



**Delivering on the Promise of Telehealth to Improve Health Status in California
Fact-Finding Listening Conferences
October 22 and December 2, 2020**

Final Report and Action Plan

- Enact legislation to permanently reimburse Telehealth services comparable to in-person visits.
- Invest in and ensure ubiquitous high-speed Internet infrastructure to support Telehealth for all patients and providers.
- Institutionalize Telehealth with accountability for improving patient outcomes and overall population health.



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SUMMARY OF PROCEEDINGS

Introduction

The Fact-Finding Listening Conferences explored the convergence of technology with healthcare to optimize Telehealth to ensure quality care for medically-disadvantaged residents and to improve overall population health. The California Emerging Technology Fund (CETF) co-sponsored the Fact-Finding Listening Conferences with Partners in Care Foundation (PICF), CENIC (Corporation for Education Network Initiatives in California), and California Primary Care Association (CPCA). Each organization has a unique perspective and together hold a collective vision to optimize Telehealth in California. The collaboration brought together experts in Telehealth, healthcare systems and providers, along with Digital Equity champions who are helping to deploy broadband (high-speed Internet infrastructure, including wireline and wireless networks) and promote adoption to get online all Californians.

PICF is a non-profit organization whose mission is to shape the evolving health system by developing and spreading high-value models of community-based care and self-management for diverse populations with chronic conditions. PICF strives to achieve better health outcomes by marrying social care and medical care. PICF is a change agent that has helped residents stay at home and out of nursing homes and hospitals during COVID-19.

CENIC is a non-profit organization established in 1997. CENIC operates the California Research and Education Network (CalREN), a high-capacity computer network with more than 8,000 miles of optical fiber. The network serves over 20 million users across California, including the vast majority of K-20 students together with educators, researchers, and individuals at other vital public-serving institutions. CENIC connects California to the world, advancing research and education statewide by providing the world-class computing network essential for innovation, collaboration, and economic growth.

CPCA is a non-profit organization established in 1994 to represent community health centers and their patients. CPCA has become the statewide leader and recognized voice for community health providers. CPCA represents more than 1,380 not-for-profit Community Health Centers (CHCs) and Regional Clinic Associations (RCAs) who provide comprehensive, quality healthcare services, particularly for low-income, uninsured and underserved Californians, who might otherwise not have access to healthcare. Many of the CPCA members are Federally-Qualified Health Centers (FQHCs).

CETF is a statewide non-profit organization directed to be established in 2005 by the California Public Utilities Commission (CPUC) as a public benefit derived from corporate consolidations. The mission assigned to CETF by the CPUC is to close the Digital Divide in California by accelerating broadband deployment and adoption. Research shows that one of the most valued uses of the Internet by residents is for finding healthcare information and connecting with health and medical care providers. Supporting and promoting the use of Telehealth is a major strategy to help close the Digital Divide.

Background

The COVID-19 pandemic shelter-in-place and social distancing orders spotlighted the need for all Californians to have access to Telehealth and exposed the existing digital access inequities. It illuminated the imperative for investments in constructing high-speed Internet infrastructure capable of supporting Telehealth services and the imperative for getting all residents online with appropriate computing devices and functional digital literacy. The Digital Divide has become a “Digital Cliff” with residents falling off into deeper poverty and greater isolation. Although much progress has been made in advancing Telehealth and the federal government issued temporary emergency waivers that removed significant reimbursement hurdles, California has not optimized the use of Telehealth to close gaps for medically-underserved communities and economically-segregated neighborhoods, which also are home to the most digitally-disadvantaged residents.

Further, technology is only a tool—powerful and empowering—but, alone not the end game. It is essential for policymakers who seek to achieve Digital Equity to understand how to effectively integrate the use of technology into all institutions and systems, including the delivery of health and medical care. Therefore, CETF, PDCF, CENIC, and CPCA joined forces to convene Fact-Finding Listening Conferences to gather data and input for an Action Plan to inform State and federal policymakers about how to optimize the use of Telehealth.

Vision Goal for Telehealth in California

Optimize the use of Telehealth to augment and enhance health and medical care for all California residents, especially those who are medically-underserved, to improve individual patient outcomes and overall health status.

Purpose of Fact-Finding Listening Conferences

- Understand the status of Telehealth in California.
- Identify the gaps and barriers to optimizing Telehealth to improve health status for Californians.
- Develop an Action Plan to advance Telehealth policy and funding in California.

Conference Focus

The Fact-Finding Listening Conferences were held virtually by videoconference on October 22, 2020 and December 2, 2020 from 8:30 a.m. to Noon (Pacific Time).

October 22, 2020 Conference Focus:

- Community Health Clinics and Federally Qualified Health Clinics (FQHCs)
- Senior Care Facilities – Skilled Nursing Facilities and Assisted Living Facilities

December 2, 2020 Conference Focus:

- Managed Health Care Plans – Private and Public
- Medical Centers
- Veterans Affairs Administration



Delivering on the Promise of Telehealth to Improve Health Status in California Fact-Finding Listening Conferences October 22, 2020 and December 2, 2020

Executive Summary

The COVID-19 pandemic exposed both barriers and opportunities to optimize Telehealth to improve the health status for Californians. It accelerated Telehealth innovation and adoption and has motivated both bureaucracies and health care providers to move quickly to identify barriers and adjust the necessary regulations, policies and practices that allow the expansion of Telehealth during this pandemic.

The Fact-Finding Listening Conferences held on October 22 and December 2, 2020 provided a robust engagement in which to: (1) Understand the status of Telehealth in California. (2) Identify the gaps and barriers to optimizing Telehealth to improve the health status for Californians. (3) Inform an Action Plan to advance Telehealth policy and funding in California. These conferences brought together thought leaders and experts from Community Clinics and FQHCs Servicing Medically-Underserved Populations, Senior Care Facilities from skilled nursing and assisted living, Managed Health Care Plans (Public and Private), Medical Centers, and Veterans Affairs Administration, as well as the Governor’s Office, Legislators, Regional Consortia, community-based organizations, and philanthropy. The Conferences were well attended—more than 170 participants on October 22 and 100 participants on December 2. This Executive Summary consists of Key Findings, Barriers, and Recommendations that emerged from the Fact-Finding Listening Conferences.

Key Findings

Telehealth Utilization Rates

Telehealth utilization rates have increased exponentially. Preliminary data from CMS suggests that services delivered via Telehealth increased from February through April 2020 at a rate of 2,632% more when compared to March-June in 2019. Due to virtual visits, patient “no show” rates have decreased dramatically in all specialties. Notably, Behavioral Health has seen “show rates” increase by 90%-100%. Psychiatry expects to see an increase in treatment for COVID-19 related to social isolation in the general population, but also among their frontline providers who have been battling COVID for the past year. The proverbial genie is “out of the bottle” and government, providers and communities alike welcome this trend and signal their support for further, collective forward momentum.

Reimagining Health Care

The pandemic created an opportunity to reimagine the delivery of health care, as poignantly stated by Dr. James Marcin of UC Davis Children’s Hospital—a perspective shared by many of the presenters from the various health care systems. Dr. Marcin explained that UC Davis is hoping to rebuild the infrastructure of its Telehealth program and its health care delivery so that it is effective and patient-centered and provider-centered system. He added that UC Davis is reimagining the way it delivers health care and is being proactive in making this health care system fairer for everyone.

Broadband Infrastructure and Access

The need for broadband infrastructure and access was a common theme throughout both Conferences. Patients must have access to broadband, especially populations in unserved and underserved communities that are in rural and metropolitan areas. Implications due to lack of access to broadband were summarized succinctly by Assemblymember Aguiar-Curry who stated that it is unfortunate that it took a pandemic for leaders to understand the importance of having broadband. Typically, broadband discussion focus on schools, which are important, but they need to be expanded to healthcare, job generation, training, and agriculture. California cannot be left behind.

Access to Devices

Equally important is the need for Californians to have access to the necessary electronic devices that allow them to access Telehealth care. Both access to broadband and devices are essential to health equity. Californians must have access to devices such as telephones, smartphones, computers, Internet-connected tablets, and high-definition web cameras. Dr. Natalie Pageler of Stanford Children’s Health shared that fortunately children had access to Chromebooks for school and were able to use them for Telehealth visits as well.

Main Drivers of Change

The main drivers of change for Telehealth were outlined by Dr. Peter Yellowlees, nationally and internationally recognized pioneer in telepsychiatry. His conclusions were echoed by presenters throughout both Conferences. These 3 main drivers of change are:

- Relaxed Regulations Associated with the COVID-19 Emergency: Licensing changed to allow providers to cross state lines. Reimbursement changed to allow providers to be reimbursed for Telehealth visits at the same rate as an in-person visits. Geographic barriers were suspended to allow providers to expand Telehealth beyond rural areas, which are now able to include urban areas that are significantly underserved in health care. Controlled substances can now be prescribed via Telehealth. HIPPA requirements have been relaxed to enable more Telehealth visits.
- Ubiquity of Mobile Devices: The revolution in mobile devices has dramatically opened the possibilities for health care. Providers are able to see, talk, and meet with patients as well as access and evaluate test results with them. Mobile devices allow patients to access and providers to administer telehealth services from virtually anywhere. Both having access to a smartphone and to broadband must be considered as part of the human infrastructure and essential for health care.

- Many Advantages of Telehealth: Telehealth makes efficient use of provider’s time—essentially, they can see patients wherever and whenever they want to be seen. Providers can offer appointment times that are much more convenient for patients, including night and weekend appointments. Telehealth saves the healthcare system money and time. It can reduce stress on providers, improve their quality of life by allowing them to work from home and reduce burnout. With Telehealth, providers can safely see an increased variety of patients, better integrate with their care team and bring families together as part of shared decision making.

Models for Telehealth

The Conference elucidated 3 models of Telehealth that provide critical considerations for informing and transforming Telehealth. Dr. Peter Yellowlees illustrated how the retail industry transformed consumer shopping from in-person to an online trusted experience. Dr. Alka Mathur of Veterans Affairs (VA) Palo Alto Health Care System shared that the VA has long been at the forefront of Telehealth and can serve as a roadmap for advancing Telehealth in California. Dr. Khang Nguyen of Kaiser Permanente shared how Kaiser provides synchronous, asynchronous and remote patient monitoring. All 3 models offer insights into constructing a Telehealth model for the future.

- Dr. Yellowlees offered the retail industry model from which can inform a Telehealth model. The retail industry transformed consumer shopping from in-person to online, but it did not occur overnight. It required the industry to invest in marketing, education, and in persuading consumers to have confidence and trust in the online modality. The retail industry helped consumers understand that shopping online was convenient, consistent, safe and of high quality. The 3 big changes the retail industry made include: (1) Changed its wholesale workflow to become more consumer focused. (2) Increased choice and range of services and goods. (3) Installed impressive IT systems to continuously monitor what is going on to predict such things as package arrival times, investing in data to inform consumers of the status of their individual transactions. Telehealth can learn from this model to place much more focus on the consumer experience, particularly populations suffering the most disparities. Data indicates that consumers prefer to be seen virtually and in their homes; therefore, providers should see patients where they want to be seen. Reimbursement for Telehealth must be the same as in-person—particularly when considering that retail consumers do not expect to pay a different price because they go into a store rather than purchase online.
- Dr. Mathur reported that the VA has been providing Telehealth services for the last two decades, and they still stand as the largest health care agency in the US that uses a Telehealth system. Since COVID there has been about a 1,000% increase in Telehealth visits across all specialties. The VA is fortunate that the Telehealth system it operates offers several essential advantages: (1) The VA has the ability to dispense technology. It is able to send WiFi-enabled iPads and iPhones to veterans that struggle with getting Internet access and also can subscribe to Internet service to allow patient access with a discounted or free device. (2) The VA has its own internal platform called BBC or VA video Connect, which it deployed nationally, and software administrators are very receptive to any changes that physicians need to implement. (3) The VA has the unique ability to provide services across state lines and access specialists outside of California.

- Kaiser Permanente (KP) is another model emerging as a leader in Telehealth. According to Dr. Khang Nguyen, KP provides synchronous, asynchronous and remote monitoring for primary care and specialty care. For example, Tele-stroke technology can be used for Emergency Room patients so that the attending physician can consult a neurologist virtually for guidance on preserving patient functions. Pre-COVID-19, virtual visits in the KP system comprised about 20% of all primary care visits and about 1-5% for specialty care visits. Once COVID hit, Kaiser transitioned to 98% virtual visits by April 2020. Dr. Li of L.A. Care lauded KP as a leader in the health care industry. He cited KP infrastructure and system that has the ability to support expansion of Telehealth effectively. KP has the program managers, thought leaders, including doctors, and administrative leadership, along with the reserves to make those investments. KP has one electronic health record (EHR) as opposed to multiple EHRs to share information among providers. He concluded that the rest of the healthcare community must step up their game and collaborate.

Telehealth Revolution

Patients and providers are now embracing virtual care and are revolutionizing the use of Telehealth. This mode of care is here to stay. The pandemic sparked the needed motivation for patients, families, and providers to try Telehealth. Barriers were eliminated due to the need to minimize the spread of COVID-19 while continuing to provide healthcare services in a safe environment. Practitioners are central to virtual care adoption and use. However, patients, payers, and regulators have a key role to move Telehealth forward.

Swift Shift to Telehealth

The pandemic required swift action to enable Telehealth to prevent and reduce the spread of COVID-19 to patients, communities and providers, while also allowing regular non-COVID related medical care. There was consistent recognition for the expediting relation of both State and federal rules, regulations and reimbursement policies to enable the expansion of Telehealth. Providers reported that, in turn, they quickly pivoted to Telehealth in a matter of a few days—many expected regulation flexibilities to require weeks or months. Providers were eager to keep their patients safe—particularly the elderly and the most medically vulnerable—to protect their populations from the spread of COVID-19.

Telehealth Advantages

There are several advantages to Telehealth, which is expected to be a greater part of the mix of healthcare delivery in the future. The right mix of in-person and Telehealth visits will have to be tailored to each patient to optimize health outcomes.

- Telehealth helps to remove barriers such as access to transportation, parking costs, needed childcare, time off from work and loss of wages for patients seeking access to health care. Telephonic visits are often the preferred mode due to patients having easier access to telephones. Many providers reported telephonic visits were often the only access patients had, and, in some cases, patients preferred this mode as they were uncomfortable with providers seeing their homes via video.
- Telehealth reduces costs in allowing patients to access the right care, at the right time and in the right settings. Patients should not have to access Emergency Room care because they are unable to seek care during traditional office hours.

- Telehealth brings people together in different ways that benefit patient care. Physicians, nurse practitioners, physician assistants, nurses and other frontline providers are able to work as a team to provide care in an integrated manner.
- Telehealth improves care, particularly for home visits. When Telehealth visits are scheduled during the time a home health nurse is seeing a patient, it can be a tremendous advantage to the patient and provider. For example, a home health nurse can help a provider identify the problem with a wound or a health condition to determine the appropriate care regimen. This process has positive equity implications.
- Telehealth can minimize developmental issues with children who have chronic health conditions and must access care frequently. These children can experience delays in development of social autonomy and/or logic skills when their routines are interrupted and when they are unable to participate in school or after school activities.
- Telehealth is being pushed by COVID-19 into a new era. Although Telehealth utilization rates are not as widespread in senior care facilities, COVID-19 has driven an increased interest in Telehealth to keep patients and providers safe and families connected to their loved ones. The advantages of Telehealth in these facilities include: (1) Providers now have an expanded number of Telehealth visits they can provide. Previously they were limited to one Telehealth visit every 30 days in nursing homes. With the temporary waivers, there are no limits to the number of Telehealth visits, and it has expanded to telephonic visits. (2) Patients do not need to access higher levels of care, such as ER, when they do not need it. (3) Telehealth reduces patient transport trauma and staff time in preparing patients for transport. Patients have to be ready two hours in advance for some transportation companies. (4) Telehealth allows access to specialists and geriatricians. In many California regions there are limited access to geriatricians whether patients are seeking a house call or even an in-clinic visit. With Telehealth, geriatricians throughout the country can be accessed.
- Telehealth allows patients in rural regions to avoid traveling long distances to receive care. Traveling to a clinic is not the most convenient or cost-effective approach for patients who must take time off from work or secure childcare to seek healthcare. Telehealth is paramount to population health management in rural regions. It is a vital tool in the toolbox to be used more effectively.

Major Barriers

The Fact-Finding Listening Conferences identified major barriers for both individual patients and for providers and medical institutions. These barriers tend to intersect and have implications for economically-disadvantaged communities and those systems that serve them. The economically-disadvantaged residents also are the digitally-disadvantaged households and disproportionately live in medically-underserved communities.

Telehealth is Underfunded

Telehealth remains grossly under-funded in support and resources needed for implementation, deployment, training, equipment and technical assistance. California lacks a comprehensive statewide strategy to expand Telehealth, as well as address disparities.

Broadband Access

The lack of access to broadband—high-speed Internet infrastructure—is an enormous barrier to Telehealth care in both rural and urban areas. These barriers impact both individuals and providers. In addition to bringing the broadband infrastructure to the site of the providers, there is a need to bring the connectivity inside the facilities (penetrate the walls) and connect to equipment. Importantly, providers with sufficient broadband capabilities can guarantee only their side of the connection and have no control over the quality of connection for their patients. This can lead to frustration for both the provider and the patient and reluctance to use Telehealth again. Affordability to connect to broadband remains an issue in unserved and underserved communities.

Access to Devices

Many vulnerable populations not only have insufficient access to broadband, but also lack access to the necessary devices (smartphones, computers, tablets, computer cameras) needed to access quality health care through Telehealth. In addition, they often lack the technical expertise and the training needed to use devices to access Telehealth.

Reimbursement

In the recent past the Centers for Medicare and Medicaid Services (CMS) did not reimburse for Telehealth due to incongruous rules. CMS would only allow reimbursement for patients in rural regions and not in metropolitan regions. However, the facts betray the CMS policy. Across the country, visits during COVID-19 shelter-in-place orders have increased about 3,500-fold for Telehealth. About two-thirds of Telehealth visits were provided to people in metropolitan areas, not rural areas. This is in strong opposition to the previous CMS view, which provided funding for Telehealth only in rural areas. This view must be changed for the long-term. Furthermore, payment parity is a major barrier. Until the notion is dispelled that there is less value in a Telehealth visit than an in-person visit, the potential for Telehealth to improve patient outcomes and overall population health status will not be fully realized.

Accommodation Barriers

The acceleration of Telehealth in response to the pandemic has given rise to understanding the various accommodation barriers that must be addressed. Non-English speaking communities face language and cultural barriers in accessing Telehealth. This often impacts the Telehealth connection and workflow with providers requiring a multi-party connection that includes the patient, the interpreter and provider, and sometimes a consulting physician or another family member at another location. Telehealth visits, whether via video or telephonically, can be problematic for patients living in large family settings without privacy for health consultations. Patients with hearing aids often experience interference when technology is in use. Elderly patients with significant hearing loss must be accommodated so they can understand and communicate with their provider.



Summary of Conclusions and Recommendations from Fact-Finding Listening Conference Delivering on the Promise of Telehealth October 22, 2020 and December 2, 2020

Major Barriers to Optimizing Telehealth

For Individuals

- Insufficient access to broadband and devices and lack of affordability for adoption.
- Need for language, culture, trust, and “ability” capacity in Telehealth.
- Lack of consumer information on Telehealth and how to request special accommodations.

For Medical Institutions and Providers

- Lack of support for implementation: deployment, training, and technical assistance.
- General under-funding of all aspects of Telehealth.
- Uncertainty about reimbursements and continuation in public policy post pandemic.

Key Action Steps to Optimize Impact of Telehealth on Health Status

1. Increase government investments in Telehealth (infrastructure, equipment, training).
2. Invest in broadband access and devices (including health monitoring devices), and adoption.
3. Sustain Telehealth reimbursement same as in-person visits post-COVID-19.
4. Authorize MediCare and Medicaid reimbursements for devices for low-income households.
5. Advocate for a national license post-COVID-19.
6. Establish a national credentialing agency for physicians.
7. Allow continuation of prescribing controlled substances via Telehealth post-COVID-19.
8. Support multiple modalities for delivery of Telehealth services and cost savings.
9. Advocate for permanent elimination of geographic location restrictions post-COVID-19.
10. Expand provider training and technical support.
11. Expand consumer information on telehealth access.
12. Understand issues of culture, language, and trust and provide necessary support structures.
13. Broaden access to virtual language interpretation services for Telehealth.
14. Review and update HIPAA requirements (enacted in 1996) to support Telehealth and IT.
15. Ensure that public policy and funding are commensurate with practice (update forms).
16. Develop comprehensive care: integrate social and medical care in the Telehealth context.
17. Include long-term care facilities in comprehensive Telehealth policy.
18. Understand and address privacy and data security issues.
19. Assign responsibility within the California Health and Human Services Agency to advance and optimize Telehealth with quantified goals and performance metrics.
20. Establish a non-profit statewide mission-driven organization to optimize Telehealth to improve patient outcomes and improve overall population health status.



Delivering on the Promise of Telehealth to Improve Health Status in California Fact-Finding Listening Conferences

Thursday, October 22, 2020
8:30AM – Noon (Pacific Time)
(Conference Will Be Recorded)

Purpose of Fact-Finding Listening Conferences

- Understand the status of Telehealth in California.
- Identify the gaps and barriers to optimizing Telehealth to improve health status for Californians.
- Develop an Action Plan to advance Telehealth policy and funding in California.

AGENDA

Time	Panel and Speakers	Responders
8:30 – 8:45 (15-Minute Session)	Open Listening Conference Welcome and Overview Barb Johnston Yellowlees, Chair, CETF Telehealth Committee <ul style="list-style-type: none"> • Background • Vision Goal and Purpose 	Leticia Alejandre <i>CETF Director of Telehealth and Human Services</i> Sunne Wright McPeak <i>CETF President and CEO</i>
8:45 – 8:55 (10-Minute Session)	A. Introductory Remarks from Co-Sponsors (1 Minute Each) <ul style="list-style-type: none"> • Partners in Care Foundation (PICF) June Simmons, President and CEO • CENIC (Corporation for Education Network Initiatives in California) – Louis Fox, President and CEO • California Primary Care Association (CPCA) Andie Martinez Patterson, VP Government Affairs 	
8:55 – 9:05 (10-Minute Session)	B. Telehealth – A Call to Action <ul style="list-style-type: none"> • Richard Figueroa Governor’s Office – <i>Deputy Cabinet Secretary</i> • Assemblyman Joaquin Arambula, M.D. <i>Assembly District 31</i> 	Jim Kirkland <i>General Counsel Trimble, Inc.</i> <i>CETF Board of Directors</i>

<p>9:05 – 9:45 (40-Minute Session)</p>	<p>C. Telehealth in California – An Overview</p> <ul style="list-style-type: none"> • California Telehealth Network, OCHIN Kim Klupenger, <i>CTN President, Chief Experience Officer</i> • Center for Connected Health Policy and California Telehealth Policy Coalition Mei Kwong, <i>Executive Director</i> <p>Questions and Answers</p>	<p>June Simmons <i>President and CEO</i> <i>Partners in Care Foundation</i></p> <p>Dorian Traube, Ph.D. <i>Associate Professor</i> <i>Dworak-Peck School of Social Work, University of Southern California</i> <i>CETF Board of Directors</i></p>
<p>9:45 – 10:40 (55-Minute Session)</p>	<p>D. Panel: Community Health Clinics and FQHCs</p> <ul style="list-style-type: none"> • Community Health Center Network (Alameda) Laura Miller, M.D., <i>Chief Medical Officer</i> • Open Door Community Health Centers Tory Starr, <i>CEO</i> • Sacramento Native American Health Center Britta Guerrero, <i>CEO</i> • AltaMed Health Services Corporation Berenice Nunez Constant, <i>VP of Government Affairs & Civic Engagement</i> <p>Questions and Answers</p>	<p>Kara Carter <i>VP for Strategy</i> <i>California Health Care Foundation</i></p> <p>Andie Martinez Patterson <i>VP Government Affairs</i> <i>California Primary Care Association</i></p>
<p>10:40 – 11:35 (55-Minute Session)</p>	<p>E. Panel: Senior Care Facilities</p> <ul style="list-style-type: none"> • California Association of Health Facilities DeAnn Walters, <i>Director of Clinical Affairs & Quality Improvement</i> • California Assisted Living Association Paula Hertel, <i>Board Member and Education Committee Co-Chair</i> • California Association of Long-Term Care Medicine Karl Steinberg, M.D., <i>Past-President; Chief Medical Officer, Mariner Health Care Central</i> <p>Questions and Answers</p>	<p>Julie Bates <i>Associate State Director</i> <i>AARP California</i></p> <p>Megan Burke <i>Policy Analyst</i> <i>The SCAN Foundation</i></p>
<p>11:35 – 11:50 (15-Minute Session)</p>	<p>F. Call to Action</p> <ul style="list-style-type: none"> • Assemblymember Cecilia Aguiar-Curry <i>Assembly District 4</i> 	<p>Louis Fox <i>President and CEO</i> <i>CENIC</i></p>
<p>11:50 – 12:00 Adjourn</p>	<p>Summary Remarks – Sunne Wright McPeak</p> <ul style="list-style-type: none"> • Next Steps • Next Session 	<p>Wednesday, December 2 8:30AM-Noon</p>



Delivering on the Promise of Telehealth to Improve Health Status in California Fact-Finding Listening Conferences October 22, 2020

SUMMARY

Purpose of Fact-Finding Listening Conferences

- Understand the status of Telehealth in California.
- Identify the gaps and barriers to optimizing Telehealth to improve health status for Californians.
- Develop an Action Plan to advance Telehealth policy and funding in California.

Welcome and Overview

Barb Johnston Yellowlees, Chair, California Emerging Technology Fund Telehealth Committee

- The purpose of the Fact-Finding Listening Conferences is to understand the status of Telehealth in California, identify the gaps and barriers to optimizing Telehealth to improve the health status for Californians, and gather input to inform an Action Plan that will advance Telehealth policy and funding in California.
- The discussion about the role and value of Telehealth in California has been in the making for more than 15 years. Now, COVID-19 has made obvious the need for Telehealth. The American Medical Association reports that in the first months of COVID-19 shelter-in-place orders, the increase in use of Telehealth was 8,000%.
- These recommendations should be considered for the Action Plan: (1) develop a national license for doctors; (2) extend beyond the pandemic current emergency regulations for reimbursement of Telehealth visits; (3) continue to allow doctors to prescribe controlled substances via telemedicine, particularly for groups suffering from addiction and for children with ADHD; and (4) review HIPPA to update the rules and regulations to apply to Telehealth technology today.

Sunne Wright McPeak, President and CEO, California Emerging Technology Fund

- The California Emerging Technology Fund (CETF) is honored to partner with the Co-Sponsors to convene the Fact-Finding Listening Conferences and to hear from all the participants.
- CETF Founding Director Barb Johnston Yellowlees is a pioneer in Telehealth in California and the nation. She wrote the foundational report on Telehealth for Governor Schwarzenegger's Cabinet that was referenced by the California Public Utilities Commission (CPUC) in directing the establishment of CETF in 2005. That report stemmed from a Cabinet Economic Vitality Conversation on Rural Economic Development with leaders from around the state who identified Broadband as the top need in rural communities to attract investment. Barb Johnston Yellowlees also led the effort for CETF to provide the original cash match to the FCC Rural Healthcare Pilot Program to establish the California Telehealth Network (CTN).

- The mission of CETF as directed by the CPUC is to close the Digital Divide in California. Research shows that people adopt technology when it is relevant to them and one of the most valued uses is for healthcare. The Fact-Finding Listening Conferences are exploring the convergence of technology with healthcare to optimize Telehealth to ensure quality care for medically-disadvantaged residents and to improve overall population health, bringing together Telehealth experts and major healthcare providers with Digital Equity Champions helping to deploy Broadband (a generic term for high-speed Internet infrastructure including wireline and wireless networks) and to get people online, including Broadband Regional Consortia and community-based organizations (CBOs), such as United Ways of California.

A. Introductory Remarks from Co-Sponsors

Partners in Care Foundation: June Simmons, President and CEO

- Partners in Care Foundation (PICF) is a non-profit organization that strives to achieve better health outcomes by marrying social care and medical care. PICF also is a change agent that has helped residents stay at home and out of nursing homes and hospitals during COVID-19. PICF helps people find “medical homes” to avoid continuously using emergency rooms.
- PICF has observed tremendous gaps in care for their clients with closed medical offices and clinics during the pandemic. Clients could not get medications and food on a regular basis. PICF is searching urgently to find ways to get and keep people connected via the Internet and technology to enhance their social connections and mental well-being.
- The pandemic emergency regulatory changes for Telehealth are great, but doing everything remotely also increases loneliness and social isolation, which are powerful drivers of social determinants of health, shortening lifespan up to 7 years—the equivalent of smoking 15 cigarettes a day. PICF is thrilled to be a partner in the Fact-Finding Listening Conferences and is appreciative of the leadership that CETF brings to advancing Telehealth.

CENIC: Louis Fox, President and CEO

- CENIC (Corporation for Education Network Initiatives in California) is a non-profit organization that connects all of the research and higher education institutions in California to high-speed Internet infrastructure to enable research. The CENIC mission has been expanded by the Legislature and Administration to include all K-12 Districts, County Offices of Education, libraries, and all of the medical centers, including the City of Hope. CENIC connects 7 large university medical centers and major hospitals with other healthcare providers in California, such as community hospitals. The montage of healthcare providers are all concerned about reaching their constituents through Telehealth.
- There are about 12,000 institutions that connect to the CENIC network with about 20 million Californian users. What happened last March during the COVID-19 shelter-in-place orders is that many of those 20 million Californians were at home trying to get online. CENIC had to think about assisting those users over the Internet to ensure continuity of education, healthcare, and employment.
- CENIC is working with residential networks to pair with its network, so the traffic does not have to go over the commercial Internet. At the next Fact-Finding Listening Conference in December, you will hear from Dr. Jim Marcin who is the head of the Health and Technology Center at UC Davis Health who describes what he does as “moving knowledge not people” which is “center stage” for CENIC. CENIC looks forward to having this conversation.

California Primary Care Association: Andie Martinez Patterson, VP Government Affairs

- California Primary Care Association (CPCA) represents community clinics and health centers across California. CPCA has long-been a proponent of Telehealth and expanded Broadband access. Rural members are innovators and have been consistently pushing CPCA to do more in Telehealth. CPCA has done so for a long time without much traction. Once COVID hit CPCA expected flexibility in payment for Telehealth to take two weeks, but it actually took three days. CPCA commended the Department of Health Care Services (DHCS) for responding so quickly, which allowed health centers to have flexibility and stabilize quickly.
- Clinics saw a deep drop in visits because patients were primarily served via face-to-face visits. Health centers rebounded quickly with 80% of visits via Telehealth but predominantly through telephonic due to Broadband challenges.
- Digital inequity exists because of high cost to rural access, and for so many other reasons as well. CPCA is pleased be a partner in Telehealth and will continue to fight with all stakeholders to ensure equity in Broadband and Telehealth delivery.

B. Telehealth – A Call to Action

Assemblyman Joaquin Arambula, M.D., Assembly District 31

- Assembly District 32 is in the San Joaquin Valley in Fresno County and includes 41% of the City of Fresno and all the rural Cities. In relation to zip codes being more predictive than one's genetic code, this Fresno District has a zip code that is one of the most disadvantaged in California and the disparities are compounded by the pandemic.
- This is an important time for California to focus on access to care with Telehealth for communities of color. The new reality requires California to meet this moment by investing in that which will bolster and enhance equitable access to and delivery of Telehealth. It must be fundamental to support to increase access for Telehealth and to aggressively respond to the social inequities, which are illuminated by this once in a century pandemic.
- The Digital Divide is real and California communities are experiencing deeper poverty along with it greater isolation. Shelter-in-place and physical distancing orders have highlighted the need for all Californians to be able to use Telehealth. It exposed the existing digital access inequities, especially for communities of color living in rural areas. California must meet the imperative to invest in constructing high-speed Internet infrastructure capable of supporting Telehealth services that gets all residents online with appropriate devices and improved digital literacy. California must look toward affordability and language and cultural competencies to meet the needs of our patients and of our communities. This engagement of stakeholders on Telehealth is welcomed.

Richard Figueroa, Deputy Cabinet Secretary, Governor's Office

- The buildout of broadband infrastructure is a necessity and must become a reality. The Governor's Office appreciates CETF for convening the Fact-Finding Listening Conferences and for stepping up and working with skilled nursing facilities (SNFs) in a Telehealth pilot that can serve as a model. COVID-19 required some changes in the way that health care is delivered during the pandemic. The 3 priorities that drove the Governor's Office action were: reduce staff exposure to ill persons; produce personal protective equipment (PPE); and minimize the impact of surge on facilities.

- Telehealth was a necessity to help provide care to patients while minimizing transmission risk to healthcare personnel, patients and the community at large. While Telehealth technology and its use are not new, adoption was not as widespread. Some recent changes during the pandemic have significantly reduced the barriers to Telehealth and promoted the use of virtual care as a way to deliver care. The Governor's Office is interested in seeing what is next in Telehealth, whether it is synchronous, asynchronous or remote patient monitoring. AB2164 by Assemblymembers Rivas and Salas was introduced in 2020, which would make permanent the temporary flexibilities for Telehealth, was vetoed by the Governor with a message saying he is supportive of utilizing Telehealth to increase access to primary and specialty care services, but that the Department of Health Care Services (DHCS) currently is in the process of evaluating its global Telehealth policy to determine what temporary flexibility should be extended beyond the COVID-19 pandemic.
- The Governor's Office is committed to Telehealth and is open to considering all learnings from this Fact-Finding Conference to incorporate them into the ultimate strategy. This convening is very timely. When budget discussions take place in 2021, the Governor's Office will have a strategy in place. However, the Administration is cautious about actions supported only by the General Fund, even as a first step. Further, it is essential to understand that Telehealth requires the necessary infrastructure to be meaningful. The Governor's Office to keep the lines of communication open and to share learnings.

Sunne Wright McPeak

- Richard Figueroa provided an excellent "call to action" and a great charge to all participants. This is an opportunity, an invitation, and actually an assignment to provide the Governor's Office with recommendations they need for both Telehealth policy and infrastructure.

Jim Kirkland, General Counsel, Trimble, Inc., CETF Director

- CETF is about bridging the Digital Divide and providing the broadband pipes used for many purposes which are too often taken for granted. The COVID-19 crisis has highlighted the huge Digital Divide: When people are on the wrong side of that Divide, they can be denied access to healthcare and education. CETF believes that this crisis highlights that broadband should be a civil right, not just for healthcare or education, but for all the economic opportunities that are associated with it.
- CETF has been working on this issue from the connectivity standpoint for more than 15 years. It is both distressing to witness the lack of progress in the transformation of healthcare delivery through Telehealth up until the pandemic and interesting to see immediate changes to respond to the emergency, yet patients too often are limited to a telephone only. Telehealth must be expanded so that doctors and patients can see one another.
- There is collective power in advancing this Telehealth agenda given the range of knowledge and the various perspectives and expertise from the range of stakeholders. CETF has convened this Fact-Finding Listening Conference to draw upon the many strengths and efforts of participants to pull together to seize this moment in time to transform the delivery of healthcare and improve overall population health through Telehealth.

C. Telehealth in California – An Overview

Presenters

Kim Klupenger, CTN President, Chief Experience Officer, California Telehealth Network, OCHIN

- CTN has promoted and fostered the provisioning of Broadband. The California Telehealth Resource Center (CTRC) is under CTN. Since April when COVID struck, the CTRC has supported 6,144 individual inquiries about how to use and promote Telehealth and it has held 28 separate events—all with very little funding. CTN is interested addressing the important question of how all stakeholders band together in the State of California.
- CTN has 177 locations, representing 88 organizations on the Broadband Health Center Control Network. This includes many clinics, which are on the electronic medical record (EMR) Epic or NextGen. CTN supports the work on the Network in partnership with CTRC.
- CTN was awarded \$1 million for California and \$1 million for OCHIN by the FCC from CARES Act funds. In California, the \$1 million allowed CTN to provide 11 organizations with the “clinic in a box” and a packet of devices. CTN sent out laptops for virtual at-home clinics, hypertension management kits, diabetes management kits, and also provided all the IT support. CTN established a helpline for patients to call into the CTN operations center and get direct support, as no one would want a provider trying to help a patient learn how to download Zoom. It is time to leverage all the technology, infrastructure, and everything that has been built collectively so all stakeholders can directly help patients.

Mei Kwong, Executive Director, Center for Connected Health Policy and California Telehealth Policy Coalition

- The Center for Connected Health Policy (CCHP) was established in 2009 as a program under the Public Health Institute to advance Telehealth policy in California. In 2012, CCHP became a federally-designated national Telehealth policy resource center through a grant from Health Resources and Services Administration (HRSA), which funds a total of 14 centers. As a national center, CCHP receives only \$325,000 annually from HRSA, which requires efficient funding management to cover both California and the nation. CCHP works with a variety of state and national partners such as the California HealthCare Foundation and AARP. CCHP also is the administrator of the National Consortium of Telehealth Resource Centers, which are Health Research Centers under the same grant program as the CTRC. CCHP collaborates closely with others to ensure efficient use of funding, such as common projects to erase duplication and provide consistent information that is disseminated.
- Preliminary data from the Centers for Medicare and Medicaid Services (CMS) suggests that services delivered via Telehealth increased from February through April 2020 at a rate of 2,632% more than compared to March-June in 2019. The status of Telehealth in California includes: (1) changes made by the State and federal governments are temporary and are not yet permanent; and (2) no significant Telehealth legislation has been signed in the 2020 legislative session. The Governor vetoed AB2164 and in his message stated that 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.”
- CCHP is the convener for the California Telehealth Policy Coalition (CTPC), which was established in 2011, and is a project of the CCHP. It includes 100 state and national organizations as members. CTPC is a resource of educational materials and provides informational webinars and legislative briefings. CTPC recommendations for 2021 include:

(1) Continue to require payment for the use of telephone to deliver services, including for FQHCs and RHCs and continue to allow them to provide services to their patients in the home. (2) Expand payment parity for Telehealth-delivered services to MediCal Managed Care. (3) Require reimbursement of remote patient monitoring and e-consult in MediCal including for FQHCs and RHCs and allow them to establish a patient-provider relationship via Telehealth. (4) Create more provider education materials on how to bill for Telehealth. (5) Generate more patient education on the availability of Telehealth and how to access it. (6) Update outdated forms that do not allow billing for Telehealth. Other issues that are beyond reimbursement and coverage include the need for broadband, licensing, and education of providers and consumers.

Responders

June Simmons, President and CEO, Partners in Care Foundation

- COVID-19 has made systemic or institutional racism more visible in specific populations. As infrastructure and system improvements are made, it is essential to connect that portion of the system that deals with social conditions with patient and person engagement—people still need to be engaged. PICF works with many agencies across the state that are part of the safety net. If people are in the street or at home, PICF works to persuade them that they should access health care that is vital, worth it, and safe—very important factors.
- PICF is interested in full integration of social care and medical care. There is movement across the country to organize both home and community-based delivery systems. There are networks statewide that involve many agencies that can be accessed through a central point, a network lead entity that is needed and equipped for this work. These networks are a big part of how PCF reaches out to engage and train community health workers.
- There is a fantastic opportunity to change quality of life and health outcomes by building bridges among consumer and community service networks linked to policy support and technology expertise. It is a “new village” that is being built.

Dorian Traube, Ph.D., Associate Professor, Dworak-Peck School of Social Work, University of Southern California, CETF Director

- The vast level of under-funding in this country for Telehealth services and coordination needs to be addressed seriously at all market levels. With efforts to close the Digital Divide, it is critical that other cliffs or divides are not created. If care is being accessed from national service providers, they may or may not be able to connect patients with regional or local services that will support and promote health. Safety nets also have to be reinforced.
- The term “social determinants of health” is fancy code for poverty, inequality and racism that appear in our physical functioning. If these issues are to be addressed with Telehealth, it means expanding beyond standard medical services delivery and pulling in allied professionals around physical therapy, occupational therapy, and behavioral health. Offerings must be expanded to have comprehensive care using Telehealth.
- The other issues that must be taken into consideration with Telehealth include: Where are the children and what is happening around pediatric care? Pediatricians historically have been very reluctant to enter into the field of Telehealth for many reasons. Closing the Digital Divide is imperative because we are on the precipice of leaving an entire generation behind, in education, health, mental and emotional health. Each of these areas need to be addressed through the collective efforts to advance Telehealth.

D. Panel: Community Health Clinics and Federally-Qualified Health Centers (FQHCs)

Presenters

Britta Guerrero, CEO, Sacramento Native American Health Center

- The Sacramento Native American Health Center (SNAHC) initially was using Telehealth for a very limited number of services. However, within about 72 hours, SNAHC was able to move into full-service delivery via Telehealth using phone visits and a Zoom platform. About 93% of SNAHC patients are dependent on MediCal, and about 60% have co-occurring disorders making them very high risk. SNAHC has many elder patients that needed to be protected from COVID-19; therefore, many changes were made on intake procedures for patients who did not need to see a provider in person.
- Telehealth has helped to remove barriers for patients, such as transportation and childcare. For patients with anxiety disorders and behavioral health issues, they have been able to have their regularly-scheduled appointments and have been able to get medication refills.
- The SNAHC no-show rate historically was about 30%, which is the national standard in the FQHC environment. SNAHC went from 30% no-show rate to a 100% show rate using Telehealth. Patients were able to do either a phone visit to have a feeling of privacy or they a face-to-face visit via Zoom. One of the issues patients reported with face-to-face use of the Zoom link was anxiety and nervousness about a provider seeing their home, which made the phone option important. SNAHC would like to maintain this option, particularly at a time when patients are experiencing isolation, depression, anxiety at higher rates.

Laura Miller, M.D., Chief Medical Officer, Community Health Center Network (Alameda)

- The Community Health Center Network (CHCN) consists of eight FQHCs in Alameda County. CHCN has more than 95 sites, 270,000 patients, and a million visits annually in primarily an urban region. CHCN is a MediCal managed care service organization that sees 67% Medi-Cal patients, along with patients with different sources of insurance and a large portion who are uninsured. The patient population is wildly-diverse ethnically, with a large proportion who are LatinX, African American, and Asian.
- CHCN has turned on a dime with regard to Telehealth. Since mid-March there has been an explosion of Telehealth visits and also a stabilization of the types of Telehealth encounters, which are mainly via telephone rather than video. Some barriers CHCN has experienced include: (1) Some patients and providers are comfortable with technology and do not have access to stable Internet service, which is clearly what CETF has been working on for so long. Sometimes video calls with elders are pixelated and freeze and not everyone has access to devices. (2) Non-English-speaking patients have incredible challenges, which include getting three people (patient, translator and provider) on the same audio or video call. (3) Lack of privacy in the home (people may not be willing to speak about behavioral health issues or interpersonal violence if they cannot find a private and safe space in the home to do so and some people are embarrassed about what their home may look like).
- CHCN proposed 5 action steps: (1) Optimize the use of connected devices (getting blood pressure cuffs in the home has been a huge challenge, much less than being connected). (2) Improve Zoom via MyChart as it has been a challenging and cumbersome process. (3) Engage in advocacy to continue to reimburse for Telehealth visits in the FQHC setting. (4) Erase the Digital Divide. (5) Identify structural barriers for patients that lead to no-show rates and work to minimize the economic burden of taking time off.

Tory Starr, CEO, Open Door Community Health Centers

- Open Door Community Health Centers serves the 2 farthest Northwestern Counties in California (Humboldt and Del Norte), which are equal in size to Connecticut, Rhode Island and Delaware combined. Open Door has 12 clinic sites, serves about 60,000 unduplicated patients, and provides 300,000 visits a year. Open Door is the largest primary care provider and the largest provider of obstetrics (OB) and emergency room (ER) care in the region.
- Telehealth presents unique challenges and opportunities for rural regions: (1) Healthcare is an archaic system in that it requires patients to come in to get care because that is the only way a provider can get paid. For rural patients, coming into a clinic is not the most convenient or cost-effective approach when it requires them to take off time from work, which makes video-care essential. (2) Telehealth provides an opportunity to expand patient access to care. It removes many barriers that people have. (3) Telehealth is the only way this region will be able to do population health management. It is a vital tool in the toolbox to be used more effectively.
- However, broadband access in rural areas is an enormous challenge because infrastructure (the “pipes”) is needed. There are many places that people cannot get to the pipes, and if they were able to do so, affordability often is an issue. Open Door continues to support both broadband deployment and affordability for adoption. The ability to get access to the technology and work with technology is especially challenging in a rural area. For example, Open Door’s region has a large senior population who need to learn how to use this technology, which takes time, energy and resources to do so.

Berenice Nunez Constant, Vice President of Government Affairs & Civic Engagement, AltaMed Health Services Corporation

- AltaMed is one of the largest FQHCs in the nation that serves over 300,000 patients in both Los Angeles and Orange Counties. When COVID-19 struck AltaMed, it became a logistical hurdle to overcome and Telehealth became a huge opportunity. The COVID-19 pandemic has accelerated Telehealth innovation, and it has moved AltaMed forward by years in just a matter of days. Telehealth visits are being provided, but building and sustaining the infrastructure has been an immense challenge.
- AltaMed provided approximately 315,000 Telehealth visits between March 15 to October 15 and nearly all were provided by telephone. In order to have true access, it requires that everyone involved is trained in the various technology modalities.
- AltaMed focuses on Telehealth from a health equity perspective: (1) Although many Californians have private insurance and have had access to Telehealth, it is only due to the pandemic that MediCal patients now have access to this technology through the FQHCs. (2) Telehealth is the new normal and it must be sustained, which is linked to figuring out the payment and reimbursement components. (3) AltaMed wants to fully utilize Telehealth but needs the support for training communities to use this technology to ensure they have access to it. AltaMed is a healthcare provider that recognizes the human component to the health care service it provides every single day.

Responders

Kara Carter, Vice President for Strategy, California Health Care Foundation

- The California Health Care Foundation (CHCF) has been committed to expanding Telehealth in California over the last 10 years. In the last few months, CHCF has awarded \$6.5 million to more than 50 organizations to try to promote and further Telehealth.
- CHCF conducted a survey among Californians and asked about their experience with health care, particularly in the last few months. The CHCF survey found that: (1) Two-thirds of Californians, both low-income and non-low-income, reported engaging in Telehealth or Telehealth visits in the last few months, and two-thirds of that group surveyed reported a good experience. (2) Related to health equity, three-quarters of people of color reported a good experience with Telehealth and two-thirds of those said they would choose a Telehealth visit over an in-person visit if given the option. This illuminates how important Telehealth is and CHCF believes it is shameful that it has taken California 10 years and a pandemic to deliver something that is so needed in communities.
- CHCF recommendations include: (1) Reimburse for Telehealth. What gets measured is what gets done—and what gets paid, gets done even more. In healthcare, California must expand its current payment environment. (2) Ensure broadband access through policy for Californians in rural and urban areas—the pandemic has lifted up this like nothing else has. (3) Monitor the utilization of Telehealth. There are numerous anecdotes and data is coming out in pieces. Widespread monitoring is needed to understand experiences across payers, particularly to assist the public payers understand what is happening and to inform California policymakers to be able to adopt policies and practices that should be ongoing.

Andie Martinez Patterson, Vice President Government Affairs, California Primary Care Association

- The CPCA central recommendation is payment. Telehealth has not been realized because of myopic views about payments and a perspective that there is less value to a telephonic or a Telehealth visit verses an in-person visit. Telehealth is limited because it is not valued or providers don't trust it as much. It would be a mistake to downscale payment for Telehealth because it brings a lot of value to the patient community. The patient does not need to drive a distance or miss work or lose wages for a 15-minute in-person visit. How value is quantified merits rethinking.
- Payment for healthcare must fundamentally change. A different payment model altogether is needed for telephonic and Telehealth visits. A fee-for-service model only incentivizes providers to see patients when they are sick. Providers must be reimbursed for the extra amount of work that is needed to keep patients healthy. CPCA is working on this issue.
- Changing payment models unleashes creativity and fosters a new framing of equity. California must trust providers and their staff to know what is best for their communities. They will use a whole new array of staff—community health workers, pro-data nurses, and case manager—and they will know how to do this much better. COVID-19 has shown us that we no longer have a choice. This must be achieved through collective action.

E. Panel: Senior Care Facilities

Presenters

DeAnn Walters, Director of Clinical Affairs & Quality Improvement, California Association of Health Facilities

- California Association of Health Facilities (CAHF) represents almost 900 of the 1200 skilled nursing facilities (SNF) across California. CAHF definitely is willing to take advantage of Telehealth, but it is taking a lot of time to get to the point where it can be readily utilized, and there is a long way to go. Telemedicine in SNFs has not had the best history. There have been multiple barriers to overcome.
- Many SNFs have begun to increase the use of Telehealth in response to COVID-19. CAHF granted up to \$3,000 to each SNF that applied for funding to implement the technology to help support physician visits virtually and many took advantage of this assistance. In many cases, staff members were utilizing their personal devices to help residents connect with their families, as the emergency rules allowed only health care personnel into the SNFs.
- There are many benefits to SNFs for utilizing Telehealth. For example, in the past, staff would take patients out to appointments because their primary care physicians typically would not see them in the SNF and residents generally are required to leave the SNF to see specialists. Telehealth saves staff time in preparing patients to go out to for medical visits, which is very time-consuming. Residents often need to be ready 2 hours before their appointment because the transportation company has a 2-hour window for pick-ups.

Paula Hertel, Board Member and Education Committee Co-Chair, California Assisted Living Association

- California Assisted Living Association (CALA) represents licensed residential care facilities for the elderly (RCFEs), which are licensed under the Department of Social Services, Community Care Licensing Division. In California there are more than 7,000 RCFEs, 6,000 of which are board-and-care homes, which generally are residences with 6 beds or fewer.
- COVID-19 has impacted Telemedicine with both challenges and opportunities: (1) The pandemic has helped doctors get reimbursed for Telehealth. This is where opportunities are and there is likely to see more use of Telehealth, which can lead to better outcomes for residents. (2) Telehealth is an incredible benefit to avoid transfer trauma. (3) Some Telehealth technology is already being used in FCFEs, such as tablets, which is helpful for quality-assurance work when COVID-19 is in a facility. There has been an uptick of using Telehealth for remote assessments and screening for the residents and staff, and for care coordination and continuity of care. (4) Telehealth has an impact on the delivery of care system. Telehealth allows residents to access specialists, in particular geriatricians, who are throughout the country; access to care is not confined only in California. Trying to find a geriatrician who can make house visits, or even to get an appointment to see one in a clinic in many areas of California, is very difficult.
- High-speed Internet connectivity must be available for RCFEs. CALA members have had connectivity problems due to the thickness of walls and have had to use repeaters, but they are not always effective.

Karl Steinberg, M.D., Past-President; Chief Medical Officer, Mariner Health Care Central, California Association of Long-Term Care Medicine

- COVID-19 has launched everyone into a new era. Previously there was a limit in nursing homes of one telemedicine visit every 30 days. Now, with the temporary waivers, there are no limits to the number of Telehealth visits, which has opened the door for telephone visits. Two important points to consider are: (1) Patients should not have to access a higher level of care when they do not need it (such as, ER care). Telemedicine visits or virtual visits can be very effective, not just for routine care, but also for diagnosing problems and looping in people for family meetings or other physicians for consultations. (2) Currently initial comprehensive visits are allowed by telemedicine and can be provided by nurse practitioners and physicians assistants (PAs). Historically, the concern had been that these visits could be abused by providers who are too lazy to drive to the nursing home and instead just do visits by telemedicine when they should be done in-person. The hope is that this abuse will not occur. It is essential to recognize that these visits do require staff time and it needs to be accounted for in any program.
- The CETF SNF Telehealth Pilot Project is important. Other pilots have occurred in San Diego with West Health in long-term care settings, which is the wave of the future. The important lesson is that a geriatrician should be on the other side of these visits. Hospitalists are not geriatricians and geriatricians would disagree with some of the treatments they provide. It is essential to have competent providers who know geriatrics and who know nursing home regulations that are providing the care.
- Telemedicine will be a huge game changer and it is especially helpful during home visits. When a Telehealth visit is scheduled while the home health nurse is seeing the patient, it can be a tremendous advantage to the patient and the provider. It can help the provider see the problem, such as wound care, and determine the appropriate care with the nurse. This kind of care delivered through Telehealth has positive equity implications.

Julie Bates, Associate State Director, AARP California

- High-speed Internet broadband and WiFi infrastructure have been proven integral to all components of life and living. This is an unintended beneficial awareness that has come as a result of the pandemic.
- AARP recommendations are: (1) Make all reimbursement and other emergency changes permanent for all Telehealth expansions and waivers. (2) Expand the utilization of the electronic health record so the patient's information goes wherever the patient may be, whether it's home or to the hospital or to their doctor's visits. (3) Ensure that reimbursement for Telehealth visits continues with the idea of pay equity and payment parity. (4) Expand licensure so that patients can continue to have access to the appropriate health professional wherever regardless of the location of the patient.
- The access to and the implementation of high-speed internet to every home will need to be a campaign similar to those that brought electricity and the telephone to the home environment in past generations. This must be accomplished. Both high-speed Internet and Telehealth have been discussed for years, followed by the excuse that broadband infrastructure is too expensive. Californians cannot live, work, access health care, or learn without it. COVID-19 may be the unintentional consequence that leads to this change.

Responder

Megan Burke, Policy Analyst, The SCAN Foundation

- There is much more that can be done with telehealth in the delivery of long-term services and supports. Telehealth can relieve the stress and trauma related to taking patients to appointments outside the facility.
- Family engagement has been left out of the Telehealth discussion. Caregivers often are thought of as only those who take care of family members in their home. “Caregivers” also should refer to those family members who support someone in a residential facility or SNF, because families continue to stay connected to the facility staff and physicians. Telehealth provides an opportunity to engage family members and caregivers in assessments and medical appointments, especially for caregivers providing long-distance support.
- Telehealth regulations must be reviewed to assess implications and opportunities to bring along the healthcare system to focus on the impact on a person’s care experience.

F. Call to Action

Assemblymember Cecilia Aguiar-Curry, Assembly District 4

- Telehealth is a life-saving tool, particularly during COVID-19. In California, inequities of healthcare access have been laid bare through the pandemic, especially with a severe shortage of providers in rural areas. With patients now embracing virtual care, Telehealth is here to stay with both challenges and opportunities that can be addressed successfully.
- Assembly District 4 includes 6 Rural Counties that lack access to health care. Telehealth has answered the need in so many ways. There has been a 750% increase in people using tele-psychiatry in one County. Priorities for action are: (1) Expand Telehealth services. (2) Make reimbursement for Telehealth equal to in-person visits. (3) Make permanent the Telehealth services subject to federal waivers. When federal waivers expire as the pandemic winds down, the Legislature must be prepared with State law to continue Telehealth parity.
- Internet for All is an imperative—high-speed Internet service in all communities, especially unserved and underserved. It is unfortunate that it took a pandemic for leaders to understand the importance of broadband. Typically broadband discussions have focused on schools, which are important, but the discussion needs to be expanded to health care, job creation, training, agriculture, etc. California cannot be left behind. The Legislature and Governor must ensure high-speed, full-proof, quality Internet access for all although it will not be easy. The intent is to reintroduce a bill similar to AB570 in the next Session and help from CETF and all participants will be needed. Mobilization is will be essential to succeed.

Louis Fox, President and CEO, CENIC

Louis Fox presented verbally the following Summary of Conclusions and Recommendations as the capstone to the Fact-Finding Listening Conference. Barb Johnston Yellowlees contributed to completing the delineation of the Recommendations.



**Summary of Conclusions and Recommendations from Fact-Finding Listening Conference
Delivering on the Promise of Telehealth
October 22, 2020
Compiled by Louis Fox and Barb Johnston Yellowlees**

Major Barriers to Optimizing Telehealth

For Individuals

- Insufficient broadband access, access to devices, affordability, and adoption.
- Need for language, culture, trust, and “ability” in telehealth.
- Lack of consumer information on telehealth.

For Medical Institutions and Providers

- Lack of support for implementation/deployment, training, and technical assistance.
- General under-funding of telehealth.
- Uncertainty about reimbursements and continuation of COVID-19 era public policy.

Key Action Steps to Optimize Impact of Telehealth on Health Status

1. Invest in broadband access, devices (including health monitoring devices), and adoption.
2. Support multiple modalities.
3. Sustain telehealth reimbursements post-COVID.
4. Increase governmental investments in telehealth (infrastructure, equipment, training).
5. Expand provider training and technical support.
6. Broaden access to virtual language interpretation services for telehealth.
7. Expand consumer information on telehealth access.
8. Understand issues of culture, trust, “ability” and provide necessary support structure(s).
9. Advocate for a national license in post-COVID-19.
10. Establish a national credentialing agency for physicians.
11. Continue allowing prescribing controlled substances via telehealth post-COVID.
12. Advocate for permanent elimination of geographic locations post-COVID.
13. Review and update HIPAA requirements (enacted in 1996) to support telehealth and IT.
14. Ensure that public policy and funding are commensurate with practice (update forms).
15. Develop comprehensive care: integrate social and medical care in the telehealth context.
16. Include long-term care facilities in comprehensive telemedicine policy.
17. Understand and address privacy and data security issues.



**Delivering on the Promise of Telehealth to Improve Health Status in California
Fact-Finding Listening Conference
October 22, 2020**

Attendance List

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>
Honorable Cecilia	Aguiar-Curry	State Assembly - AD 4
Sadia	Akmal	MedPoint Management
Rhoda	Alajaji	211 Los Angeles
Leticia	Alejandrez	California Emerging Technology Fund
Gretchen	Alkema	The SCAN Foundation
Dolores	Alvarado	Community Health Partnership - Santa Clara County
Arlene	Amaya	Community Clinic Association of LA County
Karissa	Anderson	CALIFORNIA Department of Public Health
Katie	Andrew	N/A
Honorable Joaquin	Arambula	State Assembly - AD 31
Karen	Armijo	SCAN Health Plan
Jaime	Augst	CENIC
Adam	Ballard	N/A
Gabriella	Barbosa	Children's Partnership
Julie	Bates	AARP California
Diana	Baumohl	GoodRx
Mark	Bella	Norcal Center
Heather	Bernikoff	JBM McClatchy Foundation
Lore	Bertuch	Shield Health Care
Larry	Best	California Emerging Technology Fund
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Seth	Ellis	Memorial Care
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Ellen	Kramer	Partners in Care Foundation
Mei	Kwong	Center for Connected Health Policy
Olivia	Lee	AltaMed Health Services Corp. Central Coast Broadband Consortium
MaryAnn	Leffel	
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Kelsey	Lyles	Greenlining Institute
Cynthia	Mackey	Winning Strategies
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Betty	Ramirez	City of San Jose Youth Commission
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Martha	Van Rooijen	Inland Empire Regional Broadband Consortium
Abdul	Wahid	Miskita Consulting
Susan	Walters	California Emerging Technology Fund
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Jennifer	Ward	Orange County Business Council
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Jim	Williams	Agency for Aging – Area 4
Revlyn	Williams	Manchester Community Technologies, Inc.
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Young	Yu	SAESHE Public Relations & Communications



Delivering on the Promise of Telehealth to Improve Health Status in California Fact-Finding Listening Conference

Wednesday, December 2, 2020
8:30AM – Noon (Pacific Time)
(Conference Will Be Recorded)

Purpose of Fact-Finding Listening Conferences

- Understand the status of Telehealth in California.
- Identify the gaps and barriers to optimizing Telehealth to improve health status for Californians.
- Develop an Action Plan to advance Telehealth policy and funding in California.

AGENDA

Time	Panel and Speakers	Responders
8:30 – 8:40	<p>Open Listening Conference</p> <p>Welcome and Overview Barb Johnston Yellowlees, Chair, CETF Telehealth Committee</p> <ul style="list-style-type: none"> • Background, Vision Goal and Purpose • Summary of October 22 Session 	<p>Leticia Alejandrez <i>CETF Director of Telehealth and Human Services</i></p> <p>Sunne Wright McPeak <i>CETF President and CEO</i></p>
8:40 – 8:50	<p>A. Telehealth – A Call to Action</p> <ul style="list-style-type: none"> • Assemblymember Eduardo Garcia, Assembly District 56 • Glen Xiong, M.D., Clinical Professor, University of California, Davis 	
8:50 – 9:20	<p>B. A Vision for Telehealth – From A Pioneer in the Field of Telehealth and Telepsychiatry</p> <ul style="list-style-type: none"> • Peter Yellowlees, M.D., Chief Wellness Officer, University of California, Davis <i>Former President, American Telemedicine Association</i> <p>Questions and Answers</p>	<p>Glen Xiong, M.D. <i>Clinical Professor, University of California, Davis</i></p> <p>Eliza Heppner <i>Director, Programs, AARP Foundation</i></p>

<p>9:20 – 10:10</p>	<p>C. Panel: Managed Health Care Plans</p> <ul style="list-style-type: none"> • Kaiser Permanente Khang Nguyen, M.D., <i>Physician Director, SCPMG Virtual Medical Center/Clinical Call Center</i> • Blue Shield of California Olivia Chung, R.D., <i>Principal Telehealth Program Manager</i> • UnitedHealthcare – Medicare & Retirement Saurabha Bhatnagar, M.D., <i>Chief Medical Officer, Head of Technology and Performance</i> <p>Questions and Answers</p>	<p>Dan Southard <i>Deputy Director California Department of Managed Health Care</i></p> <p>Sheirin Ghoddoucy <i>Attorney III, Health Policy & Reform Branch, California Department of Insurance</i></p>
<p>10:10 – 10:50</p>	<p>D. Panel: Public Sponsored Health Plans</p> <ul style="list-style-type: none"> • Covered California Ashrith Amarnath, M.D., <i>Medical Director, Plan Management Division</i> • L.A. Care Alex Li, M.D., <i>Deputy Chief Medical Officer</i> Len Rosenthal, <i>Director, HIT Department</i> • Contra Costa Health Plan Sharron Mackey, CEO <p>Questions and Answers</p>	<p>Dan Southard <i>Deputy Director California Department of Managed Health Care</i></p> <p>Sheirin Ghoddoucy <i>Attorney III, Health Policy & Reform Branch, California Department of Insurance</i></p>
<p>10:50 – 11:50</p>	<p>E. Panel: Telehealth and Medical Centers</p> <ul style="list-style-type: none"> • University of California, San Francisco Linda Branagan, Ph.D., <i>Director of Telehealth Programs</i> • University of California, Davis Children’s Hospital James Marcin, M.D., <i>Pediatric Intensive Care Unit</i> • Stanford Children’s Health Natalie Pageler, M.D., <i>Chief Medical Information Officer</i> • Stanford Children’s Health Anshul Pande, <i>Chief Technology Officer</i> <p>Questions and Answers</p>	<p>Louis Fox <i>President and CEO CENIC</i></p>
	<p>F. Veterans Affairs – Palo Alto Health Care Services</p> <ul style="list-style-type: none"> • Veterans Affairs Palo Alto Health Care System Alka Mathur, M.D., <i>Medical Director, Virtual Behavioral Health Services</i> <p>Questions and Answers</p>	<p>Barb Johnston Yellowlees <i>CETF Board of Directors</i></p>
<p>11:50 – 12:00p Noon Adjourn</p>	<p>Summary Remarks and Next Steps</p> <ul style="list-style-type: none"> • Sunne Wright McPeak 	



**Delivering on the Promise of Telehealth to Improve Health Status in California
Fact-Finding Listening Conference
December 2, 2020**

SUMMARY

Purpose of Fact-Finding Listening Conferences

- Understand the status of Telehealth in California.
- Identify the gaps and barriers to optimizing Telehealth to improve health status for Californians.
- Develop an Action Plan to advance Telehealth policy and funding in California.

Welcome and Overview

Barb Johnston Yellowlees, Chair, California Emerging Technology Fund Telehealth Committee

- Major discussions of Telehealth and broadband date back to 2005 when Governor Schwarzenegger’s Cabinet convened an Economic Vitality Conversation on Rural Economic Development with leaders from around the state. At that time, the leaders identified broadband as the number-1 need in rural communities to attract investment and, 15 years later, it still remains a major issue that is now compounded by the COVID-19 pandemic.
- CETF has been actively engaged in broadband with its mission to expand it to all Californians, particularly in unserved and underserved communities. CETF has a long history in Telehealth and broadband access. For example, CETF provided seed funding to establish the initial California Telehealth Network (CTN) and served on its Board of Directors.
- The COVID-19 pandemic was the impetus for the CETF Board of Directors to utilize its expertise once again in Telehealth and leadership in broadband to engage with providers, skilled nursing facilities (SNF) administrators, organizations, and government agencies on Telehealth. CETF learned of the many challenges and barriers to the use of Telehealth and embarked on this Fact-Finding Listening Conference to bring people together to learn more and discuss how to optimize Telehealth to enhance access to healthcare services across California, especially for underserved populations.

Sunne Wright McPeak, CETF President and CEO

- CETF is working again on Telehealth because the CETF Board of Directors immediately recognized the imperative to address healthcare disparities illuminated by the pandemic shelter-in-place orders. CETF has a long history of leadership in Telehealth as a founding partner for the California Telehealth Network (CTN) and the largest investor funder, providing the required cash match to original grant from the FCC Rural Health Care Pilot Program. CETF also provided the largest amount of funding to CTN to stand up operations and enable it to become an independent non-profit organization.

- CETF is advocating for significant State (> \$7B) and federal (< \$100B) investments in broadband with end-user speeds sufficient to support telehealth and distance learning for all residents. Broadband is a generic term for high-speed Internet infrastructure, including both wireline and wireless networks.
- Adoption of State policy to optimize the use of Telehealth to improve patient outcomes and overall population health will help drive these public investments in infrastructure, which in turn will enable Telehealth to meet the healthcare needs of all residents. There must be an institutionalized focus to both close the Digital Divide and optimize Telehealth.

A. Telehealth – A Call to Action

Assemblymember Eduardo Garcia, Assembly District 56

- Assembly District 56 includes both Imperial and Eastern Riverside Counties and has been hit hard by COVID-19. The lack of investment in healthcare and broadband infrastructure for medically-underserved populations is alarming. Telehealth is long overdue in the region and it is needed now as well as beyond the pandemic.
- California has the opportunity to address the Digital Divide with respect to how it delivers healthcare more efficiently and effectively. As the Legislature considers large broadband infrastructure investments, it will also need to address increasing capacity speeds and delivery of Telehealth services, while also addressing regions where there is no connectivity.
- California must deliver on its promise to ensure that 98% of all Californians are connected to what is now an essential service, not a luxury that only a few can afford but what everyone needs today. The hope is that physicians in the Legislature will take up the call to ensure that it modifies and reforms the policies necessary to make Telehealth services much more accessible to Californians.

Glen Xiong, M.D., Clinical Professor, University of California, Davis

- The media reports have accurately depicted the dire situation in long-term care facilities where an astounding 40% of mortality is due to COVID-19. In some cases the State Strike Team and the National Guard have been deployed to assist with staff shortages due to the effects of the pandemic.
- COVID-19 outbreaks in facilities have increased the call for more Telehealth immediately. Some facility administrators are asking providers to stay out of facilities for fear of bringing the disease into the facility and providers are equally concerned about entering facilities. Support for Telehealth among providers and administrators is critical for implementation and adoption Telehealth in systems.
- There is a connection between reimbursement barriers and disparities. CMS has temporarily lifted the barrier to reimbursement for Telehealth during the pandemic. In the past, providers were not reimbursed for Telehealth visits in skilled nursing facilities (SNFs) and long-term care facilities. Yet, residents in these facilities tend to be the most vulnerable with little-to-no-family support systems, nor do they have very good health insurance and most must rely upon MediCal.

B. A Vision for Telehealth – From A Pioneer in the Field of Telehealth and Telepsychiatry

Presenter

Peter Yellowlees, M.D., Chief Wellness Officer, University of California, Davis
Former President, American Telemedicine Association

- Telehealth is good for patients and providers, and it saves money. It has the potential to revolutionize the way providers deliver care via synchronous, asynchronous and remote patient monitoring. Telehealth also requires CMS to update its policies including rules for reimbursement of Telehealth visits. In the past, CMS would only allow reimbursement for patients in rural regions and not metropolitan areas. However, the data shows that Telehealth visits have increased 3,500-fold, and two-thirds of the Telehealth visits were provided to people in metropolitan areas, which is in strong opposition to the CMS view, which must be changed for the long term. In addition, psychiatry has gone 100% virtual and providers have seen “no shows” significantly decrease.
- The 3 main drivers of change that have attributed to the rapid increase in utilization of Telehealth include: (1) Relaxed regulations due to the COVID-19 emergency. (2) Proliferation of mobile devices—81% of US adults have a smartphone. (3) Promotion of the advantages of Telehealth.
- Telehealth in California can learn from the retail industry model and how it transformed online shopping. This did not occur overnight. It required the industry to invest in marketing, education, and in persuading consumers to have confidence and trust in this online modality. The retail industry helped consumers understand that shopping online was convenient, consistent and of high quality. Consumers purchased goods and services mainly through mobile platforms that were able to process electronic payments that were on systems that were easily monitored and secure. The 3 big changes the retail industry made are: (1) Changed its wholesale workflow and became much more consumer focused. (2) Increased choice and range of both services and goods. (3) Installed impressive IT systems to continuously monitor what is going on to predict such things as package arrival times. Retail also invested in data captured mainly through the use of passive approaches and would feed that data back to consumers, so they are more aware of what is going on. Similarly, Telehealth must place more focus on the consumer experience, particularly populations suffering the most disparities. Telehealth consumers require access to broadband and smartphones. Data indicates that consumers prefer to be seen virtually and in their homes—providers should see patients where they want to be seen. Finally, reimbursement must be the same whether in-person or virtual—particularly when considering that retail consumers do not expect to pay a different price because they go into a store rather than purchase online.

Responders

Glen Xiong, M.D., Clinical Professor, University of California, Davis

- Providers are essential to leading and promoting the adoption of Telehealth. Although Telehealth may take providers out of their comfort zones, such as seeing a patient in person with the ability to make eye contact, research studies have found that patients are not as concerned with eye contact as they are with receiving care and a good treatment plan.

- Telehealth allows healthcare providers to have more care coordination, but reimbursement incentives are not yet sufficient and need to appropriately incentivize providers.
- Congregate care settings have difficulty accessing strong Internet connections essential for Telehealth. Facilities often need multiple WiFi boosters to ensure a good connection in each room, an important consideration for implementation.

Eliza Heppner, Director, Programs, AARP Foundation

- AARP has focused on the Digital Divide for many years, pivoting programming to work with providers to help residents and patients use Telehealth services. Telepsychiatry especially has been a focus for AARP as well as addressing social isolation of older Americans. The COVID-19 pandemic exacerbated this issue for older adults and many other Americans of various ages who are experiencing isolation for the first time because of the pandemic.
- For older Americans, the healthcare provider is the main access point for patients who seek or need community-based services and Telehealth plays a huge role, particularly now, but even after the pandemic ends. Seniors living in affordable housing communities or in nursing homes need to connect to the outside world as it has an incredible impact on their overall health. One study found that being socially isolated has the same impact as smoking 15 cigarettes a day. Social isolation has increased due to the pandemic.
- AARP also is focused on increasing high-speed Internet access that is tied to health equity. Although AARP recognizes that disparities have existed in Telehealth for a long time, these disparities have been exacerbated—not everyone has access to Telehealth equally. AARP is interested in focusing on disparities in rural and marginalized communities and urban pockets to ensure older Californians have access to the right resources.

C. Panel: Managed Health Care Plans

Presenters

Khang Nguyen, M.D., Physician Director, SCPMG Virtual Medical Center / Clinical Call Center, Kaiser Permanente

- Kaiser Permanente (KP) uses synchronous, asynchronous and remote patient monitoring for specialty care and primary care. It also is expanding on the in-patient side. For example, KP has used Tele-stroke for years. Strokes have a short window to apply therapeutic measures to save and preserve patient functions. Tele-stroke can be used for Emergency Room patients so that the attending physician can consult a neurologist virtually for guidance.
- KP has been working to expand into the remote realm of Telehealth. Pre-COVID, KP conducted about 20% virtual visits for primary care, and even less for specialty care. Once COVID struck, KP went to 98% virtual visits in April. Psychiatry is similar with 90% virtual visits and specialty care increased to 80% virtual visits.
- To improve population health and address economic inequities and racial injustice, health systems and policy leaders must identify whether or not patients have access to devices, such as a smartphone, computer, and high-speed Internet that can accommodate video. High-speed Internet infrastructure remains a critical issue. The failure rate of Telehealth video is often due to a patient's lack of access to proper devices, high-speed internet, and the ability to be able to afford such access at home.

Olivia Chung, R.D., Principal Telehealth Program Manager, Blue Shield of California

- Long before the COVID-19 pandemic, Blue Shield of California (BSC) began implementing virtual care services. The pandemic has provided Blue Shield with the opportunity to assess the performance of its program and explore how to take it to scale.
- Reflecting on improvements, BSC was also able to leverage its position as a health insurance company to advocate for its providers and members. It worked closely with vendors to ensure BSC is using the best 21st century technology for all members.
- BSC has been challenged by how to collect data points into and coupled with artificial intelligence, machine learning, and content analysis so that it can use that data to develop accurate predictive modeling. BSC has been asking both its vendors and partners to help address this challenge with the hope of taking its existing technology to the next level.

Saurabha Bhatnagar, M.D., Chief Medical Officer, Head of Technology and Performance
UnitedHealthcare – Medicare & Retirement

- Telehealth has been an important part of UnitedHealthcare (UH). UH serves nearly 3 million members in California. Telehealth has been a big part of how UH has been able to respond during COVID-19. In 2020 from a national perspective, which includes individual and employer-sponsored plans, and Medicare and Medicaid, UH facilitated a little more than 20M Telehealth visits. This was a 20-fold increase in comparison to less than 1M Telehealth visits for the same business in 2019.
- UH has a large provider network for behavioral health services. Compared to last year, it saw a 42% increase in behavioral health services nationally and a similar increase in California – specifically using virtual visit technology. It will focus on how it can serve members and providers better via virtual technologies, include Telehealth and other technologies and ensuring they are accessible.
- UH has focused on the Medicaid business and FQHCs, both in California and nationwide. It found that FQHCs were able to develop and expand Telehealth capabilities very quickly early in the pandemic. Now there is an opportunity to think about how FQHCs shift from the quick technologies they got up-and-running during the emergency period and move into a more sustained phase going into 2021. This is an opportunity for government and other key stakeholders to think through how they can all work to support FQHCs.

Responders

Dan Southard, Deputy Director, California Department of Managed Health Care

- Telehealth has direct implications for the Department of Managed Health Care (DMHC), which has 2 main functions: (1) review health plan provider networks for adequacy; and (2) conduct medical surveys or audits of health plan activities to ensure compliance with the Knox-Keene Act, which is the body of law that gives DMHC regulatory authority. For the medical survey or audit side, DMHC looks to ensure quality, access and availability. For the provider network side, DMHC looks to ensure that health plans and provider networks are giving access to enrollees, not only in “brick-and-mortar” facilities. but also through Telehealth. This is the framework that defines the DMHC role.
- The DMHC challenge is to understand how Telehealth is being utilized in the future with respect to the quality of services in comparison to in-person visits and whether patients are consenting to the Telehealth modality and know that they have a choice.

- Payment parity has been a concern since the pandemic began. AB744 is applicable for commercial health plans on the payment-side, but it is not applicable to the MediCal plans. So there is an inconsistency and a parity issue, which makes it challenging for providers to know if and how they will be reimbursed when treating patients via Telehealth. Health plans and providers should work closely with DMHC to problem-solve moving forward.

Sheirin Ghoddoucy, Attorney III, Health Policy & Reform Branch, California Department of Insurance

- The California Department of Insurance (CDI) has done a lot of work on Telehealth in the last year. It has heard from carriers and insurers consistently that they are planning and expanding their platforms to deliver Telehealth, including behavioral health. CDI has learned surprisingly just how limited Telehealth is in behavioral health area in contrast to other medical services, but it appears to be on the mend and CDI welcomes this trend.
- Remaining areas of interest are: (1) HIPAA compliance; and (2) race and equity. With regard to HIPAA, CDI ensures compliance and privacy, confirming that insurers are using platforms compliant with those requirements. CMS made some pronouncements that in response to the pandemic that provided flexibility, and now there is a push to make these flexibilities permanent, which CDI thinks is important. With respect to race and equity, and given the range of technologies involved in accessing Telehealth, CDI recognizes that not every insured or enrollee has access to those technologies. CDI is pushing for access to these platforms. Insurance Commissioner Lara took similar action as did DMHC and began early implementation of AB744, pointing insurers to the federal regulatory flexibility. CDI continues to hear about concerns with reimbursement parity.
- Telehealth has been key for access in California with the wildfires that have occurred every year and appear to increase in frequency and duration. These emergencies not only cause displacement, but also make it difficult for patients to see their doctors. Network adequacy in rural areas always has been a concern for CDI, but in the past there has been a narrow view about what services can be appropriately delivered through virtual settings. CDI is pleased that this thinking has since evolved and everyone—regulators, carriers, providers, and patients—is beginning to recognize that meaningful care can be delivered through a virtual setting for a far-greater number of services than was thought previously.

D. Panel: Publicly-Sponsored Managed Health Care Plans

Presenters

Ashrith Amarnath, M.D., Medical Director, Plan Management Division, Covered California

- Covered California is a state-based insurance exchange marketplace committed to working with Qualified Health Plans to improve how and where their enrollees receive healthcare access that includes Telehealth. Telehealth offers greater and more timely access to medical care for enrollees, especially in services that have particular access barriers, such as behavioral health. With the COVID-19 pandemic, access to primary care and to multiple other services is equally as important.
- Telehealth provides a unique solution to a huge gap in general care services that has been caused by the pandemic, including deferred care, such as immunizations and screenings for cancer and other serious conditions.

- Utilization rates for Telehealth have increased in response to the pandemic. Before the pandemic, Telehealth utilization rate as a percentage of total visits was about 1-2%. After the pandemic, it has increased 50-80% in some plans, which is a huge testament to how Telehealth has given access to those in need during this difficult time. Covered California is reviewing policies to determine how to enhance contracts with health plans to encourage Telehealth and expand access to care.

Alex Li, M.D., Deputy Chief Medical Officer, L.A. Care

- Telehealth has progressed in a short period of time for LA Care. LA Care invested in technology, workforce, and the provider community. Virtual care has brought people together in a different way; physicians, nurse practitioners, and other frontline providers need to continue to work together in a different way to benefit patient care. The LA Care framework looked at what it can be done during the pandemic given limited resources and the 3-5-year 6-10-year goals. There must be a focus on the long game and how to get patients to be savvy users of care. All stakeholders must ensure continuity of care when patients switch insurance carriers or lose their insurance and now are among the uninsured.
- The pandemic accelerated Telehealth adoption, but it has been inconsistent across systems. For example, Kaiser Permanente (KP) does a better job than others because they have the program managers (project managers, physician thought leaders, and others in leadership) along with the financial reserves to make those investments. KP has one electronic health record for each patient to share among providers (as opposed to multiple electronic health records). The rest of the healthcare community needs to step up their game to collaborate.
- There must be an understanding about appropriate utilization of Telehealth in contrast to conventional concerns regarding over-utilization. Concern about fraud, waste and abuse is legitimate. However, Telehealth is a game changer and should not be under-utilized, particularly in light of access barriers, equity, lack of transportation, and patients with multiple jobs trying to schedule visits within a typical “9-5” operation. What may have been viewed previously as “over-utilization” may save on emergency room (ER) visits (often used because it is a “24/7” facility). Telehealth utilization is probably displacing something else, such as ER visits. It must be understood as to who is paying and how much for certain services and whether or not it is quality healthcare that makes sense for the patient. Another issue is whether patients have the right technology to optimize Telehealth.

Len Rosenthal, Director, Health Information Technology (HIT) Department, L.A. Care

- Telehealth visits are used through Urgent Care and some select providers offer e-consults for some behavioral health conditions. LA Care is in the first phase of developing a plan to strategically expand “virtual health” for the changing healthcare landscape going forward. Research has been conducted focusing on how to support the LA Care goals through Telehealth, including examining the virtual care market using a wide variety of sources, which has produced an initial study with several findings.
- The LA Care study found that: (1) Relaxed regulations and increased payments for virtual care are the key reasons Telehealth was able to take off. (2) Practitioners are central to virtual care, adoption and use. However, patients, payers, and regulators (and regulations) also have key roles to move it forward. (3) Patient access is what virtual care is all about: the safety net gets the most benefit from it just due to virtual care’s ability to expand access. (4) Tele-visits must be in place before adoption can happen in other innovations.

- Of the dozens of innovations LA Care researchers reviewed during the study, 18 were found to be significant in the next 10 years. In addition, several of those innovations showed to be promising now and are expected to have widespread adoption in 3-5 years, including tele-visits, virtual check-ins, remote patient monitoring, e-consult and patient apps. LA Care sees Telehealth as an immediate opportunity for improving healthcare.

Sharron Mackey, CEO, Contra Costa Health Plan

- The Contra Costa Health Plan (CCHP), the first publicly-sponsored managed health care plan in California, has been serving low-income populations for more than 38 years (with a contract for prepaid MediCal patients before receiving the Knox-Keene license). The CCHP Telehealth utilization rates went from nearly zero a year ago to now serving about 80,000 patients monthly. CCHP is a member of California Association of Health Plans (CAHP), which recently conducted a survey of the 16 publicly-sponsored MediCal managed health care plans that showed that Telehealth utilization has increased exponentially.
- CCHP made certain that FQHCs understood that they can provide virtual care through video and telephone visits. Many low-income populations have access to virtual care only through telephone technology due to persistent Digital Divide challenges. However, research shows that if providers engage with patients where they want to be engaged and on the platform they prefer to use—whether it is telephone, smartphone, or iPad—the patient is more likely to have positive results.
- In terms of population health, Telehealth can provide more opportunities to access to care, especially with chronic conditions such as asthma, COPD, diabetes, and hypertension. CCHP continues to champion Telehealth to help overcome barriers and looks forward to working with policymakers on legislation to optimize Telehealth.

Responder

Dan Southard, Deputy Director, California Department of Managed Health Care

- DMHC has challenges and concerns as a consumer protection agency when it comes to government-sponsored health plans, which is different from the CDI perspective. DMHC is held to the laws of the Knox-Keene Act statutes and regulations. DMHC has continued ongoing conversations with both Covered California and the Department of Health Care Services (DHCS) to seek alignment as best as possible.
- To address Telehealth, DMHC developed an e-filing portal that allows health plans to file documents with DMHC. The portal includes an e-filing Telehealth Checklist designed to get a better understanding of how health plans are implementing and utilizing Telehealth. DMHC has asked plans to submit the Checklist mainly as an information-only filing at this time, and is not looking currently to an approval process.
- DMHC encourages communications with health plans with back-and-forth exchanges to help them understand the path forward for Telehealth. DMHC wants to be supportive while also ensuring that consumers are protected. As DMHC gathers information from health plans an assessment and determination will be made regarding whether new statues and/or regulations are needed to keep virtual care moving forward. The Fact-Finding Listening Conferences will help inform the DMHC deliberations. DMHC intends to be supportive by inviting managed healthcare plans to engage in discussions and see this as an opportunity to work in collaboration to advance Telehealth.

Sheirin Ghoddoucy, Attorney III, Health Policy & Reform Branch, CA Department of Insurance

- CDI has very limited oversight for publicly-sponsored managed health care plans. However, many of the concerns that were raised are broadly applicable to the private sector as well.
- CDI has seen a slow-moving shift towards virtualization of care that accelerated due to the pandemic. Telehealth growing pains are occurring for all health plans. This trend indicates that there will continue to be expanded access in Telehealth, which CDI welcomes.
- CDI is committed as a regulator to working with carriers to help them continue to build out their capabilities and increase access. This is especially true for socio-economically disadvantaged populations where there is disparity in access to care—whether in-person or virtual—a whole set of challenges remain. Regulators must look holistically at this issue and ensure that carriers are considering the various limitations their insureds might be facing.

E. Panel: Telehealth and Medical Centers

Linda Branagan, Ph.D., Director of Telehealth Programs, University of California, San Francisco

- Telehealth at UCSF is centralized into one office where providers can go for help to figure out how to integrate Telehealth into the delivery of care. Across the institution, Telehealth video utilization rates increased 16.5 times once COVID-19 struck in April as compared to February. Behavioral health visits by Telehealth increased nearly 100% while overall for all visits increased about 60% for all ambulatory care.
- UCSF focuses on the role of Telehealth and other forms of virtual health care in terms of addressing inequities and disparities. Telehealth can reduce disparities by making care more available, especially for patients with difficulties related to reliable transportation, cost of gas and parking, time away from work, or available childcare. For years patients have reported that not having to deal with these barriers is hugely valuable to them.
- A lot of the barriers changed when everyone went into sheltering-in-place. For example, people in large family living situations can have trouble accessing the space for a private conversation with their doctor. Some patients have very limited bandwidth, others are letting their kids use all their data-plan minutes so they can attend school remotely and do not have minutes left over for their own doctor visit. UCSF recognized the importance of identifying which groups need additional support, including patients with limited-English proficiency, hard-of-hearing (hearing aids do not work well with electronic devices), and limited mobility or stability.

Natalie Pageler, M.D., Chief Medical Information Officer, Stanford Children's Health

- Telehealth has been a high priority for years for Stanford Children's Health (SCH). Pediatric populations can be more effectively served through this modality. COVID-19 motivated viewing Telehealth from the patient, family and provider perspectives. Prior barriers became less important because of the need to continue care in a safe manner. Utilization rates went from 20 visits to more than 700 visits a day in a matter of a couple of weeks.
- Telehealth has a positive impact on children. When children travel a long distance for a visit, they oftentimes miss a day of school and their family member misses a day of work, which is a double hit to the family. There is evidence that children with chronic health conditions are impacted by delays in development of social autonomy and/or logic development simply because their school routines are interrupted by medical care.

- A pediatric endocrinologist at SCH led a lot of research focused on Telehealth and found significant cost savings in terms of parents' time off work and driving time to and from visits. There were significant decreases in access to Telehealth by both Medicaid and Spanish-speaking patients compared to Stanford's overall patient population. This research underscored how big the Digital Divide is and how important it is that all stakeholders think about what collective action is needed to improve equity in Telehealth.

Anshul Pande, Chief Technology Officer, Stanford Children's Health

- Technologists control only half of the Telehealth experience, such as what devices physicians use, how they are connecting, and on which what network. However, they have absolutely no control over what is happening on the patient side, which can lead to frustration on both ends of the conversation and an inclination not to try the technology again. The SCH technology team has done a lot of work to understand how to improve experiences.
- Multi-party sessions have barriers and tend to be more needed and challenging for pediatric and high-age patients because they require a connection between a physician, patient and possibly a parent at another location, or an interpreter, or an additional physician providing a consultation. Another issue is the need to access data, share files and share content.
- With everyone working from home, including students learning online, bandwidth becomes a problem as there is an over saturation on networks. SCH worked with Comcast and AT&T to better handle this issue, and to understand how to prioritize some of what is running over those networks so that SCH can improve the Telehealth experience. In a number of cases, SCH had to actually have families go to the nearest clinic and get into a room to access a Telehealth health visit – all to help resolve the bandwidth issue or not having the right technology. These barriers and problems are now bigger issues to solve due to COVID.

James Marcin, M.D., Pediatric Intensive Care Unit, University of California, Davis, Children's Hospital

- UC Davis (UCD) is reimagining the way it delivers healthcare and is being proactive in making its system fair to everyone. The pandemic has been an inflection point. UCD wants to focus on a more efficient, patient-centered way to deliver care with e-consultations, video visits directly to patients, provider-to-provider video consultations, and remote patient monitoring with the option for in-person care—essentially, provide the right type of care, for the right patient, at the right time.
- UCD is planning to rebuild the infrastructure of its healthcare delivery system, including Telehealth, to be effective, patient-centered, and provider-centered.
- Telehealth is as an opportunity to address disparities; but, in fact, it can worsen disparities for those who do not have access to broadband and devices. UCD is acutely focused on proactively addressing disparities and ensuring that patients who are racial and ethnic minorities, socio-economically disadvantaged, or live in rural areas do not suffer further disparities as new technology strategies and deployment solutions are implemented.

F. Veterans Affairs – Palo Alto Health Care Services

Alka Mathur, M.D., Medical Director, Virtual Behavioral Health Services, Veterans Affairs Palo Alto Health Care System

- The Veterans Affairs (VA) system is quite different from others in that it is a federally-funded entity beholden to the federal government. The VA has been at the forefront of Telehealth for the last 2 decades, and it still stands as the largest healthcare agency in the US that uses a Telehealth. Since COVID-19 there has been about a 1,000% increase in Telehealth visits across all specialties.
- The VA is able to overcome one of the biggest barriers to implementing Telehealth, which is the ability to dispense technology. The VA has been able to provide WiFi-enabled iPads and iPhones to veterans that struggle with getting Internet access or connections. The VA can establish a Verizon subscription to allow a patient access to WiFi and also arrange for discount or free webcams. The VA has its own internal platform called BBC or VA Video Connect. It is developed and managed nationally and administrators are very receptive to any changes that physicians need to implement. As a federal entity, the VA has the unique ability to provide services across state lines and has the ability to coordinate with other facilities in California as well, which is a tremendous benefit for patients.
- There is an expectation that there is going to be a dramatic need for mental health services because of the pandemic. The VA has seen a huge increase in the number of cases of depression, anxiety, in-patient admissions, and suicide attempts. Psychiatry expects to see this among patients and frontline providers who have been battling COVID-19 for the last several months. More and more frontline workers are asking for this type of help. These are some of the issues on the horizon that will require collective action.

Barb Johnston Yellowlees, Chair, CETF Telehealth Committee

- This VA presentation could be used as the roadmap for going forward for Telehealth in California. The work of the VA is growing and it is encouraging to see what it has done and how prepared it was for COVID-19.
- Dr. Mathur made a very important point saying that, whatever is done with regard to Telemedicine in California, all stakeholders must ensure that they work proactively to include disadvantaged communities and that they all work to make healthcare fairer for everyone.



**Summary of Conclusions and Recommendations from Fact-Finding Listening Conference
Delivering on the Promise of Telehealth
December 2, 2020
Compiled by Leticia Alejandrez, CETF Director of Telehealth and Human Services**

Major Barriers to Optimizing Telehealth

For Individuals

- Insufficient high-speed broadband access, access to devices, affordability, and adoption.
- Need for language, culture, trust, and “ability” in Telehealth.
- Lack of access and need for appropriate accommodation for specific circumstances.
- Lack of privacy for patients who live in large family living situations.
- Lack of consumer information on Telehealth.

For Medical Institutions and Providers

- Lack of support for implementation: deployment, training, and technical assistance.
- General under-funding of Telehealth.
- Inadequate access to high-speed broadband in congregate care settings.
- Insufficient access to interpreters and integration into workflow.
- Uncertainty about reimbursements and continuation of COVID-19-era public policy.

Key Action Steps to Optimize Impact of Telehealth on Health Status *(not in priority order)*

1. Invest in broadband access, devices (including health monitoring devices), and adoption.
2. Support multiple modalities for delivery of Telehealth and promote cost savings.
3. Sustain telehealth reimbursements post-COVID-19.
4. Increase governmental investments in Telehealth (infrastructure, equipment, training).
5. Expand provider training and technical support.
6. Authorize MediCare/Medicaid reimbursements for devices, training, and technical support.
7. Broaden access to virtual language interpretation services for Telehealth.
8. Expand consumer information on Telehealth access.
9. Understand culture, trust, language disparities and “ability” to provide support structure(s).
10. Advocate for a national license post-COVID-19 emergency.
11. Establish a national credentialing agency for physicians.
12. Continue allowing prescribing controlled substances via Telehealth post-COVID-19.
13. Advocate for permanent elimination of geographic locations post-COVID-19.
14. Review and update HIPAA requirements (enacted in 1996) to support Telehealth and IT.
15. Understand and address privacy and data security issues.
16. Ensure Telehealth policy and funding address disparities in both rural and urban communities.
17. Ensure Telehealth policy and funding support emergencies (wildfires, earthquakes, storms).
18. Ensure Telehealth policy and funding are commensurate with practice (update forms)
19. Develop comprehensive care: integrate social and medical care into Telehealth.
20. Include long-term care and skilled nursing facilities in comprehensive Telehealth policy.



**Delivering on the Promise of Telehealth to Improve Health Status in California
Fact-Finding Listening Conference
December 2, 2020**

Attendance List

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>
Rhoda	Alajaji	211 Los Angeles
Leticia	Alejandrez	California Emerging Technology Fund
Brad	Alexander	United Healthcare
Gretchen	Alkema	The SCAN Foundation
Dr. Ashrith	Amaranth	Covered California
Tylana	Anderson	LA County Department of Mental Health
Karissa	Anderson	California Department of Public Health
Veronica	Bethel Parker	Legislative Staff - State Senate
Dr. Saurabha	Bhatnagar	United Healthcare
Teri	Boughton	Legislative Staff - State Senate
Dr. Linda	Branagan	University of California, San Francisco
Andrew	Broderick	N/A
Megan	Burke	The SCAN Foundation
Fred	Buzo	AARP California
Laura	Buzo	City of San Jose
Adriana	Cardenas	St. Barnabas Senior Services
Bernadette	Carter	Shield Healthcare
Kimberly	Chen	Legislative Staff - State Senate
Olivia	Chung	Blue Shield of California
Sylvie	Cosgrove	Stanford - IT Services
Dianne	Davis	Partners in Care Foundation
Johnna	Edmunds	Sonoma State University - Nursing
Louis	Fox	CENIC
Jennifer	Frehn	UC Merced
Mariella	Freire-Reyes	Los Angeles City Department of Aging
Helen	Galvan	AGIF Education Foundation
Honorable Eduardo	Garcia	State Assembly - AD 56
Amy	Geiser	Department of Managed Health Care
Sheirin	Ghoddoucy	California Department of Insurance

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Ryan	Kawamoto	Older Adult Technology Services
Frank	Leschinsky	Volcano Communications Group
Kim	Lewis	Lewis Advocacy
Dr. Alex	Li	L.A. Care
Dr. Ronnie	Lowenstein	Lowenstein & Associates
Kelsey	Lyles	Greenlining Institute
Sharron	Mackey	Contra Costa Health Plan
Dr. James	Marcin	UC Davis Children's Hospital
Jacquelyn	Marin-Sharp	Independent Living Centers of LA County
Laurie	Marsden	Staff - San Bernardino County Board of Supervisors
Renee	Martinez	CETF Board of Directors
Dr. Alka	Mathur	Veterans Affairs Palo Alto Health Care Systems
Sylvia	McBride	Griffith Park Adult Community Center
Sunne	McPeak	California Emerging Technology Fund
Linda	Merkens	L.A. Care
Mellani	Miller	Stanford
Rich	Motta	CETF Board of Directors
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Dr. Khang	Nguyen	Kaiser Permanente
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Dr. Natalie	Pageler	Stanford Children's Health
Anshul	Pande	Stanford Children's Health
David	Panush	California Health Policy Strategies
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Joanne	Preece	Community Clinic Association of LA County
Hector	Ramirez	Disability Rights Activist - Los Angeles
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Brianna	Wells	Greenlining Institute
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