Washington State Collaborative Meeting

Providence Medical Center Spokane, Washington
Thursday, November 10, 2016

Attendees (In person): Denny Lordan (Providence), Dr. Geoff Jones, Sen. Randi Becker, Dr. John Scott (UW)

Attendees (By phone or video): Alicia Herrman, Brodie Dychinco (Regence/Cambia), Cara Towle (UW), Sheryl Huchala (Premera), Julie Sylvester (Virginia Mason), Dr. Julie Stroud (Multicare), Dr. Susan Stern (WA State American College of Emergency Medicine), Joelle Fathi (Swedish/Providence), Dr. Mark Del Beccaro (Seattle Childrens), Ian Goodhew (UW)

The meeting was called to order by Dr. John Scott (UW) at 12:04 and the following agenda agreed upon.

I. Review of 9.28.16 Minutes
II. Review of Definition of Home
III. Update on Disaster Preparedness and Telemedicine
IV. Update on Website Design
V. Overview of Project ECHO
VI. Public Comment Period

I. Review of 9.28.16 minutes
    a. No change, approved
II. Review of Definition of Home
    a. As a reminder, at the last collaborative meeting there was a concern that patients may not always be the best judge of where a telemedicine visit should occur (i.e not in a private place). Hence, the desire to include term to include language that stated that the providers had also agreed to the location of the telemedicine visit.
    b. MQAC Guidelines covers the "Standards of Care" in terms of providers' responsibilities. Please see the following link for details (ttp://www.doh.wa.gov/Portals/1/Documents/3000/MD2014-03TelemedicineGuideline_approved10-3-14.pdf). Dr. Scott read out loud the section on standards of care.. In particular, MQAC states that:

    "Practitioners using Telemedicine will be held to the same standard of care as practitioners engaging in more traditional in-person care delivery, including the requirement to meet all technical, clinical, confidentiality and ethical standards required by law. Failure to conform to the standard of care, whether rendered in person or via Telemedicine, may subject the practitioner to potential discipline by the Commission."

c. Pulled up the American Telemedicine Association's guidelines for the conduct of a telemedicine visit. These best practices should be followed (see appendix for reference and pertinent section).
d. Recommendation: The collaborative agreed that home should be defined as "home or any location determined appropriate by the individual receiving the service." We would then cross reference the MQAC and ATA guidelines.
e. Sen Becker: If this is going to mirror what is being done in an in person encounter, does the patient need vital signs? Also, do they need to sign the confidentiality and consent forms?
    i. Consent
        1. You don't need a separate consent form besides the consent to care document, per Dr. Scott
        2. Denny Lordan: specific telemedicine consent forms are not being used by Providence, but it will be a part of the standard soon with Providence
        3. Adam Romney, we need his point of view on this matter
        4. Some places use the generic consent to care document and include telemedicine in that document.
        5. **Action: Denny Lordan will share Providence's consent form**
        6. **Action: Adam Romney to review whether a specific telemedicine consent form is necessary**
    ii. Vital signs. Are they necessary for a telemedicine visit?
        1. ATA guidelines are silent about requirement for vital signs
        2. For Tele-psychiatry visits, vitals are not performed
        3. If a clinician were to bill under a CPT code 99213 for example, it does require vitals, so the concern is that mal practice/fraud will happen
        4. However, this applies only if clinician is billing under complexity of care, and certain elements of history and physical exam. Moreover, needs vitals for just **new** patient visits.
        5. Most telemedicine visits are billed using time-based billing, in which the majority of face-to-face time is used for counseling and/or coordination of care. The telemedicine visit documentation needs to support the level of billing. So we should encourage providers to time base bill.

    iii. Billing and coding is a complex issue, which was not on the agenda. We have placed it on the agenda for our next meeting. Please find below questions and discussion; many of the questions were not answered definitively.

        1. Do we need to define telehealth for purposes of billing? Sometimes we talk about doctor to doctor consultations, when no patient is present. Would that be considered a billable telehealth visit?

2. **Answer**: According to Medicare and SB 5175, a billable telehealth encounter is when a clinician "sees" a patient through real-time, face-to-face video teleoconferencing.
3. If there is a specialist, the requesting physician AND the patient present, then this would also count as a billable telemedicine visit.
4. Some of the third party payers, do have doctor to doctor consultation codes, but SB 5174 and 6519 do not cover these types of visits.
5. **Action:** Brodie and Sheryl will find out if the doctor to doctor consult is a billable charge at the next meeting.
6. **Action:** Brodie will figure out if there is a difference for these other types of providers
7. **We want coders for the next meeting**

III. Update on Disaster Preparedness and Telemedicine

a. NW Health Care Response Network is a network of providers and disaster preparedness experts across state that helps plan for the medical side of disasters. Much of the funding for this group grew out of 9/11 response, but the funds have dried up. Pierce and King County now have smaller groups which meet regularly.
b. Dr. Vicky Sakata has met with Dr. Scott. She is the Sr. medical advisor and an emergency medicine physician at Tacoma General. Currently, there is no Telehealth what so ever incorporated into disaster preparedness.
c. They are very interested in learning more about telemedicine. Dr. Scott will speak to the network in December.
d. The main goal in disaster preparedness is efficient and accurate **Triage**
    i. Unfortunately, many of the algorithms end with "consult a specialist"
e. **Action**: Dr. Scott has link to the IOM report that he will make available to the collaborative: https://www.nationalacademies.org/hmd/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx
f. Also, an example of the triage process done by critical care medicine in a massive disaster can be found here:

    http://journal.publications.chestnet.org/issue.aspx?journalid=99&issueid=930941&direction=P

g. Anyone else's ideas on how to use Telehealth?
    i. Pierce county uses all their supplies for OSO and they have no funding
    ii. There is Mt. Rainier that can cause major damage.
    iii. We like this, but should we look into this with in this bill? Or is this stopping what we are initially doing?
    iv. Maybe not a requirement in this bill.

v. Biggest problem is communication. How do we communicate regionally? Getting the right resources to the right places. Telemedicine can help with that. Without it we won't be as effective. It should be a focus of the state.
vi. If you get to broad, you will lose the entire thing. We might lose the entire picture if we put disaster preparedness in this bill.
vii. It needs to happen, but we need to keep the focus of this narrow so we can get it done.
viii. Some over laps with this current work, state lines across doctor's license.
ix. A separate bill and link it in?

IV. Update on Website Design
a. Ian Goodhew has worked with WSHA to host the website.
b. The statute that passed laid out some things that the collaborative was supposed to accomplish prior to the end of the year. One is a website.
c. Explored the idea of UW medicine hosting
i. There would be a delay, need to get out asap
d. WA State hospital association is able to create and host a website for the collaborative, for free.
e. Talked what the website would look like, using state of New Mexico as a model (website) www.nmtelehealth.org
f. States the mission and goals and subpages including a membership list and the collaborative
g. Has a calendar with the meeting dates how you can connect to the meeting
h. Past minutes will be available
i. Links to past meetings videos
j. Potential to host future reports
k. Phase II build out some resources
i. Link to MQAC guidelines
ii. Link to ATA guidelines
l. Link to different provider sites to learn about their telemedicine offerings.
m. May have something to preview next time.
n. Personal contact/photos will not be on the website
o. Gen contact information like a collaborative dedicated email
p. **Action**: Brodie will contact people to come up with the logo. ACTION

V. Overview on Project Echo
a. A solution that is not currently being paid for
b. Project ECHO is a case-based, telementoring program between UW specialists and community providers for common, chronic diseases such as hepatitis C, HIV/AIDS, heart failure, TB and geriatrics. These conferences usually occur over noon hour and CME is offered. Technology to join is quite minimal and there is currently no charge to join.
c. Process
i. Started with HEP C and then broadened out
ii. All patient info is de-identified and HIPPA compliant
iii. People start to teach each other

iv. 4 pillars of ECHO
v. ECHO is efficient
    1. Sharing information to other colleagues
    2. They become mini experts
vi. This has been done elsewhere, and it shows to be very effective
vii. ECHO participants had more minorities and was safer
viii. Geoff Jones spoke about his experience
    1. Joined in 2010
    2. Very easy to do
    3. It's very effective
    4. Newport is a town of about 2000, there about 1000 ER charts, may not all be diagnosed
    5. Prior to 2010 68 referrals 5 treated 2 cured
    6. Up to 150 people evaluated and half is cured
    7. Benefits: in a rural area you are isolated. Good way to get support and ideas from other places.
    8. Hal Stockbridge: Reimbursement, L&I is very supportive. L&I will reimburse providers in the pain sense. L&I also reimburses in the collaborative care. Providers can bill for this,
    9. Some providers can't make time for these sessions
    10. If you focus on patients experience, then it makes it better

VI. Next meeting
    a. **Cambia Grove Dec 9th @2pm**
    b. January
        i. Tacoma General (Multicare) will host
        ii. Give dates to John or Priscilla
        iii. Legislative session starts the 9th of January. Want the report ready by then. Will discuss the report at the next December meeting, plus billing.
        iv. Maybe tie Echo into it.
        v. A week ahead of the next meeting the overall document will be sent out.

VII. Public Comment Period.
    a. No public comments

VIII. Meeting ended 1:44pm