

Action Steps to Address Patients' Barriers to Accessing Virtual Care: Focus on Older Adults

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00:22 - JEN DEYOUNG

Hello, welcome to the United States of care webinar action steps to address patient's barriers to accessing virtual care focused on older adults. I'm Jen D. Young, United States of care as Director of Policy leading up the building blocks of health reform initiative. I'm co-hosting the webinar today, along with Dr. Jon Zifferblatt from West health. Let me start by sharing a bit about United States of Care and what brought us here today. USofCare is a nonpartisan nonprofit organization, we work to ensure that everyone has access to quality affordable health care, regardless of health status, social need or income. The healthcare system isn't working for millions of people in the United States. And our research shows that people want a better health care system in the wake of the pandemic. In fact, we believe there may be an opening for reforms that weren't possible before. We do our work in a unique way. We go around the country listening to people's needs and experiences to send our health care reform efforts around those needs. And we're tackling these challenges on two tracks. First, we're working in states to expand access to quality affordable health care right now. Because people can't wait for a perfect solution from Washington DC. We're also working to create the conditions for long term change. We know we need a national conversation and new innovative solutions to build momentum to federal change that people can rely on that won't be overturned at every election. In 2020, we saw the COVID-10 pandemic response unleash a revolutionary expansion of virtual care, whether it be telehealth remote monitoring, or other remote forms of communication. Virtual care tools are shiny and new for many, but a USofcare. We're looking beyond the present to the potential it has for being a long term lasting solution to close gaps, address barriers and get more people access to the care they need. As part of our work, we've partnered with West health to look at the experience older adults have had using virtual care. What's worked well, what hasn't, and what do providers and policymakers need to know to make it a more equitable experience? Earlier this month, USofCare and West health published a playbook together that offers action steps for healthcare providers and policymakers that support older adults access to virtual care going into the future. I'm excited to bring you this webinar today to share with all of you our learnings from the research behind the playbook. And with that, I'd like to introduce to you my co-host for today, Dr. Jon Zifferblatt, Executive Vice President for strategy and successful aging at West health. In his role at West health, doctors Zifferblatt creates and implements West health strategic successful aging initiatives, as well as co managing the organization's platform focused on lowering the cost of health care. Prior to joining West Health, Dr.Zifferblatt has had previous roles in population health, evidence generation and healthcare business

sectors, and has served in a variety of executive research and clinical capacities in the US, China and Japan. Hello, Jon.

03:29 - JON ZIFFERBLATT

Hi, Jen. Thank you for that very nice introduction. So it's really a pleasure to be talking to all of you today. As Jen mentioned, I'm the VP of strategy for West health. We are a family of organizations that is dedicated to lowering the cost of health care, such that older adults can age in place with access to the health care and social services and support they need that preserve and protect their dignity, quality of life, and independence. And I'm very happy to be co hosting this event. This is a conversation about virtual care and older adults that I've personally been wanting to have for at least a decade. So events have conspired such that we are having it now. And I think many of you who are watching and thank you, by the way for watching now, either real time or at some point in the future, many of you are watching are probably aware that virtual primary care visits for Medicare have gone from point 1% as virtual before the pandemic to now 40% virtual. So we may have the bookends of what virtual care for older adults may be. But the truth is, surprisingly, not surprisingly, somewhere in between, but is probably more complex than then we really understand. And I think we've done a good job here to start to disentangle that. We're not necessarily here to talk about what the right amount is. But we are here to talk about what the right context use cases and characteristics of virtual health care for older adults should look like. How are they now? And how should they be? Are there barriers? To be sure? Is there potential for low value use? Absolutely. But the rewards are simply just too great not to take this on. And I want to leave you with, with this thought as we go into the meat of the presentations. And it's probably not one that it's probably one that you already have. So I won't tell you it's a new thought for you, I'll just say I want to reinforce this thought for you that virtual care is a key tool in creating a distributed healthcare system. A distributed healthcare system very much serves the needs of older adults supporting their ability to age in place, maintain their quality of life, not have to enter into inappropriate care and enlarge, enlarge hospital settings if they don't need to. It really serves the needs of older adults, and in many, many ways, it also promotes equity in the health care system and distributing health care into communities where it's needed. And it really serves us well. Not when we won't have to go through this again. But if we do, a distributed healthcare system is a much more robust one to deal with a future pandemic. So for all of those reasons, I like you. I'm very excited to hear what our panelists have to say today. And thank you so much again, Jen, for allowing me to be part of this event.

06:19 - JEN DEYOUNG

Thanks, Jon. With that, I'd like to introduce our expert panel now. And thank you all for taking time to be with us today. First up, you're going to hear from Dr. Venice Haynes, director of research and community engagement at USofcare. Dr. Haynes is a social and behavioral health scientist with over 14 years of public health experience. Her overarching research agenda has focused on addressing social determinants of health and health disparities and underserved and global populations using qualitative and community based participatory approaches. Then you'll hear from Michael Kuriland, Director of telehealth and process improvement at West Health. Michael has been working in healthcare for over 25 years and has served as a clinician administrator, strategist, consultant program and departmental leader specializing in health information technology and change management. Michael has worked across the continuum of care from pediatrics to geriatrics. Then you'll hear from

Josh Hofmeyer, Senior Care officer at a Avera eCARE in Sioux Falls, South Dakota. Josh is a licensed Long Term Care administrator for over 10 years, and is also certified as a health services executive. He works across multiple states overseeing telehealth services operating in nearly 200 locations. He has extensive knowledge in long term care quality improvement processes, and recruitment and retention and long term care, as well as experience in assisting nursing homes and other senior housing entities achieve financial success. Then we'll hear from Chris Johnson, Vice President head of corporate development and landmark health, Chris oversees strategic growth initiatives, partnerships and Public Policy at landmark health, Chris joined landmark in 2017, and originally served as the general manager of landmarks New England market. And then finally we'll hear from Amy Herr, Director of Policy at West health. Amy Herr is an expert in state and federal health policy analysis focusing on long term services and supports for seniors. Before joining the West Health Policy Center, Amy was a managing consultant with the Lewin Group. She has also served as a health policy analyst for the National Association of State Medicaid directors, and a legislative assistant in the US Senate. Amy is a member of the board of directors of the American Society on aging, and also a member of the National Academy of social insurance. Throughout all of today's event, please submit any questions you have for the panel using the q&a function, which you'll find in the lower part of your screen, we'll have an opportunity to return to those towards the end of the program. So with that, Dr. Haynes, let's start with you.

08:57 - VENICE HAYNES

Thanks, Jen. I am super excited to be here with you all today. I can't wait to give you a little teaser about what we've been up to, and putting together this work. So I'm happy to jump right in. So as Jen mentioned, and what is central to all of the work we do at United States of Care, centering people and really hearing about what they have to say. So, here's a little bit about our approach that we took to standing up this work. So from November 2020 to January 2021. We conduct mixed methods research, through national surveys, public opinion scans and focus groups to really understand what older adults experiences were with virtual care and then identifying some of the barriers and concerns that they might face. So a couple of highlights from the field. So officially due to the pandemic, virtual care has been central to maintaining the health care of older adults that have since had to adjust to an online platform to receive care. We found that for those that have participated in the virtual care space, and have had the resources to do so, older adults are in strong support of using virtual care. And while those that have not used it during this last year, they primarily said they haven't needed it. A number of various concerns with virtual care were identified, particularly among older adults and world population, people with disabilities and caregivers. So what's working well, with virtual care. Among those that have used that, we saw that convenience was kind of the winning ticket with this, right. So they didn't have to leave their home, find or pay for parking, experienced long wait times in the waiting room, so it was just kind of like a login. And we're right there, we can participate in our business. So they love the convenience of it. In fact, one of our focus group participants said, her blood pressure was actually lower because she didn't have to deal with all of the stressors of getting to her appointment. So by the time she's getting her vitals, check them, you know, historically, she'd have high blood pressure from just trying to get there. So her virtual care experience, she didn't have that problem. So in terms of another reason, virtual care has seemed to work well, because people were using it primarily for primary care visits and with providers that they had already established a relationship with. So that felt a lot for the personalization of the business that they experienced. While there were a new number of new provider experiences, but people really were already logging in with a private provider they have

met before in a face to face setting. So that was also helpful. So essentially, across all the findings, to a lesser degree, but something of work. That's rather noteworthy is the concern of the barriers, people have a virtual care that kind of impacted some of those hips able to participate and have a quality experience. So some of those overarching themes include a comfort with using technology or having a general digital literacy, figuring out the technology space to log on and navigate that having that quality and personalized experience that they used to with that face to face just wasn't the same. And a lot of times that fell on particular healthcare needs. Some people were concerned about getting an accurate assessment for what they were using virtual care for. And particularly in rural communities, everybody did not have quality, equal access to the internet. Or if they had it, it wasn't that reliable or stable to hold up their visit. So even though adults, sometimes uncomfortable, even technology, they've found ways to overcome this challenge and participate in social care experience. So ultimately given a choice. Adults will not choose to replace in person visits with virtual care, but would like to have the option to interchange them or use them in combination with in person visits that are deemed safe to return to. So that's a couple of key take home messages. And I'm going to give you a little bit an overview of some of the case studies that we'll be highlighting today that speak to some of the barriers that we just highlighted. So also part of our research, we conducted an environmental scan of organizations providing virtual care to older adults. And so from this scan, we selected three models that have effectively reduced barriers to care to profile as case studies in the playbook. And those include Gary and Mary West PACE, Avera eCARE Senior Care and Landmark Health. So I'd like to now turn over the mic to my fellow panelists representing each of these organizations to talk about their organization's unique care delivery models and how they've integrated virtual care to meet older adult needs. So first up is Mike Kuriland to talk about Gary and Mary West PACE.

14:16 - MICHAEL KURILAND

Thank you very much, pleasure to be here with everybody. I realize that a lot of folks probably don't know what PACE is. And quite frankly, even with over two decades, being in health care. Just about a little over two years ago, two and a half years ago, I had just learned about PACE. There's about 138 pace organizations throughout the country. They're operating in 31 states, and only at this point, only 55,000 participants in other places we call them patients but these are participants and you'll know why As I tell you a little bit more about it, it's a pretty innovative model. It stands for programs of all inclusive care for the elderly. It enables folks aged 55 plus. And this is really important. They have to be certified by their state to need nursing home care. But it enables these folks to live in the, in the community as independently as possible. So these individuals are living at their home, not a nursing home. And this is what really sets it apart from other models of care. PACE is truly the medical home the way most of us would like it to be. It provides coordinated, comprehensive, truly individualized care around the clock for these older adults. It includes physicians, nurse practitioners, nurses, social workers, therapists, dieticians, carried drivers, and I think the list goes on. Like you could have occupational therapists, recreational therapists. But the key is that they all work together, they share information. And they solve problems to keep the enrollees or the participants in the community, and it as independent as possible for as long as possible. It's an amazing model really. And I am looking forward to when there are more than just 55,000 people in the United States in this particular model. With all these resources in place, along with the day center and health clinic, PACE, takes it to the next level. It goes by becoming 100% at risk for the participant. That's right, folks, you heard it from me, it's 100% fall risk for these participants, they receive a per member per month capitated payment from Medicare Medicaid. And so

these pace organizations assumed full financial risk for the care of the participant. And what's beautiful about this, it's like that This and other capitated like full risk models really allow flexibility in just how you deliver care. It encourages, like innovative and creative strategies to really maintain and improve the well being of the patient. So if you're not worried about all the constraints of CMS reimbursement, because you're receiving a per member per month, you can be more flexible with how you deliver care whether it's like incorporating virtual care, or buying an air conditioner. If the pace organization believes that the action will improve the well being of the participant than they do it. It's To me, that's just how care should be. By the way, for the fee for service folks that are listening, these per member per month models have been really identified as a potential shielding strategy from events that well will hit your volume like a pandemic. So if you have decreased office visits, and you have a per member per month relationship already, you're still going to get that per member per month, and you won't be hit by the decrease in the actual reimbursements because of the decrease in the volume that you're seeing. Additionally, a differentiator of West PACE it's it's one of the very few pace organizations that have a close affiliation with the research arm of the West Health Institute. One of the many things that the institute does is ongoing research and PACE quality and process improvement. And with the goal of sharing and advancing the PACE community, period, and that's where I come in, I come in from the West Health Institute. Well, like many of us into pandemic and because of the pandemic, with pace had to close its day center and reduce its in person clinic visits to comply with social distancing guidelines. So suddenly, we had isolated home based seniors and we needed to do something. If you can switch the next slide. But you know, thankfully, prior to the pandemic, we had planned to implement some virtual care services as part of the West Health Institute on the institute's ongoing process improvement activities. So we had already identified some virtual care tools. We did the dirty work, basically, you know, getting those contracts executed. You go through all this effort, but boy, those contracts, they take a long time. We created the training materials, all this stuff was just pretty much in place right before the pandemic hit, and because of that, all that due diligence, we were able to really rapidly deploy basically compressing what would have been a six to eight week implementation time to one to two weeks. So we implemented three virtual care services. What was this patient's system video visits? We basically deploy personal care assistants as tele presenters or tell facilitators you may have heard those terms used before to facilitate real time video visits with clinic staff, or specialists like a psychiatrist. PACE is basically to go to the patients' homes and assist with the virtual visit, connecting the participant to the remote primary care provider specialists or therapists. The tele presenter ensures that the participant could connect with remote with the remote provider during the scheduled time, which is very important. And mainly, like they've really helped alleviate any kind of technology and digital digital literalist literacy issues. We found that the PACE can also enhance the video visit by like taking vital signs positioning the camera adjusting lighting, providing that in person feel, assisting in the assessment, and also, which was a nice little surprise for us. And it shouldn't have been, but when they came there. They could also assess the environment for any additional hazards like falls risks like rugs, we've had some folks just kind of adjust the house only because they were able to see it because they were there visiting and not just to drive or picking up the participant and bringing them back to the day clinic. This model really was key, it really took the variability out of the equation. A lot of organizations really, when they lift and start telehealth, there's a lot of variability when you just leave the technology at home. I'm going to speed along here. econsults very, very successful. I had never done this telehealth before. And quite frankly, it's so simple and beneficial. I wish I would have implemented it years ago. It's basically the official version of a curbside console. And you could use it for a variety of

specialists. And basically, our clinicians ask a specialist and within 24 to 72 hours, we receive a response back. That was excellent, because based on those responses, we are able to add them to our documentation and adjust the treatment plan. And lastly, we included an AI enabled device that helped us decrease social isolation, the participants were able to interact with a kiddie or a puppy through a tablet. And if there was an issue that the AI detected, there's also a person behind that, that starts to really engage with the participant, they ask for additional questions and if need be, they contact the PACE organization. And then our provider switches out with the avatar if you will, and does a video visit to check in on the participant. Last slide. And last thing I want to mention is the thing that I'm looking out for that many organizations should be looking out for to is like, everyone has kind of adjusted on the fly and stretch this rubber band to incorporate these new processes, workflows and frost like workflows around telehealth and virtual care, when I'm worried about is that after we've done all this stretching, and just pandemic alleviates a bit is that we go we snap back to where we were before. And that is just not going to work. We've learned a lot from providing this more distributed model. And there's a lot of benefits to it. And it does need to be incorporated into the standard operating procedures of all healthcare providers. And this is where I pass it on to my colleague Josh Hofmeyer.

24:27 - JOSH HOFMEYER

Great, thanks, Mike. And it's great to be visiting with everyone today and sharing some information about Avera eCARE and then specifically more about senior care. You'll see on our next slide. The things that really make Avera eCARE unique. We've been providing telehealth services now for over 28 years. And we have a great mission that was started by a couple of groups of Catholic nuns who came To the Dakotas, and we're looking to provide health care, and really figure out how we could help support all of those who needed that care and from that large health system of Avera health was developed. And we really started to look at the rural situation that was that we were focused on. And so to provide those rural services was important to us. And so everything that we've done has really been focused on our rural solution. But we have found in recent years that even in urban areas, and some of the bigger metropolitan areas, a lot of these same issues are starting to happen as physician numbers reduce, and things come into play. And so we're able to truly take that next step in making sure that we can help provide services. On our next slide, you'll see that with nearly three decades of experience, we've really expanded all of our horizons into a lot of different areas that we cover. We started off with some specialty services back in 1993, with an E-console program similar to what Mike was talking about here a little bit ago. And that has really grown into hundreds of specialists and hundreds of locations, through today's date, quickly realizing the importance of that work we are doing. And that we could start creating more important and site specific, industry specific services that we could really narrow down the scope of what we were doing. And so we started developing service lines, including many on the hospital side, from ICU to pharmacy to emergency, and then looking at what are some of the other areas that we can start to get involved in. And that's really where senior care was born back in 2012. And then our next slide, I just want to show a little bit about where Avera eCARE is right now, today, our footprint. And I always like to show this map comparison, it's if you overlay these two maps, and look at the green areas on the areas of need slide compared to the areas where we are at, you know, this is looking at some of those more rural parts of our country and where we tend to see more access issues. And we haven't specifically focused from Avera eCARE standpoint into any particular part of the country. But we grow by word of mouth and by some other marketing techniques that we use. And it seems to follow a lot of these same standards that you see here on this area map. And so

it's just always an interesting picture to really take a look at and see, you know, where are we making some of those big impacts, specifically on the senior care side of things. As we look at the next slide, you'll see one of the main things that we really find important in the work that we do, whether it's supporting skilled nursing facilities or assisted living or other entities that we support is a full interdisciplinary team approach. We are led by a team of physicians that consists of geriatricians, internal med physicians as well as family practice physicians who oversee all the work that we do. We have 24/7 provider coverage by those physicians as well as a team of nurse practitioners. And then as we have grown and adapted, we have added several more members to our interdisciplinary team based on specialty services that we want to be able to provide to our customers. And that's everything from psychiatric services and a team of practitioners that we have around that area, to geriatrics certified pharmacists, geriatric certified RN coordinators, as well as a team of social workers who are able to really help us focus in on the palliative care, hospice and advanced care planning efforts that we find are really important to the work that we do. On our next slide, you will see a little bit of a picture of how it works on RN, and on the customers end. The one picture shows one of our physicians sitting at one of our hub tables. We have a hub in Sioux Falls, South Dakota, where all of our staff come to currently. And we provide these services out to hundreds of locations, as we do this each and every day. And so they have the capabilities to see not only the resident and the caregivers on the other end, but also to be able to pull up important documentation through customers, electronic medical records, as well as our own software database that we utilize to help track what it is that we're doing. We utilize also then, as you see in this picture, a mobile cart that runs off of wireless internet capabilities. We find it very important to be able to bring the care to the resident, where they are at versus the resident to the care. And so that's why as we look at technology, and we've made changes over the years, we've always looked at things that are cost effective, mobile, and are able to help us really dig in and get the responses that we need. Not only do we have video capabilities, but we also have peripherals that go along with our equipment that allow us to do things such as listen to heart and lung sounds, look at zoomed in pictures for wound care concerns, look at temperature, blood pressure, utilize an otoscope, if needed, and others as we find pertinent. On the next slide, I'll talk just a little bit about the different programs that we have. And these really have expanded and growing over the years, we started with a program that was very specific to skilled nursing facilities and long term care residents. And quickly as we were going out and sharing with people the work that we were doing in that area, they started asking us well, what about our assisted living? And what about our independent living folks. And so we developed a senior living program that's able to help fill some of those gaps as well. We offer medical director services to sites that need medical directors, and it's hard for them to find someone who has that skill set in their local region. And then we've also started to focus in on home health care most recently, in the last couple of years. All of these programs are catered towards specific sites and what their needs truly are. And so we can do anything from 24, seven, clinical Urgent Care support, to bringing in some of those specialty services, whether it be behavioral health, or pharmacy, or some of those social work programs I was talking about, as well as things such as wound care care transition support. And again, we focus in on making sure that the elderly and the residents in rural and urban areas have the access that they need, and have timely responses to the care that we are able to provide. Our next slide talks a little bit about some of the outcomes that we have looked at and reviewed it. And I won't go over all of these, but just to highlight some of the big ones that we really like to focus in on 90% of the time or more, we're able to treat people in place for the work that we're able to do, we see significant improvements in their unplanned transfer rates and their readmission rates back

to the hospital. And that, of course, results in estimated cost savings. And we did a study as part of a Center for Medicare and Medicaid Innovation Award. And we were able to show that we could reduce spending by \$342 per beneficiary per month by implementing some of these services that we're able to provide. And on my final slide here, I just focus a little bit on the benefits that we see across the board, we'd like to look at not only what benefits the residents, but also what benefits those primary care physicians and the staff. Our goal is to, of course, provide that access and those services to the residents first and foremost. But while doing that, we want to be able to collaborate with their primary care physicians, make sure that they're getting the support that they need, knowing that each and every day. They have a lot that they're dealing with. And then also the staff at the sites that we're serving and make sure that they feel supported, and that they have the tools and the skill sets that they need. And with that, I will wrap up my comments for right now until we get to some q&a later and hand it off to Chris.

34:03 - CHRIS JOHNSON

Thanks, Josh. And good morning, everyone. Excited to be here. I'm Chris Johnson, Vice President of corporate development at Landmark health. Landmark is a technology enabled mobile geriatric Medical Group. Our physician led teams deliver longitudinal care to our patients at their place of residence. In addition to longitudinal home care, they also receive access to 24/7 in home, urgent care and access to a full interdisciplinary care team including behavioral health, social work, pharmacists and dieticians, all members of the landmark Medical Group. We contract with health plans and risk bearing provider groups, primarily Medicare Advantage plans to identify their patients with the highest chronic disease burden. Generally patients with six or more chronic conditions such as congestive heart failure, COPD, type two diabetes, and chronic kidney disease and ESRD. Our average patient is around 80 years old and has nine chronic conditions. So the model is really geared towards the sickest of the sick. We then enter full risk value based arrangements for these members, and manage them in collaboration with their existing primary care and specialist providers. A very similar financial model to what Mike alluded to earlier, in PACE. As Landmark we typically don't charge for services. Since we're at risk for the total cost of care of our members, we must generate medical savings to guarantee a return to our health plan, pay for our services and hopefully generate a surplus to fund continued growth per platform. We found that our model is able to repeatedly deliver 20 to 25% reductions in avoidable hospitalizations and snuffed days in the populations we manage. We're excited by this outcome as it helps us to fulfill our mission of transforming the care of the communities where we operate by increasing patient's healthy days at home in their communities surrounded by their family and loved ones. Since our first house call in October of 2014, Landmark has successfully expanded. Today we're in 17 states serving over 200 counties, and caring for over 140,000 Joe's and Josephine's, as we affectionately call our patients. Telemedicine has always been a tool at our providers disposal. But last March as the first wave of the covid-19 pandemic hit, we needed to quickly pivot to a telemedicine first approach as we work to secure our supply of PPE to resume our home visits. Over the course of days, we transitioned from around 98% in person care to nearly 95% virtual care, while increasing our volume of patient encounters by about 5% to 10%. We also saw an increase of 190%. In our behavioral health visits during the initial months of the pandemic, we're able to quickly transition to a virtual first model for a few reasons. First, we already had the infrastructure in place, including the clinical workflows in our own patient mobile app that enabled video visits. Two, our value based arrangements with MA payers allowed us to avoid reimbursement challenges. Since our model is based on improving the quality and

lowering the cost of care. We have a lot of freedom in terms of how we do that as an organization, and we're able to meet the needs of patients using innovative approaches. And third, we have incredibly close relationships with our patients, many of whom wanted to rely on their landmark providers' information about the pandemic to stay safe. Our average patient sees a landmark provider for an hour long visit six to eight times per year and has an additional 20 touches with various members of their interdisciplinary care team to support their needs. Ultimately, our goal is always to transition back to an in person first model of care. Our patients are very medically complex and require in person care to deliver preventative interventions and when necessary to diagnose and treat exacerbations. Even though virtual care allows us to conduct a higher volume of care, those encounters need to be complemented with that in person care. Philosophically, we've always seen virtual care as a tool for delivering robust primary care, in our case in the patient's home. However, we also quickly learned about some of the acute challenges facing a senior population with virtual care solutions. We found that around 50% of our population had access challenges. Either they didn't have a smartphone or computer, they lacked access to high speed internet or WiFi, or they didn't feel comfortable using the technology themselves. To mitigate some of this, we deployed our healthcare ambassadors to help educate and set up patients for video visits. But truly this barrier of access is significant and real especially for this elderly geriatric population. Secondly, we found that many of our patients have clinical impairments that make virtual care challenging. For example, 30% to 40% of our patients are hearing impaired and having that video or audio only interaction is just as much more challenging than an in person interaction 10% to 15% or vision impaired And around 11% suffer from dementia. These conditions that are quite pervasive in our population, make existing virtual care solutions challenging to use, and significantly less effective for our care teams than in person care. As of last fall, we've been able to return to about 85% of our pre pandemic volume as face to face visits in the home. Going forward, we're incorporating virtual care more purposefully into our model of care, it was always a tool available, but we weren't strategic with it before COVID. In fact, we believe that with telemedicine we can increase our patient touches with their longitudinal provider by up to 30%. So we aren't substituting care rather, we're enhancing care that we previously supplied. Furthermore, we believe that in the coming decades, we'll see more geriatric seniors who prefer to have access to their health care provider via virtual solutions. The patient's definition of convenience, trumps and we want to be able to meet them on their terms. We believe that virtual care solutions will unlock their full potential when a component of a comprehensive clinical model that they support is supported by a value based reimbursement that ties payment for services to outcomes. Thank you again for having me on letting me explain a little bit about Landmark and our journey with value based care during the COVID pandemic. And I'll pass it over to Amy Herr.

41:51 - AMY HERR

Thank you to Chris, Mike and Josh for the wonderful overviews and look at a real life case studies that you provided on this on the playbook and examples of virtual care working and also the important barriers that we've found. As we've expanded virtual care this year. West health is really excited to partner with USofCARE on the playbook. And based on all the research we've done. We have this list of recommendations for healthcare providers and also for policy action. So let me start with the healthcare leaders. First, we want to recommend that healthcare leaders adopt a Value Based Payment Model. Value Based Payment Models which reward providers based on patient health outcomes achieved rather than the number of services provided, offer the maximum flexibility to provide

virtual care services to your older adult population. And it's been a lot easier for organizations that had value based care to provide telehealth during the pandemic. So that's number one. Second, it's important for you to identify which older adults will benefit from virtual care. Virtual care has the potential to effectively facilitate access to care for older adults who have faced other barriers to care. But at the same time, the in person visit may be the best course of care, as Chris just mentioned. Third, we want to recommend that you consider including a tele presenter as part of the care team, the tele presenter, which was mentioned earlier by I know Mike and Josh. And Chris, you know, is a person that comes to the house and assists with the visit. The tele presenter can help facilitate the virtual visit from the patient's location and can bring the appropriate technology such as an internet enabled tablet, and assistant facilitating the assessment of the patient. And fourth, we should really educate patients and providers on the virtual care services. Healthcare leaders should consider creating opportunities to talk with patients and caregivers about how virtual care will be used to meet their care needs. And embed virtual care protocols and training programs for all staff, including those providing virtual care services but also those providing in person care and administrative staff. These steps will help to eliminate confusion and facilitate comfort in using technology and understanding its role in the patient's care plan. Okay, next slide. So for recommendations for policy action, we want to just make sure that the ultimate goal of expanding virtual care is to reduce caps in Virtual Care Access and support building a better and more equitable health care system as we come out of the Covid-19 pandemic. So for the first recommendation we have within a value based care payment model, offer a mix of both in person and virtual care, which includes video, asynchronous, telephonic and remote monitoring for older adults. And when clinically appropriate, older adults should have the flexibility to choose whether they want to receive in person or virtual care, and what's best for them. And providers should have the flexibility to offer virtual care to their patients without any geographic barriers for the provider or the patient. Second, individuals with complex care needs identify additional support to enable virtual care. This could include using tele presenters, as we've mentioned, to facilitate patient access to virtual care platforms, incorporating strategies for patient centered healthcare. And then third, and most importantly, we just need to study what we've learned in the past year. So we encourage CMS and other policymakers to research the cost quality and equity implications of virtual care models, compared to in person care models. For different populations in different geographies, we want to look at the lessons learned in the Value Based Payment models that were developed this year. And also understand how those lessons learned can apply to the fee for service structure. So in conclusion, I would just say that virtual care is a tool, and it's a tool, it's probably here to stay, I don't think we're going to be able to put the genie back in the bottle. So we need to just figure out how to continue to use virtual care in an appropriate way that works for both patients and providers. And, as we've said several times, virtual care is never going to be a standalone solution or replacement for in person care. But we want to look at how it can be best blended with virtual and in person care to promote the best care outcomes for older adults. Thanks.

47:21 - JEN DEYOUNG

Thanks, Amy. With that, I would just want to say thank you to all of our panelists. And I'd also like to welcome my co-host, and then the rest of our panelists to come back on screen. At this point, we have a chance to open it up from questions for everyone who's joined us today. And as a quick reminder, if any of you do have questions, please submit your questions through the q&a function at the bottom of the screen. I'm going to piggyback off of where Amy left off and start us with a question about the

future. So I guess looking beyond the pandemic, what do you all see as the future of virtual care? What is needed going forward to ensure that virtual care works for older adults who choose to use it to get the care that they need? And maybe I'll start with Dr. Jon Zifferblatt? Why don't we start with you?

48:12 - JON ZIFFERBLATT

Sure. Thanks, Jen. So there's probably a special place in purgatory, a very bland and disappointing one. For people who say this time, it's different. So I'll say this time, I believe it can be different. I think by and large, with the exception of organizations like some of the ones you've seen on the presentation today, to be sure. Often virtual care has taken the form of technology first, or pick up the tool first and then go looking for the use case and people filling in a Mad lib that says we're going to use telehealth to do X. And I think now, with the pandemic, we've really seen instantly, a huge need to deliver virtual care. And then people want like, Well, how do we do that? What's the right context to do it? What do we need to make happen to do that? And then sort of what are the right tools? So I think there's a lot of seeds that have been planted. Hopefully, as we go forward, I think those seeds will find a better purchase and value based care context, but I think we need to start to be able to identify and celebrate what works and then not be afraid to call out what doesn't. So I think that's a start. And certainly be very curious to hear what some of the other folks have to say.

49:32 - JEN DEYOUNG

Chris or Josh or Mike, any any thoughts that you want to chime in on? I could

49:41 - MICHEAL KURILAND

There's not like an exact point, like in one direction here. But I do just want to say to all the organizations that are just thinking about telehealth that have not started using things like virtual care that this is not a fad. It is really really I think, here it is. Stay, it's an inevitable shift that was going to happen anyway, before the pandemic, I think the pandemic really moved things up about five, maybe somewhere between five and eight years. That's just my guess. Before the pandemic, we had a decreasing amount of clinicians, we had an increasing amount of folks living longer, longer with more comorbidities. And we had decreasing amounts of unpaid caregivers. So give me an example from 2010 to 2030. We went from seven to one unpaid caregivers to four to one. And if you have anyone that you've taken care of, and these unpaid caregivers are family and friends, that numbers being almost half. So if you've kind of like put all that stuff together, you really do need to start looking at your health care system and better ways of providing care, distributing care. And virtual is one of many solutions out there. But there's really no option other than going in that direction.

51:08 - JEN DEYOUNG

Thanks, Mike. We got a question from our audience asking about mental health, telehealth. So we're hearing from a state that is looking to get up to a million dollars of additional funding to go to support mental health telehealth and asking what's the best place to target that money? That's a big infusion of funding. What's the best way to target it? If you're looking at mental health, telehealth? Maybe some of you have mentioned having to integrate mental health in as part of your telehealth practices, maybe you could speak a little bit about your experience and have some of the processes or changes that you had to make to incorporate that behavioral health or telehealth into your work?

51:55 - MICHAEL KURILAND

Sure. I'll be real quick about this one. depending upon what state you're in, you might have different needs than others, like I know a lot of funds are going to adjust the opioid crisis. But mental health is one of those telehealth types that have been around for a long time similar to teleradiology, and there are many, many organizations that are doing this across the country. So I suggest just approaching a few of the bigger players just to get a feel for what the capabilities are, but also really understanding what the needs are of your state. Because how you manage, you know, the opioid crisis in your status is different than how you may manage. You know, depression, for instance.

52:51 - JOSH HOFMEYER

Yeah, I would echo what Mike is saying, you know, we've done a lot of work at a very care in the behavioral health field and in mental health. And, you know, when when we're going down into those areas, and starting a new state, or starting with a new organization, you know, some of the main things that you want to figure out right away are, first of all, you know, what are our goals? Second, what are the state rules around this? And then, who do we need to be collaborating with, from a vendor side, but also from a payer side, and then on the state side, you need to bring all of those people together, especially if you're looking at state funding in order to be able to move forward.

53:35 - JON ZIFFERBLATT

I'll just, I'll just add in, feel free if I'm not, you know, please, so much scratch deeper and tell me that it's in fact, not so great. But I know the VA has done a lot in mental health, that's one area that they really tell them mental health. And that may just be an area to, you know, someone to look at as well, which sort of governmental funding, you know, all the things that go along with it, but tried to deploy it in service of behavioral health. So that may be one area to take a peek at.

54:03 - JEN DEYOUNG

Thank you all. I have a question that came in specifically for Landmark for Chris. And the question is how does landmark manage the risk based care contracts to ensure their own viability?

54:18 - CHRIS JOHNSON

You need infrastructure to be able to do it. So I think on the scale of value based care, I think the models like pace and what Landmark does are far right, it's unlimited downside risk that we take in our contracts. And in order to do that, you need to have a team that knows how to underwrite and build a managed care contract. You then need to have the teams internally to manage the data, understand where risk lies, and you need to feed that into your clinical workflows, your clinical models, because you really need to make sure That you're seeing the right patients at the right times making the right interventions. So, you know, I would say it's that that would be a very large first step for an organization that hasn't been in a value based care arrangement. But I think it's even if you're used to fee for service medicine, starting to figure out ways to move towards value, I think is important, not only just because the world is moving that way, but it's the natural way to incorporate virtual care services there. I think. I think if the debate continues to be around, should the fee for service fee schedule apply to virtual care, we're kind of missing, we're missing the boat there. I think that virtual care is a tool that should help accelerate the shift into value based arrangements. So that's kind of the mental model That I used to think about. I hope that answered the question.

55:58 - JEN DEYOUNG

Yeah. Thanks, Chris. We have time for just one more. We have a question around broadband access and connectivity. I know. Dr. Haynes, you had flagged that this was one of the barriers or concerns that some of the older adults that we that we listened to had expressed concerns with, for, for those on our panel, do patients, can you speak to broadband access and connectivity? And do patients receive and provide equipment? Or do they get broadband connections? How are you kind of tackling that barrier?

56:32 - MICHAEL KURILAND

like to point out, Josh, for this one, I think he's got some good answers for that

56:34 - JOSH HOFMEYER

Oh, thanks, Mike. I thought you were gonna just answer it. But you know, I think it depends on what our program is, we utilize different equipment for every one of our programs based on what the needs of the patient are. And again, it goes back to making sure that we're finding some of those cost effective, but also going to meet the goals of what we're trying to do. In terms of the connectivity, it is a battle. Many times, you know, a lot of the services specifically to senior care that we've been doing have been in the skilled nursing facilities and assisted living locations. And, you know, none of the two are ever the same, even within an organization. And so we will always make sure to do some sort of wireless assessment and figure out what it is that is going on in that building, we've learned the hard way, many times that when someone says they have good connectivity, that probably means that they actually don't have good connectivity, and there's going to be some changes that need to happen. And it can be anything from you know, adding a couple more wireless access points to having to completely configure their system. And that, of course, weighs in on what do we do? And do we move forward or not? when we're looking at going into new areas and rural areas and trying to get that initial connectivity developed. We have an information technology team that's very well versed in this area, we've developed a lot of other vendor partners as well, that we will work with to try and see what the right solutions are. But a lot of it will come back to grant funding if people just don't have the capital and things to move forward. There are a lot of grants out there, especially here recently, with a lot of these COVID relief dollars that have been put out there that are geared towards these types of instances.

58:23 - JEN DEYOUNG

Great, thanks, Josh. Well, I see that we are at the top of the hour here. And so I just want to say another huge thank you to everyone in the audience who joined us today. And also to all of our experts. On our panel here Dr. Venice Haynes, Michael Kuriland, Josh Hofmeyer, Chris Johnson and Amy her thank you for sharing your time and your insights. And a special thank you to Dr. Jon Zifferblatt for being my co host. And I just want to encourage all of you to go to our website at [United States of care.org](http://UnitedStatesofcare.org) to access a deep body of work available to support your efforts, including a recording of today's conversation. And I hope you'll consider joining us at future USofCare events virtual and one day hopefully in the not too distant future in person again, as we enter this next phase of the pandemic. We look forward to working with all of you policymakers, advocates, and concerned citizens as we strive in the midst of a public health crisis to build a healthcare system that can withstand the next one.