Telehealth in the Workforce
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Remote CART Streamtext

[Captioner standing by]

Welcome to Telehealth in the Workforce, practical strategies to help prepare patients and providers during COVID-19 and Beyond. This is the third in a multi-part series on telehealth innovation in the era of COVID-19 lessons from the field. My name is Murlean Tucker and I am running this dialogue with my colleague Kasey Deems. Thank you to our partners for today's events, UC Davis Health, Transatlantic Telehealth Research Network, CITRIS and the Banatao Institute, the International Society for Telemedicine and eHealth and the Gary and Mary West foundation. Audio options are located at the bottom of your screen and it is there you will find additional ways to connect.

Now, I'd like to introduce to you Dr. Zia Agha the moderator of this event, he's the Chief Executive Officer and at West Health.

>> ZIA AGHA: Thank you. We are all living in strange times with the unprecedented explosion of COVID-19. We've seen a tremendous surge in telehealth services. If you look at the claims data from fair health over 4,000 percent increase from commercial and federal payers between march 2019 and March 2020. Today's forum is not only timely but it is informative for all of us to learn from the experts and their organizations about how they've managed this change and how they've leveraged telehealth to address the needs of the pandemic. I have the pleasure of introducing four expert panelists today. First, Dr. Peter Rasmussen the chief medical officer of neurosurgery at Cleveland Clinic. Peter oversaw the clinic's strategy of digital [inaudible]. Dr. Nancy Albert, the chief nursing officer at Cleveland Clinic, a clinical nurse specialist at the Cleveland Clinic center for heart failure and has extensive experience and expertise in heart failure research. She will talk about her program in heart failure and telehealth. We have Dr. Karen Abrashkin, the director of Northwell north -- 2,000 home bound seniors. The program is a flagship amongst peers and a leader in telehealth. Last but not least, David Darr the national director of sales and client relation for Avera eCARE serving patients in 19 states. David brings over 18 years experience in hospital and healthcare industry. Please welcome all of our panelists: To kick off the first presentation I'm going to invite Dr. Peter Rasmussen. Dr. Rasmussen is going to talk about digitally transforming the patient and caregiver experience during COVID.

>> PETER RASMUSSEN: Thank you Dr. Agha. It's my pleasure to be here today and I'm going to try to give you an overview of how Cleveland Clinic responded to increased demand on telehealth, digital health during the pandemic. I know this is a lot to do here in the next eight minutes but I'm going to try to give it a go. I have no significant disclosures here other than being a member of the digital medicine team for the American Medical Association. Probably the most significant way Cleveland Clinic prepared for COVID and the pandemic is that we started with a solid foundation of digital health technology and platform systems. So for a long time we had been developing MyChart capabilities through epic with integrated use of Wearables and remote patient technologies. In addition we have developed a home grown app called myClevelandClinic which brings together the functionality of MyChart in addition to mobility tools that we find our patients to be very helpful. We worked very hard to develop provider mobility tools such as high could you and Canto, Secure Texting capabilities, Virtual Scribe technology to make sure our providers can work wherever they happen to be. Most importantly in the six and a half years prior to COVID we developed a strong partnership with American Well to allow for delivery of Virtual Visits. We had worked closely with in touch over the prior that greater than 10 years for provider consultations. We developed eConsults within the system to allow primary care providers to reach specialty consultation through EHR and imaging sharing technology to allow for specialty consultation without having to see the patient and select the situations. Most importantly on a backbone of a robust API network that allows most of our technology systems to talk to each other. So we really had a strong technology platform in place when COVID hit. So the first place that we asked our patients to go to during the time of the pandemic instead of coming to EDs and into the facilities was to visit our online on demand service known as express care online. And as many of you may be familiar, this is powered by American Well, and we use this not only for on demand services but for all ambulatory aspects of virtual care. And you can see a sampling of some of the specialty clinics that are available. Overall there are more than 70 different specialties using express care online and virtual clinics to allow us to reach our patients. So where were we with Virtual Visits prior to COVID? This is really the lifetime experience of each of our clinical institutes up until the end of February 2020. You can see probably the largest engaged institute was the neurological institute, they'd done 25,000 Virtual Visits at that point in time. Like many healthcare systems this changed dramatically once we were required to do this to meet our patients' needs. Despite many years of driving virtual and digital health at the CEO level. Here you can see the overnight change in virtual visit volume that happened within the month of March. On demand urgent care visits went up by six fold, and even in the busiest clinical institutes and neurological institute they went up three and a half times their volume. Effectively the ramp up of Virtual Visits kept many of the institute at full capacity despite the limitations of patient travel and difficulty coming in to in person facilities. To meet the demand like many healthcare systems found that some of the established telehealth systems and providers had difficulty scaling up rapid to meet the demand. We had no different situation in Cleveland. American Well was working

tirelessly for several weeks to add in millions of dollars of capacity to meet our demand and despite that we needed to have providers use other forms of communication with patients including zoom, Google Duo, Doximity, and telephone. As it stands now we've honed in on integrated Zoom functionality in MyChart and on demand urgent care that is hosted through American Well and of course like many other healthcare systems we continue to use telecare with our patients. To extend the reach of Virtual Visits beyond history taking and limited physical chapel it requires the ability to transmit medical imaging that may be obtained locally at your direction or perhaps by local physician and provider direction and transmit those images to us into our electronic system. And in that realm we have been working with Ambra to have imaging center to Cleveland Clinic image exchange as well as patient upload capability if they have the imaging in hand. This has really been a very strong key to allowing specialty services to continue to work in the time when visitation is very difficult. To help premier patients for the new digital experience we had long ago established digital help support desks, these are very similar to those sites that were pioneered in New Orleans and are modeled after the Apple Genius bar where patients can get friendly advice from super individuals, including advice on Wearables and purpose developed apps.

Another way that has been very significant for our organization to reach patients even in the time of COVID has been expansion and modernization of a long standing remote second opinion program. This has now become fully digitalized in 20th. The program is known as my consult. It allows for a very high white glove touch service for patients around the globe to reach our experts. We use a video enhanced nurse intake system to understand the patient's needs and questions. A fully electronic records collection system including imaging transfer, pathology interpretation system and matching with our best specialty expert to review the patient's question and deliver the second opinion to our patient customer. This is a program we developed through our new joint venture between Cleveland Clinic and American Well. This is the primary way that we are beginning to move forward and prepare for the new digital medical ecosystem that we'll all be moving to as this relationship that brings Cleveland Clinic expertise and brand in combination with American Well, the robust technological capabilities and platform and their already established ecosystem and channel partners that are in place. And the first two products that we've developed in this partnership were the enhanced second opinion product and a COVID return to work product that is aimed at employers as employees return to work. We'll continue to expand offerings through this joint venture. At this point in time I will pause and I will be staying online for questions. At this point I would like to pass the baton over to Dr. Agha.

>> ZIA AGHA: Thank you so much for sharing the learnings and the important work that you are doing at Cleveland Clinic. Our next presentation segues nicely with the work Peter shared about. Dr. Nancy Albert is going to talk about how she and her team have responded to the tremendous demand for services and particularly the work flows and implementation that happens at the bedside. So I'm pleased to have Dr. Nancy

Albert, also from the Cleveland Clinic present the next topic. Telemedicine during COVID-19 technical support of patients. Thank you. Over to you Nancy.

>> NANCY ALBERT: Thank you very much. I'm happy to be here today. I have no disclosures to discuss with this presentation. So I'm going to start off by talking about pre-COVID-19. You already heard Dr. Rasmussen talk about the fact that we had a pretty robust system in place prior to COVID-19 and many of our providers had been using Virtual Visits prior to that time. At that time, just to give you an idea of how we've morphed, at the time we used to make contact with our patients three days prior to the visit. The patient would receive an email, and complete prework through the American Well system, they would set a password, we would obtain demographics about them, we would have a conversation with patients about needing a web cam via a smart phone or a computer. And obviously for the patients that could not make that possible we would have telephone calls. But one of the key ingredients is to make sure patients are in a private place. We've had scenarios where patients were calling in for a virtual visit while driving in a car. Other people would be literally in a restaurant. So people seem to think that they could go about their busy lives and not be in a private place. In my heart failure background I had a nephew who was setting up the web cam for one of my patients and the nephew stuck around in case the patient got into any trouble. The problem for me regarding the private place was that I was trying to diagnose my patient with a new medical condition that required me to ask about a sexual dysfunction so the patient's nephew was sitting there, obviously not a very private place. So that needs to be considered as well.

And then obviously the patient needs to be in a comfortable location so they can be more relaxed during the visit. We did find that some of our patients had high anxiety about getting on to Virtual Visits especially for the first time if they had never done that before. When those scenarios happened our behind the scenes technical support was able to provide a test visit for those patients. So if you know you have visual learners they would appreciate that demonstration component to make it a little bit easier for them. Our technical team was really small so when we were dealing with 3,000 visits a week it was easy enough to get our patients geared up and the system worked pretty well. But now we have over 10,000 visits a week so we needed to pivot a little bit. Initially program managers got escalated work when patients needed extra help that the technical team couldn't meet those needs but what we started to do was align more within our institute. So I'm in the heart and vascular institute. We had medical assistants and our nurses that reached out to patients to provide assistance to them. Their real goal was to help troubleshoot issues and also to prepare patients before visits. We actually as you heard Dr. Rasmussen say, we have the Zoom system tied into MyChart, so these people can go into the system before the visit occurred with the provider and put information into the system almost like the prep part of a visit.

So that really made life a little bit easier. Again, initially we were using the American Well system. We've had that system for quite a period of time. Providers really like the

system whether we do marketing surveys about it. The prep steps were easy to learn but patients didn't always like the system as much. We've had all kinds of scenarios, for example one of my patients who didn't show up on a phone call when we called up to find out why he missed his visit he said he didn't know to go to MyChart and look for email there. Or patients will say I don't have my internet working. So we started learning that we needed to pivot even a little bit more. So I think one of the take home messages for us to consider is we need to make technology to scale for masses and it's got to be user friendly for the average consumer. If it works well for us as healthcare providers, we're tech logically savvy and it may not work well for patients. We're using Zoom more often now for Virtual Visits and it connects right into MyChart so we can document. There's scripting for the front end user and we'll communicate that when we schedule the appointment. So whoever the appointment people are, they use that script for every patient when they're scheduling so patients know what to expect. And patients can do a precheck in up to 7 days before their visit so that's makes it easy for patients to get some of the behind the scenes work done. Medical assistants can call patients ahead of the visit and can complete the rooming in process so when patients come online to talk to the provider a lot of those pieces are already done. One of the things we need to remember from a technological support scenario is that it may require new jobs for current staff and could increase the cost of care in regards to how many patients are being seen in the clinic. If some of our people are being pushed over to helping with virtual visits if volume is still high in the clinic those people were the same people rooming patients in the rooms so now they're doing double duty trying to dance around to make it work. So far it has worked for us but it's something to consider. I would say when we talk about technical support of patients there may be a lot of virtual hand holding needed and it depends on the type of visit. If you are neurology, psychiatric, behavioral area Virtual Visits may be fairly easier because it's mostly subjective back and forth between provider and patient. In my world of heart failure, I need to do both an objective and a subjective visit and try to make it all work. So we've learned that when we need to get objective data we really need to prep our patients for it. We need to ask patients to take the wait previsit. Otherwise they'll leave the house and we're waiting for them. Many of our patients do have blood pressure devices that will give us blood pressure, heart rate and maybe even oxygen saturation but if we ask them to do it during the visit it's awkward for them especially if they did listen and they're in a private area they may have to call a helper to come help them which delays the time it takes to get an appointment completed. Medication, we need to have each of the patients read medications. And you can imagine how well that work if someone has eyesight problems or health literacy problems. We've asked patients to take off their shoes, if you don't ask for that previsit, that will really delay. And then sometimes the patients are wearing socks, I will tell them to keep the socks on and I will have them move the top of the sock down so I can judge the level of edema. Winter time you have to think about turtles neck shirt. Often time patients want to see you and maintain eye contact. When they turn they're not looking straight so it makes it difficult for us to meet our needs. There are things when we're talking about virtual hand holding that need to

go on. One of the beauties of using Zoom we have increased access for family members. That is one of the wonderful things about it. There are also less privacy issues especially when people are used to using Zoom and having a lot of other people coming into the room. We need to think about room distractions. I tell everybody the first time they do this early on to please plan for extra time. Again the medication bottle reading takes time. If I need to look at body parts to get a sense of what is going on objectively, I need to be able to see things so that can take extra time. So again, we've got telehealth versus Virtual Visits. One is user friendly just being on the telephone but we encourage Virtual Visits so we're able to do everything we need to during that call. To achieve success you want to confirm audio and video connections. You want to assure the patient is really ready to go. Allow the patient to interrupt if they have issues about the platform. We try to at the end of the visit ask patients how their visit was. My key take away is Virtual Visits have advantages especially for the elderly, who have people there who can help us understand what's going on better but they can cause high anxiety so we need to think about how we can decrease technical issues. It's important to plan ahead and prepare patients especially if you need objective assessment. So I think there's more innovation we'll be seeing in the future possibly because of COVID-19 pushing us in this direction and also we need to be able to conduct research to find out what works best for patients and how we can improve our overall Virtual Visits. So with that I will hand it back to Dr. Agha for the next presenter.

>> ZIA AGHA: Thank you Dr. Albert for sharing lessons learned and tremendous work that you are doing engaging with patients and organizing this new model of care. Truly fascinating. The next presentations are segues more into the world of home care. Dr. Karen Abrashkin is going to talk to us about her innovative home based primary care model that is leveraging telehealth and community medicine delivering care during COVID-19 and Beyond.

>> KAREN ABRASHKIN: Thank you Dr. Agha, I appreciate the opportunity to participate in today's panel. It is my pleasure today to provide a brief overview of north well's experience. I will be touching on a brief overview of Northwell Health. Hopefully giving an overview of how we approach the problem based on our program's history with telehealth as well as tips and lessons learned. So by way of browned, Northwell Health is the largest private employer in down state New York, we conduct 5.5 million patient encounters each year. North well utilizes the AmWell platform and I liked this image very much but this ability to combine the right care with the right situation, right time, right location is not unique to one platform. It's a must have for all direct to patient or direct to consumer platforms out there. So we were feeling the ravages of COVID in March through May of this year. We saw an 875 percent increase on our platform which was truly unparalleled in our system's past. This gives you a sense of the growth. Prior to the pandemic we saw a few billable telehealth visits each day which increased to thousands of visits. This graph is not indicating there were no telehealth visits taking place prior to the visit. This only represents billable. During the pandemic new legislation made it possible to bill telehealth which greatly increased the reimbursable

visits we saw in the system. So with the system wide perspective in mind I will shift that. House calls is our home based primary care program that allows us to provide comprehensive services in the home some of which are listed here. Our enrollees are elderly, average age of 86, most require assistance with five to six things of daily living, feeding and walking. We serve about 2,000 unique patients annually. We deliver our care using care teams that are geographically based including physicians, practitioners, nurses, social workers and administrative medical care workers. We are backed by a 24/7 call service. I've included this table with results that we did from a survey between 2014 and 2016. Our patients have had low access to and confidence in using technology. So with every type of technology except for the bottom one of medical alert device our patients have significantly lower levels of access to and using technology than caregivers in the program. This sets the stage for our program's journey into telehealth. In 2018 we conducted a direct to patient telehealth pilot in 2018, you can see the top circle, out of those nearly 500 eligible patients we only had 39 who successfully completed a telehealth visit. This shows that patients are hard to reach by telehealth. So prior to the pandemic we made an attempt to weave telehealth into our program. We had our maybe not so successful direct to patient pilot in 2018 and we had pivoted to our mobile telemedicine technician program and of course there was our COVID experience.

Our facilitated telehealth model supplied them with mobile technology capabilities that allowed them to connect to physicians centrally located, visits were done for new conditions like new skin conditions, maybe a cough, changes in conditions or follow-up like after a make change. And unfortunately just as our model was gaining traction our EMTs were pulled back to emergency work during the pandemic and we had to put our efforts on hold.

This diagram shows how our facilitated model allowed a physician to evaluate twice the number of patients a day. Trading off every half hour with presentations to the centrally located physician. Starting in March we found ourselves located in the first U.S. epicenter of the COVID-19 outbreak. We deployed the next version of the direct to patient model we tried in 2018 but this time there was real motivation to make the model work. Relaxation around telehealth platforms and the ability to obtain verbal consent helped us to roll this out quickly. We were permitted now in the COVID-19 era to fall back on other options if needed so we rapidly consented telephonically and we completed nearly a thousand telehealth visits during the pandemic. Despite the initial starts and stops having prior experience really allowed for the rapid deployment. The work flow that allowed us to complete visits in a short time frame came down to [inaudible] much like the other presenters have discussed. We allowed application downloading so on the day of the visit the clinical provider was able to focus on the care the day of the visit. The administrative staff spent between 20 and 30 minutes of time with the preparing the patient in addition to the time with the provider. This is a graphic depiction of our weekly telephonic and telehealth, it grew week over week but even with what we considered to be great success in telehealth there's a group of patients in the

older adult population who will not even with maximum help and motivation given the pandemic be able to access a direct to patient model. For that reason we're coming full circle with the facilitated model. We'll be rolling it out again in August and giving it to those who are unable to complete a telehealth visit. We like to try and publish and make our results available to others so here are some references included in the prior slide. I also want to give you my contact information and feel free to contact me if you have any questions. Thank you. I will turn it back to Dr. Agha now.

>> ZIA AGHA: Thank you Karen for sharing the tremendous work that you are doing in response to COVID being the epicenter in New York City. Truly impressive around the learnings about changes made based on the needs of your patients.

David Darr is going to bring a perspective beyond the health system. David and his team have the opportunity to develop plans across multiple partners and David is going to share tips on how to implement telehealth programs.

>> DAVID DARR: Thank you very much and thanks again to all the sponsors that are making today's presentation possible. What I'm going to do today with our time is kind of review the eCARES COVID response programs we had with our clinics, providers and healthcare partners along with the different marketing and educational opportunities we created and how we used experiences to help roll out over 100 new and long term care assisted living sites in a short three month period of time. Avera has been delivering healthcare services to rural communities for over 25 years. We're in 600 clinical sites in 32 states working with partners across the United States. Telehealth really is poised as a solution to assist with early patient screening, support, isolation protocols and deliver specialty care to remote areas during this outbreak. Specifically to the senior care population we're located in 11 states right now. At the end of our fiscal year 20 we had 60,000 encounters all together to put this in perspective with COVID March of 2020 we had 79 locations. Within a three month period we implemented up to 174 by the end of June. So our program supports over 8,500 residents on a daily basis which we didn't even think was going to happen one year ago at this time. So in preparing an organization for rapid rollouts it's important that you prepare with a foundation, with your goals for implementation. So we've been lucky enough to partner with Dr. Agha and west health, and we also contributed to the practical guide to telehealth implementations. And by having that foundation in place you are able to hopefully move things rapidly if needed on implementations. So this is what eCARE did to help support the COVID efforts throughout our different service lines. As you can see we did a lot of different service lines with the post acute hospitals and critical access hospitals. But it all started with the COVID-19 command center.

And with various brick and mortar footprint we leveraged a 1-800 call center to triage patients and to risk patients to COVID-19 staff. The group is able to assess and direct patients to the next steps whether it's recommending the patient to stay at home or use the virtual platform or to be assessed by a medical professional or in fact they may be at designated locations for testing for the virus. So we currently have multiple COVID-19

testing sites some of which are using exam cameras to treat patients with flu-like symptoms. We also did quite a bit with educational opportunities as well.

Here are the list of some of the specific COVID-19 educational opportunities. We created a website and guidelines specific to each of our service lines. Here's a list of our IT hardware that we distributed to our healthcare partners throughout our geographic region to help promote and encourage telehealth encounters and to further protect our staff and families. Some of the challenges we have working with telehealth are having patients realize the ease and the intimacy that you can have with two way video but walls providers to understand, by sharing these different hard wears we were able to introduce telehealth to a couple of different groups that normally wouldn't have used it otherwise.

Now specific to the senior care population, we've been doing this since 2013 but we were able to leverage existing capabilities to support the following additional opportunities. So we did some virtual nursing home rounds. We added more behavioral health support, we created COVID isolation wings within the buildings we were working with and we were able to provide assistance with transfers to COVID specific nursing homes and we were able to provide [inaudible] to the [inaudible] that we have with them.

So I mentioned we added quite a few sites on to this. So in March we had 88 and moved into 174. Well, how did we do that? We did it virtually. All of the new sites we went on we rolled out virtually in nature. Keep in mind when we normally do implementations we have several phone calls that go into play, we send someone to do staff education, meet with local providers and making sure the ball is handed over smoothly. We were not able to do that with the virtual rollouts and we had to condense so implementations that normally took two months we scaled back to two to three weeks. We were able to cross train customers, provide trainer opportunities with that and had to create a new project management team to help support everything. When I say support the project management team it had everything to do with sales, IT infrastructure that we needed, implementation process itself and also our own internal hub staffing models. So to overcome some of those obstacles we started drop shipping directly from our manufacturing and distributors and other vendors. So instead of having them sent to us having everything prepared and sending them to the sites we did drop shipments directly. We were also able to help make up for some of those equipment shortages that we were going to have. We had to compensate for the large group education that we were not doing anymore along with that on ground RN support and I mentioned we did that through the trainer programs, we were able to train key staff customers on the other side so we were able to do dual presentations as well. That leaves some of the lessons we learned on there. Bandwidth challenges, yes. Reimbursement challenges we're have yet to know about for sure. Equipment shortages, and in the end for our program we were able to roll out 96 different locations to 8 different companies over a five state region. And during that 92-day period we

added on 5,000 residents to our overall program. So, the telehealth benefits themselves are pretty obvious for us. Patient and staff safety are still the utmost. Timeliness and access to provider care, we were able to preserve PPE, filling in the gaps, our two biggest take aways we might not have realized without COVID is the patient engagement is higher than ever. Patients are now seeing that telehealth is here to stay. It's providing a higher quality improved quality, and for the providers it's allowing them to partner and collaborate with another clinical team knowing that we're able to support them during those gaps of coverage where they may not be able to reach their patients otherwise.

Thank you very much. Dr. Agha I will pass that over to you again.

>> ZIA AGHA: Thank you David for sharing the tremendous work you are doing across so many different settings particularly in the long term care setting where we're seeing tremendous needs due to the COVID crisis. We have 10 minutes for Q&A with our panelists. We've received questions online and I'm going to ask, try to combine these questions so we can get as many of these answered in the brief time that we have. One question that maybe I can start with with Dr. Rasmussen and Dr. Albert is around remote patient monitoring, the role of home blood pressure, home glucose and those types of monitoring devices and how you are seeing that evolve due to the COVID pandemic.

>> PETER RASMUSSEN: Generally speaking when we started the remote patient monitoring programs at the Cleveland Clinic, the providers were extremely interested in having that information come into EPIC so that it could be viewed in the context of all of the other medical information that the patients had so that was really the first thing we needed to do from a technical standpoint. And the work that we did around that has been facilitated by our relationship with Volitic which is a company that aggregates the data from multiple different types of consumer medical devices and then through a purpose built API from Volitic to APC we can aggregate that to data sheets. That was the first step. Then that gives us flexibility and the types of devices that can be used and or the manufacturers because we don't need to maintain all of those data links. And after it was completed it was a matter of having the variety of clinical services use those technologies and platforms to run a variety of different programs. And they occurred in areas that I wouldn't have fathomed before. As an example, our sleep center is very interested in remote blood pressure monitoring. I wouldn't have imagined that but when I queried this, the answer was we need to put patients on stimulants. We don't want to be doing that if it drives their blood pressure up. These are valuable programs as long as you can use the data to the provides' satisfaction and have relatively simple solutions as Nancy alluded to, that patients can learn.

>> ZIA AGHA: Thank you. The next question is around how do we support and engage with different types of populations specifically older populations or populations that are not tech savvy? Perhaps Dr. Abrashkin and David, you can take that one?

>> DAVID DARR: Sure technology is becoming easier and easier to use every day. If you notice anything that comes in the mail for new technology doesn't have instruction manuals anymore. You learn as you go along of the so when you have technology in a building working with a nurse or others the human error is getting less and less and the ease of use is even better than it was two years ago so I think the technology is really allowing you to reach out to more of the older population and understanding that we're able to help support them just as well long distance as we do face to face.

>> KAREN ABRASHKIN: I think in the home based primary care space because we have the oldest and sickest of the community dwelling older adults in our area we've had to turn to care gives. So there are patients who are using their own technology, their own wifi and everything else but a large portion, two thirds to three quarters are accessing telehealth through a caregiver whether it's a family member or paid caregiver.

>> NANCY ALBERT: I was going to make a similar comments. It's either patients are very literate in IT or they go back to the simplest method possible unless they have a caregiver to support them.

>> ZIA AGHA: Thank you. The next set of questions are around outcomes and data. So if any of you can talk briefly about the opportunity to evaluate what you are doing and what are some of the learnings and evidence that you hope to create to further enhance the implementation of telehealth.

>> NANCY ALBERT: I would say at Cleveland Clinic we've learned a lot from the marketing department because of the patient and provide perspectives on Virtual Visits. We're learning a lot, the use is much higher, getting a variety of feedback from patients and families really can help us drive programs as we move forward in the next months to years.

>> KAREN ABRASHKIN: At Northwell we're partnering with the [inaudible] foundation to study cost of care delivery. Home based care is costly to deliver. You have physicians, nurses, social workers driving around providing care to patients in the home. We're looking at cost of care and delivery and looking to see if we can maintain the same high level of outcomes allowing us to still deliver to patients at a lower cost of delivery. I think these will be keys if we look at whether telehealth is here to say with this population. We hope it is but it's something we need to study.

>> PETER RASMUSSEN: We focus on the long term care setting we focus in on reducing the rehospitalization rate, treatment in place. Now you're getting into value based purchasing, the PDPM coming into place, where the ROI is, once we get post COVID we'll see if the [inaudible] opportunity is there to continue participating in virtual telehealth platform.

>> ZIA AGHA: Thank you. Thank you, everyone. Those are really insightful answers. Now it's time to have our sort of final question to all of you and the question is as we move beyond the pandemic what do you see happening? How are you going to

strategize to further enhance your programs and in particular where do you see telehealth playing an important role? Please be brief. I will start with Peter.

>> PETER RASMUSSEN: As I alluded to in my presentation I think the future strategy is going to be in broader partnerships that bring together clinical excellence and technology vendors. Clearly even a health system like Cleveland Clinic doesn't have all the expertise under roof and I certainly hope that regulators and payers continue to look at telehealth as a different way to access care as opposed to in person care. I tend to be the polar opposite of Nancy. She's more data driven and I'm more pragmatic. I don't know how much study we need to do to understand that a heart patient shouldn't travel from northern Kentucky to Cleveland click to get information about how to best manage heart failure.

>> NANCY ALBERT: I think down the road what we need to do is try to see how much we can simplify for patients yet at the same time how we can expand providers capabilities of having the right information at the right time at their finger tips so they can make better objective assessments and decisions about next steps in care. I think it's easier when a lot of the care is just discussion, if I want to try to do a medication titration that's an easy virtual visit or telephone call but if I am dealing with someone who has multiple co-morbidities and I'm trying to discover if it's asthma, COPD or something else I need more tools in my toolbox but I think we'll get there especially if reimbursement stays strong.

>> KAREN ABRASHKIN: I'm going to echo what Nancy said in terms of needing the push for legislation for reimbursement. As long as that's the case we'll be continuing full force with our direct to patient model and we'll be bringing back our facilitated model because we have 50 percent of our population who can't access the direct to patient model because they don't have a device or competence in using the device or wifi or any of those things so we'll be bridging our direct to patient and facilitated telehealth model and we'll be pushing for legislation for --

>> DAVID DARR: I agree with everyone and I think what we're going to find out is that the collaboration within our healthcare communities really rallied with each other and that is the most positive part of it and we're going to see provider engagement go through the roof seeing the need for telehealth. It's going to come down to change in reimbursement and making this affordable to everyone.

>> ZIA AGHA: Thank you, David. I would like to thank each one of you for the tremendous work that you are doing in your communities and thank you so much for sharing your time with us today in this very informative seminar. I would like to thank everybody who attended and engaged with us through questions online. We want you to fill out our survey. It will help us learn about what types of topics and what questions are top of mind for you. The next program will be on August 18, we're looking forward to many of you joining again in continuing the conversation with us and with that, at this

point I would like to say good-bye to all of you. All meetings that end on time are good meetings and I think this one is ending on time. Thank you.