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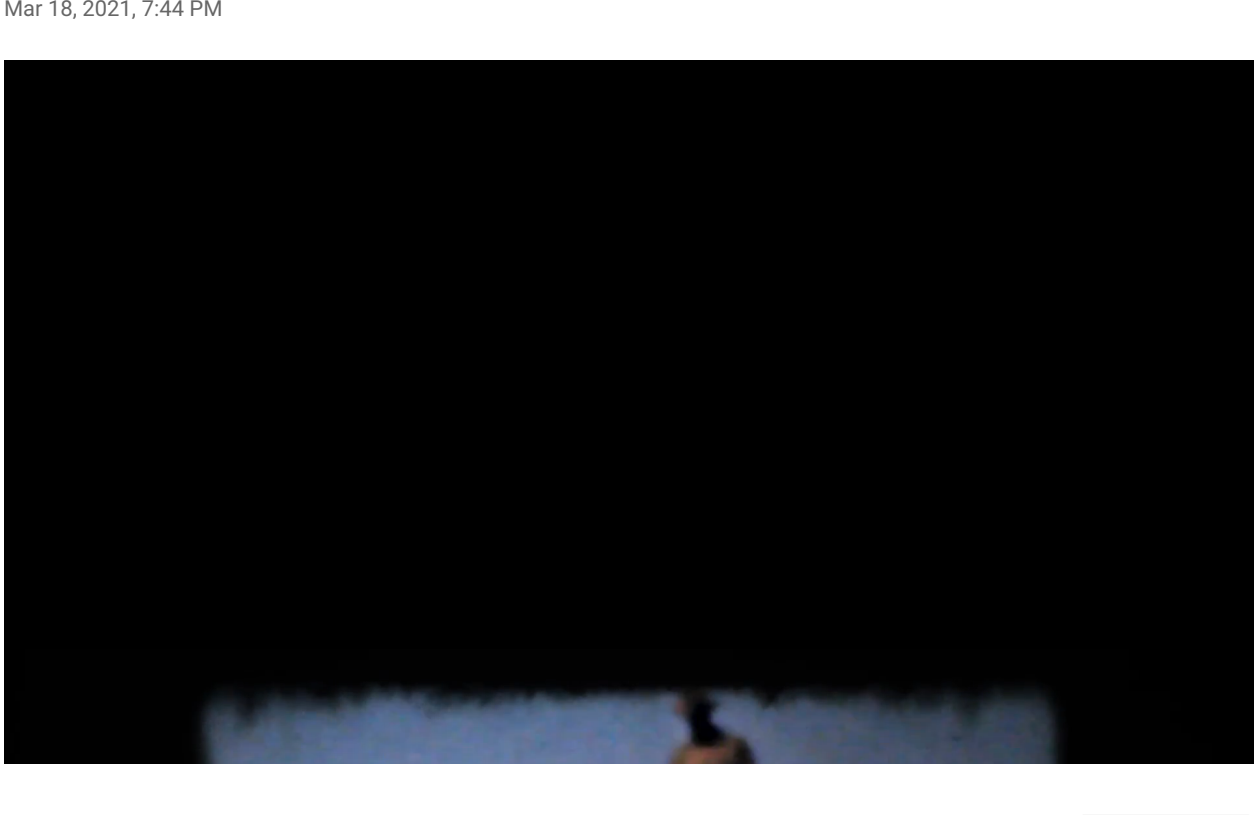
Long-Term Changes To Health Care After Year Of COVID-19

Mar 18, 2021, 7:44 PM



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SALT LAKE CITY, Utah – After every natural disaster, pandemic, or other traumatic event, there are ripples felt for generations. Families of 2.6 million people around the world are dealing with loss due to COVID-19 and countless more who have been impacted financially, mentally or physically.

What changes will we see 5, 10, 20 years down the road that we'll trace back to the year 2020 and COVID? One year in, we're looking at changes to healthcare that will likely stick around as we head into what many call our new normal. KSL+ spoke with Dr. Russell Vinik, the Chief Medical Operations Officer for University of Utah Healthcare and Dr. Patrick Carroll, Intermountain's St. George Regional Hospital Medical Director. Here are a few changes they hope or expect are here to stay.

Matt Rascon: Welcome to KSL+, the digital only newscast where we dive deep into the bigest issues of the day.

After every natural disaster, pandemic, or other traumatic event, there are ripples felt for generations. The Black Plague led to the rise of worker's rights. The Spanish Flu was a catalyst behind modern architecture–apartments with radiators to keep a unit warm even if the windows are open to allow fresh air in andunits with private bathrooms–not shared, and wide communal hallways. The Spanish Flu put many European countries on the path to centralized medicine. World War II inspired our own employer-based insurance. Young adults graduating college this year won't remember ever going to the gate to pick someone up at the airport–most were infants on 9/11.

And of course we can't forget what's happening now. The families of 2 point 6 million people around the world who lost their lives to COVID. And countless more who have been impacted financially, mentally or physically.

But what changes will we see 5, 10, 20 years down the road that we'll trace back to the year 2020 and COVID? One year in, we're looking at changes to healthcare that will likely stick around as we head into what many call our new normal.

We spoke with Dr. Russell Vinik, the Chief Medical Operations Officer for university of Utah Healthcare — and Dr. Patrick Carroll, Intermountain's St. George Regional Hospital Medical Director.

Here are a few changes they hope or expect are here to stay.

Editor's note: Interviews lightly edited for readability and clarity.

Dr. Patrick Carroll: I think we all have been a little bit more cognizant of our activities and our interactions with each other and the impact that potentially could have on spread of disease. As we move forward, I hope those are lessons, we don't forget. We have seen a dramatic decrease in influenza this year, we have seen a dramatic decrease in respiratory syncytial virus or RSV among children. Our pediatric volumes inpatient volumes have dramatically decreased. The volumes of patients here in St. George, with our pediatric unit are considerably lower than previous winters. And that's a that's a great thing. So how do we take the lessons and move forward?

I'd like to see us in a situation where we get the best of both worlds, where we get back to not needing to wear masks, and I do believe we're getting there. However, when I'm sick, when my family members sick when my neighbor is sick, It's alright to wear a mask. In fact, it's encouraged to wear a mask to prevent spread of respiratory viruses. And if we can do that, we may be able to have the majority of people not wearing masks as a minority. There are countries in the world that have been doing this for a very long time. And doing it successfully. I hope we've taken some of the stigma away from wearing masks, when you're feeling a little bit under the weather and preventing spread of that to other people.

Matt Rascon: This year, the U.S. saw one pediatric flu death, where we usually see around 200. Experts say that shows handwashing, staying home when you're sick, and wearing masks really can help in the future. They mentioned advancements in medical research and the way doctors and scientists share their findings and the way we consume that information.

Dr. Russell Vinik: mRNA vaccines and adenovirus vector vaccines have been around for decades or more but they haven't really hit primetime. Now, they've proven very well, and in part because of the significant time and effort and money that's gone into the COVID research. They've been able to prove both of these as reliable ways to create vaccines. And so the potentials are so broad, not just in treating other diseases, or infections or viruses. But also cancers. For example, there's quite a few different cancer vaccine trials that are underway, where you can literally cause one's own immune system to attack cancer cells better. And that gets a bit complicated, but having proven this technology is going to go a long way to expedite treatment for many different diseases. Cancer probably being highest on the list.

Dr. Carroll: What we saw was a scientific community worldwide, that really came together and in rapid fashion, came up with answers to a lot of those questions. And we continue to hone those answers and learn more. But one of the big takeaways that I've seen is the public I think, has been able to see medicine and science in action. And that's been, I think, at times frustrating for people, because that's led to changing recommendations from one week to the next or one month to the next. I think that was confusing for people early on. But it's important for people to see that happening. Because that's how science works. And that's how we that's how we learn and make some pretty quick changes. So you know, one of the takeaways I like to see is that we the general public have a better understanding of medical developments, scientific progress, and see how we can make changes on the fly for better care and better prevention.

I'm going to expand that question a little bit beyond just science and beyond medicine. And it's something that I think we as a society are going to have to grapple with. We're in a wonderful age of information where we have so much information at our fingertips, and some of that information is accurate. There are experts in in every field. I take my car to a mechanic that has been doing it for many, many years. They're the expert. Can I learn how to change my oil? Can I learn how to do a few things on my car? Certainly. Am I am I going to be at the same level as that mechanic? I'm not without hours and hours and hours. And truly, probably years of years of experience. I think we're all guilty of this, I'm certainly guilty of this–reading information in a particular area, and feeling like we're an expert. Feeling like we have as much information as much as the other person who has truly dedicated their life to that specialty or to that area. And so as we do that, as we move forward, I think what we need to do is identify ways that the experts can be identified as experts. And, and those that are not experts, certainly, can and should have a voice. But identify themselves as an interested party, not necessarily as an expert. So it's a big opportunity. And I think that's why we've seen more and more doctors on social media, whether that's Facebook, or YouTube or Instagram or whatever–being more vocal historically. That didn't happen as often historically. Physicians really communicate through academic medical journals and academic scientific conferences, where there was discussion. And then we meet with patients or meet with public. I think it's incumbent upon us as medical experts to be more available to be more vocal, to share that information. So there's not a vacuum of accurate and reliable information from reliable sources. So we as a profession, I think, have to take that on and make sure that we're being appropriately transparent and visible with the with information.

Matt Rascon: And of course–healthcare providers mental health is at the forefront of their minds.

Dr. Vinik: Most of us physicians, we can handle anything for a week or two or a few weeks. We trained on and worked 100 hour weeks routinely. And some of us still do. But to do that for months and months on end, the mental toll that takes on our staff is something that we really have to think through for the future. How do you prepare for that?

Matt Rascon: We had an in-depth conversation about that a few weeks ago–you can find that episode on KSLTV.com/KSLPlus and on the KSLTV app.

But there was one big change both doctor's brought up:

Dr. Vinik: Telehealth

Dr. Carroll: Telemedicine

Our KSL+ producer Shelby sat down with Kerry Palakanis, the Intermountain Connect Care Executive Director to see how telehealth is growing and what it could mean for many marginalized communities.

Shelby Hintze: Let's just start kind of broadly–how much was telehealth and Connect Care being used pre-pandemic, and how has that grown in the last year?

Kerry Palakanis: The growth is very hard to measure. It's the numbers are so large, it's crazy when you talk about it, but I'll give you an example of where we were with just video visits at Intermountain.

Prior to the pandemic, we were struggling to do about 10 video visits–basically a provider calling their patient in their home environment or in a non-clinical setting. We were doing about 10 a week. And then in the height of the pandemic, we were up to about 6,000-7,000 per week. So we rapidly scaled from that 10 to 7,000. We had a just shy of about 100 providers in their system that were trained and doing telehealth before the pandemic. Now almost the entirety of our 2,500 plus providers have access to telemedicine now and telehealth. And so we went from not even hitting the mark of a percentage of visits provider visits that occur being telehealth to where now we average around 15% of all of our visits with patients occur through a telehealth environment and during the very height of the pandemic that was up to close to 50%.

Shelby Hintze: Wow, that is like I knew it was going to be a drastic increase. But that's like, beyond drastic.

Kerry Palakanis: I've been working in telehealth for 15 years. And so I described this to somebody yesterday, I spent the better part of my career in telehealth explaining to people what telehealth was. And it hit me last weekend when the Golden Globes did a joke telehealth visit with the stars and their doctors. I no longer have to explain to people what telehealth is, it's now the norm. And I would have never thought that would happen in the speed that it happened. I definitely knew the capabilities because that was my area of expertise. But you know, it's just been delightful for those of us in telehealth to finally say, "See, I told you, that's what's going to happen. And this is going to work." So yeah, it's been fun.

Shelby Hintze: Yeah, I loved that. That was probably my favorite part. It was very representative of the communal experience right now. We all get it.

Kerry Palakanis: Well, and for me, I flashback to 10 years ago where I stood in front of the Baltimore Society of medicine and tried to explain what telemedicine was to them. And, you know, you would have thought I was describing unicorns. And would I have said, "Oh, yeah, 10 years from now on the Golden Globes, there's going to be this joke skit about telehealth." Now I no longer have to explain it to the patients. Now I just have to help providers learn how to utilize the system appropriately and effectively.

Shelby Hintze: And that goes into my next question. I think we've talked a lot about how helpful it is to patients. And how has it been for providers? I know, I had a telehealth appointment a few months ago and my provider was doing it from her home, too. We were both in our bedrooms talking to each other. And so how has that changed?

Kerry Palakanis: I come from a data perspective because I was doing it–I'm a nurse practitioner–I was doing a hybrid environment for many years when I was building telehealth. But really, there's a lot of uniqueness to being able to see a patient in an environment different from a clinic. If somebody is in their home setting I could ask you right now, "Can you take me to your medicine cabinet? And you could show me what's actually in your medicine cabinet?" instead of trying to remember what's in it. We could talk about what over-the-counter medicines you're taking as well as prescription medicines. I could ask you to take me to your bathroom to look for fall risks. And so I get a window into the true environment around you when I do telehealth, especially when you're in your home environment. Even if you're not in your home, you know, asking questions about "Okay, you know, so where are you today? And why are you there?" Is it a situation of homelessness, a safety issue, there's just so many different aspects involved with what we can do with telehealth.

But I think the most important part is we get to see the patient where they are when they need to be seen, versus the patient having to meet our needs and our environment. From a provider standpoint, I think it's an incredibly great quality of life. Some people do telehealth from their office environment. But you know, if you can do it from home even better, I have about 30 Connect care, urgent care providers that work 100% from home and we cover 24 hours a day, seven days a week, and these folks are actually in multiple states around us. They're not even necessarily in Salt Lake. And so we're looking more and more now at workforce development with telehealth, how could we provide jobs to people in rural and remote areas where jobs don't exist, but use them as telehealth opportunities? So I think more and more, you're going to see that everybody from the doctor down looking at how can we utilize telehealth effectively to reach people in areas that otherwise would be difficult to reach. And in environments that are different, like schools, community centers, things that are you know, employer based clinics that we can now man through telehealth and provide coverage?

Shelby Hintze: Yeah, I think I just keep thinking about all the implications and like, for me, I use a wheelchair. So transportation can be a little difficult for me–not impossible by any means. But if I can do an appointment via telehealth first, and then make a plan with my doctor from there. Do I need to come in? Do I not? Can this wait?

Kerry Palakanis: The physiologic effects of just being frustrated and trying to get to an appointment, even for somebody not in a wheelchair– just taking time off of work, getting in your car driving there, waiting in a waiting room with other sick people, the exposure to other illnesses, there are so many positives to it. And I think that's one of the best things that came out of the pandemic was the fact that we were finally able to put telehealth in a variety of different environments into a variety of different patient populations. And I see more and more the patient asking providers–I did that not too long ago, myself, when I went to see one of my providers. I said, "Are you doing video visits?" And they said, "Oh, not really, I'm thinking about it." I go, "Oh, you're breaking my heart, because it's my job. But aside from that, you know, let me tell you why you should do this." And it's just from the patient aspect, from the provider aspect. When you talk about people who need to have other caregivers involved in their care, being able to have a video visit where you can. If you're an adult caring for your parent, and you're at work, but you want to participate in my visit. Or if you're a child and one of the parents is at work and can't get off, but could video into the visit. There's so many opportunities available there.

Shelby Hintze: And what about rural areas?

Kerry Palakanis: We're doing quite a bit of work in getting telehealth access out into central and southern Utah. And yes, if you think about somebody in Blanding, who needs to see a specialist at Primary Children's or Intermountain, the amount of time the cost, the frustration of having to travel into Salt Lake and back, especially this time of the year when you don't know if the roads are even going to be open. Rural is where I came from and the opportunities for access to care and opening up alternative accesses to care. Folks in rural environments, they just accept that they can't see us specialists, that there isn't a specialist in their town. And so sometimes they'll even not receive care because it's just too difficult to make those arrangements to get in or they can't afford to get there. So what telehealth does is it allows anybody regardless of where they live to receive the same level of care as somebody who's living in an urban environment.

Shelby Hintze: Right. And have you seen within Utah, any challenges with people having access to internet, high speed internet in rural areas, and then also just among our people experiencing homelessness and things like that? And what are some of the hurdles that you are you're facing in expanding access?

Kerry Palakanis: It's definitely the country at large, when you get outside of urban areas that internet access and bright broadband access is a problem. Now the government has some programs to help address that. And they have been putting quite a bit of money into increasing broadband access in rural areas. But the good thing is that almost every rural environment I've ever worked in–and I've worked with quite a few–there's a library or school that has broadband. And so it's one of the reasons why I get excited when I talk about school-based telehealth. You can turn a school into a Community Health Center by using telehealth. But more and more of the technology is also moving towards cellular based technology. And cellular access is much more achievable than broadband access is at large. When we first started in telehealth, it was almost a requirement that you had broadband or internet because that bandwidth needed to be big enough. Now the technology has improved to where a patient can have a smartphone or a tablet, device that is cellular enabled, and we are able to do the exact same thing.

Shelby Hintze: I just think of my friend whose grandparents live on the Navajo reservation, and they just got water to their house seven years ago. We forget about differences in access depending on where you live.

How beneficial is a video visit versus over the phone? Where does a phone call work? And when does it need to be video?

Kerry Palakanis: Again, I'm somewhat biased here. So I will tell you that whenever I have the option for video, I take the video with the audio. But you know, you mentioned your friend on the Navajo Nation. I worked in rural Maryland and I had patients who didn't have cell access at their home. The landline was all they had, and they didn't have internet. So I take what I could get in that instance. But what video does to the audio is it enhances that. So if you're on the phone with somebody and they say "I'm fine," you go, okay, they say they're fine. Whereas if I look at you and go, "I'm fine." You know, you get to see that the nonverbal the facial expressions. And it just, it's like the difference between taking a photograph, or seeing a movie or you get that three dimensional approach to making that evaluation. And much of what we do in healthcare, it does come from our history taking and asking questions. So it's not that you can't use audio, but you're the ability to be able to see somebody's body movements in relation to what they're saying and their facial movements. And like I said, also that whole external background, and you're looking at I mean, mine's not very interesting today, because I just painted in my office. But you know, looking at what's in somebody's environment around them that you can't see on an audio, you wouldn't have the access to get an audio visit.

Shelby Hintze: Yes, I'm in my high school bedroom, because I had to move back in with my parents during COVID.

Kerry Palakanis: I love to see this. These are the things that when I do a video visit, I love hearing. Because it's so interesting, especially when you have an established relationship with a patient where you see them regularly on video, where you go, "Hey, you look like you're someplace different today. Where are you/" and what's going on, and you get to hear the background stories and children are a blast to do video visits with because they just say anything.

Shelby Hintze: They want to show you their new toy. Whereas, a kid in a doctor's office, maybe super nervous and just clam right up. Whereas if they're at home, talking to somebody like they talk to Grandma, this is normal.

Kerry Palakanis: Exactly. I mean, now for them FaceTime is normal. So I sometimes find that I have to get the parents comfortable with the platform, but the kids are great. They have smart boards in school, they learn off of an interactive technology in the school environment. And like I said, there's so much fun to do video as it's worth because they will. They'll talk about anything in your environment as well as their day. You know, it is just it's an incredibly interesting and useful technology. And what we can do to offer access to care to folks is what's most important about telehealth.

Shelby Hintze: I don't know if this is an issue. This is just something that I experienced. I called to do a telehealth appointment a few months ago and when I called, they said, "Oh, well, what's your insurance? Not all insurances are covering video visits." Is that an issue now that is starting to be resolved or is that still an issue that people need to think about?

Kerry Palakanis: It is improving with time. This is another thing that we can thank the pandemic for because prior to the pandemic, insurance companies were very restrictive about where you could receive telehealth. And home wasn't considered a valid place to receive telehealth. You had to go to a clinic-like environment. It was still somewhat helpful if you could go to a community health clinic and then have a telehealth visit with a specialist somewhere far away. But with the pandemic the government issued a bunch of COVID waivers that allowed us to expand telehealth access. And many of the insurance companies have followed suit with that during the pandemic. What will happen after 2021 is still a great debate. But I think there's enough movement, not just among health insurance and health care companies and providers. But among patients asking for continued access to care that we should see a continuation of that. And more and more there is adoption at the state federal level for including telehealth as a method of delivery for health care.

Shelby Hintze: Yeah, my I know, mine personally has been like great and they've added the 98.6 app, to our coverage–which I've used an embarrassing number of times in the middle of the night when I wake up and I'm like, something doesn't feel right. I'm just going to check and see if I need to go get help and they're always like, you're fine. Okay, okay, that was good.

Kerry Palakanis: That's a great utilization of it, because otherwise you would have gone to an urgent care, an emergency room, you had a very large bill as would your insurance company. So you're reducing the cost of health care by using those types of apps. And we see that and we track that with our Connected Care system as well. So many of the insurance companies have bought telehealth practices, like, MD Live, 98.6 or, or have partnered with them because they recognize the value of it.

Thanks for joining us on KSL+ this week. Join us next week on the KSL-tv app, website, or Facebook page as we look at changes to businesses–from childcare to working from home.

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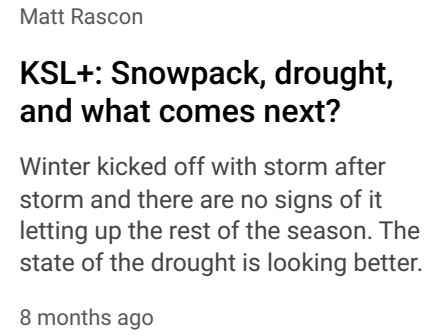

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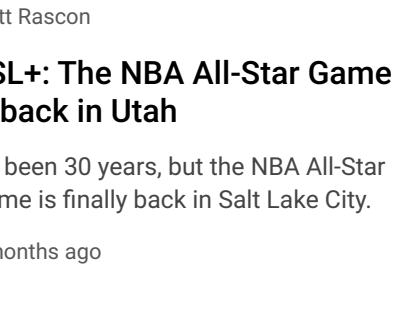

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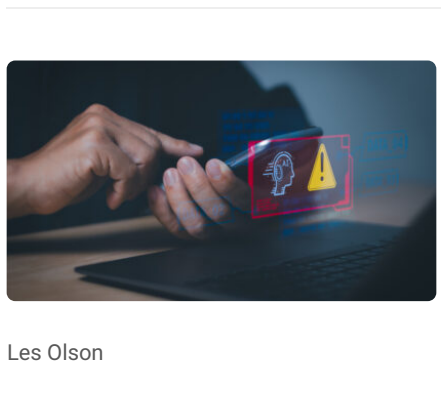

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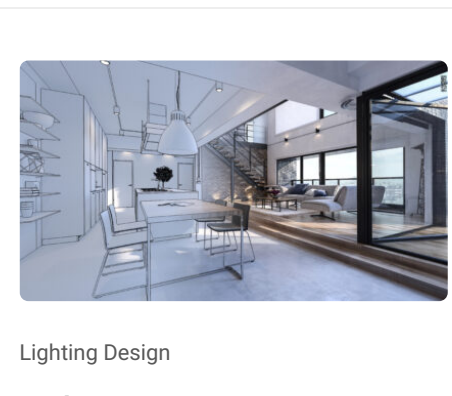

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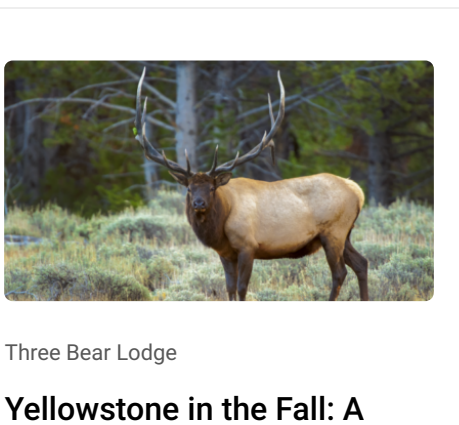

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