WashingtonState
TelehealthCollaborative

Meeting Minutes

November 14, 2022 | 10:00 am - 12:00 pm

Virtual Zoom Only Meeting

Member attendance					
Sen. Ron Muzzall	Y	Dr. Josh Frank	Y	Dr. Ricardo Jimenez	N
Sen. Annette Cleveland	N	Joelle Fathi	Y	Dr. Geoff Jones	Y
Rep. Marcus Riccelli	Y	Kathleen Daman	N	Scott Kennedy	Y
Rep. Joe Schmick	Y	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	Y
Jae Coleman	N	Sheryl Huchala	Y	Cara Towle	Y
Stephanie Cowen	Y	Amy Pearson	Y	Lori Wakashige	Y

Non-Member Presenters: Nicki Perisho (NRTRC), Romil Wadhawan (Providence), Pita Nims (Providence), Jessica Wynant (Providence), Dan Logsdon (NCIC), Tammie Perreault (NCIC), Hanna Dinh Hsieh (UWM)

Public attendees *(alphabetical by first name)*:

Alesia Black (Clearwater Counseling), Cameron Long (WA Gov), Cara Carlton (MultiCare), Caron Cargill (ForHims/ForHers), Carrie Tellefson (TelaDoc), Cassie Stokes (MultiCare), David Streeter (WSHA), Gail McGaffick (WSPMA), Gayle (National MS Society), Jeb Shepard (WSMA), Jeff Reitan (FHCC), Joana Ramos (WASCLA), Jodi Kunkel (HCA), Josh Viggers (UWM), Julia O'Connor (WA Council for Behavioral Health), Kai Neander (EHMC), Kate Baars (Providence), Koji Sonoda (UWM), Layne Croney (unknown), Leslie Emerick (WA State Hospice and Palliative Care), Marissa Ingalls (Coordinated Care), Marjorie Parkison (UWM), Matt Landers (FHCC), Melissa Rieger (Craig Hospital), Mercer May (TelaDoc), Michael Chapman (Eko), Molly Shumway (UWM), Nancy Lawton (FAANP), Nick Reed (unknown), Nicki Perisho (NRTRC), Nicole Pauly (Mindful Therapy Group), Nomie Gankhuyag (FHCC), Phil Hirsch (Synergia Integrated Telebehavioral Health), Rachel Abramson (UWM), Rolan Tripp (Televeterinary Coalition), Sean Graham (WSMA), Shannon Thompson (WMHCA), Tammie Perreault (Department of Defense), Thalia Cronin (CHPW), Tyler Bloom (SeaMar).

Meeting began at 10:01 am

Welcome and Attendance

Dr. John Scott [0:00]

State/Federal Updates

Hanna Dinh Hsieh and Dr. John Scott (UWM) [4:39]

State Updates

- The Center for Connected Health Policy (CCHP) published a new report that documented changes in telehealth policies that have occurred since Spring 2022.
    - One change reported five states adding Medicaid reimbursement for audio-only services
    - Some states allow delivery of any type of Medicaid service through telehealth while other states only allow some services via telehealth
    - 34 states reimburse for remote patient monitoring and 25 reimburse for store-and-forward
    - 17 states reimburse all modalities: live video, store-and-forward, audio-only, and remote patient monitoring
    - More states are adopting cross-state licensure exceptions with the number growing even more since Spring 2022

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

- Can you clarify on the CDC report finding of increased telehealth usage was correlated with increasing age?
    - This means that older patients were more likely to use telehealth.

Northwest Regional Telehealth Resource Center (NRTRC) Conference Update

Nicki Perisho (NRTRC) [10:50]

2022 11th Annual NRTRC Conference

- Was held in Salt Lake City, Utah on September 26-28, 2022 using a hybrid model of in-person and virtual
- Had about 200 in-person attendees and 30 attended virtually
- There were attendees from 25 different states
- For anyone who was not able to attend the conference, all of the sessions will be published on the NRTRC Youtube page after January 1st, 2023: Northwest Regional Telehealth Resource Center - YouTube

Pre-Conference Grant Writing Workshop

- Hosted by Teryl Eisinger, former CEO of the National Organization of State Office of Rural Health (NOSORH)
- Touched on all the important parts of grant writing, including the work plan, securing partners and partnerships, and what sustainability looks like
- There is a section on the NRTRC website that displays the available grants for telehealth: Northwest Regional Telehealth Resource Center (nrtrc.org)

Telemedicine as a Human[e] Centered Construct

- Presented by Adrienne Boissy, MD, MA, CMO Qualtrics
- Takeaways
    - Related to your patient, be a good human
    - The work is about telemedicine, but it's rooted in how we care for other people
    - In telehealth, it is necessary to apply the six domains of healthcare quality as outlined by the Institute of Medicine

- Unless 20% of what you do is meaningful, you are at risk for burnout
- Create your Joy Pie

An Overview from Telehealth Policy Leaders

- Presented by the following:
  - Mei Kwong, JD, Executive Director for Center for Connected Health Policy, CCHP
  - Kyle Zebly, Senior VP, Public Policy American Telemedicine Association, ATA
  - Ben Steinhafel, Director of Policy and External Affairs, The Center for Telehealth and eHealth Law (CTel)
- Telehealth policy that defined and restricted telehealth to rural areas and within the four walls of a provider's office was progressive in 1997 but is "wildly outdated" in 2020
- There are misconceptions on originating site restrictions as well as several misconceptions that telehealth is cost-increasing, along with fears of fraud and abuse
- Those working in telehealth, start engaging with state representatives – share data with them on cost and utilization. Help state representatives learn the telehealth landscape in their state.
- Note that the 151-day extension after the PHE takes us through mid-January, meaning that all bills will need to be reintroduced
- Educate and support policy makers to ensure that some of the extended telehealth benefits become permanent
- Check the Center for Connected Health Policy's comprehensive compilation of state-specific telehealth policies, including information on the states that reimburse for live video, audio-only, store and forward, RPM, communications-based technologies, payment parity, and more
- States control what commercial payers may do with regard to reimbursement

Care Reimagined

- Presented by Kristi Henderson, SVP & CEO, Optum Everycare
- Takeaways
  - Look at the data – if we can increase care and access, can we reduce hospitalizations
  - How can we build telehealth from the consumers' eyes
  - Meet patients where they are – the human connection of what we do with telehealth
  - The work is about telemedicine, but it's rooted in how we care for other people
  - Aim for near-immediate access to a provider, a whole system of care needs to occur locally – health is complex

Telehealth and Innovation: A CMS Update

- Presented by Ashby Wolfe, MD, MPP, MPH, Regional Chief Medical Officer Center for Medicare & Medicaid Services
- Takeaways
  - The Physician Fee Schedule 2023 Proposed Rule includes the work CMS is planning to address concerns in our communities across the nation especially as it relates to equity

- Currently (i.e. during the PHE), all healthcare practitioners who are authorized to bill Medicare for their professional services may also furnish and bill for telehealth services
- CMS is looking at better ways to engage with state Medicaid agencies
- Dr. Wolfe mentioned the resource Creating a Roadmap for the End of the COVID-19 Public Health Emergency, which includes a link to several factsheets that include information about which waivers and flexibilities have already been terminated, have been made permanent, or will end at the end of the PHE

Tribal Session Crossing the Digital Divide

- Presented by Anthony Torres, Special Projects Manager, Utah Navajo Health System
- Takeaways
  - In relation to lying fiber, "Technical challenges and financial challenges were not the hardest part of the project. The regulatory constraints were."
  - Fiber optic connectivity is the long-term plan, but in most cases tribal lands were rugged and frontier, which is why microwave-based technology is a great solution as it can cover great distances and does not require asking permissions from landowners
  - If you provide telecommunications to people who are on tribal lands, ask if they are satisfied with their connectivity
  - Regulatory issues are commonly the barrier, work with local service providers to find a resolution

Virtual Pariah-Self-Disrupting to Achieve Success with Direct to Consumer Telehealth

- Presented by Tim Lovell, MBA, Connect Care Operations Intermountain Healthcare
- Principled of success in building a virtual practice
  - Make telehealth a strategic priority
  - Be what consumers want
  - Disrupt without abandoning values
  - Form a high-performing team
  - Promote your service
  - Deliver on the promise
  - Prove your value
  - Continually improve and disrupt

Break Out Sessions

- There were 27 break-out sessions, which included:
  - Technology Showcase hosted by The Telehealth Technology Assessment Center (TTAC)
  - Lessons Learned: Building a Comprehensive Telehealth Quality Program
  - Bridging the Digital Divide with Human-Centered Design
  - Enhancing Telehealth Fluency Using Professional Empathy Practices
  - Sustaining Project ECHO
  - School-Based Telehealth
  - Building a Comprehensive Telehealth Program

  - Implementation of Virtual ICU during COVID-19
  - TeleNICU
  - Innovation Among Early Adopters of Telemedicine in Public Libraries
  - Understanding the Impact of Social Determinants of Health on Broadband Access
- For a full list of breakout sessions, see the agenda

Quality Improvement (QI) Course

- NRTRC is hosting a QI course with a telehealth lens and includes the following sessions:
  - Session 1: The Model for Telehealth Improvement, January 19, 2023, Noon – 1:30 pm (MST)
  - Session 2: PDSAs – The Heart of Improvement and Data – Your Telehealth Performance Enhancer, February 16, 2023, Noon-1:30 pm (MST)
  - Session 3: Telehealth Process Improvement Mapping, March 16, 2023, Noon-1:30 pm (MST)
- Space is limited to 35 spots
- Early bird cost $125

Questions/Discussion

- One of the slides indicated that it was reported there are concerns about cost increases due to telehealth and about fraud and abuse. Did anyone indicate who, in particular, holds those concerns?
  - These concerns have been expressed by Federal legislators during committee hearings
- When and where will the 2023 NRTRC Conference be held?
  - NRTRC is evaluating among three spots: Seattle, Boise, and Salt Lake City
  - Tentative timeline of Spring 2024
    - The planning will take 18 months vs. 12 months in previous years due to the changing landscape and for practicality purposes
- Dr. John Scott shares his thoughts on attending the NRTRC Conference in person. The presentations by Kristi Henderson and Intermountain touched on having a health insurance product that was virtual first, which was offered at about a 5-10% discount – starting to see this as innovation in the health care delivery space
- Representative Riccelli comments on the frequent conversations several years ago around "webside" manner and the importance of this connection between providers and patients. He believes that it seems to not have the attention it deserves recently, reinforcing the importance of this that was mentioned in the presentation slides. Are there best practices/tools/techniques that have emerged for training "webside" manner? He also notes that it seems to be a challenge for folks to receive constructive feedback on "webside" manner.
  - Nicki Perisho shares that there is a lot of literature around this topic and that "webside" manner is typically included in the telehealth trainings.
  - Dr. John Scott adds that at the University of Washington, there is an upcoming elective for students on this topic where he believes that "webside" manner should be shown on

how to do this properly in addition to reading about this in literatures. He is working on this closely with Dr. Geoff Jones (Newport Community Hospital).
    - Dr. John Scott shares that recordings could be done to provide constructive feedback.
- Cara Towle (UWM) shares the work from the Harborview Medical Center's Behavioral Health Institute since the pandemic. They offer a monthly series in training folks how to do TeleBehavioral Health appropriately, including how to do clinical engagement, how to work with certain populations, how to choose to do telemedicine vs. in-person, etc: https://bhinstitute.uw.edu/training-workforce-policy/training/telebehavioral-health/
    - The Behavioral Health Institute is also doing a study about best practices in TeleBehavioral Health from prenatal through age 25. There should be reports soon on this.

Action Items:

- Mrs. Dinh Hsieh (Collaborative Program Manager) to disseminate the presentation slides

New Member Introduction

Amy Pearson (Virginia Mason) [35:11]

Dr. Scott (Chair) introduces Amy Pearson as a new member representing Virginia Mason and replacing Claire Fleming. Amy Pearson is the RN Operations leader for Virtual Ambulatory clinics at Virginia Mason.

Review of Meeting Minutes - September 19, 2022

Dr. John Scott [35:37]

Dr. Scott (Chair) reviews minutes. Dr. Mark Lo (Seattle Children's) motioned to approve minutes. Dr. Chris Cable (Kaiser Permanente) seconded. Unanimously approved as submitted.

Action Item:

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

Providence-At-Home Program

Dr. Romil Wadhawan, Pita Nims, and Jessica Wynant (Providence) [39:27]

CMS Acute Hospital Care at Home Waiver

- The waiver allows hospital level care for eligible patients in their homes, referred to as "Acute Hospital Care at Home," building on the Hospital Without Walls program announced in March 2020
- This program explicitly differentiates acute hospital care at home from home health care, for patients who require acute inpatient admission
- CMS will be monitoring these programs within a standard set of safety and quality measures
- What initial participants are saying about impact on their hospital capacity
- Current approved list (as of 10/31/22)
    - 114 systems
    - 256 hospitals
    - 37 states

Providence Hospital At Home

- Program started in July 2021
- Shared an illustrative pathway of the patient going through this program
- Key Program Metrics: August 5, 2021 – November 7, 2022
    - 114 Total Cases Served
    - 105 Unique Patients Served
    - 4 Escalations of Care (3.51%)
    - 0 Unanticipated Mortality
    - 12 Readmissions (11.11%)
    - 3.9 Program ALOS
    - 4 Peak Census
    - 1 CMS Waivers Active
    - 9 Non-CMS Payors (18 lines of business)

Case Scenario

- Chief complaint upon admission:
    - Altered Mental Status secondary to Dehydration
    - Admitted for hypovolemia, ART d/t high output from recent ostomy
- Initial course of treatment:
    - Course of Care (Tower)
    - IV fluids (address dehydration, hypotension, creatine) starting to resolve
- Transfer to Providence Hospital at Home:
    - Ongoing medical oversight for AKI, high output ileostomy, malnutrition, coumadin coagulopathy
    - Physician rounding
        - Noted by Field clinician patient was starting to deteriorate
        - Escalation back to facility
        - Met sepsis bundle metric

Case Scenario | Escalation Timeline

- HR = 126, T = 103.1
  - 3:30 pm: Clinician in patient home; patient states "not feeling well" (Tylenol, cold compresses used to bring fever down)
- HR = 106, T = 100
  - 4:44 pm: Field RN in the home; patient self reports "feeling better"; CC MD determines patient needs to be returned
- CC MD videos in
  - 4:53 pm: MD identifies bloody output from ostomy, determines urgency of return
- CC MD determine disposition
  - 5:26 pm: Labs ordered, samples collected, abx & PPI IV ordered; transport determined, patient no NPO in prep for potential procedure
- VS taken, IV meds started
  - 6:54 pm: Field RN gathers IV meds from IP Pharm, transports back to patient, gives one dose of abx & PPI per physician before leaving
- Return
  - 7:42 pm: confirmed patient arrival

Providence Hospital at Home Operations

- **Hospital at Home leverages a "team of teams" approach** and seamless management between groups for success
- The **24/7 virtual MD/RN command center acts as the "orchestra conductor"** in this highly coordinated care model
- Leveraging strategic service **vendor partnerships** to enable rapid scale across the Providence footprint in areas they can provide more cost-effective options while maintaining high quality care

Screening Process

- There are strict criteria for which patients qualify for the Hospital at Home program
  - The biggest criteria is confirming insurance and geo-fencing (within a 30 minute drive time of the facility/resource, such as an emergency EMT team) since they're operating under the CMS waiver
- Providence built out a screening tool in their EMR, which automatically filters for insurance and zip code
  - Once this is populated, the Command Center does a first pass at a clinical review of the patient
- From the clinical review, the Command Center sends this over to the Medical team and case management for a second review to comprehensively understand the patient's home setting and that the patient can be managed safely in the home setting
- Many of their patients come as a transfer or an admit, not a discharge

- Because this is an opt-in program, after the patients have been clinically identified as a good fit for the program, they ask the patients and their families if they're interested in receiving their care in this modality.
    - There's been a great response rate of 97% who have expressed interest
- Once everyone is in agreement, then the patient is in the pathway for transfer

Quality Indicators

- **Required CMS metrics are:**
    - Volume, escalation rate, and unanticipated mortality
        - There is a low escalation rate with the program
- **Facility metrics are:**
    - CMI, Falls, Skin, Med errors, Variances in care, Patient satisfaction
- **Quality Oversight**
    - Case Reviews
    - Safety and quality review committees
    - Monthly Provider Meetings
- Top Clinical Diagnoses
    - CHF w/acute exacerbation
    - COVID pneumonia w/hypoxia on Remdesivir
    - Acute renal failure
    - Cellulitis failed outpatient antibiotics
    - COPD w/acute exacerbation
    - UTI requiring IV antibiotics
    - Pneumonia
- Hospital at Home care is levelled as inpatient acuity and assessed for quality and utilization on the same basis as the hospital's other inpatient cases, and becomes part of the hospital's reporting. However, delivering this care model tends to be highly complex, but when executed well, it's a tremendous satisfier to patients

The Providence Hospital at Home Experience

- "This program gave me the best of both worlds. I could drink as much water as I wanted, pet my dog, relax on my comfy couch instead of a hard gurney, watch stupid tv shows, and joke with my husband, all while getting inpatient-level treatment. My Care Team responded more quickly than inpatient nurses can answer a Call Button. Every question I had was immediately answered and everyone was so nice they brought me to tears.

  I have never felt more supported by a team under any circumstances. It meant more to me (and my family) than you can imagine. […] I honestly believe I got much better, much faster amidst familiar surroundings while connected to medial staff electronically."

  -Letter from recent patient

- "I have been a hospitalist for over 20 years, and I have noticed the big difference that treating a patient in their own home makes… This care model works well; patients love it, and as a hospital clinician, it has allowed me to enjoy a more personal and individualized approach to inpatient care in the home, leading to a more rewarding experience for both providers, patients, and their families.

  Personally, it has rejuvenated my career; I feel like an "old-time family doc" enjoying their work making home visits…"

  -Command Center Physician

Providence Hospital at Home | Patient Experience

- Press Ganey Pilot Survey Results
  - Overall rating of care 100%
  - Likelihood of recommending 100%
  - Staff worked together to care for you 100%

Providence Hospital At Home | July 2021 – November 2, 2022

- Key Learnings and Highlights
  - **Patients and inpatient care teams are advocates** for this care model
  - **Inclusion based on presentation** matched to model capabilities, yields higher volumes and increased physician engagement (initial inclusion criteria = 36 DRGs)
  - Payor expansion strategy yielded **9 additional payors**
  - Continued advocacy efforts for **post pandemic reimbursement strategy**
  - **Streamlined** vendor contracting to improve speed to market and scalability
  - **Potential for growth and expansion beyond the acute episode**
- Constraints for Rapid Scale
  - Epic build timelines
  - Middleware solution(s) and EMR integrations are >1 year out
  - Staffing availability and financial constraints
  - Availability of bed licenses
  - Regulatory constraints may restrict ideal field staffing model in some states

Questions/Discussion:

- Who delivers the care in the home when using Hospital At Home?
  - The team that cares for patients in the home is comprised of in-home RN, PT/OT, Tele-Hospitalist and Tele-RN. If needed, Providence can mobilize the physician team for an additional assessment and a field clinician in the home.
  - Is the in-home RN there the entire time or only for a couple of hours?
    - In-person nursing visits are twice a day and there is a virtual nursing team rounding on these patients.
- Do you have a geographic requirement for who qualifies for the program?

    - Yes, the patients need to reside within 30 minutes of the hospital to ensure safe transfer back, if needed
- How do they or the hospital get paid or how do they bill for services?
    - The hospital bills on the inpatient DRG for inpatient care delivered in the home setting, under the CMS waiver or arrangements with participating payors. A note identifies that the patient experienced all or part of their hospital stay in the Hospital at Home program.
- If the patient needs to transition back to the hospital due to an exacerbation of the admitting condition while at home, is the admission considered under the same DRG?
    - If the patient requires escalation back to the hospital during their time in Hospital at Home, it would be under the same admission and treated like a unit-to-unit transfer within the hospital to a higher level of care. Yes, this would be the same DRG. The patient is admitted during the entire duration of the program. This is not a readmission, but simply a transfer to a "different part of the hospital"/higher level of care.

Action Item:

- Mrs. Dinh Hsieh (Collaborative Program Manager) to disseminate the presentation slides

National Center for Interstate Compacts (NCIC)

Dan Logsdon (NCIC) and Tammie Perreault (U.S. Department of Defense) [1:09:49]

The Council of State Governments

- CSG is a region-based membership organization that fosters the **exchange** of **insights** and **ideas** to help state officials **shape public policy**

What is an Interstate Compact?

- A **legislatively** enacted agreement between states
- Allows states to **unitedly** respond to **national and regional priorities**
- Retains collective **state sovereignty**
- **Simple, versatile, proven, and effective**

Compacts and Occupational Licensure

- **Reduces** the social costs of licensure while preserving health and safety
    - e.g. Military Families
- **Improves** licensure portability
- **Negates** the need for federal intervention

Compact Benefits for Licensing Boards/Agencies

- **Preserves** state control of scope of practice and licensure
- **Facilitates** the exchange of licensure, investigatory, and disciplinary information

- **Allows** regulators to keep pace with technology
- **Encourages** state cooperation in regulating profession

Compact Benefits for Practitioners

- **Facilitates** mobility/portability of services across state lines
- **Increases** market opportunities including via telehealth
- **Reduce** the time and cost of obtaining licensure
- **Voluntary** participation

Compact Benefits for Consumers

- **Increases** access to health care services, including telehealth
- **Improves** continuity of care
- **Promotes** access to practitioner diversity

Compacts and Telehealth

- **Compliments** federal and state telehealth investments and the services of regional health care organizations
- **Enhances** access to mental health services
    - e.g. Mental Health Professional Shortage Areas
- **Adaptable** to the different modes of telehealth

State Participation in Licensure Compacts

- States have **enacted 230+** separate pieces of **licensure compact legislation**
- **44 states, DC & Guam** have enacted at least **1 licensure compact**
- **33 states & DC** have enacted at least **3 licensure compacts**
- **12 states** have enacted at least **6 licensure compacts**

Current Licensure Compacts

- Interstate Medical Licensure Compact: ~39 states
- Physical Therapy Compact: ~34 states
- Nurse Licensure Compact: ~39 states
- Advance Practice Registered Nurse Compact: ~3 states
- Emergency Medical Services Compact: ~22 states
- Psychology Interjurisdictional: ~34 states
- Audiology & Speech – Language Pathology: ~23 states
- Occupational Therapy Compact: ~22 states
- Counseling Compact: ~17 states

Compacts for Mental Health Professionals

- **PsyPact**
    - Licensed Psychologists

    - 28 states
- **Counseling Compact**
    - Licensed Professional Counselors
    - 10 states
- **Social Work**
    - Under development (Expected 2024)

Alaska

- No enacted compacts
- Alaska have specific requirements in providing care in rural areas and they are concerned that the compacts won't recognize this and that the service would be diminished
- Alaska also has the concern of the licensure compact requirement for criminal background checks

Idaho

- Interstate Medical Licensure Compact
- Nurse Licensure Compact
- Psychology Interjurisdictional Compact
- EMS Compact
- Audiology and Speech-Language Pathology Compact

Montana

- Interstate Medical Licensure Compact
- Nurse Licensure Compact
- Physical Therapy Compact

Washington

- Interstate Medical Licensure Compact
- Psychology Interjurisdictional Compact
- Physical Therapy Compact
- Occupational Therapy Compact

Wyoming

- Interstate Medical Licensure Compact
- Nurse Licensure Compact
- Physical Therapy Compact
- EMS Compact
- Occupational Therapy Compact

Questions/Discussion:

- Dan shares that Oregon is in the PT compact, which is the first state to adopt this. Compacts for speech therapy, OT, and counseling will be filed there next year.
- Dr. Scott shares that the fingerprinting scan requirement for criminal background checks is a barrier due to privacy concerns shared by providers on where this information is going. It was also a barrier during the height of the COVID-19 pandemic where there weren't many offices opened to do the fingerprint scan.
- Dr. Scott also comments that for all the clinicians on the Collaborative call, even though clinicians get their license through the compact in another state, they still need to be knowledgeable of those states' laws (e.g. CME requirements).
    - For example, in Washington, clinicians have to do suicide prevention training. Many states also require opioid prescribing training. In Idaho, there is a separate DEA, which is a state hurdle that clinicians have to overcome to prescribe narcotics.
- Were there any efforts to align with other state laws? For example, CEU requirements between states as part of the compact, especially for those that are also regulated by a national body (e.g. OT).
    - One of the benefits of these licensure compacts for practitioners is that you only have to complete the requirements of continuing education to keep your home state license for participation in the compact.
    - Dan reinforces that it is on the onus of the practitioner to understand, know, and practice under the state laws where the patient is located. Practitioners have to meet the competencies in the states where they want to practice.
- What thoughts do you have on how compacts approach licensure reciprocity vs. expedited licensure?
    - What compacts provide for state regulators is more oversight on the profession. There are many states that have enacted universal licensure laws where a good-standing license can be taken to another state and essentially, "trade" this for a license at that state. However, some states require that you have to be a resident at that state. Dan states that he's not seeing a lot of usage of these types of licensures.
    - Dan believes that for health and allied health professions, compacts are a better option for public protection purposes.
- Dan expresses that the NCIC doesn't believe that every profession needs an interstate compact. However, for health and allied health professions as well as professions that have a large contingent of military spouses in them, compacts make sense.
- Tammie shares that there have been many challenges with the behavioral health workforce and workgroup. She hopes that some of the tools can ease this burden of the licensure process for these providers in Washington state and throughout the western states.

Action Item

- If the Collaborative members have any further questions, reach out to Dan Logsdon at dlogsdon@csg.org or Tammie Perreault at tammie.l.perreault.civ@mail.mil

WashingtonState TelehealthCollaborative

Audio-Only Telemedicine: Established Relationship Definition

Dr. John Scott (UWM) [1:27:28]

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

Established Relationship Language

- Federation of State Medical Boards' (FSMB) policy

  "*The relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated,* ***whether or not there has been an in-person encounter between the physician (or other appropriate supervised health care practitioner) and patient.*** *A physician-patient relationship may be established via either synchronous or asynchronous telemedicine technologies* ***without any requirement of a prior in-person meeting,*** *so long as the standard of care is met."*

- H.B. 1821: Audio-Only Telemedicine Reimbursement – Definition of Established Relationship

  "*(ii) For any other health care service:*
  (A) ***The covered person has had, within the past two years, at least one in-person appointment, or until January 1, 2024, at least one real-time interactive appointment using both audio and video***

***technology**, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine."*

Questions/Discussion:

- Senator Muzzall shares that there is a challenge in getting all the various parties to agree on the definition for an established relationship. However, there is a newfound appreciation for the importance of this that came about during the pandemic.
- Senator Muzzall states that House Bill 1196 asked the Office of Insurance Commissioner and the Washington State Telehealth Collaborative to do a study into this relationship. However, there are issues with dates.
    - The OIC will be reporting back on this study in November 2023.
    - Unfortunately, the legislature will not be able to address this before it sunsets on January 1st.
    - To address this issue, Senator Muzzall asked for collaboration for the parties at be, including representatives from TelaDoc and from the Washington State Medical Association, to agree on a 6-month extension until July 1st. This proposal will be presented in the next legislative session. That way, report findings from OIC's study will be considered from November 2023. In other words, this will give more time to study this relationship before making any formal legislative changes.

Action Items

- The OIC will be on the April Collaborative meeting to report out on updates from their study

Wrap Up/Public Comment Period

[1:34:20]

- Rolan Tripp (Televeterinary Coalition) provides consultations as a veterinarian throughout the U.S. for veterinarians who need more education on psychoactive medication use. Rolan is currently working with a psychiatrist on a "one health" approach to introduce the concept of pet happiness being one portion of human happiness that is different from other types of happinesses (e.g. from spousal relationships, jobs, etc.). He has found that this area has not been well looked at, but Rolan believes the "one health" approach can help with this. He is seeking collaboration to try to understand mental, human, and animal health and proceed with next steps in doing this appropriately and professionally.
    - Dr. Scott asks where do veterinary issues get discussed in the legislature?
    - Senator Muzzall responds that there's been outreach to the State Veterinary Board and some veterinarians regarding this issue, but there's been a fair amount of pushback.
    - Representative Schmick suggests that this issue should be brought to the Agricultural and Natural Resource Committee in the House.

- Next meeting: Monday, January 9, 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

Action Items

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

Tentative Next Meeting Items:

AI and Machine Learning in Telemedicine
Restoration of the Ryan Haight Act

Meeting adjourned at 11:41 am

Next meeting: January 9, 2023: 10 am-12 pm
Via Zoom.