*Dr. Lyon meets with a community health partner at MCG's Center for Digital Health. Source: Michael Holahan/Augusta University*

Return to the Newsletter

# Keeping Patients with Confidence: Using Telehealth to Treat Patients in Rural Georgia

June 2026

Healthcare disaster preparedness is challenging in any setting, as natural and human-caused incidents can occur with little to no warning. In healthcare facilities located in rural areas, a surplus of bed capacity is often accompanied by limited complex care capabilities, limited on-site specialists available to support primary care physicians, and challenges associated with geographic isolation (e.g., lack of transport resources needed to move patients to facilities with specialty care). ASPR TRACIE met with Matthew Lyon, MD, the Associate Dean and Experiential Learning Director at the MCG Center for Ultrasound Education, and Director, Center for Digital Health, at the Medical College of Georgia at Augusta University to learn more about the development and expansion of the Digital Care Network, which began in 2019 and now connects about a third of rural hospitals in Georgia, enabling more patients to remain at their local hospitals and reducing unnecessary transfers.

## John Hick, MD (ASPR TRACIE Senior Editor, JH)

**Dr. Lyon, tell us about yourself and how the Digital Care Network came about.**

## Matt Lyon, MD (ML)

I am an emergency medicine provider by training, and I work at Augusta College of Georgia (GA), but our clinical platform is provided through Wellstar Health System, which acquired our academic health system and contributed to the development of our Digital Care Network, which I oversee. Nearly one third of the rural hospitals in GA are part of the network.

The Digital Care Network started in 2019 to support rural hospitals across the state, then expanded during the pandemic. Over the past several years, we have seen steady growth in the use of telehealth which, in turn, has contributed to a decrease in patient transfers. For example, before we launched the program, approximately 90% of

As of January 2026, Georgia is home to the following healthcare facilities:

- 31 critical access hospitals
- 1 rural emergency hospital
- 96 rural health clinics
- 199 federally qualified health center cites in rural areas
- 46 short-term/prospective payment system hospitals in rural areas

Source: Rural Health Information Hub

*Dr. Matt Lyon. Source: MCG Center for Digital Health, Augusta University*

patients would have been transferred out of rural hospitals; we have brought that down to 27%, resulting in more patients receiving care locally and reducing unnecessary use of limited transportation resources.

**JH**

**When a provider at a smaller, rural hospital has a case, what is the process for accessing the network, and who are they connected with?**

**ML**

We have digital health physicians dedicated to the program 24/7, and they all have backgrounds in emergency medicine. Some also have experience in critical care and other fellowships and skills. Any time a patient in one of the system's rural hospitals' emergency departments (ED) or on the floor needs specialist help, they are placed in our system and immediately seen by one of those digital health physicians who can tap into specialists as needed.

**JH**

**What are some of the benefits of providing virtual care in these facilities? How many patients are now able to remain at their hospital of origin compared to before implementing the program?**

**ML**

Being able to treat more complex cases under this model has allowed us to decrease transfers over time. We have been working with some hospitals since 2019, and some are just onboarding. The rate of transfers has consistently decreased for those hospitals that have been part of the system for some time. In 2025 we provided 311 Tele-ER/Critical Care consultations.

From a disaster perspective, having this virtual option is vital, as it can be rapidly and efficiently used to facilitate triage and help decrease the unnecessary utilization of transportation and other scarce resources in more rural counties.

**We are moving away from transferring patients with uncertainty and towards keeping them with confidence.**

**JH**

**Keeping patients closer to their families while also generating revenue for the smaller hospitals is important.**

**ML**

That is the key-those hospitals can take that increased revenue and reinvest it into staff and equipment, enabling them to accept more patients. It is a win-win.

**JH**

**During the COVID-19 pandemic, how did you balance and prioritize transporting patients who needed to be moved with those who could receive virtual care, knowing you had a limited number of beds in the area?**

**ML**

Seeing patients face-to-face during the pandemic helped us determine their needs and which critical resources to use. Oftentimes, we found that we could triage a patient and keep them in rural GA because while we might not have had a bed at the receiving hospital at that moment, we could keep patients in the rural hospital and virtually co-manage them. Rural hospitals were more likely to hold patients for several hours, knowing they can connect with specialists and are not providing care alone. That is still important today, as we remain faced with overcrowding, boarding, and similar challenges.

Over the last couple of years, we have been using asynchronous or e-consults, which allows rural patients access to sub-specialists who may not be credentialed by that rural hospital. Chosen specialists would review the provider's note and offer feedback or clinical guidance. However, the specialist would not directly see or treat the patient, so they typically would not need to be credentialed at that specific hospital. The exact parameters can vary depending on individual hospital bylaws and policies.

### Related Resources

MCG Center for Digital Health

Small and Rural Hospitals Receive Lifeline From Digital Care Network

ASPR TRACIE's Virtual Medical Care Topic Collection

We know that using these tactics and practicing these strategies today will make our response easier and more efficient in a disaster scenario.

## JH

**How is the program funded?**

## ML

We contract with individual hospitals, and while there was a slight drop after the pandemic, we are making progress with the independent rural hospitals throughout GA. The federal government's Rural Health Transformation Program funds provide an opportunity to each state to support multiple aspects of rural hospital patient care.

## JH

**What kind of platform do you use, and how have you overcome technological challenges?**

## ML

We originally started on the lowest resource IT resource solution we could, because there was no related proprietary issue. We have since switched to using Webex directly. We are in the process of moving to a more proprietary solution that will increase interoperability.

Accessing real-time data on specific patients and data system interoperability are our primary challenges. Some electronic health records (EHR) are very good at sharing patient data. There are multiple Health Information Exchanges (HIEs) operating in Georgia. While some data sharing occurs after discharge or in batch updates, many HIEs are capable of near real-time or real-time data exchange depending on the participating systems and integrations. The main EHRs in rural GA, however, are not well connected to the HIEs.

We face simultaneous challenges with real-time capacity data. We know there are open beds in rural GA, but we don't always know their capabilities or where they are located. We are currently working on addressing both challenges.

## JH

**When we look at strain conditions in healthcare and maximizing capabilities—where you could transfer patients to or keep patients in rural hospitals with increased patient care capabilities—overcoming these challenges would be good for patients and would generate revenue for these facilities. How are you working to address this in the future?**

## ML

We are currently conducting a needs assessment trying to understand the current state of the art. For example, some of the rural EHR systems do not have Fast Healthcare Interoperability Resources (or FHIR) capabilities, but many in the field assume the systems are interoperable. There are some solutions that can overlay and pull data, but being able to access real-time data remains a complicated process for us. This needs assessment process will help us determine not only the number of beds, but the nature of those beds (e.g., ICU beds, swing beds). Having this information will also be instrumental to an efficient disaster response.

The next phase of our work will focus on intra-rural transfers. Once our rural hospitals have these advanced virtual capabilities, it is important to maintain them. We will create a technical infrastructure that will match patients with the rural hospitals with the ability to treat their conditions. Patients in rural hospitals typically expect to be transferred to a city facility. Yet, many are willing (and probably prefer) to stay in the hospitals closer to home, as it keeps them near their loved ones and closer to swing beds and rehabilitation centers. As part of the next phase, we are working to boost their willingness to be transferred to another rural hospital in the network so they can more easily obtain additional services closer to their homes as needed.  We will accomplish this by fully explaining the process, answering any questions the patients have, and involving them in shared decision-making to ensure they feel informed and engaged throughout their care.

This is also a more efficient use of our ambulance resources, as these long-distance patient transfer trips take the emergency vehicles out of service in the counties they serve for hours at a time.

## JH

**What are some strategies you've used to increase your providers' comfort level with providing critical care?**

## ML

During the pandemic, for example, our staff became more comfortable using ventilators and intubating patients. But today, a patient is more likely to be transferred if they are intubated for a day or more because that comfort level has decreased. Once we realized this, we created a two-pronged approach to increase comfort among new staff and those who have not recently treated patients in this manner. First, we are providing very direct and frequent education on those topics. We have a monthly tele-education program to address gaps in knowledge. We also host hands-on conferences at least once a year, and in this case, the conference would be geared toward our respiratory therapists, nurses and clinicians to increase their comfort level with intubation and ventilation as treatment options.

The other strategy we are using is rooted in recruitment and retention. If applicants see our rural facilities receiving other rural transfers because they can provide that advanced patient care, they will note the investment we have made in staff to maintain their skills.

## JH

**How were you able to maintain the motivation after the pandemic so that hospitals in your network remained eager to provide specialty services such as dialysis?**

## ML

Prior to the pandemic, there was a strong sense of independence (paired with a competitive spirit) among the rural hospitals in GA. During the pandemic, many waivers were put in place that made this type of necessary collaboration easier. Now, the hospitals in our network are working together. If a patient needed dialysis, as you mentioned, our hospital staff felt that they would work to develop the ability to provide dialysis if the network continued referring patients to them for that service. Then another set of hospitals might specialize in providing thoracic surgery, or lung biopsies. As our hospitals differentiate themselves within the network, they would ideally continue transferring patients in a way that matches their treatment needs.

Having limited resources continues to be our main challenge. If you have an in-house surgery program but no cardiology program to provide a patient afterwards, it becomes tricky. Then you add the telehealth layer, and while it is helpful as far as matching treatment and conserving resources, we remind ourselves it is just a tool in our toolbox.

## JH

**Having rural hospitals focus on acquiring specialties and referring within the network is such an innovative approach that could be replicated across the country. What other unique characteristics or findings would you like to share with our stakeholders?**

## ML

We always return to the philosophy that if you use your systems every day and continually monitor for and incorporate improvements, should a disaster occur, staff are already familiar with their roles and comfortable shifting to that mode. We also continually emphasize the role telemedicine can play day-to-day and especially in emergency situations, when patient transport resources are scarce and prioritization is key.

## JH

**It sounds like this program can also help alleviate provider moral distress and aid in decision making when things are particularly overwhelming. Would you agree?**

## ML

Absolutely, and we really experienced these challenges during the pandemic in Georgia, when providers worked to determine who to transfer and how. That is still a very real challenge in rural GA, where resources are limited and would likely be strained by a mass casualty incident like a car accident with multiple patients. In these areas, providers are likely to know some patients and vice versa, and we can run the risk of being accused of "not trying everything" if we do not transfer patients. That said, we truly believe in keeping patients with confidence versus transferring them with uncertainty,

and we emphasize that to patients and their loved ones. It also keeps our providers from feeling solely responsible for the decision and outcome (which can be compounded if they actually know who they are treating), and it keeps patients closer to their loved ones and homes.

*Healthcare providers virtually consult with a patient. Source: Center for Digital Health, Augusta University*