TELEHEALTH TASK FORCE (TTF) MEETING AGENDA

Virtual Meeting Information - Join Zoom Meeting
https://jubengineers.zoom.us/j/95871643230?pwd=SWRxRWRISVo1OUY3Z3BsUzN3dE1Jdz09
Meeting ID: 958 7164 3230 Password: Telehealth
Phone audio 12532158782# or 195871643230# (US) Meeting ID: 958 7164 3230#

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Wednesday, June 24, 2020, 9:00 AM-12 NOON MST

TIME	AGENDA ITEM	*OBJECTIVE*
9:00 a.m.	**Welcome & Introductions – Craig Belcher, Co-Chair** ☐ Welcome, Introductions, Roll Call, ☐ Action Item: Approval of Minutes of May 27, 2020 Task Force Meeting	*Meeting Overview*
9:20 a.m.	**Subject Matter Expert Presentation –** Dr. Scott Dunn, Sandpoint Family Medical Center	*10-minute presentation* *10-minute Q & A*
9:40 a.m.	**Subject Matter Presentation -** Kerry Palakanis, DNP, APRN, Executive Director Connect Care Operations Valley Center Tower, Intermountain Healthcare	*10-minute presentation* *10-minute Q & A*
10:00 a.m.	**Subject Matter Expert Presentation –** Dr. Christian Zimmerman, MD FAANS, FACS, MBA, FRSM MS - Spinal Neurosurgeon, Saint Alphonsus Health System	*10-minute presentation* *10-minute Q & A*
10:20 a.m.	**Break**	
10:30 a.m.	**Subject Matter Expert Presentation –** Anne Lawler, Executive Director, Idaho Board of Medicine	*10-minutes* *10-minute presentation* *10-minute Q & A*
10:50 a.m.	**Subject Matter Expert Presentation –**Kimberly Beauchesne, Telehealth Director, CHAS-FQHC	*10-minute presentation* *10-minute Q & A*
11:10 a.m.	**Subject Matter Expert Presentation –** Dr. Kelly McGrath is a family medicine doctor in Orofino and is affiliated with St. Mary's Hospital-Cottonwood and Clearwater Valley Hospital and Clinics.	*10-minute presentation* *10-minute Q & A*

TIME	AGENDA ITEM	*OBJECTIVE*
11:30 a.m.	**Identify Action Items, Matters for Follow-up and Next Steps – Krista Stadler, Co-Chair**	
12:00 noon	**ADJOURN**	

TeleT

Telehealth Task Force

June 24, 2020 On Line Meeting
9:00 a.m. Mountain Time

Action Items:

Action Item 1 – May Telehealth Task Force (TTF) Meeting Minutes

TTF members will be asked to adopt the minutes from the May 27, 2020 TTF meeting.

Motion: I, _____move to accept the minutes of the May 27, 2020 meeting of the Telehealth Task Force as presented.

Second: _____

TeleT

Telehealth Task Force

May 27, 2020 at 9:00 am **Location: Virtual Meeting Via Zoom**

Meeting Minutes:

Member Attendees: Craig Belcher, Paul Coleman, Aleasha Eberly, Eric Forsch, Eric Foster, Jenni Gudapati, Chad Holt, Rick Naerebout, Susie Pouliot, Krista Stadler

Ex Officio Members: David Bell

Members Excused:

Members Absent: Doug Fry, Patrick Nauman

Guests on Phone: There were 38 guests in attendance.

DHW Staff: Mary Sheridan, Ann Watkins, Stephanie Sayegh, Matt Walker

Summary of Motions/Decisions:

Motion: **Outcome: Passed**

The minutes of the April 29, 2020 meeting of the Telehealth Task Force were accepted by unanimous consent of the Telehealth Task Force with corrections noted on the spelling of three names.

Agenda Topics:

Welcome and Opening Remarks; Roll Call; Introductions; and Agenda Review- *Jenni Gudapati, Co-Chair*

- Jenni Gudapati lead roll call, introductions, discussion of the charge of the task force and review of the agenda.

- Mary Sheridan explained DHW's policy regarding vendor neutrality, particularly as it relates to any subject matter experts that are invited to present at task force meetings.

Presentation by – *Dr. Brooke Fukuoka, Your Special Smiles Teledentistry Pilot Project*

Dr. Brooke Fukuoka shared a video that reviewed the recently implemented teledentistry pilot project she has overseen through Your Special Smiles, highlighting the opportunities and benefits associated with serving special needs clients through teledentistry, as well as the challenges that still need to be addressed to ensure the process can be adopted more broadly. Provider education and reimbursement policies were the two most prominent barriers identified by Dr. Fukuoka. COVID-19 has also presented additional challenges to delivery of services. This video can be viewed on the Your Special Smiles Facebook page: https://www.facebook.com/yourspecialsmiles/videos/688552478603811/

Questions included:

- Is this teledentistry practice limited by state licensure or available outside of Idaho?
    - Need Idaho license; rules requiring 75 mile proximity to patient may be changing
- Have you seen examples of a teledentistry practice partnering with clinics in rural areas? How do you ensure sanitation?
    - Yes, but the proximity to clients is still the primary concern. Sanitation processes are the same as if you were in a clinical setting; there is a significant amount of cleaning and use of plastic involved.

Presentation by – *Ann Mond Johnson, CEO, American Telemedicine Association*

Ann Mond Johnson shared the American Telemedicine Association's vision to drive adoption and normalization of telemedicine across the industry through education, outreach and advocacy efforts. Ann described the challenges associated with variation in cost and treatment of telemedicine across the country prior to COVID-19, as well as the issues of inadequate access to broadband. These telemedicine-specific challenges are compounded by a shortage of primary care physicians and the cost of healthcare. However, adaptations to delivery of services driven by COVID-19 have shown the immense opportunities and benefits to both patients and providers associated with telemedicine. Ann wrapped up her presentation by dispelling a number of myths associated with telemedicine.

Questions included:

- Do you have any policy recommendations for Idaho, which is currently limited to federal law Title 21 Section 802, Subsection 54, sub part (A).
    - Care should be given wherever people are. How care is delivered should be determined by the clinician and patient. In support of eliminating the originating site requirements.
- What are the primary access issues?
    - Both connectivity to broadband as well as availability of appropriate devices. While smart phones are widely available, data plans might be minimal.

Presentation by – *Matt Bell, Regional Vice President of Idaho, and Hilary Klarc, Director of Provider Network, PacificSource*

Matt Bell and Hilary Klarc provided an overview of PacificSource as a not-for-profit commercial payer before addressing a number of common misperceptions associated with the cost and reimbursement of telehealth. PacificSource provides reimbursement for telehealth services at parity with office visits, though the coding is slightly different in order to accurately track data tied to the use of telehealth. Hilary addressed the changes in use of telehealth services PacificSource is seeing due to COVID-19, which has shown a robust adoption of telehealth services across the region, though less so in Idaho. PacificSource is working to move the needle on the adoption of telehealth across the region through provider education and financial support for technology upgrades.

Questions included:

- Why does PacificSource so proactively reimburse at parity with office visits?
    - PacificSource sees itself as a population health company, and it was determined that telehealth provides easier, better care to many patients. Access to healthcare is the product that PacificSource is selling.
- What needs to be done to support alignment in reimbursement policies across the industry?
    - Companies that work across state lines have a variety of state requirements they must comply with. Streamlining these requirements would allow for more consistent payment standards.
- What telehealth policies will you maintain after the pandemic winds down?
    - Anything we can do to maintain and improve access to healthcare.
- What is one action the Task Force can address in the report to support conversations among payers?
    - Remove barriers that are universal to all payers.

Presentation by – *Julia Millard, Head of Partner Success, Bright MD*

Julia Millard provided an overview of Bright, MD's services, particularly during the current public health crisis. Through the pandemic, gaps in public health and capacity have been exposed, as well as impacts to business. Julia recommended implementation of value-based payment models, interoperable data, landscape-level management of health, and improvements in performance and reporting as strategies for addressing these gaps. Julia also proposed that policies need to favor all models of telehealth delivery, including synchronous and asynchronous services and automation of documentation. Julia also provided a use case of a New Mexico based healthcare system that had made tremendous strides in telehealth utilization and expansion.

Questions included:

- Is Bright, MD focused on value-based payment arrangements?
    - There is a range of scenarios that are currently supported.

Presentation by – *Dr. Sarai Ambert-Pompey, General Internal Medicine Physician, Department of Veterans Affairs*

Dr. Ambert-Pompey provided an overview of the multidisciplinary telehealth workplace learning curriculum that was implemented at the Boise VA through the Boise UW Internal Medicine and VA Nurse Practitioner Residency Program in 2019 – 2020. Based on this case study, Dr. Ambert-Pompey recommends that telehealth education be expanded to faculty, residents, and students (undergraduate and graduate level) so that it can be better integrated into outpatient practice in primary and specialty care.

DRAFT

State-level policies need to take into consideration undergraduate and graduate medical education to support the necessary learning opportunities to ensure proficiencies.

Questions included:

- Has telehealth impacted the number of face to face visits you conduct?
    - Because the VA is under federal jurisdiction, they are allowed to treat a patient clinic-to-clinic, so face to face is not needed to establish care.
- Do you currently provide in-home visits?
    - Not under this program; instead conduct quarterly site visits with clinic.

Presentation by – *Dave Hays, Health Program Specialist, Community Health Emergency Medical Services Program, DHW Bureau of EMS*

Dave Hays provided an overview of the Community Health EMS program and the opportunities to strengthen the vital services it provides through the implementation of telehealth. The benefit of the CHEMS model is that EMS/EMT providers are uniquely able to address health concerns before they become emergent by filling gaps in patient monitoring and check-ups. However, there continues to be difficulties in reimbursement of services. A value-based payment model would support reimbursement for improved health outcomes.

Questions included:

- Do CHEMS providers face the same challenges as community health workers?
    - EMTs know their communities well and are able to directly connect them to critical resources. Community Health Workers are often more focused on helping patients navigate the healthcare system.
- How do you address social determinants of health when you are in a patient's home?
    - Utilize a checklist; look for hazards and health and safety concerns.
- Currently there is no payment mechanism in Idaho for services such as the mobile triage unit. What should we do to improve this?
    - Begin working with Medicaid to develop a value-based reimbursement system.
- What are some examples of services a CHEMS provider can deliver?
    - A community paramedic can respond to a patient with a behavioral health crisis and facilitate transport to appropriate care.
    - Community EMTs can provide care and support in the management of chronic conditions.
    - EMS providers can support transitional care after a hospital discharge to prevent readmission.

Follow-up Items for Next Steps- *Krista Stadler, Co-Chair*

Krista Stadler led a discussion on the following key issues and questions to address further with the Task Force:

- Access to broadband in rural areas of the state.
    - Internet Service Providers are often present, but the cost of service is too high.
    - Grant dollars may be available to fund projects throughout the state.
- Modalities of care are siloed.
    - There is a wide variety of telehealth modalities.

DRAFT

    - Concerns with synchronous versus asynchronous services need to be addressed.
- Originating site restrictions need to be addressed through evaluation of current waivers.
- Navigation of payer policies and alignment.

The following action items were identified:

- Task Force to review waivers related to COVID-19 and develop recommendations on what should remain in place after the public health crisis ends.
- Additional data on the cost and quality of telehealth is needed. A request will be made to Ann Mond Johnson, CEO of the American Telemedicine Association for addition data.

Meeting Adjourned: 12:00 p.m. MST

Next Meeting: June 24, 2020 from 9 a.m. – 12 noon MST

DRAFT

BIO

Dr. Scott R. Dunn is a family medicine doctor in Sandpoint, Idaho and is affiliated with Bonner General Hospital. He has been practicing for 30 years. He graduated from Oregon Health Sciences University in 1990 and specializes in family medicine.

24 June 2020

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Scott Dunn MD
FAAFP

Telehealth Task Force Subject Matter Presentation

June 24, 2020

Family Health Center, Sandpoint, ID

Independent 5 FTE rural family medicine clinic
Traditional mix of fee for service payers
Patient catchment area reaches out 75 miles
Many patients are in border communities

Executive Summary of our Case Study – Top 10

10. Be open minded
9. Don't stereotype older patients
8. Work telehealth into routine daily flow
7. Be careful of state boundaries
6. Low overhead to start
5. Prepare one administrative super user
4. Personally invite. Use familiar words "video visit"
3. Understand niche role
2. Reach patients where they are
1. Be patient. Expect hesitancy.

Magic Wand Scenario (If you could waive a magic wand to develop an ideal scenario to expand utilization of telehealth in Idaho, what would you do?):

By far the biggest barrier is payment. Patients have the expectation that the premium they pay should cover all health related expenses and are resitant to pay cash outside of their known copay if they can get the same service at lower cost in person. Site neutral payment parity is needed before there will be widespread adoption by patients. During the PHE, parity is mandated, but uncertainty after the PHE

Magic Wand Scenario (If you could waive a magic wand to develop an ideal scenario to expand utilization of telehealth in Idaho, what would you do?):

Payment parity such that equivalent medical services (evaluation and management, counseling, preventive) are reimbursed by all Idaho payers at the same level regardless of patient site of service. Lacking payer willingness to adopt this care delivery option as a equivalent choice for patients, it will take legislative action to mandate payment parity (after the PHE). Medicaid is the notable exception to this and has embraced enhanced patient access through telehealth.

Summary Conclusion:

Telehealth is ready for primetime in Idaho (as we are seeing)

Patients that try it – LOVE IT!

Primary care can easily adopt this into routine daily work

Low tech, Low overhead option are readily available

In the future, telehealth will be a complimentary and convenient access option for all patients regardless of where they live IF payers embrace it.

Contact Information:

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BIO

Kerry Palakanis, PhD, is the Executive Director of Connect Care at Intermountain Healthcare in Utah where she heads up the direct to consumer telehealth product lines. She is a Family Nurse Practitioner who has worked for over 28 years in family practice specializing in rural health and telemedicine.

She has served as a featured speaker at State and National programs on issues related to rural health care delivery and telemedicine, provided testimony to state and federal legislature on telemedicine bills, piloted remote patient monitoring grant program, consulted in the development of a national chronic disease management and collaborates with various companies to develop programs to provide connectivity and telehealth solutions.

24 June 2020

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Kerry Palakanis, DNP, FNP-C

Telehealth Task Force Subject Matter Presentation

06/24/2020

Intermountain Healthcare.

About Us

Intermountain Scope & Stewardship

>200 Clinics (UT / NV)

9 States, **40+** sites

23 Hospitals
+1 Virtual Hospital

39,800 Caregivers
(includes Nevada)

900,000+
SelectHealth Members

$350M
Financial Assistance

30+ Acute Care
Services

> 1 million telehealth
Interactions

10 Out-Patient /
DTC Services

Intermountain's Virtual Services and Programs

Telehealth Programs

Critical Care
Crisis Care
Infectious Disease
Oncology
Hospitalists
Neonatal Resuscitation
Stroke
Neuro Critical Care
Emergency Department
Connect Care Urgent Care
Remote Patient Monitoring
Virtual Primary Care
Virtual Behavioral Health

Service Lines

Critical Care
Crisis Care
Infectious Disease
Oncology
Hospitalists
Stroke
Sleep Medicine
Speech Therapy
Wound Care
Pediatric Services:
Cranio-facial clinic
Hospitalist
ICU
Neurology
Nutrition
Spina Bifida
Trauma
Urology
Wound Care

Telehealth: Life After Covid?

The President will most likely go first, announcing the end of the national health emergency under the Stafford Act. This action would remove all enhanced Section 1135 waiver authority from HHS, but would leave HHS with its normal public health emergency (PHE) powers.

HHS is likely to let its current PHE expire on July 25, 2020 (90 days from its last renewal). This would be the deadline for most of the telehealth flexibility and other Congressionally – approved (CARES Act) flexibility that was tied to the PHE in statute.

It is unclear how independent HHS authorities, such as notices of enforcement discretion – that do not rely upon a specific emergency power – would be unwound. It is likely that HHS would chose to end them with PHE, but it could chose to end them at any time.

Magic Wand Scenario (If you could waive a magic wand to develop an ideal scenario to expand utilization of telehealth in Idaho, what would you do?):

1) Make all federal COVID19 waivers permanent
2) Create a national provider licensing program
3) Create a national DEA license
4) Mandate Parity

Magic Wand Scenario (If you could waive a magic wand to develop an ideal scenario to expand utilization of telehealth in Idaho, what would you do?):

5) Eliminate the term "originating site"
6) Cover remote patient monitoring
7) Include asynchronous care coverage
8) Include store and forward coverage
8)Avoid further pilots/

Questions

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SIRONA strategies

Analysis of Key Selected Blanket Waivers Under Section 1135

	Selected Waivers
Waiver Will Likely Remain in Place Until Termination of the PHE	**Flexibilities for Medicare Telehealth Services** Eligible Practitioners. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. Audio-Only Telehealth for Certain Services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services.
Waiver Will Likely Terminate Upon Termination of National Emergency Under Stafford Act	**Hospitals, Psychiatric Hospitals, and CAHs, including Cancer Centers and LTCHs** Emergency Medical Treatment & Labor Act. This waiver allows hospitals, psychiatric hospitals and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. Verbal Orders; Conditions of Participation. CMS waived Conditions of Participation requirements to provide additional flexibility related to verbal orders where read-back verification is required, but authentication may occur later than 48 hours. Reporting Requirements; Conditions of Participation. CMS waived rules that required hospitals to report patients in an ICU whose death is caused by their disease, but who required soft wrist restraints to prevent pulling tubes/IVs, no later than the close of business on the next business day. Patient Rights. CMS waived the following requirements for hospitals considered to be impacted by a widespread COVID-19 outbreak: • Timeframes in providing a copy of a medical record. • Related to patient visitation, including the requirement to have written policies and procedures on visitation of patients who are in COVID-19 isolation and quarantine processes. • Regarding seclusion.

	Selected Waivers
	Sterile Compounding. CMS allowed face masks to be removed and retained in the compounding area to be re-donned and reused during the same work shift in the compounding area only. Detailed Information Sharing for Discharge Planning for Hospitals and CAHs. CMS waived the requirement to provide certain detailed information regarding discharge planning, specifically the requirement to assist patients, their families, and their representatives in selecting a post-acute care provider by using and sharing data on facility-specific quality measures and resource use measures. Limited Detailed Discharge Planning for Hospitals. CMS waived certain requirements related to information sharing about post-acute care services such as a including in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient. Medical Staff. CMS allowed physicians whose privileges will expire to continue practicing at the hospital and for new physicians to be able to practice before full medical staff/governing body review and approval. Medical Records. CMS allowed flexibility in completion of medical records within 30 days following discharge from a hospital. Physical Environment. CMS waived certain physical environment requirements to allow for increased flexibilities for surge capacity and patient quarantine at hospitals, psychiatric hospitals and CAHs as a result of COVID. CMS permitted facility and non-facility space that is not normally used for patient care to be utilized for patient care or quarantine under certain circumstances. Telemedicine. CMS waived requirements to make it easier for CAHs to furnish telemedicine services to their patients through an agreement with an off-site hospital. Physician Services. CMS waived requirements requiring Medicare patients to be under the care of a physician. Utilization Review. CMS waived utilization review condition of participation, which requires that a hospital have a UR plan with a UR committee that providers a review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided.

	Selected Waivers
	Written Policies and Procedures for Appraisal of Emergencies at Off Campus Hospital Departments. CMS waived written policies and procedures for staff to use when evaluating emergencies at off campus hospital departments for surge facilities only. Emergency Preparedness Policies and Procedures. CMS waived requirements that hospitals and CAHs develop and implement emergency preparedness policies and procedures. Quality Assessment and Performance Improvement Program. CMS waived hospitals' Quality Assurance & Performance Improvement (QAPI) program requirements in order to reduce regulatory burden. CMS is still requiring hospitals and CAHs to maintain an effective, ongoing, hospital-wide, data-driven QAPI program. Nursing Services. CMS waived requirements for nursing staff to develop and keep current a nursing care plan for each patient and waived requirements for hospitals to have policies and procedures in place establishing which outpatient departments are not required to have a registered nurse present. Temporary Expansion Locations. CMS is streamlining enrollment and certification processes to allow hospitals to establish and operate as part of the hospital at any location meeting the COPs and other requirements not waived. Responsibilities of Physicians in CAHs. CMS waived requirements for CAHs that a doctor of medicine or osteopathy be physically present for services provided in the CAH. The physician must be available through direct radio, telephone or electronic communication. **Comprehensive Care for Joint Replacement Model Waivers** CJR Model. CMS modified participant hospital deadlines to permit participant hospitals that owe repayment to CMS for PY 3 final reconciliation and PY 4 initial reconciliation 120 calendar days after the reconciliation report is issued to appeal. **Practitioner Locations** Out-of-State Practitioners. CMS waived requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state under specific circumstances.

	Selected Waivers
	Provider Enrollment Screening Requirements. CMS waived certain screening requirements, including criminal background checks associated with fingerprint-based criminal background checks and site visits (to the extent possible). **Medicare Appeals in FFS, MA, and Part D** Extended Timeline to File an Appeal. CMS is allowing MACs and QUICs in the FFS program (including MA and Part D plans) and MA and Part D IREs to allow extensions to file an appeal and waive requirements for timeliness for requests for additional information to adjudicate appeals.

BIO

Dr. Christian Zimmerman is a neurosurgeon practicing in Boise, Idaho and is affiliated with Saint Alphonsus Boise - Neurosurgery. Dr. Zimmerman attended medical school at the University of Maryland and then went on to complete his residency programs at Oregon Health & Science University and The University of Texas Medical Branch at Galveston. After completing his residency programs, Dr. Zimmerman went on to Saint Joseph's Hospital and Medical Center to complete a fellowship in neurosurgery.

24 June 2020

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IDAHO TELEHEALTH TASK FORCE

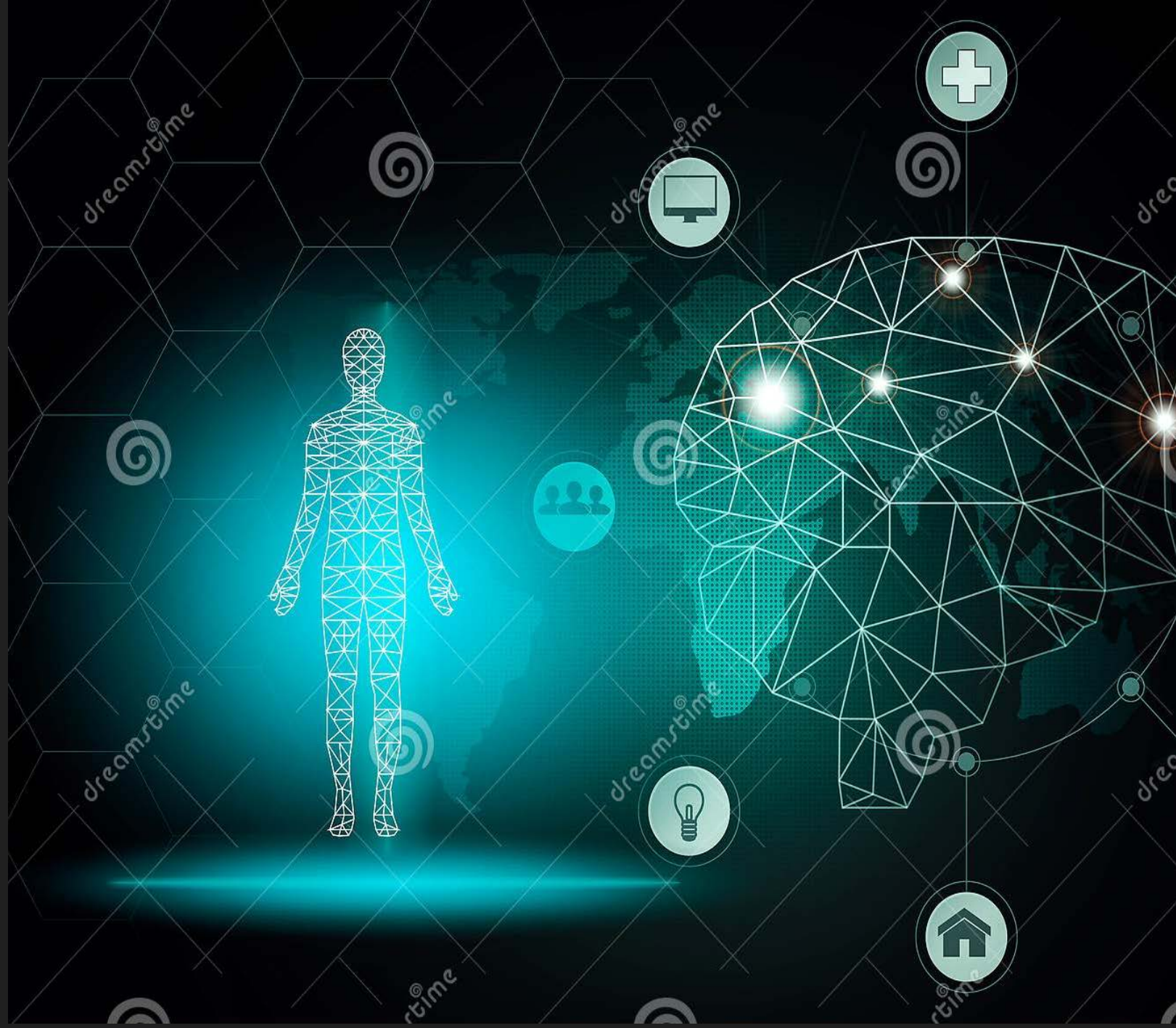
'TELEMEDICINE IN NEUROSURGERY.'

JUNE 24, 2020

CHRISTIAN G. ZIMMERMAN

M.D., FAANS, FACS, MBA, MS

SAINT ALPHONSUS HEALTH SYSTEM



Saint Alphonsus Neurological Institute Publications (1994 – 2019)

Brain	Spine	Stroke	PNS	Economics	Data	Sleep	Parkinson's	Telemedicine
74	60	24	2	22	12	44	17	**40**

Grants
Department of Defense, TATRC – Telemedicine and Advance Technology Research Center 2004

Publications

Seibert PS, Whitmore TA, Patterson CM, Otto CC, Ward MJ, Coblenz MB, Whitener N, Zimmerman CG. ***Exploring the Versatility of Telemedicine in Diverse Medical Arenas***. *Telemedicine in the 21st Century*, Nova Science Publications, 2008.

Seibert PS, Whitmore TA, Parker PD, Patterson CM, Otto CC, Basom J, Whitener, N., Zimmerman CG. Telemedicine research: ***Opportunities and challenges. Mobile telemedicine***: A computing and networking perspective. Edited by Dr. Yang Xiao and Dr. Hui Chen, published by Auerbach Publications, CRC Press 2008.

Seibert PS, Whitmore TA, Patterson CM, Parker PD, Otto CC, Basom J, Whitener N, Zimmerman CG. ***Telemedicine facilitates CHF home health care for those with systolic dysfunction***. In press: International Journal of Telemedicine and Applications.

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Pennie S. Seibert,[1, 2*] Tiffany A. Whitmore,[3] Carin Patterson,[1, 2] Patrick D. Parker,[1, 2] Caitlin Otto,[1,] Jean Basom,[4] Nichole Whitener,[1] and Christian G. Zimmerman[1, 5] ***Telemedicine Facilitates CHF Home Health Care for Those with Systolic Dysfunction***. [1]Idaho Neurological Institute, Saint Alphonsus Regional Medical Center, Boise, ID 83706, USA Oct 26, 2007

Seibert PS, Whitmore TA, Parker, PD, Payne, K, Grimsley FP, O'Donnell J.E. ***The Emerging Role of Telemedicine in Diagnosing and Treating Sleep Disorders***. Journal of Telemedicine & Telecare (2006); 12 379-381

Seibert PS, Whitmore TA, Patterson CM, Otto CC, Whitener N, Zimmerman, CG. Telemedicine technology: **Development of multiple applications for long-term program sustainability**. Submitted to: American Telemedicine Association, 13th Annual International Meeting & Trade Show; April 6-8 2008; Seattle WA.

Seibert PS, Whitmore TA, Patterson CM, Otto CC, Whitener N, Zimmerman, CG. **Providing accessible, standardized education for perioperative nurses.** Submitted to: American Telemedicine Association, 13th Annual International Meeting & Trade Show; April 6-8 2008; Seattle WA.

Zimmerman, CG., Seibert, P. **Neurosurgical Care Management Continuum: Technology as a Healthcare System Facilitator.** 2018 Annual Meeting, American Association of Neurological Surgeons, April 15, 2018, New Orleans, LA.

Neurosurgical Care Management Continuum: Technology as a Healthcare System Facilitator

Saint Alphonsus

Christian Zimmerman, Pennie Seibert*, Megan Hearn*.Cristina Zimmerman. Saint Alphonsus Neurological Institute, Boise State University*, Boise Idaho USA

Introduction

Ninety-five percent of adults over the age of 18 living in the industrialized world, own a mobile phone or personal digital device. Seventy-five percent of these adults own a smart phone, (Pew Research Center: Internet and Technology, 2017). This technological advantage can be applied to the surgical continuum of care especially in the post-operative phase. By facilitating patient awareness and decreasing postoperative visits, the formidable time saving device would bridge the healthcare gap of time and cost savings with better implementation. We propose the use of cell phone usage for post-op patient interactions especially the post-op setting.

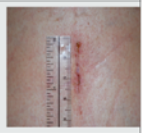
We proport the better use of mobile devices by healthcare adjuncts and patients as better method of neurosurgical surveillance especially in the immediate post-operative phase of follow-up and continuum.

Methods

- Multiple rural case studies utilized smart phone technology as a method to manage wound care and follow-up appointments. Since these patients resided in mountain communities and many miles from the operating facility, we present three cases utilizing available technology for review.

Transmitted Information Post Operative via Secure E-Mail

Telemedicine via Mobile Phone Use

Illustrative Case	First Post-op Visit	Telephone Conversations	Secondary Follow-up	Re-Evaluation
Patient X		Reproduceable Imagery from Primary Care Office	Usually in the office, unless in climate weather precludes follow up	
Patient Y		Post-op conditions discussed and supplemented with routine incisional photos following wound care. Telemedicine an active part of this rural patients experience.		
Patient Z		Secondary follow-up initiated and completed entirely through the use of telemedicine using mobile devices of both patient, patients family and the nursing staff within the clinic.		

Results

- The immediate and long term result of technological use in a neurosurgical practice is noted as a cost and time containment exercise for all provider/patients involved.
- There are HIPPA considerations and privacy concerns that adjoin to the use transmitted healthcare information, but adherence to non-social medium or use of secure avenues are the pathways to better communication.
- Our clinical experience, especially utilizing the mobile phone and its telemedicine capabilities was uniquely advantageous in the rural setting. Since the practice of complex spine had many concentric lines of referral, the ongoing delivery ofthe continuum of care was more readiy realized.

Conclusions

- Mobile Devices and Smart phones allow for an increased transmission of information between patient and neurosurgeon, prompting less in-person postoperative appointments, travel time and expense...

References

- https://www.ncbi.nlm.nih.gov/pubmed/24415916
- https://www.nuemd.com/news/2016/12/09/role-mobile-devices-healthcare

Zimmerman CG, Garabedian A, Fixx R, Malach M. ***Telemedicine Use in Neurosurgery***. 2020 Annual Meeting, American Association of Neurological Surgeons. April 25 – 29, 2020. Boston, Massachusetts

Telemedicine Use in Neurosurgery Patients

Christian Zimmerman, M.D., McKenzie Malach, Ariana Garabedian, Rikki Fix. Saint Alphonsus Neurological Institute, (SANI) 2020, Boise, Idaho 83704 (St. Alphonsus circa 1920)

Introduction

"Surgery was an early and highly adaptive user of clinical telemedicine as a method of transferring the highly visual nature of surgical events to other sites for collegial and educational consideration.

The addition of robotics in recent years further extends the scope of telemedicine into a broad range of surgical specialties.[1]

Healthcare providers can apply telehealth to surgical care in the following ways:

1. Conducting pre- and post-operative surgical consultations
2. Administering remote monitoring
3. Providing surgical education to patient and provider alike[2,3]
4. ***'Patient experience'*** as a front-runner metric, in both hospital reimbursement and grading, constantly redefines the methodologies of providers and adjunct personnel used to better serve patient populations."

Current Uses in Rural Patients

- Idaho covers 82,747 square miles, with a 2018 estimated population of 1,754,208 people – **572,101 living in rural Idaho** (USDA-ERS). Boise, the capital, is in the southwestern region of the state. The state's largest cities include Boise, Nampa, Meridian, and Idaho Falls.[4]
- SANI is a tertiary referral with a collective service patient populace of > 700,000 patients when eastern Oregon is included. In the complex spine clinic, twenty-five percent of patients seen for surgical consideration live in rural Idaho/Oregon

Rural Telehealth Services

https://intouchhealth.com/wp-content/uploads/2018/04/Saint_Alphonsus_Casestudy.png

Privacy Issues

- Location and privacy will be issue with 5G.
- FaceTime calls are protected by end-to-end encryption so that only the sender and receiver can access them. Apple cannot decrypt this data. Vulnerabilities existed through Face Palm Virus but was corrected with iOS updates. Because of most patient/provider interactions being HIPPA regulated, information and transference of that information remains confidential.

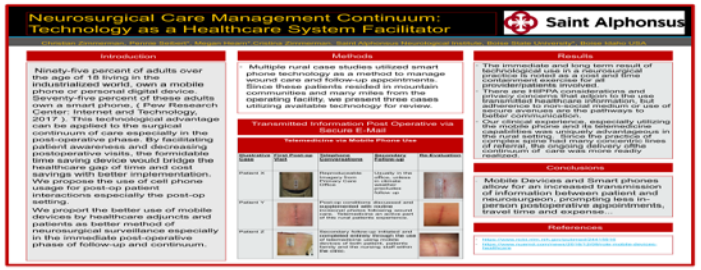
Literature Review

Author, Year	Study Design and Setting	Type of Surgery	Intervention	Result
Bednarski BK 2018	Prospective trial was conduc a single academic institution	Ileostomy	Videoconferencing for postoperative assessment of ileostomy output patients post-discharge assessment using iPad 2 tablets and FaceTime	Technology and telemedic enabled greater connectivi between patients and thei providers
Willard A 2018	Prospective cohort study design	Different pediatric surgeries	Video was used to visualize outpatient infants for follow-up post-surgery evaluation of wounds and medical equipment, such as nasogastric and gastrostomy tubes	Helped the team diagnose infection and evaluate pati sleep environment and foll readings on medical equip
Robaldo A 2010	Prospective study	Carotid endarterectomy procedures	Discharge with mobile-phone monitoring "electronic BP" and web-based videoconferencing, monitoring the patients every 4 h for 2 days	Telemedicine appeared fea and useful in carotid endarterectomy and may f other applications in vascu surgery care.
Segura-Sampedro JJ 2017	Prospective pilot study	Appendectomy	Telemedicine-based evaluation (images of the surgical wounds of cases obtained via their own mobile devices)	Feasibility of telemedicine follow-up of wounds after emergency surgery
Wood EW 2016	Retrospective study	Maxillofacial surgery	Telemedicine consultations to provide accurate diagnosis and treatment plans for patients undergoing surgical treatment with anesthesia	Telemedicine provided mo timely access from primary to specialist services, impr communication between providers, healthcare prov education, and increased effectiveness

Conclusions

- Minimizes Rural Travel especially during inclimate weather
- Significant decrease in absences and re-scheduling
- Reinforces patient engagement and appertainment
- Provides immediate informational transference
- Assurances about present and prospective care and outcomes are reiterated.
- Strengthens the patient experience and 'continuum' of care for highly complex patients wither geographically or morbidity challenged.

Previously Data



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2. https://evisit.com/specialties/surgery
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6195401
4. https://www.ruralhealthinfo.org/states/idaho
5. https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations

Current Reimbursement Codes and Reimbursements-2020

April 29th, 2020 CMS Final rule released;

- Payment for telephone calls increased. Retro to March 1, 2020
- Payment rate for RHC Telemedicine visit established at 92.00
- CMS clarifies to use current documentation guidelines and times, but only medical decision making can be used to calculate the overall code selection
- Guidance issued on how to bill facility claim-Q3014
- Guidance issued on how to bill for self pay patient for COVID 19 screening and testing

- New patient codes 99201-99203 can be used when a patient has not been seen in the past 3 years by anyone in the same group or specialty
- Taxonomy codes, tax id and group NPI numbers all determine claims (99441) adjudication on new patient codes
- APP providers have limited options for specialty taxonomy codes
- When a new patient code is not payable, a higher established patient code is in most cases eg- 99203 = 99214
- SASSI tax id dissolved July 2019 and all providers were moved to the SARMC

Summary Conclusion

'An escalator can never break, it can only become stairs.'

The interdependence of technology is ubiquitous.

Using it for patient convenience is a service and expediency.

Telehealth usage exploded during Covid-19

BIO

Anne Lawler, JD, RN, is the Executive Director of the Idaho Board of Medicine. The Board of Medicine has a staff of 15 employees in the three departments of licensure, discipline, and pre-litigation as well as an in-house attorney and three administrative professionals.

The Board has primary responsibility for licensure and regulation of physicians, physician assistants, athletic trainers, dietitians, and respiratory therapists. It is a self-governing agency operated with dedicated funds from licensure fees and their mission is to protect the health and safety of the public.

24 June 2020

TeleT
Telehealth Task Force

Telehealth Regulation
Anne Lawler, JD, RN,
Executive Director

Telehealth Task Force Subject Matter Presentation

June 24, 2020

Idaho State Board of Medicine

Idaho State Board of Medicine

Mission: To protect the public's health, safety, and welfare through licensure, discipline and education of physicians, physician assistants, dietitians, respiratory therapists, athletic trainers, and naturopathic medical doctors.

2020 Legislative Session Updates:

- H342a—Teledoc: Redefined definitions; changed the requirement for establishing the provider-patient relationship to synchronous two-way audio OR audio/visual communication→LAW
- H531—would have allowed MAT to be prescribed via telehealth. The bill passed the House but was held in Senate Committee based on concerns that more research needed to be performed.

Telehealth During COVID-19

- Idaho Code Section 54-1804(d) allows physician from another state or country with unrestricted license to practice in ID in response to a disaster
- While not required, BOM requested physicians to register with our office
- The Board has registered more than 1000 providers from out of state—mostly performing telehealth in Idaho

Telehealth During COVID-19

- Federal law waivers—HHS, CMS, DEA
- State law waivers (Telehealth Access Act)
  - I.C. Section 54-5703(4)—"Provider" defined
  - I.C. Section 54-5705—Provider/Pt relationship
  - I.C. Section 54-5707—Prescribing
  - I.C. Section 54-5712—Enforcement/Discipline

Telehealth After COVID-19

- Updating Telehealth Access Act to have appropriate reference to Ryan Haight Act.
- Currently 54-5707 states controlled substance Rx's must be compliant w/ 21 U.S.C. Section 802(54)(A)
- Need stakeholder to seek change in law to correct and expand this reference

What is the standard of care when practicing via Telehealth?

Idaho Code Section 54-1814(7): It is grounds for medical discipline for a physician or PA to provide health care that fails to meet the standard of care provided by other qualified physicians or PAs in the same community or similar communities.

How establish the standard of care for Telehealth practice?

- Research the community standard of care in the location of the patient.
- Can also use expert testimony, state, or national resources to establish a standard of care.

INTERSTATE MEDICAL LICENSURE COMPACT

- Established in October 2015
- April 2017: IMLC began issuing licenses
- Now 29 states + DC and Guam (pending in 6 more states)
- Over 7,600 licenses issued through the Compact to date
  - 634 Licenses issued by Idaho
- Brief process overview

Magic Wand Scenario (If you could waive a magic wand to develop an ideal scenario to expand utilization of telehealth in Idaho, what would you do?):

Ensure that physicians licensed in ID from other states follow the statute and rules and are truly seeking to improve the health of Idahoans and not merely to build a lucrative business.

How address? Educate, educate, educate on how to practice telehealth while following the statutes and rules!

SUMMARY CONCLUSION

- Follow the Statute and Rules, please educate others on the regulations, and use the Board as a resource.
- If you have questions about practicing telehealth or anything else related to medical regulation, please feel free to contact me or anyone at the Board of Medicine.

CONTACT INFORMATION:

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BIO

Kimberly Beauchesne is the Director of Telehealth for CHAS Health, a Federally Qualified Heathcare Clinic (FQHC) serving patients across eastern Washington and Northern Idaho. In that role, she leads the organization in strategically expanding telehealth to promote access, particularly in response to the COVID-19 Pandemic.

Previously, Kim worked at Saint Alphonsus as the project lead and Director for the telehealth team, supporting the completion and closure of two major federal grants and was responsible for transitioning the Telehealth program into a self-sustaining model that supports the strategic development of new sites and services. Kim is a graduate from the Masters of Heath Science Program with a Policy Emphasis at Boise State University.

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Kimberly Beauchesne
CHAS Director of Telehealth

Telehealth Task Force Subject Matter Presentation

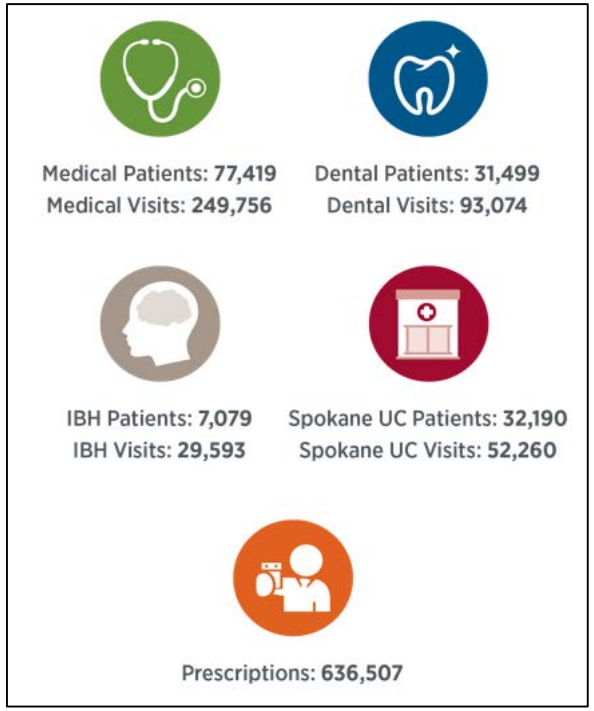
June 24th 2020

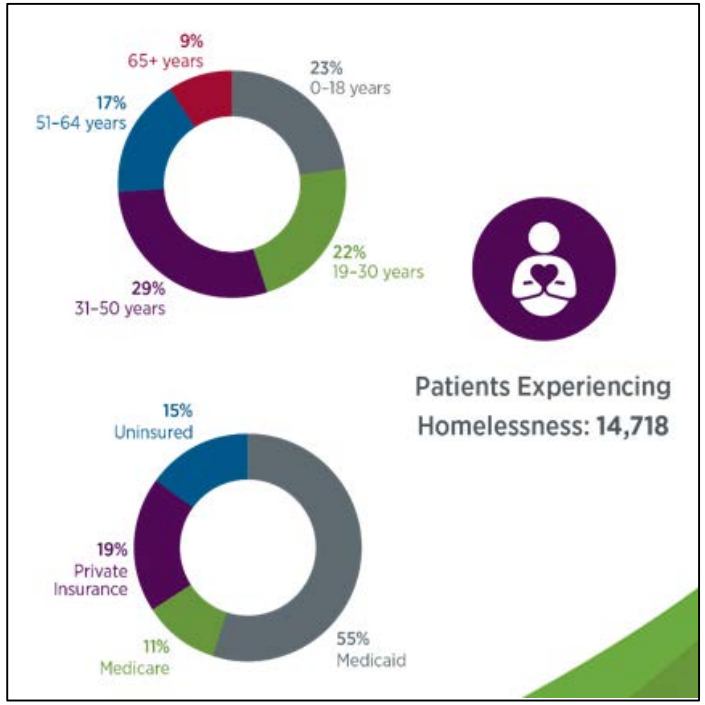
CHAS Health

The mission of CHAS Health is to improve the overall health of the communities we serve by expanding access to quality health and wellness services.

Our values:

SOCIAL RESPONSIBILITY FUN
PATIENT CENTERED
ENTREPRENEURSHIP
RESPECT FOR HUMAN DIGNITY
COMMITTMENT TO CONTINUOUS QUALITY IMPROVEMENT





Executive Summary

Telehealth at CHAS Health has been catapulted forward as COVID-19 Emergency provisions have broken down regulatory and reimbursement barriers

CHAS now provides 70% of all visits via telehealth to include Primary Care, Urgent Care, OB, Pediatric, Dental, Dietician, and Behavioral Health services

Due to favorable Washington policy and payor arrangements pre-COVID, CHAS was well positioned with telehealth infrastructure to rapidly expand services to Idahoans remotely

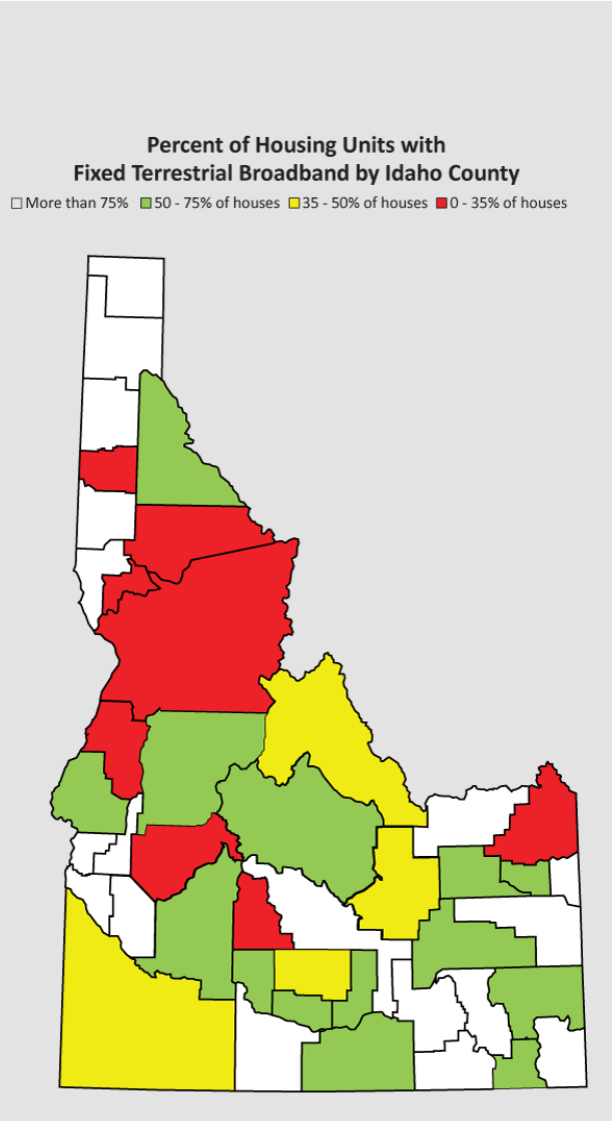
FQHCs face unique challenges providing telehealth to some of the most vulnerable populations and require creative and innovative reimbursement structures to support remote patient monitoring, eConsults and direct-to-patient telehealth

Magic Wand Scenario: Payor Parity

Establish consistent telehealth policies across the payor landscape to include coverage for proven cost-saving telehealth programs like remote patient monitoring, eConsults and direct-to-patient care

Magic Wand Scenario: Invest in rural household access to high-quality internet infrastructure

While internet infrastructure is expanding in rural communities to areas like clinics, schools and other community resources, many individuals still lack access to reliable internet needed to support telehealth at home. Idaho should fund and support recommendations outlined by the Idaho Broadband Plan Task Force



Source: Idaho Broadband Task Force (2019) Recommendations to Improve Idaho's Broadband plan

Summary Conclusion:

Establish reimbursement parity policies that support proven programs like remote patient monitoring and eConsults

Invest in rural household internet infrastructure

As we begin to imagine what "normal" clinical practices mean, telehealth is at the very center of that vision

Now, the conversation supporting telehealth is not only for access and convenience, but safety within the landscape of public health social distancing

We must address the policy barriers to telehealth to ensure this care delivery model survives beyond the emergency provisions currently in place

Contact Information:

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BIO

Dr. Kelly McGrath is a family medicine doctor in Orofino, Idaho and is affiliated with multiple hospitals in the area, including St. Mary's Hospital-Cottonwood and Clearwater Valley Hospital and Clinics. He received his medical degree from University of Washington School of Medicine and has been in practice for more than 20 years.

24 June 2020

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Telehealth Task Force

Kelly McGrath MD, MS
Chief Medical Officer
Clearwater Valley Hospital & Clinics

Telehealth Task Force Subject Matter Presentation

June 24, 2020

Clearwater Valley Hospital & Clinics

About Us:

CVHC / SMH is an integrated healthcare organization serving the needs of the rural and frontier population in North Central Idaho. We are an organization of two Critical Access Hospitals with 9 Patient Centered Medical Home (PCMH) clinics. Our organization serves a population of approximately 30,000 Idahoans. We have provided adult and pediatric Telepsychiatry services for our patients since 2009.

Executive Summary of our Case Study

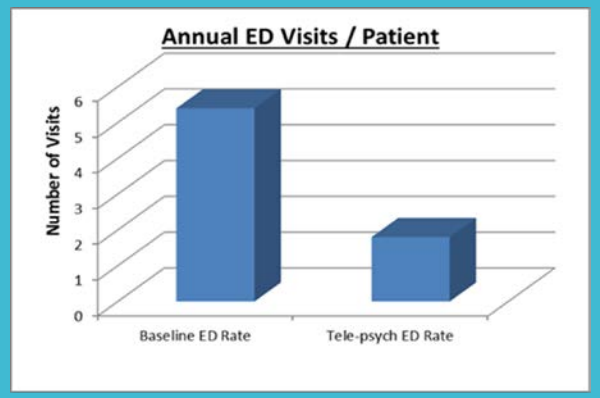
Experience with adult and pediatric Telepsychiatry service for rural/frontier communities in North Central Idaho since 2009.

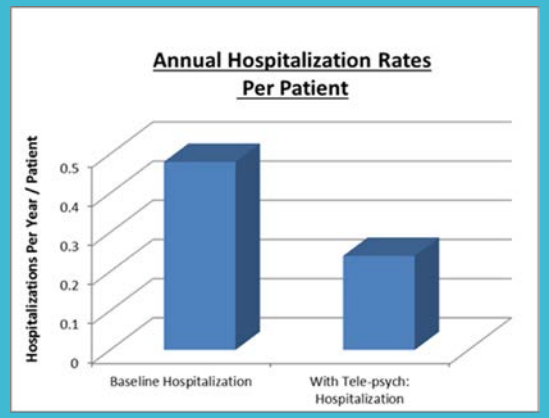
Provided first time access to adult psychiatric care for 85% of patients enrolled.

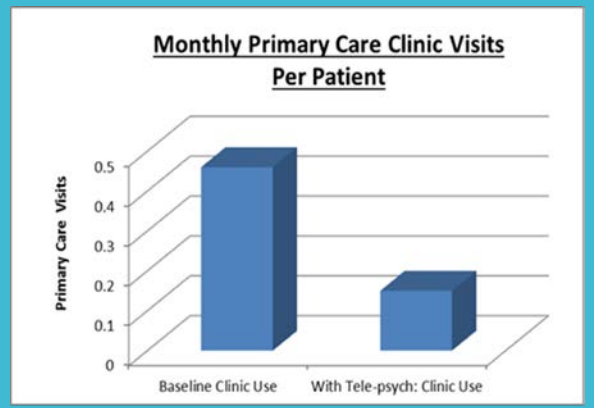
Adults enrolled had high prevalence of major mental illness and low functioning ability.

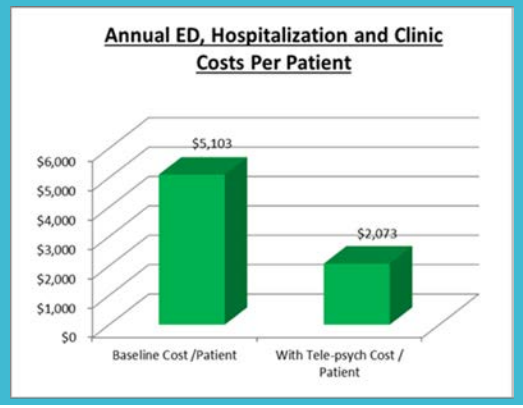
5 year study of costs and utilization showed enrollment in adult Telepsychiatry resulted in a significant reduction in cost and utilization within our system for these patients.

Executive Summary of our Case Study









Magic Wand Scenario (If you could waive a magic wand to develop an ideal scenario to expand utilization of telehealth in Idaho, what would you do?):

Improve the efficiency, scheduling and delivery of Telepsychiatry to reduce the cost of the service when purchased by a health system or clinic.

Improve the fee schedule for these services to best match the cost to deliver the service to allow at least a break even on the service.

Magic Wand Scenario (If you could waive a magic wand to develop an ideal scenario to expand utilization of telehealth in Idaho, what would you do?):

Create a system in which the Telepsychiatry service could be delivered directly to the patient where they are located (home, food banks, social service offices, clinics).

Deliver this "dispersed care" directly to the patient while maintaining collaboration/communication with the patients' PCMH.

Summary Conclusion:

Delivery of Telepsychiatry services to rural/frontier populations in Idaho achieves the triple aim of healthcare through improved population health, decreased cost and improved quality.

Telepsychiatry can be delivered in rural Idaho communities with moderate bandwidth requirements.

Payment models/fee schedules need to be improved to best support this vital service at least at a break even level.

Optimization of scheduling Telepsychiatry patients may decrease the cost of this service.

Contact Information:

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Telehealth Task Force

Use Case Name: Telepsychiatry in an Idaho Frontier Community: Experience and Outcomes

Presentation Date: 06/24/2020

Presenter: Dr. Kelly McGrath

Presenter Phone Number: 208 476-8014

Executive Summary of Use Case:

Tele-Psychiatry represents an effective solution to improve psychiatric specialty care access for high risk patients with mental illness living in geographically dispersed population areas such as rural Idaho. This project is compelling in that it demonstrates the ability to deliver tele-psychiatry services in a rural/frontier community while showing the overall improvement in health (as measured through proxy measures) and reduction of care costs for these patients within our system. Challenges remain that include lack of cost of psychiatry specialty service, lack of adequate payer coverage and, to a lesser extent, lack of needed bandwidth in rural communities. Much of the challenge with cost can be addressed through more efficient scheduling and contracts with providers. Transitions to Value-Based healthcare may drive improved payer coverage particularly with evidence of benefit.

Use Case Description:

This presentation summarizes the multi-year experience with Telepsychiatry in the rural and frontier communities of North Central Idaho. Specifically, it summarizes the characteristics of the population served as well as the impact of utilization and cost of care for the population served.

Accomplishments and Quick Wins:

Since 2009, this project has served adults with major mental illness living in rural and frontier areas of North Central Idaho. Of the patients served, 85% had no prior access to psychiatric services. Most of these adults had major mental illness and baseline low functioning ability as measured by the FAST score (on average, functioning at less than half the level of other US adults). Evaluation of their cost and utilization of services was measured over a 5-year window of time to compare these factors pre- and post- access to telepsychiatry.

We found that, on average, patients decreased their utilization for emergency department care from an average of 5.4 to 1.8 visits/patient/year. All cause hospitalizations within our system for these patients declined from 0.48 to 0.24 admissions/patient/year. Primary care visits also decreased from 0.46 to 0.15 visits/patient/month. This resulted in an average reduction of per capita cost within our system for these patients from the baseline of $5,103/yr. to a post intervention average of $2,073/yr. Through the improved access to specialty telepsychiatric care, reduced total cost of care within our system for these patients and with reduced healthcare utilization as a proxy for improved health, this project has achieved, and continues to achieve, the triple aim of healthcare through the provision of telepsychiatry care for a rural/ frontier population without other access to psychiatry specialty care.

Best Practices, Lessons Learned and A-Ha Moments (lessons learned):

A fundamental realization for us was understanding that the technology infrastructure required for Telepsychiatry is quite manageable and can be achieved in areas with moderate bandwidth. A key piece of making this program successful is having committed staff at both "nodes" of the telemedicine delivery: a champion to assist with billing, logistics and scheduling for the Psychiatrist and a program champion at the remote site to assist with technology, patient scheduling, patient reminders and even working on challenges such as transportation to the clinic. We actually were able, through strong staff at the remote site, to achieve a lower "no show" rate than the psychiatric practices were seeing in their regular practices.

Barriers and Challenges:

Although there are many barriers to telemedicine in rural and frontier Idaho which include bandwidth and engaged, available specialists, the compensation/contracting model has proven to be the largest challenge for telepsychiatry in our rural/frontier area. The contracts with the Psychiatry providers have an hourly rate that exceeds the reimbursement rate. For this reason, we have been operating at negative margin on this service for 11 years. We only continue because it serves our mission to make a healthy difference in the lives of our patients and our community. To attain wide success for this model, the economics need to be better aligned to at least place the service at a break-even threshold.

What solutions and recommendations would you suggest overcoming barriers?

While bandwidth and hardware costs may be a barrier to much of Telemedicine in Idaho, we found contracting and compensation challenges are the primary barriers for Telepsychiatry in rural /frontier Idaho. To address this, we believe the service must be delivered in a more efficient manner to reduce the contracting costs. Specifically, allowing for shared time blocks between several systems and improving scheduling efficiency could reduce the contract costs. Also, we need better compensation for the Telepsychiatric service from payers. In our study, the lower cost of care and higher overall care value supports a fee schedule more aligned with the value the service creates. We believe that there is likely a compelling economic case to support an improved fee schedule from the payers' perspective that would deliver a broader win for all.

What is your magic wand scenario?

If we were to use a "magic wand" specifically for the area of delivery of Telepsychiatry in rural and frontier regions of Idaho we would move the point of care access into or closer to the patients' homes. This could improve the access for this population while, hopefully, improving adherence to appointments. In turn, this could create efficiencies for the Psychiatric provider in terms of scheduling.

We also would use the want to improve the fee schedule to at least bring this service to a breakeven level for rural health systems and clinics.