CT Primary Care Payment Reform
Draft Capabilities Skeleton: Telehealth Visits between Clinicians and Patients
This Draft: August 20th, 2018

Understanding the Need

The Problem: While the Affordable Care Act has increased the number of patients with access to healthcare, the number of physicians in the United States is declining (AAMC, 2011). Patients experience very long wait times before they are seen by a primary care physician (PCP) (Merritt Hawkins, 2014). Patients may end up in the emergency room or forego medical treatment. Patients in rural areas are particularly affected by lack of access to physicians: 61 of 169 towns in Connecticut meet the definition of rural as adopted by the Connecticut Office of Rural Health (CT-ORH) Advisory Board.

Proven Strategy: Telehealth Visits between Clinicians and Patients

This document focuses on telehealth visits between clinicians and patients through virtual real-time communications such as video conference. These interactions may involve remote patient monitoring and other digital technologies (such as smart phones) to support provision of care. EConsults, phone, text and email communications, and remote patient monitoring are addressed in other documents.

Telehealth visits are provided for the following types of interactions:

- Urgent care or same day visits outside of a practice's normal business hours, or when an in-office visit is not available.
- Routine care that can be provided outside of the office setting for identified individuals.
- Behavioral health needs. For example, Connecticut enacted a new law that allows providers to prescribe controlled substances via telemedicine for the treatment of psychiatric or substance abuse use disorders, including medication-assisted treatment; opioid prescription is not allowed.
- Remote or home patient monitoring for chronic conditions or after an acute care episode, with a virtual visit to connect with the patient to discuss an issue, provide medical guidance or education, or adjust the treatment plan.

Depending on the system's capacity, budget, and technology available, telehealth visits are provided through a combination of mechanisms:

- Contracts with a third-party service that specializes in virtual visits, such as American Well, MDLive, or TeleDoc.[1] These are typically provided for urgent care or 24/7/365 access to a

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[1] These are examples of services, not an endorsement. This list is not exhaustive.

primary care provider. Many of these platforms allow a practice to use their own clinicians to provide services, or route patients to their network of clinicians.

- System or practice-specific platforms that enable their clinicians to have virtual visits with patients routinely or as needed, and that may be integrated with the system's Electronic Health Record and/or patient portal.

For example, Partners Healthcare, a large network in Massachusetts, uses both a third-party service and their own telehealth virtual visit platforms throughout their system. The third-party platform is offered

at the system level for urgent care visits. Their flagship hospitals have their own telehealth programs that integrate with their electronic medical record. Figure 1 demonstrates their Massachusetts General Hospital telehealth model, in which clinicians are able to conduct virtual visits, exchange communications through a secure portal with patients, and consult with other clinicians through virtual and eConsults. For virtual visits with patients, clinicians choose candidates for routine care via virtual visits. They are also expanding these virtual services to behavioral health.

Figure 1: Telemedicine at Mass General
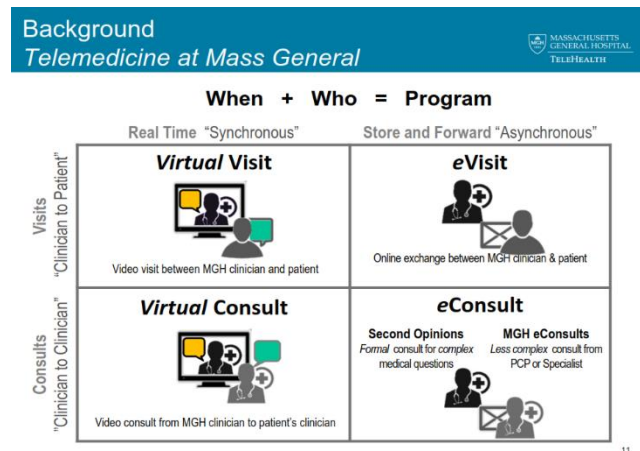
Connecticut payers, such as Anthem and Cigna, offer third-party services for virtual visits with different reimbursement practices and typically at lower cost to the consumer. For example, eligible Cigna customers can choose an appointment time or request to speak to an available healthcare professional on demand – with a reported average response time of 11 minutes – for non-emergency medical issues. A patient's out-of-pocket cost is reported to be the same or less than a visit with their primary care provider.

Intended Outcomes:
- Reduce avoidable Emergency Department visits (requires 24/7/365 virtual access to clinicians)
- Expand access to specialists in Connecticut
- Reduce hospitalizations, length of stay and readmissions
- Reduce need for office evaluations
- Improve care coordination between the patient and the caregiver team

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Consumer Needs, Concerns and Questions:
- Expanding access to providers and providing patients with the convenience of accessing care from anywhere
- Expediting the timing of medical visits
- Reducing lost work time and travel costs
- Allowing for remote second opinions
- Lowering the patient cost of a physician appointment when compared to traditional office visits

> **Health Equity Lens**:
> - Reduces access barriers such as transportation and ability for caretakers to manage getting patient to appointments as frequently as necessary.
> - Gives women with high risk pregnancies in rural areas access to specialists, with greater chance of delivering a healthier baby and better outcomes
> - Opportunity for uninsured and underinsured patients to access more affordable care
> - Allows patients in rural areas have access to specialty services that might otherwise be available only in metropolitan areas
> - Provides patients immediate access to behavioral health services in a more efficient manner

Implementing the Strategy

> **Example Scenario**: A daughter who takes care of her disabled mother who is homebound notices that her mother has developed a cough and fever. Instead of taking her to the Emergency Department, she contacts her primary care provider and schedules a virtual visit for the same day. She sends her mother's symptoms to the provider via a secure portal and they have a video conference to discuss the symptoms and evaluate her mother's condition. The physician prescribes a cough medicine and asks the daughter to send her updates on her mother's symptoms electronically via the secure portal each day. The visit and associated information is recorded in the patient's Electronic Health Record.

HIT Requirements:
- Access to high-speed broadband Internet: Sufficient bandwidth is needed to transmit audio and video data for synchronous (real-time) telemedicine interactions.
- Imaging technology or peripherals: On-site imaging technology and other data collection devices e.g., digital stethoscopes may be required.
- Training and access to technical support staff: Staff require training in use of telehealth technology.
- Secure patient and provider portals: Secure system for patient-provider interactions that works with multiple devices (e.g. computer, tablet, Smartphone)

Implementation Concerns:
- **Defining which services are reimbursable under telehealth**. For example, Connecticut law requires commercial insurers to reimburse telemedicine and telehealth services equivalent to in-person rates (CT Gen Stat § 19a-906 (2015). However, state and federal regulations as well as individual commercial carriers differ as to what is a covered, medically necessary telemedicine service. United Healthcare reimburses for care provided through live, interactive videoconferencing using CMS Medicare provisions for eligible originating sites and eligible services. Connecticut Medicaid reimburses for services provided via live video (CT Public Act No. 15-88 (2015); SB 467), and provides coverage for telehealth services that the Medicaid Commissioner determines are clinically appropriate to be provided through telehealth, cost effective for the state and likely to expand access to services for patients for whom accessing health care poses an undue hardship (CT Public Act No. 16-198 (SB 298-2016)). Reimbursement is not typically provided for initial patient set up to help the patient install and learn how to use the technology, which may take significant time.

- **Other Implementation Considerations**
  - Scheduling real-time virtual visits requires software that understands physicians' availability and allows either patient-initiated or staff mediated scheduling.
  - Specialists may be required to makes themselves available for virtual visits during certain blocks during the week. Studies must be done to determine whether they are being adequately utilized during these blocks.
  - Cross-state telemedicine licensing is permitted if the Connecticut Department of Public Health accepts an applicant's license from another state.
  - Patient consent is required, and it may be difficult to implement for some offices.
  - Startup costs for physician training and physician resistance to using new technology
  - Securing appropriate malpractice insurance for telehealth (i.e., Technology Errors & Omissions Insurance).
  - Technology infrastructure to implement telehealth, including capacity for broadband connectivity, to store and forward encrypted medical information.
  - Patient acceptability of virtual visits

Impact

Aim	Summary of Evidence
Health promotion/prevention	A study of the Informatics for Diabetes Education and Telemedicine project found that Medicare beneficiaries using a home-based telemedicine platform exhibited improved disease self-management, including improved blood sugar and blood pressure, and better cholesterol levels compared to the group receiving office-based primary care (Dixon, 2010)
Improved quality and outcomes	- Clinic-to-clinic telemedicine, or virtual visits between clinicians and patients, is an efficient and effective means of providing diabetes care to remote, underserved regions. It has been found to decrease hospitalizations of children with diabetes from 13 to 3.5 per year and emergency department visits from 8 to 2.5 per year. Access to health care improved with the average visit interval decreasing from 149 to 98 days in the first year after its implementation and 89 days in the second year of the program (Malasanos, 2013). - A study of 170 acute stroke patients treated at community hospitals with virtual access to stroke neurologists and 132 comparable patients treated in stroke center hospitals with attending neurologists found that mortality rates and levels of impairment after six months were comparable for both groups (Schwab, 2007).

Patient experience	• Telemedicine improves time-to-diagnosis, facilitates care access for patients in remote regions, and increases patient satisfaction (Bergmo, 2010). • A survey of patients participating in video visits found an average score of 92% for overall satisfaction with the visit as "excellent" or "very good" (Cheema, 2015) • Columbia University researchers found that there is no difference in the accuracy or satisfaction between psychiatric consultations provided via telemedicine and those conducted in person (Hyler, 2005).
Provider satisfaction	Physicians response has been mixed. Some see it as a good alternative to retail competition and as a means to expand their patient base and capacity for seeing new patients and to adequately assess patients for routine medical issues. However there are concerns that it will interfere with the physician patient relationship and interrupt the continuity of care directed by a PCP (i.e., people will get medications or treatments through the virtual visit that never make it into their personal medical files) (Whitten, 2005; Miller, 2016). In many models, providers maintain a regular panel of patients and consult with patients virtually between office visits, increasing workload.
Lower Cost	• Partners HealthCare/Center for Connected Health reported that patients with cardiac disease enrolled in telehealth and telemonitoring programs produced net savings over a 7-year period of approximately $10 million for 1,265 patients (net savings per patient of $8,155) (Broderick, 2013).

Please complete the survey **on this capability.**

APPENDIX

Learning from Others

Connecticut: A study on home telehealth for congestive heart failure and chronic obstructive pulmonary disease patients established that telehealth improved patients' activities of daily living and decreased costs. Patients were randomly assigned to 3 groups: a control group with traditional skilled nursing care at home; a video intervention group with traditional nursing care at home and virtual visits using videoconferencing technology; and a monitoring intervention group with traditional skilled nursing care at home, virtual visits using videoconferencing technology, and physiologic monitoring for their underlying chronic disease. The findings showed that the video intervention and monitoring intervention group showed increased scores for activities of daily living at the time of discharge and that the average costs per visit for the control group ($48.27) far exceeded the average cost of the video intervention group ($22.11) and the monitoring intervention group ($38.62) (Finkelstein, 2006). It also established that a higher number of skilled nursing staff can be managed at by a single nurse without compromising quality of care or diminishing patient satisfaction.

National: Massachusetts General Hospital (MGH)'s Center for TeleHealth operates a robust telehealth program that includes:

- Virtual visits between clinicians and patients via videoconferencing
- eVisits, or online exchanges, between clinicians and patients
- Virtual consults, second opinion consults and eConsults between clinicians

MGH launched virtual visits in 2013 and eVisits in 2014 and has since expanded availability of these services to all primary care and several specialty care practices for follow up care for over 65 conditions. Since they were launched, they have provided almost 8,000 virtual visits and 15,000 eVisits (Meller, 2017).

In a recent case-control study, researchers compared patients at MGH who received virtual follow ups for hypertension with similar patients at another local hospital who received in-person follow ups. The virtual visits platform allowed patients to enter up to five blood pressure readings taken since their last visit, report on whether they were taking medications as directed, describe any side effects and ask questions. Primary care clinicians responded to questions, adjusted treatment, and recommended repeat virtual visits, follow-up phone calls or in-office visits. The study found no significant difference in outcomes, including specialty visits and inpatient hospitalization, between patients checking in with their primary care physicians via a secure website about their hypertension care and those who had in-person office visits instead. The study also found that those in the virtual care group had an average of 0.8 fewer follow-up office visits, a decrease that was even greater among patients whose blood pressure control had been poor upon entry into the study (Mass General News, 2018).

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