VPQHC

Vermont Program for Quality in Health Care, Inc.

REPORT OUT

AUDIO-ONLY TELEMEDICINE & CLINICAL QUALITY RECOMMENDATIONS

October 20, 2020

Vermont Program for Quality in Health Care, Inc.

EXECUTIVE SUMMARY

Audio-only telemedicine has provided Vermonters access to their healthcare under COVID-19, and outside of a pandemic response, has the ability to support the continuity of care for individuals that face barriers to accessing their healthcare through traditional telemedicine and in-person visits. In this report, audio-only telemedicine refers to synchronous, telephone-based visits with a provider that replace an equivalent in person-visit; it does not refer to other telephone-based services such as brief telecommunications, or those associated with remote patient monitoring. The workgroup recognizes that audio-only telemedicine is not a silver bullet for achieving equitable access to health care, but does recognize it as a step in the right direction under the current conditions of our healthcare delivery system of fee-for-service payments, and in a world where the digital divide exists. It is imperative we use every tool available to ensure patients get a measure of care where they need it, when they need it, as we simultaneously bridge from where we are currently as a delivery system, to where we want to be. The workgroup recognizes that missteps in care delivery can occur with any type of encounter, and there is currently a lack of research surrounding the sensitivity of utilization, appropriateness, outcomes, and cost, stratified by clinical condition, health care setting, and telehealth modality.[1] Our proposed framework for ensuring quality care is delivered by audio-only telemedicine, and patient safety is safeguarded, aligns with the basic tenants of continuous quality improvement. This is with the caveat that continuous quality improvement is an iterative process, and adaptations will need to be made, and tested, as new research is carried out and best practices are identified.

[1] Cutter, Christina, et al. "Establishing a 'New Normal' for Value-Based Telehealth." *Health Affairs Blog*, 8 Oct. 2020, doi:10.1377/hblog20201006.638022.

The workgroup recommendations are as follows:

Healthcare Quality Measurement, Monitoring & Evaluation

- Establish a subgroup of the Statewide Telehealth Workgroup to identify how to utilize existing data to monitor the quality, utilization, and cost of care delivered via audio-only telemedicine (which can be embedded in a more comprehensive Vermont telehealth analysis)
- Ensure current peer review processes are applied to audio-only telemedicine
- Provide guidance on nationally-recognized healthcare quality metrics for monitoring and evaluating healthcare delivered by audio-only telemedicine; metrics that are agnostic to encounter type (ex. appropriate antibiotic use; patient and provider satisfaction)
- Apply associated benchmarks, where available, for comparative performance purposes; stratify by modality type, include qualitative and quantitative data
- Ensure providers and organizations are aware of nationally-recognized telehealth systems measure frameworks, and those in development, and support them with implementing those frameworks as needed

Provider Education and Training

- Ensure providers receive the ongoing access and support they need to deliver high-quality telehealth
- If opportunities for improvement are identified through routine monitoring and evaluation of audio-only telemedicine, work as a coordinated group to identify whether trainings exist that can address those needs, and if they do not, leverage resources to develop those trainings
- Vermont law, under 18 V.S.A. §9361, includes a robust informed consent policy for telemedicine. Continue training providers to discuss the modality options for receiving care, the risk and benefits associated with each, and any cost for the visit.

Patient Engagement & Empowerment

- Ensure patients are at the center of the healthcare decision making, and are engaged in their care plan. The Institute of Medicine defines person-centered care as: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."[2] The World Health Organization defines people-centered health services as health services that put "people and communities, not diseases, at the center of health systems, and empower people to take charge of their own health rather than be passive recipients of services."[3]
- Explore whether additional means for patient voices to be heard need be established to support continuous quality improvement
- Support patient education by disseminating tools and resources such as to how to prepare for an audio-only visit, types of questions to ask their provider, and how to advocate for their preferences

BACKGROUND

VPQHC reconvened the Vermont Statewide Telehealth Workgroup in an intensive series of weekly meetings between July 31, 2020, and October 6, 2020, to explore the intersection of audio-only telemedicine and clinical quality. The purpose of reconvening the workgroup was to be able to provide insight into key clinical quality considerations related to audio-only telemedicine, under three main categories: identifying best practice related to provider education and training, monitoring and evaluation, and identifying relevant healthcare quality measures. VPQHC arranged for a series of local, regional, national, and global, leaders in telehealth and

[2] IOM. Crossing the quality chasm: A new health system for the 21st century. Washington, DC: National Academy Press; 2001.

[3] "What Are Integrated People-Centered Health Services?" World Health Organization, World Health Organization, 20 Sept. 2018, www.who.int/servicedeliverysafety/areas/people-centred-care/ipchs-what/en/.

healthcare quality to speak to the workgroup on the topic; details on the meeting series, including the speaker line up, can be found on the VPQHC website.

During our workgroup discussions, many of the benefits related to audio-only telemedicine and quality of care were raised. It was recognized that many Vermonters face barriers to accessing in-person care, due to things such as transportation, child care, and scheduling issues. Likewise, many face barriers to accessing a remote visit that includes an audio-visual component, as they may not have sufficient access to broadband, the equipment needed to connect, and/or the digital literacy skills that are needed. In a recent study published in JAMA, it was found that nationally "26.3% of Medicare beneficiaries lacked digital access at home, making it unlikely that they could have telemedicine video visits with clinicians."[4] In addition to that, "the proportion of beneficiaries who lacked digital access was higher among those with low socioeconomic status, those 85 years or older, and in communities of color."[5] For these vulnerable individuals, if care over the phone was not an option, this could lead to no care, or delayed care. Audio-only telemedicine visits were identified as an important tool for providers and patients, and a valid means for collecting actionable information that to could help inform a patient's course of care. The audio-only component provides the means to evaluate and move the patient to the next appropriate level of care or action, including recommendation for an in-person evaluation. Other benefits raised primarily surrounded that of the preference of patients and providers, with the recognition that audio-only telemedicine is not something for everyone, but a preferred tool for some if deemed clinically appropriate.

The main quality concerns related to audio-only telemedicine raised by workgroup members during our discussions included fear that clinicians will be unable to reach the appropriate

[4] Roberts ET, Mehrotra A. Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine. *JAMA Intern Med.* 2020;180(10):1386–1389. doi:10.1001/jamainternmed.2020.2666

[5] Roberts ET, Mehrotra A. Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine. *JAMA Intern Med.* 2020;180(10):1386–1389. doi:10.1001/jamainternmed.2020.2666

standard of care using audio-only tools, and that the lack of training in this modality could exacerbate this problem, leading to adverse health outcomes, and that there is a lack of evidence-based best practice related to audio-only telemedicine to guide clinical decision-making, training, and evaluation.

Consensus was that in an ideal world, Vermonters would have access to the care modality of their choice. All Vermonters would have access to broadband, equipment, and digital literacy skills they need to navigate remote visits. Providers would be well-versed in how to deliver remote care, and all organizations would have fully functioning telehealth systems. Further, barriers to accessing in-person visits would likewise not exist, and we would no longer live under a fee-for-service reimbursement structure, but under global budgets and capitated payments. However, as we do not have these structures currently in place, audio-only telemedicine is seen as an important tool for supporting access to healthcare for all Vermonters, in the interim, as we bridge from where we are currently, to where we want to be. Furthermore, patient preference for audio-only, as a modality of care on its own, should be available to patients who prefer it, and for whom it is deemed clinically appropriate. The following section outlines our clinical quality findings and recommendations for consideration related to audio-only telemedicine, and accompanying recommendations for establishing a system that works towards addressing patient and provider concerns as well as supporting continuous quality improvement.

RATIONALE FOR RECOMMENDATIONS

Healthcare Quality Measurement & Evaluation

Healthcare quality measurement is an integral component to ensuring a system of continuous quality improvement. Providers should be held to the same standard of care, regardless of whether a visit is held in person, remotely with an audio-visual component, or over audio-only telemedicine. As Judd Hollander, a national leader in telehealth, and one of our featured guests, stated: “quality care is quality care, whether it is delivered on the 4th floor of a building or the

5th."[6] For audio-only telemedicine, the same, nationally recognized, healthcare quality measures should be applied to assess the quality of care delivered. Examples of these metrics include: appropriate antibiotic prescribing in pediatric visits, and measures of patient and provider satisfaction. These measures are agnostic to modality type.

Given these national measures exist, and in recognition of administrative burden and the need to avoid duplicative quality reporting, the workgroup would be wary of supporting the development of a Vermont-specific measure set to assess the quality of care delivered over audio-only telemedicine. However, we do support exploring how we can use existing data to monitor and evaluate the quality of care delivered by audio-only telemedicine. We also support ensuring providers and healthcare organizations are aware of nationally-recognized frameworks for assessing their telehealth systems, and have the support they need to implement those systems. We do anticipate that given the ever-evolving world of healthcare quality measurement that changes will be made, and new nationally recognized frameworks will be developed. It is our recommendation that a subgroup of the statewide telehealth workgroup be convened to explore how we can leverage existing data to monitor and evaluate the quality of care delivered by audio-only telemedicine, and stay current on nationally recommended frameworks for telehealth quality measurement. This subgroup can provide updates to the broader Statewide Telehealth Workgroup.

Provider Training & Education

Providers must be supported with the training they need to deliver quality healthcare. While we were unable to identify trainings specific to audio-only telemedicine, we did identify several trainings and resources for developing telehealth skills more broadly. It is the workgroup's recommendation that as monitoring and evaluation of the quality of care delivered by audio-only telemedicine continues, and opportunities for improvement are identified, gap analyses are

[6] Hollander, Judd. VPQHC Statewide Telehealth Workgroup. 28 Sept. 2020, Zoom.

conducted to identify what trainings already exist to address areas of opportunity for improvement. If it is found that needed trainings are not available, it is our recommendation that the Vermont Statewide Telehealth Workgroup work together as a coordinated entity to leverage resources to ensure those trainings are developed and made available to Vermont providers. In addition, we anticipate additional educational opportunities will be developed as more research is published based on findings during the pandemic response. The Vermont Statewide Telehealth Workgroup is positioned well to act as a means through which this information can be disseminated as appropriate, across the continuum of care. In addition, Vermont law, under 18 V.S.A. §9361, includes a robust informed consent policy for telemedicine. We must continue to train providers to discuss the modality options for receiving care, the risk and benefits associated with each, and any cost for the visit.

Patient Engagement & Empowerment

Patients should be at the center of any healthcare decision-making, regardless of modality type, including audio-only telemedicine. It is important to note that during the COVID-19 emergency, many more patients felt that the risk of infection required them to use remote care than would normally have *preferred* remote care, which will in turn affect perception of cost and value. Patients must be educated regarding their options for receiving care – whether it be audio-only, a video visit, or in-person - and provided a means to voice their preference, and have that taken into account, when there is an option (i.e. outside of heightened pandemic response). We recognize that audio-only telemedicine is not for everyone, both on the patient receiving end, and the provider delivery end. This will necessarily lead to much-needed, and natural, conversations between patients and providers to determine the best course of care and the co-creation of a care plan. A concern that was voiced in the workgroup discussions was that patients may not have a reliable outlet through which they can voice their opinions related to the quality of care delivered; patient satisfaction survey results typically have low return rates, and some patients may not feel comfortable addressing their provider directly out of concern for the impact it could have on their relationship. We recommend that the Statewide Telehealth Workgroup discuss

whether additional avenues should be explored and cultivated to establish an open, and protected, outlet for patients to voice their opinions about the quality of care received. In addition, members of the Statewide Telehealth Workgroup should share tools and resources that can be disseminated to patients, describing what to expect from an audio-only telemedicine visit, how to advocate for their preferences, and how to properly prepare for a visit.