WashingtonState
TelehealthCollaborative

Meeting Minutes

September 9, 2021 | 10:00 am - 12:00 pm
Virtual Zoom Only Meeting

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

Non-Member Presenters: Dr. Brian Wood (UWM), Dr. Joshua Liao (UWM), Hanna Dinh (UWM), Christopher Chen (HCA), Jane Breyer (OIC)

Public attendees *(alphabetical by first name):*

Aimee Champion (Pierce County Alliance), Alexa Silver (unknown), Amy Etzell (BREE Collaborative), Ashley Mammen (Protiviti), Carrie Tellefson (Teladoc Health), Cameron Long (WA Gov), Claudia Tucker (Teladoc Health), Cori Tarzwell (DOH), Crystal Chindavongsa (Teladoc Health), David Streeter (WSHA), Don Downing (UW School of Pharmacy), Gail McGaffick (WSPMA), Jaleen Johnson (NRTRC), Jeb Shepard (WSMA), Jodi Kunkel (HCA), Josh Morse (HCA), Joy Lee (UWM), Julie Sylvester (UW), Kristine Joy Culala (UWM), Lauren Baba (UWM), Linda Moran (MS Activist Tacoma), Lynda Dougan (Unity Care NW), Maia Thomas (DCYF), Marissa Ingalls (Coordinated Care), Meg Jones (unknown), Melissa Johnson (unknown), Mike Zwick (Cambia Health Solutions), Molly Shumway (UWM), Morgan Young (L&I), Nancy Lawton (ARNPs United), Nicki Perisho (NRTRC), Patrick O'Brien (UWM), Rachel Abramson (UWM), Scot Sigmon (ZoomCare), Shannon Thomson (WMHCA), Stephanie Shushan (CHPW), Thea Mounts (unknown), Tracie Drake (DOH), Tucker Bronkema (WA Gov), Tyler Bloom (Sea Mar)

Meeting began at 10:01 am

Welcome, Attendance and Review of Meeting Minutes - June 24, 2021

Dr. John Scott [0:00]

Dr. Scott (Chair) reviews minutes. Mark Lo (Seattle Children's) motioned to approve minutes. Joshua Frank (Confluence) seconded. Unanimously approved.

Action Items:

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

New Member Introduction

Senator Ron Muzzall (R-10), Republican Senate [7:22]

Dr. Scott (Chair) introduces Senator Ron Muzzall as a new member representing the Republican Senate and replacing Senator Randi Becker. Senator Ron Muzzall represents the 10th legislative district, which is primarily made up of Island County, Skagit River delta, and Stillaguamish River delta. He is a farmer by background. He expressed that telehealth has a very important place in rural health and isolation is less so when we can utilize telehealth, especially when you live on an island.

Action Item:

- Moving forward, if Senator Ron Muzzall has any agenda items for future Collaborative meetings, he or his staff will send them to Dr. Scott and Mrs. Dinh.

UW Medicine: Madison Clinic Telemedicine Data Presentation

Dr. Brian Wood (UWM) [10:05]

Background: Early Pandemic Telehealth Uptake Uneven – Clinical Data on Disparities in Usage

- UPenn primary care & subspecialty outpatient visits
    - Less telehealth: older, Asian, limited English proficiency (LEP)
    - Less video: older, female, Black, Latinx, lower income
- UPenn Cardiology & GI clinics
    - Phone not video: Black, female, older, lower income, LEP
    - Less likely to use online portals: Black, older
- MGH Cardiology
    - Less video: older, lower income, public insurance, Black, Latinx

Recent Explosion in Telehealth: Data from California Federally Qualified Health Centers

- Overall rate of visits for primary care and behavioral health did not change much from February 2019 through August 2020

- But, most of the face to face visits were replaced by phone visits as opposed to video – people were relying on phone visits much more, which led to the motivation of the study at HMC Madison Clinic

Factors Associated with Video Visit Use: HMC Madison Clinic

- Methods:
  - Identified cohort of patients engaged in care prior to the pandemic (≥2 visits w/in 24 months prior to March 15, 2020)
  - Of those patients, identified those who had a visit during the pandemic (March 15, 2020 to December 31, 2020)
  - Recorded visit type based on billing code
  - Collected demographic factors from EPIC and a social work database (age, sex, gender identity, race, ethnicity, language, housing status, insurance) and history of MyChart portal login
  - Logistic regression to assess factors associated with at least one video visit during the study period

Visit Types by Absolute Count: HMC Madison Clinic

- In the first couple of months starting in April 2020, phone visits were over 50% of the visits the clinic was doing vs. video visits
- Over time, there was a plateau of video visits around 10% and 15-20% of visits were by phone

Visit Types by Percentage: HMC Madison Clinic

- Displayed another way of looking at the same data above
- Early in the pandemic, about 50% of visits were by phone and at the end of the study period, the phone visits leveled off around 15%

Table 1. Patient Characteristics

- Displayed univariate analysis data on who has successfully completed video visits by various social determinants of health
- There were significant differences by age, race, insurance, and history of patient portal login
- There were no significant differences by sex assigned at birth, gender, ethnicity, language, and housing status

Table 2. Results of Multivariate Analysis: Factors Associated with ≥1 Video Visit

- There was a significant association with the following factors in the less likelihood to successfully complete a video visit
  - Age 50 to 65 and above 65 compared to 18-35 years old
  - Black, Asian, or Pacific Islander race compared to white race
  - Medicaid insurance status compared to private insurance
  - Patients who had a portal login

Conclusions

- Main findings:
  - Video visit uptake modest (now stable around 10% of visits)
  - Phone visit use higher than expected
  - Social determinants of health associated with video visit use
  - Patient portal login strongly associated with video visit use
- Limitations:
  - Couldn't compare by: gender identity, income, geography
  - Doesn't address why the disparities in video visit use exist
- Next steps:
  - Patient survey (awareness of options, preference, satisfaction)
  - Interventions to improve access

Questions/Discussion:

- Do you have any concerns in delivering care via audio-only?
  - Dr. Wood tries to encourage video for his patients. But when video is not available, phone visits are a great safety net for patients and reinforces patient engagement with their care.
- Geoff Jones (Newport Community Hospital) comments that there is little bandwidth for patients and staff to troubleshoot technology issues. With that said, it is much more advantageous to use audio-only
- Regarding uptake in use of patients who had access to their portal, is this partially because of the ease of using the button function to enter the visit or are patients more technologically-oriented?
  - Sending the video link not only by the portal, but also by text message
  - It does seem like the use of the portal is a marker for some ability or willingness to use video visits even if the link is sent by other means
    - There is an active discussion on how do we use this information to address patient barriers?
  - At UW Medicine, Dr. John Scott shared that they encourage patient sign-ups for the portal due to ease of registering for vaccine appointments and ease of using the button function to start the video visit
    - Currently exploring ways to use email in sending the video link as well
- Is there any information on patient satisfaction on video visits from the patient's phone, laptop, iPad, or any other device?
  - Dr. Wood anticipates there is a difference by generation
  - Geoff Jones (Newport Community Hospital) has found that video visits generally are much more effective on a laptop or desktop computer than on a patient's phone. But patients often only have phones as an option.
  - Mark Lo (Seattle Children's) has found that in adolescent patients and parents of children, receiving the video link by text is much more reliable for connection vs. receiving the link

by email. He believes that mobile connection may be more population than a laptop/desktop.
    - Dr. John Scott shares that Mass General and UT San Antonio have deployed "digital health navigators" to help patients identified as having technical issues/access to get devices, learn how to use them, etc.
- Regarding private insurance, are all the variables associated with a successful completion of a video visit independent of each other or confounding?
    - As an independent factor or in conjunction with the other factors, having Medicaid insurance compared to private insurance was associated with never having a video visit
    - Surveying patients (e.g. focus groups) to understand the barriers better is necessary
    - Chris Cable (Kaiser Permanente) shares that they did a similar survey where there was a different outcome in which the BIPOC community was more likely to use video and telehealth tools.
        - This is considering where the population is all insured under Kaiser Permanente
- Future question to ask and determine is why there are differences in the likelihood of patients using and completing video visits
- In late 2020 to early 2021, there was a huge uptake in patient demand in face to face and telehealth visits as an aggregate, which raises the question of the utilization and easy access to telehealth tools. Are you seeing this same uptake in demand and what do you think are the drivers behind this?
    - There is not as much ongoing demand, but more of a plateau
    - Dr. Wood is continuously trying to encourage patients to use video and offer it to everyone to address the barriers
    - Need to research more into the drivers
- Regarding digital health navigation, a study was done at the University of Illinois in Chicago that looked at two specialty areas: pulmonary medicine and oncology. This study showed a significant drop-off in access to smart phones with video capability for those who were aged 50 and older.
    - Access is an issue and comfort/confidence level dropped off significantly.
    - Joelle Fathi (UW School of Nursing) emphasizes the importance of getting people access and making telehealth tools simple, comfortable, and understandable to use
    - Chris Cable (Kaiser Permanente) adds that the Kaiser Permanente survey showed that increasing age was associated with significantly less use of telehealth tools
- UW Medicine Madison Clinic at Harborview is different from the other clinics in the system.
    - There's about a 3 to 1 ratio of video to audio visits at UW Medicine whereas the Madison Clinic is more than this with more reliance on audio visits.
    - Their population is much more vulnerable where it is detrimental to the patients if they fall out of their care

Action Item:

- Chris Cable (Kaiser Permanente) to check in sharing Kaiser Permanente's telemedicine data

- Mrs. Dinh (Interim Collaborative Program Manager) to post Dr. Wood's presentation slides on WSTC website

State/Federal Updates

Dr. John Scott [33:33]

- CMS released a proposed physician fee schedule in July. These rules maintain parity and allow patients to be in their homes and in non-rural areas. However, for mental health services, CMS requires that patients be seen in person within 6 months before a tele-mental health visit.
  - Submit a formal comment here
  - Open comment period until September 13th
- SB 5423 codifies into Washington law the current practice of physicians conducting consultations with colleagues outside of Washington state via telemedicine regardless of their licensure status in Washington. This became effective on July 25, 2021.
- The Improving Medicare Beneficiary Access to Innovative Diabetes Technologies Act was reintroduced before Congress that aims to expand access to diabetes prevention tools, such as mHealth and telehealth, for seniors in need of diabetes care management
  - Press release here
- Many states' public health emergencies expired in July, including Arizona, Colorado, Maryland, and others, which many states are reconsidering changing their telehealth rules and flexibilities post-pandemic.
  - With the latest surge, some of the states are reinstating
- S. 1988 Protecting Rural Telehealth Access Act proposes to make permanent the ability for patients to be treated at home, that payment parity is allowed for audio-only telehealth services, and to let RHCs and FQHCs serve as distant sites for telehealth services
- Advancing Telehealth Beyond COVID-19 Act of 2021 aims to extend telehealth flexibilities under the Medicare program such as for RHCs and FQHCs and removing originating site and geographical limitations
- The Senate passed the $1 trillion Bipartisan Infrastructure Deal on August 10th, which includes $65 billion for broadband investments
  - White House fact sheet
- Telehealth Access for Seniors (University of Washington Team) created a guide on Lifeline, a government program that can provide free or discounted WiFi/data and a free or discounted phone for those who have limited access to the Internet.
  - Lifeline setup guide lists the Lifeline providers in Washington state, their cost, and what is included for each provider
- The USDA Emergency Rural Healthcare Program has allocated $5.4 million to Washington state in supporting rural healthcare programs/services, including the purchase of telehealth equipment and technology as eligible uses of the funds

  - Applicants can apply for this funding that is available in two separate tracks: Track 1 is for Recovery, and Track 2 is for Impact.

Questions/Discussion:

- Regarding SB 5423, Don Downing (UW School of Pharmacy) shares that this bill doesn't state the physicians speak to practitioners. This affects all licensed healthcare providers.
- Marissa Ingalls (Coordinated Care) shares that the USDA funds are available until they are all spent

House Bill 1196: Established Patient Relationship Proposed Recommendations

Dr. John Scott [39:54]

Bill's Language

- Requires reimbursement for audio-only telemedicine services if "the covered person has an established relationship with the provider"
- "Established relationship" means the covered person:
  - has had at least one in-person appointment within the past year with the provider providing audio-only telemedicine, or
  - with a provider employed at the same clinic as the provider providing audio-only telemedicine, or
  - was referred to the provider providing audio-only telemedicine by another provider who has had at least one in-person appointment with the covered person within the past year and has provided relevant medical information to the provider providing audio-only telemedicine
- Original bill language here

1st Proposed Change

- Should the language include real-time interactive appointments using audio and video technology?
- "Established relationship" means the covered person:
  - has had at least one in-person **or real-time interactive appointment using audio and video technology** within the past year with the provider providing audio-only telemedicine, or
  - with a provider employed at the same clinic as the provider providing audio-only telemedicine, or
  - was referred to the provider providing audio-only telemedicine by another provider who has had at least one in-person **or real-time interactive appointment using audio and video technology** with the covered person within the past year and has provided relevant medical information to the provider providing audio-only telemedicine"

- Collaborative Members Discussion
    - Chris Cable (Kaiser Permanente) feels using real-time interactive appointments with audio and video technology would be more forward-compatible
    - Geoff Jones (Newport Community Hospital) also supports this from a rural health perspective to help with access to care
    - Joshua Frank (Confluence Health) believes this is most likely the direction that will be taken over time and there's a lot of value in patients having good access. However, there are concerns about moving there in regards to establishing a relationship by video only.
        - There wasn't a strong opinion to move towards this direction at this point in time.
    - Was there a discussion or concern about patients having to have the in-person appointment in Washington?
        - No level of specificity identified
    - Could a third party vendor come in and start seeing patients who have no relationship with Washington state?
        - Sheryl Huchala (Premera Blue Cross)
    - Representative Riccelli provides an option for a potential delay in implementation vs. a language change
- Public Comment
    - David Streeter (WSHA) propose to the Collaborative to not adopt this change due to the following concerns:
        - That the substitution of the audio and video would remove the ability to track the patient's longitudinal health in person and potentially leave condition undetected or undertreated
        - Allowing an audio-video visit to satisfy the in-person visit removes any impetus for in-person care or could potentially go in this direction
    - Jeb Shepherd (WSMA) requests the Collaborative to not adopt this recommendation
        - Believes that audio video technology should augment and not replace in-person care
        - To ensure high quality care, having an established relationship in person is necessary and important
        - From an equity lens, there is concern regarding part of the state having access to primarily telemedicine services rather than in-person care. Establishing a relationship virtually and continuing to see this patients via audio video only may result in funneling them exclusively into virtual care
        - Could potentially be supportive of mental and behavioral health services that could warrant special considerations as they do not require in-person assessments
            - This could possibly leave to a carve-out for these services where the audio video visit could satisfy the established relationship requirement
    - Marissa Ingalls (Coordinated Care) strongly supports this recommendation as it would address barriers to care and potential delays to care.
        - Believes that this language is appropriate because it does not dictate standards of care and would allow patients more opportunities to receive care

- Don Downing (UW School of Pharmacy) shares an equity lens where the language should not exclude patients who call and should not exclude marginalized patients with English as their second language, transportation issues, and other barriers
- Voting Results

Yes	8
No	1
Abstain	4

2nd Proposed Change

- Should the language include three years?
- "Established relationship" means the covered person:
  - has had at least one in-person *or real-time interactive appointment using audio and video technology* within the past **three** year with the provider providing audio-only telemedicine, or
  - with a provider employed at the same clinic as the provider providing audio-only telemedicine, or
  - was referred to the provider providing audio-only telemedicine by another provider who has had at least one in-person *or real-time interactive appointment using audio and video technology* with the covered person within the past **three** year and has provided relevant medical information to the provider providing audio-only telemedicine"
- Collaborative Members Discussion
  - Chris Cable (Kaiser Permanente) endorses this change largely because it aligns with the Medicare standards for the definition of a new patient
    - There was a concern that having the language be one year would force unnecessary visits
  - Joshua Frank (Confluence Health) and Kathleen Daman (Providence) approve this change
  - Claire Fleming (Virginia Mason) concurs with the 2 public comments below and believes that the substitution of not coming in within three years in person is not adequate
    - Proposes that patients have to come in person at least once within the three-year time period for adequate health care
    - Joshua Frank (Confluence Health) seeks clarification based on Claire Fleming's comment regarding the dependency of in-person as well as audio and video only within the three year time period
  - Joshua Frank (Confluence Health) believes that once the language adopts that an audio and video only visit suffices for a provider-patient relationship, it will bring into question many other items down the line
  - Cara Towle (UWM) shares the same sentiment as Claire Fleming that it's difficult to vote on time frame when there is uncertainty in the language referring to in-person or in-person and/or audio and video
- Public Comment

- David Streeter (WSHA) recommends to not adopt this change
  - Shares the concern that this would create more time between when a patient is actually seen by their provider and their ability to get in-person care
  - Would place further inconsistencies with Washington State and the Medicaid program, which an in-person visit within 6 months before each audio only encounter
- Don Downing (UW School of Pharmacy)
  - Shares the concern that there are many patients who live in Washington state who are not in a medical system
  - There are also going to be some high risk patients who do not fit within this proposed criteria and would not want to exclude from care

- Voting Results

Yes	7
No	0
Abstain	7

3rd Proposed Change

- Should the language include medical group?
- "Established relationship" means the covered person:
  - has had at least one in-person *or real-time interactive appointment using audio and video technology* within the past *three* year with the provider providing audio-only telemedicine, or
  - with a provider employed at the same **medical group or** clinic as the provider providing audio-only telemedicine, or
  - was referred to the provider providing audio-only telemedicine by another provider who has had at least one in-person *or real-time interactive appointment using audio and video technology* with the covered person within the past *three* year and has provided relevant medical information to the provider providing audio-only telemedicine"
- Collaborative Members Discussion
  - Chris Cable (Kaiser Permanente) shares that Kaiser Permanente is a multi-clinic medical group where patients get care across and between clinics. He believes that the language of "clinic" seems unnecessarily narrow and supports the expansion of this definition to "medical group"
  - Joshua Frank (Confluence Health) agrees that this change is reasonable
    - If audio and video only is the way to establish the provider-patient relationship, it brings up issues to be strongly considered such as regulating an integrated EHR into the local system in which the patient exists and accountability to the local system

- Joelle Fathi (UW School of Nursing) supports this change, but proposes to consider adding language around the medical group/clinic having an EHR system or access to electronic healthcare records
  - This helps to reinforce continuity of care and provides the confidence that medical groups and clinics can provide the care that's needed
  - Mark Lo (Seattle Children's) agrees with Joelle Fathi's point and brings up that when he thinks of same medical group or clinic, there's the assumption that there's a sharing of an electronic health record or shared knowledge across that group
  - Chris Cable (Kaiser Permanente) proposes combining the third and fourth proposed change in the same phrasing
- Kathleen Daman (Providence) supports the change in light of EHR access and multiple specialties
- Representative Riccelli agrees that the intent in incorporating this language is lined up. But, he proposes that he'll have a subcommittee with any interested Collaborative members and legislators to wordsmith this language offline
  - Additionally recommends having a carve-out for mental and behavioral health services, where an audio-visual telemedicine visit could satisfy the established relationship under HB 1196
- Do we need some language to make clear that this law applies to a specific specialty where the patient is already established?
  - This language would not apply to other specialties unless the patient is established at those additional specialties

- Public Comment
  - Stephanie Shushan (CHPW) shares that some smaller practices, especially BH providers might not have EHRs
  - David Streeter (WSHA) supports this change and believes it will provide clarity to practitioners
- Voting Results

Yes	10
No	0
Abstain	3

4th Proposed Change

- Should the language include the added point below?
- "Established relationship" means:
  - the provider providing audio-only telemedicine has direct access to the covered person's real-time or electronic medical record
- Collaborative Members Discussion

- Chris Cable (Kaiser Permanente) adds additional nuance in the term "direct" where this may need more wordsmithing for clarity
  - Shares the example where in Epic, Care Everywhere would not meet this standard.
  - Elaborates that "direct" means within the instance of the EHR system and accessing the true direct access to all components and functions of the EHR
    - For further clarification, if anybody has access as a partner via a CareConnect relationship, then this would suffice
    - The language would mean direct, unfettered access; same as the primary care provider's access, for example
- Does this language assume that the providers are in the same medical group or clinic?
  - Some wordsmithing is necessary for clarity
- An item to consider is possibly incorporating the definition of the EHR to be where the patient's primary care resides because patients can have different EHRs in different systems

- Public Comment
  - Don Downing (UW School of Pharmacy) shares that this language assumes patients have a medical record where most marginalized patients won't be able to qualify or meet this standard
- Voting Results

Yes	8
No	1
Abstain	2

Action Item:

- Collaborative members to let Dr. John Scott know of their interest in joining Representative Riccelli's HB 1196 sub committee

Digital Divide: WA Medicaid Telehealth Evaluation

Dr. Joshua Liao (UWM) [1:20:06]

Value & Systems Science Lab (VSSL)

- VSSL ("vessel") was created to transform data and ideas into actionable insight about health care payment and delivery
- A priority is to use evaluation and analysis to support policy.
- What is the relationship between telehealth and health care access, quality, and spending?
- How do these effects vary between primary, mental health, and specialty care?
- What is the effect of telehealth on disparities?

Data

- Includes WA Medicaid claims data (2019-2020)
  - Capture pre-COVID and post-COVID time periods
  - Incorporate demographic information
  - Assess clinical complexity (revised Charlson Comorbidity Index; CCI)
  - Measure service utilization
- Includes geographic social risk data, specifically using Social Vulnerability Index (SVI) to drill down into the granularity

Sample

- Adult beneficiaries residing in Washington State
- Enrolled in Managed Care
- Enrollment criteria
  - Used a comprehensive cohort where they are ≥11 months: this is the narrowest, but most comprehensive and least vulnerable to data gaps
  - Shared qualitative and quantitative data on sample collected, including incorporating the various Social Vulnerability Index (SVI) factors

Tele-Services

- Assessment using the following visit types:
  1. New patient visits (CPT 99201-99205)
  2. Established patient visits (CPT 99211-99215)
  3. Outpatient consultations (CPT 99241-99245)
  4. Audio-only visits (CPT 9941-99443)
  - Tele-Services identified for #1-3 based on modifiers (CR, GT, GQ, G0, 95) and place of service (POS 2)
- Trends
  - Overall Period: October 2019-December 2020, considering pre and post COVID periods and key dates for Washington's state of emergency and the state-wide stay-at-home order
  - Overall Trends
- Factors Associated with Use
  - Goal: to evaluate factors associated with tele-service use in the post-COVID period
  - Greater tele-service use during COVID-19 was associated with:
    - Older age
    - Female gender
    - Greater clinical complexity
    - English as primary spoken language

        - Black race
        - Residence in area with greater household type and transportation vulnerability
    - Lower tele-service use during COVID-19 was associated with:
        - Hispanic ethnicity
        - Homelessness
        - Lower income
        - Residence in area with greater minority status and language vulnerability
        - Residence in area with greater household composition & disability vulnerability
    - Greater intensity of tele-service use during COVID-19 was associated with:
        - Older age
        - Female gender
        - Homelessness
        - Greater clinical complexity
        - English as primary spoken language
        - Residence in areas with greater socioeconomic status vulnerability
        - Residence in areas with greater household composition & disability vulnerability
        - Residence in areas with greater household type and transportation vulnerability
    - Lower intensity of tele-service use during COVID-19 was associated with:
        - Hispanic ethnicity
        - Black race
        - Lower income
        - Residence in areas with greater minority status and language vulnerability

Next Steps

- Assess tele-service use among pediatric populations (under way)
- Evaluate variation in the impact of COVID on health care use among racial and ethnic minority groups (under way)
- Evaluate specific tele-service modalities and service types (planned)

Summary

- Amid COVID, use of common services by adult WA Medicaid beneficiaries decreased, compared to before
- Increase in tele-services did not fully offset decrease in in-person services. **In other words, it appears that telemedicine was largely substitutive, not duplicative.**
- Tele-service use was not uniform across beneficiaries: certain characteristics were associated with use and intensity of use

Questions/Discussion:

- Telemedicine utilization doesn't seem to increase overall utilization

- There's been a concern that telemedicine is additive where patients have a telemedicine visit and then, they are to seen in person as well
  - Dr. Joshua Liao's data doesn't support this conclusion and it is also not seen in the pediatric population
- Are there next steps in assessing tele-service use in the future, for example in a non-COVID world?
  - Yes, extending the survey longer is important as the curves of utilization is changing over time
  - The hope is to apply local areas of COVID cases to see if this is related to the use of audio only and other types of tele-services

House Bill 1196: Cost Impact of Audio-Only Telemedicine

Chris Chen (HCA) and Jane Breyer (OIC) [1:43:07]

- The Collaborative, HCA, and OIC are tasked with commenting on certain issues related to HB 1196 around audio only, fraud, and increasing utilization
- The Legislature tasked the three groups to develop a report/recommendation by November 2023 looking at the following elements – this report is limited to audio-only
  - Preliminary utilization trends for audio-only medicine
  - Qualitative data from health carriers, including Medicaid MCOs
  - Look at any information as to whether requiring reimbursement for audio-only telemedicine affects the incidence of healthcare fraud
  - Impact of access to audio-only telemedicine on healthcare services for historically underserved communities and geographic areas
    - Dr. Joshua Liao's previous presentation shared the types of factors that are of interest to look at
  - Looking at relative cost to providers and facilities of audio only medicine compared to audio video and in-person services
- Ongoing theme is whether telemedicine is additive or substitutive, which looking with a utilization data lens would be beneficial
- Looking for partnership, especially with clinicians to ensure clinicians' perspectives and feedback are incorporated
- Dr. John Scott, Jane Breyer (OIC), and Chris Chen (HCA) have had the following meetings:
  - SEIU: home healthcare workers shared experiences of their members as patients, not providers
    - Made up of mostly women in the population who don't speak English
    - Expressed challenges in using video telemedicine
    - Audio is the majority of how they access care remotely

- Insurance companies: there needs to be some agreement on definitions and making sure that the data is collected
  - It is not uniform that audio is being broken out from video telemedicine and the vast majority of insurance companies are not yet collecting this data
- Been working closely with Dr. Joshua Liao and VSSL with this evaluation
  - Data gaps will be important to address
  - Coding may change as time goes on and as the rest of the landscape recognizes some of these gaps
- Washington and other states have made modifier requests to the AMA on CPT coding that allows audio only services to be designated
  - Phone codes are relatively limited, which delays the scope of service that could be provided, especially in behavioral health with their significant level of specificity
  - It is important to call out audio in addition to audio and visual regarding coding

Questions/Discussion:

- Dr. John Scott asked the insurance companies how they detect fraud, which they do so in two ways:
  - Claims data
  - Patient complaints
  - Not aware of fraud at this time, but may be early in their analysis
- What are the best approaches in getting the utilization data?
  - The great value in Medicaid data is that it already has some indicators that HCA had directed providers to use whereas there was incomparable direction to the commercial carriers
  - OIC does have the authority to do data calls and require carriers to submit data to OIC, which could be a potential approach for the study
  - Bree Collaborative is hoping to finalize their draft recommendations soon after incorporating public comment and feedback from their Collaborative meeting
- What is the most effective approach in collecting qualitative data from carriers, providers, and consumers?
  - Some possibilities include a provider survey and focus groups
  - Regarding surveys, there is a concern around survey fatigue
  - WSMA and WSHA can provide assistance with survey development and implementation as they have a large membership group of providers
  - Can potentially tap into the set of organizations that OIC usually works with
- What about the value of focus groups?
  - Molly Shumway (UWM) shares that there is a plan for UW Medicine to conduct focus groups with community groups to receive data on how do they want to get access, what are the access barriers via different modalities, etc

        - However, with focus group, there will be different responses from different geographic areas
    - Amy Etzel (Bree Collaborative) suggests reaching out to Federally Qualified Health Centers (FQHCs) and/or the Washington Association of Community Health Centers to target some of the vulnerable populations discussed, especially around language
        - Dr. John Scott recommends connecting with Dr. Ricardo Jimenez at Sea Mar Community Health Center to get access to these patients
- Joelle Fathi (UW School of Nursing) suggests to think more broadly and be inclusive of other workforce providers, including nurse practitioners
    - Also recommends including providers across the continuum from private practice to health systems, FQHCs, and private healthcare providers
    - One suggestion to consider is connecting with the Nursing Commission
    - Don Downing (UW School of Pharmacy) recommends connecting with the Pharmacy Commission or Pharmacy Association
    - There is consideration in connecting with the Washington Behavioral Health Council with the community behavioral health centers and their psychologists, MSW therapists, and other providers
    -
- Joelle Fathi (UW School of Nursing) also recommends connecting with professional organizations in Washington state such as in psych mental health, pediatrics, school nurses of WA
    - Be inclusive of folks who have been on the front lines in different ways
    - These organizations could easily survey their professional populations directly

Action Item:

- Collaborative members to email Jane Breyer (OIC) at janeb@oic.wa.gov for additional ideas or feedback

Wrap Up

[1:59:55]

- Next meeting November 4, 2021 10AM-noon
- No public comment period at this meeting since it was incorporated during the HB 1196 proposed recommendations discussion
- Meeting materials, including presentation slides, will be posted on the Collaborative's website and sent out via the newsletter

Tentative Next Meeting Items:

Federal/State Updates
Bree Collaborative's Telehealth Guidelines
Interstate Licensure

Meeting adjourned at 12:01 pm

Next meeting: November 4, 2021 10 am - Noon
Via Zoom.