WashingtonState
TelehealthCollaborative

Meeting Minutes

September 19, 2022 | 10:00 am - 12:00 pm

Virtual Zoom Only Meeting

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

Non-Member Presenters: Mike Zwick (Cambia Health), Dror Ben-Zeev (UWM), Ashok Reddy (UWM), Jamie Robbins (CHPW), Hanna Dinh Hsieh (UWM)

Public attendees *(alphabetical by first name)*:

Al Hansell (CHPW), Andi Bensuaski (Unity Care NW), Angie Treptow (Country Doctor), Avanti Bergquist (WSPA), Barry Robinson (unknown), Ben Maclean (unknown), Cameron Long (WA Gov), Cara Carlton (MultiCare), Carrie Tellefson (TelaDoc), Christopher Chen (HCA), Dan Weiner (CHPW), David Streeter (WSHA), Diane Lada (unknown), Erin Boespflug (Regence), Gail McGaffick (WSPMA), Hal Stockbridge (DOH), Herminia Magdaleno (YNHS), Jane Beyer (OIC), Jane Douthit (Regence), Jeb Shepard (WSMA), Jeff Reitan (FHCC), Jennifer Zech (UWM), Jinn Schladweiler (AAPPN), Jodi Kunkel (HCA), Jonathan Staloff (UWM), Jubi Lin (UWM), Julia O'Connor (WA Council for Behavioral Health), Karl Moser (Providence), Kai Neander (EHMC), Katherine Mahoney (Virginia Mason), Koji Sonoda (UWM), Lauren Baba (UWM), Leslie Emerick (WA State Hospice and Palliative Care), Lisa Roche (Providence), Marissa Ingalls (Coordinated Care), Marshall Glass (Boulder Care), Michael Chapman (Eko), Molly Shumway (UWM), Nicki Perisho (NRTRC), Nomie Gankhuyag (FHCC), Phil Hirsch (unknown), Rachel Abramson (UWM), Rachel Ferguson (MultiCare Indigo Health), Rosy Navarro (YNHS), Sam Miller (unknown), Sandra Durbrow (unknown), Sara Young (unknown), Scott Sigmon (ZoomCare), Sean Graham (WSMA), Shannon Thompson (WMHCA), Shanon Hardie (Unity Care NW), Shawn O'Neill (HCA), Simon Casson (OIC), ,Sylvia Gil (CHPW), Tammie Perreault (Department of Defense), Thalia Cronin (CHPW), Tom Holt (ZoomCare).

Meeting began at 10:00 am

WashingtonState TelehealthCollaborative

Welcome, Attendance and Review of Meeting Minutes - May 25, 2022

Dr. John Scott [0:00]

Dr. Scott (Chair) reviews minutes. Dr. Joshua Frank (Confluence Health) motioned to approve minutes. Dr. Mark Lo (Seattle Children's) seconded. One edit suggested to change the next meeting date from July 11 to September 19, 2022. Unanimously approved as submitted.

Action Item:

- Mrs. Dinh (Collaborative Program Manager) to post approved May 2022 notes on WSTC website

State/Federal Updates

Hanna Dinh Hsieh and Dr. John Scott [6:40]

Alaska's Telemedicine Licensure Policy

- Alaska's H.B. 265 signed into law on 7/14/2022 and is effective immediately with the following language:

> *A physician licensed in another state may provide health care services through telehealth to a patient located in the state as provided in this subsection, subject to the investigative and enforcement powers of the department under AS 08.01.087, and subject to disciplinary action by the State Medical Board under AS 08.64.333. The privilege to practice under this subsection extends only to:*
>
> 1. *Ongoing treatment or follow-up care related to health care services previously provided by the physician to the patient and applies only if:*
>   A. *The physician and the patient have an established physician-patient relationship; and*
>   B. *The physician has previously conducted an in-person visit with the patient; or*
>
> 2. *A visit regarding a suspected or diagnosed life-threatening condition for which*
>   A. *The patient has been referred to the physician licensed in another state by a physician licensed in this state and that referral has been documented by the referring physician; and*
>   B. *The visit involves communication with the patient regarding diagnostic or treatment plan options or analysis of test results for the life-threatening condition*

State Updates

- The Center for Telehealth and e-Health Law (CTel) created a 50 State Public Health Emergency Survey, detailing which states have expired PHEs and which states have PHEs that may be expiring in the near future.
  - This survey will be updated on a weekly basis

  - 7 states and DC have active public health emergency orders: California, Illinois, West Virginia, New Mexico, North Carolina, Rhode Island, Washington, and Washington, D.C.
- The Washington Department of Health (DOH) launched more telehealth options to expand COVID-19 treatment access to uninsured patients – specifically helps patients obtain the FDA-approved antiviral, Paxlovid.
  - Press article here.
  - DOH announcement here.
- Effective June 9, 2022, per the H.B. 1708 Audio-Only Telemedicine Facility Fees, hospitals licensed under Chapter 70.41 RCW that serve as either an originating or distant site for audio-only telemedicine are prohibited from charging a facility fee to uninsured and self-paying patients.
- Beginning January 1, 2023, per the H.B. 1821 Audio-Only Telemedicine Reimbursement – Definition of Established Relationship, providers seeking reimbursement for audio-only telemedicine services must establish a patient-provider relationship consistent with the newly modified "established relationship" definition.

H.B. 1821: Established Relationship Definition Modified

1. *Bifurcated Requirements for Behavioral Health and "Any Other Health Care Service"*
   - Stakeholders urged that the definition distinguish between the two service types since behavioral health services do not always necessitate an in-person visit
2. *Audio-Visual Telemedicine Allowed for Establishing the Relationship*
   - Supplements the in-person requirement with specific allowances:
     i. For behavioral health services: Audio-visual telemedicine or an in-person visit may be used to establish the patient-provider relationship. This is a permanent change.
     ii. For any other health care service: Audio-visual telemedicine is temporarily allowed to satisfy the relationship for audio-only telemedicine during calendar year 2023 only. The allowance ends after CY 2023, which means the original in-person visit requirement will be the only method to establish the relationship and receive reimbursement.
3. *Relationship Duration Extended*
   - For behavioral health services: The duration is extended from 1 year to 3 years.
   - For any other health care service: The duration is extended from 1 year to 2 years.
4. *Medical Record Access Required*
   - Requires all audio-only telemedicine providers to have "access to sufficient health records to ensure safe, effective and appropriate care services"
5. *More Practice Scenarios Satisfy the Established Relationship*
   - H.B. 1821 expands the practice settings to include medical groups and integrated delivery systems operated by a carrier licensed under Chapter 48.44 RCW or Chapter 48.46 RCW

Federal Updates

- CMS developed a roadmap for the eventual end of the Medicare PHE waivers and flexibilities, and is sharing information on what health care facilities and providers can do to prepare for future events.

  - CMS also released fact sheets that will help the health care sector transition to operations once the PHE ends, whenever that may occur. They summarize the current status of Medicare Blanket waivers and flexibilities by provider type as well as flexibilities applicable to the Medicaid community.
  - CMS article here.
- On July 27, the U.S. House of Representatives passed the H.R. 4040: Advancing Telehealth Beyond COVID-19 Act of 2022 bill that extends telehealth benefits implemented during the COVID-19 pandemic.
  - The legislation would extend most of the PHE telehealth waivers through December 31, 2024.
  - Allows FQHCs and RHCs to furnish telehealth services under the Medicare program through December 31, 2024
  - Delays the 6-month in-person requirement under Medicare for mental health services furnished through telehealth through January 1, 2025
  - This bill will be sent to the U.S. Senate for their consideration
  - Bill text here.
- On July 15, the Department of Health & Human Services extended the federal COVID-19 public health emergency (PHE) an additional 90 days through 10/13/2022.
  - Declaration of renewal here from Department of Health & Human Services
- On July 7, CMS published the Proposed Medicare Physician Fee Schedule for Calendar Year 2023, including policies related to Medicare telehealth services – solicited public comment until Tuesday, September 6th
  - Implement the telehealth provisions in the Consolidated Appropriations Act (CAA) of 2022, which extends certain flexibilities in place during the PHE for 151 days after the PHE ends, including:
    - Allowing telehealth services to be furnished in any geographic area and in any originating site setting, including the patient's home
    - Allowing certain services to be furnished via audio-only technologies
    - Delaying the 6-month in-person visit requirements for mental health services furnished via telehealth

Questions/Discussion

- For the Alaska update, what does the emergency provision include?
  - This provision is still vague regarding what is and is not permitted. The key item is that this needs to be documented in the requesting provider's chart.
- Is the Alaska update referring to physicians only or does it include other providers like ARNPs or PAs?
  - This is believed to be physician only since the policy's language only states physicians.
- Are there comments in H.R. 4040 about Ryan Haight Act and whether DEA rules will return to pre-PHE status?
  - The Ryan Haight Act is still in effect and the H.R. 4040 will not change this unless Congress reverses this. This will affect folks who are taking care of patients with mental

health problems and needs the prescription-controlled substances outlined in the Ryan Haigh Act.

Cambia Telemedicine Updates

Mike Zwick (Cambia Health) [19:22]

Partner Telehealth

- A graph was shared comparing medical visits and behavioral health visits regarding engagement and utilization with their telehealth partners
    - Partners include vendors or third-party solutions – the visits are not with Cambia's network providers
- There is a big increase in utilization for both medical and behavioral health services
- Utilization has remained strong, even as in-person options are back

Omni-channel Virtual Care Ecosystem

- This refers to Cambia's strategy around virtual care
- The focus of 2023 is on how to bring their partner solutions together to create a more seamless member experience
    - This includes being able to intervene/intercept at the right entry point when the members are trying to access care
- The strategy is always ensuring that the members have a primary care provider whether that'd be in-person or virtual
- Cambia launched a virtual primary care pilot with one of their partners and will be expanding this to another partner in 2023 to roll it out more broadly. This allows members to have a virtual primary care provider, if desired or there is not a good in-person option available for them
    - One of the great benefits is that the member can access all the care that they need virtually including nurse triage, urgent care, primary care, behavioral health, and certain specialty care in the same ecosystem

TeleDermatology

- Partnered Solution that was launched last year
    - Asynchronous interaction with a Dermatologist (Store & Forward)
    - Diagnosis, treatment, and prescription
    - 50 state coverage
- Engagement
    - Over 600 encounters since launch
- Top Reasons for Visit
    - Acne
    - Dermatitis
    - Psoriasis

- Tinea Versicolor
- Rosacea

Washington Market

- Leading in virtual care engagement
- **35%** of total partner utilization is from Regence BlueShield Washington members
- WA Market **leads** in partner behavioral health visits
- Majority of WA-based groups have **opted-in** for a telehealth partner benefit

Questions/Discussion

- If the patient is moved into urgent care, is there a specific type of urgent care service that they are referred to?
  - This is left open to the patient with various options to choose from based on their clinical needs and specific benefits
- If the patient is advised to go to a different service/location in an in-person setting, is Cambia reimbursed for the telehealth piece?
  - Yes, Cambia would still pay a claim for the telehealth piece
- Is TeleDermatology by referral only and if so, is there a patient cost?
  - This program includes both where members can choose to access this service, or they can be referred to it.
  - Regarding patient cost, there is a claims cost and additional fees depending on the members' benefits. However, this is significantly less expensive than an in-person dermatologist visit
- Is a national company being used for TeleDermatology?
  - Yes
- Regarding the graph on the Partner Telehealth slide, are the values referring to the total percentages or total number of the visits?
  - The values are referring to the total number of visits
- For folks who use urgent care, how much of an effort is it to connect them to a primary care provider? Are you able to track who uses urgent care only vs who's connected to their primary care provider?
  - Yes, they track membership who have a primary care provider
  - There are care teams at Regence who work with members specifically to help them get connected with a primary care provider
  - They also work with their partners to develop workflows to always check if a member has a primary care provider. If they don't, they can help explain to the member in seeing a primary care provider and navigating the members to the right place to find one.
  - Their virtual care programs rolling out in 2023 is intended to target the segment of the population who do not have a primary care provider and gives the members the opportunity to establish one
- Are there metrics available for members going to urgent care?

    - There are specific criteria that flag members who have gone to an emergency room or urgent care multiple times or had very high cost claims – then, Cambia proactively reaches out to those members to get them connected to a primary care provider
- Providence has run into coverage issues when the provider (e.g. specialists) and the patient are in different service areas where neither service area is covering the telehealth service, specifically for Regence, Premera, and Blue Cross. Do you have a recommendation on how to address this? Will there be a new policy with guidance regarding billing in this situation?
    - There is a virtual care policy committee that meets regularly to discuss concerns and issues. Michael offered to connect Lisa Roche (Providence) to this committee on her specific concern.

Action Items:

- If the Collaborative members have any further questions, reach out to Mike Zwick at Michael.Zwick@cambiahealth.com
- Mrs. Dinh (Collaborative Program Manager) to disseminate the presentation slides

Prescription Digital Therapeutics Follow-Up

Dr. Dror Ben-Zeev (UWM) [41:48]

Disclosures

- Dr. Ben-Zeev has financial interests in Merlin LLC, FOCUS technology, and CORE technology.
- He has an intervention content licensing agreement with Pear Therapeutics and has provided consultation services to Trusst Health, K Health, Boehringer Ingelheim, eQuility, Deep Valley Labs, and Otsuka Pharmaceuticals

Global mobile-cellular subscriptions, total and per 100 inhabitants, 2001-2017*

- United Nations estimates show that in 2001, there were approximately 1 billion mobile cellular subscriptions worldwide.
- At the end of 2017, that's the point where the number of active mobile phones exceeded the population, which demonstrates the penetration of technology
    - This opens the doors to access health care and mental health care in a way that has not been seen before up until that point

Mobile-cellular telephone subscriptions per 100 inhabitants, by region, 2021

- The numbers of mobile-cellular subscriptions also apply to the rest of the world – it's not specific to the United States
- Low- and middle-income countries seem to be closing the gap or have closed the gap with more developed countries
- LLDC stands for landlocked developing country
- LDC stands for least developed country

- Smart phone services are the primary access point to the internet and online resources, which is important for access to health care

UW Behavioral Research In Technology and Engineering (BRiTE) Center

- The main mission is to think creatively on how to use mobile technologies as a primary tool for assessment, prevention, and ideally real-time, real-place treatment

Using Mobile Technology for Mental Health Care

- This starts from the simplest level of person-to-person interventions (e.g. texting platforms) and then, moving into a higher rung of technological sophistication into sensing, natural language processing (e.g. leveraging sensors embedded in smart phones, accelerometry, GPS, light sensors, microphones, etc. in partnerships with patients).
- Automated interventions are at the most sophisticated level of technologies where they assess and deploy interventions such as FOCUS
    - Trying to create as close as possible to a "therapist in your pocket" without requiring the time, labor, and resources of therapists

Automated Interventions: FOCUS

- A smartphone app for people with serious mental illness
    - This has been evolving and developing since 2012
    - Started with patients who have schizophrenia
- User-centered development process
    - Stage 1: Needs Assessment
        - Client survey (n=904)
        - Practitioner interviews (n=18)
        - CMHC leaders
        - Started with palm pilots
    - Stage 2: Intervention Development
        - Assemble multidisciplinary team
        - Technology selection
        - Content development
        - Programming
        - Moved into early versions of smartphone applications
    - Stage 3: Usability testing
        - Usability cycle 1
        - Intervention adaptation
        - Usability cycle 2
        - Intervention refinement

FOCUS: Intervention Description Demo

- 3 daily prompts

- "On-demand" resources
- Native app
- 5 targets: voices, social, meds, sleep, mood

FOCUS: Prompt Demo

- System prompt: 3 times daily
- Patient launched: on demand 24/7

FOCUS: Clinical Status Assessment Demo

- 6th grade reading level
- Simple geometry
- Low working memory load
- Intuitive

FOCUS: Cognitive Assessment Demo

- Multiple wording variations
- Common dysfunctional beliefs

FOCUS: Intervention Demo

- FOCUS starts responding with either written content or verbal depending on what suits the patient
    - Written content is meant to be brief and very actionable
- There are rotations of different combinations of permutations of "quick and dirty" interventions for self-management

Bringing the "Pocket Therapist" to Life: FOCUS AV Demo

- If patients choose the video option, they will see either one of two therapists or actors demonstrating self-management techniques on their device

24/7 Web-Based Provider Dashboard

- All the patient responses to the questions they are presented with are uploaded to a secure dashboard where clinicians have access to this information
    - It gives clinicians visual indicators of how patients have been doing over certain periods of time (e.g. over the last week, last month, etc.)
    - This dashboard also shows trajectories, and all the videos that patients have been using to see what types of interventions they gravitate towards the most and what is most helpful to them

FOCUS: Comparative Effectiveness Trial (12 Week RCT)

- This trial compared FOCUS with WRAP, which is a clinic-based group intervention where it's representative of standard mental health care where folks meet in a group on a cadence to address their challenges
- These interventions were deployed for 3 months
- There's no difference in clinical outcomes or satisfaction ratings between conditions

FOCUS: Engagement Over Time

- When people were randomly assigned that they're going to get a smartphone mental health intervention, 90% of them started care
- When the other half were assigned to clinic-based care, only 58% of those patients ever made it into the clinic for a single session
    - This demonstrates that the target audience is lost at the time of randomization assignment due to a host of challenges that are associated with brick-and-mortar services

FOCUS: Depression (12 Week RCT)

- There were similar reductions in depression across both arm of interventions

FOCUS: Depression Transdiagnostic Effects

- When breaking this down into different sub-diagnoses, the effects on depression held true regardless of whether someone had schizophrenia, bipolar disorder, current psychotic symptoms, and taking antidepressant medications
- The treatment effects in reducing depression cut across all of these categories
- The one area where there was a difference was whether the participants had minimal/mild and moderate/severe depression. However, the treatment effects were greater for those with moderate/severe depression

FOCUS: Recovery (12 Week RCT)

- There were also similar positive effects on self-rated recovery meaning do folks think they can cope with their symptoms and do they feel enslaved by their psychotic symptoms

FOCUS: Treatment Satisfaction (12 Week RCT)

- The patient ratings were indistinguishable between the two treatment modalities; overall, the results in terms of treatment satisfaction were similar

FOCUS costs <u>HALF</u> OF Group Intervention

- Cost analysis was done with FOCUS – more info on the article: Ben-Zeev et al. (2021). <u>Cost of mHealth Versus Clinic-Based Care for Serious Mental Illness: Same Effects, Half the Price Tag</u>. *Psychiatric Services.*
- The overall cost of deploying a mobile health intervention (including the human resources in making remote calls and providing the devices) is half the cost of providing clinic-based care, while both interventions produce the same treatment effects

- $256 vs. $520 per client, per month

FOCUS: Peer-Reviewed Evidence Base

- There are 16-17 articles published on FOCUS

Statewide Implementation

- Currently involved with a National Institute of Mental Health-funded implementation study where they're partnering with the Health Care Authority in deploying FOCUS and testing how to implement this in clinics
  - The implementation is regarding the strategy vs. implementing FOCUS itself
  - The study is looking at: Do we use external facilitators (e.g. specialists who are trained in mobile health to deliver care remotely) or is it better to train people at the clinics to serve as mobile health support specialists?
  - About to start year 5 of this 5-year study

Helpful Reviews: Intervention Apps

- For those who are interested in learning more about mobile health interventions for psychiatric conditions specifically, Dr. Ben-Zeev provided some recommended articles:
  - Torous, J., Bucci, S., Bell, I. H., et al. (2021). The growing field of digital psychiatry: current evidence and the future of apps, social media, chatbots, and virtual reality. *World Psychiatry*, 20(3), 318-335.
  - Chivilgina, O., Wangmo, T., Elger, et al. (2020). mHealth for schizophrenia spectrum disorders management: A systematic review. *International Journal of Social Psychiatry*, 66(7), 642-665.
  - Linardon, J., Cuijpers, P., Carlbring, P., Messer, M., & Fuller-Tyszkiewicz, M. (2019). The efficacy of app-supported smartphone interventions for mental health problems: A meta-analysis of randomized controlled trials. *World Psychiatry*, 18(3), 325-336.

Questions/Discussion:

- Would FOCUS be an adjunct to clinician-delivered care, or as a free-standing intervention?
  - The intention is to augment community-based services. However, in situations where patients are on the waiting list for care, if there is the capacity to deploy digital health interventions to fill completely unmet needs, then FOCUS is likely to fill this gap.
- How does security and privacy work?
  - FOCUS does not collect any identifiable information – everything is coded and no data is personalized
    - There is no option to take photos, collect audio, collect GPS location for the patient
    - There is no option to plug in identifiable information
    - Although the data is encrypted, what gets transmitted is numeric codes (e.g. number of responses to multiple-choice response options)

    - This does create challenges for the providers who are using FOCUS's provider dashboard because they are not able to identify individual patients
    - There is no PHI or Personally identifiable information (PII) in FOCUS, but this does not hold true for all mobile health applications
        - The data collected is usually encrypted, but there are also fail safes put in to ensure data are de-identified when they arrive at their specific data storage locations
- Is FOCUS only available for participants in the clinical trial or can other patients use it? Are any of the insurers covering for this service?
    - There are ways of gaining accessing to FOCUS. If interested, Dr. Ben-Zeev encourages folks to email him.
    - There are currently evolving conversations around insurance coverage of FOCUS.
- Would it be possible to receive a copy of the journal article that was recently published?
    - The articles noted are in the meeting minutes and folks can always email Dr. Ben-Zeev.

Action Item:

- If the Collaborative members have any further questions, reach out to Dr. Dror Ben-Zeev at denzeev@uw.edu and/or learn more about the UW BRiTE Center at www.brite.uw.edu.

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

Dr. Ashok Reddy (UWM) [1:10:50]

Disclaimer

- All material presented are preliminary and subject to change

Audio-Only Telemedicine Evaluation

- Section 7 in HB 1196 directs the Washington State Office of the Insurance Commissioner (OIC), in collaboration with the Washington State Telehealth Collaborative and the Health Care Authority, to study and make recommendations related to audio-only telemedicine
- VSSL was engaged to assist the OIC in this evaluation

Value & Systems Science Lab (VSSL)

- VSSL ("vessel") was created to transform data and ideas into actionable insight about health care payment and delivery
- A core focus of the Lab is evaluation using:
    - Literature Review
    - Surveys
    - Claims data (Medicare, Medicaid, commercial)
    - Advanced statistical methods (difference-in-differences; instrumental variables; regression discontinuity)

VSSL Team

- Ashok Reddy, MD, MS
- Jubi Lin, MPH
- Jennifer Zech, MSc
- Anna Morenz, MD
- Jonathan Staloff, MD, MSc
- Edwin Wong, PhD, MA
- Joy Lee, MPH
- Joshua M. Liao, MD, MSc

Value & Systems Science Lab (VSSL)

- A priority: to use evaluation & analysis to support policy. Examples of experience:
    - Physician-Focused Payment Model Technical Advisory Committee - US Department of Health and Human Services
    - RUC Advisory Committee – American Heart Association
    - Comprehensive Primary Care Plus – Center for Medicare & Medicaid Innovation
    - Health Care Cost Transparency Board – Washington State Health Care Authority
    - Foundation for Health Care Quality Board
    - Primary Care Transformation in Washington State

Components of HB 1196, Section 7

- Preliminary utilization trends for audio-only telemedicine
- Qualitative data from health carriers, including Medicaid managed care organizations, on the burden of compliance and enforcement requirements for audio-only telemedicine
- Preliminary information regarding whether requiring reimbursement for audio-only telemedicine has affected the incidence of fraud
- Proposed methods to measure the impact of audio-only telemedicine on access to health care services for historically underserved communities and geographic areas
- 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

VSSL Scope of Work Overview

- The slides will touch on VSSL's activities for each of the HB 1196 Section 7 Components:
    - Preliminary utilization trends for audio-only telemedicine
    - 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
    - Preliminary information regarding whether requiring reimbursement for audio-only telemedicine has affected the incidence of fraud
    - Qualitative data from health carriers, including Medicaid managed care organizations, on the burden of compliance and enforcement requirements for audio-only telemedicine

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

Utilization Trends Using Claims Data

- This addresses the preliminary utilization trends for audio-only telemedicine from HB 1196 Section 7
- Analysis will use data from the Washington State All-Payer Claims Database (WA-APCD), which contains claims from many (>30) but not all payers in the state
- Included: Commercial, Medicare Advantage, Medicaid Managed Care, Public Employees Benefit Board
- Excluded: Medicare and Medicaid FFS, most self-funded plans, Veterans Health Administration
- The WA-APCD provides the most inclusive view available for assessing trends in audio-only telemedicine utilization
- However, like all claims databases, it has some limitations with respect to:
  - Data availability (which variables are included)
  - Data missingness (of included variables, how completely values are recorded)

APCD Data Analysis

- **Purpose:** Describe trends is audio-only telemedicine use over time
- **Identification of audio-only telemedicine use**
  - Base case: using new CPT code modifiers (FQ, 93) effective 1/1/2022 + selected CPT codes (e.g. 99441-99443)
  - Expanded case: Base case + CR modifier
  - Max case: Expanded case _ GT and 95 modifiers
- **Study Period:** 1/1/2022 – 12/31/2022
- **Eligible Sample:** ~5 million Washington State residents who were enrolled in a health plan for at least 6 months out of the prior year' inclusive of both adult and pediatric populations
- **Subgroup analyses:**
  - Individual-level (age, gender, race, ethnicity, most common diagnoses, insurance type)
  - Provider-level (clinician type, specialty, urban/rural location, telemedicine only)
  - Area-level (county, rurality, Area Deprivation Index, COVID surge wave)
- Data limitations and missingness may preclude certain analyses, such as those by patient experience, English proficiency, education level, employment status)

Literature Review

- This addresses the following components from HB 1196 Section 7:
  - 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
  - Preliminary information regarding whether requiring reimbursement for audio-only telemedicine has affected the incidence of fraud

    - Qualitative data from health carriers, including Medicaid managed care organizations, on the burden of compliance and enforcement requirements for audio-only telemedicine
- To maximize rigor and thoroughness, we are applying systematic review methods to conduct a multi-step search of peer review & other literature
- This approach incorporates:
    - Consultation with health sciences librarian to optimize search strings and database use
    - Search term best practices (e.g. MeSH, tiab, free text)
    - Parallel review from multiple team members

Web-based Survey

- This addresses the following components from HB 1196 Section 7:
    - 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
    - Preliminary information regarding whether requiring reimbursement for audio-only telemedicine has affected the incidence of fraud
    - Qualitative data from health carriers, including Medicaid managed care organizations, on the burden of compliance and enforcement requirements for audio-only telemedicine
- Develop a web-based survey based on preliminary results from the literature review and conversations with stakeholders
- **Survey Development**
    - Review literature on telehealth to identify key gaps in knowledge
    - Analyze literature on payer surveys to identify common practices in question types
    - Coordinate with partners to identify key domains of interest and specific questions to deploy for MCOs commercial payers:
        - Enforcement and compliance burden
        - Incidence of fraud
        - Differences between telemedicine-only providers vs. in-person and telemedicine providers
        - Audio-only telemedicine during surge and non-surge conditions
        - Impact of audio-only telemedicine on value-based care programs

Measure Impact on Access

- This addresses the following component from HB 1196 Section 7:
    - Proposed methods to measure the impact of audio-only telemedicine on access to health care services for historically underserved communities and geographic areas
- Provide a summary of methods that would be proposed for future evaluations to measure the impact of audio-only telemedicine on disparities in access among historically marginalized communities

- Summary will include information about:
  - Methods for quantitative evaluation of claims data
  - Methods for primary data collection and both qualitative evaluation of data obtained from individuals from historically marginalized communities

Current Progress

VSSL Activities	Deliverables	Status
Descriptive Analysis of Utilization Trends in Audio-Only Telemedicine Among Patients Using Claims Data (January 2022 – December 2022)	Analytic Plan	Completed
	Preliminary Report	Anticipated completion 5/2023
	Final Report	Anticipated completion 8/2023
Literature Review: (a) regulatory issues, costs, clinical effectiveness, and experiences; (b) costs assessment based on available information on CPT and RVU-based estimates	Report	Anticipated completion 7/2023
Web-Based Survey of Commercial Carriers and Medicaid Managed Care Organizations	Draft of Survey	Anticipated completion 10/2022
	Survey Disseminated	Anticipated dissemination 1/2023
	Report	Anticipated completion 7/2023
Proposed Methods to Measure the Impact on Access to Health Care Services for Historically Underserved Communities and Geographic Areas	Report	Anticipated completion 8/2023
Hold interested parties meeting	Meeting Report	Anticipated 10/2022

Questions/Discussion:

- How easy was it to work with Washington State All-Payers Claims Database?
  - There was a bit of time in getting access to this database. However, they are continuously looking at any quality issues that come up amongst the different payers. Trying to clean the data up is part of their early claims data analysis.

Action Item

- VSSL will present an update on this work at the next Collaborative meeting in 6 months

Community Health Network of WA's Digital Navigation Program

Jamie Robbins (CHPW) [1:25:05]

About CHNW

- The Community Health Network of Washington (CHNW) represents 21 federally qualified health centers across the state of Washington
- These community health centers (CHCs) provide primary care services to underserved communities, particularly Medicaid patients
- Over 1,000,000 Washington residents receive care at hundreds of CHC sites across the state
- CHNW is the delivery system for Community Health Plan of Washington (CHPW)

- CHPW is one of 5 managed care organizations (MCOs) serving Medicaid in Washington and is the only not-for-profit health plan in the state.
- The missions of CHPW and CHNW are aligned to support equitable access to care for all patients in Washington, including telehealth services and programs.
- A major barrier to equitable access to healthcare is the Digital Divide and challenges with digital navigation.

The Digital Divide

- **The Digital Divide**: the gulf between those who have ready access to computers and the internet, and those who do not
- Washington State
  - **13**% of households do not have a smartphone
  - **10**% of households do not have an internet subscription
  - 5% of households do not have a computer
- Nationally
  - **31**% of rural areas lack access to high-speed broadband
  - **Only 46**% of patients utilize telehealth services

The Digital Divide in Washington State

- Counties with a high digital divide index are more rural
- Populations most impacted by the digital divide are often poorer, older, and less educated than those living in low digital divide areas
- A Washington State map was shared of the 2020 Digital Divide Index, which shows counties and their digital divide level: low, moderate, or high.

Digital Navigation

- **What are digital navigation services?**
  - Digital navigation services include ongoing assistance with affordable internet access, device acquisition, technical skills, and application support – *National Digital Inclusion Alliance (NDIA)*
- **What does digital navigation look like in a healthcare setting?**
  - Patients learn how to use technology tools to access and connect to all available healthcare resources:
    - Downloading and using CHC patient portals and applications
    - Scheduling appointments and receiving appointment reminder calls and texts
    - Refilling prescriptions and receiving test results via a patient portal
    - Texting and emailing their provider or clinics
    - Receiving healthcare via a virtual telehealth visit
  - When patients are connected to technology resources, health clinic operations can prioritize other clinical needs

Link to Care WA Program

- Grants awarded to CHNW for Jan 2022 – June 2022 from the Washington State Department of Commerce, Office of Broadband & extended through June 2023
- Statewide resources for community health centers' patients
    - Hotline (launched Feb 1)
        - Live connection to State and Federal resources
        - Live technical assistance
        - Personalized education about telehealth services
    - Website (launched Mar 1)
        - Self-service connection to State and Federal resources
        - Education about telehealth services
        - Education about types of technology
    - CHC Sites (YNHS & HealthPoint)
        - In-person support and education
        - Device distribution
        - Connection to other program resources
- Nearly **800 smartphones** activated as of September 2022
- Over **600 patient calls** to the Hotline
- Over **3,000 website views** during the initial grant period

Hotline

- **Our dedicated call center team:**
    - Supports all community health center callers – not just Medicaid patients, and serves patients of all health plans
    - Offers technical assistance with technology access and use
    - Connects eligible callers to federal and state programs for subsidized smartphones and broadband internet
    - Helps patients prepare for telehealth visits
    - Shares resources and provides great customer service
    - **Includes bi-lingual staff and free interpretation services**
- The hotline provides follow up call assistance for each caller
- Call 866-757-1831 (TTY: 711) M – F, 8 am to 5 pm

Website

- Program's website is here: www.LinktoCareWA.org
- There is a screenshot of the program's marketing material where it reads as one long infographic to support folks who are learning to engage with websites and technology for the first time

Program Success Stories

- **Who has benefited from engaging with a CHC site?**
    - Migrant farm workers

  - Recently-arrived refugees
  - Single-parent families
  - People with complex medical and social needs
  - People with mental and behavioral health needs
  - MOUD individuals
  - People experiencing a housing insecurity
  - There are no citizenship requirements for CHC patients to participate
- **Who has benefited from calling the hotline?**
  - Geographically and socially isolated individuals
  - People with limited mobility
  - People without reliable transportation
  - People with ongoing digital navigation & education needs
  - People needing connection to subsidized broadband or device programs
  - People wanting to learn about technology and telehealth services
- **What support did they receive?**
  - Digital navigation support & digital literacy skills education
  - Connection to other Link to Care WA program and community resources
  - At a CHC site, a free smartphone with hotspot capability & pre-paid service for 12 months
- There are also many unanticipated benefits of this program, including:
  - Better connections to community and society
  - Identification of other needs such as housing or employment
  - Helps build relationships with other community partners
  - Tool to attract and re-engage patients at CHCs

Next Steps: Program Expansion

- Digital Navigation Learning Collaborative in Fall 2022 will convene a group of at least 4 CHCs across the state
- Meeting with CHCs across the state to discuss how the program can benefit their patients
- CHCs are advertising the Hotline and website to their patients via promotional materials (available in 17 languages)
- Pursuing additional partnerships with organizations committed to addressing the Digital Divide and providing digital navigation services
- Continuing to advocate for the program and demonstrate its success

Questions/Discussion:

- Which languages are these services available in?
  - The website has a Google-supported translation feature that can translate into some top languages
  - For the hotline representatives, there are two who are bilingual in English and Spanish. There are also free third-party interpretation services for all other languages.

    - For the promotional materials, they are available in 17 languages that the CHCs pass out to patients, including for Afghan and Ukrainian refugees
        - The program will translate into any language that a CHC informs them that there is a patient need for, which is how they've built up to 17 languages
- From the standpoint of internet access, can you comment on trends in bringing high-speed internet to the "dark blue" communities on the map for the "Digital Divide in Washington State" slide? Any idea of timelines for the same?
    - CHPW participates in National Digital Navigator Meetings hosted by the National Digital Inclusion Alliance where this question has been an ongoing topic. One of the ways is trying to spread the word about the Federal Affordable Connectivity Program, which provides low-cost, subsidized internet to eligible families and households.
    - Also have to consider the larger infrastructure of cell carriers and internet providers prioritizing this in those "dark blue" communities
- What happens if the patient leaves the area? Is there some continuing connections or benefits of having the phone and connection to the Link to Care resources?
    - If a patient receives in-person digital navigation support and a smartphone, it is theirs to keep regardless of if they leave the area or state
        - The smartphone is pre-paid for a year, but this can be renewed – the vision is to renew the cell service indefinitely as the program receives more funds and grants
    - There is no requirement that the patient stays in the area/clinic where they received the resources.
    - The hotline and website are a great way to stay engaged with the program vs. having to stay engaged at a single geographic location at the CHC site

Action Items

- If the Collaborative members have any further questions, reach out to Jamie Robbins: Jamie.Robbins@chpw.org
- Mrs. Dinh (Collaborative Program Manager) to disseminate the presentation slides

Wrap Up/Public Comment Period

[1:53:31]

- Next meeting: Monday, November 14, 2022 at 10:00 am – 12:00 pm
- Meeting materials, including presentation slides and recording, will be posted on the Collaborative's website and sent out via the newsletter
- The 11th annual 2022 NRTRC Telehealth Conference is on September 26-28
    - Folks can attend in person at Salt Lake City, Utah or virtually
    - Registration is still open at the following link: Northwest Regional Telehealth Resource Center (nrtrc.org)

Action Items

- Collaborative members to share agenda topics for future Collaborative meetings and email them to Dr. Scott / Mrs. Dinh
- For anyone that would like access to any of the presentation slides, please email Mrs. Dinh at hannad7@uw.edu.

Tentative Next Meeting Items:

Northwest Regional Telehealth Resource Center (NRTRC) Conference Highlights
National Center for Interstate Compacts (NCIC) Updates

Meeting adjourned at 11:56 am

Next meeting: November 14, 2022: 10 am-12 pm
Via Zoom.