WashingtonState
TelehealthCollaborative

Meeting Minutes

January 9, 2023 | 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	Y
Rep. Marcus Riccelli	N	Kathleen Daman	Y	Scott Kennedy	Y
Rep. Joe Schmick	N	Dr. Frances Gough	Y	Mark Lo	Y
Dr. John Scott	Y	Lisa Woodley	Y	Heidi Brown	Y
Dr. Chris Cable	Y	Emily Stinson	N	Adam Romney	Y
Jae Coleman	N	Sheryl Huchala	Y	Cara Towle	Y
Stephanie Cowen	Y	Amy Pearson	Y	Lori Wakashige	Y

Non-Member Presenters: Brad Felker (VA Puget Sound), Eliza Brink (Spruce Psychiatric Associates), Brad Younggren (98point6), Hanna Dinh Hsieh (UWM)

Public attendees *(alphabetical by first name)*:

Al Hansell (CHPW), Alesia Black (Clearwater Counseling), Billie Morgan (unknown), Brittainy Wittg-Valieva (FHCC), Cameron Long (WA Gov), Caron Cargill (ForHims/ForHers), Christopher Chen (HCA), David Streeter (WSHA), Derek Nogle (Unity Care), Gail McGaffick (WSPMA), Gayle Rundstrom (National MS Society), Hayley Tanzman (Uniform Law Commission), Jaleen Johnson (NRTRC), Jeff Reitan (FHCC), Jessica Rongitsch (Capital Hill Medical), Jinn Schladweiler (AAPPN), Jodi Kunkel (HCA), Jordan See (TelaDoc), Josh Viggers (UWM), Kai Neander (EHMC), Kat Jong (WSPA), Koji Sonoda (UWM), Lisa Roche (unknown), Maia Thomas (DCYF ESIT), Mandy Latchaw (DOH), Marissa Ingalls (Coordinated Care), Marjorie Parkison (UWM), Mark Gerth (WSPA), Michele Radosevich (unknown), Michelle Lin (UWM), Molly Shumway (UWM), Nancy Lawton (FAANP), Nicki Perisho (NRTRC), Nicole Pauly (Mindful Therapy Group), Nomie Gankhuyag (FHCC), Phil Hirsch (Synergia Integrated Telebehavioral Health), Rachel Abramson (UWM), Remy Kerr (WSHA), Sam Miller (unknown), Sara Young (Boulder Care), Sarah Koca (CHPW/CHNW), Shannon Thompson (WMHCA), Shanon Hardie (Unity Care), Sheela Tallman (unknown), Simone J (unknown), Thalia Cronin (CHPW), Tom Holt (ZoomCare).

Meeting began at 10:00 am

Welcome and Attendance

Dr. John Scott [0:00]

Review of Meeting Minutes - November 14, 2022

Dr. John Scott [4:36]

Dr. Scott (Chair) reviews minutes. Dr. Frances Gough (Molina) motioned to approve minutes. Sheryl Huchala (Premera) seconded. Unanimously approved as submitted.

Action Item:

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

State/Federal Updates

Hanna Dinh Hsieh and Dr. John Scott (UWM) [8:22]

Federal Updates

- On October 13, the Department of Health & Human Services extended the federal COVID-19 public health emergency (PHE) an additional 90 days through 1/11/2023.
  - Declaration of renewal here from Department of Health & Human Services
- 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.
- The Journal of the American Medical Association (JAMA) published a new study to examine the quality performance measures for patients receiving in-person vs. telemedicine primary care in a large integrated health system.
  - The study showed that telemedicine scored higher on 13 of 16 Healthcare Effectiveness Data and Information Set (HEDIS) measures, suggesting that telemedicine delivers similar or better quality care than in-person visits
- CDC reviewed telehealth data from 2021 to determine engagement levels among adults.

- Findings include increased usage trends correlated with increasing age, women were more likely than men to use telehealth, and telehealth usage positively correlated to education level, but varied by family income
- Hispanic, Black, and Asian populations reported lower use of telehealth than White and American Indian or Alaska Native populations

Questions/Discussion

- Does this new bill cover the Ryan Haight Act?
  - During the meeting, the initial understanding was that the new bill covered the Ryan Haight Act. However, after further research and clarification from the Collaborative members and attendees, the new bill **does not** extend the Drug Enforcement Administration's (DEA) waiver of the Ryan Haight Act. Under the current state of the law, the waiver of the in-person visit requirement will expire by the end of the Federal Public Health Emergency in April 2023. However, there is much lobbying currently happening to create both an interim and long-term solution for this.
  - Jordan See (TelaDoc) shares that the CAA included report language directing the DEA to release its guidance regarding the Ryan Haight Special Registration for Telemedicine. This can be found in Commerce, Justice, and Science (CJS) explanatory statement that defers to the House report language on page 79: https://www.congress.gov/117/crpt/hrpt395/CRPT-117hrpt395.pdf
  - Cara Towle (UWM) comments that the suspension of in-person visits applies to the new legislation regarding telemental health, which permanently allows telemental health services to provide care into patients' homes and without geographic restrictions. But, there is a requirement of an in-person visit within 6 months of the first telehealth visit and every 12 months thereafter. She references this article: https://mhealthintelligence.com/news/spending-bill-to-extend-telehealth-hospital-at-home-waivers-by-2-years

Telehealth Training Best Practices

Dr. Brad Felker (VA Puget Sound) [12:40]

Telemedicine Works

- A few assumptions:
  - Quality medical care can be delivered via telemedicine
  - Access care can be improved
  - COVID Pandemic caused a rapid transition to providing Telemedical care
  - No going back to previous models of care

No clear guidance on how to best train students, residents, and clinicians

- Literature on teaching telemedicine and Telehealth Competencies

- Much has been written recommending Telehealth Competencies (Shore et. al. 2018. Hilty et. al. 2018, 2015).
- But no consensus has emerged on how to best teach telehealth (Pourmand et. al. Telemed and e-Health 2021. Chike-Harris et al. Telemed and e-health. 2019, AAMC From Bedside to Webside, 2018).
- Recent review attempted to "Harmonize" Telebehavioral Health Competencies into 10 Domains (Pedersen et al. ps.psychiatryonline.org Advance)

Emergence of Training Competencies and Toolkits

- American Telemedicine Association
  - https://www.americantelemed.org/resource/learning-development/
- American Psychiatric Association
  - https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit
- American Psychological Association
  - Guidelines for the practice of telepsychology (apa.org)
- American Association of Medical Colleges
  - https://www.aamc.org/data-reports/report/telehealth-competencies

AAMC Telehealth Competencies: Domains

- Domain I: Patient Safety and Appropriate Use of Telehealth
- Domain II: Access and Equity in Telehealth
- Domain III: Communication via Telehealth
- Domain IV: Data Collection and Assessment via Telehealth
- Domain V: Technology for Telehealth
- Domain VI: Ethical Practices and Legal Requirements for Telehealth

Competencies for Remote Psychological Interventions

(Pedersen et al Psychiatric Services in Advance (doi: 10.1176/appi.ps.202100677)

- Domain 1: Emergency and safety protocols for remote services
- Domain 2: Facilitating communication over remote platforms
- Domain 3: Remote consent procedures
- Domain 4: Technological literacy
- Domain 5: Confidentiality and privacy during remote services
- Domain 6: Practitioner-client identification for remote services
- Domain 7: Verbal and nonverbal communication during remote services
- Domain 8: Engagement and interpersonal skills for remote services
- Domain 9: Establishing professional boundaries during remote services
- Domain 10: Encouraging continuity of care during remote services

Cannot wait until a consensus arrives on Telemedicine Competencies and curriculum is developed

- UW GME Telehealth Policy provides a good foundation upon which to build.

- There is need to provide core content on how to educate students, trainees, and clinical staff on how to provide telemedicine.
- There is a need to arrive at common training goals for the Supervisor and the trainee when providing telemedicine.
- There is need to focus this training on completing a Professional Encounter.
- Common training goals could be developed and applicable across disciplines.
- Training goals could be rapidly developed and implemented.

Suggested Telemedicine Training Goals to provide professional clinical encounters

- Understand core telemedicine literature for a specific field.
- Be able to provide Informed Consent and Document.
- Be able to create the professional office and use effective communication and engagement strategies.
- Be able to provide basic Technology Trouble-Shooting tips.
- Be able to provide safety planning and documentation

TeleBehavioral Health 101

- Online Self-Study:
- Courses
    - Introduction to TeleBehavioral Health and Policy Overview
        - *Meets telehealth training requirement as established by Washington SB6061.
    - Getting started: Facts & Myths, and Security & Privacy
    - Digital Health Do's & Don't's, Workflows, and Safety planning
    - Billing and Reimbursement for TeleBehavioral Health
    - Clinical Engagement over Telehealth
    - Clinical Supervision in Telehealth
- A certificate of completion will be issued for each module completed
- NASW accredited: provider #1975-433
- CME Accreditation
    - The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
    - The University of Washington School of Medicine designates this enduring material for a maximum *1 AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation
    - in the activity.
    - Learners have the opportunity to complete up to 6 modules, with each module accredited for 1 AMA PRA Category 1 Credit™.

TeleBehavioral Health 201

- Online Self-Study:

- Courses:
    - Telehealth Policy – the changing federal and state landscape
    - Preparing Patients & Technology for Telehealth
    - Doing Groups over Telehealth
    - Mobile Health (mHealth) for Serious Mental Illness
    - Provider Self-Care & Wellness in the Era of Telehealth and Covid
    - Behavioral Health Apps
    - Children & TeleBehavioral Health
    - Applying Telehealth SUD Treatment in Community-based Settings
    - Cultural Competence & Humility in TeleBehavioral Health
    - Applying Telehealth to Measurement-based Care
    - Suicide Risk Assessment over Telehealth
    - Couples & Family Therapy over Telehealth
- A certificate of completion will be issued for each module completed
- NASW accredited: provider #1975-433
- CME Accreditation
    - Accreditation with Commendation: The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
    - Credit Designation: The University of Washington School of Medicine designates this Other Activity for a maximum of *36 AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity. (Each 1 hour module is 1.0 credits).
    - *Note: accreditation includes additional webinar and online series offerings.

TeleBehavioral Health 301

- Courses
    - Jan 21, 2022: Bree Collaborative Telehealth Guide & Hybrid Models
    - Feb 18, 2022: Crisis Management & Risk Assessment
    - Mar 18, 2022: Safety & Consent Planning
    - Apr 15, 2022: Substance Use Disorder Treatment over Telehealth
    - May 20, 2022: TeleBehavioral Health & Groups: lessons from Dialectical Behavioral Therapy
    - Jun 17, 2022: TeleSupervision
    - Jul 15, 2022: Whole Health & Telehealth
    - Aug 19, 2022: Children & Adolescents
    - Sep 16, 2022: Trauma-Informed Care
    - Oct 21, 2022: Remote Teams & Tele-Teaming
    - Nov 18, 2022: TeleMental Health and Professional Liability
    - Dec 16, 2022: Reimagining practice: integration of AI, digital therapeutics and automation in behavioral health
- A certificate of completion will be issued for each module completed

- NASW accredited: provider #1975-433
- CME Accreditation
    - Accreditation with Commendation: The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
    - Credit Designation: The University of Washington School of Medicine designates this Other Activity for a maximum of *36 AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity. (Each 1 hour module is 1.0 credits).
    - *****Note: accreditation includes additional webinar and online series offerings.

TeleBehavioral Health 401 (2023 Series)

- Jan 20th: WA State TeleBH Rules & Regulations – HCA panel
- Feb 17th: COVID-19 Policy Changes & Impacts on Telehealth for Substance Use Disorder Care – Allison Lin MD MS
- Mar 17th: TeleBH Assessment of Cognition in Older Adults – Stephen Thielke MD MS & Emily Trittschuh PhD
- April 21st: TeleBH & Chronic Pain Care – Lisa Glynn PhD
- May 19th: Clinical Use of Virtual Care and Patient-Generated Health Data – Christina Armstrong PhD
- June 16th: How to Support People with Disabilities when Providing TeleBH Services: Advantages, Disadvantages, Special Considerations, and Best Practices – Jennifer Pearlstein PhD

<u>Questions/Discussion</u>

- Often patients have depression or might be suicidal or become actively suicidal during a telemedicine visit – what are the best practices for what to do in this situation?
    - Dr. Felker presents his telehealth safety protocol (his "flight checklist" before doing an appointment), which has been adopted widely at the VA and many VA's across the country. Folks can be trained easily and the protocol can be adopted for various types of settings. The protocol includes informed consent and an emergency plan, including where is the care being provided (e.g. patient's home, another clinic, etc.). Depending on the environment, the safety planning approach is different regarding what you need to know, the resources available, backup information, contact information, etc.).
    - Dr. Felker shares that if the originating site is different from where the provider is located, there has to be a system in place to ensure the police travels to the right location where the patient is – providers may call the e911 center to speak with an agent who will facilitate contact with a 911 operator at the patient's location
        - Dr. Felker advises to not call this number for testing purposes
    - Dr. Felker advises that providers should always know where the patient is located in case they need to access the patient.

    - A couple of attendees asked if Dr. Felker can share his telehealth safety protocol/template, and he is happy to share with folks.
    - Cara Towle (UWM) comments that there have been several courses held multiple times a year on safety planning, suicide assessment, as well as crisis and risk management over telehealth where they are very well-attended – this is an indicator that these topics are on the forefront of providers' minds.
    - Dr. Felker adds that telehealth can be as good as in-person visits as long as there are a lot of foundational pieces in place, beyond safety planning. How do we start thinking about a virtual community of practice and coming back to the professional encounter and setting up this structure from the beginning?
- For the e911 number, is this for Washington and can we use this?
    - Yes, this is anywhere in Washington state that this number can be used.
- Dr. John Scott (UWM) shares that there is the Washington State Health Collaborative telehealth training where it's hosted on the NRTRC website: https://nrtrc.catalog.instructure.com/
    - Recent changes were made regarding the legislations and language on audio-only telemedicine and other recent legislations from the last year.
    - Hanna Dinh Hsieh (UWM) adds that CME will also be offered again for this training

Action Items:

- Mrs. Dinh Hsieh (Collaborative Program Manager) to disseminate the presentation slides
- Mrs. Dinh Hsieh (Collaborative Program Manager) to share Dr. Felker's telehealth safety protocol/template.
- Mrs. Dinh Hsieh (Collaborative Program Manager) to share the Washington state telehealth training with Dr. Felker and get his feedback.

New Member Introduction

Lisa Woodley (CommonSpirit Health) [34:42]

Dr. Scott (Chair) introduces Lisa Woodley as a new member representing CommonSpirit Health and Informatics, and replacing Sheila Green-Shook. Lisa Woodley is one of the System Managers for Health IT Compliance Oversight team at CommonSpirit Health. This group reports up to their compliance structure. Lisa's team oversees all compliance and regulatory-related items to health IT. The current areas of focus include privacy impact assessments on new technology and/or new use cases for existing technology. Lisa is also currently helping to set up the Compliance Center of Excellence for information governance, records retention and destruction, ethical use of AI and machine learning as well as other technologies. Before moving into her current role at CommonSpirit Health, she was at Virginia Mason for about 15 years in the health information management department interfacing primarily with informatics and IT teams.

Quality Psychiatric Care Through Telehealth

Dr. Eliza Brink (Spruce Psychiatric Associates) [37:05]

About Me

- Dr. Eliza Brink went to the University of Washington and after graduating in 2013, she worked as a nurse practitioner in a fast-paced, large, multi-specialty clinic working with patients who were struggling with their mental health and mental complex abuse.
- In 2014, this was the first time she started working with patients via telehealth.
- Fast forward to the pandemic, this is when she was using telehealth 100% of the time with her psychiatric patients. With telehealth, she was able to target some of her most vulnerable patients more effectively than in-person.

Spruce Psychiatric Associates

- Dr. Brink created Spruce Psychiatric Associates to increase access to telehealth, but noting that the quality of care is not jeopardized through telehealth. Not all telehealth is the same
    - Making sure that providers are upholding the same standards of care via telehealth as in person.
- Dr. Brink has been teaching at the University of Washington (UW) for the past 10 years and she has a specific interest in continuing to develop psychiatric skills across all nursing specialties.
    - She works in both the undergraduate and graduate programs and teaches classes from psychopharmacology to introduction in psychiatric skills.
- Dr. Brink's goal is to continue to develop skills through one's professional career and this is also her goal at Spruce.
- At Spruce, there are now 8 nurse practitioners (3 who recently graduated where Dr. Brink is doing regular supervision with). She spends a couple of hours a day meeting with providers on a group and individual basis. There are regular seminars and supervision throughout the week. Her nurse practitioners are in the office Monday through Friday with the option to work from home and teleconference in – 90% of the time, the providers are in the office.
- Dr. Brink first started Spruce with the idea of mentoring one to two nurse practitioners. But, she noticed a high need and desire to have this collaboration among providers, which is where Spruce has grown organically over the past few months.
- At Spruce, they value education very highly.
    - All of the providers have doctorates
    - 7 out of 8 providers went to UW
    - 1 provider went to Seattle University
    - 6 out of 8 providers currently teach at various universities in Seattle
    - They currently help and support two doctorate projects
    - They are currently precepting students from both UW and Seattle University
- At Spruce, they value the community aspect involvement to better help support their patients, but also better help support their providers via telehealth.

Benefits

- Increased access
- Increased demographic of patients served
- Improved coordination of care
- Increased compliance with follow up
- Decreased no shows
- Improved medication compliance
- Decreased provider burn out and flexibility

Practical Barriers

- Personal preference for in-person
- Technical difficulties
- Insurance coverage
- Laws and regulations

Improving Access Through Telehealth

- Dr. Brink shares a patient story where this patient had a bipolar disorder who she started seeing several years before the pandemic. They would often have a difficult time getting to her clinic where they would either show up late or not show up at all. This patient would come in and out of treatment and often only come during an acute crisis or post-hospitalization discharge after a manic episode or depressive crash. Dr. Brink's ability to take care of them was subpar due to limitations of an outpatient center.
- When the COVID-19 pandemic started, they started coming in regularly where Dr. Brink was able to get them medication to help stabilize their symptoms and follow them more closely. This patient went from having five to six hospitalizations a year to none in the past two years. She believes that telehealth helped contribute to the patient's ability access care. They no longer had transportation concerns or had to arrange time off from work. She's found that it's often the most vulnerable patients that benefit from telehealth the most.

Questions and Contact

- Eliza Brink (she/her/hers), DNP, PMHNP
  Psychiatric Nurse Practitioner
  Spruce Psychiatric Associates
  Associate Teaching Professor
  University of Washington
- ewbrink@uw.edu

Questions/Discussion:

- What proportion of your visits are by telemedicine vs. in person?
  - 63% are in person for the intake. For follow-up, it's 90.3% via telehealth.

- Regarding Dr. Felker's point in his presentation on maintaining professional standards of care in telehealth visits, is this something your providers are actively trying to guard against at Spruce?
    - At Spruce, the provider team is in the office in person and the providers collaborate every day to discuss patient cases. Dr. Brink believes that this collaborative environment is difficult when the providers are fully remote and their patients are fully remote.
- From a policy perspective, if you had a magic wand and had one wish, what would that be?
    - Dr. Brink would like to see the in-person visit requirement in the Ryan Haight Act to continue to be waived and that the insurance companies are not going to pay less for telehealth vs. in-person visits.

Action Item:

- If the Collaborative members have any further questions, reach out to Dr. Eliza Brink at ewbrink@uw.edu.

AI and Machine Learning in Telemedicine

Dr. Brad Younggren (98point6) [54:42]

- The goal is to discuss how to leverage artificial intelligence (AI) and machine learning tools to accomplish a variety of tasks.
- 98point6 was founded in 2015 and was focused on leveraging text-based communication to have access to be in the room of every case.
    - This allows for peer-to-peer chart reviews for quality management and patient safety as well as determining what kind of AI systems would be beneficial in care delivery and then, testing and observing this directly.
- One of the broad approaches in using AI tools is gathering information on the behest of the clinician, which 98point6 was exploring.
    - The reason for exploring this approach was to determine if it's possible to collect lots of information for the clinician so that it relieves them of this task.
    - The nuances to this include if the clinician cannot consume the information or if the clinician will repeat the questions – this leads to the AI tools not being of value.
- It's not about developing a symptom checker, but about putting AI tools in the hands of clinicians and clinical operations experts.
    - It's also about integrating with the clinical experience with the patients, what does this look like, and how does this leverage and change how one approaches AI systems.
- AI is a very broad term – the most commonly used terms in the industry are machine learning or expert system approach.
- Dr. Younggren believes what is the future in AI is determining how much one can pull those technologies forward into the virtual exam room.
- 98point6 built a machine learning approach to gathering information, which can reduce the amount of time a clinician spends on this – this is through their text-based system.

- A machine learning approach is good for the gathering of information is this approach is how clinicians and patients converse.
    - If the patient tells a provider 25 things about their holiday break, the provider teases them down to the three medical issues, and then, categorizes into medical and non-medical issues, etc. – this is the art of medicine.
- When 98point6 started in 2015, they set up alpha testing with all the different kinds of approaches.
    - There was positive patient feedback for all of the approaches because in 2015, this was all new and interesting.
    - However, when they asked the patients a follow-up question on which approach most similarly replicates their experience with their doctor and in a brick and mortar system, the machine learning approach was the most selected choice.
- From a gathering of findings approach and leveraging machine learning/AI tools, Dr. Younggren believes that there should not be a limit to how much patients can write regarding how they're feeling health-wise – this is what patients want and they want to be heard.
    - Then, the AI system would be able to look through this content, pick out what's important and not important, ask relevant follow-up questions in a sequence that feels authentic and real to the patient. Be mindful of not losing the patient with technology because when this happens, trust is lost with the patient.
- 98point6's focus in the last few years is determining if one can pull forward automated expert systems and rules-based systems that one wants for their health care system – this can be clinical or non-clinical.
    - Dr. Younggren shares an example where a health care system could have a rules-based system where when a patient comes in and says they have a laceration, a technology sequence could be built that refers them to one of the local urgent care clinics. There could also be the option to make an appointment for the patient and inform the patient of their appointment for an optimized patient experience.
- AI systems can also be helpful in hybridized care models.
    - This is referring to when you have to transition from virtual to brick and mortar, how do you optimize those hybridized models, in terms of an optimized patient experience?
- It is important to incorporate practice standards into these tools and in gathering data.
    - From the perspectives of health care systems or care delivery operations, this can significantly impact cost of revenue (e.g. reduce time to care).
    - At 98point6, anytime a practice standard isn't followed, their cross-functional team of data sciences, clinicians, etc, they dig into these cases to understand the discordances.
    - This creates efficiencies in the care delivery, increases quality, and improves patient safety, and reduces clinician variability.
    - One can't create practice standards for all systems, but for the ones you can (e.g. hypertension, urinary tract infection, etc), clinicians can be freed up to work on the more complex patients.

- The machine learning approach empowers clinicians to drive the standard of care, empowers health systems and other organizations to report out and understand how to drive what they want into the care delivery, and the patient is getting the best care possible.
- Expert and AI systems can be built to perform non-clinical tasks (e.g. pharmacy location changes).
- From a time perspective, when adding the machine learning approach and expert systems, the clinician visit time can be significantly reduced.
- In summary, the four exciting aspects of AI and machine learning are:
    - Improving efficiency in allowing the physician to focus more of their time cognitively and having less of their secretarial input.
    - Creating value for the patient so that they have more time with the clinician and decrease practice variability.
    - Lots of opportunities in quality – as a clinician is working on their note, they are getting prompted for questions that are considered to be a part of the quality interview.
    - Reducing healthcare costs

Questions/Discussion:

- How are you ensuring that the data algorithms being written are addressing the issues related to social determinants of health?
    - At 98point6, there is a health equity cross-functional committee (which includes internal and external stakeholders) that looks at these issues every month.
    - The goal is not to replace the clinician, but to empower them with these tools. Machine learning is about gathering data and if there is something missed, the provider could ask additional questions such as health equity-related questions.
        - When the provider is asking these additional questions during a visit, do they get ingested into building the system model?
            - Yes, there is no buying of outside data – it's a self-trained system.
- Are there any best practices that you recommend in terms of integrating AI and machine learning into workflows and if you have any experience with this?
    - 98point6 gives 10% of their times to do peer-to-peer chart review every month, including going into the room with the cases retrospectively to understand issues around quality, patient safety, or technology.
        - The clinicians are critical in understanding what best practice changes would need to be made to effectively move a system along. For example, what are the clinical items that clinicians forget to ask/do or do not get often that they need to reference some sources? – this is what AI and machine learning may be able to help with this.

Action Item

- Dr. John Scott to connect with Cindy Jacobs to present on the FDA regulations on AI and Machine Learning in the next Collaborative meeting in April.

Draft Uniform Telehealth Bill

Dr. John Scott (UWM) [1:25:45]

Senator Cleveland asked for feedback on this bill that she is interested in introducing to the legislature. She is based in Vancouver, Washington and she has a number of constituents who go over the river to get care in Portland, Oregon, which sometimes, this continuity of care is challenging – therefore, she was looking for solutions to address this, including this uniform telehealth bill.

Section 6: Out-of-State Health Care Practitioner (pages 3-4)

(1) An out-of-state health care practitioner may provide telemedicine services to a patient located in this state if the out-of-state health care practitioner:

- *a) Holds a current license or certification required to provide health care in this state or is otherwise authorized to provide health care in this state, including through a multistate compact of which this state is a member;*
- *b) Registers under section 7 of this act with the disciplining authority responsible for licensing or certifying health care practitioners who provide the type of health care the out-of-state health care practitioner provides; or*
- *c) Provides the telemedicine services:*
  - *I. In consultation with a health care practitioner who has a practitioner-patient relationship with the patient; or*
  - *II. In the form of a specialty assessment, diagnosis, or recommendation for treatment*

(2) A requirement for licensure or certification of an out-of-state health care practitioner who supervises an out-of-state health care practitioner providing telemedicine services may be satisfied through registration under section 7 of this act.

Section 7: Registration of Out-of-State Health Care Practitioner (ages 4-5)

(1) A disciplining authority listed under RCW 18.130.040, including the secretary of health, shall register, for the purpose of providing telemedicine services in this state, an out-of-state health care practitioner not licensed, certified, or otherwise authorized to provide health care in this state if the health care practitioner:

- a) *Submits a completed application in the form prescribed by the disciplining authority;*
- b) *Holds an active, unrestricted license or certification in another state that is substantially equivalent to a license or certification issued by the disciplining authority to provide health care;*
- c) *Is not subject to a pending disciplinary investigation or action by a disciplining authority;*
- d) *Has not been disciplined by a disciplining authority during the five-year period immediately before submitting the application, other than discipline relating to a fee payment or continuing education requirement addressed to the satisfaction of the disciplining authority that took the disciplinary action;*
- e) *Never has been disciplined on a ground that the disciplining authority determines would be a basis for denying a license or certification in this state;*

f) *Consents to personal jurisdiction in this state for an action arising out of the provision of a telemedicine service in this state;*
g) *Appoints an agent for service of process in this state in accordance with other law of this state and identified the agent in the form prescribed by the disciplining authority;*
h) *Has professional liability insurance that includes coverage for telemedicine services provided to patients located in this state in an amount not less than the amount required for a health care practitioner providing the same services in this state; and*
i) *Pays the registration fee under subsection (4) of this section.*

(2) A disciplining authority may not register an out-of-state health care practitioner under this chapter if the health care practitioner does not satisfy all requirements of subsection (1) of this section.

(3) A disciplining authority shall create an application for registration under subsection (1) of this section and a form for identifying the agent under subsection (1)(g) of this section.

(4) A disciplining authority may establish a registration fee that reflects the expected cost of registration under this section and the cost of undertaking investigation, disciplinary action, and other activity relating to registered health care practitioners.

(5) A disciplining authority shall make available to the public information about registered health care practitioners in the same manner it makes available to the public information about licensed or certified health care practitioners authorized to provide comparable health care in this state.

(6) This section does not affect other law of this state relating to an application by an out-of-state health care practitioner for licensure or certification.

Questions/Discussion:

- Is the intent that both licensed and non-licensed providers would register?
    - If you're licensed, you do not need to take any additional actions. This bill provides an alternative to being licensed – in other words, instead of being licensed, there'd be a telemedicine registration required.
    - The intent is to have additional providers available for telehealth.
- Adam Romney (Davis Wright Tremaine) comments that there doesn't seem to be a geographic limitation noted in the draft bill. Currently the way the bill is drafted, it would allow a provider in any state to register. There are a couple states who have similar registration procedure for a quick expedited licensure process. This registration process would make it much easier than going through the compact or what other states have in place for practicing in Washington.
    - Dr. Kat Jong (WSPA) shares that Oregon has a Telehealth-only license because providers can't get a full medical license there without an in-state location, which is more restrictive and they'd still have to pay the full fee.
- Is this bill for other providers such as ARNPs, licensed RNs, PAs, therapists, psychologists, etc?
    - This bill is only for MDs, DOs, and naturopaths – will clarify with Senator Cleveland.

- Are there other requirements to register aside from the Washington state training for providers?
    - The bill does not explicitly indicate that providers have to take this training.
    - Haley Tanzman (Uniform Law Commission) shares that there is no training requirement, but providers should abide by Washington's standard of care, professional ethics, and any practice requirement imposed by the applicable Washington board.
- Dr. Chris Cable (Kaiser Permanente) endorses the idea that this bill should be limited to bordering states, which would need further discussion. He also thinks it'd be interesting to compare how this stands to existing opportunities such as how is this different in terms of effort and cost from getting licensed in Washington. Similarly, he also is interested in how this registration process compares to the interstate medical license compact process and where this stands.
    - Marissa Ingalls (Coordinated Care) adds that she is curious how this registration body interacts with the medical commission.
    - Dr. John Scott (UWM) shares that it seems like this registration process disadvantages currently licensed providers who went through the costly licensure process. He mentions that Washington state is one of the most expensive states to have a medical license.
- Dr. John Scott (UWM) adds the following points:
    - He is concerned about the quality of going through a registration process, which isn't as rigorous as the licensure process – will the folks who have a disciplinary action be captured in this registration process?
        - The licensure process has a robust way of sharing information.
    - Traditionally, naturopaths have been separated from MDs and DOs.
    - Some of the language in the bill contradicts legislation around what constitutes an established relationship. For example, the Collaborative recommended that there needs to be an in-person visit to establish a relationship, which Senator Muzzall wanted to further look at.
- Will there be a way to track new disciplinary issues (perhaps in another state)? This is part of the interstate licensure compact process where if a provider has a disciplinary action in another state, they will notify Washington in addition to that state.
    - This question will be directed to Senator Cleveland.
    - Dr. Kat Jong (WSPA) comments that Washington state has a very different involuntary treatment law than many states that would also be important for folks to know about.
    - Jinn Schladweiler (AAPPN) adds that there are also some referral resources that an out-of-state provider may not know about, which can cause referrals to be challenging.
- What is the bill number?
    - There is no bill number yet because it has not been formally introduced to the legislature – uncertain if Senator Cleveland will introduce this bill based on feedback received.
    - Hayley Tanzman (Uniform Law Commission) shares that this bill was pre-filed last week, but she hasn't seen it on the Washington legislature's website.
- Remy Kerr (WSHA) shares a concern that out-of-state providers may be less likely to accept Medicaid, which would be leaving in-state providers with a disproportionate share. Also,

Washington has a continuity of care policy for specific scenarios where it's in the patient's best interest to see an out-of-state provider.

- Jordan See (TelaDoc) comments that Florida and Arizona have set up similar registrations for out-of-state providers.
    - Florida's registration process came out of the COVID-19 pandemic where they saw that there were a number of folks who were having a continuity of care issue with their primary care physicians who live somewhere else or in Florida. Once a provider registers in Florida, the state has the right to report back to the state the provider is a resident of on any disciplinary action, similar to the compact's process.
    - Jordan also adds that there should be a conversation around changing the definition of an in-state provider. If a provider is licensed in the state of Washington, then they should be considered an in-state provider because they're already licensed regardless of where they live.
- Haley Tanzman (Uniform Law Commission) shares that they drafted this bill. For background, the Uniform Law Commission is a quasi-governmental organization through which every state has a delegation, which is appointed by an appointment body or governor. Each state delegation comes to this organization to draft better laws that ideally every state then passes so that there's uniformity and consistency across the laws.
    - This draft act is the result of a multi-year collaborative drafting process, which many stakeholder organizations were involved to provide their input.
    - Haley provided her contact information for anyone who'd like to reach out for further question on the bill: htanzman@uniformlaws.org
- Is the bill currently being put forward by any other states?
    - Haley Tanzman (Uniform Law Commission) responds Florida and Arizona have not introduced this bill yet. Nevada has pre-filed and Washington D.C. is about to file.
    - Haley believes there are seven states who will introduce the act this year.
    - Michele Radosevich is the drafting committee chair for this bill and is a great Seattle area contact for further questions on this bill: MicheleRadosevich@DWT.com
- Dr. Kat Jong (WSPA) shares a concern about the naturopath licensing being lumped in this bill given that the training and credentialing standards are not uniform in every state and they have very different scopes of practice in other states compared to Washington.

Action Items

- If the Collaborative members have additional questions/comments to send to Senator Cleveland, please email Dr. John Scott (UWM) at jdscott@uw.edu and Hanna Dinh Hsieh (UWM) at hannad7@uw.edu
- Dr. John Scott (UWM) and Hanna Dinh Hsieh (UWM) to share today's feedback to Senator Cleveland.

Wrap Up/Public Comment Period

[1:41:19]

- Next meeting: Monday, April 17, 2023 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
- Tom Holt (Zoom Care) shares that he's very supportive of the draft bill by Senator Cleveland from a Zoom Care perspective even though many of their providers are licensed in multiple states.
    - Additionally, putting on his volunteer hat, he has served on the Board of the ALS Association of Southwest Oregon and Washington for about 10 years where he acknowledges that the cross-border issue is a very big problem medically fragile and complicated patients (e.g. ALS patients). It takes about 2-3 hours, if they're at the advanced stage, to only get out of their house. They've been hearing many reports of people having difficulty dealing with the teaching hospital in Portland because of perceptions on licensure and no licensure. These patients are also being told that they have to come in-person even though they have an established relationship. The direction of this bill would be helpful for these kinds of patients who are seeking specialty care outside the state of Washington and have established relationships.
- Alesia Black (Clearwater Counseling) shares that she would like more information on prescribing both controlled and other medications out-of-state, which goes beyond the Ryan Haight Act.

Action Items

- Collaborative members to share agenda topics for future Collaborative meetings and email them to Dr. Scott / Mrs. Dinh Hsieh

Tentative Next Meeting Items:

CMS Telehealth Policy Updates
House Bill 1196: Cost Impact of Audio-Only Telemedicine Updates
AI/Machine Learning FDA Regulations

Meeting adjourned at 11:41 am

Next meeting: April 17, 2023: 10 am-12 pm
Via Zoom.