Phillip Stringfield (00:01):

Good afternoon, everyone. We are at two o'clock, so I want to go ahead and get started and welcome you to next Telehealth Office Hours. My name is Phillip Springfield. I serve as a specialist of health center operations training here at NACHC. Also, joined my colleague, Susan Sumrall, deputy director of State Affairs, and Gina Capra vice president of NACHC training and technical assistance department.

As we get started today, I want to just remind you all to please make sure your phones are muted. I want to make sure we minimize any disruption throughout today's session, and we want to save time for questions and answer at the end of the presentation. So just please make sure as you're coming in, to mute your audio. And if I hear any in-between, I'll make sure to try to mute it as well, but I'm sure we'd have a few folks joining us today.

So we definitely want to make sure everyone's able to hear without any interruptions. So I thank you for making sure that your audio is muted. As we go up to today's session, if you do have a question or comment related to the presentation, you can use the chat box, we will be monitoring it and keeping track of all the questions that come in. So feel free to put them there and we'll make sure to get them answered for you.

And so, that's pretty much where the chat feature is, if anyone is unable to see it. And like I said, we'll make sure to get your questions answered when time is appropriate. And then just one to keep you all updated. All of our COVID-19 resources, as we've been saying are located at nachc.org/coronavirus.

This is essentially served as our resource hub in ensuring that all the materials and resources and webinars that we have and putting out throughout the scan of COVID are housed on this webpage here. In addition to some other resources and our online learning community, Noddle pod centered around COVID-19 response.

If you would like to join that, you can email Susan Hansen at shansen@nachc.org, you'll see that at the bottom of your screen. I also want to make you aware and theme of today's presentation, we do have Updated resources for Veterans for FQHC. And I'll make sure to put that link in the chat box so that way you can access it as well. But definitely want to make sure you get opportunity to check those out.

If you joined us throughout June or throughout the summer, you may have heard us talk about sustainability. We were really focusing on that, or may with these telehealth resource centers, and following that theme in June as well. And we really wanted to make sure that we're giving organizations the essentials that they needed to start up telehealth services in their organization.

And we were joined in June by Amanda Laramie with Coleman associates who did a deep dive of NACHC Telehealth Implementation Quick Guide. That recording is on our webpage, and we'll make sure to keep that up. So if you've had any issues connecting or accessing that. Please let me know. We'll make sure to get that resolved for you. And so what I'm going to do now is hand things over to my colleague Gina Capra. Who's going to do an introduction for today's presenter before we get started.

Gina Capra (03:21):

Great. Thank you, Phillip. Can you hear me okay?

Phillip Stringfield (03:24):

I can hear you fine.

Gina Capra (03:27):

Right. Well, hello everyone, and welcome to NACHCs monthly Telehealth Office Hour. NACHC is pleased to offer this convening for health center professionals each month. We strive to elevate operational issues and highlight best practices occurring in health centers across the country. Special thanks to my NACHC teammates, Phillip Springfield and Susan Sumrall, who coordinate next Telehealth Office Hours. Thank you, Phillip and Susan.

This month is all about learning from our colleagues in the United States Veterans Health Administration also known as VHA. The VHA provides healthcare services to over nine million enrolled veterans who receive care through a national network of inpatient medical centers and outpatient clinics staffed by providers who specialize in caring for military veterans and their families.

In addition, the VHA relies on an extensive network of community-based providers to whom VA refers to veteran patients if wait times or driving distance are a barrier to care. NACHC encourages all health centers to consider participating in VA's community care network. And Phillip just showed you some resources to help guide you through that program. We hope you'll take advantage of those.

The VHA has been an early adopter and innovator in the use of technology and particularly telehealth for more than 15 years. The VA has embraced technology to increase access to their services while focused on quality improvement research efforts, to validate the effectiveness and efficiency of virtual care.

Today, we will learn about what I call, the continuum of connected care utilized by VHA. From sinful telephone-based cardiac rehab in a patient's home to complex tele-intensive care unit services. There is a whole spectrum of what is possible when technology is strategically and thoughtfully deployed, keeping the patient's health and wellness at the center of every decision.

Let me be clear today is not about how to finance these systems. We recognize that much of the reality of implementing and sustaining telehealth in health centers relies upon reimbursement and related policy mechanisms. This is not part of today's discussion. Instead, free yourself to consider fully what health outcomes might be achieved for your patients, based upon the operational deployment ideas you'll hear today from VA.

I'd like to personally thank Dr. Kevin Galpin, Executive Director of VA's office of connected care for his time and willingness to be with us today. And I'll ask Philip and Dr. Galpin to get us started, enjoy today's session.

Phillip Stringfield (06:29):

Thank you Gina, and I'm passing the ball over to you, Dr. Galpin now.

Dr. Kevin Galpin (06:35):

Okay. Well, as we're doing that, I'll just say good afternoon everyone, and thanks for inviting me to this conference this afternoon. I'm going to go ahead and stop my video and start sharing. This will just take a second and then we should be able to get going. All right. If someone can confirm that they are seeing my screen, I will get started.

Gina Capra (06:59):

We see it.

Phillip Stringfield (06:59):

Yes we are.

Dr. Kevin Galpin (07:00):

Okay. Thank you very much. Again, thank you for allowing me to come today and talk about VA's Connected Care program and what we call our Anywhere to Anywhere telehealth Initiative. Today I'm going to go through really three main areas. I want to talk about what we were doing before COVID. Kind of the vision, some of the modalities we used, the data that we had, the direction we were going, and then talk about how everything changed following COVID-19 and kind of where we are now, and where we plan to go.

And just spend a little time on where we plan to go and the lessons learned over the past six months, and then hopefully we'll have time for questions. So to start out, just our vision. So, VAs as we will leverage telehealth, so the accessibility capacity, quality and experience of VA healthcare providers, their families, and their caregivers, anywhere in the country. This is what forms the foundation of our Anywhere to Anywhere initiative.

We say this matters because of those four things. Accessibility through telehealth, we can bring care closer to the veteran. The care that they were getting in the main medical center, they can now get into a community-based clinic or into their home. So it makes it more convenient. We can Hansen capacity. We have a national enterprise program. We can hire providers in a large urban setting to deliver care to veterans in small rural locations where it's harder to find healthcare providers. We can enhance quality.

We can bring them right provider to the veteran at the right time. We can engage veterans in between their appointments to improve health outcomes. And we can add another set of eyes onto an ICU unit to make sure that veterans are getting the right care. And all of that translates into better experience, both for the provider and the veteran.

So those are our four priorities and part of why it matters. It also matters because patients really seem to like telehealth and just hear some testimonials. Telehealth has been invaluable life-changing that the telehealth program really saved my life when I had COVID-19. VA video connect is really a time-saver. Telehealth did more than save me a trip to the medical center and it detected my cancer.

Home telehealth was the best move I ever made. And so on. It's also important and it matters because we do a lot of it. This is a way that we deliver healthcare to veterans, and this is before COVID and now it's significantly grown. But if you look back at '19, 15% of our veterans, more than the 10% got an element of their care through telehealth, if they got care in the VA at all.

We provided over 2.6 million episodes of care and served over 900,000 veterans. And it's continuing to grow. I mean, this is just our encounter growth since 2003. And you can see even between 17, 18, and 19, upward deflection of our curve, this is a program that continues to gain traction.

So before continuing, I did want to just take a big step back and say, what is telehealth? It goes by different names in different organizations. Some people include telephone into their metrics, some don't. We generally do not, although certainly it is a way that we are delivering care virtually.

So, when I talk about virtual care, I often talk about tele-health plus telephone plus electronic consult. But in our organization, this is our definition of telehealth. Telehealth is the use of electronic information or telecommunications technologies to support clinical health care, patient professional health related education, public health, and health administration added distance.

Really though our program in our data definition is much more limited in scope. So if you look at that definition, it does include all those things, telephone, eConsults. But when we're reporting out on data and talking about our telehealth program, we're really talking about three modalities. So it's the Clinical Video telehealth. That's a real-time video.

Store-and-Forward telehealth that's a synchronous communication, and then Remote Patient Monitoring, or what we traditionally call our Home telehealth program. I wanted to go a little bit into each of these. So Clinical Video telehealth, very traditional, and I think people understand what this is, real-time communications over video.

So veterans on one side, providers on the other side, they can see and hear each other. What's interesting is where we do this and how we organize it. So right now, we provide a lot of telehealth into the hall. We have our VA video connect application that can deliver telehealth to pretty much any device. We do have peripherals that we can associate with those.

So we have a specific application that is essentially a mimic of VA video connect. We can send veterans stethoscopes. We can send them Bluetooth, connected thermometers, weight scales, Spirometers, whole socks is et cetera, that connect into that system and allow the results to be displayed to the provider. And that's an area that we expect to grow.

We also do a tremendous amount of telehealth in the clinic, and that's our clinic to clinic video model. And that usually involves a provider in one location sitting in their clinic and a veteran sitting with, or working with a tele-presenter or some type of technician or clinical staff member who is the hands of the remote provider.

So in this case, we can do advanced physical examinations with high definition cameras. We can use stethoscopes, otoscopes, we have all sorts of different types of peripherals that we can use to provide a much more comprehensive exam. We deliver Video telehealth in the ER. And so, we've got a Telestroke program.

So a veteran comes in the ER that doesn't have a stroke neurologist on call and is exhibiting telehealth or not telehealth symptoms, but stroke symptoms that they can get in touch with a stroke neurologist to review the patient to look and do some physical examination, to look at the CT scans and determined whether that veteran needs thrombolytics or transfer for a vascular inter intervention.

We also do it in the ICU. And probably one of our more complex programs. We will set up individual ICU rooms with camera equipment, monitors, a button on the wall, so that if somebody wants to hail a remote provider, they just literally hit a button with camera turns on. We connect all the physiologic monitors in the unit to a remote monitoring station, and essentially can monitor the veteran.

We can intervene. So if the local staff needs us to do something, we can alert them if something is going wrong, we can put in orders remotely and really help cover that patient in the unit. So again, that's the Video telehealth program. Again, we do it in many different locations.

We also organize it at different levels. So the provider may be part of the local healthcare system taking care of their one veteran patient. That's usually how into the home operates in the clinic. The clinic model, a lot of it is regional. So, one facility is helping to support other facilities and programs like the telestroke program are done nationally. There's one center that distributes that program for the rest of the country. And so, it's done in many locations and it's organized in many different ways, depending on the clinical service. So that's video.

The Store-and-Forward program is the collection of information on one side that has been transferred to a provider for interpretation to then sends recommendations back to the referring provider. Classic examples of this are dermatology, retina imaging, which is pictured here spirometry and sleep medicine.

These are generally other than sleep medicine done in the clinic. So there's a technician who takes the image of the back of the eyes if the veteran's got diabetes, to make sure that they don't have diabetic retinal changes. Sleep medicine, obviously being an exception.

This is an area that we think is going to grow and grow the efficiency of doing asynchronous telehealth really promotes this as one of the ways that we can provide more services with less overhead because it doesn't require that real time interaction.

We're also really transitioning now to start doing it more into the home. And it won't be just images, it'll be tests, it'll be videos clips as well as images. So, that's the Store-and-Forward telehealth program.

And then the Remote Patient Monitoring program, this is another area where we expect tremendous growth. Our traditional model, we sign up veteran to generally have complex chronic disease, or we have concerns about their independence at home. And we assigned them technology, and we assign them a care coordinator.

And they're asked questions every day. How are you feeling? Are you taking your medications? It may request biometric data from them. All that information goes into dashboards for our care coordinators who can monitor the veterans and intervene. So with education, it can connect them to their primary care provider and make sure they're doing well at home.

And it's designed to improve health outcomes. It's also designed to help veterans stay independent, where they want to be in their homes versus becoming or needing institutionalization. So, a really important program for a lot of our veterans.

I did want to focus on some of the initiatives that were really driving. And again, this is still all pre-COVID. One of our big initiatives was Video Care to the Home. So we said providers will integrate clinical telehealth into the home, into routine operations to enhance the access health care for veterans or family members and their caregivers.

And this was our big VA video connect initiative as part of our, Anywhere to Anywhere telehealth initiative. This was announced at the White House. It was in the in 2017. So VA video connect is our software that we use very simple video conferencing tool. So WebRTC based application. Secure and simple, it works on any device. Non-Proprietary in pretty much any location, as long as the veteran has the technology and the internet to participate.

This is what it looks like. It is a program that is based off of a commercial product called Pexip. We label it, then we add additional features. One of those features is if you look at the upper left-hand corner here, something called E991, that is really critical for us. If a veteran passes out in their home, we need a way to get emergency services to them. So this is something we integrated into VA video connect.

We can put the veterans address at the beginning of the visit, validate that they have a local public safety access point that can reach them. And then if there is an emergency, we click a button, we get the number directly to that piece at the public safety access point. So the concern is, if you're remote from a patient, you dial 911 from your location that doesn't help. You need to know and dial the 911 at their location.

911 can often transfer you. But in this case, we can go directly to the peace app where the veteran is located and it get services more quickly to them. So this is our application. We had set really aggressive targets for video into the home. So in 2018, we said we wanted to get started, but by the end of 2020, our expectation was that 100% of our primary care clinicians and 100% of our mental health clinicians would be capable of delivering care to veterans in their homes through VA video connect.

We talked about capability, we talked about they had to complete training. They had to get the equipment. They had to set up a clinic so that they could capture their workload, and they had to work in a clinic where there was a scheduler who knew how to schedule these visits for veterans. So our goal,

again, at the end of this year was to have all of our primary care mental health clinicians capable of doing this, that included the nurses, the social workers, the dieticians who were doing remote blood pressure monitoring or remote blood pressure checks.

So it was the whole team for primary care mental health. And then by the end of 2021, the expectation was that all inventory healthcare professionals would be capable. To track that, what we did is we defined the metric that every provider had to do one. And we didn't expect 100% of the providers to do one, but that's how we track if they were capable.

And our approach on that was, if we can get them doing the one, if we can just make sure that they're capable, then we can let veterans know this is a capability we have. And then the veteran could help drive the program growth. And it was a pretty successful approach and something that I think other organizations should consider, although post COVID, there's such a driver to do this anyways. I think it's less relevant as a strategy, but this is just our progress over FY 19.

So at the beginning of the year, about 15% of mental health and primary care clinicians had done one of these visits. And we grew pretty significantly to the point where over 60% of both categories had done the visits. And if you look at our encounter data, you saw that same level of growth. Again, this was launched at the end of '16, '17.

We saw about 100% growth over '17 to '18. We saw a couple of 100% growth '18 to '19. And we felt pretty good about this, but look at this number. So just under 300,000 video visits to home, and we'll come back to this with the post COVID data it's significantly different now.

So another big initiative we had, so that was all VA Video connect and Video to the Home. Huge part of our strategic plan and what we were trying to accomplish. We recognized while we were launching this, that would be great for many veterans, but not all. That there are many, but it's about 15% based on the FCC report from last year.

So 15% of our veteran population that don't have broadband internet in their home. And this was a concern. And so we had to figure out a way to make this available to all veterans. We wanted to make sure we were providing equitable health care. Now, I love this picture because this is a great starting point. If you look at the left, the dots on this slide represent VA facilities, and you can kind of see their concentration across the country.

The flag on the right represents Walmarts, which are significantly more ubiquitous as far as being available locally. So I'm going to talk through some of the initiatives that we are using to help overcome the digital divide, again, a huge problem, or for both us our program and our veterans who need to get VA services. So one of the programs and why Walmart is such a relevant picture there is that we establish a program called Accessing Telehealth Through Local Area Stations or ATLAS.

And I think this is really exciting. And it's something that I think community health centers may want to work with us on. I actually think this is a great opportunity for collaboration. I'll kind of explain why. What we say here is that we know there are veterans who can't get their services in their home, but maybe we can set up a community location that's a therapeutic environment where all the equipment, all the technology internet is already set up, and they can book that appointment there.

So they can meet with their provider, not in their home, but in their communities, 10 minutes away from their house as opposed to three hours for a clinic. And so, we developed strategic partnerships with Walmart, with Phillips and with veterans service organizations that are looking to partner with a lot more and establish these locations. Phillips was amazing. They set up, if you look at the left picture here, these telehealth pods, they've got moonlighting.

When you walk into them, you can pick. If you want an ocean theme and you hear sounds, and it's got lights and there's a picture of an ocean, or you can do a country theme. And it's a really, again, nice therapeutic environment. We didn't want an antiseptic kind of hospital feeling space, but more like a family room, a place where this was instead of the veteran being at home.

We're building these out in veteran service organizations. We then also partnered with Walmart. So these are being put in, not with the pods that Phillips developed, but in Walmart spaces. So that again, a better can book out the space and receive their care locally. One of the exciting things is the way we're developing this program. We always had the thought that these could be shared spaces.

So our application that we developed at scheduled these spaces, one very nice works with the workflow of telehealth scheduling. You can identify a veteran's zip code and see if there's a ATLAS site near where they live to see if it's an option for them. But our thought was always that the application would create shared calendars.

So let's say there's a public library and a community that if there was a ATLAS site in that public library that we could book into there that someone could book that space separately for job interviews or another health care could book it. Organization could book it for their health care services. But we'd all be able to see each other's calendars without any of the PII or PHI, but just know 10 o'clock is booked, 11 is open, 12 booked.

So that we can get more services out to rural areas. So it's a very exciting project for us. It really just started getting going before COVID shut it down temporarily so we could work out new infection control protocols, but it's now beginning to open again. So that's ATLAS and again an exciting project for us.

One of the other things we did is, work with our strategic partner office and internet service providers on a zero rating program. So this was with the understanding that there are veterans who have internet, they may not be sufficient. Maybe someone's got a rate limited data program or a data plan. And so they can do telehealth, but it might take up all their data, or they could do it for 20 minutes and they really need two hours of session.

So we develop partnerships with just amazing companies, T-Mobile Sprint, which is now owned by T-Mobile Verizon and SafeLink. And what they did is, they said they will white list our VA Video connect application. So for veterans who are using VA Video connect on their network, they will never be charged for their data usage, as long as they're connecting with VA.

We're working with more partners. We see this potentially expanding, we're expected to expand in the near future as well. We are also working with Microsoft on their Airband program. So Airband is a new way of bringing internet into communities and uses unused TV white space. And what they did is they're helping us.

They took FCC data, VA data, they've mapped it out in the United States, and we can now drill down and say, what are the counties with the population of veterans that don't have access to different internets and live 60 minutes drive time for the VA, or 60 minutes from the VA, we're 60 miles from the VA, so we can focus areas where then Microsoft will then bring in internet, as well as digital skills training to help those veterans who otherwise don't have access to internet. So again, another exciting program.

I think the biggest thing we're doing now, and I think this is, I'm hoping to see this expand to other organizations as well, but we're establishing a digital divide consultation. So there are programs out there like FCCs lifeline program. We'll talk about that a minute. That there's people that probably don't know they qualify for.

And we found this to be a problem, is that we wanted to make sure that that people would that we institutionalize, that we systematically assess our veterans for the digital divide to make sure that they have the capability of connecting our services to other programs that are important, social networks, et cetera. And so, we're institutionalizing this by creating a digital divide consult. We just sent out a memo. It's being implemented now and we'll finish up mid September.

But essentially what we did is providers now, when they talked to veterans, the veterans would like to do telehealth or the provider suggesting, some type of digital therapeutic, they can refer that veteran to a social worker and the social worker will sit down with them. They will assess them for their eligibility, for different federal programs, private programs, or VA specific programs to help them overcome the digital divide.

So we think this is very exciting that the two tools we have in their tool belt right now is our iPad program. So we have especially three tools, I should say. We lone veterans 4G Connected iPads. So for the veterans, again, that don't have technology, don't have internet, they can get this loner tablet for us, it's got a 4G connection. And so, they can access telehealth through this platform and IF they don't need it anymore, It can be returned.

For our homeless veterans, we have a similar program, but it's with phones with the understanding that they don't have phone service the patella is not the right technology. And the other big tool that we have in the social worker tool belt right now is the lifeline program. So social workers will assess veterans for their eligibility for this program. If the veterans interested. For those who are not familiar with this program basically people can get a $9.25 cents a month subsidy on their phone or internet services.

And if they're on Tribal or native lands up to $34.25. So it's a really nice benefit in our assumption which is that many people have no idea that they are eligible for this. And if they did, they would sign up for it and again, help overcome that divide. There are veterans that are automatically eligible. And so we are working to actually combine datasets so they can make that eligibility determination in the social worker's office.

But again, this is part of the digital divide process. We expect to develop more partnerships, identify other federal programs to add to that tool belt over time. And again, feel like this is an important step in making sure and identifying that the digital divide is an important part of social determinations of health. What last initiative I'm going to talk about is our Clinical Resource Sharing initiative.

We say we're going to enhance our capacity to provide high quality consistent services by creating Critical Resource Sharing within between facilities and networks through telehealth. This is that matching supply and demand concept. We're going to take one medical center, that's able to hire, we're going to hire providers at that location to distribute those services where those services are needed.

We have many programs that leverage this type of resource sharing, but we have one specific program called our Clinical Resource hub initiative. We have 18 of these hubs that have been developed in the 18 VA regions called [inaudible 00:29:50]. They all deliver primary care mental health. And again, they served that model. They hired those providers, they delivered the services where we have gaps in service, where we have absences in rural communities.

And so, this is a very exciting program that we are growing. We are adding specialty care and really organizing around this type of access gap model. All right. So, COVID right? So, everything changed this year and I just a lot to talk about, but I just want to go through how our priorities changed. So, clearly why this matters, why telehealth became, or is important is different in 2020, than it was in 2019.

And, the big priority changes we're now doing telehealth because it is the safe way to deliver care. We can deliver care with the veteran while adhering to social distancing guidelines. Early on in the pandemic, we identified three work streams that we felt tele-health could be involved in to help veterans and the organization through the pandemic.

So the big one was expanding telehealth to the home and actually from the home. So delivering care to the veteran in their home, but allowing the providers as well to work from home. Second was supporting veterans in isolation or quarantine. And the third was supporting our critical care capacity in our intensive care units. So, we'll talk about just expanding telehealth at home and some of the things that went along with this.

So this is the data, right? So this is, if you look, and I asked you to think back to that '19 slide, where over the year we provided 294,000 video to home visits. That was a lot. That was a big program. And going into FY 20, we are still seeing growth in the program, you know, modest. We were seeing about 34 or 41,000 video visits to home every month.

And then with COVID in March, we tripled that in April, we tripled that practically again, and we went to from 41,000 video appointments a month to over 657,000 video appointments a month, just to understand the daily average at the beginning of the March, we were having about 2000 video visits a day, and now we are touching 32 to 33,000 a day.

Now, this was a huge challenge for the organization. So, our video system one initially did not have the capacity to handle the this many video visits, again, recognized very early. We had to work week over week with it to expand the capacity. Our system initially managed about 3000 veterans at a time, or could. At max now it can handle 15,000. But that required a tremendous amount of engineering, same thing with our scheduling system.

Our scheduling system needed to be re-engineered twice to stay ahead of the demand. And the other thing that was a real challenge was our help desk. So, we have a help desk, and I think this is one of the real critical operational components when you're developing Video to the Home is that, because of the digital divide, because of people's unfamiliarity with applications or telehealth, it's really important to help them either have a test call service, that's automated, which we have.

But we also have a person based test call service with our national help desk. So veterans can call up and do an initial session with a help desk technician before they actually had their first video visit with a provider. And just our numbers for our help desk skyrocketed. We had to practically quadruple the staff with the help desk to manage the demand. And this actually addresses both veteran and providers support.

We continue to see, I showed you these numbers for '19. Again, we accelerated all of our initiatives this year. So, we were saying by the end of the year, primary care mental health needed to be capable of doing this. And we said, "Okay, now, it's got to be done like two weeks." And then we started making a big push for specialty care.

And again, we also helped providers transition to home. And so many of our staff members went home and we provided education on how to do it from their personal devices, or we tried to get government equipment, but you can see the significant growth here. So we're now at about 90% of mental health and primary care clinicians have done video visits and specialty providers it's about 50%. Remember that was the goal for '21. But again, just accelerated all this year.

So our second big work stream was supporting veterans in quarantine. And what this was, was just the concept behind this is, we needed a few veterans who'd come to the emergency room or into the hospital. They might have COVID symptoms. They might get a test that they wouldn't need hospitalization, but at the same time, they might need support when going home.

And we have different categories. There were some veterans that needed just a little bit of support, and there's some veterans that might need more support. So for that first category of veterans, we leveraged one of our applications called the Annie Text Messaging system. And Annie is really, really neat. So, it's an automated text messaging system that basically sends in a very friendly way, messages to veterans on a protocol, you know, "Hi, this is Annie, how are you feeling today?"

And then based on the responses, it provides automated response back. And so very quickly, we set up protocols for isolation and quarantine asking veterans how they were feeling their temperature or shortness of breath. And depending on the results gave them guidance or education, this was very well received. Just feedback for veterans about 75% found this intervention to be helpful. Many felt that it helped prevent them from needing to seek services from VA through other modalities.

And what was amazing, this is an automated program, but because of the personal touch, many people responded and some of the testimonials that they felt comforted less anxious. It really made them feel cared for. And that was a really great outcome. And again, we use this in many, many different for many clinical situations, but it's been really handy and important during COVID.

The other program that we leveraged was that Remote Patient Monitoring Home telehealth program. Again, this is where we provide the technology, but now it's not an automated system completely there's a clinician on the other end, who's seeing all the results of the question. So veterans are still asked that same question, "How you feeling, can you provide your temperature today?"

But all that information goes to a dashboard and there's a clinician looking at that and can provide feedback to the veteran or help connect them to services. What's really neat. Well, what's really interesting about this graph is if you look at the bottom part, the green lines we had the surges initially with COVID around April, May, the use of the service went up and then it went down in June and then starting in July and August are went up again.

So it's clearly following the surges of the virus. And one veteran in particularly there was a nice article written about him. He attributes his care coordinator of this program to saving his life. He was sent over from the hospital. He was put on his modern new program actually felt well, or thought he was doing well. And his care coordinator called him and said, "Listen, there's something wrong. Your vitals don't look right. You need to come back in the ER."

He came back in, and ended up getting admitted, I think for like one or two weeks with bilateral pneumonia. And he said, he would not have known that anything was that going wrong initially. And so we really feel like them getting them back in did save his life. And this was an important program and is what we're doing now. And then finally, we focus on expanding critical care.

So we have this Tele-ICU program that covers about 39% of our facilities. And as I mentioned it before, again, you have a hub of critical care providers. So nurses and physicians who are in one location and they can monitor veterans all over the country in these ICU's that are set up, they've got audio visual connection, they see bedside monitors, physiologic data.

And our concern here was that there would be surges hotspots where ICU would become overwhelmed or we would... That plus clinical staff would get sick and we'd lose capacity. And then there could be providers who were less experienced, like a primary care provider or a hospitalist who doesn't normally independently cover the ICU, but now needed to help in these areas of surges or loss of clinical personnel.

And so our goal was that and we did this in three phases is let's extend out our critical care program to cover all the facilities that have ICUs. And so we really did a quick pivot on this. We created national phone books. We got those critical care providers access to all the medical records around the country or system that would give them that access.

We made sure that we had a process nationally for privileging and essentially created a service that at any facility. If any facility needed help from this group of providers, they could request it and they would be available to assist. It was a lot of through telephone and via VA Video connect initially. So literally we need like a two week plan, and so we have facilities set up, tablets on IB poles, computers on wheels.

I mean, anything to help create that connection with the idea that the phase two of the plan would get official TeleCritical care equipment. That's where we are now. And then phase three is to expand the full program across the country. And we've just sent out a notice to the field that anyone who's ready to sign up now, we'll put them on a plan to get them the full program.

So again, very critical obviously during COVID to make sure that you have enough critical care capacity. And this is just to show how we got far with phase one. 98% of the facilities had access to the telephone program. And 95% have access to the phone and video component of this service with VA Video connect.

Okay. Just real quick lessons learned, and then we'll get into the questions. The foundations, I mean... For telehealth, both during normal times, but exacerbated it. And I would say foundations are important during normal times, but critical because of the emergency. We spend a lot of time focusing on foundations, IT infrastructure, since FY 18, we've been focusing on making sure we have enough internet at all of our clinic locations.

That's been an ongoing project working on legal authority. I know that's, specific for us, but policy staff, technology, all those things are things that you can't do quickly when an emergency comes up. And so focusing on those is critical. Related to that is, we recognize that we can't be too lean in our operations.

I think we, we pride ourselves on anticipating growth, developing a roadmap and meeting those objectives in a lean way. And the reality is, we need to be flexible. We have to be ready for things that we don't anticipate. And so, one of the things that we did during the pandemic was we had to increase the capacity of our VA Video connect system or scheduling system.

But we did it in a way that it's now flexible. So, when we need to expand going forward we have that capability to turn it up much faster than we did before. We also learned that people use telehealth and generally like it, something we've gotten some really good feedback from providers and veterans. They definitely prefer it.

We did some structured interviews or some interviews with veterans and what they told us is that they like it more than telephone because it makes them feel more connected to their providers. So, that's really, really important feedback. The digital divide needs to be addressed. This is a major problem. And, with COVID-19, I mean, the amount of people who are employed and working from home, people who need to educate from home, people who need to get healthcare from home.

I mean, it's really something that as a country we need to address, it's very difficult for people to manage without having the connectivity that is almost expected to be employed, to be educated in this country, certainly during the pandemic to get your healthcare. And then I would say the biggest positive lesson learned is that you've been going in the right direction with telehealth that really there's been great vision.

There's been great leaders. You know, for the past 20 years, who've really pushed telehealth in the right direction. Certainly helped us get where we need to be. And it's really paid off. I mean, we see the services we can provide now that we otherwise wouldn't have been able to perfectly during this emergency. And I think it's really, it really justifies via the approach.

So the next step though is, a really big focus on the experience, both the provider and the veteran. Over the past six months, really for the first four and a half, we did things the way we needed to, right? It was all right, provider. You normally work in a clinic. We need to get you home. To the veteran, you normally come into clinic, we now need to do services in a different way if you want adhere to social distancing.

But now we have an opportunity to go back and say, "Okay, let's do this the way that we want to do it. Let's focus on the experience. Let's make sure all of these things are in place." And when I think about telehealth experience, when we talk about the provider side technology, the veterans' side technology, the preparation, the website manner.

And so what we are going back to doing is saying, okay, every facility we need to set up the test call program. So when a veteran was first being talked to about telehealth, it's not, "Hey, do you want to do telehealth?" It's, "We have an option for your care that you can do, it's telehealth, it's through this technology. We can help you do it the first time, if you'd like, if you're interested."

And so that instead of it being this thing that they might be afraid of it's, "Hey, we're going to walk you through it." Same thing with the provider, making sure that they're comfortable, making sure that their workflows and in video match their in-person workflows. So, they are accustomed to having a nurse come in and do triage of their patients before they see them. Have the vitals done, have certain questions to answer that same experience is completed with the video visits.

With the technology, we initially sent a lot of providers home, we said, "You know what, use what you can." So a of people were using tablets phones, but the reality is the experience with a static web cam on a computer with a hard wired internet connection is going to be better than the shaky phone that you're holding. And so, transitioning to make sure everyone has that set up.

They have the right background, they have the right technology, they have the right lighting to make sure that the experience on the other end is good is, is really critical. And then from the veteran's side standpoint, continuing to work on that vision of abide, if they don't have the technology, they can't do it at all.

If they don't have good technology, the experience may be bad. So making sure all of these things are in place. And so this is going to be a huge focus. And I mean, it is right now and going forward is again, getting all this work, all this health care in the way that we want it to be delivered. I will stop there. I think we can go to see if there's any questions.

Phillip Stringfield (45:46):

Thank you so much Dr. Gaplin for that great overview. Some of the service, your initiative, in addition to the lessons learned I really think there is some great insight that you share with our audience. We did get a couple of questions, so I'm going to go ahead and just fire off one that came in. So it goes, "What is your strategy for staffing the help desk, and does that help desk have any tool that allow them to connect to the patient veterans device?

Dr. Kevin Galpin (46:19):

We contract with our help desk and they monitor the metrics. We check every day, average speed to answer, what is the abandonment rate. I mean, they essentially staff that program to achieve those metrics. Forget the equation, the... I'm sure someone knows that I'm going to call, but there's a certain staffing equation that people use. I can't say that our contractor uses that or not. But I think most contact centers do, but that is what we monitor.

So in that March, April period, we saw huge increases in average speed answer and abandonment rate. And that's where we said, "Okay, we need to rapidly increase the staffing". And we actually pulled... I mean, just to let you know, kind of the situation we're in. We pulled a lot of contractors off of projects who had telehealth experience and put them at the help desk to make sure we can answer the veteran phone calls. And I'm sorry, what was the second part of the question? It was staffing?

Phillip Stringfield (47:19):

I'm sorry. So the second part it says, "Does the help desk have any tools that allow them to connect to the patient's device?"

Dr. Kevin Galpin (47:28):

Yeah, not at this point. So we've been discussing that about, would that be beneficial? We think it would, the challenge is just any of the privacy standpoint. I think that the tools that we were looking at you'd have to download something on the veteran's device to get the connectivity. And so we haven't done that yet, but we definitely see the value of that. And it would make it much easier to help the veteran.

Phillip Stringfield (47:54):

Thank you. Looks like that was the main question that we received. So if anyone else does have any questions for Dr. Galpin, feel free to put them into the chat box and we'll make sure to get them answered for you. Just throughout the presentation, I did have a question of my own that I wanted to ask, regarding the ATLAS initiative. I know you said they are still the revamping up now that certain precautions are in place for COVID. But has there been any conversation or any connectivity with any community health centers? It seems like that may be a good opportunity for those that might be in a local area.

Dr. Kevin Galpin (48:35):

[inaudible 00:48:35] conversations over the years and I don't know why that hasn't progressed forward, but I think it is a huge opportunity. So I would be very interested in discussing with any community health centers that would be interested in partnering on this, to see if we can come up with a plan to help integrate the services or provide the services at those locations.

Phillip Stringfield (48:57):

Awesome. Yeah. I just spoke ahead, and someone just put in the comment it says, "Is it possible for community health centers to partner with the VHA on the ATLAS project?" So definitely we'll make sure to share contact information, but if you are interested, definitely reach out to us, and let us know we'll put you in communication.

Dr. Kevin Galpin (49:20):

Yeah. That'd be really exciting. I think that's again a great direction. There's a lot of need out there and I think that'd be a great partnership opportunity.

Phillip Stringfield (49:33):

Awesome. And then just one last one. So what about doing the sustainability theories throughout the summer, and really focusing on some health centers that may have to revamp or set up their Telehealth services overnight to respond to the COVID-19 pandemic outlet. What advice would you give to organizations that may be within their first year of implementing Telehealth services?

Dr. Kevin Galpin (49:59):

I would say as much as you can integrate. The biggest challenges you have initially is getting the culture changed, it's all the change management. So as much as you can integrate the processes into your providers operations, the better you'll be. From the point of, how does it get scheduled? Is there a simple mechanism to do that? Do the schedulers have an application? How is that communicated to your patients?

It's that integration component, particularly if you can get it in your medical record, that makes a huge difference, so that it just feels like... You've got to make it as easy to do as any other type of care. I mean, the thought process we want for the providers is, "I have a patient in front of me, I need us to provide them a service. Let me talk to that patient and determine what's the best way to provide that service." What do I think clinically is needed? What is their preference and whether that's in-person, phone, video, whatever?

The thought process shouldn't be, "It's really hard to do videos, so I'm going to do phone, or it's just so much easier if I have them come back, even though they live three hours away." Like you got to get to the point where all those are equally equivalent options, so the focus can be truly on the patient's needs and their preferences. And so that integration piece, so it's just like there for them, and they don't have to go out of their way to do it is critical.

Phillip Stringfield (51:30):

Thank you for your advice. It looks like we are getting some folks that would be interested in learning more about the ATLAS project. So NACHC PTA department will definitely be in communication with the group also to Dr. Gaplin, to see if we can kind of connect together and maybe have an info session or a quality [inaudible 00:51:49] a little bit more detailed for everyone. But with that, it looks like I don't have any other questions on my end, but I will just open it up for Gina or Susan if there was anything else that I may have missed.

Gina Capra (52:05):

Hi, this is Gina from NACHCs PTA department and just want to thank Dr. Gaplin for his time and wonderful overview today at VA's work. I think there's a lot that is similar for us in the health center world in terms of increasing access and you've given us some good ideas to think about. Thank you, Dr. Gaplin.

Dr. Kevin Galpin (52:26):

Again, thanks for inviting me. Appreciate it.

Phillip Stringfield (52:31):

Thank you. And we're getting thanks from the comments as well. So I want to thank everyone for your time. Thank you Dr. Gaplin for that great form of presentation... I mean overview. And just want to wish you all a happy National Health Center Week. If you do have any specific Telehealth questions, if you would like to be featured on a future call or share any best practices that you may have, feel free to give

us an email, you can send it over to telehealth@nachc.org and we'll make sure to get them answered for you.

That is pretty much our main communication. So if you needed recurring calendar invitation, feel free to give us an email and we'll make sure to get you everything that you need. So with that, I want to wish you all a happy weekend coming up and enjoy the rest of your evening. Have a good day.