Expanding Access to Care

This report summarizes the Telemedicine Initiative Grantee Convening, “Expanding Access to Care,” co-sponsored with the Children's National Health System on April 6, 2018. The learning event highlighted ongoing telemedicine grant initiatives begun or bolstered by a $2.7 million-dollar investment by CareFirst BlueCross BlueShield in its coverage region. Thank you to all the grantee participants for their commitment to expanding access to care through innovation and for presenting their ongoing program implementation.
Introduction

Between 2013-2017, CareFirst invested more than $2.7 million in telemedicine initiatives to expand access to care and catalyze change in the healthcare delivery system. Telemedicine services provide an opportunity to reduce barriers to healthcare access including geographic distance to provider, language barriers, and transportation costs. Nine grantees participated in a CareFirst BlueCross BlueShield Telemedicine Initiative Grantee Convening, Expanding Access to Care, on April 6, 2018 co-sponsored with Children's National Health System with guest speaker Latoya Thomas, Director of State Policy Resource Center for the American Telemedicine Association (ATA). Grantees presented progress on their respective efforts to improve access to healthcare services using telemedicine, as well as to share lessons learned in the planning and implementation of the services. We gleaned from the discussion that telemedicine services provide models for catalytic changes for increasing healthcare delivery.

Background

Telemedicine, also referred to as telehealth or mHealth, is a mechanism to deliver healthcare services using technology. (ATA, 2018) Many modes of technology-based communication exist in providing healthcare services. For the purposes of Medicaid billing, telemedicine refers to “two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.” (Medicaid, n.d.)

The overarching purpose of telemedicine is to provide clinical support through functions such as condition monitoring, treatment, therapy, education/advice on condition management, specialist consultation, clinical assessments, and screenings. (World Health Organization, 2010; Flodgren, Rachas, Farmer, Inzitari, & Shepperd, 2015) In an environment where 20% of Americans still live in areas of physician and specialist shortages, telemedicine presents an opportunity to leverage technology to increase availability of healthcare services and reduce the challenges to accessing care (Yang, 2016). Barriers such as geographic location of services, language and translation challenges, may contribute to delays in treatment, exacerbation of conditions, increased emergency department utilization and inpatient admissions, and undo financial stress upon patients.

Telemedicine presents an opportunity to reduce these challenges without affecting quality. Scientific studies show that increasing the availability of care with telemedicine services produces the same if not better-quality care or outcomes for heart failure and diabetes, specifically. A review of literature on interactive telemedicine services found no difference in mortality between health failure patients accessing traditional in-person care compared with telemedicine services. The same review found that telemedicine was more effective at reducing the level of HbA1c compared with standard of care (Flodgren, Rachas, Farmer, Inzitari, & Shepperd, 2015).
Grantee Convening Themes

The nine grantees are working broadly in three health sectors: maternal and child health, behavioral health services, and safety net with comprehensive care management services. Grantees that offer maternal and child health services include Virginia Hospital Center Foundation. Grantees focusing on behavioral health services include:

- Caroline County Health Department,
- Cornerstone Montgomery, and
- Mosaic Community Services.

Most grantees focused on increasing capacity and services in safety net clinics and enhancing comprehensive care services included:

- Children's National Health System,
- The George Washington University Medical Faculty Associates,
- The Medical Society of Northern Virginia Foundation,
- Queen Anne's County Department of Health,
- University of Maryland Baltimore Foundation,
- Virginia Hospital Center Foundation, and
- Western Maryland Health System.

The demonstrable focus on services targeting chronic disease such as diabetes, hypertension, as well as behavioral health conditions, through the telemedicine investment indicates the need to address such illnesses across underserved communities. Chronic diseases are challenging to manage and associated with prohibitive costs to both the patient and the health system.

Investments like the telemedicine grants provide an opportunity to influence chronic care management and associated healthcare costs. The impact of the grantees’ telemedicine programs in improving quality of care, patient satisfaction, and preventing avoidable admissions in alignment with the triple aim of healthcare¹, provides regional models for catalytic changes in leveraging advances in technology to reframe healthcare delivery.

Telemedicine initiative grantee population targeted with services included vulnerable populations facing barriers such as lack of access to specialty services, inflexible work schedules, lack of child care, and low availability of services in remote areas.

Grantees used a diversity of models and tools to serve and engage patients in telemedicine services. While each grantee presented pros and challenges of the tools that they used to provide specific services, they recommended that future programs dedicate sufficient time to review, test, and train providers on tools and processes before and during implementation. Provider training and provider buy-in were critical elements to smooth implementation, especially in contexts with higher turnover. One program also cited that building in hands-on training and practice with service providers prior to engaging patients as a standard practice bolsters initiative effectiveness and consistency of implementation. Beyond provider buy-in, patient comfort with technology, ensuring a warm introduction to services improved uptake. Establishing and operationalizing the programs was an iterative process where programs troubleshooted technological, ease of use, logistical, and geographic challenges.

Guest Speaker

Latoya Thomas is the Director, State Policy Resource Center for ATA. Ms. Thomas presented on the Federal Telehealth Laws: Understanding State Medicaid Requirements Including Licensure, Credentialing, and Reimbursement. In the United States, telemedicine services and coverage of services (including parity) varies across states. Currently, Medicare pays for certain telemedicine services while Medicaid telehealth services are state-specific. (ATA, 2018) State-based parity laws for private insurance coverage of telemedicine grew from 5 states in 2000 to 35 states in 2018 with 4 additional states with proposed parity bills. Currently, 35 states and DC have achieved the ATA’s 2016 state-based analysis of telemedicine services using 13 indicators on coverage and reimbursement rated MD with a B, DC with an A, and VA with an A. (Thomas & Capistrant, 2016)

Grantee Progress Profiles

Telemedicine initiatives such as those presented below are catalytic investments for CareFirst, in accordance with the mission to improve healthcare delivery system and access in the Maryland, District of Columbia, and Northern Virginia for the underserved. Below we provide a summary of each grantee’s work presented at the convening.

1. Virginia Hospital Center Outpatient Clinic (Telemedicine Program)

Virginia Hospital Center Outpatient Clinic (VHC) provides health care services to a diverse group of low income, publicly insured, and uninsured adult patients. Patients faced barriers to care including inability to take time off work, lack of child care availability, long wait times, and transportation challenges. VHC’s Telemedicine Program’s supported patients in helping manage chronic diseases such as diabetes, hypertension, and thyroid disorders, and served medically complex patients and women with high-risk pregnancies. The primary objective to improve access simply, seamlessly, and with a patient-centered approach. The program encountered implementation challenges such as patient comfort with technology, availability of reliable technology, quality of data plan, accessibility of support from technology vendor, and reliability of telemedicine software platform. Even while experiencing delays with software platforms, the initiative has served 45 chronically ill and medically complex patients, and 21 high risk obstetric patients in nearly 6 months of implementation.

Members in the program with diabetes (A1c >7) for more than 4-6 months have seen a 10.5% reduction in A1c. Cesarean section rates (c-sections) for those enrolled in the telemedicine program was comparable (16%) with that of VHC’s overall rate. However, clinic telemedicine patients c-sections rates showed that 33% of participants had c-sections, which is lower compared to VHC’s overall average of 54%. The program now is moving to a more sustainable model as it has sufficient provider and patient capacity to incorporate in protocol-based enrollment. Enrollment is available for all consenting English- or Spanish-speaking patients with a smart phone or computer with a diagnosis of diabetes, hypertension, thyroid disease, and pregnant women less than 30 weeks gestation. Through the telemedicine program, VHC is lowering barriers and increasing accessing care for underserved community members.

2 Additional information regarding the American Telemedicine Association can be found http://www.americantelemed.org/home.
2. Caroline County Health Department *(Telemedicine Program)*

Caroline County Health Department began their planning process as a new addition to telemedicine services. Caroline County faces multiple health issues including sexual and reproductive health, chronic disease, and substance use disorders. During the planning process, the initiative team decided to focus on behavioral health conditions including substance use disorders. The program secured telemedicine providers to expand existing treatment for their suboxone patients as well as providers including those from the Sheppard Pratt tele-psychiatry to strengthen continuum of care for Caroline Country residents.

3. Cornerstone Montgomery *(The Cornerstone Behavioral Telehealth Program)*

Access to behavioral health services is a growing need. The goal of the Cornerstone Montgomery Behavioral Telehealth program was to improve access to behavioral health services for unserved communities including Medicaid-insured, uninsured, homeless clients, and veterans. The program provided access to services upon discharge from hospital care for ongoing health management, telemedicine to current clients admitted to a hospital, and comprehensive behavioral healthcare to community members experiencing homelessness and veterans. The program encountered challenges including billing as about half of the telemedicine claims were rejected due to clients having Medicare. Specific state-based models around behavioral health management limited where patients could use telemedicine for behavioral health needs such that patient telemedicine sessions cannot occur in the home. Finally, the program navigated buy-in from hospital-based providers. Once memorandums of understanding, clinic processes, protocols, and policies were finalized, 71 clients served, 26% diverted in community from ED, 117 telehealth consults completed (April 2018). Qualitative feedback from clients highlighted that telemedicine services improved efficiency of assessment services, increased access to care among clients who have difficulty leaving their homes, and facilitated changes in care planning and prescriptions so that patients can access behavioral health services efficiently and effectively.

4. Mosaic Community Services *(TeleCARE)*

Mosaic Community Services began the TeleCARE Project in July 2016. The objectives of the project were to increase availability to behavioral health services through improved outpatient telemedicine infrastructure, services, and care coordination to improve the standards of care and outcomes for clients. The services were targeted to Baltimore City, Baltimore County, Carroll County, and Harford County. During implementation occasional disruptions in transmissions, navigating eye-to-eye camera and display angles important to engagement with patients, and patient documentation requiring provider signatures were identified as challenges and opportunities for lessons learned. The program learned that not all patients were appropriate for telehealth services, especially in behavioral health needs where counseling services were not present to compliment psychiatric services. Triage is required to assess patients before engaging in telemedicine/telehealth care. The TeleCARE initiative has served seen 1,191 clients to date with overall satisfaction at 93% and increased provider prescriber capacity by 20%.
5. **Children's National Health System (Direct to Consumer Program)**

Children's National Health System (Children's) has been providing telecardiology services and virtual care since 1998, which decreases burdensome transport for vulnerable patients. With the CareFirst investment, Children's Direct to Consumer (DTC) initiative aimed to improve access to in-home pediatric care for Medicaid and uninsured patients. The CareFirst grant specifically addressed specialty care and patient enrollment. The virtual office-based pediatric specialist consultation leverages existing technology and support staff to facilitate inclusive attendance. Children's completed 389 consults across the DTC program, of which 40 consults were associated with the CareFirst grant. Between April 1, 2016 through February 28, 2018 Children's Primary Care comprised the majority of services (n=111), with neuropsychology (n=95) and endocrinology (n=63) following closely. Average time spent in video by specialty ranged between 4-56 minutes, and average waits by specialty ranged between 0-11 minutes, representing a 97% reduction in in-person visit wait time. The 389 consults saved an average of 52 miles and 116 minutes driven per consult for a total of 19,832 miles saved. This is associated with 8.33 metric tons of carbon dioxide saved. Patients and families were satisfied with the initiative, particularly with efficiency, and 92% of providers surveyed believed telemedicine services could provide a safe medium for managing certain conditions.

6. **George Washington University Medical Faculty Associates (The Improving Access to Specialty Care via Telemedicine)**

Accessing specialty care requires additional travel outside the usual source of a patient's care resulting in potential obstacles for patients. The George Washington Medical Faculty Associates (MFA) Emergency Medicine Innovative Practice Group launched a telemedicine partnership with Unity HealthCare and Anacostia Health Center. Already experienced in providing telemedicine services to maritime industry, the GW team proposed leveraging the same skills to delivery specialty services locally by providing specialty consultation for chronic disease patients (such as diabetes, hypertension, chronic kidney disease) at a patient's usual source of care. There are numerous hidden costs of the seeking healthcare services including travel time, clinic time, and face-to-face time. The primary objective of the initiative was to reduce no-show rate including secondary outcomes time to referral completion and specialty consultation, clinical measures, and healthcare utilization. The program served to restructure service delivery using telemedicine to facilitate access to specialty referrals. Overall, the program has optimized the standard specialty referral process, increased patient and provider acceptance of telemedicine efforts, increased exchange of information between providers, and established successful reimbursement processes for com. Since the initiative began, 68 consultations were completed across 46 unique patients with a 32% no show rate. Both providers and patients indicated high satisfaction with telemedicine services.

7. **Medical Society of Northern Virginia (Doctors TeleMed)**

Supported and managed by the Medical Society of Northern Virginia Foundation (MSNVAF), in collaboration with CareClix (technology partner), DoctorsTelemed® delivers online, secure, live-video consults by licensed and board-certified clinicians. MSNVAF expanded its services to lower income and uninsured patients in northern Virginia through a telemedicine initiative launched in June 2016. Volunteer providers delivered services to patients in safety net clinics: Arlington Free Clinic, Culmore Clinic, Fairfax County Community Clinics, and Neighborhood Health. During implementation the program learned that the most patients were comfortable with social-media-
based phone applications such as Whatsapp and FB messenger. However, safety net providers and patients did experience some hurdles in clinical virtual interactions. Overall, patients appreciated an opportunity to engage with specialists from the health center. The program enrolled 82 volunteer physicians across 23 specialties to serve 105 patients. The initiative is exploring further opportunities to expand pilot project to pre-K and elementary schools in the northern Virginia region, adding psychological services, as well as increasing the portfolio of services to nutrition consults.

8. Queen Anne's County (Mobile Integrated Community Health Project)

Managing multiple comorbidities is a challenging task for most patients. Mobile Integrated Community Health (MICH) project from Queen Anne’s County is to use an integrated multi-agency team to improve access to healthcare services and enhance health outcomes. The program's three-part approach is comprised of the field team (nurse, paramedic, counselor), telehealth component (pharmacist), and management (medical director). The field team provides home visiting services including health history, physical examinations, patient social support assessments, home safety assessments, discusses safety issues, advises program participants on how to modify hazards, and provides need-based referrals to support services. Over the course of implementation, the program has evolved its recruitment strategy from identifying frequent 911 callers to incorporating EMS, ED referrals, and regional hospitals post discharge referrals. Operational challenges encountered and addressed included data collection, managing declinations, and financial sustainability. The team encountered medically complex patients as well as patients who were facing significant social isolation and behavioral health challenges. The top three diagnoses among the cases were hypertension, high cholesterol, and injuries from falls. The average number of diagnoses per patient was 5.99, and on average, patients were using 10.01 medications. Of those patients who engaged with prescription consultations, the intervention identified 43 (19.28%) cases with problems in prescription needs. The team provided 1211 total services linked to patients; the majority of services linked to safety (with over 400 services). On average, the program linked 6.5 service per patient. Majority of patients strongly agreed or agreed that they were better able to manage their health, services improved quality of life, and that the referrals were appropriate and/or useful. Of the MICH participants in the program for a year, 43.71% of patients saw a reduction in 911 transports.


As demographic changes occur in the country, the aging population increasingly uses emergency departments (ED) and is readmitted to hospitals. The University of Maryland (UMD) sought to reduce avoidable ED use and limit avoidable inpatient admissions for older-adult residents of Skilled Nursing Facilities (SNFs) with acute medical problems by providing access to emergency medicine expertise via telemedicine consultation 24-hours/day in the SNF. The project was implemented as part of a research study. The study provided access to services in one initial site in Baltimore City, which the UMD team leveraged to acquire additional funding for two more sites 3 and 7 months later. The implementation process included lessons learned about choosing the right technology to meet the needs of the program. The program recommended working through many of the processes such as initial procedures, testing equipment consistently even if not in use, and training
staff and accounting for turnover. Having an on-site clinical advocate, planning for HIPAA data issues, and ensuring communication across sites and with different teams is consistent and ongoing were critical processes to successful implementation. Over 9 months and across the three sites, the team completed 34 telemedicine consults. Of the 34 consults, 23 (72%) patients remained in the SNF rather than the SNF transporting the patients to the ED. In the CareFirst funded site, there were 114 changes in condition which resulted in 72 calls to 911. Of these cases, 42 could have been telemedicine specific consults while 17 were telemedicine consults. Of the patients who received consults, over half (65%) remained in the SNF, avoiding discomfort to patients in transition and healthcare costs associated with ED visits.

10. Western Maryland Health System (Population Health Telemedicine Program)

The Western Maryland Health System faced high readmission rates after patients were discharged from the hospital. In addition, reaching patients with care coordination services within 48 hours was difficult due to significant distances between patients' homes. To address these healthcare challenges, the Telemedicine Program the overarching goal was to help improve management of chronic conditions among discharged patients. Using telemedicine, the initiative provided dependable monitoring of patient vitals, which allowed for more immediate interventions. The program team used four key factors to determine which telemedicine product to employ in their initiative: ease of use, experience of the third-party monitoring service, affordability, and compatibility with landlines due to geographic need in the area. The team addressed multiple logistical and operational challenges during implementation process including a change in monitoring service to better align services to patients' contextual needs as well as leveraging resources within the health system to improve in cleaning and maintenance processes. Since it began, the program has currently enrolled 39 and graduated 29 patients. The patients in the program on average have a readmission rate 7% less than the health system's overall average.

Conclusion

The development of innovative models for care delivery provide an opportunity to improve cost outcomes, patient experience, and population health. The profiles of telemedicine grantees' work highlighted the learning and the impact of their respective efforts, the critical need for such initiatives, and CareFirst's investment in promoting the integration of a health care system that meets the health care needs of all the residents.
References


