Delivering on the Promise of Telehealth in California

October 22, 2020

Kim Klupenger, President, CTN
Chief Experience Officer, OCHIN

California Telehealth Network
An OCHIN organization
Who We Are

• **CTN** has promoted and fostered the provisioning of broadband access and telehealth adoption for healthcare providers across the state leveraging FCC and State funding for over 10 years. CTN became a subsidiary of OCHIN* 3.5 years ago in order to merge the missions that access to healthcare for all with broadband access being foundational.

• **CTN** is an awardee of HRSA Telehealth Resource Grant (CTRC receives $325k annually) funding tasked with supporting telehealth program adoption.

*OCHIN is a national, non-profit health information and innovation organization serving the most fragile and underserved populations.*
Redesigning Health Care for Complex Patients

What We’re Learning

Clinical Complexity
Patient Level

Social Complexity
Community Level

Patient Outcomes
OCHIN members’ patients living in communities with the highest social deprivation are **24% more likely** to have poor diabetes control.

How We’re Improving Access to Care

- Broadband Network Services and Telehealth Program Adoption Support (CTN and CTRC)
- eConsult and Telehealth Tools
- Adoption of Virtual Care Solutions
- Patient Engagement Solutions including Interpreter Services
- Social Service Resource Locators
Our Work in California

133 Total Organizations*
- Broadband: 88 (177 locations)
- Epic: 33 (31 CA FQHCs on OCHIN Epic)
- NextGen: 5
- HCCN: 36
- Research Partners: 2

*Some customers have more than one product

Special California Program Needs
- Alternative Payment Models
- CA Telehealth Resource Center
- CAIRS2
- CHDP
- CPSP
- Every Woman Counts
- FamilyPACT
- HCCN HRSA Network Grant
- Medi-Cal
- OSHPD
- 340B

As of August 2020

3M annual visits
1.3 M patients
500K Medi-Cal patients
30% of OCHIN EHR visits are in California, more than any other state
33 California groups on OCHIN Epic, all on Managed Medi-Cal
$325k per year CTRC support for telehealth adoption
Broadband Investments in California

FCC Subsidy Obtained for the 2020 Funding Year:

$1,650,567  (Net 2020 Funding Year)

56% Rural Members

177 Member Locations:

157 Clinics

20 Hospitals
EMR Agnostic Technical Training and Support

Through our Health Center Controlled Network we’re learning more about gaps in:

• Provider support for new ‘webside manner’ needs including specific workflows and technical training/IT support

• Continued support for broadband access

• Patient Engagement: technology out of the box

  • Isn’t culturally competent
  • limited language access
  • requires high technology literacy-need “help” line support
FCC Telehealth Funding Awards

We received 41 applications totaling more than $12.9 million in requests from members of the two OCHIN-run consortia: OCHIN Broad Network Services (OBNS) and the California Telehealth Network (CTN).  *(NOTE: One organization alone in California requested $4.2m in critically needed hardware and devices to support virtual care in the pandemic)*

With only $2 million awarded to us from the FCC, we managed a highly competitive process based on the criteria set out in the application.

**We awarded 24 health care organizations:**

- 11 from CTN (CA) for $1M
- 13 from OBNS (22 states) for $1M

**Packages included:**

- 220 Virtual Clinic-At-Home
- 679 Hypertension Management
- 356 Diabetes Management
- 445 Device & Service
For California Members, Percentage of Gross Charges for Behavioral Health and Primary Care Services Increase, While Charges for Dental Service Decrease During COVID-19

Percentage of Total Gross Charges (California Members), by Month

Source: Financial Cubes, retrieved 10/05/2020
Telehealth Encounters in California Remain Steady in Response to COVID-19

Source: F2F vs Telehealth Encounters Tableau Dashboard, retrieved 10/05/2020
What We’ve Learned So Far:

The appetite for virtual care has **increased with the advent of COVID-19** and corresponding changes to reimbursement rules.

While adoption has dramatically increased in 2020, several barriers pose a challenge to adoption:

- **Ease of Use**
- **Reimbursement**
- **Access to Technology**
- **Comfort level with Technology**
- **Support for Additional Languages**
Virtual Care Advocacy in California

CTN/ OCHIN is partnering across the state to advocate for stability in virtual care payment and support for health centers.

Efforts In Sacramento include:

• Supporting the ability for providers to establish new patients via telehealth beyond the end of the public health emergency
• Continuing virtual care payment and flexibility options in preparation for future disasters or outbreaks
• Advocating for FQHC/RHC to continue to be both originating and distant sites to provide virtual patient care
• Supporting Medi-Cal payment for asynchronous care such as eVists and eConsults
• Continued support for expanding funds and access for broadband and helping close equity gaps around telehealth
Key Actions to Support Virtual Care Adoption: Call for Working Together

1. Build certainty in sustained telehealth reimbursement
2. Continue broadband investments to reduce the digital divide
3. Support provider training, patient engagement and patient portals
4. Support for Patients using these tools
DISCLAIMERS

• Any information provided in today’s talk is not to be regarded as legal advice. Today’s talk is purely for informational purposes.
• Always consult with legal counsel.
• CCHP has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this program.
ABOUT CCHP

- Established in 2009
- Program under the Public Health Institute
- Became federally designated national telehealth policy resource center in 2012 through a grant from HRSA
- Work with a variety of funders and partners on the state and federal levels
- Administrator National Consortium of Telehealth Resource Centers
- Convener for California Telehealth Policy Coalition
TELEHEALTH STATE-BY-STATE POLICIES, LAWS & REGULATIONS

Search by Category & Topic

**Medicaid Reimbursement**
- Live Video
- Store & Forward
- Remote Patient Monitoring Reimbursement

**Private Payer Reimbursement**
- Private Payer Laws
- Parity Requirements

**Professional Regulation/Health & Safety**
- Cross-State Licensing
- Consent
- Prescribing
- Misc (Listing of Practice Standards)
# Telehealth Policy Changes in COVID-19

<table>
<thead>
<tr>
<th>Medicare Issue</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic Limit</td>
<td>Waived</td>
</tr>
<tr>
<td>Site limitation</td>
<td>Waived</td>
</tr>
<tr>
<td>Provider List</td>
<td>Expanded</td>
</tr>
<tr>
<td>Services Eligible</td>
<td>Added additional 80 codes</td>
</tr>
<tr>
<td>Visit limits</td>
<td>Waived certain limits</td>
</tr>
<tr>
<td>Modality</td>
<td>Live Video, Phone, some srvs</td>
</tr>
<tr>
<td>Supervision requirements</td>
<td>Relaxed some</td>
</tr>
<tr>
<td>Licensing</td>
<td>Relaxed requirements</td>
</tr>
<tr>
<td>Tech-Enabled/Comm-Based (not considered telehealth, but uses telehealth technology)</td>
<td>More codes eligible for phone &amp; allowed PTs/OTs/SLPs &amp; other use</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medicaid Issue</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modality</td>
<td>Allowing phone</td>
</tr>
<tr>
<td>Location</td>
<td>Allowing home</td>
</tr>
<tr>
<td>Consent</td>
<td>Relaxed consent requirements</td>
</tr>
<tr>
<td>Services</td>
<td>Expanded types of services eligible</td>
</tr>
<tr>
<td>Providers</td>
<td>Allowed other providers such as allied health pros</td>
</tr>
<tr>
<td>Licensing</td>
<td>Waived some requirements</td>
</tr>
</tbody>
</table>

- Private payer orders range from encouragement to cover telehealth to more explicit mandates
- Relaxed some health information protections
IMPACT OF TELEHEALTH POLICY CHANGES

- Chart from ASPE Issue Brief, July 28, 2020 “Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of the COVID-19 Pandemic”

**Medi-Cal** Policies, Update Summer 2019
- All covered services can be provided by live video or store-and-forward, at the provider’s discretion
- Home is an eligible originating site
- Certain limitations for FQHCs and RHCs

- Oral or written consent to use telehealth permitted

**Commercial Plans:** AB 744 (2019) requires payment parity for commercial health plans and insurers, for all contracts executed or amended on or after January 1, 2021

- All Medi-Cal enrolled providers
- All Medi-Cal services covered for live video and store-and-forward.
- E-consult also covered
- Allows for all sites including the home. Limited for FQHCs/RHCs
- All modalities, except remote patient monitoring

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### Key temporary California policy changes during COVID-19:

- Medi-Cal and commercial plans are required to reimburse for services provided by telephone.
- In Medi-Cal, FQHCs/RHCs have expanded ability to recoup reimbursement for telehealth.
- Governor relaxed consent and privacy requirements.
- Commercial health plans are required to cover telehealth, at payment parity.
- Many temporary changes tied to federal public health emergency (PHE).

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>MEDI-CAL</th>
<th>COMMERCIAL HEALTH PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic Limitation</td>
<td>N/A – Did not have limitation pre-COVID-19</td>
<td>N/A – Did not have limitation pre-COVID-19</td>
</tr>
<tr>
<td>Site Limitation</td>
<td>Waived restrictions for FQHCs/RHCs</td>
<td>N/A – Did not have limitation pre-COVID-19</td>
</tr>
<tr>
<td>Provider Limitation</td>
<td>Allowed greater flexibilities to providers at FQHCs/RHCs</td>
<td>DMHC requested plans not limit provider types eligible for reimbursement</td>
</tr>
<tr>
<td>Services Eligible</td>
<td>DHCS required Medi-Cal Managed Care Plans to cover telehealth services to the same extent as in-person equivalents</td>
<td>DMHC required health plans to cover telehealth services to the same extent as in-person equivalents</td>
</tr>
<tr>
<td>Payment Parity</td>
<td>DHCS required Medi-Cal Managed Care Plans to cover telehealth services at same rate as in-person equivalents</td>
<td>DMHC required health plans to cover telehealth services at same rate as in-person equivalent</td>
</tr>
<tr>
<td>Billing Frequency Limitations</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Modality</td>
<td>Expanded coverage to include phone as a modality to deliver services</td>
<td>Expanded coverage to include phone as a modality to deliver services</td>
</tr>
<tr>
<td>Licensing</td>
<td>Limited exceptions for certain facilities that apply for a waiver through the California Emergency Services Agency</td>
<td>Limited exceptions for certain facilities that apply for a waiver through the California Emergency Services Agency</td>
</tr>
</tbody>
</table>
Preliminary data suggest that services delivered via telehealth increased from February through April 2020.

- 34,538,375 services delivered through telehealth from March through June 2020.
- 2,632% more services delivered compared to March through June 2019.

Note: Data for recent months are likely to be adjusted upward due to claims lag; see slides 5 and 11 for additional details on claims lag.

Preliminary data suggest that services delivered via telehealth were highest among working age adults, followed by children and older adults.

Note: Data for recent months are likely to be adjusted upward due to claims lag; see slides 5 and 11 for additional details on claims lag.

Note: Many beneficiaries age 65 and older are likely to be dually eligible for both Medicare and Medicaid. Therefore, the results may underestimate telehealth utilization in this population.

Chart & Information from CMS Preliminary Medicaid & CHIP Data Snapshot for Services through June 30, 2020.
Preliminary data suggest that, among children, services delivered via telehealth per 1,000 beneficiary months from March through June 2020 varied across states.

- Telehealth rates among children peaked in April for nearly all states and then fell in May.

Across states in April 2020, Maine had the highest monthly rate at 402 services per 1,000 child beneficiaries, and Vermont had the lowest monthly rate at 23 services per 1,000 child beneficiaries.

Note: Data for recent months are likely to be adjusted upward due to claims lag; see slides 5 and 11 for additional details on claims lag.

Preliminary data suggest that, among adults age 19 to 64, services delivered via telehealth per 1,000 beneficiary months from March through June 2020 varied across states.

- Telehealth rates among working age adults peaked in April for nearly all states and then fell in May.

Across states in April 2020, Missouri had the highest monthly rate at 520 services per 1,000 beneficiaries age 19 to 64, and South Carolina had the lowest monthly rate at 51 services per 1,000 beneficiaries age 19 to 64.

Note: Data for recent months are likely to be adjusted upward due to claims lag; see slides 5 and 11 for additional details on claims lag.

Chart & Information from CMS Preliminary Medicaid & CHIP Data Snapshot for Services through June 30, 2020.

Telehealth & Commercial Payers

June 2020 – For AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

* Chart from Fair Health Monthly Telehealth Regional Tracker - [https://www.fairhealth.org/states-by-the-numbers/telehealth](https://www.fairhealth.org/states-by-the-numbers/telehealth)
TELEHEALTH & COMMERCIAL PAYERS

JUNE 2020 – For AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

* Chart from Fair Health Monthly Telehealth Regional Tracker - [https://www.fairhealth.org/states-by-the-numbers/telehealth](https://www.fairhealth.org/states-by-the-numbers/telehealth)
TELEHEALTH & COMMERCIAL PAYERS (2)

JUNE 2020 – For AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

* Chart from Fair Health Monthly Telehealth Regional Tracker - https://www.fairhealth.org/states-by-the-numbers/telehealth
In a survey conducted by the Health Resources and Services Administration (HRSA) of CHCs, an average of 27.13% of the health center visits were conducted virtually (either telephone or a telehealth modality) for the week of October 2, 2020.

OTHER ISSUES

- Beyond reimbursement/coverage
- Broadband
- Licensing
- Education of providers and consumers
- Out-of-date forms, regulations
Where do we stand now?

Still only have temporary changes, nothing made permanent yet

No significant telehealth legislation was signed this past session

In Governor Newsom’s veto message, DHCS “is currently in the process of evaluating its global telehealth policy to determine what temporary flexibilities should be extended beyond the COVID-19 pandemic.”
CA TELEHEALTH POLICY COALITION

- Established in 2011
- A project of CCHP
- 100 State & National Organizations as members
- Wide variety of state organizations participate
- Valued resource of educational materials
- Informational webinars and legislative briefings
COALITION RECOMMENDATIONS FOR 2021

For California, necessary policy changes for 2021 include:

● Continue to require payment for the use of telephone to deliver services, including for FQHCs and RHCs.
● Continue to allow FQHCs and RHCs to provide services to their patients in the home.
● Expand payment parity for telehealth-delivered services to Medi-Cal Managed Care.
● Require reimbursement of remote patient monitoring and e-consult in Medi-Cal, including for FQHCs and RHCs.
● Allow FQHCs and RHCs to establish a patient-provider relationship via telehealth.
● Create more provider education materials on how to bill for telehealth.
● Generate more patient education on the availability of telehealth and how to access it.
● Update outdated forms that don’t allow billing for telehealth.

California has the opportunity to learn from COVID-19 so that when our next major emergency occurs, the state and its providers are prepared to use telehealth to meet Californians’ needs.
CCHP Website – cchpca.org

- Telehealth Federal Policies -
  https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies

- State Emergency Waivers/Guidance -
  https://www.cchpca.org/resources/covid-19-related-state-actions

- Subscribe to the CCHP newsletter at cchpca.org/contact/subscribe
Thank You!

www.cchpca.org
info@cchpca.org
Telehealth in Community Health Centers

Laura M. Miller, MD
CMO – CHCN
October 22, 2020
Who we are

8 Community Health Centers

95+ Sites

270,385 Patients

1,243,914 Visits

Coverage Source

- Medi-Cal 67%
- Uninsured 17%
- Medicare 8%
- Amer./public/Child 4%
- Private - 3%

Patient Race & Ethnicity

- Latinx 40%
- African American 16%
- Asian 24%
- White 11%
- Unreported - 3%
- More than 1 race - 2%
- American Indian/Alaska Native - 1%
Current State

- Rapid pivot in March 2020
- Faster than our specialty network

Visit Count By Week for Vendor: CHCN, Clinic: All, Specialty: All
Date Updated: 10/19/2020 4:50:50 AM

Grey – non TH
Green – TH
Yellow – TH BH
Purple – TH FQ
Red – TH other
Pink – TH transmittal
Specialty Network Telehealth Adoption

Visit Count By Week for Vendor: Non CHCN, Clinic: All, Specialty: All

Date Updated: 10/19/2020 4:50:50 AM
Technology and Practices

• Multiple modalities
• Audio only
  – Doximity dialer
  – Clinic-purchased i-phones
• Video
  – Doximity dialer
  – Zoom via OCHIN EPIC My Chart
  – Face-time via clinic-purchased i-phones
Use of Telehealth

• Primary care visit numbers are only slightly lower than prior to Shelter-in-Place
• In September, 61% of visits were via telehealth
• In a study done by LifeLong Medical Care, 81% of respondents were satisfied with telehealth, and 40% of those were over 65 years old
• Much reduced no-shows for primary care and behavioral health
Barriers

• Comfort with technology
• Access to stable Wi-fi
• Access to devices
• Non-English speakers
  – Challenges with 3-way calls for translation in both video and audio visits
• Lack of privacy in the home
  – May make behavioral health and inter-personal violence harder to approach
Key Action Steps

• Optimize connected devices – BP control is a glaring example of need
• Make FaceTime HIPAA compliant
• Integrate devices in to the EHR
• Simplify access to Zoom for MyChart
• Continue to reimburse visits in the FQHC setting
• Erase the digital divide
Key Action Steps regards Structural Barriers

• Telehealth can reduce disparities in access by minimizing the economic burden of taking time off work

• Transportation is a structural barrier that is mitigated by use of telehealth
Telehealth Promotion Project
CETF Presentation
October 2020
Tory Starr, Chief Executive Officer
Daily Visits – 2018 thru Oct 21-2020

All Services - Daily Visits by Type - Daily Average of Weekday Visits

- **2018**
- **2019**
- **2020**

- Decision to move to Telehealth

- **70% Virtual**
- **30% Onsite**

*Included encounters have an end of day appointment status of arrived or completed or are posted in billing. Unappointed encounters are excluded until posted in billing, so there is a lag.

*Reference lines display the average weekday visit counts for the respective month.

*Telehealth includes encounters that have either a Telehealth appointment type, encounter type or program code attached.

*Telehealth Video & Phone are distinguished using the appointment type and/or the encounter reason codes. Telehealth encounters without these reason codes are included as Telehealth Unspecified.
Video Care Values Statement

Open Door Community Health Centers removes barriers, improves access, and creates lasting and transformative change to the way we provide healthcare by equipping patients and staff with what they need for a high quality video visit experience.
**All Service Lines - Daily Visits by Type**

**Visit Types**
- Telehealth (Phone)
- Telehealth (Video)
- Telehealth (Unspecified)
- In-Person Visits

**Date / Weekday Abbrev**
- 09/13/20
- 09/14/20
- 09/15/20
- 09/16/20
- 09/17/20
- 09/18/20
- 09/19/20
- 09/20/20
- 09/21/20
- 09/22/20
- 09/23/20
- 09/24/20
- 09/25/20
- 09/26/20
- 09/27/20
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- 10/08/20
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- 10/10/20
- 10/11/20
- 10/12/20
- 10/13/20
- 10/14/20
- 10/15/20
- 10/16/20

**Visits**
- Sun
- Mon
- Tue
- Wed
- Thu
- Fri
- Sat

**Visit Types and Percentages**
- Telehealth (Phone)
- Telehealth (Video)
- Telehealth (Unspecified)
- In-Person Visits

**Included encounters have an end of day appointment status of arrived or completed or are posted in billing. Un-appointed encounters are excluded until posted in billing, so there is a lag.**

**Telehealth includes encounters that have either a Telehealth appointment type, encounter type or program code attached.**

**Telehealth Video & Phone are distinguished using the appointment type and/or the encounter reason codes. Telehealth encounters without these reason codes are included as Telehealth Unspecified.**

**Percentages in gray outside of colored bars display daily total visits as percentage of prior year moving average weekday visits.**
Goal: By October 31st, 50% of all virtual medical visits will be done by video.
Staff Resource Development

Video Care Resources

- Video Care 101
- Video Care Workflows
- Patient Resources

Family Practice Virtual Visit Types

- Primary Care Virtual Visit (878) — Any Video or Telephone Visit where the Staff can send a Zoom, DOXY, or other Platform invite for a virtual visit. This is for visits that would normally be scheduled in a Family Practice department, including Case Management, Latino Health Coordinators, Nursing, or other Non-Billable visits.

- MyChart Virtual Visit (973) — Any Video Visit where the patient has an active MyChart account and can self-check-in and launch the Video Visit from MyChart. This is for visits that would normally be scheduled in a Family Practice department, including Case Management, Latino Health Coordinators, Nursing, or other Non-Billable visits.

Behavioral Health Virtual Visit Types

- BM Virtual (977) — Any Video or Telephone Visits where the staff can send a Zoom, DOXY, or other Platform for a virtual visit. This visit type is to be used in the Mental Health Departments only for behavioral health providers.

- MyChart BM/MIH Grp Virtual Visit (951) — Any created Virtual Group meeting that has many participants and a facilitator or two that is part of the Mental Health Departments. Patients can self-check-in and launch Zoom or a facilitator can send a Zoom invite via text or email.

Dental Virtual Visit Types

- Dental Virtual Visit (961) — Any Video or Telephone Visit where the staff can send a Zoom, DOXY, or other platform invite for a virtual visit. This visit type is only for the Dental Department.

- MyChart Dental Virtual Visit (937) — Any Video Visit where the patient has an active MyChart account and can self-check-in and launch the Video Visit from MyChart. This visit type is only to be used in the Dental Department for behavioral health providers.

Telemedicine Visit Types

- Telemedicine (1) [121] — Any visit where a patient comes into the clinic for an appointment and a staff member connects the patient to another provider or specialist via Zoom, DOXY, or other video.

Virtual Visits [946] — Not currently being used

Open Door Community Health Centers provides quality medical, dental and mental health care and health education to all, regardless of financial, geographic, or social barriers.
Patient Resource Development

Video Care at Open Door Community Health Centers

Glossary of Terms

**Video Care for Patients**

*Video Care* is how Open Door Community Health Centers refers to care delivered using a video conferencing platform like MyChart Zoom. **Video Care** is available for primary, dental, behavioral, non-billable, and specialty visits.

Other Common Terms

There are many other terms used to describe care delivered remotely (not in person), including:

- Telehealth – refers broadly to all electronic and phone services used to provide care at a distance. It can include communication between patient and provider, or consultation between providers.
- Remote Patient Monitoring – when patient data is collected and sent electronically to a provider (think blood pressure results).
- Mobile Health – when patient data is collected using a mobile wearable device or smartphone app and sent electronically to a provider.

Source: [https://cakubhcare.com/blog/the-different-types-of-telehealth/](https://cakubhcare.com/blog/the-different-types-of-telehealth/)
Patient Video Support

During Phase 1 Telemedicine & EMR teams helped track data:

Ave time helping a patient onboard to video care:
• 5-10 min for patients with medium confidence with technology
• 20+ min for patients with low confidence with technology

Next Steps:
• Build capacity at all levels to support patients with video support.
• Build capacity within the EMR Team for enhanced patient & staff video care support.
# Staff Training

<table>
<thead>
<tr>
<th>Training Name</th>
<th>Learning Objectives</th>
<th>Target Audience</th>
<th>Length of Training</th>
<th>Resources Needed</th>
<th>Trainers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Solving/ Troubleshooting</td>
<td>How to get patients connected to different platforms &amp; workflow overview.</td>
<td>Front office/ Back Office</td>
<td>~1 hr./ lunch</td>
<td>Zoom, computers</td>
<td>Jessica Clower primary Training Team back up</td>
</tr>
<tr>
<td>Workflow Training</td>
<td>Step-by-step training of the EMR video visit workflow.</td>
<td>Front office/ Back Office</td>
<td>~1 hr./ lunch</td>
<td>Zoom, computers, EMR prep</td>
<td>Training team primary Breezy back up</td>
</tr>
<tr>
<td>Video Visit Best Practices</td>
<td>Customer care training to help staff feel confident in their video care role.</td>
<td>Front office/ Back Office</td>
<td>~1 hr./ lunch</td>
<td>Zoom, computers</td>
<td>Resolution Care</td>
</tr>
<tr>
<td>Provider Resolution Care Training</td>
<td>Basic etiquette and best practices for providers regarding Video Visits. CME attached.</td>
<td>All providers</td>
<td>~1 hr./ lunch</td>
<td>Zoom, computers</td>
<td>Dr. Fratkin Resolution Care</td>
</tr>
<tr>
<td>Provider Workflow Training</td>
<td>Step-by-step detailed training and troubleshooting EMR for video visits.</td>
<td>Providers with low % of video visits</td>
<td>~1 hr./ lunch</td>
<td>Zoom, computers, EMR prep</td>
<td>Alisa Panel of experienced providers-TBD</td>
</tr>
</tbody>
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## Which Providers are Struggling?

<table>
<thead>
<tr>
<th>Department</th>
<th>Prov Name</th>
<th>Visit Types</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Telehealth (Phone)</td>
<td>Telehealth (Unspecified)</td>
</tr>
<tr>
<td>OD EHC FP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOORE, GEORGE</td>
<td>50.96%</td>
<td>42.04%</td>
<td>100.00%</td>
</tr>
<tr>
<td>WEST, CHRISTOPHER</td>
<td>47.39%</td>
<td>24.82%</td>
<td>29.10%</td>
</tr>
<tr>
<td>RICE, ASHLEY</td>
<td>49.05%</td>
<td>24.03%</td>
<td>27.92%</td>
</tr>
<tr>
<td>CARTER, PATRICIA</td>
<td>47.90%</td>
<td>7.01%</td>
<td>42.75%</td>
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<tr>
<td>ALFANO, ANGELO</td>
<td>62.61%</td>
<td>10.43%</td>
<td>26.96%</td>
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## How Many Patients Need Video Care?

<table>
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<tr>
<th>PDSA Cycle No.</th>
<th>What is the barrier or challenge?</th>
<th>Description of test</th>
<th>What do you predict will happen?</th>
<th>How will you measure if your test made an improvement?</th>
<th>Date(s) of test</th>
<th>Where?</th>
<th>Who?</th>
<th>How?</th>
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<tbody>
<tr>
<td>1</td>
<td>Gap in understanding re: how many patients need assistance with getting onto video care</td>
<td>Collect data on patient confidence with technology</td>
<td>50% of patients asked will score low-medium confidence with technology</td>
<td>* % of patients by site across the organization for each category of confidence: 5=I am very confident with video calls, such as Zoom, Facetime, or Skype, and I use it all the time. 4=Mostly confident, I have done video calls quite a few times. 3=I have done a video call once or twice. 2=I have never done a video call. 1=I don’t even know what you are talking about.</td>
<td>10/12-10/16</td>
<td>All Open Door sites</td>
<td>Sarah Kerr and Sarah Ross will work with Site Administrators to have front desk staff ask this question of all patients scheduling a video call appointment (VAV). Front desk staff will ask patient their level of confidence with video calls and document the patients confidence level in the appointment note. Example: VAV Conf # (1)</td>
<td>Tammy and the EMR Operations Team will review appointment notes and document confidence level. Confidence level data will be saved in S://MEETINGS/Video Care/ Data Collection for Patient Video Support</td>
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</table>
The Future
Thank You!
Telemedicine in Long-Term Care: What has COVID-19 taught us?

Karl Steinberg, MD, CMD, HMDC, HEC-C
President-Elect, AMDA
Past President, CALTCM
Email: karlsteinberg@MAIL.com  Twitter: @karlsteinberg
Telemedicine in SNFs

• Historically, strict criteria had to be met for telemedicine visits to be covered
  • Limited to one visit every 30 days
  • Defeats the purpose of medical necessity, or follow-up after a change of condition
• Federal waivers during the pandemic have greatly relaxed the ability to perform (and bill for) virtual visits, and HIPAA
• Proposed rule indicates one telehealth visit in NF/SNF once every three days
  • Multiple professional societies requesting no specific limit, just medical necessity
• Avoiding unnecessary ED visits and hospitalization/rehospitalization is a key goal
Telemedicine in SNFs

• Telemedicine, virtual visits, can be very effective
  • For providing medical care and advance care planning
  • Ability to loop in family members who may be in a remote location, great for family meetings

• Some of the waivers may be made permanent
  • Initial comprehensive visits allowed by telemedicine
  • Advanced practice practitioners doing initial comprehensive visits
  • Concern about possible abuse/overuse of these visits, where clearly they are not the same as an in-person visit

• These visits do require staff time. That must be calculated into any programs.

• Who should be on the provider side?
  • “Talk 9” proposed an ED physician remotely, with an EMT onsite
  • Experienced geriatricians/post-acute and long-term care clinicians might be a better option, with a nursing home nurse onsite
Telemedicine in Assisted Living

• There are lots of medically ill and complex patients residing in AL
• It’s increasingly difficult for the industry to cling to the “we’re not medical” mantra
• There is a need for medical supervision in these settings
  • **Telemedicine** can fulfill at least some of this need
  • Unnecessary emergency department utilization would be appreciated by all – Title 22 makes it difficult to avoid without a medical evaluation
  • How does a six-bed get medical supervision? Who pays for it?
  • Inappropriate use of hospice occurs, reasons multifactorial—how can AL residents get palliative care when they are either philosophically or prognostically not eligible for hospice? Telemedicine!
What Have We Learned in Hospice & Palliative Care?

• Virtual visits can be surprisingly effective – including family conferences
• In the pandemic, patients can crash too fast for hospice to get adequately involved
• Continued workforce shortage of specialty palliative care
• Telehealth solutions can improve efficacy for specialists—especially in community private home settings and in small residential homes
Thank You
TELEHEALTH FACT-FINDING LISTENING CONFERENCE

Paula Hertel, MSW
Senior Living Consult – Lead Consultant
California Assisted Living Association (CALA) Board Member,
Co-Chair of the Education Committee
Licensed Residential Care Facilities for the Elderly (RCFEs) include a diverse group of communities and operators with a wide range of approaches, amenities and care options.

There are 7,361 RCFEs in California

- 6,123 of these RCFEs have six or fewer beds
- CALA has 671 provider members with over 85,000 licensed capacity
  - 620 – Assisted Living and Memory Care
  - 51 CCRCs
We do not have comprehensive data on how many communities are using telehealth in California.

- The COVID-19 pandemic has necessitated telehealth in many communities and for many clinicians. (The reimbursement changes helped drive this shift)
- We do see an uptick in larger communities utilizing sensors and technology analytics to help identify early warning signs (e.g. changes in sleep, mobility, continence, falls, elopements)
EMERGING USES

Emerging Uses
- Telehealth Tablets and Robot QI in COVID-19 Isolation Units
- Remote Assessments and Screening
- Care Coordination Applications
- Lighthouse for Older Adults Project
- Telehealth Start-ups and Collaboration

Areas for Further Exploration
1. **Assessments** - Offsite remote assessment, especially with new residents and residents returning from higher levels of care
2. **Emergency /Specialty Intervention** - Need for clinical interventions relating to high risk negative outcomes – falls, negative/harmful behaviors, medications. Emergency Room visits are often traumatic to residents.
3. **Primary Care Oversight for Memory Care Residents** – medical appointments for residents living in memory care can be difficult to coordinate
4. **Chronic Physical and Mental Health Needs** - Easier access for residents with high acuity physical and cognitive needs, support complex care coordination.
BARRIERS AND OPPORTUNITIES

Barriers

- Risk and Regulatory Restraints (e.g. 87465)
- Different Payer Platforms and Internal Processes
- RCFE Staffing Resources and Training
- Connectivity in the Residential Community (access and costs)
- Confidentially and Privacy Protocols
- Older Adult Adoption of Telemedicine
- How to Address Multi-System Chronic and Acute Symptoms

Opportunities to Solve Challenges

- Address Ongoing COVID-19 Issues
- Increased Access to Geriatricians and Specialist Care
- Immediate/Timely Access to Health Care Services and Interventions
- Better Assessment and Onsite Interventions for Poor Reporters, Especially Residents with Dementia
- Ongoing Monitoring of Physical and Cognitive Changes in Condition
- Increased Involvement and Care Coordination among Resident, Family and Clinical Team
- Collaboration with ALW and Managed Care
- Utilize Professionals’ Full Scope of Practice
Since she was elected, Assemblymember Aguiar-Curry has authored and supported several ground-breaking policies to expand the access and use of telehealth technology and improve the health outcomes of millions of Californians. These policies include: AB 744 which creates telehealth parity by requiring that a health plan or insurer must reimburse a healthcare provider for services delivered to an enrollee through telehealth, if those same services are covered when in-person. In addition to AB 1494 that ensures during a declared state of emergency our community clinics can be reimbursed for telehealth provided to Medi-Cal patients in the aftermath of a disaster, and AB 401, which she authored in her first year as a legislator, authorizing the first-ever use of telepharmacy technology in medically underserved areas of California, where there is no pharmacist within ten miles or more.

This year, Aguiar-Curry worked to expand telehealth services eligible for equal reimbursement to in-person health services and to make permanent the telehealth services subject to federal waivers. When those federal waivers expire as the pandemic winds down, Assemblymember Aguiar-Curry noted that we must be prepared with State law to continue telehealth parity.

Equity in the use of telemedicine requires critical investments in our state’s broadband infrastructure, particularly in our hardest to reach areas, that have been left behind for too long. This year, in partnership with the California Emerging Technology Fund and our widespread coalition of support, the Assemblymember authored AB 570 that would have provided the necessary funding and safeguards for our most vulnerable communities, critical to fully realizing the innovative capacity of telemedicine.

This upcoming session, Assemblymember Aguiar-Curry in partnership with CETF is reintroducing broadband legislation that will provide the necessary funding and bonding capacity to pave the way for statewide investment in future-proof infrastructure and high-speed internet access for all. Together, we can expand broadband access in our most unserved, high-poverty communities, equip small businesses with the connectivity they need to survive, and truly achieve Internet For All.