PHI
POLICY AND REIMBURSEMENT CHANGES WITHIN
TELEHEALTH DURING COVID-10

JUNE 23, 2020

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MURLEAN: Welcome to telehealth policy and reimbursement changes in COVID-19. Perspectives from the United States and Scandinavia and France. This is the second in a series. My name is Murlean Tucker and I am running this Dialogue4Health web forum with my colleague Tonya. Thank you to our partners for today's event.

Audio options for this forum are located at the bottom of your screen. There you will find additional ways to connect. Real-time captioning is provided today by Jean of Home Team Captions. To access the captions click the multimedia viewer located under the circle with three dots at the bottom of your screen. On the right side of your screen located the link in the captioning panel that says show/hide header. If captioning disappears click multimedia viewer to bring it back.

We encourage you to participate in Q&A. We want to hear your thoughts and questions about today's presentation. We'll answer as many as we can. Open the QA panel -- black circle with three white dots. On the right side of your screen select all panelists from the drop-down menu so your question is directed to the right place. Now I would love to introduce to you the moderator of this event Dr. Heather Young. She is Professor and Dean America of the Betty Irene Moore School of Nursing at the University of California Davis. She is a nurse leader, educator, scientist and nationally recognized expert in gerontological nursing. Dr. Young I'm going to hand the microphone over to you.

HEATHER: Thank you. I like to welcome everyone to today's webinar Policy and Reimbursement Changes within Telehealth During COVID-19: Perspectives from the United States, Scandinavia, and France. I am thrilled we are getting perspectives from the United States Scandinavia and France. I want to also acknowledge our sponsors. [reading slide]. Thank you to all of our sponsors.

We have a terrific panel today. Our first speaker is Mei Kwong a nationally recognized expert on telehealth policy. She is the executive director of the Center for connected health working with national and regional partners on telehealth issues.

Providing policy technical assistance to state and federal lawmakers, industry members, providers consumers and others. We are looking forward to hearing your presentation on US telehealth policy in COVID-19.
MEI: Thank you Heather. As Heather said I am Mei Kwong. I like to start off with disclaimers. Any information provided today should not be considered legal advice. CCHP recommends you consult legal counsel for a formal legal opinion. And if I mentioned a company or product neither I nor CCHP has any financial arrangement with such company.

The Center for Connected Health Policy started off as a California organization established in 2009. We are program underneath the Public Health Institute. We became the federally designated national telehealth policy resource Center in 2012. We have been in that capacity ever since. We work to provide technical assistance and are a recognized source of nonpartisan unbiased information. We also work with other partners on more specific projects related to telehealth.

We track all of the state telehealth loss. Medicaid policies. Relations. We also track on the state and federal level. We keep this information updated. That is a picture of our website we have that information publicly accessible. Spring and fall update. Information is good through February 2020. We were in the midst of our spring update when COVID happened. We went forward with the established information because a lot of the policy changes in the United States have been temporary changes so far.

COVID-19 has dramatically changed the landscape for telehealth. That is probably what it has done for other countries but in the U.S. it was a very radical change. Like an actor who was not really recognized suddenly being cast as a star. Like Chris Evans to Captain America. That has happened with telehealth. It was really an area where not a lot of people were familiar with it. Talking to the average consumer or patient, they really did not understand what telehealth did. As an example I have been doing telehealth policy for one decade and I still had family and friends who before COVID-19 were confused what I did for a living. That has changed with the advent of COVID.

In US telehealth policy there were four areas of policy that were addressed during COVID. Reimbursement. Licensure and credentialing. Prescribing patient relationship. Policy and security. Those were the four main areas where we saw a lot of temporary policy changes. The big one being reimbursement. Most existing US telehealth policy was centered on reimbursement. Which can be broken down into four element. What where to how. What service is provided. Where the patient is located. Who is the provider. And what modality are they using?

Some of the U.S. policies -- you will see these four elements. Behavioral mental health services are covered if delivered via video if the patient is in a clinic and provided by psychiatrist. That is how a lot of the policy is structured in the United States. With COVID, those policies need to be addressed because they were acting as impediments. Especially location of the patient. A lot of existing reimbursement policies were limiting where the patient can be when they received services. Not widely available for a wide right of services and a library of programs. So they needed to relax these policies to allow people to be able to access services via telehealth in their locations. Typically the

home. I understand these slides will be available later. You can contact CCHP and we can send you a PowerPoint as well.

You also see areas where they created temporary waivers around licensing. Why the other elements. And also in prescribing -- relaxing some of those prescribing limitations on how you can use telehealth.

Where will we see telehealth in a post COVID-19 world? Right now a lot of these changes in the United States have been very temporary changes. On the federal level and state level they have an expiration date. Either a specific date or when the public health emergency is declared over. Right now nobody quite knows when that will happen. There have been extensions to a lot of the orders because they had a date for the end of April or the end of May. And they have been extended out. But they do have an expiration date. They will end at some point. We just don't know when.

Questions raised are what happens at that point? If we revert back to a pre-COVID-19 world then a lot of the investment, a lot of the familiarity using telehealth will go away. Patients will be told they cannot get that anymore. Providers who invested resources into standing up these services suddenly not able to utilize that. And policymakers recognize that potential problem of suddenly having that taken away from so many people. And they are looking at what they need to keep around. What they need to do alleviate or not have that sharp drop-off happen so quickly.

They are also grappling with the idea that public health threat will not be resolved immediately. You will still need people receiving services via telehealth. They were probably still be limitations on interaction. Staying at home for the most part. So you still have to figure out how are you going to be able to get them services with the threat still out there. And ensure they receive health services they need.

What I think will happen is that we will see some policy changes stay with us. The ones I would give the best odds of staying far the ones related to location. Allowing patient to receive services in a variety of places. Particularly the home. What services allowed to receive -- expanded greatly. I think some of those changes will stick around. And type of providers -- before COVID-19 usually a lot of the policies limited who could provide the services and get paid for it. They expanded that list. I think that will stick around. At least parts of that will stick around.

What is uncertain is during COVID-19 we saw an increase in use of audio only type of modality. Before COVID-19 was not really considered a part of telehealth. Allowing audio only to deliver during COVID-19 because policymakers recognized not everybody has access to telehealth. May not have connection or equipment at home such as smartphone or laptop. They aloud audio only. That is the bigger question -- how much of that will remain. COVID-19 also highlighted some of the issues BRC here. That still need to be addressed. Connectivity. Telehealth does not work unless you are able to connect. So policymakers will have to address that. And the digital divide. They aloud audio only phone because not everyone has access to technology to do telehealth visit. What you do with that population? How do you ensure they are still able to receive services? How do you ensure -- these are questions they will have to think about -- ensure nobody gets left behind if we use telehealth more? Those are questions in the

United States that policymakers are working on and struggling with and trying to answer right now as they consider what telehealth policies to keep. These are links to the CCHP website. Resources we have to US policy you might want to check out. And also email address -- I know the formatting was off on some of these lies. If you'd like a copy of the slides feel free to reach out to CCHP. And I will hand it back over to Heather.

HEATHER: Thank you Mei. I would like to introduce my esteemed colleague Dr. Birthe Dinesen. Professor and head of laboratory telehealth telerehabilitation and Department of health science and technology at Aalborg University in Denmark. In 2012 she initiated the transatlantic telehealth research network between Danish and American research institutes. That is where I had the privilege of meeting her first. Six years later Dr. Birthe Dinesen initiated telehealth network. She will present telehealth policy and telerehabilitation issues perspectives from Scandinavia.

BIRTHE: Thank you. I would like to go over the aim and methods on how I make this presentation and then a short note on the welfare state in Scandinavia and how COVID-19 has influenced the cases in Norway, Sweden and Denmark.

The aim is I would like to give perspective on telehealth policy and reimbursement issue in the era of COVID-19 from Scandinavia. On the map you can see Scandinavia is Norway, Sweden and Denmark. Denmark is the little one in the middle. We are not very big [laughing].

I have reviewed literature to see what has happened. Interviews with colleagues. Used files. But I also contacted WHO and EU response monitor. So you can go on this link and see what has happened in countries all over the world during this COVID-19. A very nice tool if you are interested.

Fax about Scandinavia. The three countries. In Norway there are five convoy millions. Sweden is double with 10.3 million. Denmark we have 5.8. What is common for all three countries are that we have a welfare state which means through taxes paid to the state and the state is running the healthcare system. Except for GP which are like private companies but they are also paid through taxes.

All three countries before COVID-19 started -- we had policies on ehealth well-established. We were very well off with ehealth solutions in Norway Sweden and then Mark.

When COVID-19 started suddenly it all accelerated. We were challenged that we did not have the reimbursement structure only for specific areas like COPD. It was a lot of challenge on our reimbursement structures in the three countries. What was in place before or was teleconsultations paid by the government. Three countries have had different strategies during the COVID-19 I think that influence is also registration and reversal.

Norway has had lockdown strategy. Sweden has had partly lockdown strategy -- I will come back to that. And Denmark at eight lockdown strategy.

In Norway all patients were asked if they had problems related to COVID-19 to stay at home. If they had more severe they could call their GP. This was for the GP -- they got to speed consultations up and running much more than before. So GP and patients

met virtually. The activity in Norway has gone from 3% to that 90% of their services. What happened at the time was that it was running well but the GP's are like private companies. So what happened was that suddenly the patient would not go to the GP because they were afraid of COVID-19. Suddenly they did not show up so the GP could get paid by video consultations but patients with chronic diseases that did not turn up at the GP. They were losing money. So the doctors were free but the patient did not come.

So health services are paid by the government. In that way the GP was very vulnerable in that case. In Norway they made a triage for COVID-19 patients who are very sick to go to hospitals. And they had telehealth solutions out there and they have made temporary reimbursement structures for handling this. But only for the next couple of months.

We will have to see. There is nothing that indicates if this will move on or stay only for a short time.

Sweden. Regions have different guidelines. They were partly lockdown. They said the regents were responsible for COVID-19. It made it a bit different. All the primary care sector -- public health -- had to make own different guidelines. For this case, it was made for recommendation instead of registration. So different regions of Sweden have had different ways of handling this. There has been some internal discussion in Sweden on if this was the way forward but there strategy was to protect seniors and vulnerable citizens and to slow down the spread of the virus. But doing it in different regions of Sweden. They have also had an increase in video solutions with GP's. But there is no data on how specific -- I have not been able to find -- on how they have changed for GP services and video. But we know how services are paid by the government.

But the big difference here has been it was not registration it was more based upon recommendations.

Denmark. We had national guidelines. Lockdown. Between patients and GP's was the hospitals were reorganizing. There was the app for GP and patient but it was not used very well. But within one week they integrate it video into it. At that time they were also negotiating a new agreement with GP's and public health care sector. They made the reimbursement structure at the same time. I think we were very lucky this was going on at the same time. Within 12 Sir2 weeks the video solutions were implemented in Denmark. They also had the reimbursement structure in place. I have managed to get some statistics on this. You can see from the beginning of March they had 69 video consultations and how it increased during April and May. In the next life I have it all divide it into weeks. How the increase the video consultation. I think we were lucky in Denmark that there were negotiations on payment with the GP's when this COVID-19 hit. Otherwise it might have maybe have taken a longer time.

I think the GP's have helped you with these statistics. I think it is going to be a service that would last. It will be much more used. But we have the same trend like in Norway. That national health authorities in Denmark at one time in the middle of the crisis were asking patients to go to the doctors because suddenly the GP's were lacking

patients. Not having money enough into their companies. So it was the opposite. Services are free but the patient did not go. It was a paradox. But I think we have found a way now where we have to be. So I would like to say thank you. I think this was a fast overview here from Scandinavia.
MURLEAN: Thank you so much Birthe. Is.
HEATHER: It is my honor to introduce you to Dr. Robin Ohannessian. He is cofounder and Director of Telemedicine 360. In addition he is an academic researcher on telemedicine apply to neurology and stroke at the University of [indiscernible]. And board member of the French Society of digital health. Dr. Robin Ohannessian published a call to action in response to COVID-19. He will presenting on telehealth policies in France before and after COVID-19.
ROBIN: Hello, everyone. This is Dr. Robin Ohannessian. Thank you for the invitation. I will present some information. The first figures to start with are the changes of the volume of teleconsultation before and after the confinement. France had a national lockdown strategy. Before confinement we had around 10,000 teleconsultation reimbursement per week by health insurance. And after confinement it went on to 80,000 500,000 of two 1 million per week for a population of around 65 million people.

Additionally, sorry for the little visual errors. At the peak of the activity 44% of GP had at least one teleconsultation in the week. 26% of total consultation at the peak were done remotely via video consultation. And 81% of the teleconsultations were done with known patient for publicly reimbursed teleconsultation.

How did all this happen? There were a few key elements to make this drastic change. First, telemedicine was integrated within the public health response at an early stage of the epidemic. Which helped to boost the activity. Second, we had regulation update on telehealth and telemedicine which I will show just after. We had as well telehealth clinical protocols and guidelines which have been developed by the Ministry of health in collaboration with scientific societies.

Additionally there was advocacy to public and professionals with a lot of communication caught media, professional information and webinars in the country. And lastly we had a strong public-private cooperation between the health authorities, hospitals, and private providers of solutions.

You will find here the list of all the changes that happened since March regarding telemedicine. As you can see there has been more than 10 changes. One element which is important to consider in comparison to Sweden or USA is that France is a national country. All healthcare legislation applies to the whole country at once. We do not have separate regulation.

In detail I will go through the ones in red. It started in March with teleconsultation and Tele expertise funded for COVID-19 patients suspected and confirmed.

Then on the 14th of March it was recommended by the government to have a teleconsultation first policy so the patient with -- strongly encouraged to do teleconsultation before going to see a doctor. Two days after that we had clinical guidelines on how to examine a patient with preliminary symptoms and risk factors. And on the 19th of March we had the funding for nurses to follow up patients by video or

phone. And other telecare activities for midwives to follow up with pregnant women. And for speech therapist. And we also had remote patient monitoring national protocol which has been extended in any regions. Still ongoing so far.

Then we had occupational therapists. Psychometricians. And on the 15th of May -- two months after the first policy -- teleconsultation was expanded for all patients until the end of emergency status. One week ago it was again extended until the end of the year. Until stated otherwise. So this is the change for France. But we had a strong foundation already. We had pre-existing regulations since 2009. And pre-existing funding policy. Public policy funding. Since 2018. For teleconsultation and Tele expertise. As well as some experimental funding for remote patient monitoring.

The change that happened in May is that now patients who did not see the doctor before can also be reimbursed for teleconsultation. We also had pre-existing activities and a diversified and mature solutions market with more than 50 providers.

Finally, from this statement and seeing the differences between countries and especially France and Italy we decided to publish this global call to action. To promote telehealth changes everywhere. With a dedicated framework -- I will not go through it now. Thank you for participating in this event. You have my email address if you'd like to contact me for further information. As well as our services there. And I will give the microphone back to the next speaker. Thank you.

HEATHER: Thank you very much, Robin. It is my pleasure to introduce our last speaker Florence Gaudry-Perkins. Head of Strategy and International Development for HRD. Developed next-generation telemedicine. CEO and founder of Digital Health Partnerships. A company focused on scaling digital health in developing and emerging countries. The organization advises governments, private sector, NGO, investors and international decisions as well as nurtures stakeholder partnerships. Florence.

FLORENCE: Hello, everyone. It is a pleasure to be with you today. Thank you to the organizers for the opportunity.

I'm going to attempt to give you a very quick glimpse of policy changes in some select countries around the world. This is in no way all-encompassing because a lot of information is not made available. Before we take a look -- I am having an issue with the slides. Here we go. Before we take a look at policy changes I thought it would be useful to show you the increase of adoption with telemedicine in a few countries. Mom say there was poor progress achieved in a month than in 10 years. You heard Mei talk about the change in reception -- I think this is true in many countries if not globally.

If you look at China's Ping An Good Doctor the numbers are fairly spectacular. In January they saw a rise of 900% compared to the month before and most of the people were actually new patients. To give you an example in the UK you can see that you consult went from 300 consults per month to 360,000. Multiples of over 1000 here.

In countries like Columbia and India we still see a rise. And in the graph below there was also a substantial rise in teleconsultation in Singapore Indonesia and Australia. Let's now look at some select changes in policy around the world. I will not go through each one of these countries for lack of time but I will focus on key messages.

In China although telemedicine was already active there were big moves on regulation and legislation. Telemedicine was not allowed prior to COVID for first-time diagnosis. And this was relaxed. Perhaps even more significant was the early March announcement that telemedicine and E prescriptions would be covered by China's health insurance. Huge move. Very important.

He would see that Australia expanded telehealth and provided extra incentives. The three countries you see above are considered to be early adopters in Asia. The other countries below made some moves but we're not quite as aggressive. Japan and Indonesia are considered to be more followers. And South Korea and Hong Kong have been categorized as poor conservative the doctors. Which is interesting because most of us know how advanced South Korea is on the digital print at large. And yet they do not seem to be quite as advanced on telemedicine.

I think it is important to note that the countries that were more mature in telemedicine are the ones who were able to scale fast and leverage telemedicine during COVID. The ones that had systems and existing policies already in place. This is true of digital health at large.

On the next slide I picked a few other countries where we saw news on telemedicine policy. Two are worth pointing out. India made spectacular progress. As we know there are more than a billion people living in India. The fact they made some changes is a big deal. Although they had no official policies on telemedicine prior to COVID. They not only issued a practice guideline for telemedicine and made it legal when they published it in the India Gazette. They went as far as allowing telemedicine to be reimbursed. This was set by the insurance regulatory industry in India.

Another example worth pointing out is South Africa which is a bit on the other extreme. They had existing telemedicine policy but it was quite restrictive. It was allowed only for under-resourced settings. And a patient had to be face to face with a health practitioner. And only under that condition another physician to connect and consult. This part was relaxed but they still required a patient to have an already established relationship. This is interesting because the medical associations lobbied and created a fuss around this. Against it. And the government finally relaxed this as well. But still indicating there is a preference for an established elation ship with a physician.

Just a few words of conclusion. In view of the spectacular progress of telemedicine across the world. Especially in some countries -- more mature once. And all the benefits even more visible today. Robin pointed out there are substantial differences between countries. The ones that are not quite as advanced would benefit tremendously from having more information from the ones who are more advanced and have taken many years to get to where they are. I listed on the right two WHO guidelines which address telemedicine to some extent. But I think it would be worthwhile at this stage to do a specific focus on telemedicine. Whether a toolkit or showcasing the best practices around the world. It would be very helpful I think to other countries. Thank you very much for your attention. My email information is on the slide.

And I have included an annex which I will not go through but he gives you an idea of maturity levels in different countries of the world. Thank you.
HEATHER: Thank you Florence for a very quick lesson. I appreciate all the presenters providing us with a very fast look across the globe. At a very complex and nuanced issue. And I appreciate your conversations very much. I would like to encourage everyone who is listening to share your questions with us in the chat. Please use the chat feature. To send your questions to us. We are very interested in hearing what is on your mind. Please feel free to respond to the panelists and ask important questions.

While they are waiting, I will post the first question to the panelists. I am interested in knowing what do you think will be the key to maintaining or expanding telehealth going forward? It sounds like a tremendous amount of growth has happened across the globe. And probably to write benefit for many people. What you see as the most important issue in maintaining this momentum? We will start with Mei.
MEI: For the United States it is definitely having those policies in place. As I said, the relaxations, expansion, in the United States were in reaction to COVID and they are temporary. So if telehealth is going to stick around and be used more widely we will need those policies to stay in place. At least some of them. I don't know if all of them will remain. I doubt all will remain. That were waived or relaxed during COVID. But we need some of them to keep the momentum going at least in the United States.
HEATHER: What will make that happen? How can we advance that?
MEI: Right now discussions are going on. There was a Senate hearing to look at federal policies. The thing with U.S. policies is you have multiple levels. Is very convocation in the United States. For the starting level you need federal policies changed. The only Congress to enact legislation to allow changes to happen. And a lot of those changes relate back to reimbursement. Providers will not provide the services unless they get paid for it. That will need to change on federal level and states will need to change their policies in order to keep that moment going.
HEATHER: Birthe what do you think?
BIRTHE: Three things. Reimbursement structure -- keep that in place so it is more broad. Hospitals and primary sector. And scalable solutions. That are stable. Easy to use. Also solutions -- we have national ID in Denmark. Maybe not all patients are able to use this. Can go to GP. I think it has to be easy solutions as well. And also keeping up motivation by healthcare professionals. You might think -- many will keep up with the new digital habits but there might be some who will go back to their old working pattern. So I think there needs to be somebody to keep up good digital habits that we have integrated today. I think there are three legs to walk on.
HEATHER: Thank you. Robin, what do you think about in France for sustaining the momentum?
ROBIN: We still have a lot of discussion ongoing. One of the two big moves have been funding for tele- care for nonmedical professionals. Nurses. Pharmacists. Others. As well to have funding for all patient irrespective of if they have seen their own Dr. before. These are the two main points of discussion that are now ongoing. There is a wide expectation by authorities that this should be continued. The details will be discussed

but the majority of healthcare associations, scientific societies, doctors union are supportive of this. So we have very good momentum. We have other challenges in France regarding health policy right now. Due to COVID-19. So we will see how it goes but it should be positive.
HEATHER: Thank you. And Florence, would you give us your perspective? I know you have many countries on your radar. Maybe you could summarize in general what will help this momentum to continue.
FLORENCE: There are so many countries yet and I had the opportunity to work with Africa quite a bit on national digital health strategies. We did a lot of lobbying on that as of about three years ago. Until a country defines a regular Tory framework and of course that comprises also reimbursement mechanisms, it is very difficult for innovators and telemedicine actors to come in and scale. So that is really essential. I think what will really make a difference is getting the word out from the countries who have been at this for years. The more advanced countries. And trying to share the best practices on how that was done. And what policies and what it involved. With countries who are less advanced. It would make a substantial difference I think. In the uptake globally on telemedicine.
HEATHER: Thank you. My next question is about research. I am seeing questions coming in on the chat that have to do with research around patient satisfaction and quality of care metrics. I will start with you Birthe. What you think are the important research questions for telehealth researchers right now? We have an incredible opportunity to provide evidence. Where would you suggest our colleagues and research consider pursuing questions?
BIRTHE: I think what is very important is -- good question -- how can we use this telehealth innovate situation like COVID-19 comes up again so we can make sure we do not get all the patients into the hospital. I think it is very important that the digital technologies our future patients are willing to use -- are they willing to use digital technologies even more than they have done today? I think that will be very important for the future.
HEATHER: And what about the issues around outcomes of this? What are your thoughts and research around outcomes, Birthe?
BIRTHE: I think on outcomes it is both quality of life but also access to the healthcare professionals. Both at the hospital but also the GP's. And security. The patients feel secure. If you are an old lady is important you feel secure with your doctor. Is also important you have access -- mobile phone or iPad you can connect. So I think outcomes are quality of life. Access to healthcare. Having the right technology but also reimbursement. What would be the economic outcomes -- consequences that we focus on. And design a healthcare system that easily can go into a situation like COVID-19 but with patients and healthcare professionals on the same level and feeling secure.
HEATHER: Thank you. Robin I would like you to answer the research question as well.
ROBIN: Yes. Various points we should focus on right now. For the next month or so. We should really document what happened in various countries by doing retrospective of research by describing volume of participation. Who participated. What was the

profile. For which reason. Very descriptive, basic research on what was the activity. That I think will help us a lot because in previous situation we did not have this research. That would be the 1stpoint.

2ndpoint would be I think I would say digital [indiscernible]. With the mass scale of telehealth we need to have a common ground of how to examine the patient remotely. What is the clinical exam remotely? How to do this. As a doctor I have been trained on books and patients on how to physically examine a patient but now I think for existing doctors and new doctors, they need to have in their manual both physical and digital exams. So this is one field of research I think we need to pursue. And the third point would be the public health population approach of the impact of telehealth. Not only teleconsultation but as well tell expertise and remote patient monitoring. And other subspecialties. To see the impact on access. As well as satisfaction. We should consider system as a satisfaction service for the population and not just access to a GP.

HEATHER: Thank you, Robin. My next question is for Mei and Florence. The question came in from an attendee -- for cross-section partnerships and collaboration what is your perspective on managing risk? The respondent said he knows some organizations are reluctant to partner due to lack of trust. Accountability of infrastructure. What has been your experience, Mei?

MEI: As far as -- I'm trying to understand the question.

HEATHER: Cross sector partnerships. How have you seen that when you are looking at an industry partner with governmental? Perhaps private provider -- how does that all come together from a policy perspective in managing the needs of all the parties?

MEI: That has been really one of the interesting things in working in telehealth. Prior to my telehealth career I worked in education. It was not as collaborative as I have seen in the healthcare industry. As far as working with the various partners of government and private and public partners. It has actually been a little bit more cohesive than what I have seen in some of the other industries I have worked in. I think probably because telehealth started off small. At least with what I have been involved in. I have been involved in California policy. In California we have a good cross sector of groups that try to work together in order to relate policy. So it would work with all groups. Where the element for telehealth in the United States as far as who you have working together collaboratively informing that policy -- where it has been missing, to an extent, where the representative that has not worked as much on it until maybe now. Has been the consumer groups. You have had people like health insurance companies. Government representation. And the industry. But before COVID it was a bit lacking from the consumer side of things. Working to help build those policies. That is starting to change. We do have some consumer groups taking a more active part in the telehealth policy and developing that. AARP represents seniors in the United states and have been very active over the last years. But for a lot of the policies before COVID-19 there is not a lot of consumer involvement. I think that is changing now because of COVID-19. And have greater consumer awareness. But for the most part in developing the policies before COVID you had various groups working to an extent in developing some of the policies.

HEATHER: Thank you. Florence do you have any thoughts on the question?
FLORENCE: Yes. Very good question. I have been in the field of digital for about 10 years. I always believed in partnerships. The biggest constraint I saw back in 2010 is that it involved work between the ICT sector and the health sector. And I joke they come from different worlds -- doctors and engineers. Things have improved quite a bit over 10 years but 10 years ago there was no juncture really between ICT and health. But has progressed considerably. I can give you an example -- diabetes program. In Senegal. We had to bring in software to distribute messages. Mobile operators. And for the health side talking about patient Association. Doctors insurance and Pharma. The biggest constraint over the years that I have found was breaking silo between Ministry of health and Ministry of ICT. For a true national digital health policy or strategy to be put in place there really needs to be coordination and a partnership between those two industries also. To give a silly example as you talk about data security that will be more ICT ministry of telecom subject. Whereas if you're talking about patient privacy it will be more help. Until those people come together and partner together to work on it it is very difficult. So partnerships are absolutely key in the success of all this. Across-the-board.
HEATHER: Thank you so much, Florence. I appreciate that. I want to thank all of you. I want to thank our presenters for your wonderful presentations today. So interesting. I want to thank our sponsors. And I want to thank all of you who have attended. All attendees will receive a survey and we welcome your feedback and ideas for future topics. This program including the presentations and transcript will be archived and available on the Dialogue4Health.org website in one week. We hope you will join us July 21st when we examine workforce issues in telehealth with strategies for preparing stuff and patients for all health.

I want to thank you all very much for joining us today. Goodbye.

[END OF SESSION]