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GET Access: A Student-led Initiative to Increase Geriatric Patients’ Utilization of Video Telehealth Technology During the COVID-19 Pandemic

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Ethical approval: The institutional review board of the University of Michigan Medical School reviewed the evaluation of our program and determined that it did not constitute human subjects research as it was a Quality Assurance/Quality Improvement (QA/QI) initiative limited to improving healthcare quality and delivery, and collecting, measuring, and/or reporting patient or provider data was used for clinical, practical, training, or administrative purposes (UM-HUM00182975).


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To the Editor: “Wait, so we just… go home?” I asked my fellow clinical students in the neurology team room. The COVID-19 pandemic brought the world, our education, and our connection to patient care to a halt. Like many of my classmates, I felt powerless, wanting to do something to help.

Ambulatory patient care abruptly transitioned to telehealth. Geriatric patients, who often have greater health care needs, are also at increased risk of COVID-19 morbidity and mortality. Video visits provide better interpersonal connection and higher patient satisfaction than phone visits. In the University of Michigan Geriatric Psychiatry and Medicine Clinics, staff schedulers attempted to provide education and support for video visits. However, the vast majority of visits defaulted to the telephone due to lack of patient access to and comfort with technology.

My mentor and I created GET Access: Geriatric Education on Telehealth, a volunteer initiative to help geriatric patients learn the skills for video telemedicine.1 We created a procedures manual, including an algorithm, to determine the best platform for each patient based on their individual resources to avoid overwhelming them with unnecessary options. In 2 weeks, we had recruited and trained eager medical students and launched the program. Volunteers called patients prior to their scheduled phone visit. Together, patient and volunteer practiced a virtual visit and debriefed after the health care encounter.

Over 12 weeks, 26 volunteers assigned to individual providers' schedules made 219 total calls, converting 88.75% of scheduled phone visits to video. Participating providers had a video visit rate of 43% compared to 19.2% prior to participation. The keys to success were tailored delivery of training, patience, and sufficient time to practice outside the health care encounter.
The GET Access Program is expanding to other clinics within the health system. As the availability and understanding of telehealth benefits grow, more programs like GET Access will be necessary to confront the inequity surrounding technology. While there are many health disparities to address, older adults can benefit from deliberate, targeted programs. With dissemination of our work, we aspire to continue advocating for standardization of these services within every clinic at Michigan Medicine and share our experiences with other systems.

Reference