

clinical provider contacting them via phone-call. Two 30-day pilots were conducted, which collectively enrolled 33 patients who were prescribed PAP for the first time.

Results: Most patients were White, Non-Hispanic (54.8%, n=17), males (64.5%, n=20), with a mean age of 52 years. Two patients did not receive a PAP machine by the end of the pilot. PennPALS engaged patients via text message 115 times. Of the 31 patients who started PAP, 7 (22.6%) were adherent from the start of enrollment and only received positive enforcement text messaging. Across the 24 (77.4%) patients that experienced issues, there were 58 text message conversations, which resulted in 32 clinical escalations. Twenty-one (67.7%) patients triggered text messaging interventions for using PAP for < 4 hours/night on average over a 7-day period or experiencing a large mask leak, n=10 (32.3%) and n=11 (35.5%) respectively. At 30-days, 17 (70.8%) of the 24 patients were adherent (i.e. using their PAP at least 4 hours/night on average over the last 7-days). Patient feedback was generally favorable with a Net promoter score (likelihood to recommend) of 68.4 (n=19).

Conclusion: PennPALS effectively identified/intervened with patients at risk of non-adherence to PAP therapy, and the bidirectional text messaging system helped patients become adherent in the first 30 days of treatment. Further testing and longer-term monitoring is needed to examine the effectiveness of PennPALS on long-term PAP adherence.

Support (If Any):

0362

THE COST OF IN-PERSON VERSUS TELEHEALTH PAP INITIATION FOR PATIENTS WITH SLEEP APNEA

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Introduction: Telehealth has been widely integrated into healthcare systems during the COVID-19 pandemic and is likely to remain a part of routine clinical care. At the VA Greater Los Angeles Healthcare System (VAGLAHS), positive airway pressure (PAP) set-up visits transitioned from in person to telehealth for newly diagnosed sleep apnea patients during the pandemic. The telehealth pathway included mailing of PAP machines to patients with follow-up video/phone education by respiratory therapists (RTs). As part of a larger study examining the clinical outcomes resulting from telehealth versus in-person PAP initiation, we performed a cost analysis of these two treatment pathways within VAGLAHS.

Methods: We examined the total variable direct cost of telehealth versus in-person PAP initiation for patients newly diagnosed with sleep apnea at VAGLAHS between March and October 2021 (n = 2,662 PAP set-ups) using a bottom-up analysis. There was an average of 16 PAP set-ups per day with 11 set-ups (68.7%) via telehealth and 5 set-ups (31.3%) in person.

Results: The total variable direct cost of telehealth PAP initiation was \$98.87 per patient. The total variable direct cost of in-person PAP initiation was \$50.58 per patient. For telehealth, there was an additional cost of mailing the PAP machine and 31.2% more RT time spent on educating patients compared to the in-person pathway. After the initial PAP set-up visit, a larger subset of patients required additional troubleshooting help from RTs about proper PAP use after telehealth compared to in-person set-ups (5% versus 1%).

Conclusion: The telehealth PAP initiation pathway was nearly two times the cost of in-person PAP initiation. This resulted from the additional

cost of mailing the PAP machine, more RT time spent on education, and a greater need for troubleshooting after the visit. Telehealth visits may need to be supplemented by written educational materials or web-based resources to reduce the need for additional support after the initial visit.

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0363

PERCEPTIONS OF THE NEED FOR PERIOPERATIVE OSA EDUCATION: AN INTERDISCIPLINARY AND MULTI-INSTITUTIONAL SURVEY

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Introduction: Advanced Practice Providers (APPs; Advanced practice registered nurses, physician assistants) and physicians-in-training (residents, fellows) receive inadequate education on obstructive sleep apnea (OSA)/perioperative OSA risks. However, they are front-line providers assessing these patients. Failure to mitigate this risk has led to significant postoperative morbidity/mortality. We assessed these providers' perceptions to OSA/perioperative OSA training.

Methods: Surveys were sent to three provider roles, APPs, residents, and fellows, in four categories of practice at nine academic institutions between May 9-June 30, 2021. Chi-square and Fisher's exact tests assessed association between survey responses and participant characteristics. False discovery rate adjustment accounted for multiple comparisons, threshold of q<0.05 for statistical significance. Cochran-Mantel-Haenszel tests evaluated associations stratified by institution.

Results: 2236 of 6724 (33.3%) participants responded: 48.4% APPs, 11% Fellows and 40.6% Residents. Primary category of practice included: 20.3% Anesthesiology, 8.9% Family Medicine, 34.1%, Internal Medicine (IM)/IM subspecialties, 6.7% Obstetrics/Gynecology/Gynecologic Oncology, 25.9% Surgery/Surgery subspecialties, 4.1% Other. While 93.2% of respondents believed OSA is a risk factor for perioperative complications, fewer respondents reported that they felt adequately trained to assess for OSA (50.9%) in general, with significant differences noted by provider role (range 42-70%, q=0.001) and across the categories of practice (range 12-82%, q=0.001). Even fewer felt adequately trained