



Working together to improve health care quality, outcomes, affordability, and equity in Washington State.

Telehealth

2021

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Executive Summary

Health care delivered through an audio-visual or solely audio medium, in this guideline called telehealth, can greatly increase the accessibility and efficiency of clinical care and impact patient satisfaction. The differences between telehealth and in-person clinical visits warrant consideration of risks, benefits and potential unintended consequences especially due to the rapid increase in use.

The Bree Collaborative elected to develop recommendations for the delivery of health care services via telehealth in 2020 and convened a workgroup from January to September 2021. This guideline is directed to all those who provide, receive, and pay for health care and includes specific action steps following our framework for telehealth quality of **appropriateness, person-centered interactions, and measurement and follow-up** for:

- Health care providers,
- Delivery sites and systems,
- Health insurance plans,
- Those receiving care (consumers), and
- Employer health care purchasers.

This report does not recommend specific patient conditions as appropriate or not for telehealth services; we recommend the Oregon Leadership Council's Telehealth Service Recommendations April 2021 White Paper, available [here](#), as a supplement for providers in making these determinations. Special consideration should be given in relation to cultural awareness, fear of leaving a digital footprint, and certain behavioral health conditions when determining appropriateness of telehealth. Our aim is to not be overly prescriptive in our recommendations in a way that inhibits a provider from being able to meet a patient where they are within their health care journey.

We summarize available evidence for the application of telehealth for health care services through systematic reviews or meta-analysis from the Agency for Health Care Research and Quality's Research Findings and Reports, Cochrane Reports, Veterans Administration Evidence-based Synthesis Program, the Centers for Disease Control and Prevention, and the Institute for Clinical and Economic Review as well as best practices for the delivery of care in an audio-visual or audio-only medium from primarily specialty societies; we are not considering store and forward technologies such as e-visit or e-consult for these recommendations. Lastly, our report includes guidance (current as of 2021) for measuring and assuring quality and safety.

We hope that this guideline is useful to our health care ecosystem and people being served as we navigate the opportunities for care improvement.

Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” The Bree Collaborative was named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of previous health care quality improvement collaborative projects.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying health care services annually with substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State’s largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

Bree Collaborative members identified telehealth as a priority improvement area and convened a workgroup to develop evidence-informed standards. The workgroup met from January to September 2021.

See **Appendix B** for the workgroup charter and a list of members.

See **Appendix C** for results of the guideline and systematic review search.

Background

Clinical delivery of health care has historically focused on the in-person interaction(s) between a person, and sometimes family or other support, and a provider, and often a care team. The introduction of health care delivery through an audio-visual or solely audio medium, known as telehealth or telemedicine, has great potential to increase accessibility and efficiency of clinical care and patient satisfaction.¹ This guideline uses the term *telehealth* throughout to be inclusive of multiple health care services.

However, care delivery absent in-person observation can raise concerns about appropriateness, efficacy, and unintended consequences.^{2,3} Framing risks and benefits of telehealth care by outlining intended and unintended consequences is helpful to ensure quality and trust for patients, providers, health plans, purchasers, and those who regulate clinical care. The Bree Collaborative strongly supports that all health care visits follow the Agency for Healthcare Research and Quality (AHRQ) adaptation of the Institute of Medicine's Crossing the Quality Chasm domains that care delivery be:^{4,5}

- Safe (avoid harm),
- Effective (avoid underuse and misuse),
- Patient centered (respectful of and responsive to patients),
- Timely,
- Efficient (avoid waste), and
- Equitable.

Several laws passed by the Washington State Legislature increase the practical accessibility of telehealth for providers in Washington state.

- **SB 5175**, passed in 2015, requires insurers under the purview of the Office of the Insurance Commissioner to pay for care provided via telehealth if they pay for in-person treatment, unless the subscriber's health plan excludes telehealth.
- **SB 5385**, which took effect on January 1, 2021, requires insurers to pay the same amount (parity) for treatment provided by telehealth as they would for the same treatment provided in person.
- **SB 6061**, which passed in 2020, requires providers except physicians and osteopathic physicians to take training that meets certain requirements if they will deliver care using telehealth.
- **HB 1196**, which takes effect on January 1, 2023, requires payment parity for audio-only consultations (adding on to parity for audio-visual consultations).

Availability of telehealth services has been trending upward over the last decade due to increased availability of supportive hardware (i.e., smart phones capable of transmitting high-quality video) and software that is compliant with privacy rules coupled with increasing reimbursement of telehealth care. Use of telehealth then rapidly increased in use in early 2020 due to SARS-COV-2 restricting in-person interactions to reduce viral transmission.⁶ Approximately 34.5 million telehealth services were delivered to Medicaid and CHIP beneficiaries from March through June 2020, representing an increase of 2,632% compared to March through June 2019.⁷

This comparatively rapid acceleration of telehealth use can lead to a knowledge gap in how to determine if a service is appropriate for delivery via telehealth. Telehealth can also raise unique issues related to confidentiality, access, and other legal barriers. While there is not complete certainty whether all services that can be delivered via telehealth are completely equivalent to those same services when delivered in person, many have been shown to be equivalent, and in some circumstances, better (see **Appendix C**). Downstream health care utilization due to unmet need continuing after the visit remains a concern. In some cases, telehealth may be generally appropriate to meet a person's need(s) but is not a good fit for a particular person and may have unintended consequences. In one direct-to-consumer example, patients who accessed telehealth services for an acute respiratory infection were almost twice as likely (5.9% vs 10.3%) to seek follow-up in-person care within seven days.⁸ Legal considerations such as prescribing of controlled substances and licensure across states is an evolving area; we recommend tracking Washington State regulatory changes at the Center for Connected Health Policies website [here](#).

The volume of literature is rapidly increasing due to expanded use of telehealth services and more focused investigation into benefits and potential unintended consequences, shining light on whether a service is safe, effective, and efficient. Broadly, literature shows that costs and benefits are dependent on the health care service, the patient, and the overall health context.⁹ Furthermore, most patients surveyed tended to be satisfied with telehealth encounters; a finding that is also seen when providers are surveyed.^{10,11}

Focus Areas

To develop telehealth recommendations, the workgroup developed focus areas based on AHRQ’s IOM framework, available evidence, and expert opinion.

Just as an individual provider is bound to weigh the potential risks and benefits of a particular test or procedure with a patient, so should the risks and benefits of a virtual visit be weighed and communicated to the patient receiving care. Virtual care is a mode of care or a tool that, when used appropriately, can greatly enhance convenience, access to, equity of, and overall cost-effectiveness of care. If applied inappropriately, telehealth may be unsuitable for a particular patient and/or situation and may result in poor outcomes.

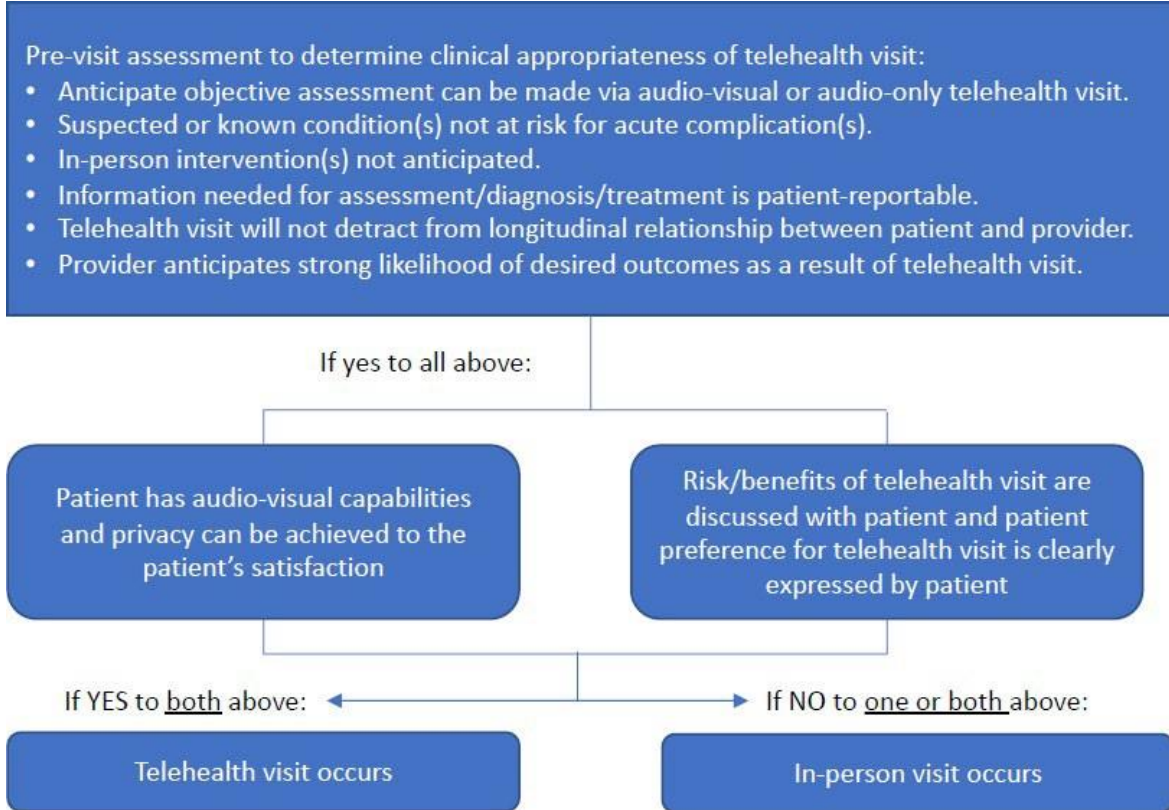
Prior to a visit, when considering risks and benefits of offering a particular health service to a person, ensure that (1) telehealth service is a good fit for the particular visit objectives, (2) provider subjectively assesses that telehealth is a good fit, (3) patient agrees that telehealth visit also meets their objectives and they understand risk and benefit, (4) patient has audio-visual capabilities to connect virtually, or audio only if this is acceptable for the provider and to the patient, (5) privacy can be ensured, (6) data, information and/or discussion is secure, and (7) patient understands that they can ask for an in-person visit at any time and that an in-person visit may be recommended at the provider’s request or if privacy is not able to be guaranteed.

Clinical details below are further outlined for delivery systems, providers, consumers, health plans, health care purchasers, and others on pages 8-11.

Focus Area	Clinical Details
Appropriateness	<p data-bbox="435 1098 1414 1167"><i>Use clinical judgment in determining whether telehealth services are suitable for a given service, a given person, and a given situation and the list below.</i></p> <ul style="list-style-type: none"> <li data-bbox="443 1209 1430 1772"> <p>• Clear criteria to determine appropriateness of telehealth service(s):</p> <ul style="list-style-type: none"> <li data-bbox="529 1245 1393 1308">○ Visit does not detract from longitudinal relationship patient has with usual source of care. <li data-bbox="529 1318 1430 1486">○ No need for a hands-on physical examination (i.e., assessment can be made visually or auditorily, information gathered is anticipated to be largely verbally reported but may include information gathered through physical observation of the patient). Outcome or evaluation would not be changed by physical exam or other information collected in person. <li data-bbox="529 1497 1344 1528">○ No anticipation of a needed procedure or urgent intervention(s). <li data-bbox="529 1539 1157 1570">○ Condition(s) not at risk for acute complication(s). <li data-bbox="529 1581 1398 1612">○ Patient fully understands risks, benefits, and safety of telehealth visit. <li data-bbox="529 1623 927 1654">○ Patient wants telehealth visit. <li data-bbox="529 1665 1252 1696">○ Patient has audiovisual or at least audio-only capabilities. <li data-bbox="529 1707 1325 1738">○ Privacy can be ensured during visit to the patient’s satisfaction. <li data-bbox="529 1749 1360 1772">○ Anticipated interventions can be addressed within the visit, at the discretion of the provider. <li data-bbox="443 1791 1373 1908"> <p>• For new patients, follow the same procedures for gathering patient chief complaints as for in-person visits. Emergency medical conditions or chief complaints representing the risk of an emergency medical situation, should not be scheduled into visits either in person or virtually.</p>

	<ul style="list-style-type: none"> • Episodic, direct-to-patient telemedicine services used only as an intermittent alternative to usual source of care to meet immediate acute care needs and is evidence-informed (e.g., not overprescribing). • Equitable access such as not restricting a telehealth appointment based on the person having video capabilities, their age, language proficiency, or if a component of information to be gathered (e.g., labs) are required to be done outside of the person's home. • For patients with limited English proficiency, utilize interpreter services. • Plan in place in case patient needs in person care through a warm handoff.
Person-Centered Interaction(s)	<ul style="list-style-type: none"> • Provider/care team understands patient's expectations; patient understands capabilities of care provided via telehealth. • Provider/care team uses a cultural awareness lens when discussing options with patient. • Clearly communicated contingency plan in the case of technology failure or urgent need. • Patient can opt-into a face-to-face visit. • All staff who interact with the person and their credentials are clearly identified. • Staff are professional, interacting with the person in private areas and in professional dress. • Patient's usual source of in-person care is identified or noted if no usual source of care exists. • Information from telehealth visit is integrated into medical record immediately following the telemedicine encounter; or provided to patient if not an established patient. • Provider/care team have defined process to coordinate transfer to appropriate level of care if medical needs cannot be fulfilled via telemedicine visit.
Measurement and Follow-up	<ul style="list-style-type: none"> • Data infrastructure differentiates in-person, audio-visual, and audio-only. • Standardized quality and safety measures are routinely monitored through: <ul style="list-style-type: none"> ○ Downstream healthcare utilization. ○ Evidence based care. ○ Patient-reported outcome(s). ○ Patient satisfaction. • Metrics are stratified to identify disparities in outcomes and utilization by: <ul style="list-style-type: none"> ○ Race/ethnicity ○ Language ○ Sex ○ Age categories (i.e., <18, 18-44, 45-64, 65-74, >74 [or 75 or older]) ○ Insurance status

Figure 1: Telehealth Decision-Making Flowchart



Checklists

Health Care System and Delivery Site(s)

- Adopt the following criteria in determining whether a specific health care service is offered via telehealth:
 - Assessment and evaluation
 - No need for a hands-on physical examination (i.e., assessment can be made visually or auditorily, information to be gathered is anticipated to be verbally reported). Outcome or evaluation would not be changed by physical exam or other information collected in person.
 - Medical record is examined for past diagnoses and medication interactions.
 - Management and treatment
 - Visit does not detract from longitudinal relationship (e.g., assessment for acute sinus infection vs. diabetes self-management coaching).
 - If visit is being offered by site or providers other than the person's primary care provider or team, ensure that information flows back to primary care provider and/or team.
 - No anticipation of a needed procedure or urgent intervention (when communication is between patient and provider).
 - Condition(s) not at risk for acute complication(s).
- Do not** deem services inappropriate for telehealth:
 - Based solely on a patient's age or language.
 - If a portion of the information needed (e.g., blood work) needs to be gathered outside of the person's home (e.g., at a lab).
- Engage staff and clinicians in designing telehealth workflows.
 - Discuss/anticipate quality and safety concerns including unintended consequences and how to monitor for and address adverse events.
 - Designate one technology platform system-wide to support telehealth services to ensure that documentation reliably flows back to patient's medical record.
- Institute central governance over implementation of telehealth so that one person or team (instead of multiple separate service lines) ensures consistency and the involvement of a quality department or staff.
- Designate a clinician leader and/or staff champion(s) who are accountable for monitoring, tracking, coaching, training, and/or providing guidance to organization staff and clinicians on appropriate, high-quality, effective use of virtual care/telehealth.
- Adopt and define system-wide protocols regarding:

- Practicing and testing equipment prior to the visit.
- How to obtain consent to participate in a telehealth visit prior to seeing a provider including that patient is of consenting age for the diagnosis or has an appropriate parent or guardian present and they desire to participate in the virtual visit (e.g., not just at recommendation of staff)
- How to ask the patient about:
 - Technology capability.
 - Whether they are able to effectively communicate verbally or through a keyboard.
 - Whether privacy and safety can be ensured to their satisfaction during the visit.
- How the provider and care team should address:
 - Best communication practices within the visit (see page X).
 - Technology failures during the visit.
 - Privacy breaches or safety issues during the visit.
 - If during the course of a telehealth visit, the provider determines that an in-person visit is needed, steps taken to provide in-person visit and documentation of steps.
 - How to introducing new staff who will interact with the patient.
 - Handling emergencies during the visit.
- Provide access to:
 - Initial staff and clinician telehealth training, including cultural awareness training.
 - Ongoing training/education as technology improves, protocols change at a system, state, or national level, and as evidence grows for successful strategies to implement telehealth services. This may be informal and/or through CME.
- Track completion of training.
- Participate in a community-wide workgroup (perhaps implemented through the Bree Collaborative or the Washington Health Alliance) to seek health care delivery system agreement upon standardized, common measures of quality of telehealth services in Washingtonstate.

Health Plans

- Modernize claims data infrastructure to differentiate in-person, audio-visual, and audio-only services.
- Monitor, report, and act on quality, experience, and adverse outcomes related to vendor care outcomes through existing standard quality monitoring programs, with participation by licensed peer clinicians.
- Perform meaningful vetting of chosen vendor provider credentials and qualifications.
- Do not incentivize, encourage or require members to disassociate their care, including virtual care, from existing longitudinal relationships with providers or care team.
- Ensure the vendor is properly credentialed and appropriately HIPAA compliant.
- Participate in a community-wide workgroup (perhaps implemented through the Bree Collaborative or the Washington Health Alliance) to seek health plan agreement upon standardized, common measures of quality of telehealth services in Washington state.
- Publish and update guidelines for billing and credentialing.
- Require vendor to identify patient's usual source of care where in-person visits can be delivered in coordination with telemedicine services, and provide a copy of the medical record and/or coordinate care immediately following the telemedicine encounter.
- Ensure vendors have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

Employers and Health Care Purchasers

- Prioritize receipt of telehealth services from usual sources of care such as a health home, primary care provider, or care team. This can be done through financial incentives or network design.
- Routinely educate employees and dependents about telehealth services through regular communication tools such as employee newsletters or company intranet (e.g., when telehealth is appropriate, what to expect, importance of linking to primary care provider, etc.).
- If directly contracting for stand-alone telehealth services, encourage vendor to identify patient's usual source of care where in-person visits can be delivered in coordination with telemedicine services, and provide a copy of the medical record and/or coordinate care immediately following the telemedicine encounter.
- Ensure stand-alone telehealth vendors have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.
- Ensure the vendor is properly credentialed and is able to and does send information back to a person's usual source of care.
- Participate in a community-wide workgroup (perhaps implemented through the Bree Collaborative or the Washington Health Alliance) to seek purchaser agreement upon standardized, common measures of quality of telehealth services in Washington state.

Consumers

- Prioritize receiving telehealth services from your usual source of care (e.g., health home, primary care provider). If no current usual source of care relationship exists, we recommend establishing care with a provider whenever possible.
- If you do receive care from a telehealth provider not associated with your usual source of care, ensure that your information about the visit and any follow-up is communicated back to your primary care provider. If no primary care provider relationship exists, maintain personal records of visits for continuity of care between providers.
- Choose a channel of care that is comfortable for you, and be clear on all available modalities including a face to face visit if preferred.
- Manage expectations on what services can and cannot be administered via telehealth (e.g. examination of the inner ear).
- Confirm credentials and identity of Providers.
- Prepare for and treat the appointment as you would an in person visit:
 - Ensure a safe, private environment
 - Have a backup plan should technical issues arise during the appointment

Review of Evidence

Appropriateness

A proliferation of guidelines in 2020 and 2021 has grown the conditions and patient populations for which and for whom telehealth is recommended. Established evidence does not necessarily exist for all types of clinical interactions recommended by various guidelines as many lean heavily on expert opinion to prioritize patient safety and reduce the risk of viral spread. At the start of the SARS-COV-2 pandemic, the Centers for Disease Control and Prevention recommended telehealth for: low-risk urgent care, management of chronic health conditions and medication, coaching around chronic health conditions, physical and occupational therapy, monitoring clinical signs of chronic medical conditions, case management, post-hospital discharge follow-up, advance care planning and counseling, non-emergent care for those in long-term care facilities, and providing education and training provider to provider.¹²

The Agency for Healthcare Research and Quality (AHRQ) conducted a review of evidence for telehealth in 2016 that found a variety of systematic reviews and thousands of studies with sufficient evidence to support: “Remote patient monitoring for patients with chronic conditions; communication and counseling for patients with chronic conditions; and psychotherapy as part of behavioral health.”¹³ A subsequent AHRQ review in 2019 found varying results that were highly dependent on setting and individual patient factors; “remote intensive care unit consultations likely reduce mortality, specialty telehealth consultations likely reduce patient time in the emergency department, telehealth consultations in emergency services likely reduce heart attack mortality, remote consultations for outpatient care likely improve access and clinical outcomes.”¹⁴

A 2015 Cochrane review comparing effectiveness, patient and provider acceptability, and costs of telemedicine in addition to or instead of face-to-face interactions found the function of telehealth to focus on: “monitoring of a chronic condition to detect early signs of deterioration and prompt treatment and advice, provision of treatment or rehabilitation, education and advice for self-management, specialist consultations for diagnosis and treatment decisions, real-time assessment of clinical status, screening.”¹⁵ The review reports strong evidence to support telehealth as acceptable in the management of heart failure, control of blood glucose for patients with diabetes, and treatment for a variety of behavioral health conditions. Other Cochrane reviews have reported telehealth to be appropriate for medication adherence for prevention of heart disease; management of chronic respiratory disease, chronic obstructive pulmonary disease, chronic kidney disease, and asthma; symptom management for adults with cancer, rehabilitation after stroke and for multiple sclerosis, pain management for children and adolescents, blood glucose monitoring during pregnancy, treatment of anxiety and depression, diagnosis of skin cancer, in adults.^{16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31} Telehealth has been used to effectively deliver care to improve quality of life outcome scores for cancer patients.³²

The Veterans Administration Evidence-based Synthesis Program reports similar patient outcomes as in-person for telemedicine treatment for major depressive disorder, post-traumatic stress disorder, and chronic pain.³³ Telehealth has been shown to be appropriate for a wide range of ages, from pediatric to geriatric care. Adolescent clinics report successfully implementing and utilizing telehealth for treating

eating disorders, contraception/menstrual disorders, gender-affirming care, general adolescent medicine, HIV treatment, and substance abuse.³⁴ Among older adults with chronic illness, care delivered via telehealth has been associated with improved self-care skills, self-monitoring behaviors, and other outcomes.³⁵

Standards Developed in Response to COVID-19

Due to a rapid increase in telehealth utilization following the COVID-19 pandemic and stay at home orders, many associations, and governmental and non-governmental organizations developed frameworks or guidelines for telehealth care delivery. Some of these guidelines are more useful than others and this report will not offer a comprehensive summary of all these frameworks. In August 2020 a group of western states, Washington, Colorado, Nevada and Oregon, developed joint overarching principles for telehealth to assist providers, patients, and systems in navigating telehealth delivery:³⁶

- **Access:** Adequate, culturally responsive, patient-centered, equitable access to health care
- **Confidentiality:** Protected confidentiality, informed consent
- **Equity:** Addressing inequities and disparities in care.
- **Standard of Care:** Applied to all services and information provided, including quality, utilization, cost, medical necessity and clinical appropriateness.
- **Stewardship:** Evidence-based strategies, mitigate and address fraud, waste, discriminatory barriers and abuse.
- **Patient choice:** Patients, with providers, should be offered choice of service delivery mode including retaining the right to receive health care in person.
- **Payment/reimbursement:** Reimbursement for services provided via telehealth modalities will be considered in the context of individual state's methods of reimbursement.

Centering People and Equity

This guideline recommends consent elements prior to a telehealth visit, rather than a strictly uniform consent process or script. Examples of telehealth consent protocols are listed in **Appendix D**. Providers should be sure to reiterate that telehealth may not be a good fit as issues are addressed during the visit and to ensure that the consumer understands the limitations of telehealth as a mode of communication and treatment delivery.

Utilization of telehealth varies based on patient factors, indicating inequitable access. Older adults, those in rural areas, women, those who are married were more likely to use telehealth.³⁷ However, those with anxiety and depression were also more likely to use telehealth.³⁷ Mobile health apps also continue to show unmet needs.³⁸ Solutions to address disparities include: proactively exploring potential disparities in telemedicine access, developing solutions to mitigate barriers to digital literacy and the resources needed for engagement in video visits, removing health system–created barriers to accessing

video visits, and advocating for policies and infrastructure that facilitate equitable telemedicine access.^{39,40}

Patient barriers should be assessed and addressed prior to a telehealth visit. Barriers reported by patients include technology to connect with providers or peer support not being available, technology malfunctioning, not understanding how to connect, poor internet connection, and not being able to access a virtual visit in a private setting (e.g., living in a shelter, living with multiple residents).⁴¹ Providers and systems should not assume that age or language itself makes telehealth a poor fit for an individual.

Best Practices During the Telehealth Visit

Best practices for a provider during a telehealth visit are similar to best practices for interpersonal interactions in-person and are based in common sense (e.g., establishing rapport by asking about goals and values, reviewing chart(s) before the visit). Differences include the need to ensure that two-way communication is possible (e.g., sound from the provider, sound from the patient) and professional (e.g., dress, background) with added communication techniques (i.e., screen-side manners) to facilitate trust and information exchange including:^{42,43}

- Asking for a phone number in case of technology failure
- Asking for a current address in the case of an urgent need during appointment (e.g. mental health crisis, stroke)
- Addition of pauses between speakers to accommodate tendency to talk over one another during an audio/visual engagement
- Greater attention to reiterating what the person has said
- Having the person mimic your actions (e.g., how you are holding the phone)
- Prior to ending the call, asking if the person has additional questions (i.e., doorknobquestion)
- If utilizing video, leaving camera on

The Centers for Medicare & Medicaid Services developed a General Provider Telehealth and Telemedicine Tool Kit, available [here](#). The American Medical Association offers a quick guide to telehealth, [here](#), and recommends best practices including:⁴⁴

- Basics of audio-visual communication (e.g., lighting, sound)
- Make sure you and your patients can connect prior to the visit
- Dress professionally
- Have a backup plan for technology failure

The American Hospital Association offers best practices [here](#). The Institute for Healthcare Improvement (IHI) recommends making a telehealth visit age-friendly through the 4M framework:⁴⁵

- **What Matters:** Asking about values, needs, priorities
- **Medication:** Including medication reconciliation
- **Mentation:** Assessing the person's cognitive state
- **Mobility:** Observing how a person gets around a home

Telehealth Adoption

As with all types of systematic change, case studies of telehealth implementation show the need for leadership engagement, clinical champions at multiple levels, multiple forms of staff education, and telehealth-specific measures.⁴⁶ The US Health and Human Services offers guidance [here](#) on developing a workflow including preparing and training care teams, scheduling, gathering and entering information, supporting patients who have limited English proficiency and/or disability and other best practices.

Lessons from clinics who have successfully adopted telehealth include: strengthening team dynamics, engaging with and supporting frontline staff, training prior to implementation, ensuring that all user know how to maximize the modality for optimum benefit.⁴⁷ For a delivery site prior to the SARS-COV-2 pandemic, investment in telemedicine reached a break-even point financially ranged from one to nine years.⁴⁸ The IHI recommends focusing on:⁴⁹

- Design and implementation (e.g., central governance within the organization over telehealth, investigation of unintended consequences)
- Clinician support (e.g., access to patient data)
- Patient engagement (e.g., checklist to prepare for visit, example [here](#))

Measuring and Assuring Quality and Safety

Telehealth services should be as effective and safe as in-person service, should increase efficiency and not add to total cost of care (e.g., through added downstream health care utilization), and should respect a person's preference and values.⁵⁰ Due to the use of telehealth in health care services for which evidence is emerging or does not exist, the workgroup recommends continuous monitoring of health outcomes and patient-reported satisfaction measures by delivery modality. The workgroup is also sensitive to the possibility of perversely incenting audio-visual or audio clinical interactions over in-person interactions with potentially detrimental patient effects. The workgroup objective is comparison between delivery systems and health plans and therefore recommends a standardized measurement of telehealth as in other areas of health care. The American Medical Association's Return on Health: Moving Beyond Dollars and Cents in Realizing the Value of Virtual Care, available [here](#), frames digitally-enabled care as a facilitator of higher-quality, safer care and offers different metrics. The following quality and safety domains should be measured, including:⁵¹

- Downstream care utilization (e.g., to measure additional total cost of care)
 - Number of emergency department visits
 - Number of hospitalizations
- Patient experience and/or other patient-reported outcome measure
 - Patient activation measure (PAM)
- Improvement in health outcomes
- Effectiveness
- Access
 - Time to third next available appointment or consultation
 - Percentage of patients with disabilities who are able to conduct a virtual visit through adaptive technologies

Interactions should be differentiated based on modality of delivery in order to track quality and safety and intervene if needed. The American Academy of Pediatrics offers guidance [here](#), and the American Academy of Family Physicians [here](#), *"Telemedicine services may make up 2 distinct services, depending on where the patient is located during the telemedicine encounter"*⁵²

Standardization of requirements for submitting claims would reduce administrative burden. Following Medicare's lead, claims can be submitted using the 95 modifier, *"Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system....append this modifier to an appropriate CPT code."*⁴⁸ Medicare uses the 95 modifier, and will "...pay the non-facility amount for telehealth services...billed with the place of service (POS) the physician would have used if the service had been provided in person (e.g., POS 11 – Office). Physicians should append modifier -95 to the claim lines delivered via telehealth. Claims with POS 02 – Telehealth will be paid at the normal facility rate, which is typically less than the non-facility rate under the Medicare physician fee schedule."⁵³

Codes unique to non-face to face encounters include:^{54,55}

- 99421-99423: Up to seven days cumulative e-visits that cannot be used for scheduling appointments or conveying test results.
- 99441-99443: Audio-only visits

Appendix A: Bree Collaborative Members

Member	Title	Organization
Susie Dade, MS	Patient Advocate	
David Dugdale, MD, MS	Medical Director, Value Based Care	University of Washington Medicine
Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed, MD	Chief Medical Officer	Confluence Health
Mark Haugen, MD	Family Medicine	Walla Walla Clinic
Darcy Jaffe, MN, ARNP, NE-BC, FACHE	Senior Vice President, Safety & Quality	Washington State Hospital Association
Karen Johnson, PhD	Director, Performance Improvement & Innovation	Washington Health Alliance
Norifumi Kamo, MD, MPP	Internal Medicine	Virginia Mason Franciscan Health
Dan Kent, MD	Chief Medical Officer, Community Plan	UnitedHealthcare
Wm. Richard Ludwig, MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
Drew Oliveira, MD	Executive Medical Director	Regence BlueShield
Mary Kay O'Neill, MD, MBA	Partner	Mercer
Kevin Pieper, MD	Chief Medical Officer	Kadlac Medical Center
Susanne Quistgaard, MD	Medical Director, Provider Strategies	Premera Blue Cross
John Robinson, MD, SM	Chief Medical Officer	First Choice Health
Jeanne Rupert, DO, PhD	Provider	The Everett Clinic
Angela Sparks, MD	Medical Director Clinical Knowledge Development & Support	Kaiser Permanente Washington
Hugh Straley, MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
Shawn West, MD	Medical Director	Embright, LLC
Laura Kate Zaichkin, MPH	Director of Health Plan Performance and Strategy	SEIU 775 Benefits Group
Judy Zerzan, MD, MPH	Chief Medical Officer	Washington State Health Care Authority

Appendix B: Workgroup Charter and Roster

Problem Statement

Telehealth utilization has increased significantly since the onset of the COVID-19 pandemic. Approximately 34.5 million telehealth services were delivered to Medicaid and CHIP beneficiaries from March through June 2020, representing an increase of 2,632% compared to March through June 2019¹. Rapid acceleration of telehealth has identified a knowledge gap among physical and behavioral health providers in appropriateness of telehealth care delivery, and highlights issues related to confidentiality and access.

Aim

To increase the appropriateness and quality of the delivery of clinical care via telehealth.

Purpose

To propose evidence-informed recommendations to the full Bree Collaborative on:

- Appropriateness of telehealth as a modality of care delivery for both physical and behavioral health
- How telehealth can increase equitable access to health care including individual patient characteristics that optimize outcomes or serve as barriers to
- Positive patient experience in telehealth services including efficiency
- Measuring success in how telehealth meets patient and provider need
- Addressing barriers to integrating telehealth as a modality of care into current systems
- Identifying other areas of focus or modifying areas, as needed

Duties & Functions

The workgroup will:

- Research evidence-based and expert-opinion informed guidelines and best practices (emerging and established).
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

¹Centers for Medicare and Medicaid Services. Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries During COVID-19. Accessed: January 2021. Available: www.medicare.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-COVID-19-snapshot-data-through-20200630.pdf

Structure

The workgroup will consist of individuals confirmed by Bree Collaborative members, appointed by the chair of the Bree Collaborative, or appointed by the workgroup chair. The chair of the workgroup will be appointed by the chair of the Bree Collaborative. The Bree Collaborative staff will provide management and support services for the workgroup.

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

Meetings

The workgroup will hold meetings as necessary. Bree Collaborative staff will conduct meetings along with the chair, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members may be added at the discretion of the workgroup chair.

Name	Title	Organization
Shawn West, MD (Chair)	Chief Medical Officer	Embright
Christopher Cable, MD Sarah Levy, MD	Executive Director of Operations, Telehealth and Access Management Medical Director Solution Center and Telehealth	Kaiser Permanente Washington
Christopher Chen, MD Jodi Kunkell	Associate Medical Director Occupational Nurse Consultant	Health Care Authority
Crystal Wong, MD	Telehealth Services Director	University of Washington Medicine
Cara Towle, RN, MSN	Associate Director, Integrated Care Training Program	University of Washington Psychiatry & Behavioral Sciences
Darcie Johnson, MSW, CPHQ	Director of Quality	Premera Blue Cross
David Tauben, MD, FACP	Chief, Division of Pain Medicine	University of Washington Medicine
Janna Wilson	Employee Benefits Sourcing Manager	King County
Jeb Shepard	Director of Policy	Washington State Medical Association
Omar Daoud, PharmD Jennifer Polello MHPA, MCHES, PCMH-CCE Stephanie Shushan, MPH	Director of Pharmacy Senior Director of Quality and Clinical Transformation Senior Analyst, Integrated Programs & Strategic Initiatives	Community Health Plan of Washington
Laura Groshong, LICSW	Private Practice	Psychotherapist
Lindsay Mas	Senior Program Manager, Behavioral health	SEIU 775 Benefits Group
Lydia Bartholomew, MD	Chief Medical Officer, Clinical Health Services, West and Southcentral	Aetna
Mandy Weeks-Green	Senior Health Policy Analyst	Washington Office of the Insurance Commissioner
Todd Wise, MD, MBA	Chief Clinical Officer, Ambulatory Care Network	Providence
Wendy Brzezny	Whole Person Care Collaborative Manager	North Central Accountable Community of Health

Appendix C: Guideline and Systematic Review Search Results

	Year	Title	Summary or Findings
AHRQ: Research Findings and Reports	2019	Telehealth for Acute and Chronic Care Consultations	In general, the evidence indicates that telehealth consultations are effective in improving outcomes or providing services, with no difference in outcomes; however, the evidence is stronger for some applications, and less strong or insufficient for others. However, as specific details about the implementation of telehealth consultations and the environment were rarely reported, it is difficult to assess generalizability. Exploring the use of a cost model underscored that the economic impact of telehealth consultations depends on the perspective used in the analysis. The increase in both interest and investment in telehealth suggests the need to develop a research agenda that emphasizes rigor and focuses on standardized outcome comparisons that can inform policy and practice decisions.
	2016	Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews	The research literature on telehealth is vast and varied, consisting of hundreds of systematic reviews and thousands of studies of use across various clinical conditions and health care functions. There is sufficient evidence to support the effectiveness of telehealth for specific uses with some types of patients, including— Remote patient monitoring for patients with chronic conditions; Communication and counseling for patients with chronic conditions; Psychotherapy as part of behavioral health.
Cochrane Collection	2021	Healthcare stakeholders' perceptions and experiences of factors affecting the implementation of critical care telemedicine (CCT): qualitative evidence synthesis	Our review identified several factors that could influence the acceptance and use of telemedicine in critical care. These include the value that hospital staff and family members place on having access to critical care experts, staff access to sufficient training, and the extent to which healthcare providers at the bedside and the critical care experts supporting them from a distance acknowledge and respect each other's expertise. Further research, especially in contexts other than North America, with different cultures, norms and practices will strengthen the evidence base for the implementation of CCT internationally and our confidence in these findings. Implementation of CCT appears to be growing in importance in the context of global pandemic management, especially in countries with wide geographical dispersion and limited access to critical care expertise. For successful implementation, policymakers and other stakeholders should consider pre-empting and addressing factors that may affect implementation, including strengthening teamness between bedside and hub teams; engaging and supporting frontline staff; training ICU clinicians on the use of CCT prior to its implementation; and ensuring staff have access to information and knowledge about when, why and how to use CCT for maximum benefit.
	2021	Mobile phone-based interventions for improving adherence to medication prescribed for the primary prevention of	There is low-certainty evidence on the effects of mobile phone-delivered interventions to increase adherence to medication prescribed for the primary prevention of CVD. Trials of BP self-monitoring with mobile-phone telemedicine support reported modest benefits. One trial at low risk of bias reported modest reductions in LDL cholesterol but no benefits for BP. There is moderate-certainty evidence that these interventions do not result in harm. Further trials of these interventions are warranted.

	cardiovascular disease in adults	
2021	Telerehabilitation for chronic respiratory disease	This review suggests that primary pulmonary rehabilitation, or maintenance rehabilitation, delivered via telerehabilitation for people with chronic respiratory disease achieves outcomes similar to those of traditional centre-based pulmonary rehabilitation, with no safety issues identified. However, the certainty of the evidence provided by this review is limited by the small number of studies, of varying telerehabilitation models, with relatively few participants. Future research should consider the clinical effect of telerehabilitation for individuals with chronic respiratory diseases other than COPD, the duration of benefit of telerehabilitation beyond the period of the intervention, and the economic cost of telerehabilitation.
2021	Digital interventions for the management of chronic obstructive pulmonary disease	There is insufficient evidence to demonstrate a clear benefit or harm of digital technology interventions with or without supported self-management, or multi-component interventions compared to usual care in improving the 6MWD or self-efficacy. We found there may be some short-term improvement in quality of life with digital interventions, but there is no evidence about whether the effect is sustained long term. Dyspnoea symptoms may improve over a longer duration of digital intervention use. The evidence for multi-component interventions is very uncertain and as there is little or no evidence for adverse events, we cannot determine the benefit or harm of these interventions. The evidence base is predominantly of very low certainty with concerns around high risk of bias due to lack of blinding.
2020	Telephone interventions for symptom management in adults with cancer	Telephone interventions provide a convenient way of supporting self-management of cancer-related symptoms for adults with cancer. These interventions are becoming more important with the shift of care closer to patients' homes, the need for resource/cost containment, and the potential for voluntary sector providers to deliver healthcare interventions. Some evidence supports the use of telephone-delivered interventions for symptom management for adults with cancer; most evidence relates to four commonly experienced symptoms - depression, anxiety, emotional distress, and fatigue. Some telephone-delivered interventions were augmented by combining them with face-to-face meetings and provision of printed or digital materials. Review authors were unable to determine whether telephone alone or in combination with other elements provides optimal reduction in symptoms; it appears most likely that this will vary by symptom. It is noteworthy that, despite the potential for telephone interventions to deliver cost savings, none of the studies reviewed included any form of health economic evaluation.
2020	Telerehabilitation for people with low vision	We did not find any evidence from RCTs or CCTs on the efficacy of using telerehabilitation for remote delivery of rehabilitation services to individuals with low vision. Given the disease burden and the growing interest in telemedicine, the two ongoing studies, when completed, may provide evidence in understanding the potential for telerehabilitation as a platform for providing services to people with low vision.
2020	Mobile technologies to support healthcare provider to healthcare provider	Our confidence in the effect estimates is limited. Interventions including a mobile technology component to support healthcare provider to healthcare provider communication and management of care may reduce the time between presentation and management of the health condition when primary care providers or emergency physicians use them to consult with specialists, and may increase the likelihood of receiving a clinical examination among participants with diabetes and those who required an ultrasound. They may decrease the number of people attending primary care who are referred to secondary or tertiary care in some conditions, such as some skin

	communication and management of care	conditions and CKD. There was little evidence of effects on participants' health status and well-being, satisfaction, or costs.
2020	Telerehabilitation services for stroke	While there is now an increasing number of RCTs testing the efficacy of telerehabilitation, it is hard to draw conclusions about the effects as interventions and comparators varied greatly across studies. In addition, there were few adequately powered studies and several studies included in this review were at risk of bias. At this point, there is only low or moderate-level evidence testing whether telerehabilitation is a more effective or similarly effective way to provide rehabilitation. Short-term post-hospital discharge telerehabilitation programmes have not been shown to reduce depressive symptoms, improve quality of life, or improve independence in activities of daily living when compared with usual care. Studies comparing telerehabilitation and in-person therapy have also not found significantly different outcomes between groups, suggesting that telerehabilitation is not inferior. Some studies reported that telerehabilitation was less expensive to provide but information was lacking about cost-effectiveness. Only two trials reported on whether or not any adverse events had occurred; these trials found no serious adverse events were related to telerehabilitation.
2019	eHealth interventions for people with chronic kidney disease	eHealth interventions may improve the management of dietary sodium intake and fluid management. However, overall these data suggest that current evidence for the use of eHealth interventions in the CKD population is of low quality, with uncertain effects due to methodological limitations and heterogeneity of eHealth modalities and intervention types. Our review has highlighted the need for robust, high quality research that reports a core (minimum) data set to enable meaningful evaluation of the literature.
2019	Psychological therapies (remotely delivered) for the management of chronic and recurrent pain in children and adolescents	There are currently a small number of trials investigating psychological therapies delivered remotely, primarily via the Internet. We are cautious in our interpretations of analyses. We found one beneficial effect of therapies to reduce headache severity post-treatment. For the remaining outcomes there was either no beneficial effect at post-treatment or follow-up, or lack of evidence to determine an effect. Overall, participant satisfaction with treatment was positive. We judged the quality of the evidence to be very low, meaning we are very uncertain about the estimate. Further studies are needed to increase our confidence in this potentially promising field.
2019	Techniques of monitoring blood glucose during pregnancy for women with pre-existing diabetes	Two new studies (406 women) have been incorporated to one of the comparisons for this update. Although the evidence suggests that CGM in comparison to intermittent glucose monitoring may reduce hypertensive disorders of pregnancy, this did not translate into a clear reduction for pre-eclampsia, and so this result should be viewed with caution. There was no evidence of a difference for other primary outcomes for this comparison. The evidence base for the effectiveness of other monitoring techniques analysed in the other five comparisons is weak and based on mainly single studies with very low-quality evidence. Additional evidence from large well-designed randomised trials is required to inform choices of other glucose monitoring techniques and to confirm the effectiveness of CGM.
2018	E-Health interventions for anxiety and	At present, the field of e-health interventions for the treatment of anxiety or depression in children and adolescents with long-term physical conditions is limited to five low quality trials. The very low-quality of the evidence means the effects of e-health interventions are uncertain at this time, especially in children aged under 10 years. Although it is

	depression in children and adolescents with long-term physical conditions	too early to recommend e-health interventions for this clinical population, given their growing number, and the global improvement in access to technology, there appears to be room for the development and evaluation of acceptable and effective technologically-based treatments to suit children and adolescents with long-term physical conditions.
2018	Teledermatology for diagnosing skin cancer in adults	Studies were generally small and heterogeneous and methodological quality was difficult to judge due to poor reporting. Bearing in mind concerns regarding the applicability of study participants and of lesion image acquisition in specialist settings, our results suggest that teledermatology can correctly identify the majority of malignant lesions. Using a more widely defined threshold to identify 'possibly' malignant cases or lesions that should be considered for excision is likely to appropriately triage those lesions requiring face-to-face assessment by a specialist. Despite the increasing use of teledermatology on an international level, the evidence base to support its ability to accurately diagnose lesions and to triage lesions from primary to secondary care is lacking and further prospective and pragmatic evaluation is needed.
2017	Different methods and settings for glucose monitoring for gestational diabetes during pregnancy	Evidence from 11 RCTs assessing different methods or settings for glucose monitoring for GDM suggests no clear differences for the primary outcomes or other secondary outcomes assessed in this review. However, current evidence is limited by the small number of RCTs for the comparisons assessed, small sample sizes, and the variable methodological quality of the RCTs. More evidence is needed to assess the effects of different methods and settings for glucose monitoring for GDM on outcomes for mothers and their children, including use and costs of health care. Future RCTs may consider collecting and reporting on the standard outcomes suggested in this review.
2016	Remote versus face-to-face check-ups for asthma	Current randomized evidence does not demonstrate any important differences between face-to-face and remote asthma check-ups in terms of exacerbations, asthma control or quality of life. There is insufficient information to rule out differences in efficacy, or to say whether or not remote asthma check-ups are a safe alternative to being seen face-to-face.
2015	Interactive telemedicine: effects on professional practice and health care outcomes	The findings in our review indicate that the use of TM in the management of heart failure appears to lead to similar health outcomes as face-to-face or telephone delivery of care; there is evidence that TM can improve the control of blood glucose in those with diabetes. The cost to a health service, and acceptability by patients and healthcare professionals, is not clear due to limited data reported for these outcomes. The effectiveness of TM may depend on a number of different factors, including those related to the study population e.g. the severity of the condition and the disease trajectory of the participants, the function of the intervention e.g., if it is used for monitoring a chronic condition, or to provide access to diagnostic services, as well as the healthcare provider and healthcare system involved in delivering the intervention.
2015	Telerehabilitation for persons with multiple sclerosis	There is currently limited evidence on the efficacy of telerehabilitation in improving functional activities, fatigue and quality of life in adults with MS. A range of telerehabilitation interventions might be an alternative method of delivering services in MS populations. There is insufficient evidence to support on what types of telerehabilitation interventions are effective, and in which setting. More robust trials are needed to build evidence for the clinical and

		cost effectiveness of these interventions.
2014	Psychological	Currently, insufficient evidence exists on psychological interventions or approaches to support people with cystic
<u>2019</u>	Systematic Review: Effectiveness of Remote Triage	<p>The majority of included studies did not demonstrate a decrease in primary care or emergency department (ED) use; however, the current evidence is limited and of marginal quality. Only 1 study with high ROB found a significant decrease in primary care utilization when comparing a national telephone triage system to a more local telephone triage system, and no study found a decrease in ED utilization. Yet, 4 studies reported significant increase in utilization among patients in the remote triage condition.</p> <ul style="list-style-type: none"> · Evidence from 2 studies suggested that local, practice-based telephone triage services have higher case resolution outcomes and refer fewer patients to emergency or primary care services compared with regional/national telephone-based remote triage. · While we also explored safety outcomes including ED visits, emergent hospitalization, and death, neither of the 2 studies identified statistically significant differences in safety outcomes among study arms. · No clear pattern emerged about the effects of remote triage on patient satisfaction. Some evidence supports that patient satisfaction is affected to the degree that patients perceive the service they receive to differ from the service they expected (eg, same-day vs after-hours advice). · Last, we addressed the comparative costs of a telephone triage system. Two studies evaluated the costs of in-person primary care compared to either GP-led or nurse-led telephone triage and found no difference in overall cost of care. A third study compared a national telephone triage system to a local triage system, finding that overall cost was not different when controlling for the triaged patient's final point of health care contact.
<u>2017</u>	ESP Report: Access Management Improvement	A key finding of this review is that evidence about primary care access management is essentially limited to implementation of Advanced/Open Access, with all but 3 publications coming in a ten-year period of time from 2001-2010. Most studies reported dramatic improvements in access. The most commonly used intervention components were reducing the backlog, using fewer appointment types, and setting goals, but whether these are key features of success cannot be determined from the data. Some studies of longer duration reported more mixed results, with rising wait times and the need for modifications to the access management strategy reported in 2 large and long-term studies. Patient populations and contexts have been described at only a basic level. Five toolkits were identified, most coming from settings described in implementation studies

Health
Technology
Assessment
Program

N/A

Centers for
Disease
Control and
Prevention

2020

[Using Telehealth
to Expand Access
to Essential
Health Services
during the COVID-
19 Pandemic](#)

Telehealth services can be used to:

- Screen patients who may have symptoms of COVID-19 and refer as appropriate
- Provide low-risk urgent care for non-COVID-19 conditions, identify those persons who may need additional medical consultation or assessment, and refer as appropriate
- Access primary care providers and specialists, including mental and behavioral health, for chronic health conditions and medication management
- Provide coaching and support for patients managing chronic health conditions, including weight management and nutrition counseling
- Participate in physical therapy, occupational therapy, and other modalities as a hybrid approach to in-person care for optimal health
- Monitor clinical signs of certain chronic medical conditions (e.g., blood pressure, blood glucose, other remote assessments)
- Engage in case management for patients who have difficulty accessing care (e.g., those who live in very rural settings, older adults, those with limited mobility)
- Follow up with patients after hospitalization
- Deliver advance care planning and counseling to patients and caregivers to document preferences if a life-threatening event or medical crisis occurs
- Provide non-emergent care to residents in long-term care facilities
- Provide education and training for HCP through peer-to-peer professional medical consultations (inpatient or outpatient) that are not locally available, particularly in rural areas

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N/A

Appendix D: Example Consent Language

Example 1: Integrated into the telehealth platform.

Agreement to get care by video.

By clicking \"Join Appointment\" you consent to participate in a Telemedicine appointment with XYZ provider via video conferencing, you understand that at any time you may request a face-to-face, in-person appointment, and you acknowledge the opportunity to access physician licensure information through the following resources: Washington State Medical Commission.

Example 2: Verbally at the start of the visit

Discuss with the patient at each visit the risks and benefits of using telemedicine for that specific visit. Address any concerns or hesitations the patient may have about engaging in a telehealth appointment.

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