EMERGING TRENDS IN HEALTHCARE TECHNOLOGY:
RURAL-URBAN HEALTH RESPONSES TO COVID-19

PANELISTS:
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Moderated by Alexander Mills, Senior Corporate Counsel at DaVita Kidney Care

[edited for reading]

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Casey Goggin: Without further ado, I'm going to go ahead and introduce our first moderator for our first panel: Alexander Mills. Alexander Mills is currently the senior corporate counsel at DaVita Kidney Care. Before joining DaVita, Mr. Mills worked as the Director of Operations and General Counsel at High Plains Crop Production and worked in the Healthcare Compliance and Operations group at Waller. He also served as judicial clerk to W. Neal McBrayer at the Tennessee Court of Appeals. Mr. Mills graduated from Western Kentucky University with a Bachelor's degree in psychology and received his J.D. here at Belmont College of Law. He had an impressive law school career at Belmont, graduated summa cum laude, and was a member of Law Review. He also participated in moot court and mock trial competitions. So I'll kick it over to you, Alex.

Alexander Mills: Thanks Casey. I appreciate the kind introduction and I really enjoyed that video a lot. Chase Doscher was actually a former mentee of mine in the Inn of Courts program, so it's kind of cool to see him on the video. And then I saw Caitlyn Page as one of the panelists in the past and she's also a former colleague, so that was pretty cool to see how this is developed over the past few years and how everything's coming along. As Casey said, my name is Alex Mills. Fellow Belmont College of law alumni and senior corporate counsel at DaVita Kidney Care. I'm going to be moderating today's panel discussion on rural and urban healthcare responses to COVID-19. Joining me today is Linda Rippey-Moore, General Counsel at Maury Regional Healthcare; Luke Hill, Chief Legal Counsel at Cookeville Regional Medical Center; Gabe Roberts, founder and CEO of Roberts Consulting Group; and Eric Gray, Managing Counsel of the Technology Law Group at HCA.

Just as a reminder: all views and opinions expressed here are those of the individual and do not necessarily reflect the positions of the clients or businesses they represent. With all that said, let's just go ahead and kick things off. I'd like to take a little bit of time here at the beginning for the four of guys to have a chance to introduce yourself and kind of talk a little bit about your practice and your experiences in healthcare, and with that I guess maybe we could start with you Linda.

Linda Rippey-Moore: Great. Thank you for letting me be here this morning. I'm General Counsel for Maury Regional Health. We are a four-county hospital system servicing a nine-county service region. Our flagship hospital is in Columbia, Tennessee, and is a 255-acute-bed hospital. We also have two other hospitals, a critical access hospital in Marshall County and a solo community hospital

in Wayne County. And being the sole in-house counsel I run the gamut of practice, both being a lawyer and on the operational side. I do a lot of contracting, physician-hospital relationship contracting, compliance, legal, risk management, and internal audit run up through me through a reporting structure, so I get a lot of exposure to those areas as well, so.

Alexander Mills: Great, thanks Linda. We are going to appreciate you sharing your experience with us today. Luke, why don't you go next?

Luke Hill: Thanks Alex, thanks for having me on the panel. Similar to Linda, I am the sole attorney at Cookeville Regional Medical Center, Chief Legal Counsel, been here about four years. We're a little smaller than Maury Regional in that we've got just one hospital and a good outpatient practice of about seventy-five employed physicians. Prior to this, I was at Baptist Memorial Health Care over in Memphis, and I appreciate you having me on the panel.

Alexander Mills: Glad to have you, Luke. Gabe, I think we've got you next on the screen.

Gabe Roberts: Sure, hey, thanks Alex, really great to be here. This is the second or third Belmont panel I've participated in. It's really a great resource for us and our community so I appreciate having me. I'm Gabe Roberts, I do consulting work now and have been for the last year or so, but before that I was at TennCare. I was the TennCare director, which is the Medicaid agency here in Tennessee, and then I was in previous roles before that including General Counsel. Started my law career at Sherrard & Roe and graduated from Vanderbilt, so been in Nashville for almost twenty years and I think Linda and Luke are probably glad that I'm out of TennCare. [inaudible] Looking forward to the conversation.

Alexander Mills: Thanks so much, Gabe. And last but certainly not least we've got Eric.

Eric Gray: Thank you. Morning everybody, my name is Eric Gray. I'm Managing Counsel of the Technology Law Group at HCA. First of all, thanks for having me and thanks for setting this up. It's an awesome experience for all of us, I think it'll be a good conversation. Everybody kind of brings a little bit of different flavor and backgrounds, so I think it's really good. I work for HCA. HCA is based out of Nashville, it's a healthcare company. We spread across I think around twenty states across the US. We have 186, I think, hospitals along with physician offices, ambulatory surgery

centers, urgent cares. We have a few practices in the UK, mainly around London, but that's our only international area.

So we're a little bit different. Luke and Linda run the show, I do not. We have around 120 or so attorneys at HCA with various different legal departments, kind of [inaudible] groups within the legal department. Our group is the technology law group. We support HCA's IT arm, so the [inaudible] of HCA providing all the technology and IT to all the facilities and other healthcare operations out there. We're kind of their general counsel support for them. A lot of my work, I'm not in the facility on day to day basis. We're more kind of in the background supporting. We do a ton of contracting–one of our kind of key areas we support is supporting and contracting with IT vendors, so a little bit of my perspective is how the contracting process has changed during the pandemic. Again, thanks for having me. Alex, back to you.

Alexander Mills: Thanks Eric. I think to start us off here I'm just going to kind of lob up kind of a larger question on the topic and we'll kind of get into more pointed questions as we go on. So to start us off, you know, the pandemic has generated this need for a wide range of innovations to kind of help overcome obstacles that it's presented, and find new and creative ways of meeting patients' needs. And I guess as a first question, what kind of challenges has the pandemic caused in your practice or at your business, and what kind of strategies have you guys had to implement to overcome these challenges? Kind of as a sub question, what kinds of digital initiatives have you worked with to try to overcome some of those challenges, or have you seen in the field? What have you guys found that's been successful, and maybe what kind of things have you done that have been not so successful that you've kind of had to rethink. I think we can start that one off–Luke would you like to take the first shot at it?

Luke Hill: Sure. You know, anytime you're talking telehealth, the starting point is HIPAA compliance. You know, security, safety. An old HIPAA mentor of mine always said there's bad people – the bad guys are trying to infiltrate at every opportunity that they can, so the starting point's always got to be HIPAA compliance. When we started–when the pandemic started early last year, it was–telehealth was on our radar but it was all of a sudden thrusted upon us that, you know, okay we've got this little run up and now it's, "We gotta go full boar into telehealth."

The technical opportunities, we went in all sorts of different directions. Started with Zoom, started with the go-to meeting, and

what we saw was there's a lot of bad actors out there. When back in March of last year, no one really knew even what Zoom was and then the whole Zoom hacking issue…A lot of people had to duck and weave and start going, you know, start focusing in on that security aspect of telehealth. And we here at Cookeville Regional ended up landing on a system called doxy.me[1], which I think a lot of other entities have utilized. We use that for our inpatient side, and then our outpatient side we use Athena Health.[2] So lots of different avenues for those connections to our patients, but the starting point's always got to be security, patient health security, HIPAA, and what avenues can we use to bring access to the patients that we treat.

Alexander Mills: Thanks Luke. Linda, do you have anything you'd like to add to that?

Linda Rippey-Moore: I guess we were blessed. We hired a manager of telehealth in 2017, sort of already viewing that this was going to be the direction that we would like to be heading. So we had already implemented at Maury a tele-stroke program, we had a few avenues of remote patient monitoring, we had implemented an agreement with IRIS, which was for diabetes patients for retinal imaging, and offsite, obviously, provider reading in a read-only format integrated with our server network. So we had done a few things and we had also started our Maury On-Demand, which is, you know, the app for urgent care visits. So we had already dipped our toes in to a number of different areas but obviously the pandemic changed, as Luke said, all those were HIPAA compliant, you know, it had been vetted completely. You knew the privacy, security aspects, you had your SOC reports, you had NIST standards being met–all of that stuff which is way beyond my expertise. But we had all our key players, stakeholders weigh in on all of that.

And then, obviously, to Luke's point–not that it went by the wayside, but with the waivers and more latitude on, okay, you know, Zoom isn't HIPAA compliant but how are we going to utilize that? Because we have patient care needs that aren't being met. We don't want the patients in the offices, there is a much greater risk of, obviously, bad outcomes for patients if we (a) don't see them or (b) bring them into the office because of PPE limitations.

All of those things played in and so to Luke's point, we deployed those same sorts of things and it was challenging, obviously, because it required a change of mindset where compliance didn't look the same way. And it was compliant under

[1] See DOXY.ME, https://doxy.me/en/ (last visited Jan. 8, 2022).
[2] See ATHENAHEALTH, https://www.athenahealth.com/ (last visited Jan. 8, 2022).

the law but it wasn't the way we had previously viewed compliance. And obviously the education, getting the technology, getting staffing to be able to support that change of workflow. So our experience was similar to Luke's in that regard.

Alexander Mills: Thanks Linda. I think you raise an interesting point there that I'd like to explore a little bit further in just a minute. But first just to kind of get maybe a different perspective on that first question, Gabe I'd like to hear some of your thoughts with your background at TennCare and your current consulting work. What kind of things are you seeing in your field as reactions to the pandemic, and what's been successful and maybe not so successful?

Gabe Roberts: Yeah. So what I think is one of the most interesting things really kind of builds on what Linda and Luke were talking about. You know, we had this rapid deployment and this rapid acceleration–perhaps we went years in advance in just a few months with respect to adapting to a telehealth environment, a virtual care environment, to payors kind of maybe coming off, to some level, kind of their, not hesitancy, but just concern around utilization, control, etc. So what I think is going to be really interesting is, what I've seen a little bit with some of my clients is, what are the policy implications kind of down the road post-public health emergency? I think, you know, from my perspective as a board member on a couple of providers, we've gone to almost entirely virtual care. And all of our quality marks have either been maintained or increased in some cases, which is a really interesting thing that the payors have said, this is really interesting and eye-opening for us to kind of see that.

And so when we kind of get back to whatever the new normal is, is there a chance to holistically review reimbursement in U-type, utilization management-type policies with providers? And maybe even as regulators, right? Say these are the outcomes that we want and we're going to be a little bit less prescriptive in how our providers get there. So I think that's helpful. I think maybe the second- or third-order, perhaps, policy implications are that do we get away from, or do we at least start talking more seriously about alternative payment arrangements for providers. I mean the rural providers in this state, and really across the country, have been really kind of at crisis points for a lot of reasons for many years.

And so, you know, you can't necessarily code yourself out of that. Now I'm not an expert like Linda and Luke are in their teams but that's really important. And so if you're driving cost reductions and you're driving efficiencies as a provider, there have some

bottom line impacts to you. And is there an opportunity for you to enter into symbiotic relationships with payors and/or regulators to be able to share in some of those efficiencies so that you're not just getting paid, you know, at a code level, so I think that's also interesting.

The third thing I would say that I've seen that I think works really well, in addition, clearly, to the virtual health piece is a lot of the providers reaching out, kind of especially in the last few months at the end of calendar year 2020, around trying to get folks re-engaged in the healthcare system. I mean there's wellness visits that have been missed, there are really important quote unquote electives that haven't been, that haven't happened, there is some education effort that's, you know, had to be taken back on by the providers. And I think that's going to be really interesting from a trust and relationship standpoint with the patients, and so I think that's also a value that providers can bring to the payors that might inform some policies down the road.

Haven't really seen a ton that hasn't worked. It seemed like early on it was kind of like whatever it takes let's do it. And then to Luke and Linda's point, you start realizing there's some pretty serious vulnerabilities legally, and so, you know, you've seen some really good adaption there. But I really think that this idea of a patient and provider relationship that can really drive value to payors and regulators is going to be something that will be a lasting legacy of this, and I hope that provides a little bit more fiscal sustainability to providers in all areas of the states and of the country.

Alexander Mills: Thanks Gabe. I think that both you and Linda have raised this at this point, and I think it's an important question to consider in all of this. You know, I think that in healthcare there's often a kind of a fine balancing line between innovation and regulation and that we want to find new and better ways to serve our patients but because of the highly regulated nature of the field, it's often difficult to adopt or try new things. And there's a lot of, call it "legal red tape" that we have to wade through before we can kind of offer those kind of solutions and, you know, it makes sure that guys like me have jobs so that's great.

But I'm interested in kind of hearing your all's experiences and how maybe that balancing act has changed a little bit during the pandemic given the urgency of being able to provide these new and innovative healthcare methods now, you know, with the need today. And I can kind of fill it up generally, or Eric would you like to start us off on that one?

Eric Gray: Sure, yep, thanks Alex. Yeah I mean a couple things come to mind on that, and maybe I guess my perspective may be a little bit different. I mean a lot of what we do in our group is focusing on data protection. So I mean looking at privacy issues, thinking how are these vendors, how are they accessing the data, number one, what are they doing with the data, number two, and then where is it going to be stored? Stored on our location, is it stored at their location, is it stored in some cloud for someone else that we don't know?

So back prior to the pandemic, you know, kind of like Linda said, it was a longer process. We had time, we had the ability to go do all these checks. We'd go through security checks, privacy checks, contract negotiations, operations…there's a whole bunch of different areas that get involved and areas we've got to kind of check off on the checklist to make sure we've gone down that road. With the pandemic, contract negotiations that used to take months or longer took days and weeks. And so we were doing things that hadn't been quicker, and again it was patient-care focused, I mean it was obviously needed to be done and we had to do it. But it was either we were, you know, taking on more risk or we were just doing things that we didn't have the answers, so it's kind of like we're jumping into the unknown. May be perfectly private, secure, all may be well, we just didn't know at that point.

And so our job was a little bit, I don't know if it was more difficult, it may have been easier because we had less time to go through things and to talk about it, but we had to take on a little more risk. So I think with COVID, obviously some of the regulations were eased. We had more rights, more abilities under HIPAA and other areas to kind of use some alternative options which we normally would not have been able to, so that was good and that was helpful. You know, obviously that took a while from when COVID started to actually those regulations and waivers kind of changed and came into play. But I think a little bit of it was taking on more risk, and it was finding how to, and we still do it today, but how do we get to the end quicker? How do we on the legal side get our boxes checked to make sure we feel comfortable from a risk perspective? How does operations get things out for the patients, get patient care going? So kind of like the groups are almost getting together and talking quicker.

And again maybe Linda and Luke and others have a different perspective. From our perspective we have, because HCA is big, there's so many different people talking and getting involved–things

take a long time. Now we're trying to get, kind of, all together quicker up front, and maybe that's, like I said, easier from their perspective because it's less people, maybe not, I don't know. But just from my perspective, it's hard to get everybody, all the right people in that room at the same time to make that decision. So it's just been a tough, interesting run.

And I'll just say from a legal contracting perspective, it's just funny because, again, we're trying to tell people what the risks are. So they tell us hey, this is the most important thing, got to be done, got to do it, legal is slowing us down. So we drop everything, focus on it, and then the next day they're like, "Well you know what, no that didn't work. We're now doing this." So it's kind of a funny thing of like, hey we're trying to run with you guys, just tell us which way to run! It's been an interesting time, good and bad.

Alexander Mills: Eric, thanks for your response. And given my experience relatively recently at DaVita, I think I know what you're talking about when you're trying to steer a ship that large with that many people, it can oftentimes take a long time to turn it and I think it provides the perfect follow up there. I may be wrong, but Luke and Linda I suspect that you guys are a little bit lighter on your feet as a smaller organization and able to pivot a little bit more quickly and kind of deal with some of this stuff, but maybe I'm wrong there. Has that been your experience or how are things working at your institutions? Would one of you guys like take that one?

Luke Hill: I'll just take that one. Yeah we're a little smaller obviously than large HCA-, CHS-type of systems. We do have the ability to make some changes and do them quickly, but that doesn't change the fact that the regulations are the same. And that we have those same considerations like Eric said. It's, you know, this direction one day and then the next day it's this direction. It changes fluidly and you have to be able to duck and weave.

You talk about innovations versus regulations…we saw a great relaxation from our friends at the government with regards to regulations and simple things like being able to do telehealth via phone quickly after the pandemic hit. You used to require the face to face interaction, that regulation was relaxed to allow our providers to have visits via phone. It's been all hands on deck, not just with making quick decisions here at the local level, but the government's been great with interim final rules and waivers and what not to help us meet that demand. So yeah, we're able to make those changes quickly but it applies to everybody.

Alexander Mills: Sure. Linda, Luke just mentioned some of the waivers and things that the government has been passing through the pandemic to make things a little bit easier on providers, give you guys the leeway that you need to react. Is there any waiver or allowance in particular that you found that you guys have kind of relied on more than another to really help you guys to react to these kind of changes?

Linda Rippey-Moore: Well I guess that the two things that really come to mind, and I'm certainly not an expert on exactly the minutiae of the waivers, but obviously the ability to use video for visits was huge. You didn't have to have the level of privacy and security all put in place, you could deal with it through patient consent, saying you understand that this is not a HIPAA-compliant format and yet you are consenting to have this virtual visit with me. So that's an obvious one.

The second thing is the reimbursement aspect, which is huge because obviously if a physician is going to provide the service, they also want to be paid for the service. And so the insurers paying for the services, which isn't quite exactly what you said, but that's a huge component. And obviously though that aspect has not been resolved for the long term, where it's resolved for the moment but not for long term. Also, site-specific, and I say waivers, but the ability to have the patient be at home versus be in a particular clinic site or ambulatory site location also is a factor.

And the long term impact of that is not clear. So for the time being it works, but at some point in time, and this kind of goes to Gabe's point of where that shakes out from a policy standpoint, from a payer standpoint, is going to have a huge impact on how we deliver care on an ongoing basis. Because the patient can like it, the doctor can like it–all that may work but if you can't get paid for it or the government says, "This isn't going to be an ongoing platform" via regulatory means, it's not going to be workable. So that that's where policy comes in.

Luke Hill: I'll step back in here, Alex. And I'll just say to Gabe's point and Linda's point that there's uncertainty with regards to payment, but I think that that will shake out because I think the general consensus is that everybody appreciates and likes telehealth. They like being able to do this, the convenience, the increased access to care. Yes, those conversations need to happen, but at least from what we've seen, the benefits are far outweighing the downside. And when you can move the needle on population health through telehealth, why wouldn't you have full payment parity for a

telehealth visit as if it was an in-person visit? At least that's what we're seeing.

Alexander Mills: Luke, I appreciate that perspective. I think that in general, we're seeing or finding that businesses can operate remotely, as we've been challenged to work from home over last year, and I don't see why it shouldn't be applied in a healthcare context as well. Particularly, with rural providers who may not have access to the same specialist or may have difficulties finding those and this being a potential workaround.

Gabe, I'd like to throw two questions your way, if you don't mind. The first being your take on how you advise your clients on the whole "innovation versus regulation" risk perspective, and then I'd like to get some of your thoughts on the issues that were just raised by Luke and Linda. What do you think the future of telehealth may look like after this pandemic, as far payor parity and side of service and some of these other issues that they've raised?

Gabe Roberts: Because I always do this, I'll start with the second question.

Alexander Mills: Oh good!

Gabe Roberts: You know, I think the jury is out, clearly, on what's going to ultimately end up being the case. I mean to Luke's point, I think there's a growing body of evidence that full parity of payment may very well be appropriate. I also think there's some growing evidence that, well, if we don't do full parity in payment, are there some alternative payment mechanisms that we can get involved in that may not be as beneficial to the provider at the point of service, but might over the long haul be beneficial to them. And I think that's going to be an interesting conversation to have. I think it depends on the provider's willingness to do that. I think it's going to be dependent on–can the larger health systems or the hospitals, or even physician groups, find participating physicians, and providers and NPs, etc., to be willing to do that? So I think that's going to be interesting. I think that then gets into some downstream issues from a policy standpoint around cross-border licensing, and whether doctors or NPs in Kentucky in their downtime can provide services in Tennessee, and what that looks like. And that'll take many more months, if not years, to regulate or resolve. And I'm staying clearly out of that fight. I've been there before too many times!

But I do think that's going to be a really interesting post-public health emergency piece. The providers, in my opinion, are

for the most part going to be able to show really good quality, really good outcomes. The question's going to be, okay, what does it look like, in amount-wise? And I think the jury's out on that. And I think that from the providers' perspective, clearly, I think there's a lot of really good evidence. But from the payors' perspective, and I'm kind of shooting the middle here, perhaps maybe too much, but I think the payors also probably have some really valid, if not concerns, at least thoughts around "What do we do?" and "How do we do this?", and "What does it look like going forward?" But where I'm hopeful, and what I do predict (and the only thing I feel comfortable predicting), is that whatever ultimately happens is going to be better, I think from a payment perspective than it was pre-COVID, pre-pandemic.

And look, I'm talking as a former Medicaid director that testified at length about both the benefits of telehealth in our Medicaid population and also the concerns around utilization, control, etc. So I mean, I get it. Frankly, I was part of the interests that probably weren't really good in advancing the conversation. The point is we're beyond that. I think we're beyond either the regulators or payors completely winning the argument and maybe the providers completely demanding full payor parity in payment. I don't know how it'll shake out. And it could be different depending on setting. I mean, rural and underserved and even in densely, underserved urban areas may have a much better shot at full parity than someone in a metropolitan areas where there's a lot of access. So I think it's just going to be interesting to watch, and my only prediction around how that gets resolved is it'll be a little bit down the road. So those are my thoughts on that piece of it.

With respect to innovation versus regulation and risk, I think that's really important. Luke hit on some really interesting topics there, and so did Eric. I think that at the end of the day when you're trying to advise your clients, I take the same perspective that I took with my team when I was with the state, like tell me what the risks are, and then I can weigh, pretty good, what is the need for access? What are the patients' needs? And if the risk is not completely mitigated, depending on what the needs are and how exigent they are, I might be willing to take that risk and just deal with what happens down the road. I don't know if that's how every provider is, but my perspective is that all the providers that I've worked with, both as clients but also when I was at the state, the patient needs always will come first.

Reimbursement is a close second, because you can't keep the lights on and continue to increase access if you don't get paid

for what you're doing, to Linda's point. But I think it just becomes, how comfortable are you and how comfortable are we as a system, being able to weigh that risk in operating gray areas where there may not be clear answers because of things that we didn't anticipate. And I think that goes to preparedness, right? I mean one of the things that I've seen that I was really impressed with was how fast state regulators, and I mean all of the regulators, so the governor's offices, the legislators, the Medicaid agencies, the public health departments, as well as CMS, really activated and came quick to say, "We may not be able to provide the silver bullet to make this work for everybody, but we're going to start relaxing things and we're going to start taking the low hanging fruit, and we're going to do that quickly, and then we're going to try to look at some more incremental steps." And I think that's been pretty interesting.

The last thing I'll say on it–you know, there's a lot of frustration I think, even well-intended policy, well-intended regulation, protection-type issues…There can be some real frustration when on-the-ground operations realize they're inhibiting us from providing better care. I think the part two regulations around connecting folks with substance use to better care, depending on who can see that, and how it's been one of those things that have maybe gummed up the works a little bit, with respect to continuing care and handoff between providers, etc. And so again I'm hopeful that those types of things have not only…we've realized as a system that they may not work, but I also think we realized that maybe some of these are creating some barriers to access of care, maybe some health inequities that really are going to advance the conversation to try to address those down the road.

I don't know that we'll ever get to an innovator's dream with respect to health care regulation, but hopefully we at least have a better working construct in context for the next generation of leaders to come in and say, we need to be able to have legitimate protections and control the system, also allow, around significant issues, some flexibility, and if something doesn't work just right, let's don't throw the book at him. Let's just stop, reassess, and go in a different direction, as long as everybody was well intentioned. So that's my hope. That's not a great answer, but those are my hopes.

Alexander Mills: I think that's actually a really interesting point and I really keyed in on the word you used: flexibility. I think that's a good hope to have going forward, maybe a less-rigid environment where innovation's a little bit more encouraged and looked at a little bit more positively as we try to change and adapt through strategies to promote access to health care.

I think everybody's already touched on this question a little bit but just to maybe dig in a little bit further, or if any of you guys do want to comment on it. What kind of impacts are you seeing from telehealth, as far as access to care of you patients, the effects on quality of care, how is it affecting your overall system? I guess I'll just throw that one out there generally, is there anyone who would like to take it?

Linda Rippey-Moore: I'll take it, at least the tee up of it. It's interesting being in more rural communities, I think Luke said that their community has embraced it, ours has been a little less embracing. In the beginning, and we're pretty far flung in our in our service area, our telehealth manager said it was probably telehealth visits, these virtual visits, were probably 30 to 35% of what was being utilized in the spring. Dropped off at the end of the summer to about 10%–actually no, take that back– dropped off to about] 5%, and then in the peak in January was back up to about 10 to 15%. So it's not clear that, from our experience anyway, that it is being embraced.

What we've concluded is that a lot of it is doctor-driven, that if the doctor is gung-ho and on board with it, then the patients are more apt to embrace it. If the physician is not gung-ho and wants to see them, which is more common in a more rural setting, then the patients aren't insisting upon it. From a quality standpoint, from what we can tell, there has not been a decrease in quality. There has been an increase–our satisfaction scores, generally, have been higher, which is awesome.

So those aspects are good but I don't know what others are seeing, obviously, Eric and Luke, in terms of the patients coming in, but we are seeing patients that are continuing to delay care. Our cancer diagnoses for patients coming in are at a–and I'm throwing this out there, I don't know exactly what the statistics are–but more stage-three, stage-four, than we have historically seen. We are seeing a decline in volumes in our clinic, just encounters (however you want to count them, virtual or just in the office), a decline in encounters across our system, in our ED. So our patients just delaying care, not necessarily embracing the technology per se or not, just opting out. And that has, obviously, financial implications but also public health implications. And I don't know what the others have experienced.

Luke Hill: I'll jump in right here. What Linda says, you know, the physicians really drive this. If you can convince your providers that

teleheath is good, and we struggled with that as well. We had a lot of physicians that just didn't want to embrace it and we had to have a plan for, okay, what does this physician need to be able to embrace telehealth? Do they need additional staffing, do they need additional equipment? Those are some of the hurdles that we encountered.

But once you get the physician on board and they realize, this isn't so bad. I can still deliver a good solid diagnosis via telehealth, be comfortable with it. We found that a lot of them–we turned to them, they liked it and the patients seemingly do as well. You talk about some of the hurdles, good lordy. For two months we had trouble getting laptops, we had trouble getting into webcams and microphones, I mean it was like buying toilet paper there for a little while. But once you got that infrastructure down, once you got the staff needed for our physicians, and you help them see that telehealth was a good option, it seemingly was well received by physicians and the patients that they saw.

Eric Gray: Hey Alex, I'll jump in real quick if you don't mind, I'll go kind of fast. From HCA's perspective we've had an area focusing on telehealth for a couple of years, probably longer. I think it was just a slow slog, trying to push people that direction, trying to explain the benefits and how it could work here and there, and everything else. And from their perspective this just ratcheted it up, this just pushed them ahead years and years based on a few months just because everybody was going towards it.

And probably everybody else has said, once people started using it, they saw that it actually was working and was workable in many different areas, and there was a patient satisfier. If you have a communicable disease, instead of coming in and sharing with everybody, you're actually calling on the phone and maybe they direct you to the right place. Say, hey wait a minute, no no, don't come in, don't sit in the waiting room around all these twenty other people, wait over here, we'll get to you. I mean it's just trying to direct them to the right place has been a huge new area for HCA, and again for everybody's health, to make sure that patients are safer, to make sure the doctors are safer, to use less PPE, waste less equipment. It's just been a big dramatic positive, for the most part.

To everybody else's point, with all providers. If you've got all different providers, not everybody's going to love one system. Not everyone's going to love it or not everybody's going to think it's going to work for their practice. But I think with training and education, can kind of help get them going. Once they started it and saw it was working, that obviously increases things dramatically.

From what I've heard, a lot of it was really based on patients' technology. The patient didn't have access to something or didn't have the technology they needed, then it just didn't work well. It was either a choppy interaction or just didn't go well. Those, from what our perspective was, was the main area where it didn't work very well, some people didn't like it. I think as long as people had Wi-Fi it worked well, the connection was good, people like it and enjoy it. It definitely has uses but just making sure it works going both ways was it was a big key.

And again, into the future what it's going to look like, I don't know. I think our telehealth visits went up dramatically, have kind of come down a little bit. People think they're either going to level off or go down a little more once it gets back to normal. From a personal perspective, I've used it a couple times, I thought it was great. Didn't have to go drive 30 minutes to the doctor, sit in the waiting room for 20 minutes, sitting in the back room for 20 minutes, talk to your doctor for two minutes. I mean I felt like it was a nice process, I think there definitely are uses. I think to Gabe and everybody else's points it's going to be, what are those uses? How does that work, how does payment work, what's proper? Getting all that together is just going to take some time.

Alexander Mills: Great! I definitely want to try to find some time to dive into some questions about HIPAA with you, Eric. But first I'd like to just kind of pick up, it's a point that you guys have all just touched on, and Linda I actually wrote it down when you said it. Adoption of telehealth has been doctor-driven and maybe that's a little bit more self-evident for those of you guys have been practicing or involved in the health care industry longer than I have. But the adoption of a new treatment method, looking at telehealth and that kind of lens, I guess I thought of it as initially, you have to sell this to the patients. But really it's the doctors in large part who are driving this practice.

So I guess the question then is what efforts are being made to educate doctors about telehealth? Is this a situation where you have to get the boomers to get comfortable with Zoom and new technology, or how do you get them more comfortable with using telehealth? And as a follow up to that, are there certain practice areas that adopt themselves more readily to telehealth and other ones that maybe are not as appropriate, and that you think that going forward, post-pandemic, will probably revert more naturally to face-to-face encounters.

Linda Rippey-Moore: I think it was directed at me, at least to start.

Alexander Mills: Wide open!

Linda Rippey-Moore: Obviously there are some specialties, if you have to have a hands-on exam, orthopedics, surgeons, for the most part. Obviously, you can do the pre-surgery, post-surgery education, follow up. But for a surgeon, wound debridement…there are certain things that you've got to be there and they do not lend themselves typically to telehealth.

Primary care certainly does, we've seen neurology, like I said we've got tele-stroke. We're utilizing some outpatient initiatives like two nursing homes in our community where we're using our critical care nurses. They round virtually with the nursing home facility to say, is this a particular patient that needs to come in, basically. They do education on sepsis, on antibiotic stewardship, so like I said behavioral health is a perfect one, I think because it is a critical need in our community. We actually have a joint venture with HCA for a behavioral health hospital in our community, but apart from an inpatient admission, needing that virtual visit. And we are looking into that platform to provide that for our staff, for our employees, for patients, and for the community generally through an app and through artificial intelligence because that is a critical need.

But back to your point about the doctors being on board–yes, some are, some aren't. It's driven by specialty, it's driven by their own belief about it, you know, back in the day, not thinking that nurse practitioners could do or be as valuable to their practices as they are. Can you do a virtual visit? That's confidence. Can you do a virtual visit as well as you can do it in person? So it's education to them and convincing them that, yeah they're as good virtually as they are in person. Some feel that way, some don't, some like to see the patients. It's preference. That's the way they've always practiced, that's the way that they want to practice. It's how savvy they are technologically, it's multifactorial, it really is.

Luke Hill: Even a piggyback on that, some of the areas that people don't realize that we implement some form or fashion of telehealth is, when the pandemic hit, all hospitals put a stop to visitation. Get the foot traffic down. And what that resulted in was the inability to communicate with families and we struggled with that. I think everybody struggled with that. When you have a patient in a bed that has a family member standing next to them, that they're serving as a surrogate. And when you take that surrogate out of the situation, and because of COVID we thought, "Hey you can't be in the facility,

zero visitation," you take that person out of the care plan and out of the communication loop. We struggled with that, and so there's a telehealth aspect there. What strategies should we be implementing to allow the family member that's serving as the surrogate to communicate with the patient, to communicate with the physician, to serve in that role as the caregiver at home.

Another aspect that we struggled with was, when the whole PPE thing was happening and we had to conserve, can we create some sort of telehealth communication between the patient in the room and the caregiver just out in the hallway. You know, reduce the number of visits into the room so we can conserve PPE. We don't have to don and doff all the protective equipment. To say that we're still struggling with that today, even though the COVID numbers are down, we're being very mindful of our PPE and if we don't have to don and doff all the gear, we're trying not to. Telehealth is a lot more than just patient and physician, it's communication with family members and in the patient rooms. The breadth of telehealth is a lot more than just that, "what can I bill for, is this a visit and a diagnosis."

Alexander Mills: Thanks Luke. We are running somewhere short on time, but two things I would like to do is Gabe, I'd like to get your perspective on this question. You disappeared–there you are, everybody just rearranged on my screen really quick, and it threw me off. I'd like to get your perspective on this question, Gabe. And then, Eric, I would like to talk to you a little bit about HIPAA before we close.

Gabe Roberts: Yeah, I'll be quick. I mean, Luke's point he just made is so smart and it's so good about there's so much more from a real doctor and patient interaction, often times. Especially in hospitals, but it can be in nursing facilities; it can be in a whole host of cases. That there are surrogates and advocates and caregivers and family members that are really important to that equation. And really thinking about and reminding us to think about that telehealth can't just be between the doctor and the patient. I mean, it can. But it doesn't have to be, and it shouldn't be considered that way. It's too much of a false constraint. That's such a good point.

The only other thing I'll say is that everybody did a great job explaining my thoughts. What I've seen is more of a, this is not profound, but continued disaggregation of care from institutions. So, trying to partner some type of virtual care with some type of in-home. Or, you know, providers in different locations and trying to be better about resource allocation. I think that's going to be

interesting to see how that shakes out. And then I think the earlier point about consumer behavior. I think the point was that consumer technology drove a lot of the ability for doctors to really drive in on telehealth early. I think consumer behavior is also interesting. I mean, I know a couple years ago when I had friends that would do Skype, it seemed like *Back to the Future*[3] to me, or *Demolition Man*[4], like my 1980s movies references. And now with FaceTime, and how normal that is with my kids trying to talk to my parents six hours away, it now kind of seems like a normal call is like a telegram. And so, I feel like, that whole consumer evolution of behavior is also perhaps going to be a boon to whatever the kind of post-public health emergency looks like from an adoption standpoint.

Alexander Mills: Thanks Gabe. Eric, so this next question could probably be the topic of an entire panel, but we've got around three minutes.

Eric Gray: Perfect.

Alexander Mills: Do with it what you'd like. You know, we spent a lot of time talking about the telehealth regulations and kind of how they've changed during the pandemic and how we expect some of those changes to kind of continue after the pandemic and then kind of change how healthcare practice is working going forward. But what about HIPAA? I mean, I think we've had to loosen up some of these regulations in order to allow people to react to the pandemic, but I would suspect that you will probably see that stuff tightening back up in a post-pandemic world. What kind of changes do you think might occur with how we control privacy given that, you know, there's probably going to be this wider adoption of telehealth moving forward?

Eric Gray: Yeah, and like you said, I think I have one minute or maybe less, I that's a ton of time. Well, and I guess couple things on that. I mean, I think the, and I'm not sure if this is where you're going but I guess I want to talk about, privacy laws overall are just scattered. There's nothing that's, not a one law that's kind of on point. I mean you have HIPAA.[5] You have the new Cures Act, which puts out these new information blocking laws.[6] You have state privacy laws. You have the CCPA.[7] You have GDPR in the

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[3] BACK TO THE FUTURE (Universal Pictures, 1985).
[4] DEMOLITION MAN (Silver Pictures, 1993).
[5] 42 C.F.R. § 164 *et seq*.
[6] 21st Century Cures Act, PUB. L. NO. 114-255, 130 STAT. 1033 (2016).
[7] CAL. CIV. CODE § 1798.100 *et seq*.

U.K.[8] You don't have a unified federal privacy law on point, other than HIPAA. And so, kind of keeping track of all of those I think is making our job really, really hard. Cause, I mean, HIPAA is telling us, you have to restrict data, you can only use PHI in a certain way. These new information blocking laws actually tell you they want to expand that. They're trying to say, "Hey, the patient wants you to give all of their data to this app developer. You need to do that." And it's kind of like, we're trying to say, "Hey, wait a minute. HIPAA is very restrictive about what we do. Now we've got these new information blocking laws that tell us, we have to kind of open it up. It's just very confusing right now. Then you got, we have patients in California, so you got the CCPA. We have, we're in the U.K., we have the GDPR.

So it's just, I don't know if I'm answering the question, and I'm kind of doing it in a roundabout way. But it's just, right now, it is very difficult to comply with all of those different laws. So, I mean, we're hoping that the government is going to say, "Hey, let's actually think about that. Let's get something more on point and more unified so that actually it's an easier way to kind of get yourself through all of those different laws." So, right now we're having, we're struggling a little bit between, "Hey, we're protecting our patients' data," which we think is very, very important and that's our goal. But, then there's these other laws about that, "Hey, don't restrict how you send data to an EMR or to a payer or to an app developer. And so, kind of, making those all work together I think has been really tough so far and it's going continue to be, so.

Alexander Mills: That's an interesting point. That whole idea that we need a unified theory of privacy law or maybe a unified thing. I see Casey popping back on. We're out of time. I probably went a little bit over. I just want say, thank the four of you so much for coming on and thank you to the Belmont Health Law Journal. I've had a lot of fun doing this. This has been great.

Eric Gray: Agreed. Thanks.

Linda Rippey-Moore: Thank you.

[8] 2016 O.J. (L 119).