### MEMBERS PRESENT

| Shawn West, MD, FAAFP (Chair), Chief Medical Officer, Embright | Sarah Levy, MD, Medical Director, Solution Center and Telehealth, Kaiser Permanente |
| Lydia Bartholomew, MD, Aetna | Greg Marchand, The Boeing Company |
| Wendy Brezny, North Central Accountable Community of Health | Lindsay Mas, SEIU 775 Benefits Group |
| Christopher Chen, MD, MBA, Washington State Health Care Authority | Stephanie Shushan, MHA, Community Health Plan of Washington |
| Susie Dade, MS, Patient Advocate | Cara Towle, Telepsychiatry, University of Washington |
| Omar Daoud, PharmD, Director of Pharmacy, Community Health Plan of Washington | Janna Wilson, King County Human Resources Department |
| Darcie Johnson, Director of Quality, Premera Blue Cross | Crystal Wong, MD, University of Washington Medical Center |
| Mark Haugen, MD, Family Medicine, Walla Walla | Morgan Young, Associate Medical Director, Chiropractic, Labor & Industries |

### STAFF AND MEMBERS OF THE PUBLIC

| Amy Etzel, Bree Collaborative | Nicholas Locke, MPH, Bree Collaborative |
| Howard Berryman Edwards, MD | Ginny Weir, MPH, Bree Collaborative |

### BREE COLLABORATIVE OVERVIEW
Shawn West, MD, FAAFP (Chair), Chief Medical Officer, Embright welcomed members to the workgroup and those present introduced themselves and gave a short summary of their background.

**Motion:** Adopt January minutes  
**Outcome:** Minutes adopted unanimously

### SCOPE AND FOCUS

Dr. West led a discussion on how to develop a reasonable scope for the workgroup. Members discussed:

- Harder to implement a long list of changes.
- Starting with the end in mind.
- Should focus on what we feel to be durable principles as this is a rapidly changing field.
- Telehealth was rapidly rolled out due to COVID-19 and so may be in an imperfect space – such as those who believe this is under or over-utilized.
  - May drive up cost.
  - Telehealth does increase convenience.
- Walking through the telehealth definition map
  - Synchronous vs asynchronous
  - Audio vs audiovisual
  - Inpatient vs outpatient
  - Important to have the technical definition map – we are often missing how the patient or consumer is viewing it which is different than the words we use. Need to have the
lens or the view of the consumer – i.e., how to I connect with my clinician. All can be helpful if applied within the right construct.

- Center for Connected Health Policy definitions are good [www.cchpca.org/about/about-telehealth](http://www.cchpca.org/about/about-telehealth)
- Do not like the implication of flow or hierarchy in this specific image.

- Telemedicine is defined in state statute.
- Advocate for using definitions that already exist and review of the definitions document.
  - Definitions may sound similar but are not the same.
  - Start by working within the state statute and look within that framework at issues related to quality, access, and equity. Phase II may be moving beyond statute.
  - Real-time audio-visual is the modality.
- Like the term telehealth as an umbrella term as it is a moving target.
- Need to think about place of service.
- Audio-only is sufficient for some lines of clinical care such as psychiatry and a way to give services to those who may be unable to use newer modalities.
- Clear definitions are important as we think about generating deliverables and for billing and coding.
- Need to link our work to legitimate frameworks in the state and ideally some tie to the National Quality Forum – purchasers who cross state lines are especially in need of this.
- Interaction with clinician in real-time to get care is the most resonant.
- [https://patientsafety.uw.edu/sites/patientsafety.uw.edu/files/VSSL_outreach_TelehealthinCovidEra_2020_0817_AC.pdf](https://patientsafety.uw.edu/sites/patientsafety.uw.edu/files/VSSL_outreach_TelehealthinCovidEra_2020_0817_AC.pdf)
- Broadband access is a huge barrier.
- Constituent groups to consider: rural v. urban, those living in dense housing have locational issues, cultural and language barriers, those with limited vision and hearing, engaging with telehealth for those who have paranoia.
  - Some patients may not be able to engage
- Should focus on the positives of telehealth, from a consumer perspective not positive from every single individual but is an overall positive.
- Should focus on the right patient, right care, right time. Should include some guidelines about how to determine what type of person would have needs met over the phone.
- Outline barriers or areas of consternation.
- Need to develop a feedback loop to avoid duplication of services.
- 98.6 is a local company that has is focused on delivery of telehealth.
- Telehealth from different vendors might add to the fragmentation of the system- they might over prescribe unneeded medication.
  - HCA decided to stick with giving providers zoom licenses rather than add another vendor that would not communicate.
- Musculoskeletal care is another area for which variability and quality are an issue.
- Telehealth also is an opportunity to increase delivery of evidence-based care.
- Continuity of care intersecting with telemedicine.
- We could focus on what is clearly appropriate and what is clearly not appropriate and work toward the middle.
  - Conditions where telehealth is clearly appropriate.
  - Conditions where telehealth is clearly inappropriate.
  - Not come up with definitions that describe every single clinical scenario – what does the evidence say and what are the things to clearly consider.
• We should focus on both physical and behavioral health. We do not want to take a step back from whole-person care.
• Should also focus on both specialty and primary care.
• E-consults – have been around for a long time in certain systems – primary care docs can prepare information for a specialist who has access to a chart and can provide recommendations to the PCP and transmit information back and manage the relationship and the care of the person.
  o Is good fit for many conditions – teledermatology, telerheumatology.
  o Used to be known as curbside consult
  o Asynchronous information sharing.
  o Not reimbursed by many payors.
  o Worth making reference to this.
  o This is a provider tool that is behind the scenes and not necessarily a direct link to a person.
  o Not considered telehealth by medicare.
  o Could be a future topic
  o This is good for a patient and almost guarantees there is continuity of care. Employers love this as it allows not the loss of productivity. Multiple reasons to promote this.
• AHRQ six domains of health care quality www.ahrq.gov/talkingquality/measures/six-domains.html = safe, effective, patient-centered, timely, efficient, equitable.

• Parking lot
  o E-consults.
  o Substance use disorder services.

Action items:
  • Sarah Levy and Crystal Wong to outline the barriers/issues inherent to telehealth.
  • One-two pager to react against for the next March discussion.

GOOD OF THE ORDER
Dr. West thanked all for attending and adjourned the meeting.