CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

"Using Technology to Improve Care for Patients with Chronic Conditions"

Care Transformation Collaborative of Rhode Island

Learning Collaborative Quarterly Meeting | January 27, 2022

Before we get started:

Please go to

https://pollev.com/reidplimpton415

& add a word to the word cloud

(or scan QR code below)

Agenda

5 min	Welcome & Review Agenda	Susanne Campbell
5 min	Where are we today? Cohort 1/Cohort 2, Word Cloud	Susanne Campbell
60 min	Cohort One Storyboard Sharing	Sue Dettling
15 min	Remarks from NETRC on looking forward and developments in Telehealth nationally, what is happening in RI in 2022, including status of state compacts	Reid Plimpton, NETRC
5 min	Questions and Answers/Wrap up– Cohort 1/Cohort 2	Susanne Campbell

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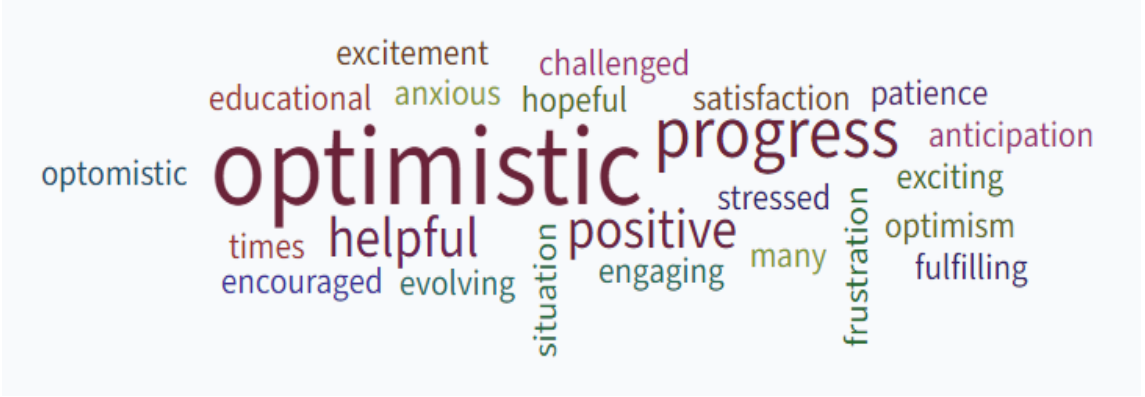
Where are we today?

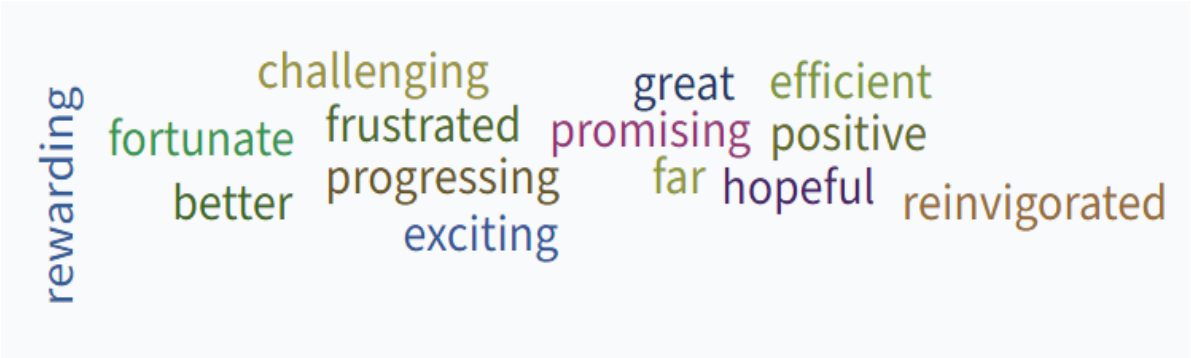
Congratulations to Cohort 1!	Cohort 2 ***Implementation phase Cohort 2: Sept '21 - April '22***
✓ Storyboards are submitted for all practices	✓ Submitted for all practices: new tests of change for PDSA: identify high-risk patients and community partnerships
Most final PDSAs submitted– please double check that your PDSA addresses high-risk patients	Deadline for storyboard and final PDSA: April 18
Upon receipt of final PDSA and storyboard, final payments will be processed in early February	Upon receipt of final PDSA and storyboard, final payments will be processed in early May

Responses from our First Meeting in May

August Meeting



November Meeting



Today's responses

Cohort 1 Practices Presenting Today

1. Richard Ohnmacht, MD - ADHD
2. PRIMA Inc. - ADHD
3. Barrington Family Medicine - HTN
4. CharterCare Blackstone - RPM Diabetes
5. Coastal Adult Primary Care - RPM
6. MARI - ABPM
7. A to Z Primary Care - RPM - CHF
8. Hasbro Primary Care - Asthma Telehealth
9. Hasbro Med Peds – Type 2 Diabetes
10. Encompass Family Medicine - Telehealth Diabetes Management

Sample Questions to Keep in Mind During Presentations

- What has participating in this learning collaborative meant to you?
- How has this collaborative changed your practice?
- Do you plan to continue this work? What is your sustainability plan?
- What do you wish you would have known ahead of time?
- Patient stories
- Outcomes
- What impact do you think you've made?

Richard Ohnmacht, MD (ADHD)

STUDY

In our initial analysis (June-Dec. 2020), we Identified 91 total patients. Of those four were no longer in the practice and three were newly diagnosed and thus excluded. Of the remaining 84, 68 were seen, with 5 via Telehealth (7%), with a visit rate of 68/84 or 81% Of note of the 16 not seen, two were cancellations of scheduled visits for weather related reasons

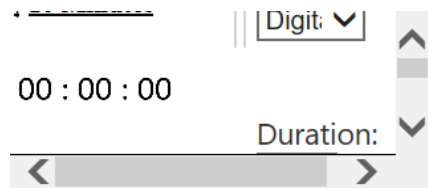
Our follow up analysis identified only 68 total patients (June – Dec. 2021) Of these two were no longer in the practice and were thus excluded, leaving 66 patients to review. Of these 66, 64 had office visits, 6 via Telehealth (9%) and one patient decide to discontinue their medication for personal reasons. This led to a visit rate of 64/66 or 97%

Telephone surveys revealed a general acceptance of Telehealth among the participants with no identified insurmountable barriers to continuing to offer this service.

There was general skepticism on the part of the provider in general about TH prior to this study; perhaps the most important result of this study was the general acceptance of the provider of the value of TH in at least limited situations, specifically medication follow up visits.

ACT

Telehealth offers a reasonable alternative to in person visits for a select group of pediatric patients with ADHD. Our practice guidelines require visits every four months for medication management for those patients. Telehealth will be offered for every other scheduled visit in the future, thus removing barriers of transportation, weather and extra time off for work for patients and their caregivers.



Although the absolute number of Telehealth visits did not increase substantially in the second group, this was more a reflection of the time of year (summer) when patients customarily schedule in-person annual wellness visits. We expect the numbers to increase in the winter months.

P.R.I.M.A., Inc (ADHD)

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STUDY

Results: Number of Telehealth and In-person Visits		
Apr- Dec 2020	621 TH visits	128 (20%) ADHD Med Checks
Apr-Dec 2021	509 TH visits	252 (50%) ADHD Med Checks
One quarterly analysis conducted for July-Oct 2021: 54% of ADHD pts had at least 1 TH		
One quarterly analysis conducted for July-Oct 2021: 46% of ADHD pts had In Person only visits		

Patients who missed a recommended visit	
Jan-Apr 2021	N=8
July-Oct 2021	N=2

NOTE: We could not track 2 & 3 past Oct. due to loss of office staff who managed data reporting

Observations:

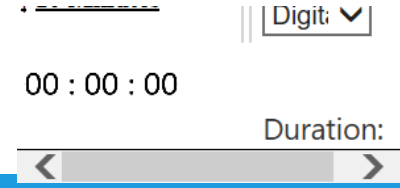
1. Many of the same patients opt for repeated TH visits
2. Patients have adjusted to this new process and they know what to expect so satisfaction continues to be positive
3. Providers thought there would be more resistance from patients to come in to the office following TH visits, but this is not the case

ACT– Main Takeaways

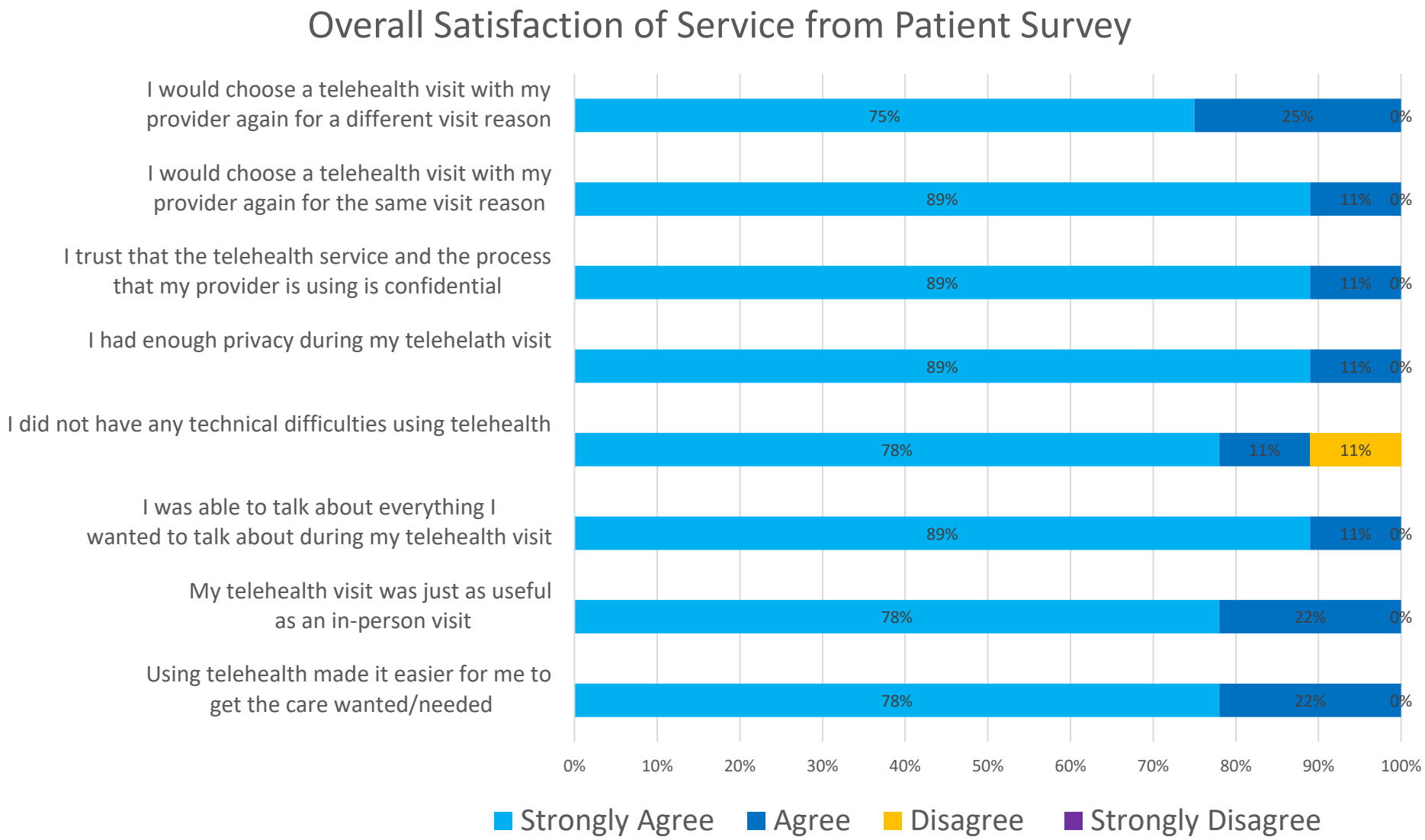
- **Workflow** is "as good as it gets" – we have developed a strategy that can be used for other conditions as well
- We have learned a lot about how well **teens** can take responsibility for their own health
- **Hybrid model** seems to be the preference for providers and patients
- Practice is **more accessible** to patients with TH; hadn't used TH at all before 2020; we might have been able to utilize it before 2020

Concerns about **reimbursement**/sustainability:

- TH is here to stay, so it must be paid for
- Video connectivity issues still often exist even with DOXY, so reimbursement for audio-only is imperative for sustainability



P.R.I.M.A., Inc (Graph of Patient Satisfaction)



Barrington Family Medicine (Hypertension)

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STUDY

PDSA Cycle 1: We found bluetooth technology cumbersome for patients, did not interface with EMR as hoped, and monitors were unreliable.

PDSA Cycle 2: Blood pressure machines with memory feature worked well for many patients. SDOH impacted ability of patients to complete home readings and/or return equipment.

PDSA Cycle 3: Continuous ambulatory blood pressure monitors captured useful information, occasionally did not work as intended, and was cumbersome for patients to use. In one case, we determined that a case of "uncontrolled hypertension" was actually white coat hypertension with dangerously low ambulatory readings.

PDSA Cycle 4: The in-office, unobserved protocol was reliable, easy for patients and staff, and was relatively unaffected by SDOH (e.g. transportation access, technology literacy).

Patient surveys: patients with uncontrolled hypertension reported a high degree of confidence in their ability to manage their blood pressure. Confidence was not increased through ambulatory blood pressure activities.

During this project, we recognized that we were not providing systematic support and ongoing HTN education to patients who were at target blood pressure ranges. We added this component to our routine visits via motivational interviewing and tailored teaching.

ACT

This project highlighted the many barriers to obtaining accurate blood pressure readings, the important role of standardized protocols, and the usefulness and limitations of a variety of technologies to capture blood pressure readings.

Although the first several PDSAs used home-based technology, we found that the in-office technology (unobserved 10-minute protocol) was reliable, easy for patients and staff, and was relatively unaffected by social determinants of health (e.g. transportation access, technology literacy).

This project was developed with our very small practice (panel size of 450). As our physician and patient panel are about to join Ea Community Action Program (>7,000 patients), we will bring the equipment purchased and lessons learned from each of our PDSA c organization with a more diverse patient population.

Barrington Family Medicine (Hypertension)

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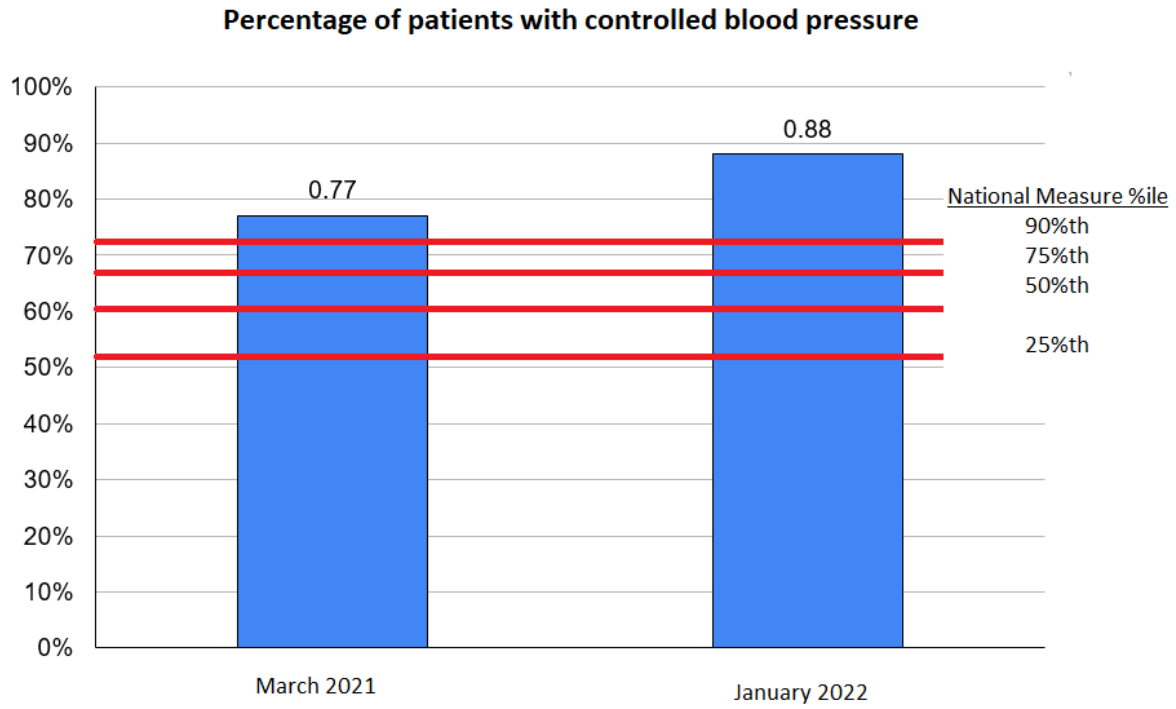
Measure definition: The number of patients ages 18-85 with a dx of HTN whose latest blood pressure is <140/90.



Prior to intervention: 77% (59/77) of hypertensive patients had adequately controlled and documented blood pressure.

Post intervention: 88% (69/79) of hypertensive patients had adequately controlled and documented blood pressure.

Charter Care Blackstone (Remote patient monitoring for diabetes)

STUDY

We had planned for Qure4U, the platform we used for this project, to set up a patient survey, so that each patient would be asked about their comfort level with measuring their blood sugar at the beginning of the project and how that changed over time. Unfortunately, a programming snafu meant that this information was never collected. We manually pushed out the surveys to 12/13 patients and received 5 responses. All 5 rated their comfort level at 10/10. However, we have no way of comparing that to their original comfort levels.

At this point, about 70% of patients are consistently measuring their blood sugar up to 4x/day (9/13 patients). For those patients who are consistently monitoring their blood sugar, we have seen an improvement in their glycemic control.

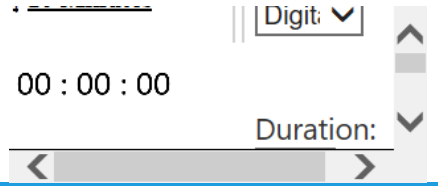
We also monitored blood pressure and weight, even though that was not the goal of this project.

We had been skeptical before this project about the clinical value of RPM. This experiment has shown that RPM has clinical value and the potential to improve patient care. RPM can play an important role in the way we manage our patients with diabetes

ACT

We have just begun to use billing codes and anticipate that the program will be financially viable. We are finding it to be an efficient way to monitor blood sugar, which makes the program sustainable from a personnel perspective.
The integration of a telehealth solution-RPM platform into the electronic health record meant substantial cost savings and made feasible the deployment of the RPM platform without the need to hire additional staff.
We think this model could be implemented in other small practices at a low cost. It is manageable without having to invest capital and staff. It is also scalable, so that if we wanted to add many more patients, that would be possible.

Even with the limited number of patients that we had, there was a small profit to our practice.



Charter Care Medical Associates Charts

Remote patient monitoring for diabetes

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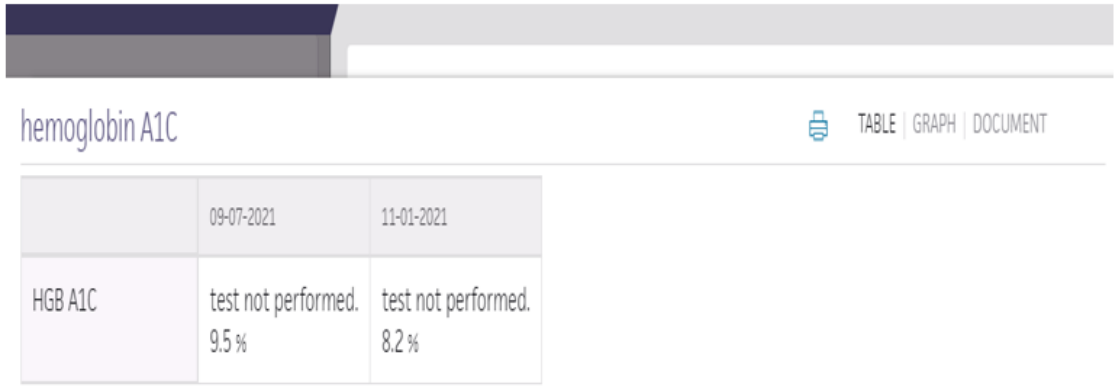
Blood Glucose Data

HbA1c: previously drug naïve patient (before and after drug intervention)



hemoglobin A1C

TABLE | GRAPH | DOCUMENT

	09-07-2021	11-01-2021
HGB A1C	test not performed. 9.5 %	test not performed. 8.2 %

Coastal Medical (RPM Monitoring Expansion)

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STUDY

Upon the completion of 2021, Coastal observed an 81% increase in enrollment into our RPM program. Our year end enrollment totals by RPM program are as follows:

COPD: 286 patients | Diabetes: 355 patients | Heart Failure: 235 patients | Hypertension: 500 patients

Patient satisfaction surveys consistently demonstrated high net promoters scores across all programs. Clinician satisfaction with RPM services similarly scored 4.29 out of 5 stars.

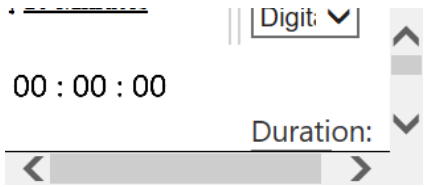
Beyond enrollment and patient/clinician satisfaction, this technology provided the ability to increase opportunities for interventions that would have otherwise resulted in an emergency department visit. Our interventions over the course of 2021 when this work started are shown below. Through implementing this technology, we observed 30% greater opportunities for intervention for patients in our high-risk heart failure program in Q1 2021 compared Q1 2020.

ACT

The calculated cost avoidance for patients enrolled in our remote patient monitoring programs in 2021 is shown in the chart to the right.

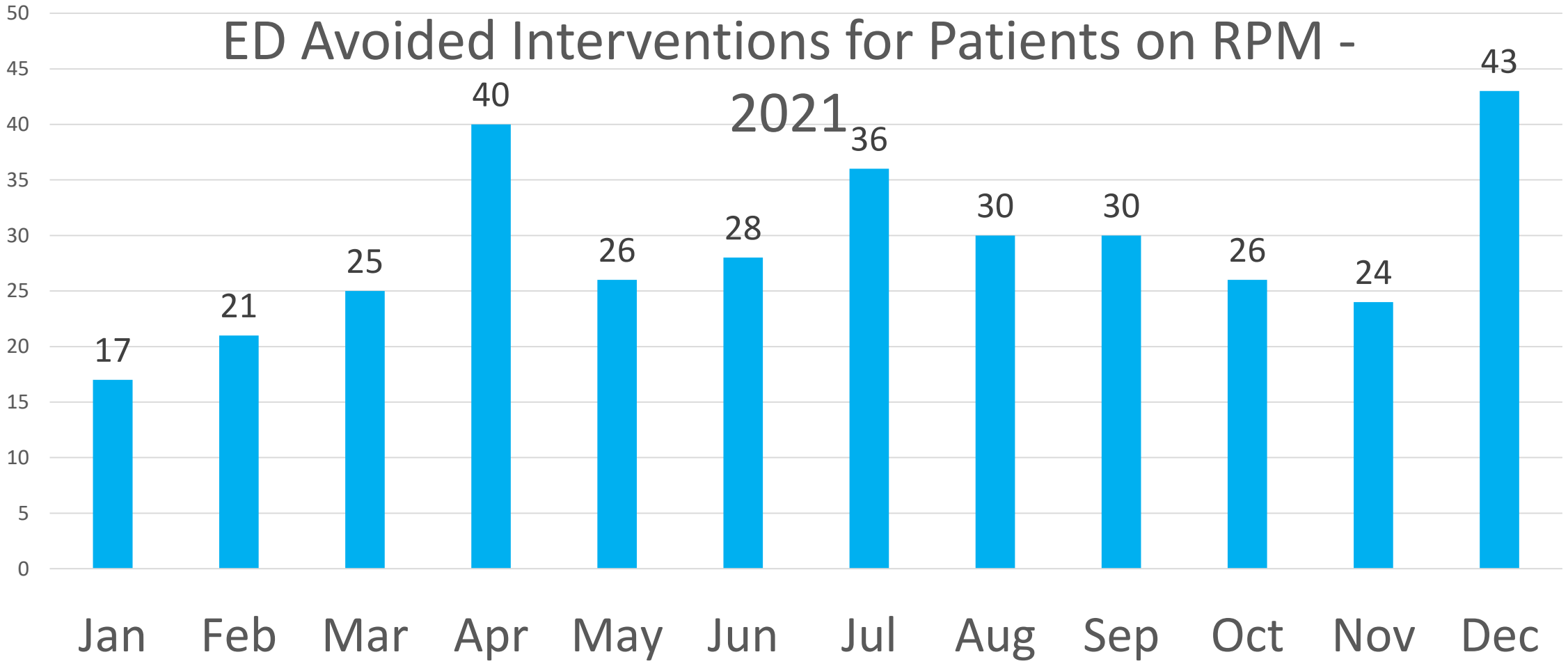
Cost Avoidance	
Total ED Cost Avoidance	$241,502
Total IP Cost Avoidance	$2,539,517
Total Cost Avoidance	**$2,781,019**

- Cost avoidance clearly demonstrates the return on investment for use of this technology.
- The improved patient experience of care by expanding **access and response** of the care team for our patients is an unanticipated triumph of this technology.
- Remote patient monitoring is a tool to improve the efficiency and effectiveness. It is not limited to biometric monitoring. The clinical context informs the clinical team and better supports the next steps in patient care.
- We are continuing to expand RPM services to wellness monitoring for care management and pediatric Behavioral Health remote monitoring.



Coastal Medical Charts

Remote Patient Monitoring Expansion



Medical Associates of RI (Pharmacist-directed 24-hour ambulatory blood pressure monitoring)

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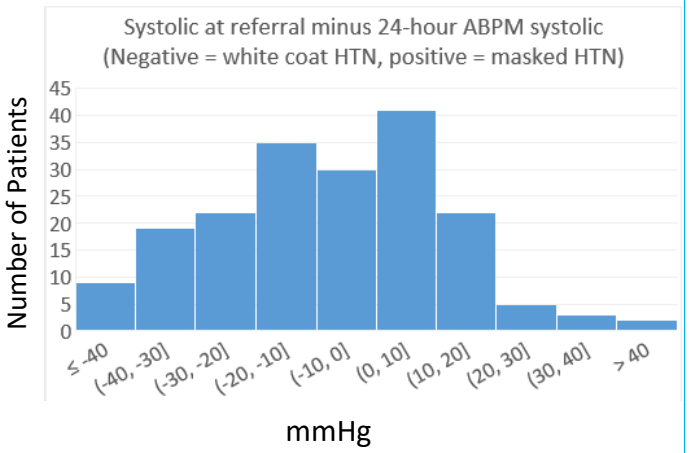
STUDY

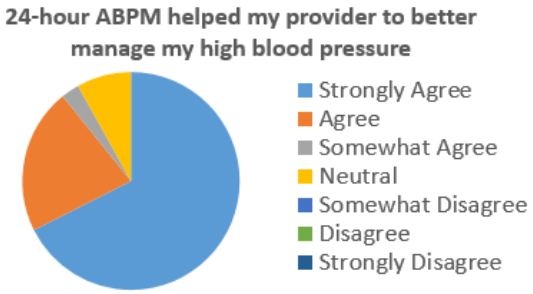
Quality Measures

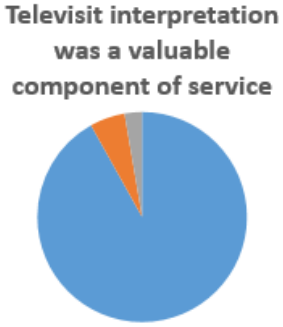
- Total referrals: 211
  - Declined or pending: 23
- Completed studies: 188 (89%)
  - Gaps closed with first study: 71 (60%)
- Gaps at referral: 118 (63%)
  - Closed by EOY: 33 (28%)

Data Trends



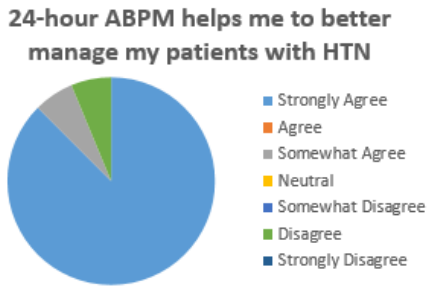
Patient Satisfaction n=37

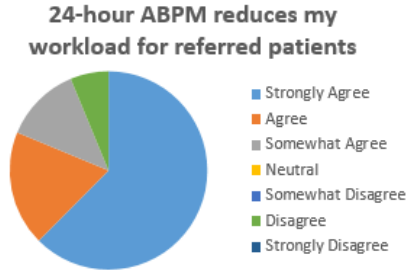




ACT

Provider Satisfaction n=16





Time Use

Activity	Time
Schedule visits*	5 min
Program/place cuff*	20 min
Retrieve data*	5 min
Patient discussion	10 min
Interpretation/plan	10 min
Set follow-up*	5 min
Data entry*	5 min
Total	**60 min**

*Over half of the time required to complete one study comprises activities that could be completed by a pharmacy technician, etc.

A to Z Primary Care (Congestive Heart Failure)

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STUDY

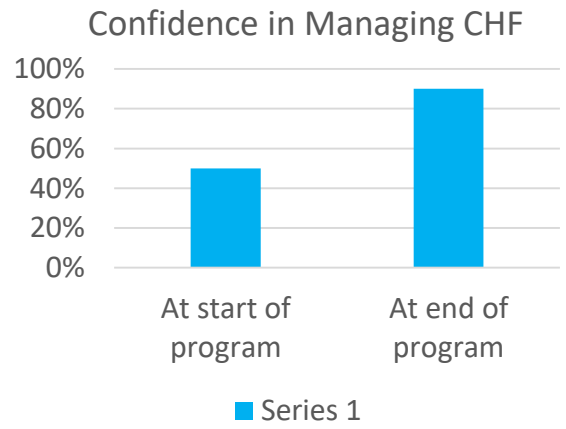
Fourteen patients participated in this project. They engaged weekly with the nurse care manager (NCM) and with our provider, as needed. We were able to manage more than 50% of our patients with CHF at home. All but one patient avoided ED or in-patient utilization. Families and caregivers became more involved and educated during this process. Some patients enjoyed having frequent communication with our NCM, others expressed fatigue with the process.

Participation in this learning collaborative has pointed to the need for continuous education with our patients. Frequent check-ins have shown the importance of reviewing different aspects of care frequently, such as medication regimens and diet.

	2020	2021
ED utilization for patients with CHF	0	1
In-patient utilization for patients with CHF	7	1

Overall patient satisfaction with program: 80%

Would patients continue with checking their vital signs and weight daily after the end of this program?
50% will continue daily weights and vitals; 50% will check at least once a week



ACT

The current system is probably not sustainable for two reasons: it requires several hours of nurse care manager time per week and patients are experiencing fatigue with the frequent check-ins. We are planning to check in with patients monthly, rather than weekly, for three months and then reassess. We will also continue to schedule patients with CHF to come into the office every three months.

- We are researching the Omrom Vital Sight program to see if that might be a cost-effective and efficient way to continue the program.
- Other next steps include a change to education on good health monitoring and recognizing changes in symptoms that require attention.
- Navigating and maintaining patient motivation is something we would like to learn more about.

Hasbro Primary Care (Asthma-Nurse Educator Telehealth Visits)

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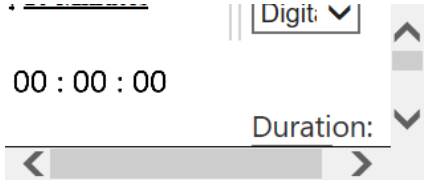
STUDY

Successful visits: Visits were successful when completed: when visits could be scheduled and completed, RNs received positive feedback from families and patients. Asthma symptoms and medications reviewed, follow-up scheduled.

Engaged RNs: RNs engaged and excited by patient care: good RN engagement and sense of purpose during video telehealth visits. With the original random list of patients with persistent asthma, connecting with families was a challenge – multiple avenues explored to connect.

Challenges with continuity: RNs originally selected were not able to continue due to time constraints: unable to build consistent team of RN educators due to factors outside the project.

Loss of PCMH project manager: PCMH nurse project manager moved on to a new role during the project, taking away essential knowledge and oversight.



ACT

Sustainability	Next Steps
Funding Sustainability: The provider must bill for this project to be self-sustaining. An RN must be a certified asthma educator to bill for the services provided in this project	**Funding Next Steps:** Identify an interested RN and support asthma educator certification. Identify additional stakeholders such as the Pediatric Department, other grants, Insurance Companies
Provider Sustainability: If an RN certified nurse educator is not identified, it may be difficult to allot time in the current nursing workflow for a nurse to make asthma follow up calls	**Provider Next Steps:** The patient's primary care provider (NP or MD) could provide a telehealth follow up video visit within 2 weeks of an urgent care visit for asthma using the template developed during this project.
Enrollment Sustainability: It was difficult to reach patients and families who were unaware they were enrolled in this pilot project and perceived it as a "cold call."	**Enrollment Next Steps:** Providers could place a direct referral to the program or enroll a patient while they are in clinic for an urgent care asthma visit

Hasbro Medicine Pediatrics (Type 2 Diabetes)

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STUDY

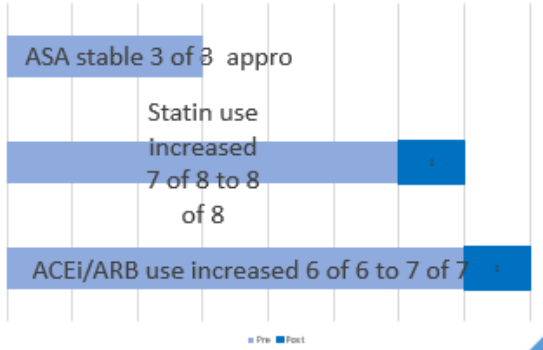
- Nurse manager develops EPIC report to identify 60 patients with a1c > 9; iteratively refined by comparison with chart review of completed visits with known T2DM
- Practice manager clarifies requirements for virtual visits through department and contracting, and creates scheduling templates allowing flexible option of in-person or virtual visits
- Pharmacist/CDOE develops and refines visit template with iterative feedback from PMDs
- After 2 months & 5 months, chart review of all scheduled visits related to registry patients and T2DM care, assessing show-rate, visit content and follow-up plan

10 tracked patients with

Patients with follow-up in 3 month timeframe: 23 in-person, 19 phone (4 w/interpreter), 0 video

1 exclusive in-person, 1 exclusive virtual, 8 of 10 with blend of in-person and virtual = **proof of concept!**

Medications reflect Best-Practices for T2DM care:



UTD on screening measures

- Dental care 10->30%
- Eye exam 30 -> 40%
- Flu vaccine 0 ->80%
- Pneumovax 100->100%
- Foot exam 30 -> 50%
- Revisit within 3 mos 60 -> 100%

Change in A1c:

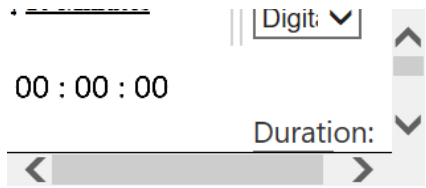
Mean drop 3.1%

Needed changes:

Changes in Lifespan preferred video platform/5 months delay to receiving tablets able to download necessary apps for NurseCDOE and Pharm CDOE to conduct virtual visits.

ACT

- Proof of concept with patient use of both in-person and virtual visits AND positive Pharm & CDOE experience of sessions with varied visit-types AND PMDs appreciative of structured input
- Varied ages, gender, co-morbidities, duration of condition, insurance and language engaged to-date suggest intervention appropriate for diverse population
- Pharm and RN-CDOE staffing supported on-going
- ***On-boarding care coordinator for on-going registry maintenance and reporting***
- ***Video visits would be a PLUS to illustrate some key concepts for med device use AND nutrition recs***



Encompass Family Medicine (Diabetes Mellitus)

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STUDY

Analysis and Results of Patient Survey:

Of 22 patients surveyed, it was determined that 5 of the pediatric patients with diabetes were Primarily followed by an endocrinologist; 17 out of 18 remaining adult patients responded.

- ***77% of patients indicated satisfaction with length of their telehealth visit***
- ***71% indicated they would use telehealth again***
- ***29% indicated they do not wish to use telehealth again***

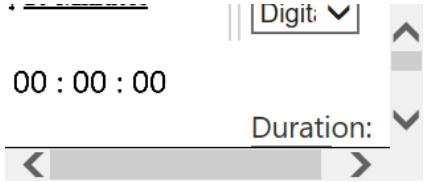
"Apart from the known convenience of a telehealth, management of my diabetes via telehealth has been a game changer to me. Follow-up at regular intervals has made me aware of how I can better take care of my health to lead a better quality of life. Thank you Dr. Venkat and team!"

Future telehealth patient satisfaction plans: *Ask patient every 2 to 3 visits – staff to follow up with patient to ask about their telehealth visit OR ask at annual physical – ask in person what satisfaction has been with past telehealth visits*

ACT

A fishbone diagram was used to identify the challenges for underutilization follow-up telehealth visits. Modifications included: =

1) *patients with diabetes needed to understand the policy of having a telehealth visit for follow up visits;*
2) *practice began using a policy/telehealth for follow up visits for patients with anxiety (patients with special needs or anxiety had frequently missed in person visits; with telehealth, patients with anxiety have better compliance with keeping appointments)*
3) *Block appointments for telehealth, generally from 11:30 am – 12:30 pm; and between 4 – 4:30 pm; these were the most requested times for telehealth appointments; This type of scheduling has proven to be very beneficial for patients and staff. Staff is able to get administrative tasks completed without patients in the office during these blocked times.*



Next Steps*: Practice plans to continue providing telehealth for patients with diabetes and also extend it to patients with anxiety. The model implemented in the practice is very flexible. At this time, it is not sustainable to execute for all chronic care management unless more resources were available.*

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Presentation from Reid Plimpton, MPH

Project Manager at Northeast Telehealth Resource Center

Looking Forward: Developments in Telehealth Nationally and in Rhode Island

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NORTHEAST TELEHEALTH RESOURCE CENTER NETRC.org

Telehealth in 2022 and Beyond

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1/27/22

Northeast Telehealth Resource Center

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About Us:

NETRC aims to increase access to quality health care services for rural and medically underserved populations through telehealth. We serve New England and New York, and are a proud member of the National Consortium of Telehealth Resource Centers.

Disclaimer:

- Any information provided by NETRC is for educational purposes only and should not be regarded as legal advice.
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www.NETRC.org

Telehealth Policy Landscape

24

TELEHEALTH POLICY CHANGES IN COVID-19

FEDERAL	
MEDICARE ISSUE	**CHANGE**
Geographic Limit	Waived
Site limitation	Waived
Provider List	Expanded
Services Eligible	Added additional 80 codes
Visit limits	Waived certain limits
Modality	Live Video, Phone, some srvs
Supervision requirements	Relaxed some
Licensing	Relaxed requirements
Tech-Enabled/Comm-Based (not considered telehealth, but uses telehealth technology)	More codes eligible for phone & allowed PTs/OTs/SLPs & other use

- DEA - PHE prescribing exception/allowed phone for suboxone for OUD
- HIPAA - OCR will not fine during this time

STATE (Most Common Changes)	
MEDICAID ISSUE	**CHANGE**
Modality	Allowing phone
Location	Allowing home
Consent	Relaxed consent requirements
Services	Expanded types of services eligible
Providers	Allowed other providers such as allied health pros
Licensing	Waived some requirements

- Private payer orders range from encouragement to cover telehealth to more explicit mandates
- Relaxed some health information protections

A Few Examples of Federal Policy Possibilities

- The Cures 2.0 bill, the finalized version of which was introduced in the House of Representatives last November.
  - Details policies that should be implemented by CMS to extend telehealth access and coverage to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.
- The Connect for Health Act, which would allow telestroke evaluation and management sites, Native American health service facilities, and dialysis facilities to serve as originating sites for telehealth visits.
  - The act would also include telehealth and remote patient monitoring as basic benefits in Medicare Advantage plans.
- The Telehealth Extension Act, which aims to lift geographic and site restrictions to allow Medicare beneficiaries to access telehealth no matter where they live.
  - Additionally, it would extend select COVID-19 emergency telehealth waivers for two years.
- Expanded Telehealth Access Act
- Telemental Health Care Access Act
- And more: https://connectwithcare.org/telehealth-legislation/

RI Medicaid

- The Rhode Island Medical Assistance Program reimburses for some specific codes via live-video.
- **A newly passed law requires Medicaid provide coverage of telemedicine, which includes live video, store-and-forward and remote patient monitoring.**
  - *CCHP has not located documentation from RI Medicaid that they are implementing the policy yet.*
- "**Originating site"** means a site at which a patient is located at the time healthcare services are provided to them by means of telemedicine, **which can include a patient's home where medically necessary and clinically appropriate.**
- Rhode Island Medicaid's fee schedule lists several telehealth service CPT codes for outpatient visits and limited emergency department inpatient telehealth consultations under procedure/professional services. Reimbursement is available for initial inpatient telehealth consultation and follow-up inpatient telehealth consultation.
  - See their fee schedule look-up tool and telehealth specific codes, including G0406, G0407, G0408, G0425, G0426, G0427.
  - SOURCE: RI Department of Health. Medicaid Fee Schedule Look-Up

Audio Only- Federal

More Clarity TBD; However, if/when PHE Ends:

- CMS this year is redefining the definition of “telecommunications system” which is not defined in federal law.
- Mental Health Services rvices can be provided for the evaluation, diagnosis and treatment of mental health disorder IF
  - Established patient
  - Patient at home
  - Provider has capability of doing live video
  - Patient cannot or does not want to do it via live video
  - Has an in-person visit with the telehealth provider 6 months prior/12 months subsequent

Audio Only- State

- Audio Only was included as a permissible modality in the 2021 Telehealth Legislation for RI
- However, Like other improvements/new additions to the Telehealth Statute; State Rulemaking appears incomplete, and this may cause confusion
- Check in with your Medicaid Office and OHIC

Private Payers- Parity

Service Parity (I.E. Telehealth Coverage)

- A health insurer shall not exclude a healthcare service for coverage solely because the healthcare service is provided through telemedicine and is not provided through in-person consultation or contact, so long as such healthcare services are medically necessary and clinically appropriate to be provided through telemedicine services.

- RI General Law, Sec. 27-81-4(b). as amended by RI SB 4 (2021 Session) & HB 6032 (2021 Session)

Payment Parity

- All such medically necessary and clinically appropriate telemedicine services delivered by in-network primary care providers, registered dietitian nutritionists, and behavioral health providers shall be reimbursed at rates not lower than services delivered by the same provider through in-person methods.

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Private Payers- Important Definitions & Rules

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- **Prior authorization** requirements for medically necessary and clinically appropriate telemedicine services shall not be more stringent than prior authorization requirements for in-person care.
- **Except for requiring compliance with applicable state and federal laws, regulations and/or guidance, no health insurer shall impose any specific requirements as to the technologies** used to deliver medically necessary and clinically appropriate telemedicine services.

“So what does this mean for me”

Federal

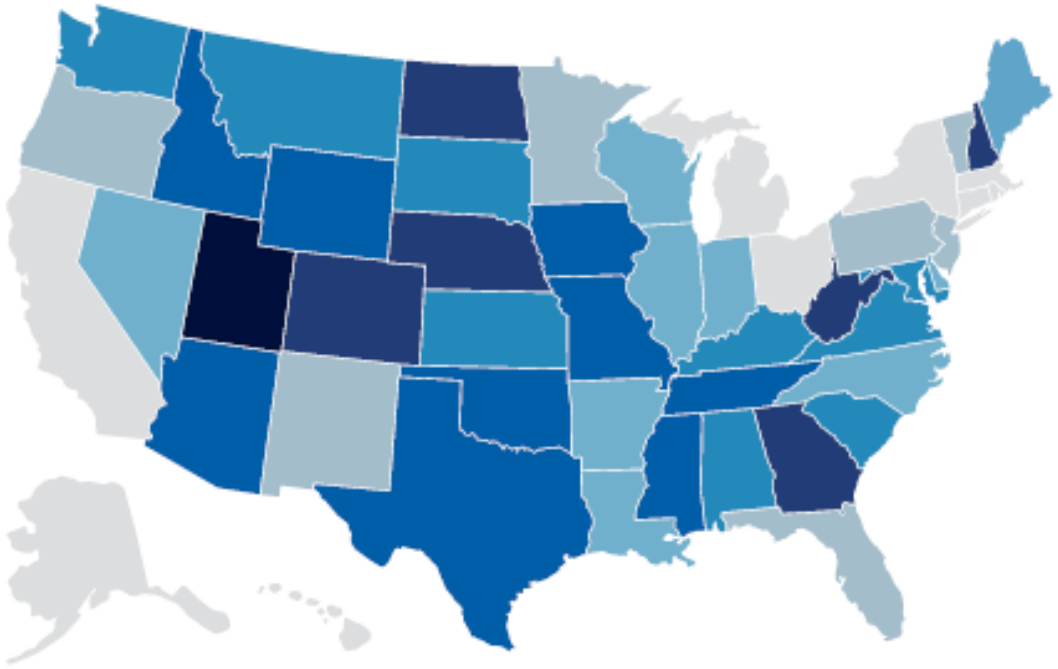
- Watch The Federal PHE
  - https://aspr.hhs.gov/legal/PHE/Pages/COVID19-14Jan2022.aspx
  - Effective 90 days from 1/16/22
- Review the CMS PFS CY22 for the 3 “Categories” that new Telehealth codes fall into
  - https://www.cms.gov/files/document/mm12519-summary-policies-calendar-year-cy-2022-medicare-physician-fee-schedule-mpfs-final-rule.pdf
  - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

RI Medicaid and Private Payers

- Look for RI Rulemaking Results
- Look for Medicaid Guidance
- Plan for all modalities to be permissible for Medicaid and Private Pay

32

Licensure Compacts



None
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2 compacts
3 compacts
4 compacts
5 compacts
6 compacts

PHYSICAL THERAPY (PT) COMPACT:
AZ, AR, CO, DE, GA, IA, KY, LA, MD, MS, MO, MT, NE, NH, NJ, NC, ND, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, WI, WV

INTERSTATE MEDICAL LICENSURE COMPACT (IMLC):
AL, AZ, CO, GA, ID, IL, IA, KS, KY, ME, MD, MI, MN, MS, MT, NE, NV, NH, ND, OK, PA, SD, TN, UT, VT, WA, WV, WI, WY, DC, GU

EMERGENCY MEDICAL SERVICES (EMS) COMPACT:
AL, CO, DE, GA, IA, ID, IN, KS, MS, MO, NE, NH, ND, SC, TN, TX, UT, VA, WV, WY

ENHANCED NURSE LICENSURE COMPACT (ENLC):
AL, AZ, AR, CO, DE, FL, GA, ID, IN, IA, KS, KY, LA, ME, MD, MS, MO, MT, NE, NH, NJ (partial), NM, NC, ND, OK, SC, SD, TN, TX, UT, VA, WV, WI, WY

PSYCHOLOGY INTERJURISDICTIONAL COMPACT (PSYPACT):
AZ, CO, DE, GA, IL, MO, NE, NV, NH, OK, TX, UT

ADVANCED PRACTICE NURSING (APRN) COMPACT:
ID, ND, WY

AUDIOLOGY & SPEECH-LANGUAGE PATHOLOGY INTERSTATE COMPACT:
UT, WV, WY

Rhode Island HB5194 AN ACT RELATING TO BUSINESSES AND PRO-
On March 16, 2021 in the House: Committee recommended measure be held for further study
FESSIONS -- NURSE LICENSURE COMPACT

IMLC 2021 Effort **Unclear where this ended up**

Resources and More Information
https://compacts.csg.org/

https://compacts.csg.org/wp-content/uploads/2020/11/Compact-Resource-Guide-1-1.pdf

https://compacts.csg.org/wp-content/uploads/2020/11/OL_Compacts_InAction_Update_APR_2020-3.pdf

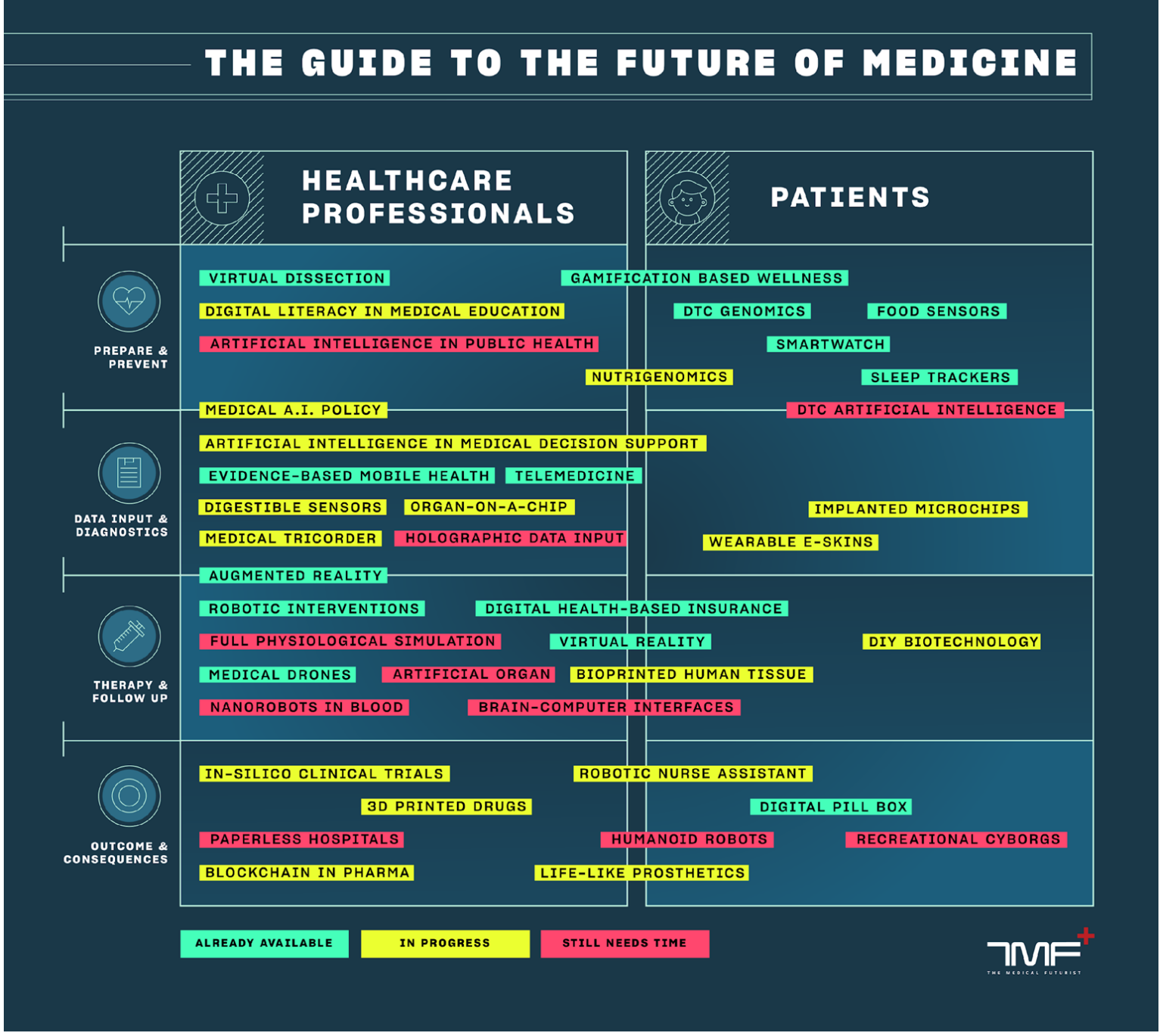
NOTE: Compacts differ RE: Mutual Recognition vs. Expedited Licensure

Post PHE Predictions

Telehealth Improvement & smooth implementation will likely continue to be a moving target

- Don't expect “business as usual” once pandemic is "over"
- HIPAA provisions will likely claw back
- Payment parity/equity will unleash
- Optimization of telehealth implementation and design (started messy out of necessity)
- Hybrid models of care
- Connectivity/broadband expanded
- Community access points will expand (i.e. library)
- Audio-only as a critical means for communication
- Interoperability is critical
- Telehealth cliff?

34



[Bertalan Meskó, MD, PhD,](#) Director of The Medical Futurist Institute https://medicalfuturist.com/

Looking Forward

HYBRID

HEALTH EQUITY

ACCESS

INTEROPERABILITY

36

Virtual Care Moving Forward

"Telehealth, remote care, virtual care: in a few years' time, in the minds of providers and consumers alike.....

it will be simply *healthcare."*

- Miles Romney, CTO, Co-Founder, eVisit, ATA 2021

37

Additional Policy Background and Context
+
Resources and References

Landmark Telehealth Legislation

HISTORY OF FEDERAL TELEHEALTH POLICY IN MEDICARE

Balanced Budget Act of 1997

- Medicare beneficiaries in rural HPSAs may receive care via telehealth
- Practitioner required to be w/patient during consult
- Consulting & Referring physicians share fee (75/25)

Benefits Improvement & Protection Act 2000

- Included non-MSA sites
- Eliminated fee sharing
- Expanded eligible services for reimbursement

Medicare Improve. for Patients & Providers Act, 2008

- Expanded list of facilities that can act as an originating (patient location) site

Various Changes Made Administratively

- Credentialing & Privileging Regulations
- Increase in number of codes reimbursed
- Redefinition of "rural"
- Inclusion of Chronic Care Management Codes

Medicare telehealth statutory policy was limited and hadn't changed much in recent years…

<u>until COVID</u>

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Legal Issues and Documentation

- Critical to be aware of local telehealth laws and regulations
- Policy and reimbursement is evolving
  - Varies by state, payer, geography etc
  - Risk/Compliance Officer = point of contact for questions, issues
- Factors critical for continuity of care, reimbursement include:
  - Licensure and malpractice
  - Informed consent
  - Clinical documentation
  - Insurance coverage, billing
  - Privacy, security (HIPAA)

42

Ethical & HIPAA Considerations

HIPAA COVID PHE Flexibilities

- PHE encouraged connection regardless of HIPAA
  - Connecting = goal
- HIPAA-compliant telehealth solutions will be required once PHE ends

Looking forward

- Develop a policy for each communication method with Risks & Compliance officer(s)
- Communicate policies
- Consider diverse populations with various levels of access, technology, technology literacy etc.
- Consider safety planning and other interaction based protocols
- https://health.ri.gov/healthcare/about/telemedicine/
- https://www.careinnovations.org/resources/telehealth-scheduling-guide/?utm_campaign=meetedgar&utm_medium=social&utm_source=meetedgar.com

43

Plenty of Unresolved Issues To Tackle

….but well worth it

- Patient access (disability, language)
- Digital literacy, technology supports
- End user training
- Broadband availability
- Clinical workflow integration
- Continuity of care
- Non-integrated patient communication/engagement tools
- Reliability of patient contact information
- Ease of use
- Licensure barriers
- Evolving policy
- Reimbursement equity/parity
- Privacy/security concerns (perceived, actual)
- Relationship, trust; cultural barriers
- And more.....

Telehealth Sustainability

- **<u>Here to stay</u>**
- Significant federal funding available (see grants.gov and search “telehealth”) & more coming!
- "**Hybrid**" - portfolio of telehealth in a clinical practice will vary
  - Access
  - Geography, patient location, payer
  - Clinical discipline
  - Legal/regulatory/reimbursement
  - Efficiency, effectiveness
- Need to ensure access, equity, payment parity
- Highly dependent on policy

45

New Resources

- Emergency Broad Band program replaced by: www.ACPBenefit.org
- Ocean State Center for Independent Living: http://www.oscil.org/
- Rural Telehealth Report from the National Quality Forum
- RI State Telehealth Laws
- Considerations for Using Telemental Health Services for Children and Youth: Proceedings of a Workshop–in Brief

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Additional Discussion and Questions?

We'll see you at the Cohort 2 Wrap up meeting:

April 27, 2022