Bree Collaborative | Telehealth Workgroup
April 2nd, 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
Judy Zerzan-Thul, MD, MPH (for Christopher Chen, MD, MBA,) Washington State Health Care Authority
Susie Dade, MS, Patient Advocate
Omar Daoud, PharmD, Community Health Plan of Washington
Darcie Johnson, Premera Blue Cross
Mark Haugen, MD, Family Medicine, Walla Walla
Marian Hollingsworth, Patient Advocate
Jeb Shepard, Washington State Medical Association
Cara Towle, Telepsychiatry, University of Washington
Crystal Wong, MD, University of Washington Medical Center
Morgan Young, Labor & Industries

STAFF AND MEMBERS OF THE PUBLIC

Jackie Barry, PTWA
Howard Barryman
Lee Brando
Amy Etzel, Bree Collaborative
Nicholas Locke, MPH, Bree Collaborative
Marissa Ingalls
Michelle Martin
Stephanie Shushan, MHA, Community Health Plan of Washington
Ginny Weir, MPH, Bree Collaborative
David Wilson, GSK Vaccines

WELCOME AND APPROVAL OF MINUTES

Shawn West, MD, FAAFP (Chair), Chief Medical Officer, Embright welcomed members to the workgroup and those present introduced themselves.

Motion: Adopt March minutes
Outcome: Minutes adopted unanimously

HB 1196: AUDIO-ONLY TELEHEALTH

Ginny Weir, MPH, Director, Bree Collaborative, reviewed the progress of House Bill 1196 that is scheduled for a hearing today at 9am in Senate Ways and Means.

- Amendment about established relationship as a requirement prior to providing audio-only care.
- Not a good code that exists for billing.

TELEHEALTH GUIDELINE FRAMEWORK

Dr. West discussed the process of developing community standards in an area that is different than our typical topic-focused recommendations including:

- Telehealth is a tool or set of tools not a specialty. Needs to be used appropriately and watch for overutilization and fragmentation of care especially cutting ties that exist between a person and a provider.
- Promise of improved access, convenience, better for employers, equity in some circumstances, potentially reduce cost.
- Multilateral consent process. We want everyone to understand mutual perspectives.

The workgroup discussed:

- Evidence-free zone that is rapidly evolving.
- Have seen bad outcomes in which patient factors would have been caught if the visit would have been in person. Would be better to reimburse for primary care in a value-based methodology. California is thinking of audio-only for three years in-line with getting broadband everywhere.
- Patients who are non-English speaking who are not using telehealth and those who are using telehealth going to the ER more.
- Guidelines will be iterative and may need to be revisited annually.
- Likely have to be golden rules to make this easier.
    - Meets patient's needs.
    - Enhances care including coordination.
- Fraud – much fraud within in-person as well. Not unique to telehealth. Need to be aware and create safeguards. Good to understand what types of fraud are happening.
    - WA part of five-state Western Collaborative (CA, NV, WA, OR,
    - NV and CA are noticing a lot of inequity in who gets phone vs video.
    - Most of the investigations are active and can't say.
    - Guardrails would be helpful as no one wins when Medicaid takes back money. Documentation is paramount.
- Equity. Oregon is the most advanced and has a multi-stakeholder group.

DETERMINING APPROPRATENESS

Ginny Weir reviewed the flowchart of how to determine if a service is appropriate.

- Whether the provider needs to obtain an objective medical finding.
- Whether to weigh into needing an established relationship prior to offering phone only. Need to see and understand bio-psycho-social aspects of a person.
- Specialty care especially in rural areas the distance can be difficult. Especially whether the person has already had an evaluation by a specialist.
    - Need to think about efficiency like enhanced e-visit.
- Episodic urgent care companies. Would a physical exam change the evaluation of the patient.
    - Episodic low acuity vs chronic
    - Can't be sole way to provide care.
    - Guidelines for suggestions on capturing blood pressure. Wt, Height, immunizations, mental health
- Physical exam should be in person.
- Best practices for the virtual-only vendor
    - Needs to have findings documented with the provider.
- Need to be encouraging the right things – what we know to be associated with good outcomes.
- Elements of appropriate consent is on the to-do list.
    - This is difficult given low literacy levels among some/most patient populations.
- What you are trading for convenience i.e., risk of bad outcomes. Fast food of medical care.
- Checklist of sorts for consideration about appropriateness to support this flow.
- Concepts that have stood out:
    - Intent of visit: is required to obtain an objective medical finding to inform Dx and/or treatment;
    - Meets consumer needs for "whole person care"
    - Tool for "in between care" for established patient relationship;

    - Not the “fast food of medical care”
- SOAP note (subjective, objective, assessment, plan) documented
- Tying to aspects that can prove this is enhancing whole-person care over time.
- defining the "nutritious" elements of telehealth will help inform consumers about bad care received in person too?
- For chart flow - perhaps have an arrow down after telehealth visit to schedule in office visit
- Need to keep person at center of everything.
- Plan perspective:
    - Very interested in the one-off vendors compared to brick and mortar.
    - Have seen benefit for behavioral health but mixed bag for physical health.
- Telehealth should be held to the same standards as in-person care. How in past there were a lot of standards for hospitals but none for free-standing surgical centers.
- As an immunization organization a concern is the impact to routine immunization and could telehealth be contributing to the rates reduction (not just covid) we are seeing across adolescents and adults.
- Measuring quality
    - NCQA has included Telehealth in most HEDIS measures at this point.
    - If you are seeing reoccurring visits in another setting w/in some time frame there is poor quality.
- Best practices around auditing, education, and training.
    - Incorporating telehealth into regular QI reporting structure.
    - Capturing in peer review and auditing process.
    - Developing a quality tool that is standardized capturing all the high points.
    - Evaluation of successful telemedicine visits – those that started as telemedicine and ended as telemedicine instead of being converted to audio-only.

Other articles or recommendations to include:

- American family physician Telehealth musculoskeletal exam guidelines (https://www.aafp.org/dam/AAFP/documents/journals/afp/Yedlinsky.pdf)
- PCORI has large portfolio around telehealth (https://www.pcori.org/topics/telehealth)
- Greene, Jeremy A. “As Telemedicine Surges, Will Community Health Suffer? Boston Review (April 13, 2020) - history of medicine perspective

Action item:

- Judy to connect Ginny and Amy with the Oregon telehealth equity group.

GOOD OF THE ORDER

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