
Bree Collaborative | Telehealth Workgroup

March 5, 2021 | 8:00 – 9:30 a.m.

Virtual

MEMBERS PRESENT

Shawn West, MD, FAAFP (Chair), Chief Medical Officer, Embright

Lydia Bartholomew, MD, Aetna

Wendy Brezny, North Central Accountable Community of Health

Christopher Chen, MD, MBA, Washington State Health Care Authority

Susie Dade, MS, Patient Advocate

Omar Daoud, PharmD, Director of Pharmacy, Community Health Plan of Washington

Darcie Johnson, Director of Quality, Premera Blue Cross

Mark Haugen, MD, Family Medicine, Walla Walla

Marian Hollingsworth, Patient Advocate

Sarah Levy, MD, Medical Director, Solution Center and Telehealth, Kaiser Permanente

Greg Marchand, The Boeing Company

Jeb Shepard, Washington State Medical Association

Lindsay Mas

David Tauben, MD, University of Washington

Cara Towle, Telepsychiatry, University of Washington

Mandy Weeks-Green, Office of the Insurance Commissioner

Crystal Wong, MD, University of Washington Medical Center

Morgan Young, Associate Medical Director, Chiropractic, Labor & Industries

STAFF AND MEMBERS OF THE PUBLIC

Jackie Barry, PTWA

Lee Brando

Amy Etzel, Bree Collaborative

Nicholas Locke, MPH, Bree Collaborative

Michelle Martin

Stephanie Shushan, MHA, Community Health Plan of Washington

Diana Vinh

Ginny Weir, MPH, Bree Collaborative

David Wilson

Keith Zang, Department of Health

WELCOME AND APPROVAL OF MINUTES

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.

- Members discussed whether our group is meant to only focus on synchronous care rather than asynchronous, primary care and low- to mid-acuity care.

Motion: Adopt February minutes

Outcome: Minutes adopted unanimously

AUDIO-ONLY TELEHEALTH

Ginny Weir, MPH, Director, Bree Collaborative, reviewed the content and process of House Bill 1196.

The bill has passed the house and is currently in the Senate. Services must be provided by a provider with whom the patient has an established relationship; services must be covered, medically necessary, and/or essential health benefits under the ACA; and determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards (less defined than other elements). The workgroup discussed:

- That some payors have stated wanting removal of the established patient requirement and limitation to behavioral health.
- Has to be documented like an office visit.

- Whether an audio-only visit able to obtain the same clinical information as an in-person visit or an audio-visual visit.
- What is not included – calling with test results etc.

FOCUS AREAS

Amy Etzel, Implementation Manager, discussed four proposed focus areas: Appropriate Service, Patient Characteristics, Person-centered Interactions, Measurement and Follow-up with an equity approach throughout. Members discussed:

- How to ensure that our work does not contribute to further fragmentation of services. Need to ensure that services are coordinated.
 - Telehealth has much opportunity to do care coordination.
 - Where are the feedback loops – need to make sure care is integrated into a person’s medical record.
 - Difference between what people want and what may be deemed appropriate by providers – e.g., immediacy vs. coordination.
- Effective services (AHRQ definition) is part of appropriate and person-centered interactions.
- How to determine which services are clearly appropriate and clearly inappropriate.
 - Start with high and low first then move into the gray areas in the middle.
 - How do we provide guidance to medical communities to not miss strokes etc.
 - Avoiding liability
 - Many visits for which a physical exam is not necessary, some for which required, some for which the patient will benefit more from in-person.
 - In an episode of care, starting with telehealth may change the order of operations had they started in person, but may still all happen.
 - Levers for managing inappropriate service
 - Factors that deteriorate professionalism of practice (therapist delivering care from their bed)
 - Importance of non-verbal communication from a person to a provider.
 - Is a physical exam necessary?
 - Clinically necessary?
 - Does the patient need the physical exam?
 - Is telehealth meeting the person’s needs? Does it work for them?
- Measurement should be separate as an area.
- Maybe "Continuity and Collaboration" replaces the patient characteristics (which get divided into appropriate service and person-centered). Can discuss, care collaboration, continuity, frequency of in-person follow up, integration of telehealth and in-person care, etc
- Early results of research with UW indicate that about 1/3 of the time telehealth was chosen based on Provider preference. Only about 1/2 by patient preference.
- Building triage into the workflow to determine whether and with what urgency in-person visit is needed.
- Consent process for telehealth:
 - Clearly calls out opportunity for face-to-face visit if they prefer.
 - To track if that was an appropriate channel for the care delivered.
 - Best practice of how you identify yourself for the patient as a provider.
 - E.g., not recording the visit.
 - That you are alone, where are you in your home.
 - Don’t insist the person doesn’t put video on if they are uncomfortable.

- What happens when it is supposed to be a video visit, but the camera fails? That is confusing for providers.
- Is there value in having subgroups break off? Physical vs. behavioral health vs. substance use disorder.
 - Wait until after the April meeting.
- Consensus that four focus areas is a good start.
 - Person-centered interactions is what happens in the moment.
 - Whether to combine the appropriate clinically and appropriate person should be combined.
- Consent requirements vary greatly between payors, federal and state, and whether HIPAA-compliant platform or not...UW best practice is to do an informed consent for telemed that includes Expectations, Patient rights & responsibilities, Benefits & risks, Security information, Right to refuse
- L&I also has specific requirements regarding consent for telehealth. It would be fantastic to see consistent requirements across state payors, at least.
- Receiving all primary care in a virtual setting.
 - Can't all be virtual – need to look at the person.
 - Access to the medical record is important. Medical home paradigm.
 - Virtual-only providers coming in, highlights the friction in healthcare. Access is hard and barriers to care are so prevalent.
 - Visibility into a whole person's journey.
 - Not primary care unless you have the ability to see the person in-person.
- Telehealth first health plans. Fundamentally different from telehealth only companies.
 - Whole-person care needs the ability to offer in-person.
 - What is the oversight for a facility that doesn't have brick and mortar.
- Systems have not caught up with technology. We would not know if a provider is virtual in claims. Can't see physical address in claims.
- Many primary care providers have been unable to do standard screening. like PHQ9 in a virtual setting, so it seems like they are missing elements of that whole person interaction.
- is "appropriateness for receiving all of your primary care in a virtual setting" different for behavioral health issues?
- Add documentation to measures section.
- If something were to worsen, could you see that person in person?
- Impact of age on preference for virtual care.

Action item:

- Draft focus areas for group
- Sarah Levy and Crystal Wong to outline the barriers/issues inherent to telehealth.

GOOD OF THE ORDER

Dr. West thanked all for attending and adjourned the meeting.