Speaker 1: 00:01 Quality Improvement In the Time of COVID-19 is brought to you by the American Heart Association with support from Novartis Pharmaceuticals. As physicians, scientists, and researchers worldwide struggle to understand the COVID-19 pandemic, the American Heart Association has developed its COVID-19 CVD registry, powered by Get With the Guidelines, to activate data and aid research on the disease, treatment protocols, and risk

Dr. Sandeep Das: 01:41 So Kannan, can you tell us a little bit about the heart failure program at your hospital before the COVID era?

Dr. Kannan Muth...: 01:47 Certainly Sandeep. We have a strong interest in understanding the continuum of heart failure therapy. And I think one of the things that we worked very closely on is transitional care for heart failure patients. So we have a special program called the Heart Failure Bridge and Transition Team, that's really designed to help ensure close follow-up after the hospitalization for patients who are hospitalized with heart failure.

metrics. Do we need new metrics for the virtual environment? Do we need to adapt any of the existing metrics?

Dr. Kannan Muth...: 04:58 It's a great question. I think one of the things that's different about this environment is, we don't even necessarily have a full description of what we're doing. So even before I think we can get to process metrics that drive outcomes for telemedicine, I think we would really want to understand what is a description of how we're employing this? How are we using this within

Dr. Kannan Muth...: 07:31

Absolutely Sandeep, it's such an important question. This is something that people have described as a digital tech divide or gulf, where people who could use this infrastructure the most, then be supported the most by it. A population that perhaps is burdened by a lot of comorbidities and would benefit the most by not coming into the hospital during the COVID era, because they're at the highest risk for contracting the disease and ultimately suffering from it, is also the population that has the least support to avail themselves of telemedicine. We talk about Apple watches or other devices that can help us take care of a patient remotely. Being able to use a video to at least have some type of proxy for physical examination. But some of these things people just don't have. If you don't have a data plan, if you don't have a smartphone, you're not able to avail yourself with these things.

So, I think this is a big problem, where we're stuck in this paradox. We have this conundrum where the patients who need telehealth the most, we're least able to deliver it to them. And so, I think as a society, we want to address this. So, I have a lot of concerns about this motion towards telehealth, creating greater rather than fewer gaps in health equity. And I think that's something that we have to pay attention to.

Dr. Sandeep Das: 08:46

Yeah, it's a tough situation, definitely. And Robin, I wonder if you could comment on the role of advanced practice providers in the developing new treatment paradigm?

Robin Fortman, ...: 08:57

Yeah. I think the advanced practice provider, really pre-COVID,

Dr. Kannan Muth...: 12:57 Yeah. So one anecdote, I have twin girls that are six and, if I had a patient that I need to talk to, not that this is an everyday thing, but if I need to talk to them, I'll say, "Yeah, let's schedule a telehealth visit for 8:00," after the kids go to bed. That's not something that you can do routinely. So in some ways, it's a blessing and a curse, this whole digital connectivity we now all experience. But in many ways, I think, it offers flexibility for

get a stent. Or an EP physician for an AFib ablation. Or even just a conversation around atrial fibrillation ablation, seems at that point, "Okay, I've already seen the cardiologist. I already know the center. I trust the cardiologist, and therefore I trust the cardiologist's referral within the discipline," that secondary referral within the space, it seems like patients are very happy to5.6 (5.6 (5.7 l)2.7 (i)1p-1.3 (ic6 (m- (ic6 (m6.6.3(e))28 (p)5 9(e))28 (p)5

Dr. Kannan Muth...: 20:42 I think they should. I think that coupled with that, we also have to understand that not everything that is said out loud versus typed, versus vetted or peer reviewed, is perfect the first time. So I think we have to also build an expectation that look, when we're speaking, what comes out may not be precisely what is meant in that moment. I think if anyone looks at a transcript of how they actually speak day-to-day, they would be completely horrified. So I think so long as we build that expectation that, hey, rely on the written, vetted document, over what comes out in natural speech, I think that is reasonable.

The next level of that is, should patients have open access to hospital notes and things like that? Also, it's a challenging question, because it is patient information that ultimately patients have access to, but also the way we write to each other, to nurses, APPs, is very different than how we would discuss something directly to a patient. So I think that might require a little more careful thought, thinking about what written documentation in real time is accessible to patients, versus what is accessible to patients after going through medical records and things like that. But it's a great question. I think we're moving pretty quickly to something like that.

Dr. Sandeep Das: 22:08 Fantastic discussion. I'm wondering if you guys have any parting

number three, we have to figure out a way to balance those two things and be able to reach out to people wherever they are, but at the same time, bring them into where we are, and therefore be able to deliver better care for them.

Dr. Sandeep Das: 23:52 Thanks guys for a great discussion. It really struck me how similar things that you describe at Northwestern are to things that we're seeing in Dallas, and I bet that means that it's similar to a lot of cities and institutions across the country. I do think