Older Adults' Experience of Virtual Care: Action Steps to Increase Access and Equity

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00:40 JEN DEYOUNG

Hello everyone and welcome. I'm Jen DeYoung senior director with United States of Care leading up our Innovation Lab. I'm thrilled to partner with West Health today to bring you this webinar looking at older adults' experience with virtual care. United States of care is a nonpartisan nonprofit organization that is committed to expanding access to quality affordable health care. At US of Care, we drive change at the state and federal level in partnership with everyday people, business leaders, healthcare innovators, fellow advocates and policymakers. Over the past two years, we have seen the COVID-19 pandemic response unleash a revolutionary expansion in virtual care, whether it be telehealth remote monitoring, or other remote forms of communication. Virtual care tools are shiny and new for many. But at US of Care, 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. I'd like to introduce you all now to my co-host for today, Amy Herr, Director of Policy at West Health. Welcome, Amy.

02:07 AMY HERR

Thank you, Jen. Great to be here. We're so excited to be here to share our findings today. As Jen mentioned, I'm Amy Herr, Director of Health Policy for West Health. And West health is a family organization focused on lowering the cost of health care to enable seniors to age in the place they want. And with access to health care services and social services that they need to support living independently. I'm really happy to co-host today's session. As Jen mentioned, our findings build up some work we've done over the past two years. And we're really excited to build on the work that we published last year. And I think as we all know, you know, telehealth was such a very miniscule part of the healthcare system before the pandemic and then it just exploded. And we've really seen a leveling off, which we think is the sweet spot. So we're really excited to help policymakers figure out how to keep the best parts and do away with the rest and really figure out the right way to promote telehealth and virtual care going forward. We will be having a playbook that we publish that is associated with this webinar and findings that have been on our website in a couple- well shortly. And we'll make sure that all the webinar participants get a link to that playbook when it comes out. And I just wanted to give everyone a short overview of today's webinar session. So we're going to start with Jen DeYoung will

provide some research findings from our project. We just have a couple of slides, but wanted to show you what we found in our work. And then we'll move to me. I'm going to moderate a fireside chat with five organizations that have successfully integrated virtual care for older adults into their programs. So really excited about that, and then we'll turn back to Jen for closing remarks. So let's get started.

04:14 JEN DEYOUNG

Thanks, Amy. So I wanted to start our conversation today by sharing some background on what the virtual care landscape has been like in the US to just get us all grounded in the discussion. As Amy mentioned, pre-pandemic. So prior to 2020 we were seeing a huge demographic shift as people are living longer and they're needing more extended health care services from an already tapPED system. Meanwhile, the only option really was in-person care for many people. At the time we were seeing only .1% of Medicare primary care visits being provided via telehealth and then COVID hit and we saw this surge in telehealth usage for all populations as people and providers looked for alternative ways to get people the care they needed. To help with this, a lot of the restrictions around telehealth use got lifted under the public health emergency. And by April 2020, we were seeing 43.5% of Medicare primary care visits being provided through telehealth. And now we're in the second year of the pandemic and we're starting to see the spike in telehealth use level off as Amy had mentioned, as people are becoming more comfortable being back in person. And we don't have the Medicare data quite yet. But as I'll share in the next couple of slides, and as you'll hear from our panel later on, people are gravitating towards wanting a mix of in-person and virtual care. And we're seeing healthcare organizations respond by finding really innovative ways to embed virtual care into their model of care for the future. So I mentioned earlier and Amy did as well that US of Care and West Health, we work together on a study looking at older adults use of virtual care. And this slide here lays out our approach for it. Our key question that we centered around is how can virtual care close gaps in access to care and health inequities for older adults. And to do this work, we conducted mixed method research, which involved doing our own national survey with West Health in 2021 and then again in 2022. We also reviewed public opinion scans and hosted focus groups among other activities. And we also looked at several organizations as case studies for how they provided virtual care to meet their older adults populations needs during the pandemic. And you'll be hearing from these organizations later today. And then we took all that information and identified action steps for healthcare leaders and policymakers. So overall, here's a really high level summary of what we found. Bottom line is people like virtual care and this has been a consistent theme throughout the pandemic. For the next couple of slides, I'm just going to dig in a little deeper for you on each of these findings for you. So this slide here gives you a snapshot of our data on who is using virtual care. Most people have used it and a majority of those using virtual care have done so two times or more since the start of the pandemic. Our poll also found that most older adults' virtual care visits occurred mainly with their primary care provider. However, we found differences between age groups when it comes to which providers older adults saw. Those aged 50 to 64 were more likely to have seen a mental health professional. While those 65 Plus were more likely to have seen a specialist virtually. This slide here looks at trends in satisfaction with virtual care. And as you can see older adults like virtual care, including the convenience of not having to leave home, avoiding crowds, and more scheduling options. And while it's helpful to us to understand what people like about virtual care, what's also helpful is to understand why people are not using virtual care or if they have used it what are the challenges they experienced with using it. Through our research, we identified five main barriers from people: concerns around health data privacy, comfort with using

technology, having access to reliable and accessible internet, concerns around whether their visit would be high quality and personalized to meet their needs, and concerns around whether they could get an accurate assessment. So I want to look at each of these slides individually with you so you can see the data we got on it. First off, a number of older adults reported not having or not being comfortable with various forms of technology. Similarly in more prominent and rural areas where issues older adults had with accessing reliable internet services for their virtual care visits. People also had concerns that the provider might miss something or felt the provider couldn't get an accurate assessment or just generally felt that the virtual visit wasn't very personable.

09:03 JEN DEYOUNG

And something we saw new this year was an increasing concern among older adults who have not used virtual care because they had concerns around privacy of their health data. The main concern they held was around the privacy of their health data and integration with electronic medical records. And the second leading concern was that the provider could not be in a private location for the visit, followed by needing assistance from another person hindering privacy. And some of these concerns were felt slightly more among the adults agde 50-65 class. So after looking at what people like and don't like about virtual care, what's most instructive is whether people would want to continue to use it into the future. And as you can see, most people favored wanting a blended option of in-person and virtual services. However, we saw differences in the age groups, about a third of older adults aged 65 plus said they would not continue using virtual care services after the pandemic if they had a choice of in person visits. On the contrary, about a quarter of respondents aged 50 to 64 said that they would use virtual care more often to seek health care services if they were given a choice. So as part of our research, not only do we gather data on people's experience with virtual care, we also profiled several organizations who incorporated virtual care into their practice as a way to meet people's needs during COVID. And looked at how they took innovative steps to address their patients' barriers. You'll get to hear more from these organizations as part of our panel discussion in just a bit. But before we go there, I wanted to share the recommendations that came out of our work. So this slide here lays out the key insights we had for healthcare providers. I'm not going to go through each of them, but you can see that they range from adopting a Value Based Payment Model. Specifically, we found that value based payment models which reward providers based on patient health outcomes achieved rather than the number of services provided, they offered maximum flexibility to provide virtual care services to older adults. And another insight on this list was creating transparency for a successful blended care model. So really making sure to communicate clearly with patients which types of services can be conducted virtually versus in person and why. That transparency about blended care decisions builds trust in patients that they're receiving the highest quality of care. More details on each of these insights you'll be able to find in our upcoming playbook publication that Amy mentioned at the start. And lastly, we also had several recommendations for policy action. First, within a Value Based Payment Model offer a mix of in person and virtual care. So when clinically appropriate, older adults should have the flexibility to choose whether to receive in person or virtual care. And second, for individuals with complex needs identify additional support to enable virtual care and this could include making an audio only option available using telepresenters to facilitate patient access to virtual care platforms, and incorporating strategies for patient centered health care. And third, research the quality cost and equity implications of virtual care models compared to and or in addition to in-person care for different populations and

geographies. So with that, I am going to pause and turn the screen over to Amy, who's going to introduce us to our panelists and lead us in our discussion.

12:45 AMY HERR
Great, thank you so much, Jen. We're really excited for the fireside chat that we have right now with four organizations that have been using virtual care for the older adult populations and have adapted their practices over the past two years to really meet the needs of older adults. So first, we have David Fletcher, Associate Vice President, The Center for Telehealth at Geisinger, and Geisinger is a fully integrated hospital and clinic system located in Pennsylvania. Next, we have Josh Hoffmeyer. Josh is Vice President and General Manager for senior care services at Avel eCare, which is a service virtual care program for seniors with a significant reach in rural areas. Next, we have Mike Kurliand, Director of Telehealth and Process Improvement at West Health. And Mike will be talking about Gary and Mary West pace, which is a fully integrated program for all inclusive care for the elderly, in northern San Diego. And finally, we have Greg Snyder, Vice President for Clinical Strategy and Quality Improvement at Medically Home. And Medically Home is an acute care hospital and home services company that partners with health systems to co-operate virtual hospitals, decentralizing care into patients homes. Thank you so much for being here. So we want to start with a little bit of an overview from each of the panelists and I wanted to hear a little bit about, you know, now that we're two years into the pandemic, what have you experienced? And how has your use of virtual care services changed to meet the needs of older adults? So we'll start with Mike at West PACE.

14:35 MICHAEL KURLIAND
Thank you, Amy and Jen. It's a pleasure to be here on the panel with everybody else. I have to say just like as a fan, I'm really interested in hearing what everyone else has to say because it's a really innovative set of organizations with some really awesome leaders that I'm co-speaking with. So I'm pretty stoked just listening a little bit about PACE for folks that just don't know about it. Imagine a program that is pretty much 100% at risk for nursing home eligible patients that you just try to keep at home and try to keep healthy and out of the hospital. That's what PACE is. So I'll give you an example, if someone needed an air conditioner to help them stay healthy PACE can do that, they can provide an air conditioner, that they can build a ramp, they could also send services to the person's home. And there's usually a clinic associated with PACE. And the idea is that you're getting these participants to come into the clinic when you need to. The challenges with these with these patients, and they're called participants. As part of pace, it's just kind of like the nomenclature. So I might say participants challenges around travel a lot. So you can imagine that if you're a nursing home eligible patient or participant, that you are elderly, fragile, and you're not always going to want to travel. And sometimes travel could be anywhere between like 30 and 60 minutes. So it's not unusual that patients may cancel at the last second, that it's hard to kind of get them to come in, when you really do need to see them. So PACE has to incorporate, like different strategies in order to see these patients and meet their needs. And one of those needs is like, Oh, how do we get around this travel issue. And so one strategy that we incorporated right when the pandemic hit, was bringing in specialties that can see the patient virtually, and the one that really has like kind of stuck, that really, really has taken off. It's probably no surprise to anyone that's listening has been like mental and behavioral health. And if I'm being really honest with the folks on this call, and all the panelists, I think it stands out from other specialties. Because the providers of that mental health and behavioral health clinic, they were really committed out

of the gate to stay with behavioral health and telehealth. other specialties that like you know, like we contract with other major hospitals and healthcare organizations in the area. And they also kind of like slammed in telehealth at the during the pandemic. And there was a level of like, yes, we're committed to it. And then, like Amy and Jen, say, like it kind of like dropped off. And it's like leveling out. But it's leveled out to the degree where it's like, we're doing onesies and twosies with other specialties. So the real takeaway for us is like, when we're when we're engaging with like these clinics and practices that are providing specialty services, for instance, we really need to hit it out of the gate around telehealth engagement, and how does that happen from a scheduling perspective, other things that kind of like have helped, and I'll get into a challenge real quick and go to the other panelists is that we started using econsults. And that's really stuck. And econsults is basically this provider to provider, kind of like specialty consultation. And that and that's been great in helping us kind of avoid having to schedule the specialist just to answer one or two simple questions that our own providers can address with a little bit of guidance. The other thing that we've incorporated is an interesting contract with an organization that goes out to participants' homes and improvise like urgent or acute care. It's like urgent care on wheels, if you will, they could do wound care, they could do change condition assessment, like post false. And there's been a few instances where this clinician which is typically an RN beams in to like, you know, beams, like beams, the provider from the clinic and says, hey, does this person Are they okay to like maybe come into the clinic tomorrow based on our assessment, or should they go to the ED right now, or can we treat them at home?

19:38

And that's been really, really successful in helping avert some like what would have just been a kind of a reflexive ED transport. And what we're also trying to do is get some telefacilitators in to do other things, but we'll, I can get to that a little bit later. I got to tell you one of the challenges is and it's around the telefacilitator is staffing. I don't know about you and your organization's but staffing was an issue before the pandemic. But the pandemic exacerbated it and finding clinicians that can help kind of cofacilitate some of these visits has been a real challenge. And I'll get into some of the opportunities that we're currently missing out on until we get some of that staff.

20:33 AMY HERR

Great. Thank you, Mike. I'm really excited that we have another panelist that joined us Christopher Stark, is the Chief Clinical Officer at Landmark Health and Landmark provides longitudinal and palliative in home geriatric care, including behavioral health and urgent care services. So actually, I'll turn it over to you, Chris. Now that we're two years into the pandemic, you know, what, how has your use of virtual care changed for your population?

21:00 CHRISTOPHER STARK

All right, thanks. I apologize, everybody for being late. I'm in the middle of like a hurricane here in the panhandle. It's not really but I got off a plane and got into a torrential downpour. So I apologize for being in a car and looking like this. So but yeah, Landmark Health is a geriatric specialist, physician group, where we do a combination of in-home care as well as televideo and telephonic care, to bring all sorts of services into the home for a very acute, sick population of patients. There are typically six or more chronic medical conditions, 13 or more medications, our average age is in the high 70s. And they have four to six specialists apiece. So we take these groups of people and do a combination of in-home care

for longitudinal care. So we'll make appointments and see people in their homes to deprescribe. We'll try and optimize their home medical care. We'll also run an urgent care on wheels much like you might, where we'll go to the patient's home, we carry IV fluids, we do suturing, we do nosebleeds and a whole variety of breathing treatments and anything else that can be a low budget ER visit or an urgent care type visit. And we can run those visits right in the house. And we're as well a at risk corporation. So when the pandemic hits, so we were almost 100% face to face in homecare with our behavioral health wings, our social workers, our ambassadors, and all of our providers going in the home to see people. When the pandemic hit, we shut down just like everybody else for PPE and everything else. The homecare for about three months and switched to 100% televideo and telephonic care. Then as we got PPE, we started to find that happy place we started to move from where did we need to see people face to face versus where did we need to see them from a tele video, telephonic route. And we've gotten to about an 80/20 split of face to face visits and televideo visits for our patient population, which we find really helps keep them happy, healthy and at home as much as possible. But we found lots and lots of challenges in those three months as well as in the continuing training people how to do tele video visits. What kind of physical exams can you do? What kind of diagnoses can you make over the phone and over video? What can you do to treat them at home utilizing family, utilizing what we call agentive extenders, which are a lot like what you do Mike with RNs, LPNs, and paramedics going into the home doing a tele video assisted visit with our own nurse practitioners in our call center. And then if that doesn't work, we have our own providers in the market that will go locally to go see those people face to face. But trying to train people how to do the videos, how to look professional on video, unlike myself today, and how to have good backgrounds and good lighting and make sure your internet is up and running and your equipment is good. And make sure all those those challenges that we have living in the virtual world these days to train providers who are used to going to see people face to face.

24:52 AMY HERR
Great, thank you so much Chris.

24:54 CHRISTOPHER STARK
Hopefully I answered your question, Amy.

24:56 AMY HERR
Yeah, that's great. I appreciate it. So I wanted to turn to David next. And one of our questions is around what do patients like or dislike about virtual care and how does Geisinger address that?

25:13 DAVID FLETCHER
Sure, yeah. So, you know, we've done a lot of surveys in our area, as well. And, you know, we've seen very high satisfaction for our patients who use telemedicine. I think most health systems have, you know, we're in the generally in the upper 90, upper 80s, low 90s. And that includes all ages, you know, we looked specifically at the 65 plus age group, and they've got high satisfaction, it's not quite as high as the younger population. But when we look at our older population to other older populations across the country, we've seen a little bit higher satisfaction for our patients and I think it's because we designed our process where our patients don't go through a portal or a registration process to get their telemedicine visit, we really just send them a link, and they click on that link, and they go right into the video visit because we have all the integration with our EMR and so I think that that has helped, you

know, we've kind of stabilized the satisfaction scores across the demographics a little better than than I initially hoped, honestly. And I think, you know, generally the things that patients like are the things that you would intuitively assume that not having to travel, not being in a waiting room with other folks who have, you know, could have COVID, you know, things like that. Now, when we asked those patients, you know, okay, great, you love it, you're highly satisfied with it, do you plan to use telemedicine going forward? Much like the data we saw earlier, we saw it being lower than the satisfaction score would lead you to believe. And so we asked, okay, well, what concerns, if any, would you have about using telemedicine going forward. And what we found was the highest response on that was, I'm just concerned that it may not be as comprehensive an exam as in person. And so I think that's where we've been putting a lot of effort is, you know, really educating the patients. I think there was a bit of an assumption that, hey, this was an emergency measure just to get us by through COVID. And then once it's over, we're gonna get back to just go into in the clinics. And so I think, you know, we've been putting out videos of some of our doctors talking about instances where they like to use telemedicine, but also, I think equally important, is instances where they don't like to use telemedicine and you know, we're really diving into the data now to really understand, what does it mean, you know, I think there's a lot of studies out there that show kind of equivalence between a telemedicine and in person visit for the visit itself. But what does it mean downstream? Are there any impact to the way that a patient might navigate the health system, if they have certain visits via telemedicine? And I think, you know, we had it in mind to share that data with policymakers and our providers. But I think it's equally important to share it be really transparent and share that with the patients as well. And so, so they understand, you know, we won't offer telemedicine unless it's clinically appropriate, and we kind of have some data to back that up.

28:18 AMY HERR

Great, thank you, Josh, or Greg, do you want to weigh in on what patients like or dislike about virtual care?

28:28 GREGORY SNYDER

Yeah, I think that when, when we think about patients and Medically Home in terms of home based acute care, post acute care, home based emergency department in the home care, and transitional care, you know, I think it's helpful to clarify that when we bring patients into these models, and specifically for home hospital, that they're really opting into a model of care that is and begins with acute care in the home. And our model, I'm referencing some of the comments made earlier because it's fascinating to me the way in which, over the course of the pandemic, there has been a blend of virtual care, tethered to in-home clinical providers. That is a crucial part of our model of care where we would have a telemedical command center that is tethered to providers of clinical services in the home, and you need that for acute care in the home. So to your question around how patients participate in and experience virtual care to our patients virtual care is a blend of telemedical care and in-person care. And to clarify, 100% of our physician video visits are virtual. 100% of our RN visits for the primary bedside patient are virtual and then those clinicians are complemented by providers that go into the home on an as needed basis as part of that care team or providers of clinical services that are tethered to those telemedical providers in the home. And, and so patients really experience virtual care in terms of what we're doing now speaking to providers on on video, and appreciate that for really the strengths of what I view to be medical care in the hospital that is history taking and, and learning about patients

through what they're telling us less our physical exams. Of course, our physical exam remotely is then augmented by a provider that's tethered into the home. And so the patient's experience of virtual care is of that tethering. So that's our that's our focus. And I think that is very different for an acute hospital substitution patient where we're taking a patient out of an emergency department off of a medical surgical floor, out of a skilled nursing facility, for instance, as compared to an emergency department or urgent care in the home visit. The blend of in person or virtual care in those models is slightly different, but the patient's experiences still have a blend.

31:04 AMY HERR

Great, thanks so much Greg. And I'm gonna turn it to you, Josh, talk about patients in your model, but especially efforts that your organization has done to assist patients that are experiencing barriers to virtual care.

31:21 JOSHUA HOFMEYER

Yeah, thanks, Amy. Great to be with everyone today. So at Avel eCare, we've been providing telemedicine services for nearly 30 years across a variety of settings. And so as you can imagine, as we've deployed over 30 years, and we have, you know, numerous different types of telehealth that we provide, we've come across a lot of different barriers and had to get creative and innovative on how can we help overcome those barriers and move forward because we know that access is an issue across the country, in rural and urban areas, and telemedicine can really help fill in those access gaps. It's also a big support for clinicians that are out in the field and may just feel the overall overarching burden of so much to get done in a day, and how can we help support them. And so getting past those barriers and making sure that the services are there to help take care of patients is definitely important. As I look at the services we provide for seniors, we have telemedicine programs that we roll out into skilled nursing facilities and long term care sites, assisted living, independent living, and we also do some home health. All of ours come with a kit that works off of typically wireless signals once in a while on cell phone signals if we need to go that route instead, to allow our clinicians to both see and interact audio wise with the patient, but also use different peripherals such as the stethoscope and otoscope to help do a full assessment. And so with doing that work, some of the barriers that we typically see one of the first ones always is that connectivity, and how do we ensure that that connection is there and that we can have that when we need it. And so we've done a lot of spent a lot of time looking at the different types of equipment that are out there, the different connectivity methods, and really try to find those that are simplest, if there is such a thing with some of those connectivity stuff, to really do those interactions, and make it as easy as possible on both the clinician and the patient that were that we're serving. So from the start making sure that connectivity is there, or working through that hurdle is really important. You don't want to implement a telemedicine solution, and then go to do your first encounter and realize that the connectivity doesn't work. Even if you have all your I's dotted and T's crossed, there's still going to be times where the connectivity doesn't work for a variety of reasons. And then making sure you have some backup plans to be able to do that then is important to overcoming that barrier. Another barrier that we sometimes see is just the adoption rate of sites that we can partner with. It's a big change when we bring telemedicine services into a skilled nursing facility or a senior living campus. And so getting the staff and the residents and their families and also the community as a whole on board in understanding what it is that we are doing and what the goals of the program are, are really important. And so as part of our overall implementation process, we have a lot of different steps that we

take with each of those groups of people that I mentioned, to make sure that they understand what the program is why the program is coming to their community, how it's going to benefit them, how it's going to benefit their primary care physician and placement of their primary care physician, and things along those lines. So there's a lot of other minor barriers that you run into as well. But I would say those two really cover the top that we see a lot of times.

35:17 AMY HERR
Great. Thanks so much, Josh.

35:19 CHRISTOPHER STARK
Yeah, Josh, connectivity is always the huge issue of trying to get in with these patients, a lot of them don't have internet, they have cell phones, so everyone has a phone that you can get into it. But if you really want to get televideo and get that connectivity, that becomes a real challenge, especially with the geriatric age group that a lot of us are seeing at this point, especially with our risk cohorts, you know, and trying to get equipment or ship enabled devices and things like that into these homes is a challenge. So some of us have hired people that go out to do the video visits, assist the visits with those providers. Some of them, we do the best we can to hook up the patients. And the different ways that they log into those platforms is a challenge, like our technology was app based, which wasn't really good because they didn't remember their passwords. So they couldn't download the apps because they didn't remember their passwords. We find a lot more success with the link type of systems where you can text them a link, and all they have to do is hit the link, and then suddenly, they're in the platform. So that with the HIPAA that was dropped during the pandemic emergency where you could use WhatsApp, you could use FaceTime, those types of things really helped out a lot for a while because they were all talking to their grandkids on FaceTime. But now they've just started to take away some of those leniencies. So I just was alerted that a state like Mississippi just got rid of the ability to use the non secure HIPAA secure platforms. So you can't use WhatsApp, you can't use FaceTime anymore. So we're going to start running into more connectivity challenges again, the more and more states release those emergency mandates.

37:14 GREGORY SNYDER
So I love that you're talking about connectivity challenges as you sit in a monsoon in the panhandle and have perfect video connection. It's so wonderful and I think there's been such great, you know, progression in that space. You know, I we certainly agree that, you know, as a part of this type of care, it's table stakes to really augment connectivity. And to Josh's excellent point, you know, I think that the design and implementation of these systems, and the installation of the right systems is just as important as the coverage. And when we admit a patient in the setting of acute care into the home, there is a technology installation process, where we're putting in the biometrics and the redundancy and connectivity. And then the communications technology is not just video, it's also phone based connectivity, it's personal emergency response systems, all in the setting and service of acute care to be clear, which I recognize is different. But I think that there a common thread of the need for redundancy and connectivity and communication modality, across here, and then I think there is the question of how to break down the barrier of technical literacy with patients, right, as you're implementing and installing that technology there's the opportunity to really engage a patient and understanding their level of technical literacy, and then teaching and hearing back from them what they

need help with, you know, Medically Home, we work with a lot of providers systems, those are our partners. And so at times, this will be both technical literacy education around the system that we're using now, and potentially portal adoption for further virtual care in the future after the episode. I just say that as we look to sort of how to take care of frail elderly patients, because I think there's also opportunity to use tele presenters or technology installers, or that tethered personnel in the home, to also understand understand social determinants of health, the built environment, the home safety, the caregiver burden, all the things that really make a difference in terms of preventing episodic care.

39:29 AMY HERR

Thank you. I wanted to move then to providers, and whether you've had resistance from providers or what you've had to do to help train your providers and really get them organized and comfortable with using virtual care. I know Chris you mentioned at the very top of the call about you know, not being in a car but having a background or having like a professional place to do video calls. What other barriers and solutions have you found for providers?

40:06 CHRISTOPHER STARK

I think for the providers was a lot of it was just getting thrown into it very, very quickly. Just from one day you were seeing patients in the home to the next day you are 100% virtual with your kids that were now not going to daycare and the dogs that are running around in the house that you're not used to having in your working environment. So training them how to separate their working environment, from their living environment, to make a professional type of background and professional type of lighting so that people look at you and see you as a professional, they don't see you sitting in a car in a monsoon in a polo shirt, they see you in a in a tie and in a jacket in a nice environment with books behind you that looks like what you would expect a provider to be seeing their patient in, because the extension around you is the extension of your office, since this virtual environment is now your office and teaching them the skills of what can you do and what can you evaluate in the patient? What can't you evaluate in the patient? What do you need that person in the home to do? So you have some drawbacks and you have some benefits to it, you can see a lot more people a lot more efficiently, you can jump on with somebody that has an urgent need, and not have to have that 45 minute drive to their house and the 45 minute drive back that takes a lot of care out of their systems. But the internet wasn't designed to do this. So a lot of them needed upgrades of their Wi Fi systems, they needed different equipment in the home, they wound up getting multiple screens, holders for their cell phones so that they weren't holding them out with their hands shaking while they're trying to type and do other things along with the visit. So there were lots and lots of challenges along with the IT things that we've mentioned before is just developing systems and figuring out the best way to do it, you know, we we developed our own app from the ground up and figured out, it wasn't the best app, it wasn't the best system to use. And learning and modifying and bending is what we had to do as a company, from the provider level all the way up to IT and management, we all had to figure out how to, to bend to this new environment. And I think overall, we're showing that this environment excels at helping us take care of patients. It's a tool, but it's a valuable tool.

42:38 MICHAEL KURLIAND

Amy I'm sure David can probably give a little bit more insight into this too. But you know, I think the behavioral management change management aspect of it has been quite challenging. Yes, during the

pandemic, everyone kind of like, you know, stretched and did something different to accommodate, you know, their own work environment, and you know, patient safety. And they transitioned a lot to like video phone calls, did whatever needed to be done. But as things subsided, like you know, like everyone got vaccinated, you got PPE. You see this kind of like reflexive, behavioral, you know, change to go back to where things were comfortable and things were like they were before the pandemic, seeing most of my patients in the clinic. And although I have some, you know, champions and believers of it, I also have some of the folks that are like, Oh, okay, yeah, so we're still trying to do this telehealth thing. And it does require some education just kind of require reinforcement of like, the pros and cons that everyone on this panel had like mentioned already. I'm just wondering if David has experienced something like that as well.

44:06 DAVID FLETCHER
Yeah, absolutely. So I mean that that was a big C change for you know, pre COVID Almost every telehealth program we had came because a provider a specialty was really interested in it and kind of by definition, we had active, actively engaged providers and now it's just a standard of care. We went from less than 1% of our visits being telemedicine to over 10% now of our outpatient visits, so 20 specialties to 70 specialties so the majority now of our providers who are doing telemedicine don't really care about telemedicine either way. So if it's a barrier, if it has problems, the answer is we'll just have them come into the clinic. You know, I'm not invested in telemedicine. And so, the key I think that we found is it's got to we've got to really build those integrations. So our providers, they're in our EMR all day, everything's got to integrate with that EMR. And I think that that's one of the things I really emphasize to vendors who come, you know, they may have a great product, great idea. But if everybody has their own separate portal and expects the doctors to sign into one of 20 different portals all day, every day, it's never going to happen, you know. And so we see even within a single specialty wide variation from doctor to doctor of telemedicine uptake. So I think it's in a way, the bigger challenge even on the patient side is the provider side. And we've got to make it really easy and seamless for the providers, and generally the patients, they trust their providers. And so if the providers are enthusiastic about it, the patients will be as well by and large.

45:45 AMY HERR
Great, thank you. I wanted to move to the role of caregivers and family caregivers and how they can support your patients and wanted to start with Greg, about how virtual care has helped or hurt the role of the family caregiver.

46:03 GREGORY SNTDER
Yes, thank you, Amy. I think that for us, you know, I'll speak specifically about home hospital because I think it's a little different from what we're thinking about in the ambulatory virtual care space. And when we admit a patient for a virtual home hospital episode, we're admitting both that patient and their family and their caregiver, right, we're doing video visits with them, but we're also sending providers of clinical service to their home. And those visits are happening actually more frequently than they may occur in the brick and mortar setting for certain service categories. And so the family if they are there is a part of the care. And so that's a part of the consent process for how we assess and then consent patients for the model of care. To be clear, you do not need to have a family member or caregiver for this model of care. And so where there is lack of caregiver support or interest and supporting or burden in the home,

we support that through the rapid response supply chain and services network that we have to build as part of this acute care, home based care infrastructure. And we do that through home health aides, providers of service going into the home for manual therapies, PT, OT, speech therapy, home based nursing. And so you know, we first have to assess caregiver support before we even admit a patient, so to speak, if you will. And then as we assess that we have to understand the caregivers ability or willingness to participate in care, we assume that they are not able or willing to as we provide their services to patients. But where they are, we see a lot of strength, we see that a caregiver can be very helpful in managing chronic disease burden, during even an acute care episode can be helpful in us understanding goals of care for a patient in the setting of acute illness especially as they wouldn't have brick and mortar hospital health care proxy, for instance. And so we have to really assess a caregivers willingness or ability to participate in the model. We also include them by the way in that technology literacy piece that I was speaking about before, because if a patient in the virtual home hospital is acutely ill with sepsis and you know, decompensates at home, that patient will have many opportunities for us to check in with them for them to check in with us to press a personal emergency response device. But it's equally important that all of our providers of service and the caregivers in the home know how to do that as well, should they sort of be the first to notice the line. And so that's all built into the way that we think around this. And you know, I think I guess my overarching point is that caregivers when they are able and willing are a part of our multidisciplinary care team.

48:53 AMY HERR

Great, thank you. Great, I wanted to talk about how virtual care can be a tool or can be used to reduce healthcare disparities. Because one of our key messages from the playbook is that if implemented the right way, we really have an opportunity to reduce health disparities. And so I wanted to start with Chris about how you see the use of virtual care, reducing health disparities.

49:16 CHRISTOPHER STARK

Yeah, so when we talk about social determinants of health, there's a broad variety of ways that virtual care really can assist with that. So when we're in the home, when we're seeing patients face to face in their environments, we see an awful lot of the environments that they live in the neighborhoods they live in the different challenges that they have, you start to lose some of that with the virtual world that you can't see around you as much. But the tools themselves allow us to see patients where there's transportation issues, where they live in deserts of different areas and different, you know, resources that they have. And this allows our providers to get into those environments much more often to give them supportive care in behavioral health, supportive care with social workers, with the providers just to be able to get into areas where normally those people have difficulty coming out to clinics, they have difficulties getting care, and they can have varieties of care that they normally wouldn't have had. Because they can get to specialists now that are nowhere near where they live, they can talk and get second opinions and third opinions, and they can have their families looped in so that they get the educational component of it all. The whole family gets educated, not just the patient. I mean, I think we've talked throughout this entire panel session about different social determinants of health, just in different little aspects throughout the entire process. But the education, the financial, the transportation, all those things are highly benefited by the virtual world, as long as we can get the technology into the homes in different ways, which we've already talked about.

51:08 AMY HERR
Right, thank you, Chris, Does anyone else want to comment on reducing health disparities?

51:13 GREGORY SNYDER
Amy I'd say that, you know, in our view, virtual care is a tool to use to decentralize care. And decentralizing care is really what addresses social drivers and social determinants. And so, you know, taking patients out of facility based settings, and putting them in the home or in the right site for the care needs that they have. Because I think that to some of the earlier points by Chris and Mike and David and others, allows us to really understand, you know, a patient's socioeconomic vulnerability, their education and access to care, their access to the quality of care that they need. And then all of the home based and built environment drivers that lead to so much recidivism, and excess utilization of acute care. And so virtual care, its ability to drive change in social drivers in my view, is really, in allowing for us to put patients where they are and where they live, so that we can meet them there.

52:19 DAVID FLETCHER
And I agree with all of that completely. And I mean, I think, you know, certainly we got small towns where, you know, a neurologist is never going to set up shop, you know, and we were able to get access to those locations. The only kind of just caveat I worry about a little bit in the future is, you know, like our health system when we schedule telemedicine visits, you know, first question we ask is, do you have broadband in your home? And if the answer is no, we try to get them into their local clinic and do telemedicine there. So they don't have to drive all the way to the tertiary care center. But, you know, do we end up having kind of this two tiered system, if we don't, you know, kind of answer some of these challenges we've talked about with broadband access. And I think it could get, you know, even more as there are more tools and, and, you know, like digital stethoscopes, is that going to become another question that we ask, it's like, hey, what do you have in your medicine cabinet? Do you have all these digital tools that allow us to do a whole broad range of visits in the home? And so we've got to be careful, I think, as we think through these things to make sure that, you know, financial resources aren't, you know, kind of one of the preconditions to having the convenience of telemedicine in the home.

53:30 AMY HERR
That's perfect, David, and that's a perfect segue to our final lightning round question of what you know. What should we get rid of from telehealth, what's here to stay, and what are your organization's going to do going forward on telehealth? So I'll start with you, Mike.

53:48 MICHAEL KURLIAND
Alright, I'll start at the end first. We are doubling down on the tele facilitator model. One of the main reasons and everyone's kind of discussed it is that it really minimizes the inequities, like, you know, broadband financial, the literacy, so, and it also helps us use other disciplines and roles within our own clinic, for instance, even our physical therapy and rehab, and let's call it an occupational therapist, for instance, sometimes you have to go to the participants home. And now we could send a facilitator there and for something that would have taken like maybe 15-20 minutes in person for one of these therapies like hey, let me teach you how to use this piece of medical equipment or training like let's practice transferring and things like that. This tub facilitator can do that in advance and then the therapist can like beam in and like double check at the end. So that tele facilitator model, I don't think we're going to

get away from that anytime soon. What were the other questions that you asked like know what's here to stay? I think it telehealth is here to stay. Like it or not. A lot of those reasons like that we're very familiar with, we have an increasing population that's living longer, chronically ill, decreasing neighbor pool, decreasing amount of caregivers, increasing costs. All this really does create demand for innovative models of care and telehealth just is one of many tools that has to be really honed in and optimized for my colleagues.

55:42 AMY HERR
Okay, great. Who wants the last word?

55:49 CHRISTOPHER STARK
I can jump in for a second here. It's actually a QA question that goes right along with this. So I'm gonna read it. I don't know if it pops me off the video but so does virtual care exacerbate existing isolation and loneliness amongst older adults? And I think, yeah, that can. But I think giving a virtual environment people have now come to accept the virtual world, that it is a form of meeting people and seeing people and being part of the entire package of somebody's social existence. I think it as long as it's used as a tool, and not as the complete package. I think it helps people who feel isolated and lonely by giving them a connection point. It's the same way that they're talking their grandkids, why wouldn't they talk to other people in the environment? It's a reason why peloton exists. People now can feel a virtual gym, and they feel connected to people and they feel connected to those people in the stream who are motivating them to workout. So I think there is a definite positivity to all of this. I think it's just it has its place, and it has its usage. And we need to just make sure we find that happy place, that happy medium between seeing people face to face and seeing people virtually.

57:11 AMY HERR
Perfect. Thank you so much. To David, Mike, Josh, Greg, and Chris really appreciate your insights today. And I want to turn it over to Jen DeYoung to close this out.

57:24 JENNIFER DEYOUNG
Thanks Amy and yes, thanks to all of you. I just really appreciate you being here today and sharing your time and insights. I just learned so much listening in on this conversation and just really enjoyed the dialogue. So for all of you listening in, thank you for tuning in. Today, I want to encourage all of you to go to our website at unitedstatesofcare.org. You can access a deep body of work available to support your efforts, including a recording of today's conversation, and links to recently published resources we have on virtual care like our forthcoming playbook on older adults' experience with virtual care. And I hope you all will consider joining us at a future US of Care event. Thanks so much and have a great afternoon. Goodbye