EXECUTIVE INSIGHTS

RESILIENCY + RECOVERY

NAVIGATING SHIFTS BETWEEN IN-PERSON AND VIRTUAL CARE

Using digital engagement to improve patient communication and safety

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NAVIGATING SHIFTS BETWEEN IN-PERSON AND VIRTUAL CARE:

Managing communications, navigation and patient flows in the pandemic era

As hospitals and health systems reset for the next normal of care, organizations are adopting mobile platforms that help patients feel safe and provide frictionless access to in-person, virtual and at-home patient visits. At the beginning of the COVID-19 pandemic, hospitals experienced a spike in demand for telehealth, and providers quickly scaled to meet patient needs. Now organizations must also manage suppressed volumes and utilization, while understanding how spikes in telehealth utilization affect referral patterns, new patient diagnoses and delayed treatment starts. Providers are becoming digitally adept at using mobile solutions that serve as a direct conduit to patients and provide them with immediate access to health care services.

KEY FINDINGS

1. Virtual care can reduce friction and provide care to patients with limited access. Digital health is here to stay, but the percentage of care that will continue via digital platforms may depend on patient demographics and provider care specialty.

2. Patient satisfaction and outcomes with virtual behavioral health services have been positive. Behavioral health providers also report satisfaction in providing these services virtually.

3. Access to technology and technology proficiency can be obstacles for seniors and low-income patients. Understanding how to meet patients "where they are" is key to improving access to telehealth.

4. In teenage diabetic patients, virtual care options increased the number of times providers saw the patients annually from an average of one visit per year to three. Best practice is four visits per year.

5. Digital tools are part of engagement strategies in patient and public outreach for COVID-19 vaccinations.

6. Limited reimbursement and state-level restrictions for telehealth and other digital health services beyond the public health emergency are significant barriers to greater provider adoption and investment. For rural communities, the main barrier is access to reliable broadband.

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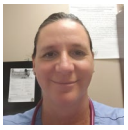

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MODERATOR *(Lindsey Dunn Burgstahler, (American Hospital Association):* **At this point in the pandemic, what is your current experience with coordinating and integrating in-person and virtual care, and what are your thoughts about how it might change in the future?**

ERIC WAGNER *(MedStar Health):* MedStar has offered urgent care e-visits for five or six years. Pre-pandemic, the peak number of patients per day was in the 20-25 range; it just hadn't scaled. When our governor said, 'We're discontinuing electives in physician offices,' e-visits spiked. In fact, we made the tactical decision to take down the paywall for MedStar eVisit, because it was a valuable tool to help keep people out of our urgent care centers and emergency departments (EDs). Previously, we had been charging $50 dollars per e-visit. At its peak during the pandemic, we hit 550 visits in one day.

We scaled clinical manpower way up to support MedStar eVisit and we trained more than 75 physicians to use the e-visit platform. Since these physicians' offices had been closed to comply with the governor's emergency orders, we could redeploy our workforce. That proved to be a useful tool to get patients to the right place for care. We were able to handle their needs using the e-visit platform and tell patients, 'We'll deal with this over the phone and determine whether (1) you don't need any next step, (2) you may need to go to an urgent care center and get tested, or (3) you may be sick enough that you need to head to the ED.'

Within a week, we set up another video visit platform that employed physicians could use for scheduled e-visits. At our peak, we were doing 5,000 visits a day across the enterprise. Those visits, unlike the urgent care e-visit platform, required you to make an appointment with the office. Patients using the platform go through a check-in process, and just before the appointment, we send a text message to click on a link and connect to your physician.

We've continued to refine and add capabilities and make it easier to use, but even in its first week, it was getting strong reviews, 4.8, 4.9 or 5.0 out of 5.0 from patients. Practitioners also gave it high marks. Even today, almost a year after we reopened and began doing electives, usage has been relatively stable now over the last few months. We're starting to think that it may be part of our new normal.

> **"I would say that virtual visits are going to stay in the 40% to 50% range on behavioral health, probably 15% to 20% on primary care and lower for other specialties."**
>
> — Eric Wagner —

MODERATOR: **A recent Modern Healthcare survey of CEOs found that they expect anywhere from 11% to a quarter of ambulatory visits to remain virtual going forward. I thought that was an interesting data point. How many visits do you think will stay virtual and what will that volume be?**

WAGNER: I think that it's going to be specialty-dependent. I would say that virtual visits are going to stay in the 40% to 50% range on behavioral health, probably 15% to 20% on primary care and lower for other specialties. Our behavioral health providers think it's more effective than in-person visits for many patients because of better patient compliance and lower no-show rates.

JOSHUA TITUS *(Gozio Health):* At Gozio Health, we work with many clients, so we get a broad view of what folks are doing, which was a trickle of virtual visits prior to the pandemic. Then there was just a fundamental shift. For instance, in Tennessee, one of our health systems was not reimbursed for virtual visits, and virtual visits were at 20 a month. When they were reimbursed for virtual visits, they went up to 25% of all their ambulatory visits.

It's a sea change, and we're not going back to

pre-pandemic levels. Ambulatory visits are now back down to 20%, and other specialties are going to be 5% or 10%. Depending on the specialty, having a virtual offering as one of the available modes of care makes sense.

MODERATOR: Great point on the reimbursement. Gozio works with systems across the country, so we appreciate your insights.

DAVID HOFMEISTER *(Kearny County Hospital):* In the frontier of Kansas, it's more difficult when you don't have much bandwidth and you're trying to do virtual visits. When COVID-19 hit and we had to shut down elective procedures, we built a platform on our website called Kearny Connect to enable patients to set up appointments quickly and easily. Few people used that platform to make an appointment. Most called registration to schedule a visit with a provider. Our providers' ages range from about 31 to 41 years of age, and they are adept with technology. They used the technology that they already had — a tablet, laptop or smartphone to connect with patients who wanted a virtual visit. We put a lot of effort into doing all the televisits.

Since then and considering that we never had a second wave, there's a lot of interest in coming back in for care. Five percent of our daily visits are virtual, and most are in person. Reimbursement is the issue. We have a rural health clinic associated with our hospital and without better reimbursement, there's not a lot of incentive for providers to make a tradeoff that would impact their overall productivity.

STEVEN BARKLEY, M.D. *(Cottage Children's Medical Center):* Like everybody, we found ourselves hurled into the virtual space. We rapidly went from an almost nonexistent virtual experience to being nearly completely virtual. There are certain patients for whom it just didn't work. We have settled down to a mix of about 60% virtual for the pandemic, and now we're at 20% to 25% virtual.

We run a multispecialty clinic in pediatrics that had no virtual access before the pandemic, but there was clearly a need. It can be challenging to get adolescents with diabetes to come to the office, but they are happy to talk to you all day long from their iPhones. According to the guidelines, best practice for these children is four visits a year. We were seeing them once a year, and now we're seeing them three times a year. There's a whole group of children we can serve whom we didn't fully appreciate.

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We're learning to cluster virtual visits together. Our docs have been trying to fit in-person visits with virtual visits in a given day, but the scheduling demands are really difficult.

MODERATOR: That's a great example of how digital sometimes increases friction, but here it reduced it, making it easier to see those patients.

ALICIA RIDLEN, R.N. *(Chase County Clinic):* In southwestern Nebraska, we are using Zoom, iPhones, iPads, whatever we can get our hands on. We don't have a lot of response, maybe one to two a month. The pandemic didn't affect us much that way. We would swab patients in the morning in the parking lot. If they were negative, they could come into the clinic. Everybody saw the patients while wearing full personal protective equipment. There's a mistrust culture. If I'm not sitting in the room with my physician, it's not an office visit. We're really having a hard time getting our older clients, 65-, 75- and 85-year-olds, to buy into virtual care. We are also limited on technology, equipment, funding, and the reimbursement rate is horrible. There's not much incentive to do it.

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MODERATOR: As we think about these patient journeys, the patient demographics, their communities, as well as some of the specialties, it seems to make more sense for behavioral health. On the broadband access issues, the AHA is advocating for it as part of the infrastructure bills. We also think of it as a social determinant of health; as care increasingly relies on digital technologies, broadband will be an important piece.

MARY MOSCATO *(Hebrew SeniorLife Health Care Services and Hebrew Rehabilitation Center):* My organization is a comprehensive senior care organization. We have all levels of inpatient care, including long-term care and subacute rehab, but also a large scope of home- and community-based services. Our geriatricians provide primary care community services. Research has shown that only one in three seniors had the capacity for technology. How do you reach seniors who are in congregate housing to ensure that they're getting their preventive and primary care?

We tried many routes. We purchased iPads and left them at the congregate housing sites so that the housing staff walked door-to-door with the computers. Here it's not a broadband issue; it's a technology knowledge challenge to reach seniors. On the inpatient care side, we were able to get specialty care and reach families of isolated seniors through technology. For the 1,500 seniors in primary care plus, we came up with protocols and did assessments for memory, occupational therapy and home safety. I was proud of our team's innovative thinking in how to reach these seniors.

TITUS: I'll share data that we have on our mobile platform and mobile usage. With age, we see a bit of a fall-off in terms of aptitude and the desire to learn a mobile platform. What's interesting is that as you lose mobility, aptitude goes back up. It becomes the way you stay in touch with family, with the grandkids. I think by meeting people where they are, they can learn to use Zoom and FaceTime as long as they are accessible and straightforward.

MOSCATO: I love your statement, Joshua, of meeting seniors where they are. If we can stress that a little more, I think our reach will be great.

JOEL HENDRYX, D.O. *(University Medical Center of El Paso):* At one point, we were probably above 50% online by telephone, iPad or whatever we could use to contact our patients. Now we're probably down to 20% or 25%. I have not seen any analysis as to who is using it, but my impression is that it's either mature individuals or young people who don't want to come in and because it's convenient. In the future, they may not have to come in for many things. For our mature patients, sometimes they just need a prescription refill or they are touching base. There are people who continue to need in-person visits periodically. I will be interested if we can analyze our data to see what population groups are benefiting from this. I like to see my patients, and there's a lot to be said for in-person visits. Having said that, this is the new paradigm for a new population group.

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>
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BARKLEY: We're largely referral-based. We don't do any primary care, and we had a low rate of referral. When COVID-19 restrictions relaxed and pediatricians began seeing patients again, our pediatric cardiology program became swamped. There is a hazard in thinking that virtual and in-person visits are fully interchangeable. You need to use discretion in deciding who needs what type of visit.

MARTY FATTIG *(Nemaha County Hospital):* In southeastern Nebraska, a rural county, we have a problem with broadband as well. Has anybody done research

on whether the health of the community or patient population is increasing or decreasing with virtual visits? Or, is that yet to be determined?

WAGNER: The compounding factor is that we had people who weren't getting any care for a time because they hadn't figured out the video visits or they didn't have the technology. We found that when in-person care resumed in June 2020, the case mix in our hospitals went up. Interestingly, our quality scores didn't take a deep dive. I think that's because of the use of the video visits and an intensive outreach effort.

RIDLEN: We're seeing more seniors come to us with complex issues now. They had wound concerns because they were isolated so long and didn't get checked. We're seeing some deterioration that we hadn't seen before.

MODERATOR: Let's shift to COVID-19 vaccinations and using digital for some populations to engage patients and deal with vaccine hesitancy. Are there any tactics that have proven successful in your organizations?

WAGNER: On the Medicaid health plan, we have an intensive effort that is based on texting. Not everybody has a smartphone, but most people have a cellphone. In addition, we are using our outreach staff to make outbound calls to those living in high-risk areas, or where we know there's a vaccination clinic scheduled, such as at a church. Uptake on it has been somewhat disappointing. In one recent example, we had 200 slots available at a vaccination event and, after a week of calling, we only filled 20 of those slots.

On the medical group side of our organization, we've used outbound call generation and automated outbound call generation.

FATTIG: In rural Nebraska, when we were giving the vaccine to those 75 and older, we had a land-rush business. The phones rang off the wall, and things were going well. We experienced the same thing with people 65 and older. When we offered the vaccine to all age groups, we could not find enough recipients. It's really discouraging in the rural areas; less than half of the population is now vaccinated with at least one shot. That's a huge issue.

TITUS: During the pandemic, our clients needed a more aggressive form of communication. We re-enabled this push notification feature — a specific, targeted message to consumers for a predefined set of boundaries, such as a ZIP code — and one of our clients ran with it. Based on the level of vaccination by ZIP code, they would send notifications of available vaccination slots to the under-vaccinated ZIP codes. They were able to level up and distribute vaccines equitably across their entire catchment area. On the mobile platform, 33,000 users a day and 700,000 users a month were reacting and responding to these notifications. They attribute that approach to not wasting a single vial.

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BARKLEY: In our group, which is children with special health care needs and medical complexity, we have made a big direct push that has been mostly digital. We made some phone calls and it's been reasonably embraced. The families of these children are anxious to do whatever they can to mitigate their risk.

Our community developed a comprehensive method of messaging for children. We have print ads and public service announcements on both radio and television. Public health, hospitals, private pediatricians and schools worked to unify that message and then push it out into the community.

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Gozio Health offers an end-to-end, customizable mobile platform exclusively for hospitals and health systems that helps anticipate consumers' needs, engage them in their care and strengthen their overall care experience. The extensible solution provides a hand-holding experience at each stage of the patient journey — from the home to the parking lot to the point of care — and allows hospitals to push out important consumer notifications, further strengthening provider-patient relationships. Popular patient engagement features include patented wayfinding with turn-by-turn navigation, virtual visits, physician directories, appointment scheduling, access to electronic health records, urgent care and emergency department wait times, online bill pay and extensive analytic capabilities.

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