EXECUTIVE INSIGHTS

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REAL-TIME MOBILE ENGAGEMENT

Managing communications, navigation and patient flows in the pandemic era

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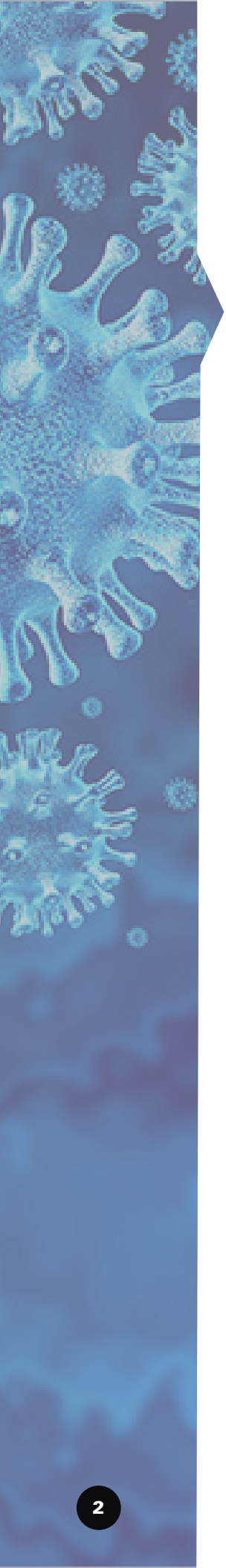

REAL-TIME MOBILE MANAGEMENT:

Managing communications, navigation and patient flows in the pandemic era

During the pandemic, health systems were pushed to transform their digital strategies quickly to meet the needs of their patients and communities. The coronavirus brought to light how the real-time digital response of a location-aware mobile platform allows a health care system to stay agile and act immediately on situational awareness. A direct conduit to patients and their communities, hospitals recognize its value to provide alerts, access to telehealth, navigation to off-site testing locations, symptom checkers to triage patients, and to manage patient flows and improve access to care. Hospital leaders participating in a virtual executive dialogue discussed how COVID-19 has affected their operations and how the integration of mobile technology helped to address issues for front-line staff, patients and their families. They also explored what is next for their organizations as they leverage their mobile platforms into a new normal.

KEY FINDINGS

1. The impact of COVID-19 has pushed health systems to create seamless, robust digital resources. Now, mobile platforms are providing the key applications needed for front-line staff and patient interaction with features such as hospital at home, telepsychiatric services, virtual meetings and patient monitoring. Changing payer reimbursements and requirements also play a role in the integration of digital platforms.

2. Health care leaders are aware that the new normal will continue to rely on digital technology as more patients enter the hospital for in-person visits, with a percentage of the population preferring to meet virtually. The evolution of this hybrid model of care will unfold more opportunities for both physicians and patients with the goal of well-integrated care and a seamless digital interface.

3. Rural health systems and hospitals that have older populations use the mobile platform less than younger patient populations. This creates a unique set of opportunities and challenges while trying to minimize in-person visits. It is evident that broadband telecommunications is a public health need in rural settings.

4. Health systems may face organizational barriers that prevent them from integrating digital platforms into their processes of care. Health leaders are preparing solutions that address digital integration on both the inpatient side and in other processes of care.

VIRTUAL PARTICIPANTS

Daniel Handel, M.D.
VICE PRESIDENT AND CHIEF MEDICAL OFFICER, SOUTH CENTRAL REGION
IU Health | BLOOMINGTON, IND.

Joel Hendryx, D.O.
CHIEF MEDICAL OFFICER
University Medial Center | EL PASO (TEXAS)

Barbara Kragor
VICE PRESIDENT
Gozio Health | ATLANTA

Debra Laughery
VICE PRESIDENT, MARKETING AND COMMUNICATIONS
WakeMed | RALEIGH, N.C.

Euthemy LeBrew
CHIEF SYSTEM REVENUE CYCLE OFFICER
University Hospitals | CLEVELAND

Charles Reuland
EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER
Johns Hopkins Hospital | BALTIMORE

Jim Scheulen
CHIEF ADMINISTRATIVE OFFICER, EMERGENCY MEDICINE AND CAPACITY MANAGEMENT
Johns Hopkins Medicine | BALTIMORE

Keith Starke, M.D.
SENIOR VICE PRESIDENT AND CHIEF CLINICAL OFFICER
Mercy | ST. LOUIS, MO.

MODERATOR **Suzanna Hoppszallern**
SENIOR EDITOR, AHA CENTER FOR HEALTH INNOVATION
American Hospital Association | CHICAGO

MODERATOR: *(Suzanna Hoppszallern, American Hospital Association):* **What digital resources did you have in place pre-COVID-19? How did your health system use these resources to communicate with patients during the pandemic?**

JOEL HENDRYX, D.O. *(University Medical Center El Paso):* We're a county hospital and the safety net hospital for our area. We're situated on the border with Mexico, which creates its own challenges. Our mass shooting a year ago created unique communication challenges. Our catchment area is approximately 280 miles. We are a Level I trauma center and receive patients from that area. We tend to have a large number of unfunded patients, from about 60% now down to 36%. We have a mass notification unit. We employed Everbridge HipaaBridge prior to all of this, which is secure texting. As far as telemedicine or telehealth, it was rather limited. We didn't have a robust communications system.

DAN HANDEL, M.D. *(IU Health):* We have a large community hospital based in Bloomington, Ind., along with two critical access hospitals, a freestanding emergency department (ED) and about 65 clinics throughout an 11-county region. We set up a virtual hub for COVID-19 screening for symptomatic testing, and we started using telepsych particularly in our critical access hospitals. We've used bots such as Twizzle on Microsoft for ongoing patient monitoring of those who tested positive and also to track those who are not well. It cut down significantly on our call volume. We've also started to ramp up our hospital-at-home program, discharging patients sooner with close monitoring from home.

CHARLES REULAND *(Johns Hopkins Hospital):* We're an Epic shop, using MyChart. Our video visits were limited before the pandemic. They were queued every day, tens and maybe hundreds a month, and then went to 5,000 a week in March. We have a wayfinding app that we're about to launch with Gozio. We've done some remote visits, and some telehealth within the hospital, with Sickbay, a software-based monitoring and analytics platform. We also have cared for a patient in a COVID-19-positive unit where we utilized Zoom calls with their family. Certainly we're farther ahead now than we were in February.

"Our video visits were limited before the pandemic. They were queued every day, tens and maybe hundreds a month, and then went to 5,000 a week in March."

— Charles Reuland —

JIM SCHEULEN *(Johns Hopkins Hospital):* Virtual visits have made an enormous difference to those people who feel uncomfortable being seen in person. The number of patients who used virtual visits corresponded directly with the significant decrease in ED visits across our system.

DEBRA LAUGHERY *(WakeMed):* We're a three-hospital system, with 941 beds, three stand-alone EDs, about 350 employed physicians and about 80 other locations throughout the Wake County area. We were fairly far down the path when COVID-19 hit. We launched our wayfinding app with Gozio in July 2019. It turned out to be a key communications tool for us during this time. We are an Epic shop, so we use My Chart to do a lot of communication as well. We, too, were struggling with telehealth in the primary care and specialty practice arena. We did it both within MyChart and also WebEx for those who did not have MyChart capabilities. We conducted virtual behavioral health visits and we have a hospital-at-home program. We also launched a robust outpatient rehab program for COVID-19 patients, because their overall mobility capacity was greatly compromised following COVID-19 recovery. In terms of communicating with the public, we used our website, social media, podcasts and held virtual forums with our chief medical officer for the community to keep people informed about what we were dealing with.

KEITH STARKE, M.D. (*Mercy*): Our geographic footprint is across Missouri, Oklahoma, Arkansas and Kansas. Mercy had embarked on a strategy a number of years ago around virtual care. We have a virtual care center which originally focused on external provisions of care — ICU and virtual stroke. About two and a half years ago, focus changed to an internal focus on ambulatory and inpatient hospitalist care. This fortunately provided us with a structure and process to leverage with COVID.

EUTHEMY LEBREW *(University Hospitals Health System):* We have 15 facilities with more than 2,600 employed providers as part of our network. Leveraging technology has been part of our framework for many years. We have an internally developed digital patient front door, which consolidates many of the applications that patients can download to communicate with our providers. It includes online scheduling, provider and specialty wayfinding, bill paying and links to other tools. Our personal health record that enables communication between the patient and provider on both the specialty and primary care sides is also encompassed in this front-door link.

When COVID hit, it was a great opportunity to accelerate that strategy. We quickly shifted to telehealth, ensuring that we had data integrity for the providers and visits where they otherwise would have been rendered, which is an important piece considering some of the changes we saw with Medicare. Our providers leverage doxy.net, MDLIVE and Zoom as the primary tools for patient interactions. We activated two major software solutions for patient monitoring at home and for communication: Masimo, to connect with patients and monitor their at-home care; and Conversa, an artificial intelligence engine that interacts and quickly identifies and communicates between the patient and provider. We also are leveraging it for our own employee workforce with daily screenings.

We were leaders in the space of a unified command, having a central unit of clinicians to help both our patients and employees with COVID-19 and screening, and having a distinct algorithm based on symptoms and directives. We also were leaders in developing the Healthy Restart program to ensure the safety and health of our patients, visitors and employees.

BARBARA KRAGOR *(Gozio Health):* As a little background, Gozio started as a wayfinding company and quickly figured out that patients need a lot more. They want that single, digital front door and a frictionless experience to access their EHR, ability to make an appointment, access virtual visits and have all hospital services at their fingertips.

"We were fairly far down the path when COVID-19 hit. We launched our wayfinding app with Gozio in July 2019. It turned out to be a key communications tool for us during this time."

—Debra Laughery —

There was a need for the digital front door even before the pandemic, but now a digital platform is critical providing communications and easy access care. Nationally we have seen during this COVID crisis a need for other features such as virtual triage tools like chat bots, ability to send out real-time alerts and notifications that are geofenced, and tools to decrease face to face contact and contactless arrival.

One of the challenges that many systems face, is they are using a hybrid for their virtual visits and the experience is clunky. They need to make sure it's seamless. Deep integrations are key so patients do not have to download multiple apps, systems need to provide a single interface with their hospital branded app.

We have seen that wayfinding is still key because patients want to be guided to the exact location

of care and many services have changed locations or add new locations, such as a new testing site. This is a key element to making patients feel safe to receive care.

The concept of contactless arrival has become important as well. When a patient arrives in the parking lot, they can check in through their registration and when they are notified to come in we navigate them directly to the point of care, and it's contactless.

Overall it is that single interface for all communications, access to services and amenities, wayfinding and access to digital resources such as EHR and virtual care. Key is making it seamless for the patient.

REULAND: I'm interested in how all of you are employing your ambulatory physician practices and whether you're going to use hybrid models or attempt to segregate in-person visits from virtual care. We are working our way through those issues. Is there a consensus or preponderance of views in how you are approaching this?

STARKE: It's challenging to determine what would be the best. Some of the refinements depend on the physician's level of comfort with the technology. We have some physicians who would adopt all digital and others who find it more challenging. What we're trying to do is adopt a hybrid model where a certain time of the day is virtual and another time it's in-person. If we can balance the in-office with virtual, we can decrease some of the strain we're experiencing at the moment.

HENDRYX: We are trying to get more of the chronic patients back in because they have to be seen on a person-to-person basi and to obtain vital signs. It is up to the physicians and how they manage telemedicine to some degree. About 45% of our clinical visits are through telemedicine.

HANDEL: With the current fluid situation, we're trying to make appointments interchangeable. One of the challenges is technologically integrating the telehealth platform into our electronic health records (EHRs). We're in the process of going to Amwell One by the start of next year. In theory, you'll be able to visit both in person and virtually. Doing telehealth visits is a technological challenge in some rural communities. Some of our older patients have flip phones, and some have a degree of hearing loss. We are also aiming to minimize our no-show rates by providing options for virtual visits.

MODERATOR: **Did your digital resources perform as expected during the pandemic crisis? Which were unable to handle the communication or operational demands of the pandemic? How will you change your digital strategy moving forward?**

"Doing telehealth visits is a technological challenge in some rural communities. Some of our older patients have flip phones, and some have a degree of hearing loss."

— Dan Handel —

LAUGHERY: I was surprised how quickly we were able to mobilize so many different resources with our information systems team. Things that had taken us years to get off the ground happened within weeks. Virtual visits became reality in every single one of our practices. Our "you-can't-touch-this" approach went live within all of our clinics with e-check-in, Hello Patient and all of the different MyChart tools.

SCHEULEN: We saw some rapid deployment of tracking systems, understanding where our patients were and their status. It was impressive how quickly things happened when they needed to. A lot of our systems, though, in terms of the hospital's daily operation, were already strong. I feel as though we had a bit of a head start because we had a good digital picture of what was happening in the hospital and the status of patients.

MODERATOR: That is impressive. Do you think that as things begin to move into a new normal, people will still expect this level of rapid change and adjustment?

SCHEULEN: When we get back to normal, we will have to pay attention to multiple things at the same time, and that often means that things will take longer. We're all surprised by the incredible focus that this brought to all of us — not just in our digital strategies, but in making some difficult operational decisions and deciding that we were going to do things differently. At Hopkins, we have some pretty deep-set traditions and things are done a certain way. My challenge now is to say, "Well, if it worked for the last six months, why can't it work for the next 15 years?"

HANDEL: As part of a 17-hospital system, we're looking at this as the start of our journey. With a new chief medical officer for digital health, our focus is to create a smooth interface between in-person and digital visits. We've historically had anantiquated way of scheduling. How are we creating a seamless digital interface with patients throughout all aspects of the care encounter? This has stimulated us to have a much larger conversation. We in health care have never been at the cutting edge when it comes to technology.

HANDEL: All of this has highlighted the fact that broadband is a public health need now. We have to get broadband into our most rural communities, which is spotty at best.

MODERATOR: Kathy, are there some areas in which technology didn't serve you as well as you had hoped?

LEBREW: It is important to be able to tie together not only the patient but the care team and other stakeholders in the care continuum. We have various steering committees, through which we engage our department chairs as well as our primary care network. One of the issues that was raised early on, was some dissatisfaction with the telehealth technology. Soon after, we quickly assembled a team that created an RFP to identify long-term solutions for integrating to our EHRs via multichannels.

We are working on identifying a leading practice solution that understands not only the current requirements, but also recognizes that payer requirements are changing, and has the capability to understand what those requirements are before we engage in telehealth visits.

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— Jim Scheulen—

STARKE: We had an interesting experience at the beginning of the pandemic in Saint Louis that spoke volumes about how we could learn from the crisis as well as organize more effectively to use digital solutions. This resulted in different thinking as well as the elimination of many silos that existed prior. Mercy Hospital St. Louis admitted the first COVID-19 patient in the city. At that time, our governor urged citizens to call health care provider hospitals to be tested, but we didn't have sufficient testing supplies. We were inundated with calls requesting tests on a Friday night. By Sunday, we had put together a team to handle those phone calls. Within two weeks, we had set up testing centers, created a digital portal to triage callers and make assessments. The coordination of our communications, virtual capabilities and technology [Epic] platform created a solution that allowed us to continue to operate without the chaos we were all feeling.

MODERATOR: Who wants to weigh in on some of the organizational barriers to implementing some of these solutions?

HANDEL: I think it's just making sure we get reimbursed for it. That's really the big thing. It's all good in theory until it becomes a free service. We've hit the tipping point where everyone realizes this has to be a core service provided.

MODERATOR: What about some of the integration issues? Some of you have solutions that require a lot of integration and different departments to cooperate. Is that still a barrier? Do you say, 'We addressed that during COVID-19, so can we now take that level of organizational functioning to the next challenge?'

STARKE: We've been more intentional in trying to integrate our virtual care center into our care processes, such as the hospitalist or critical care units, and not just to provide assistance or monitor from a distance. In our facilities in Northwest Arkansas, the critical care unit only had two doctors and they were overwhelmed. The virtual care center then managed a percentage of the patients virtually while the critical care doctors on the ground evaluated new COVID-19 patients. It demonstrated that we could integrate and care for our patients virtually and adds to the standardization of the care as we go forward.

We are focusing on further integration of virtual on the inpatient side of our care model. We are continuing to drive ongoing patient care via virtual visits in the ambulatory space. Usage of virtual in the ambulatory space did fall back somewhat during the summer only to reemerge with many of our clinics at 20 to 25% usage.

LAUGHERY: With any complex organization, breaking down the silos and getting everyone to behave in the same manner for a consistent experience is always a challenge. While COVID-19 made people step up, it's easy for someone to go back to their old ways of doing things. I think it's just a constant reminder that we're a system and the experience needs to be the same.

"The impact to patients' experience and the benefits we have seen from a national perspective is that it makes the patient feel safe to engage and receive care."

— Barbara Kragor —

MODERATOR: Do we have any indication of how this is impacting the patient experience? And have we seen any real benefits for the patients?

SCHEULEN: Our patient experience numbers, especially with relation to the virtual visits, have skyrocketed. Patients just love the virtual visits. In some ways, everything is going to come back to the bottom line. But if we can make virtual visits work going forward, I think we'd like to continue.

KRAGOR: The impact to patients' experience and the benefits we have seen from a national perspective is that it makes the patient feel safe to engage and receive care. ●

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