, and there's very little organized telemedicine in that facility. And then I wanted to talk a little bit about just patient digital literacy. So Anne said, you know, we deal with childbearing women, most of which are digital natives, but we're learning to work on where they are. So one thing that we found out over the course of these many years is we assume that people have a computer at home. They don't. We have converted, for example, our entire diabetic teaching at home with patients to mobile devices. If we can't, almost everybody we can get, even in rural areas, will have some kind of cell phone. We can't do all of our visits on a cell phone. It's hard to see on the little screen. But as we learn more and more, every size doesn't fit all in terms of the technology that the patient is accessing on so you do have to pay attention to what is the program and where is the patient, and what's the access for the patient. So before we kind of open it for questions, I wanted to talk have Anne talk a little bit about where do we think we're headed, and what kinds of things are we seeing for tele MFM that are a little bit here or coming down the pike?

Dr. Anne Patterson 45:56
Well, I think telehealth is always evolving, which is important. And one of the things that I think is evolving right now, especially for patients in rural areas, is that if the patient is having to stick her finger three or four times a day, Medicaid is now allowing CGMS for them, for those patients to have. And I think that's really important. I think that's certainly a real an adjunct to care. It's not brand new, but it's going to be more utilized, I think. And I think that's very helpful in low risk patients, which some of the patients in New Mexico definitely were. They were able to have virtual antepartum visits at home for part of their care. I don't think it should be all of their care, but certainly that is something that's going to be seen, I think, in patients that are low risk and don't always have to come in on a set schedule. In addition, remote monitoring can be done. A lot of it can be done at home, so patient patients don't have to come in and have a non stress test once a week if they don't need to be seen. So I think some of those things are on the horizon, and certainly Virtual Patient Education, which we utilize right now with diabetic education and using the smartphone apps, sometimes using those in conjunction with a telehealth platform, which can be done and we do, has been very helpful. And clearly, behavioral health has been probably in the forefront of telemedicine, because people have been able to access care they otherwise would never have gotten and there's some absolutely excellent platforms that provide that today.

Tanya Mack 47:47

So one of our goals today is just to broaden your mindset and learn a little bit about what other people outside of wherever you are sitting and visiting with us from, what are other people doing in other regions in the realm of tele MFM, and we want to talk a little bit about how you can help advance this from where you sit. First one is like with a lot of telemedicine, not just maternal fetal medicine. After covid opened up, everyone's thinking, from providers to patients. We are all learning that telehealth is a required tool to see patients in a practice, there are certain kinds of diagnosis that lend itself to tele MFM. We're trying to fill gaps in the provider chain and in the healthcare plan chain, so use of telemedicine isn't even optional anymore, whether it's for our specialty or any specialty, but for high risk OB and the statistics that we're seeing that is really an epidemic for Maternal Fetal Medicine care in the United States, it's essential as a tool. We also think that we would encourage those of you that are hospital administrators or practice managers or somebody that's influential in the community to think about connected telehealth and not just zoom encounters. We now have Bluetooth. We have medically evidence based telehealth technologies. We've had them for a long time. We've used them for a long time. It's just time to get all of the data together to make the best care plan for the patient, certainly in your states. You've heard me talk a couple times about how state by state, we we have a lot of variance in what one state does to another, both in telehealth and also maternal fetal health. So just be an advocate for telehealth policy and reimbursement in your area. If you're providing it, invite the payers to come show them what you can do, give them statistics about what you've done, or get connected to somebody that can help you. We do a lot of collaboration, as you saw in our case study about all the disciplines. We have regular meetings with NICU doctors, with midwives, with OBS, with community leaders, with departments of public health, a variety of stakeholders. It is not unusual when we go into a facility or a community that when we have our very first kickoff meeting or education session that we will have 20 to 40 stakeholders on one virtual call. Everybody has a little piece of it, and the best outcomes that we've had are when we actually involve people from the beginning and we cross into the other disciplines and bring them in to get the whole picture. So really reach out to other stakeholders. We've gotten payers to pay for equipment setups. We've gotten some continued centering grants by showing evidence of what we did with the first one, we've gotten a lot of people to cooperate in ways we never expected. And I'm sure there's opportunities in your community too. The other thing I would say is just don't assume that you're don't assume anything. Make sure that you get the real data. I sit in CEOs offices and meet with leaders all the time, and I hear the funniest stories about what they think telehealth implementation will take, how much it costs? What will I get? I'll give you an example. I had one CEO in a rural facility say, You know what? That is a great idea. We are never going to do it, because I'll only get paid $11.38 what a random number had no idea what he was talking about. It ended up being an old QR code for the electronic transmission only, not even billing for the service. And once we fix the assumptions and show them what's possible and real instead of what is assumed that for somebody that's never done it, I'd say, call an expert, get the facts, and don't assume much about a service that you're not providing. And then lastly, I'd like to point to our host today, because we started with the southeast region, teaching us how to do our very first encounter. We've been to the American Telemedicine Association meetings. We've met a lot of people at the TRC centers. They have resources for you, for clinical policy, for reimbursement, for connecting with other providers. I call Lloyd all the time when I get stuck with something, and he has never failed to say, I can help you or let me find out. So please access them. They're a huge resource, right where you sit? So Lloyd, thank you for the opportunity today, and I think we have 10 or 15 minutes for questions.

Lloyd Sirmons 52:36
Yeah, absolutely. Great presentation, great information. Thank you guys so much. Aria, I see there's a couple of questions. I know one of those questions you did answer. Tanya, you talked about, I was talking about, what states do you work across? So I know you kind of touched on that. And then another question referenced virtual interpreted interpreters. Sorry that are trained in medical terminology. And how do you guys address that issue when you know when you're looking at language barriers?

Dr. Anne Patterson 53:13
That's a great question. We have fortunately been able to find a really kind of robust platform, particularly for Spanish speaking patients, that does a really good job. And so the the patient can actually see the interpreter. And so they can see us, they can see the interpreter and where the telehealth presenter is also there. So, you know, it kind of, it's almost a five way conversation, if you like, but that way the patient herself can address questions with the interpreter, who can then obviously ask me, or whomever the provider is. So we make certain that the patient truly understands. And a lot of times it's important for you for us to ask the interpreter, if you know, what are her concerns, or what is she, you know, what is her background, and what, Where is she from, and what are her customs? And it's fine to ask that, because that way the patient also understands that you're acknowledging her situation, which can be quite different from different places. We've used another source for patients who are Haitian. We do see a lot of Haitian patients, and obviously they speak real, and that's important, that we connect with that as well. So there are some. There are several options out there. I personally prefer the one where the interpreter is virtual. One thing I

Tanya Mack 54:43
would say is it's not one size fits all. So different communities have different resources. Sometimes we go to the hospital and the hospital will encourage us to use their language options. Sometimes we have the right staff and we provide them as our employees. Sometimes it's a different platform in different areas. So I think the key to the question is it's out there. You just have to explore what there is and look for the different solutions. But I agree with Anne that when the patient can see the interpreter and not just hear it, just adds a lot to the conversation and makes the encounter better.

Lloyd Sirmons 55:17
Yeah, that's great. There is another question that just came in talking about, you know, how to get by. And we, we've talked about this a lot just over the years, with telemedicine and, you know, bringing virtual, you know, providers and practitioners into communities. And know, this individual is just kind of asking if you could address address, you know, how do you get buy in in the community? And, you know, kind of overcome the idea that you're going to be taking business away from people.

Dr. Anne Patterson 55:52
I think that's a question. Go ahead. Anne, so one of the things we'll do is, when we say, we go into a hospital and we ask to set up, and we will engage a patient. Obviously, she's consented that, and she knows that she's going to be talking to the obstetricians that are in that community, and we will do a full consult. She'll let us see her images of her baby, then she is available to talk to the obstetricians who are there. And so the first step is to get buy in from the obstetric in our in our profession, and from the obstetric community, because that way they know, you know, obviously we're not going to be doing deliveries. We're not going to be taking those patients away. We are truly virtual. We are not going to be there, but we need to convince them that we can provide quality service and that we they are their medical partner, so that, you know, if they have a problem and it's three in the morning, they we're as close as the cell phone, call us up. We do have the capability of looking at things as well, if we need to in the middle of the night, but the buy in first is through the provider community that you're serving, and make them aware of what you can do and also reassure them that you're really there as their medical partner. And then when the patients come, obviously for them to have a really good and welcoming experience is important. And I have on occasion, had patients say, Well, I'd rather come see you, which we don't really obviously, we tell them that's not possible here. And they go, Well, you listened. But it's very important that you engage your patient and really listen to what they have to say and make sure all their questions are answered. And I think if you are able to communicate and work with your local obstetric community in our situation and then engage the patients, the pushback is goes away

Tanya Mack 57:58
quickly. Yeah, I would like to weigh in too, because as the business person for women's telehealth, I have a little bit different perspective. So there's more than one way in if you're trying to get stakeholder engagement. And certainly has mentioned one critical way, and that is, if you can't engage the OBS that make the referrals to high risk, you won't get very far. And one thing that we found that we do is we do on site demos. And so again, we see a lot of assumptions, like this is what I think it's going to be, but when we invite them to come in, look at a virtual encounter, look at live ultrasound scanning, the OBS almost can't believe it. And so seeing is believing. And we do a lot of demos all over the country to show the local OB community what is possible versus their assumptions. A second way in in business development is through administration of the facility. And so we have a one page ROI spreadsheet that we put together that shows them, right now you are getting patient bypass. Patients are going around your facility, and they're traveling to where they have to go to get in person care. But if you can keep them local, then you're not going to lose your revenue, and you can build your facility. We have one facility that, when we started, they did about 1500 births per year. We've been there seven years. We do 24/7, call worse, five days a week. Outpatient Center, no MFM in the community has ever been in person, and over those seven years, they've been able to keep the patients in their NICU. Occupancy rate has grown. They've built a whole Women's Center new to support it, and now they're talking about a children's hospital. So you have to engage if the OBS want it, but the hospital or facility administrators won't foot the bill for it. It won't happen if the administrators want it, but they cram it down the throat of the OBS, that won't happen either. So you just have to really engage. But really, I believe that Seeing is believing.

Lloyd Sirmons 1:00:07
All right, so we'll keep us moving. And of course, communication, I think, on the front end is key, and I think that's key with any telemedicine or any telehealth program you know that you're going to launch into, and I think including the right partners on the front end makes a big difference. So someone's asking if you could just elaborate a little bit more on the technology piece for, you know, for doing these type of consultations.

Dr. Anne Patterson 1:00:37
Okay, so there are two platforms that we use. There are several out there. There are two that we use pretty consistently. Obviously, Lloyd's, with Global Partnership for telehealth, we utilize them, and have found their services to be pretty seamless. It allows us to see the patient, it allows us to see ultrasound real time, and it allows us to talk to the patient if we're doing real time ultrasound. So, you know, that's been a pretty robust platform and a very, very helpful one, and they've always been there for us. So and it, you know, we just don't have any complications. Now, any type of technology you need backups, and I usually have three or for all of them, but this has been a very robust platform that's worked very, very well. So that's one. Then we also obviously have to send out a report. We have to see the images. So there's another platform to see the images on and do reporting on, and that can be sent very seamlessly out to several different locations at one time, we can send it to the hospital, EMR, we can send it to the physician's office. We always get a copy to make sure if we get it, it should go everywhere else and anyplace else that they desire it to go. So, you know, techno, technically, we can send that to anywhere, and we do reporting and turn that around and get it to whatever is needed pretty directly. So those are the two main platforms we use. We have backups to everything, as I said, and one of the backup platforms is the one we use virtually for our home education. So you know, they're they're different modalities out there, but those are the three I think we utilize the

Tanya Mack 1:02:24

most. The other thing, I would say is sometimes the facilities mandate our platforms. And so if the if it's an HCA hospital, and they have telemedicine throughout the facility, and we might have a say, we might not have a say. And so you have to be very flexible with what works, so we know how to connect all the dots, like the camera has to go to the laptop has to go. Here, I will say one thing that is kind of a crawl under my skin on the tech side is that we, a lot of facilities, are still using telemedicine carts. When we started. They were custom made by specialty so a cardiology cart would not be the same as a maternal fetal medicine or a primary care card. But lately, we just have all moved to apps and laptops and Bluetooth stethoscopes, and so it has really dropped the price from 10s of 1000s of dollars to under about $10,000 to put in a system that will really work to do a virtual encounter for even sub specialties like ours. So again, that's assumption that tech is very expensive to put in. It's not really that much anymore. So I did just want to mention there are multiple platforms. There's a lot of them that works. It's knowing how to connect the dots in a facility and integrate with what that facility is doing. We don't sell tech. We only provide the services. So we've learned a lot about how to connect the dots with different technologies. But Anne is right. Typically, we'll have one for AV, connectivity, for the patient visit, and then we'll have another one for imaging, EMR, all that kind of stuff. But typically we use two or three solutions per client.

Lloyd Sirmons 1:04:03
All right, good deal. Yeah, technology has advanced tremendously, and has also driven the cost of, you know, getting a telemedicine program up and running. It's driven that cost way down. So another question, we have a virtual doula service, and the question is around working with you guys, are they able to work with you? Do you have a doula service that you work with on things and it talks about escalating red flags or so, or do you guys only work with the referrals

Dr. Anne Patterson 1:04:36
through OB? Okay, so because maternal fetal medicine is a referral subspecialty. We do get referrals from nurse midwives, and we do get referrals from obstetricians, but the patient has to always have some obstetric provider. Doesn't have to be a physician. Can be family practice, can be an OB, can be a CNM, but they do have, you know, some type of OB provider, I would assume, for a doula, that would be more in venue, working with the midwife or the obstetrician. Certainly, I think there is a push to pay for doula services out there today on a state level. I've certainly seen that at the Georgia legislature. So I think it is very helpful. I think women do often have a lot better outcome if they have somebody there. They feel with them at all times. I think that's helpful. But we don't, personally, in any plat platform or practice work with doulas because of the subspecialty

Lloyd Sirmons 1:05:39
gotcha All right, and then someone's just asking either one if you could just kind of talk about the states again. Might be difficult to name all the states, but I guess Dr Patterson, the states that you're licensed in,

Dr. Anne Patterson 1:05:53
oh, wow, we're in 22

Lloyd Sirmons 1:05:58
you're licensed in 22 states.

Dr. Anne Patterson 1:06:00
The company with their providers, we are licensed in 22 states, all the southeast, a good bit of the southwest and some of the Midwest and two of the Northeast states.

Tanya Mack 1:06:15
Okay, we're probably the lightest in the Pacific Northwest, yeah.

Lloyd Sirmons 1:06:21
And of course, you'll have, you can have their contact information to reach out to them directly to you know, if you're in a state and you want to know, hey, are you licensed here? So happy to talk to you. Yeah. And we do have a someone who says that they've had the pleasure of utilizing MFN, MFM, telehealth in an HCA facility when their MFM wasn't available. And says very, very beneficial. It says, was the 8.8% reduction in the counties you served, or a statewide reduction

Tanya Mack 1:06:59
counties it was in the 18 counties around the that district, public health office, okay,

Lloyd Sirmons 1:07:06
so that consortium, so to say that you were working with, you know, when you guys went back and you, you know, crunch the numbers, you're saying there was an 8.8% reduction in that there were

Tanya Mack 1:07:17
just 218 8.8 point 828.

Lloyd Sirmons 1:07:22
8.80 got you. Okay. Okay,

Dr. Anne Patterson 1:07:26
we were better than the national average in an area that had been the worst in the state. And that is really exciting. And we were able to maintain this for eight years. There were no direct maternal mortalities. There was one from a car accident when she was two years post delivery. So we're very proud of those statistics, because it made a huge difference.

Lloyd Sirmons 1:07:51
All right. Another question, is your team able to provide referrals for patients in need? For example, if they would benefit from home visiting dual doula services, case management, etc. Can you guys send those referrals, or would you have to collaborate with the main OB person?

Dr. Anne Patterson 1:08:10
No, we can't. We do communicate with the main OB, but no, we can do referrals and do and we have a staff. For instance, we have a patient that has a specific problem, we do the referrals and the OBS know, we will do those referrals.

Lloyd Sirmons 1:08:26
And the last two comments that I have here are not actually questions or comments talking, just saying, Thank you, great service, great program, and I will echo that. Thank you very much for being with us today and sharing. You know, for our national consortium of telehealth resource centers, Aria, I kick it to you.

Aria Javidan 1:08:47
Thanks, Lloyd. Just a reminder that our next webinar will be held on Thursday, October 16. It will be hosted by the telehealth Technology Assessment Resource Center. The telehealth topic is still being finalized, but we'll post the registration information on the telehealth resource center.org, websites once it is and then lastly, we ask that you do take a few short minutes to complete the survey that will pop up

at the conclusion of this webinar, as your feedback is very valuable to us. Thank you again to the southeastern telehealth Resource Center for hosting today's webinar, and to Dr Patterson and Tanya for their presentations. Have a great day, everyone.

Tanya Mack 1:09:20
Thanks, everybody. Thanks, everybody. Bye.