

Good afternoon. I'm Commander Ibad Khan, and I'm representing the Clinician Outreach and Communication Activity (COCA) with the Emergency Risk Communication Branch at the Centers of Disease Control and Prevention. I would like to welcome you to today's COCA call, The Impact of Telehealth on Health Equity from the Perspective of Large Healthcare Systems during the COVID-19 Pandemic. Free continuing education is offered for this webinar. Instructions on how to earn continuing education will be provided at the end of the call.

In compliance with continuing education requirements, CDC, our planners, our presenters, and their spouses/partners wish to disclose they have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters. Planners have reviewed content to ensure there is no bias. This presentation will not include discussion of the unlabeled use of a product or a product under investigational use. CDC did not accept commercial support for this continuing education activity. At the conclusion of today's session, participants will be able to accomplish the following.

Describe the impact of telehealth on health equity from the perspective of large healthcare systems, describe lessons learned from healthcare systems experiences and using telehealth to address health equity before and during the COVID-19 pandemic, list strategies to address health equity and telehealth, and discuss CDC's health equity and telehealth initiatives and recommendations. All participants joining us today are in listen-only mode. After today's presentation, there will be a Q and A session. Using the webinar system, you may submit a question at any time by clicking the Q and A button at the bottom of your screen. Tap your question in the Q and A box and submit your question.

The video recording of this COCA call will be posted on COCA's webpage and available to review on demand a few hours after the call ends. If you're a patient, please refer your questions to your healthcare provider. For those who may have media questions, please contact CDC media relations at 404-639-3286 or send an email to media@cdc.gov. I would now like to welcome our presenters for today's COCA call.

Our first presenter is Dr. Jeffrey Hall. Dr. Hall currently serves as the Chief Health Equity Officer for CDC's COVID-19 response. Dr.

Hall also serves as the Department Director for the Office of Minority Health and Health Equity and the lead for the Minority Health and Health Equity team for CDC. Our second presenter is Dr. Edward Lee. Dr. Lee is the Executive Vice President of Technology and Chief Information Office at the Permanente Federation.

He also serves as executive Vice President for IT and Chief Information Officer for the Permanente Federation. Dr. Lee's work at the Permanente Federation is focused on expanding the accessibility of health information and decision support tools for patients as well as leveraging and enhancing the technology available to physicians to improve the quality and efficiency of care. Our third presenter for today has been changed to Dr. Leonie Heyworth.

Dr. Heyworth is the director of Synchronous Telehealth at the Veteran's Health Administration in the Office of Connected Care. Her focus is the development of virtual care tools and implementation of video telehealth at Veteran's Health Administration. Our third presenter will actually be our fourth presenter for this presentation, and his name is Mr. Matthew Rogers.

Mr. Rogers is the architect and director for the Clinical Resource Hub Program for Veteran's Health Administration, where he actively sees patients in the Clinical Resource Hub, which is designed to establish equity for underserved veterans and is currently serving more than 700,000 veterans. At this time, I would now like to turn it over to Dr. Hall. Dr. Hall, please proceed.

All right. Good afternoon everyone. Again, thank you for the opportunity to be here for the presentation. I am honored to have the opportunity to speak on behalf of the Chief Health Equity Officer Unit and on behalf of my home office in the Office of Minority Health and Health Equity here at CDC. On September 15, 2020, the COCA webinar on telehealth and health equity involved comment by our office director Dr.

Leandris Liburd. Dr. Leandris Liburd is CDC's First Response Chief Health Equity Officer. In her brief presentation Dr. Liburd described telehealth access as one actionable step through which health equity may be promoted, and she did so specifically in the context of the COVID-19 pandemic.

Specifically, in her comments, she mentions that telehealth options should be tailored to the needs of patients, ensuring that access to chronic disease management as well as services should be maintained in order to prevent illnesses and a progression of infirmity. Today, with the time that I've been allotted, I'll briefly expand on thoughts offered by describing considerations and possibilities for telehealth expansion, identified using the framework for action to achieve health equity of CDC's Office of Minority Health Equity. I do so in light of known digital device, disparities, and inequities. My treatment specifically attends to interrelated population, provider, organization, and systems characteristics and how they affect the pursuit of health equity. A first promising practice requiring further evaluation involves identifying and measuring digital needs.

In other words, completing what some of us might refer to as a digital needs assessment or an assessment of digital needs. Digital needs assessment furthers understanding of barriers and enablers affecting telehealth use viability. This includes not only the circumstances of the populations we serve. It also includes the circumstances of care and service providers as well as their encompassing organizations and systems. As just one example, inequalities in connectivity, in device access, in access to software, cybersecurity, and maintenance services and in skills and uses options all affect telehealth participation opportunities individually as well as jointly.

They create digital advantages and disadvantages that coincide with other social advantages and disadvantages that have been linked to health disparities both generally and to COVID disparities specifically. Telehealth implementation hinges on understanding capacities for full digital engagement as well as factors allowing for enjoyment for some but not for all. Digital needs assessment, that is, measuring barriers and enablers to telehealth participation and how they vary across populations in place becomes the basis for creating infrastructures, programs, and policies to promote equity in access to digital care. Infrastructure considerations and characteristics affect abilities to connect both socially and virtually. Barrier and enabler assessments support attention not only to limits in tech access and infrastructure, they also allow description of limits in understanding of digital inequalities as well as how they combine with other inequities and disparities to increase social vulnerability.

This is something that we can focus on specifically in the case of public health crises but also more broadly where other public health considerations are in view. One requirement for effective telehealth access expansion involves accounting for how resource inequities and differences among different patient populations, different provider groups, and barriers in public health systems serving different places affect health maintenance and improvement opportunities. Conversations about concepts such as

digital inequality stacking, that is, the previously mentioned layer of inequalities in elements such as connectivity, device access, software access, etc, are a necessary overlay for discussions of the compounding of inequities occurring in and beyond the pandemic. To properly uphold expectations on requirement for pursuing health equity via telehealth options requires such conversations.

Characteristics of digital and socioeconomic divides preceding COVID-19's emergent effect telehealth viability for both patients and providers impacting opportunities to remain connected. Considerations of this nature are even more important given that the level of resources required for treating critical patients is increasing and that COVID-19-related losses may also affect patient retention of internet access. One potential programmatic option for unearthing and fully exploring such considerations within local context is to develop digital health equity teams. These teams can include policy makers, public health and health experts and community leaders who can view telehealth and tech use through a health equity lens. This type of team is used, for example, by the Greenlining institute in California to address digital divide elements limiting economic opportunity and to pursue technology equity.

This model is one that could be considered for use as we strive for health equity despite and in view of the effects of COVID. Lastly, strategies combining policy and program initiatives are important to fully advance health equity through telehealth interventions during and beyond the pandemic. A wide selection of policy recommendations involving provider and program activities are available from organizations such as Families USA. The recommendations document developed by Families USA is particularly informative as it provides state-level policy recommendations around themes such as improving financing and implementation, removing provider barriers, as well as improving patient access to telehealth services. In closing, with my brief time, I have structured my comments using the framework for advancing health equity developed by CDC's Office of Minority Health.

I've emphasized brief examples of conversations happening in management, infrastructure, program, and policy domains. We hope that this brief treatment of health equity within this framework peaks your interest and furthers your resolve to explore health equity as an option for reducing inequalities during the pandemic. I now will transition the presentation to Dr. Lee. Dr.

Lee. Dr. Lee. Great, thank you so much, Dr. Hall.

First off, I wanted to thank COCA for the opportunity. I'm honored to be participating today with our colleagues from the CDC and the VA, and I'm glad to be accompanied by my Permanente Medical Group colleagues, Drs. Irene Chen and Steve Parodi, who join me during the Q and A portion of the session. Next slide please. I wanted to start by taking a moment to give a brief overview of Kaiser Permanente.

We are an integrated healthcare delivery system that serves over 12 million members in eight states and in Washington, DC, and while you may have heard of Kaiser Permanente, you may not know that the health coverage and medical care provided represents a partnership between separate organizations. The Permanente medical groups, Kaiser Foundation hospitals, and Kaiser Foundation health plan. Our medical groups are self-governed, physician led, multispecialty groups across our eight regions, and we have over 23,000 physicians within our groups. And in many of our regions, Kaiser Foundation owns hospitals, and this model ultimately allows our physicians and staff to focus on preventive care, optimal quality outcomes, and ongoing care delivery innovation through continuous improvement. Next slide please.

So, here is a snapshot of what we are doing in telehealth at Kaiser Permanente. The numbers you see represent care that was delivered during the last week of October. There was a high volume of remote interactions with respect to audio-only visits, video visits, activity within our call centers, emails sent through our secure online portal, eVisits, and our health bot. What's not listed here are other telehealth channels that have also grown in usage including remote patient monitoring, remote diagnostics, and online chat with our clinicians. Now, I'm not going to go into the details of each of these, but I did want to call out a couple of highlights.

The channel where we've seen the most dramatic increase has been our video visits platform. There's been an exponential growth of almost 4000% compared to what we did in 2019. Video care is something we always thought would be used more in the future, but COVID brought the future rapidly to the present. And while being in the midst of COVID, we felt that this was something that had to be done out of necessity to allow our patients to physically distance during the pandemic and to provide ongoing care, both for acute and chronic conditions management and in particular for our most vulnerable populations, and having this avenue for our patients to continue so receive care from doctors that they know and that they trust. The other part of this slide that I wanted to point out, and this, in the lower left-hand corner is a graph.

So, when COVID started to take hold in March of this year, we saw a sharp increase in the use of phone and video appointments and a corresponding drop in in-person visits. It's similar what other health systems saw. And we saw to 80% telehealth during the early part of the pandemic. As the months have passed and as we've seen how we can best balance between in-person and telehealth, the percentage of in-person has increased again, video visits have decreased -- sorry, phone visits have decreased -- and what's been a pleasant finding is that our video visit proportion has stayed fairly steady over the past several months. There was really a lot of fear at the start of the pandemic, and so patients were simply just not coming in.

And that's what led to the decrease in in-person visits. We also know that not all conditions can be handled remotely, so that's part of the reason why more in-person care has occurred over the past several months. This also has shown that our patients realize the value and convenience of telehealth and in particular video visits, and there are physicians and our healthcare delivery system as a whole is now accustomed to effectively deliver high-quality care, and this is a way now and into the future of the way we would deliver care. Next slide please. So, I'd like to spend this last slide here talking about health equity in telehealth at Kaiser Permanente.

So, obviously, we all recognize the fact that there is a digital divide, and not everyone has the ability to connect via telehealth, whether it's because they don't have broadband internet, a smartphone or computer, or because there are language barriers or difficulties with understanding the use of technology. Knowing and understanding the barriers has helped us try to close some of these gaps. So, what we've done is to make it as easy as possible to access our telehealth services, and knowing that most of our patients have a phone that they can use to join a telephone visit, we've made sure that we have an abundance of telephone visit appointments available, though we also are cognizant of the fact that we want to offer our patients choice in the way that they want to receive care, whether it's telephone or in person or if they have the capability to do a video appoint, to have that offering as well. For patients who have at least a basic level of technology, we've been intentional in our efforts to make our technology as intuitive and easy as possible. And then for non-English-speaking patients, we've included the ability to easily bring in an interpreter whenever necessary and so that we can have a three-way conversation between our physicians, the patient, and an interpreter during our video or telephone visits.

So, inclusive of these efforts, I do think that telehealth in general can provide access to care that can reduce health disparities. and so, for example, we've got essential workers who can't take time off of work to come in person for doctors' appointments. But they can reach their physicians remotely either synchronously through telephone or video or asynchronously through email, either this or other channels. We also have social determinants. We also know that social determinates play a huge role in overall health with transportation and security as one of those factors.

We can mitigate those with the use of telehealth and remote care. Our elderly patients who don't always use technology as much as other segments of our population, and we realize that, so what we've done is leverage in-person visits to help them along. And so, if they have a smartphone and just don't know how to use it for a video visit, we have workflows in place where we can guide patients through the use of the technology in preparation for future telehealth opportunities. On the other hand, if they don't have the technology, we've started delivery cellular-enabled iPads to some of our patients so that they can connect via video with their physicians. And finally, in terms of culturally competent and responsive care, I've already mentioned that we can add interpreters to our video visits, but I also wanted to say that specifically around COVID, we've created videos on how to care for yourself if you do have COVID, both in English and in Spanish.

We've established text campaigns to promote our multilingual COVID prevention website, and we've also created fotonovelas to engage our LatinX community on COVID prevention. Aside from the COVID photo stories that we have, we've also created informational pages on healthy living, healthy eating, decreasing stress, and maintaining healthy weight as well as other photo stories. We'll address some more of the things that we're doing during the Q and A session, but I'll stop here and pass it along to Dr. Heyworth. Dr.

Heyworth, are you on the line?

Hi. I think I just unmuted myself if you can hear now. Thank you.

Yes, Dr. Heyworth. I can hear you. Please proceed.

Thank you. And a lot of callers between the work that Kaiser is doing and again that underscore of making sure that in this digital revolution and expansion that we're not leaving our more vulnerable patients behind. Next slide. The VA has already been on a journey of transforming from a hospital-based to a clinic-based system, and then thinking in the '90s and beyond about hospital at home and in-home programs. So, now, focusing on care on any device so that our veterans can choose a time and the location where they receive their care by video or by other asynchronous means.

Next slide. And then next slide. The VA Video Connect is our platform for care into the home, and we have customized this, adding features such as an emergency or e-9-1-1 contact so that when we have our frontline providers delivering care, and if there is an emergency, there is an easy way and a quick and timely way for emergency services in the patient's specific catchment to be activated and to be brought to the location of the patient. Of course, if I'm a provider in the clinic and I dial 9-1-1, that ambulance is going to show up at my doorstep as opposed to my patient's home. So, having that feature built in helps to provide additional confidence about our ability to respond timely to emergencies, and you can see navigating around our platform, we also have the ability to see very clearly who is in the session and participants, mute guests if needed and disconnect them, in some cases, as well as a chat box where we can share links, names of medications, spelling them out, connections to videos or other resources, and of course, the screen sharing feature, which is my favorite.

I can review labs. I can review radiology and other imaging with the patient just as if they were in clinic with me. Next slide. We also have a suite of so-called peripheral devices. So, these are Bluetooth-connected devices that can connect to our video platform.

We have a digital stethoscope, which can just be turned on with one click. the lights blink. Our patient can put that visual stethoscope up to the chest or over their lungs for transition of sounds, and in the case of a heart exam, we can actually get lead two of the EKG across our video product so we could actually make some determines about heart rate and rhythm. We also have a blood pressure machine to determine blood pressure and heart rate as well as other peripheral devices that integrate fully into our video system. Next.

Getting at those veterans who do not have the ability to do video telehealth at home, and this concept that Kaiser has also focused on around the digital divide and ensuring that folks aren't being left behind, particularly with COVID in the expansion of video and other telehealth services. We have an initiative called Accessing Telehealth Through Local Area Stations or ATLAS, and sites located at VFW and American Legion sites as well as Walmart sites where there are telehealth access points that are set up to deliver healthcare in those locations so that they're for our veterans who are enrolled but perhaps have to travel a distance to the nearest VA facility or perhaps do not want to because of the potential exposure to COVID, and the increasing video overall that we're doing into the home space, we understand that not every veteran is going to have the broadband necessary for a quality video visit, these ATLAS locations may provide our patients the ability to have continuity of VA care on main street as opposed to requiring them to come into facilities mid-pandemic. Next slide. In September, we also formerly introduced a digital divide consultation to connect veterans with equipment, connectivity, and equipment may be either a tablet or a smartphone if needed to engage in telehealth services into the home. We already had a loaned iPad program in existence, but the digital divide consultation added to this process by adding in an assessment of connectivity so that for those veterans who perhaps only require connectivity in the way of home Wi-Fi, they would be able to get that instead of necessarily getting a device.

So, getting closer to customizing that need for connectivity or a device, formerly through this digital divide consultation and the opportunity to engage social workers in this process as we build out the additional resources for connectivity, subsidies in different programs that our veterans may be eligible for to make this more affordable. Next slide. And in order to make sure that we are assessing our needs as far as staffing across the enterprise, we have regionally owned clinical resource hubs, and I will hand it over to Matt Rogers to share a little bit more about these.

Great, thanks Dr. Heyworth, for that. So, the concept of clinical resource hubs really is taking those devices and modalities to connect veterans to care with the clinicians that can do so. And so, in the VA we've invested in a network of clinicians and clinic staff that are assigned to locations where it's relatively easy to recruit and retain and attract clinical expertise so that we can serve areas that are quite rural or otherwise have low service from various clinical services. This image here that you're seeing is a map of our clinical resource hubs, what we call host facilities.

So, the VA has established 18 different regions. Within these regions there may be one or two host facilities that have been identified where we might identify say a group of cardiologists or primary care physicians or clinical pharmacists or nurses, and we assign them to this unit within a hospital, and their job is not to serve that local hospital but to provide service to veterans in areas where they may not have that clinical service. So, places like the VFW post with the ATLAS locations, for example, might be served by a group of psychiatrists and psychologists out of Salt Lake City, but they're providing their care to veterans in Eureka, Montana. And so, through this network, what we've done is we've built a

regional owned, regional governed group that's sole focus and purpose is to provide access to care where care might not otherwise exist. Now, in the VA system, we have the luxury of being able to cross state lines and use a single state licensure as a clinical staff to provide care to veterans and other VA facilities or to veterans in their homes and other locations.

Recognize fully that's not always the opportunity within other entities, and there might be some challenges for private groups that are to do so. But within the construct of federal supremacy and federal legislation, that is something that we are able to do in the VA we can support. As mentioned at the intro of this call, we're currently serving just a little over 700,000 veterans in this model today with plans to grow. Our starting point last year was really focused on primary care and mental health services, and we're expanding into surgical medical specialty and rehabilitation services. One of our colleagues earlier mentioned the challenge with in-person care that needs to be completed for some of the routine things.

So, primary care, for example, in a primary care visit might need to perform a biopsy, do an invasive exam, or sometimes veterans and patients just really want to have that face-to-face contact. And so, within the model itself for virtual care with this, we build in and bake in this idea that in addition to the virtual care, we intersperse that with some in-person deployments on a routine. During the COVID pandemic, of course, that's been challenging, and we've scaled that back until the bulk of our care is virtual, until we can travel again and catch up on some of those physical exams that we're delaying at this point in time. Or, we're asking veterans to receive care from other folks in the community where it exists to receive those visits. Next slide.

This here is, once you can receive this presentation, if you have it already, these are all hyperlinks that will take you to a number of resources where you can click on these and you'll see videos on clinical resource hubs, the ATLAS program that Dr. Heyworth mentioned as well as another effort that we're engaged with, which is Telehealth Emergency Management. This Telehealth Emergency Management takes advantage of the infrastructure built within Clinical Resource Hub as well as other VA clinicians across the states that may have capacity to provide virtual support to disaster environments. In our current pandemic situation, we have examples of infectious disease specialists, we have examples of social workers providing end-of-life care, and they are able to travel from one hospital system to another in a virtual state and provide additional manpower to provide clinical services to the surges where they occur across the states. In addition to the pandemic, we have experience with this in hurricane settings, post earthquake, and a number of drills, and so you can see here our resources as you click through those.

There's a lot more information that details the Telehealth Emergency Management overview of what we do. And then there's finally related to our modality of VA Video Connect, the devices that we use to connect better into their homes is also detailed here. And I think that concludes our presentation for the VA. I'll hand it back to our moderator. Oh, and I apologize.

We have a couple of background slides here. Dr. Heyworth, would you care to comment on the increase of VA Video Connect during COVID-19? I'll be happy to stab at that. So, you can see here, very similar to what we saw.

Sorry, Matt. I think I had to unmute again. So, I was talking on the, this graph basically shows the increase in video in the early months of the pandemic. So, you can see we already had an existing effort to expand video pre-pandemic but really saw that take off across multiple services, particularly mental health, who was using this at higher levels pre-pandemic. In looking at who actually had access to video at this time, breaking down the demographics of the patients receiving video, we can see that we

actually saw more video use amongst our veterans who were low income, who had a disability in our system, who were homeless, and who had multiple chronic conditions including mental health conditions.

Where our gaps remain with older adults and with veterans in rural areas, likely due to connectivity challenges. And we did not across the board see any differences as they relate to race and ethnicity. Thanks Matt, back to you.

Thanks, and if we could go to the next slide here. And if you want to remain unmuted, Dr. Heyworth, that would be great too. So, I'll just describe briefly what we're looking at here. This is a, I mentioned the example of the Atlas pod out of Eureka, Montana.

This is the physical location with Dr. Heyworth, center left, left photo, and this is a private booth, if you will, where veterans can receive their clinical care via primary healthcare consultative services or mental health services within the space in a VFW post in the community where there currently is no other access to any sort of clinical services. The veterans there would have to drive several miles to the neighboring community to receive some sort of care. So, this brings in services --.

And if we can go to the next slide on that so we can see the pictures.

Yeah.

You can advance one slide forward there. I still see the graph.

It's showing the pictures on my end. You did a nice job with the actual pod itself.

Okay, good.

And then there's a, the porch, would you care to comment on the porch setup at the American Legion there in Springfield?

Sure. So, two different ways of building out the telehealth access point depending on the existing space at the location. So, as Matt outlined, the Eureka, Montana, pod, essentially all you need is a space in a corner to have a pod inserted into. If you have an existing private room that can be modified, you have a wall solution where you can engage in that telehealth setup with closing the physical door and sort of creating a pod. So, two different conceptual options we have for this model of care.

And next slide please. That concludes our presentation. Thank you.

Thank you so much, Mr. Rogers. Presenters, thank you so much for providing our audience with such useful information. We will now go into our Q and A session. Audience, please remember, you may submit questions through Zoom by clicking the Q and A button at the bottom of your screen and then typing your question.

For our Q and a session, I would also like to welcome Dr. Stephen Parodi and Dr. Irene Chen, who will be joining us for the Q and A session. Dr. Parodi serves as Associate Executive Director for the Permanente Medical Group and is responsible for hospital operations, inpatient quality, patient safety, care of complex and special needs populations, skilled nursing facilities, home health, hospice, and analytics.

He is also Executive Vice President. Dr. Chen serves as Associate Executive Director at the Permanente Medical Group, where she provides executive leadership oversight and accountability for outpatient quality and population health programs and comprehensive and culturally responsive care to paneled patients at Kaiser Permanente Santa Clara Medical Center in English, Spanish, and Chinese. To start our Q and A session, we have a question regarding Kaiser's presentation. Can you please take a min to differentiate between video visits and e-visits at Kaiser?

Yes. No, definitely, happy to take that one. So, the term e-visits, I understand, can potentially be confusing because that's sort of the term that we use within our organization. It's relatively simple, and the same type of modality that's used elsewhere, but what it is basically is where patients can go online to get care about common health concerns, and depending on the situation, the patient can get advice from their doctor, get a test ordered, get a prescription written, receive guidance to schedule an appointment or to get further care. And so, it's sort of a way that they can do down a path to answer simple questions and get answers to their health conditions.

Right now, a lot of the volume of our e-visits is driven by COVID concerns. Prior to COVID, we did have additional conditions that we addressed including things like sore throat, cough and cold, pink eye, urinary tract infection, and things like that. And so, we've found that it's an effective way for patients to receive self-guided, self-directed care that they can access at their convenience.

Thank you very much. Our next question is directed towards the entire panel. Do the telehealth visits that you described include mental health as well as intensive outpatient programs and partial hospitalization programs?

Yeah, I'm happy to start with that and would love to hear from my colleagues as well. Our mental health teams are definitely utilizing our telehealth means, and our patients are using that to access care through there, and in fact, it's one of our departments that have seen the most success in terms of our use of telehealth and the highest percentages of telehealth. I think that, you know, with the pandemic, a lot of our patients are dealing with increase in mental health concerns, and there's always been some sort of a stigma with respect to receiving mental health care, and this actually has opened up the ability for our patients to access our mental health services in a private and convenient way. And so, looking across our organization, there are some departments within our facilities that are seeing up to 80% of their care being delivered through telehealth, and so it's actually been quite successful.

Yeah, and I'll just mention from the Kaiser Permanente angle that from a care experience point of view, we have gotten significant positive feedback when it comes to mental health care via telehealth. So, it's afforded patients greater agency, greater control, particularly with these sensitive conversations, being able to do it from an environment such as your own home is a safer place sometimes than having to transport yourself and adhere to all the COVID protocols that we have in place for in-person visits right now. The other thing I'll just mention is that there's been a great deal of training for our providers to make sure that we can have these sensitive conversations, and so, ensuring that we have, you know, the backup for individuals to feel comfortable, both on the provider side as well as the patient side with these visits has been critically important.

This is Irene. Just to also add onto the services that we offer, we understand that a lot of times it's working with the entire team. So, during COVID time, not only are there clinicians trained to do telehealth, a lot of the care team members, including the psychologists, the health educators, can also be part of this care extender team to provide telehealth. So, for mental health, we also offer group sessions as well as one on one in our remote telehealth platform. Thank you.

Thank you very much. And for the remainder of questions that we'll be posing today, if I can please ask our speakers and presenters to please identify yourself when you answer the question. That would be very helpful for the transcript purposes. Next question. Can you all please discuss the issue of interstate telehealth and whether or not we can look forward to or hope to look forward to a national solution to help resolve this problem, particularly when considering mobile populations or providers who are practicing in border communities.

This is Leoni Heyworth. I'd be happy to share the VA's experience on that. In 2018, we had legislation go through authorizing VA providers and giving federal supremacy for cross-state telehealth and recently had approval for trainees, to have this privilege as well. And this is something that is different for the private sector. So, I'll let my colleague comment on that piece.

Yeah, thank you. Steve Parodi from Kaiser Permanente. So, I think that what this has really shown, and actually, I'm envious of our VA colleagues because we are dependent on individual states participating in an interstate compact. Within our system, we do have a number of states that are participants, and so, we have been able to leverage the ability of an individual clinician to do care across state lines. And I would say this extends beyond individual provider practices that are near a state line.

This is really what the VA actually demonstrated that this is much bigger, that we are able to leverage services across, you know, the entire country if we will and if we need to. And in particular, when it comes to access to subspecialty services, whether it is during the pandemic or what I think we're going to be needing post pandemic, we really would welcome additional legislation to assure, number one, the ability to provide this care, but secondly to assure the quality of that care, and that we have standards built in to our licensing when it comes to medical licensing so that telehealth is recognized as an actual part of our practice of care and medicine and that there are standards that need to be fulfilled to be able to practice within an interstate sort of compact. Thank you.

And this is Leonie Heyworth from VA. We've been able to make good use of that with opportunities to support ICUs across our enterprise using volunteers, physician critical care volunteers from anywhere. So, it's certainly been something that has been particularly beneficial for the pandemic.

Thank you very much. Our next question is directed towards Dr. Heyworth. Do you have a training program that you can share or refer to for the patients to ensure that the patients are installing the remote exam devices properly?

We have extensive training on that, and in fact, you know, whether it's the complex equipment or the basic equipment, what we did actually during the pandemic was this concept of not leaving any veteran behind and ensuring that veterans were equipped and confident to do a video visit. We actually directed our facilities to implement a veteran test call program to walk through the basic equipment, software requirements in order for a veteran to then feel confident and able to do a video visit without too much trouble shooting during the time of the clinical encounter.

Thank you very much. Our next question asks can you all please highlight how you have gone about quantifying the changes in access among health disparate populations in your user populations while the pandemic has been going on?

Hi, it's Dr. Steve Parodi --.

This is Leonie Heyworth from VA --.

Oh, go ahead.

Okay, go ahead.

Yeah, so I'll start off, and then I was actually going to hand it over to my colleague, Dr. Chen, who has done a great deal of work in this area. So, early on, we recognized with reports actually external to KP and then also internally we started looking at actually outcomes, multiple types of outcomes. So, they're the ones that have been published when it comes to mortality, rates of admission, and then rates of actually just contacting our system or not based on ethnic and racial diversity, and so then we decided to actually take a deeper dive into looking at both from the telehealth standpoint, which I know we're talking about today, but also many different clinical care outreach programs and health education and engagement programs that needed to be formed and of course then informed by results based on the metrics that we had developed internally. And Irene, I don't know if you had additional things to add there.

Sure. Actually, can you repeat that question just so that I could address it more appropriately?

Yes. I would be happy to do so. One moment please. The question asks, can you please highlight how you all have gone about quantifying changes in access among health disparate populations in your user populations during the pandemic?

Thank you very much. So, this Irene Chen from the Permanente Medical Group. We internally actually follow a lot of metrics, and from the access perspective, we always look at how patients are accessing our care, and we are able to modify our metrics to include the telehealth portion so we understand the population that are truly getting the care. And in terms of patients that are leverage telehealth, we also can find out what's the percentage of population currently using our platform. And with that, we also track.

And I think in referencing to what Dr. Steve Parodi mentioned, as we outreach to patient at a population level, we historically have been following those measurements, understanding how we could engage them, for example, to come in for preventive care services. For every single message that we send out, we understand what the percentage of read rate of those messages and if there's an action to ask them to, for example, follow up with an appointment or do some lab testing. We also have internal reports to understand what the percentage of folks responding to them. And we also leverage culturally responsive messaging so that the outreach messaging are tailored actually with the specific cultural group to increase their engagement.

We understand by doing so we could increase their outreach. So, internally, we continuously have those performance improvement efforts to monitor, and during COVID time, we did have to tweak some of our languages so that we could ensure that the members understand our facilities are safe for them to come in and to help them weigh between the COVID situation with the healthcare that they need so that we can make a good, collective shared decision-making point. Thank you.

And this is Dr. Heyworth from VA. We also have monitoring of this continuously including reports that help guide us as far as what we've been doing for usage, the demographics of veterans engaging. It also helps that our congressional colleagues are very interested in the same. So, we're able to share that information with them.

Thank you so much for everyone's comprehensive answers. Our next question asks for the concept of the porches, how is access restricted to maintain HIPAA?

This is Dr. Heyworth from VA, I can go on that one. On the slide, I showed our video platform. We actually have the ability to lock the conference so that external folks can't join, even if they have the link to join. The provider can make that determination whether to lock the room and let somebody in or to lock the room and to keep it locked.

And part of our provider training is once everybody who is in the room is present to then go ahead and lock that conference room. The other thing is the emails and the text messages that are sent to patients with the video link are all federally compliant with and other standards for encryption.

Thank you very much. Our next question asks can you please share any strategies that would be beneficial when using telehealth systems and adapting them to dentistry and dental care?

This is Dr. Heyworth. We actually at VA had a number of our dentists use this, use our video platform to a great extent, and I'd be happy to share more information about that by email as far as the specifics of their program. They did use a basic telehealth setup, but as far as clinical applications, I'm happy to dive more into those details offline if there's interest.

Thank you very much. We also have multiple questions about the fotonovelas that were mentioned by the Kaiser presenters, and our inquirers are wondering if there is a way they can either see examples or have access to some sort of a template or anything like that, any resources that are publicly available that you would be willing to share.

Hi. This is Irene from the Permanente Medical Group. Our website is actually available on the public domain. So, for those folks who are interested, you could check out kp.org/mydoctor, and within that micro site, there is actually a search functionality where you could narrow down a lot of the resources that are available in Spanish and also Chinese.

During COVID time, we actually intentionally created up a specific website just on COVID resources, and we're actually expanding a subside of that COVID website to make it more visible for equitable care. And in it, a lot of our resources are available. And if you just type fotonovela in that search box, you'll be able to pull up a lot of the resources again available on public domain including even things like diabetes care, which is not related to COVID. And in the presentation slide, if you go back to the very last slide that Dr. Ed Lee presented, at the bottom right corner on that slide, we had talked about a text campaign.

And if you just look at the information on the slide, there is a phone number that you could text to and we the key words fotonovela, or if you put in key word like COVID. And if you just text that phone number with the key word to your cellphone, it will feed you a direct link to the website. And give it a try, and then if you could actually, as I mentioned, this is available on public domain, and we really believe in sharing all these resources with our communities to really improve the health outcomes. And you will be able to share this very quickly with any members that you like or any patients that you like so they could receive the website and start browsing on it. Thank you.

Thank you very much.

And this is Dr. Heyworth from VA. We have resources similarly available to the public on connectedcare.va.gov.

Thank you so much. I really appreciate both answers. And we will be sharing the website for the COCA call in just a few minutes, and you will be able to find those slides posted there that were mentioned. Last question that we have time for is can our presenters please discuss any strategies that have used or acquired during this pandemic, during these months, to actually extend the hours that visits were possible and that patients had access for visits by utilizing telehealth. Yeah, hi, this is Ed Lee from the Permanente Medical Group, and even prior to COVID, we have a clinical contact center that is 24/7, and here in northern California, and what they have the ability to do is to intake and provide advice to patients through voice, through a series of scripts and protocols, and if the script and protocol led to the patient requiring a higher level of care, whether it's a phone call with a physician or a video call with the physician, we have the ability to do that through our extended hours physicians that we're manning the video visits appointments during that period of time.

So, we do that in northern California. There is also a program that I am aware of in our mid-Atlantic states where they have an after-hours program as well. So, we've established those, and we are also looking to promote that throughout all of our different regions and have seen a good level of response and acceptance and appreciation for having that care that is at convenient times for the patients to access.

Thank you very much. This concludes today's COCA call. I want to thank all our presenters for their time and sharing this useful information. All continuing education for COCA calls is issued online through the CDC Training and Continuing Education Online System at <https://tceols.cdc.gov>. Those who participate in today's COCA call and wish to receive continuing education please complete the online evaluation by January 11, 2021, with the course code WC2922-120820. The access code is COCA120820. Those who will participate in the on-demand activity and wish to receive continuing education should complete the online evaluation between January 12, 2021, and January 12, 2023, and use course code WD2922-120820. The access code is COCA120820.

Continuing education certificates can be printed immediately upon completion of your online evaluation. A cumulative transcript of all CDC/ATSDR continuing education obtained through the CDC Training and Continuing Education Online System will be maintained for each user. Today's COCA call will be available on demand a few hours after the live webinar. You can find the video recording of today's call at emergency.cdc.gov/coca.

[gov/coca](https://emergency.cdc.gov/coca). You will also be able to find materials that were highlighted during this COCA call at emergency.cdc.gov/coca. Please join us for our next COCA call where the topic will be practical decision making for crisis standards of care at the bedside during the COVID-19 pandemic.

This call will be held next week on Thursday, December 17, at 2 p. m. Eastern time. Please continue to visit emergency.cdc.gov/coca to get more details about this call and others as we intend to host COCA calls to keep you informed of the latest guidance and updates for COVID-19. Be sure to subscribe to receive notifications about upcoming COCA calls at emergency.cdc.gov/coca. Also, please share these call announcements with your clinical colleagues.

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