Using Telehealth to Expand Healthcare Access for Older Adults

KEY TAKEAWAYS

- The Geisinger at Home program was designed to increase access to care, reduce the need for unnecessary emergency room and hospital utilization, and enable healthier living for those with chronic and acute medical conditions.

- Telehealth services delivered using a physician extender care model helped the program extend physician reach to double the number of homebound patients per day in a largely rural area.

- Through increased reliance on telehealth and recruiting community health assistants (CHAs), the program has resulted in reduced utilization rates, high patient satisfaction, and cost of care savings for the Geisinger Health Plan.

THE CHALLENGE

Geisinger is located in central and northeastern Pennsylvania, which presents socioeconomic and geographic challenges to providing accessible, coordinated, and equitable medical care—especially to older adults. In addition to being largely rural, 18% of Geisinger Clinic's service area is 65 years old or older, which is 4% higher than the percentage of older adults within the U.S. population. The average household income is $60,378 and 13.1% of the population has a household income of less than $15,000. Furthermore, the area is

mountainous with few interstates resulting in long, potentially risky, commutes to and from clinic appointments.

Due to these factors, among others, a significant percentage of patients in the service area face barriers in accessing transportation and internet connection, and thus, in-person and virtual medical care. In fact, their service area is a designated Medically Underserved Area, according to the U.S. Department of Health and Human Services' Health Resources and Services Administration criteria. To alleviate these challenges and provide

convenient care for their Medicare population, Geisinger Clinic developed a home-based primary care program called Geisinger at Home (GAH). GAH uses telehealth services to augment its capacity to deliver care and treat a greater number of patients.

THE GOAL

The primary aim of GAH is to increase access to care and enable healthier lives for those with chronic and complex medical conditions. The program prioritizes ensuring homebound older adults can receive safe, appropriate care in the home to reduce the need for unnecessary trips to the emergency room and the burden of traveling to in-person clinic visits. The primary goal of integrating telehealth services was to connect more patients to providers by using virtual visits to extend physician reach.

IMPLEMENTATION

GAH began in Spring 2018 with a partnership between Geisinger Health Plan, the Chief Nursing Officer, the Office of Population Health Initiatives, and the Center for Telehealth. It was designed to provide whole-person care to address social and behavioral health needs in addition to medical ones. An interdisciplinary team is deployed to meet all patient needs before exacerbation occurs and during acute events.

The program began operations using a direct-to-patient care model, utilizing only physicians to monitor patients and conduct home visits. However, this approach quickly became very costly and time-consuming, which stifled growth. Seeking a more cost-efficient strategy to reach more patients, the team switched to deploying community health assistants (CHA) and nurses to conduct in-home visits. These mobile team members completed initial assessments and then connected the patient to a remotely located provider via a video visit. This reduced the travel demands on clinicians and

expanded clinician capacity allowing them to see double the patients per day. Pivoting to a physician extender model allowed the GAH program to expand their mobile field team and patient census without reducing quality of care.

Having diverse skill sets and a team-based approach contributes to the success of the GAH program. Vital staffing roles include:

- **Mobile Teams:** The mobile team includes CHAs, nurses, physicians, specialists, and other healthcare professionals. These team members are at the forefront of in-home clinical care for patients in this program.
- **Specialists and Clinicians:** These professionals are crucial to assist with care planning and treatment for patients with complex health conditions such as cancer, kidney disease, dementia, etc.
- **The Triage Team:** These individuals have been integral in coordinating and scheduling care for patients and their care teams.
- **The Telehealth Team:** This group provides essential recommendations for the technology used, ensures the technology and devices are easy to use, oversees the telehealth platform and the scheduling/billing workflows, and is responsible for training.

Patients are identified for enrollment by GAH staff or referred by their primary care physicians. New patients start with an in-home assessment to obtain vitals, establish a baseline, and identify additional clinical services or home modifications necessary to support the older adult. The mobile team uses Bluetooth-enabled instruments — blood pressure cuff, pulse oximeter, stethoscope, scales, etc. — to record the baseline data, and are equipped with a MiFi device (portable Wi-Fi) in cases where there are connectivity issues. The mobile team then collaborates with the patient and the remote clinician to create a care plan. Other clinical services that

are offered through GAH are acute care, wound care, regular in-home testing, and post discharge telehealth visits. GAH healthcare and mobile teams are provided with specialized training to support areas of need and care for patients. One example of this is a training program for staff that uses interactive sessions with trained actors and case studies to support learnings about end-of-life care. This specialized knowledge is crucial because the program seeks to address end-of-life needs and decisions in a culturally sensitive and appropriate way. Additional training topics include how to operate technology and equipment, as well as conduct and document social determinants of health and falls risk assessments.

Additionally, patient satisfaction is crucial for the success of the program. To measure patient satisfaction, the team developed a survey that is administered through the telehealth platform immediately after each visit. Patients are asked about their overall telehealth visit, as well as their experiences with the technology.

METRICS

GAH operates in over 15 counties and actively manages 2,200 patients with an average age of 75 years. The average annual cost to care for GAH patients is $30,000, with some patients having costs of more than $100,000 per year.

Tracked key performance metrics are numbers of telehealth visits, emergency room and hospitalization data, annual total cost of care, and patient satisfaction. Tracking emergency visits and hospital utilization is a way to assess if appropriate services are deployed at the right time and adequately address needs.

Providers complete an average of 330 telehealth visits per month, representing 46% of all GAH visits. The other 54% are in-person visits with a nurse or CHA.

The program has seen a 30% reduction in emergency department utilization and hospital admissions with the inclusion of telehealth visits.

Nearly 3,000 patients completed the satisfaction survey between 2019 - 2022:

- Ninety-eight percent of patients reported they were satisfied or very satisfied with their ability to understand medical recommendations made through telehealth visits.
- Ninety-two percent of patients reported they had improved confidence in the provider due to the ability to have a telehealth visit.
- The audio and video portions of the telehealth visits received high praise, with 97% of patients stating they were very satisfied or satisfied with the audio sound, and 98% were very satisfied or satisfied with the visual images.
- Ninety-seven percent of patients said they were satisfied or very satisfied with the overall experience with the telehealth visit.

Additionally, the team has found that telehealth visits create time for more thorough and comprehensive visits because it eliminates provider commute time. . These successes have only further encouraged the program team to continue increasing outreach as an additional 10,000 patients in the Geisinger service area have been identified as potentially benefiting from these home-based primary care and telehealth services.

HURDLES

The GAH team overcame a few valuable hurdles in their efforts to scale the program. One notable hurdle was the increase in call volume from patients that outpaced the small mobile team. Patients would call for a variety of reasons that spanned from low to high acuity and urgent to non-urgent needs. However, the mobile team were challenged to address calls as well as manage their patient visits and documentation. As a result, there were often delays in response and scheduling appointments.

To overcome this, the GAH team set up triage staff to answer calls so the mobile team could focus on patient visits. Triage staff could address low acuity needs like medication and supply orders and coordinate visits and coordinate visits and tests. The triage staff manages more than 1,200 patient calls per week and are integral in supporting communication between specialists and primary care providers.

Another hurdle encountered by GAH involved ensuring the CHAs had the proper training to conduct medical assessments. The team initially presumed CHA's adept in certain clinical skills to perform assessments. However, they discovered in some cases, CHAs did not possess adequate clinical knowledge, for instance, how to properly use a stethoscope. Clinicians would attempt to train in real time over video or the phone. However, this proved difficult and training protocols needed to be improved. The GAH staff pivoted to integrate clinical training of CHAs into the workflow. This involved having dedicated training sessions with a nurse educator. Including training in the workflow gave confidence that all staff were working with the same base of knowledge.

CONSIDERATIONS

Many lessons were learned developing and operating this program.

The first lesson is to start small; leverage existing infrastructures and seek support and buy-in from the right collaborators, including payers. Geisinger Clinic leveraged Geisinger's existing telehealth infrastructure and relationship with their health plan to develop the physician extender model. Providers participating in GAH had previous training and familiarity with the telehealth workflow. They started small so that the initial start to the program was manageable and then found ways to scale.

The second lesson is that consideration should be given to the amount and type of equipment needed to support clinical services offered through telehealth. To do this, the

GAH team evaluated connectivity in their service area to identify barriers and possible solutions. The team focused on using equipment that was easy to use for both the mobile team, the patient, and provider to minimize time spent training them in new technology. The mobile team was provided with portable Wi-Fi devices. In doing so, GAH could coordinate specialized treatment to patients in their home, as well as expand telehealth services.

The third lesson was that developing a workflow plan with the healthcare team that incorporated the [Principles and Guidelines for Telehealth and Aging](#) — developed by [The Center of Excellence for Telehealth and Aging](#) (CE4TA) — was integral to long-term success. The GAH team makes continuous improvements in the way patients are triaged, visits are coordinated, equipment is used, and ensuring workflows are equitable, patient-centered, and integrated. Ongoing collaboration between staff and patients is necessary to continue to identify and overcome challenges to workflows as the program expands.

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About The Center of Excellence for Telehealth and Aging

West Health Institute (WHI), the University of Virginia (UVA) Department of Geriatrics, and the Mid-Atlantic Telehealth Resource Center (MATRC), partnered to create the Center of Excellence for Telehealth and Aging (CE4TA). CE4TA was established to advance the adoption of age-inclusive telehealth. It is a unique platform to foster a national discussion and movement to advance age-inclusive telehealth for older adults.

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