WashingtonState TelehealthCollaborative

Meeting Minutes

January 26, 2022 | 10:00 am - 12:00 pm

Virtual Zoom Only Meeting

Member attendance					
Sen. Ron Muzzall	Y	Dr. Josh Frank	N	Dr. Ricardo Jimenez	N
Sen. Annette Cleveland	N	Joelle Fathi	Y	Dr. Geoff Jones	Y
Rep. Marcus Riccelli	Y	Karen Gifford	N	Scott Kennedy	N
Rep. Joe Schmick	N	Dr. Frances Gough	Y	Mark Lo	Y
Dr. John Scott	Y	Sheila Green-Shook	N	Heidi Brown	Y
Dr. Chris Cable	Y	Emily Stinson	Y	Adam Romney	N
Jae Coleman	N	Sheryl Huchala	Y	Cara Towle	Y
Stephanie Cowen	N	Claire Fleming	Y	Lori Wakashige	Y
Kathleen Daman	Y				

Non-Member Presenters: Dr. Jacob Gross (UWM), Dr. Mackenzie Welsh (UWM), Christopher Chen (HCA), Jane Beyer (OIC), Hanna Dinh (UWM)

Public attendees *(alphabetical by first name)*:

Alicia Eyler (SCCA), Cameron Long (WA Gov), Crystal Chindavongsa (Sound Government Solutions), David Streeter (WSHA), Erica Bryan (Valley Medical Center), Erin Christianson (Seattle Children's), Gail McGaffick (WSPMA), Gayle (National MS Society), Jaleen Johnson (NRTRC), Jeb Shepard (WSMA), Jodi Kunkel (HCA), Kai Neander (EHMC), Leslie Emerick (WA State Hospice and Palliative Care), Lisa Roche (unknown), Maia Thomas (DCYF), Marissa Ingalls (Coordinated Care), Meg Jones (PacificSource Health Plan), My-Phuong Jawort (UWM Pain Medicine), Mike Zwick (Cambia Health Solutions), Molly Shumway (UWM), Nancy Lawton (ARNPs United), Nicki Perisho (NRTRC), Patrick O'Brien (UWM), Rachel Abramson (UWM), Shannon Thompson (WMHCA), Stacia Fisher (Providence), Stephanie Shushan (CHPW), Travis Tomulty (Eden Health Telehealth), Tyler Bloom (Sea Mar), Zach Correia (MultiCare)

Meeting began at 10:00 am

WashingtonState TelehealthCollaborative

Welcome, Attendance and Review of Meeting Minutes - November 4, 2021

Dr. John Scott [0:00]

Dr. Scott (Chair) reviews minutes. Dr. Geoff Jones (Newport Community Hospital) motioned to approve minutes. Dr. Mark Lo (Seattle Children's) seconded. No edits suggested. Unanimously approved as submitted.

Action Item:

- Mrs. Dinh (Interim Collaborative Program Manager) to post approved November 2021 notes on WSTC website

State/Federal Updates

Dr. John Scott [11:19]

- The CONNECT for Health Act permanently removes all geographic restrictions on telehealth services and expands originating sites to include the home
    - It would also allow health centers and rural health clinics to provide telehealth services, a provision currently in place due to the pandemic on a temporary basis.
    - Press release here.
    - One pager here.
- H.R. 5837 was introduced to the U.S. House of Representatives where the legislation expands access to telehealth services relating to substance us disorder treatment.
- The National Health Law Association released this briefing on telemedicine fraud during the pandemic and beyond.
    - The acceleration of telemedicine brought in certain pandemic waivers where there's a push to make these permanent in further expanding telemedicine coverage. However, the impact of these laxer restrictions may create conditions susceptible to fraud and abuse in the post-pandemic world, which calls for telemedicine to be increasingly monitored.
- The Telehealth Expansion Act of 2021 (H.R. 5981) makes permanent a waiver created by the CARES Act in allowing Americans with Health Savings Accounts (HSAs) to access telehealth services without first having to meet their deductible.
- The Cures 2.0 Act includes several telehealth provisions, including permanently removing Medicare's geographic and originating site restrictions, and gives the HHS Secretary the authority to expand the licensee groups that can bill Medicare for telehealth services.
    - Press release here.
    - Section-by-section bill analysis here.
    - Bill text here.

- The American Medical Association's CPT panel has established a new code, or "modifier" (Modifier 93) that will indicate whether a health care service was furnished using audio-only communication. This new modifier became effective on January 1, 2022.
    - More details on this modifier here.
- This article looks at the historical effects of redlining on broadband access that was taken from Milwaukee, Wisconsin
    - The redline maps can be cross referenced with The Federal Communications Commission (FCC) fixed broadband deployment maps.
- The study on Video Teleconferencing for Disease Prevention, Diagnosis, and Treatment looks at video teleconferencing as a substitute for in-person health care or as an adjunct to usual care
    - Replacing or augmenting aspects of usual care with video teleconferencing generally results in similar clinical effectiveness, health care use, patient satisfaction, and quality of life as usual care for areas studied.
- Revisions are currently being made to the Digital Equity Act Bill, which is a modified version of SHB 1460 (2021). It aims to close the digital equity divide by increasing the accessibility and affordability of telecommunications services, devices, and training.
    - This bill establishes a broadband assistance program (a state lifeline program), a teleconnect service program (a state e-rate program), a digital equity opportunity grant program (formerly CTOP), and a digital equity planning grant program.
- H.B. 1708 restricts the ability for hospitals to charge facility fees for audio-only telemedicine

H.B. 1821: Definition of established relationship for purposes of audio-only telemedicine

- Redefines what constitutes an "established relationship" for the purpose of insurance coverage for audio-only telemedicine services, to apply to all state regulated health plans
- In mental/behavioral health settings, an established relationship is constituted by:
    - an in-person or audio/visual telemedicine encounter with a practitioner at the **same medical group or clinic within the last three years;** referral from a practitioner who has provided in-person or audio-visual telemedicine services **within the last three years**; OR in any scenario where the treating practitioner **has direct access to the covered person's "current health record."**
- For services other than mental/behavioral health the standards are similar:
    - an in-person encounter with a practitioner at the **same medical group or clinic within the last two years;** referral from a practitioner who has treated the patient in-person **within the last two years** and has provided relevant medical information to the treating practitioner; OR in any scenario where the treating practitioner **has direct access to the covered person's "current health record."**
- Bill text here.

Questions/Discussion

- Representative Riccelli asks the Collaborative to think about ways to strengthen digital equity, which will help reinforce the legislation around this issue

- Representative Riccelli shares that a lot of money was allocated for broadband expansion last year, but rollout is ongoing. The next step is determining how to repurpose this money with the goal of lighting up the state from an equity side.
- Representative Riccelli shares updated language around access to "sufficient" patient's health records. Link available here.

PROPOSED SUBSTITUTE HOUSE BILL 1821
By Representative Schmick

Original bill: Changes the definition of "established relationship" for purposes of audio-only telemedicine reimbursement.

Substitute bill compared to original bill: The substitute bill:

- Removes direct access to a patient's health record as a separate way to demonstrate an established relationship; and
- Instead, requires access to sufficient health records to ensure safe, effective, and appropriate care services in all circumstances where an established relationship is required for audio-only telemedicine.

Committee: *House Health Care & Wellness Committee*
Staff: *Jim Morishima (786-7191), Office of Program Research*
Draft: *H-2351.1/22*

- Dr. Frances Gough (Molina) shares a concern around access to the Medicaid population, specifically among Behavioral Health providers that are small or not a part of a large system. As a result, they may not be able to access health records.
  - The current language also greatly impacts the ability to use the larger vendor models that employers and health plans are using to provide value-add for their members/employees
  - Her ask is to consider having accommodating language for the providers at small systems, especially Behavioral Health providers and for the Medicaid population
  - Dr. Gough will send Representative Riccelli some suggested language
- Dr. Chris Cable (Kaiser Permanente) clarifies that patients can have multiple health records in multiple systems, which he thinks is not the intent of this language. The intent is clarifying what it means to have a relationship.
  - Because relationship-based care is part of the definition and foundation of primary care that the current health record should be defined as where the patient's primary care is currently being delivered.
- Dr. Geoff Jones (Newport Community Hospital) thinks "sufficient" is the key word in this language.
  - As physicians, they are trained to evaluate patients without records – records are nice, but not essential. Patient have multiple records and so, physicians would have to access which records are sufficient to treat their patients.

        - Dr. Scott comments that many patients do not know what their medications are and if physicians are not able to verify their medications, there's a potential for drug interactions/allergies.
    - Jane Breyer (OIC) comments that having physicians have some context around the patient's whole health is the goal of this requirement, especially for those who have medical comorbidities and Behavioral Health disorders.
        - "Sufficient" is a term that has a fair amount of wiggle room and relies on the practitioner's judgement. It depends if people are comfortable with this much flexibility on the practitioner's end.

Action Item

- Collaborative members to send any suggested language to Representatives Riccelli and Schmick

UW Medicine: Pain Medicine Tele-Resources

Drs. Jacob Gross and Mackenzie Welsh (UWM) [30:42]

The Problem

- Pain is complex, as is Opioid Use Disorder
- Often overlap
- Both are biopsychosocial phenomenon
- And both are challenging to manage

Consensus: Five Most Concerning Behaviors

1. Missing appointments
2. Taking opioids for symptoms other than pain
3. Using more opioid medication than prescribed
4. Asking for an increase in opioid dose
5. Aggressive behavior towards provider or staff
6. Alcohol and other substance use

Solution

- UW TelePain sessions are collegial, audio/video-based conferences that include:
    - Didactic presentations from the UW Pain Medicine curriculum for primary care providers
    - Case presentations from community clinicians
    - Interactive consultations for providers with a multi-disciplinary panel of specialists
    - Education in use of guideline-recommended measurement-based clinical tools to improve diagnosis and treatment effectiveness
    - Follow-up case presentations to track outcomes and optimize treatments for ongoing care of your patients

- UW TelePain sessions for community health care providers are held each Wednesday, noon to 1;30 pm
    - Invited to present difficult chronic pain cases or ask questions, even if you don't present a case
    - The expertise of the UW TelePain Panel spans pain medicine, internal medicine, anesthesiology rehabilitation medicine, psychiatry, addiction medicine, and nursing care coordination
- UW Medicine Pain and Opioid Consult Hotline for Clinicians: 1-844-520-PAIN (7246)
    - UW Medicine pain pharmacists and physicians are available Monday through Friday, 8:30 am to 4:30 pm (excluding holidays) to provide clinical advice at no charge to you
    - Consultations for clinicians treating patients with complex pain medication regimens, particularly high-dose opioids

How We Can Help

- WA State rules → meets consultation requirements
- Triage from Hotline to TelePain
- Discuss complex patient cases
- Medication management → opioids and adjuncts
- Education regarding pain management, risk assessment, and opioid use disorder
- CME credit

How It Works – TelePain

1. A challenging case is presented
2. Register for TelePain
    a. Complete brief consultation form
        i. TelePain team will give access to PainTracker to complete a patient assessment form with your patient
    b. Complete the longer case consultation request via REDcap instead

- UW TelePain Updated Format
    - 12:00-12:05: Daily Announcements
    - 12:05-12:30: Didactic Lecture Series
    - 12:30-1:00: Standard Community Case Presentation
    - 1:00-1:30: Optional "Curbside Consult" or Pertinent Pain Topics Discussion
- If you don't want to present a case, it's not a problem
    - Attend weekly sessions to increase knowledge and skill pertaining to chronic pain management
    - Get CME for weekly didactic sessions
    - Ask questions!

Pain and Opioid Consult Hotline Processes

1. Challenging/Complex patient case or question?
2. Call 1-844-520-PAIN (7246)
3. Triage Pharmacist sends your information to the pain pharmacist
4. Pain pharmacist returns call **within 24 hours** and discusses questions and/or patient cases

- Common hotline topics include, but not limited to:
    - Opioid rotation, tapers, and titrations
    - Risk assessment / evaluations
    - Buprenorphine for pain management
    - Perioperative Buprenorphine and Naltrexone
    - Multimodal pain management to include adjuncts (gabapentinoids, antidepressants, muscle relaxants, etc)
    - Education regarding Washington State rules and CDC guidelines
    - Opioid withdrawal management

Questions/Discussion

- My-Phuong Jawort shares that she's the Pain Division Manager who can help anyone who's interested to get in touch with the TelePain or Pain Medicine hotline programs or has any questions: myjawort@uw.edu
- Are there any specific chronic pain programs for children?
    - Dr. Mark Lo (Seattle Children's) shares that Seattle Children's has a pain medicine service that deals with the complexity of pain and are recently moving into suboxone and this field.
    - Kathleen Daman (Providence) will look into programs at PSJH and report back

Kaiser Permanente Telemedicine Data

Dr. Chris Cable (Kaiser Permanente) [47:13]

Background & Methodology

- Kaiser Permanente would like to understand the landscape for telehealth access, especially among underserved populations such as BIPOC, women, elderly and people with disabilities
- The goal is to ensure service delivery is meeting everyone's needs
- This study will provide a benchmark against which to measure the performance of future initiatives
- Access & Usage
    - Awareness and usage of virtual healthcare, especially during COVID
    - Explore technical and practical barriers, such as device ownership and internet access
- Video Visits
    - Interest in and barriers to accessing virtual healthcare offerings

- Attitudes & Perceptions
    - Explore emotional/cultural barriers to virtual healthcare
    - Demographics that identify any differences across groups and opportunities therein
- Approach
    - Quantitative online survey
    - 15-minutes in length
    - Available in English, Spanish and Vietnamese
    - Fielded February 4-26, 2021
- Participant Criteria: 1945 healthcare decision-makers
    - Kaiser Permanente members
    - Adults 18+, mix of gender
    - Target underserved populations:
        - Non-minority members: 1334
        - BIPOC: 215 Black, 220 Latino, 212 Asian, 90 Indigenous
        - 563 ADA-qualified disability
            - 406 Hearing impaired
            - 71 Vision impaired
- Geography
    - Washington State areas with KPWA coverage

Key Findings

- Device usage is widespread, comfort is moderate
    - Only half of elderly and people with disabilities are very comfortable with computers and phones
- Virtual care usage is moderate with opportunities to expand usage
    - The app, CNS, and interactive tools such as CareChat and video visits have less usage and exposure
- Video visit may require a customized approach
    - Increasing exposure and comfort with tech troubleshooting will help those less familiar overcome concerns.
    - Elderly and people with disabilities report less interest in video visits.
    - 36% report slow or average internet speed, which may be a contributing barrier
- Understand me and demonstrate you care
    - ¼ to 1/3 of members feel providers can do more to meet their unique needs and almost half of members feel insurance companies care more about money than patient care

Key Findings: Underserved Populations

- BIPOC
    - High device and virtual care usage, along with high intent and likelihood of future use.
    - Opportunity to increase their feeling understood and accepted
- Elderly

  - Leveling up tech skills in healthcare requires patience, messaging and education.
  - Some may use tech to interact with grandkids, but extra handholding in the less-familiar healthcare space encourages use
- Women
  - Women are less confident about virtual healthcare, but often have greater exposure to devices, services, and video visits.
  - A more accommodating environment could encourage comfort
- People with Disabilities
  - Disabilities limit members from using certain devices and services, so building in accessibility tools delivers a sense of "just for me".

Access

- Access to technology is widespread, and underserved populations are actively using devices and services
- Device usage is widespread, especially computers and phones
  - BIPOC are more likely to use and are especially comfortable with phones
  - Even though people with disabilities have a similar likelihood to use, only about half are comfortable using computers (53%) and phones (49%)
- BIPOC are more likely than white members to use and be comfortable with smartphones
- People with disabilities are significantly less likely to own and/or use and be comfortable with most devices.
- Older members use fewer devices than younger members and are less comfortable with technology
- Most have internet access at home, including underserved populations
  - BIPOC are more likely to access the internet using their phone
  - Black and Latino members are more likely than white members to access the internet via smartphone.
  - People with disabilities are more likely to have slower internet
  - Older members are more likely to have average-to-slower internet
- The vast majority have used videoconferencing at least occasionally, especially BIPOC and women
  - Black, Asian and Latino members are significantly more likely than whites to use videoconferencing tools regularly
  - Usage of these tools is quite lower among Native Americans, people with disabilities, and older members
- Virtual care usage is widespread, however opportunity exists to promote the app, CNS, and interactive tools
- Black and Latino members are more likely than white members to have used online interactive health tools.
- People with disabilities are more likely to have had a video visits

- Older members have had phone appointments at high rates but are less likely than younger members to have tried video visits

Video Visits

- Many manage their healthcare online, but some are not comfortable with the "next level" of interactive tools and capabilities. There is a lot of interest in video visits, but some have concerns.
- Almost half of those who have not had a video visit want to try, but many are not aware of the service
    - Video visits are still a new concept for healthcare appointments
    - Messaging has the potential to drive awareness and motivate those who are unsure to try
    - Communication from their doctors is also important to help normalize (and even popularize) video visits
- Latino and female members are the most likely groups to be willing to try video visits
- Native Americans and members 70+ are the least likely
- The most common concerns about video visits relate to the intangible benefits of in-person
    - Some believe the ability to touch and look up-close is necessary for good quality of care
- Those who have had video visits are mostly satisfied, but still note the loss of intangible benefits of in-person
- The most significant differences in concerns about video visits are with members 70+ who have never tried video visits and seem to be reluctant to get out of their comfort zone
    - These concerns diminish a great deal among this group once they have had a video visit
- Education and support will help offset concerns among those who have never had a video visit
- Some kind of "pre-visit" is wanted, along with a website to answer questions
    - Vision-impaired members would like an in-person demo
    - Younger members prefer self-serve help via website, whereas those 70+ are more likely to prefer in-person help
- The role of video visits post-pandemic is uncertain for some, but BIPOC intent to continue using
- Members want facts and trust official sources
    - BIPOC are more likely to trust healthcare organizations' websites, especially Asian 76% and Latino 71% members (vs. white 67%)

Attitudes & Perceptions

- Members actively use virtual healthcare management tools and want to foster strong relationships with their healthcare teams
- Members value strong doctor relationships
    - Many believe that in-person visits are the best way to be understood by doctors. However, virtual healthcare tools are helping some find depth in their relationships remotely.

    - While older members prefer in-person visits, BIPOC have adopted virtual healthcare tools to build relationships from a distance as they may be less likely to feel accepted and understood
- But more than one quarter of all members feel doctors can be doing more to meet their needs and only a third are confident with video visit tech support
    - The issue is not with insurance companies promoting virtual care
- For BIPOC and people with disabilities, strong provider relationships are important, but in-person communication is much easier than virtual
- Although most say they feel understood, Black members are much less likely to always trust their care team and the most likely to say there is more that can be done to meet their needs
- People with disabilities have the lowest confidence in their ability to find tech support
- BIPOC members are more likely than white members to appreciate the convenience of virtual care
- Asian members are the most likely to say they are healthy but the least likely to be proactive about their health
- Although almost half of these groups believe insurance companies care more about money than patient care, very few see virtual care as a money-making scheme
- Younger members are much more likely than older members to feel virtual communication is easy.
- Males and older members are more likely to trust their healthcare teams and feel understood
- Younger members see more benefit in the convenience of virtual care than older members but are equally unsure about finding tech support
- Females perceive themselves to be more proactive than males.
- Younger members have less trust in insurance company motives than older members

What could make health care better?

- When asked on an open-ended basis, about 2/3 members offer thoughts about what would make healthcare easier to use and understand
    - More information, better access, simplicity in processes and language, and continuity of care are mentioned most often
- Asian members are the most vocal about what can be improved
- Younger members would like more information and straightforward language

Recommendations

- Develop targeted approached for the elderly and people with disabilities, as they appear to need the most support
- Target BIPOC members who have the highest tech usage and openness to technology but reassure them that virtual care can offer strong provider relationships
- Younger members are the most tech-literate but are most likely to request simple language and process because navigating healthcare can be overwhelming
    - They are also much more likely to be skeptical of insurance company motivations

- Build trust with underserved populations by hiring for diversity, modeling behavior and creating opportunities to be heard
- All members would appreciate more information, better access, and a simplified experience overall.
    - In the case of video visits, pre-visit tech confirmation that everything will work will put patients more at ease the first time
- Experience and exposure to video visits helps to allay fears and concerns, so ensure the first time is as smooth as possible

Questions/Discussion:

- Is the pre-visit currently being done or is there a plan to do this in the future?
    - Yes, this has been done at a small scale at Kaiser Permanente, but they are looking into doing this in a scalable way.
- Did this data cross reference with the language of care preferences or any other social determinants of health metrics?
    - This survey did not include language as a variable, but this ask is being requested for the next round of surveying in February
    - Kaiser Permanente does offer interpretive services, but isn't always do-able when typing to patients in their own language.
        - Dr. Scott brings up the closed caption Zoom feature for transcription to patients who are hearing-impaired
        - Dr. Cable shares that Microsoft Teams has a language translation feature in addition to transcription

Action Item:

- Mrs. Dinh to share the presentation slide deck to the Collaborative members

House Bill 1196: Cost Impact of Audio-Only Telemedicine Updates

Chris Chen (HCA) and Jane Beyer (OIC) [1:11:22]

Preliminary utilization trends for audio-only telemedicine

- New audio-only CPT code modifiers (-FQ, -93) noting a service was furnished using audio-only communication technology is effective 1/1/2022
- Confirm with OnPoint that this modifier would be included in claims via ACPD Data Submission Guide
- Access to commercial claims data: either VSSL DUA or revision to OIC DUA
- Access to Medicaid claims data: through APCD or HCA encounter data?
- If modifier use begins February 1, 2022 for physical health and April 1, 2022 for behavioral health, first "clean" commercial claims to review would be available about September 1, 2022
- Given 11/2023 report due data, consider the data range of claims that could be examined
- Define methodology for analysis

Qualitative data from health carriers, including Medicaid managed care organizations, on the burden of compliance and enforcement requirements for audio-only telemedicine

- Written survey of commercial carriers (approx. 12 have 1% or more commercial market share) and Medicaid MCO's
- Focus group: commercial carriers and Medicaid MCO's
- Identify any differences in experience between telemed only providers (e.g. TeleDoc) vs. providers who provide in-person services as well
- Experience pre and post-PHE
- Audio-only telemed impact, if any, on use of VBP methodologies?

Preliminary information regarding whether requiring reimbursement for audio-only telemedicine has affected the incidence of fraud

- Written survey of commercial carriers (approx. 12 have 1% or more commercial market share) and Medicaid MCO's
- HCA review of any internal fraud investigations/findings
- Survey of other states/federal government regarding audio-only telemedicine related fraud investigations/enforcement actions

Proposed methods to measure the impact of audio-only telemedicine on access to health care services for historically underserved communities and geographic areas

- Claims data analytics
    - If race, ethnicity, LEP data available, integrate into claims data analysis
    - Geographic analysis, e.g. rural/urban differences, and historically underserved communities
    - Other ideas?
    - Match quantitative analysis as above with an equity lens
- Focus groups
    - For each focus group:
        - Develop questions for focus group, e.g. satisfaction, choice of in-person, A/V or audio-only, ease/challenges of access, perceived quality of care
        - Recruit participants
        - Hold focus group
        - Contractor report back
    - Potential groups:
        - Ethnic/racial minority and LEP patients and/or organizations that work with this population, e.g. FQHC's (International District, ACRS, YVFC, SeaMar, etc)
        - Rural residents and/or organizations that work with this population, e.g. RHC's
        - Tribal members, in consultation with AIHC
        - Commercially insured
        - ACH's (possible)

An evaluation of the relative costs to providers and facilities of providing audio-only telemedicine services as compared to audio-video telemedicine services and in-person services

- Written survey: What is the likelihood that providers/facilities will respond to a written survey on this issue?
- Focus groups:
    - For each focus group:
        - Develop questions for focus group, e.g. satisfaction, choice of in-person, A/V or audio-only, ease/challenges of access, perceived quality of care
        - Recruit participants
        - Hold focus group
        - Contractor report back
    - Potential groups:
        - BH providers
        - Med/surg providers
    - See "Other issues" below regarding scope of provider/facility focus groups
- Literature review to see if there is any research data on this question from WA state or nationally

Other issues the insurance commissioner deems appropriate

- Potential ideas
    - High level literature review regarding clinical effectiveness of audio-only telemed
    - Should we be asking providers about more than relative cost of audio-only telemed, e.g. perception of clinical effectiveness, quality of interactions, ease/challenges of use of audio-only, experience with obtaining patient consent to bill for audio-only visit?
    - Current OCR HIPAA enforcement forbearance in effect during federal PHE. Address whatever the state of HIPAA and audio-only telemed is in 2023?
    - Search for reports from other states regarding experience with audio-only telemed and summarize in report (Appendix)?

Questions/Discussion:

- Joelle Fathi (UW School of Nursing) suggests collecting the top ten diagnoses that drive the audio-only visits
    - Dr. Scott adds comparing this data with telemedicine vs. in-person visits
- Dr. Scott suggests looking at time and the seasonality of the visits
- Additionally, Dr. Scott recommends looking at subsequent utilization whether the visit is substitutive or additive – perhaps learn from Dr. Joshua Liao and VSSL on how their study was conducted around this and emulate a similar study
- Dr. Chris Cable (Kaiser Permanente) recommends looking into utilization in terms of both subsequent visits (important – but difficult to baseline) and total visits within common diagnostic groups, as Joelle Fathi suggested.

    - This would address both the effectiveness (downstream visits) and uptake (total visits) – both of which have impacts on WA health care costs
    - Total visits meaning F2F and audio only, compared to some baseline – 2019?
- Dr. Geoff Jones (Newport Community Hospital) is interested in if the audio-only visits make the in-person visits more productive the next time, what is the effectiveness of doing audio-only visits and how does this compare to doing video visits?
- Dr. Scott comments that for chronic conditions, there are often labs and sometimes imaging
    - Suggests asking during the focus groups on how will this get worked into the visits?
- Joelle Fathi (UW School of Nursing) comments that it might also be interesting to evaluate a subset of recurrent audio-only users and determine their utilization for all visit types or if their utilization trends steer from in-person visits to predominant telehealth/audio-only visits
- Representative Riccelli asks if there is a checklist for providers while conducting audio-only visits or are the audio-only visits very reliable that there is no need for this?
    - Dr. Scott shares that if patients already have their vital signs collected and ready to share with their physician, this is helpful information during the visit.
    - Representative Riccelli follows up with the question on if these patient-generated vital signs are accurate and how do you verify this over phone
        - Joelle Fathi (UW School of Nursing) comments that if this is an established patient, there are previous vital signs recorded that can be cross referenced to those collected over phone.
- Heidi Brown (Providence) suggests surveying if telephone visits are resulted because visit visits were abandoned due to bandwidth or issues related to use
- Dr. Chris Chen (HCA) shares that identity verification over the phone could be a good basic checklist element too
- Cara Towle (UWM) suggests adding a safety plan, including the location of the patient at the time of visit as part of the checklist

Action Item

- Collaborative members to send any additional ideas for what they would like to see in the study data to Dr. Scott, Jane Beyer, and/or Dr. Chris Chen
    - Dr. Scott: jdscott@uw.edu
    - Jane Beyer: jane.beyer@oic.wa.gov
    - Dr. Chris Chen: christopher.chen@hca.wa.gov

Patient Medical Records Access

Senator Muzzall (R-10) [1:30:22]

- There was interim work around patient medical records access and through surveys and other information-gathering approaches, physicians are increasingly frustrated by the amount of data-entry time that is being spent.

    - This impacts the amount of time spent with the patient where physicians want to spend most of their time on
    - The question is how to balance this to make data-entry an effective tool while allowing physicians to do what they're trained to do in treating patients
- With Telehealth, there was discussion earlier in the meeting about how to access the medical record for an appropriate patient diagnosis and treatment.
- The goal is to have providers have access to medical records almost instantaneously and be able to look at the patient background.
    - There's also consideration and a responsibility of patient safety.
- Another goal is to determine a methodology to have medical records follow the patient and have them up to date and accurate
    - This will help address a lot of the aforementioned challenges
- One of the solutions was to have a grant program for those systems/clinics who are still on paper records to move up to having them electronically accessible
- There is an initial rough draft of the bill, but no bill number assigned yet

Questions/Discussion:

- Dr. Scott shares that there is no true health information exchange yet.
    - He comments on an example where Epic is a great system for looking at other systems' medical records.
    - However, if patient is not seen in an Epic clinic or hospital, it can be quite laborious and time-consuming to get the necessary information.
- Dr. Scott also states that EMRs are very expensive and reinforces that physicians are not satisfied with the time spent entering data
- Heidi Brown (Providence) states that if we will be entertaining a local/state health information exchange, it makes sense to do this together with the federal information exchange (e.g. CommonWell or Carequality)
    - She shares that there may be pushback from the IT analysts regarding connection and maintenance of this local/state health information exchange
        - Dr. Scott reinforces this statement with IT's concern on privacy and security
- Stephanie Shushan (CHPW) comment that there's connection with EHRs and reporting for value-based payment. There are statewide efforts to transition towards these payment methodologies
    - She reinforces this benefit of EHRs where they are important for collecting data to prove or measure performance/value-add
- Marissa Ingalls (Coordinated Care) shares that they would like to see wider use of z-codes to track social determinants of health needs. EMRs may or may not be able to incorporate this information, but it would be an investment if not already incorporated

Action Item

- Collaborative members to send any additional thoughts to Senator Muzzall or Dr. Scott/Mrs. Dinh
- Mrs. Dinh to share the initial draft of Senator Muzzall's bill to the Collaborative members

Wrap Up/Public Comment Period

[1:41:38]

- Representative Riccelli brings up a possible agenda topic on what opportunities are there in doing new screenings for social determinants of health via telehealth means and/or what opportunities are there for patient interactions via telehealth to collect more of this robust data?
    - How to standardize these social determinants of health?
    - Dr. Scott agrees to add this to the May Meeting agenda
- Next meeting: Wednesday, March 16 2022 at 1-3 pm
- A survey was sent out yesterday to the Collaborative members to assess availability for specific dates and times in May
- Meeting materials, including presentation slides, will be posted on the Collaborative's website and sent out via the newsletter

Action Item

- Collaborative members to fill out survey for May availability
- Collaborative members to share agenda topics for future Collaborative meetings and email them to Dr. Scott / Mrs. Dinh

Tentative Next Meeting Items:

Molina Telemedicine Updates
Nursing Telemedicine Updates
Health Information Exchange
National Telehealth Technology Assessment Resource Center (TTAC) Presentation

Meeting adjourned at 11:43 am

Next meeting: March 16, 2022: 1-3 pm
Via Zoom.