Bree Collaborative | Telehealth Workgroup
May 7, 2021 | 8:00 – 9:30 a.m.
Virtual

MEMBERS PRESENT

Shawn West, MD, FAAFP (Chair), Embright
Lydia Bartholomew, MD, Aetna
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
Greg Marchand, Boeing
Jeb Shepard, Washington State Medical Association
Cara Towle, Telepsychiatry, University of Washington
Crystal Wong, MD, University of Washington Medical Center
Morgan Young, Labor & Industries
Lindsay Mas, PhD, SEIU 775
Mandy Weeks-Green, Insurance Commissioner
Michelle Martin, PhD, University of Washington
Stephanie Shushan, MHA, Community Health Plan of Washington

STAFF AND MEMBERS OF THE PUBLIC

Jackie Barry, PTWA
Howard Barryman
Lee Brando
Amy Etzel, Bree Collaborative
Nicholas Locke, MPH, Bree Collaborative
Marissa Ingalls, Coordinated Care
Michelle Martin
Ginny Weir, MPH, Bree Collaborative
Mark Stephens, Oregon Pain Guidance
Ben Boyle, APTA WA
Meg Jones
Carrie Tellefston, Teledoc

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 April minutes
Outcome: Minutes adopted unanimously

UPDATES: HB 1196 TELEHEALTH COLLABORATIVE, CONFERENCES

Amy Etzel, Bree Collaborative reviewed the passage of House Bill 1196. Concern focused on the established relationship clause.

- Telehealth collaborative 2017 came out of a bill from Sen. Becker. Goal is to forward telehealth in Washington. Has four Legislators on the collaborative. Advocacy organization.
- At the conference there was concern about confidentiality around domestic abuse and having an abuser in the same physical space and teens wanting to keep their concerns confidential from their parents. One solution is to have an MA do a 360 "rooming" of the patient.
    - Washington Medical Commission is working on rules. Filed 101 pre-COVID. Early next year. WSMA will share their comment letter. The Commission has very prescriptive elements that may not be appropriate for rulemaking.
    - Now focused on crystal ball thinking.
- Mark Low at Children's gave a good presentation on informed consent for minors and that we do want to include his points.

- MAs are not exempt from state mandatory telehealth training. Whether we want to do a recommendation for staff.

TELEHEALTH GUIDELINE FRAMEWORK

Dr. West discussed previous meetings and the intentional time previously on scoping. Bree staff have taken this conversation and drafted recommendations. Today's discussion will focus on this draft. Members discussed:

- The Oregon guidance. Our work parallels the content and framework with about 95% agreement. How to translate/refer to it.
    - Not something to duplicate but is helpful to get into the clinical mindset of a patient with COPD and how to treat it.
    - Not agree 100%.
    - Ease to the tool. Puts thought into why you wouldn't have a telehealth and puts guardrails to why you would not consider telehealth.
    - General agreement that the layout of the guidance is helpful but would need a column of what is not recommended.
    - Connection to Oregon telehealth group to mitigate waste.
    - Western Compact started in April 2020 as a collaboration between Washington, Oregon, California, Nevada, Colorado. Oriented around reaction to the pandemic. Number of different topics Governor's collaborated around including telehealth and health equity. This is very high level.
        - More information: https://www.governor.wa.gov/news-media/washington-colorado-nevada-and-oregon-announce-coordination-telehealth
    - Challenging to categorically say which services are not appropriate for telehealth. This was our initial direction and we decided to pivot away from this as there are always a few patients for whom something might make sense.
    - Should explicitly reference this so it is easy for busy clinicians.
- Equity
    - Not always possible to have an established relationship with a provider before having a telehealth visit as some people may not be physically able to get to a site.
    - Having an interpreter.
    - Transparency in who the patient is speaking with – such as residents identifying themselves and whether they are licensed.
        - This is an important responsibility of organizations – that they are licensed and qualified to provide that care.
- Patients respond to recommendations for telehealth from their trusted provider. Choosing telehealth de novo is a much bigger leap for many.
- Confidentiality and informed consent seem like key issues that might have unique challenges with telehealth and be worth tracking as performance metrics.
- Checklists
    - Systems
        - Are we recommending that a delivery site defines services and creates standards or is that the role of this group. We are recommending that they institute the structure.
        - Everyone is making up their own standards.
        - That we do want to include specific quality metrics
        - Elaborate about safety.

        - How to address if a patient is unable or unwilling to come to the clinic for an in-person visit.
    - Health Plans
        - If we have specific recommendations to the telehealth vendors we need to include that.
        - They credential providers or delegate it.
        - Aligning with other payer policies.
        - Data – can't see whether something was audio only, audio visual, or in-person in claims data. Can't even see if a brick and mortar is present. Need to modernize data infrastructure to match new delivery system.
            - Billing: decided that for this first round we would not engage in this.
            - Data modernization would be a good area for us to talk about how to see what is reasonable.
        - 95 modifier: Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system. Append this modifier to an appropriate CPT code (listed in Appendix P in the CPT manual) for a real time interaction between a physician or other qualified healthcare professional and a patient who is located at a distant site from the reporting provider.
            - Medicare is using the 95 modifier, interested if private carriers are as well.
        - Cannot identify what an audio-only visit is. Need to ensure we don't end up with perverse incentives.
        - How health plan can support providers. Everyone had to scramble to create systems in the beginning and the plan's responsibility is to help. Remote monitoring. Give people the option.
        - Important – do not incent patients to disassociate their care.
        - Say we want to encourage that continuity of care is the goal – positive not negative.
        - Some plans using different codes to differentiate audio and visual in claims. voice procedure codes 99421,99422,99423,99441,99442,99443
        - Issue is if the providers actually use the modifiers correctly. That appears to be a challenge in the early data we're analyzing.
        - Problematic to have every plan developing their own quality metrics. It does not permit any type of comparison among plans or providers. There must be standardization of quality measurement in telehealth (as well as other areas of health care).
    - Employers
        - Can educate their covered members about what is telehealth what should you look for. When is it appropriate when is it not appropriate.
        - To recommend how to access telehealth at the workplace. How to avoid coercion from an employer. L&I does not allow this to happen at an employer site because of these concerns. Balance of access and privacy. Are doing some work on risks and rewards.
    - Regulators
        - What are regulators doing to assess vendors?
- Ultimate goal is for people to make an informed decision about what they are getting. Not to tell them what to do.
- Training

    - Whether to recommend the WA telehealth training or if that is too prescriptive.
    - Collaborative training is intended to be for sites that do not have their own material.
- Decision Making Flowchart
    - SEUI 775 did a qualitative study to understand barriers to using telehealth over last year of English and Spanish speaking caregivers – for Spanish speaking caregivers – have map of patient journey from awareness of different modalities – they stopped at consideration of virtual care they did not go further. They lack trust. Too much of a risk to try this different modality.

Action Items: Send any resources to Bree staff.

GOOD OF THE ORDER

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