

Proprietary

**Sustainable Models of Telehealth in the Safety Net Evaluation: Select Findings from Phase 1 Qualitative Interviews**

**Submitted to**

The California Healthcare Foundation

**Submitted by**

RAND Corporation

1776 Main St, Santa Monica, CA 90401

**Authors**

Lori Uscher-Pines and Allison Ober

**Preliminary draft. Not cleared for citation or distribution.** This version of the report has not been approved for public dissemination as it has not officially met all of RAND’s quality assurance procedures. Do not cite, quote, or distribute without permission.

Contents

[Section 1: Introduction 3](#_Toc521351078)

[1.1 Overall Purpose of Qualitative Interviews 3](#_Toc521351079)

[1.2 Purpose of Phase 1 Interim Findings Report 3](#_Toc521351080)

[Section 2: Findings on the SMTSN Initiative and Evaluation 3](#_Toc521351081)

[2.1 Health Center and Health Plan Feedback on the SMTSN Initiative 3](#_Toc521351082)

[2.2 Health Center and Health Plan Recommendations for Improving SMTSN Technical Assistance 4](#_Toc521351083)

[2.3 RAND Recommendations for Technical Assistance 5](#_Toc521351084)

[2.4 RAND-Identified Challenges for the SMTSN Evaluation 5](#_Toc521351092)

[Section 3: Summative Evaluation: Baseline Findings 9](#_Toc521351093)

[3.1 Barriers 9](#_Toc521351094)

[3.2 Roles and Motivations of Health Plans 10](#_Toc521351095)

[3.3 Sustainability 11](#_Toc521351096)

# Section 1: Introduction

## Overall Purpose of Qualitative Interviews

As part of the SMTSN evaluation, RAND is conducting qualitative interviews with telehealth coordinators and other relevant staff at all health centers and health plans participating in the initiative. The overall purpose of the interviews, which are taking place at the beginning and end of the initiative—is to assess the goals and activities for achieving greater telehealth volume, barriers to telehealth before and after the initiative, ways in which the initiative facilitated telehealth expansion, and areas for improvement. Wave 1 interviews were completed in July 2018, and wave 2 interviews will be conducted in the summer/fall of 2019. Following wave 2 data collection, we will conduct a formal qualitative analysis of the interviews and report all findings in the evaluation report.

## 1.2 Purpose of Phase 1 Interim Findings Report

In this report, we present findings from the Wave 1 interviews to summarize feedback for improving ongoing technical assistance (TA). We also present findings that emerged around barriers to telehealth, health plan motivations, and perceptions of telehealth sustainability to collect baseline data for the summative evaluation. Findings were identified through preliminary review and coding of all interview transcripts; additional findings from the formal analysis will be presented following wave 2 data collection.

# Section 2: Findings on the SMTSN Initiative and Evaluation

## 2.1 Health Center and Health Plan Feedback on the SMTSN Initiative

## 

In the section below we summarize participant feedback regarding the initiative, including activities undertaken and technical assistance received. We also present participants’ recommendations for improvement. Based on the range of comments we heard and our knowledge of telehealth and quality improvement, we also offer for the TA team’s consideration several recommendations for improving the initiative. Inclusion of participant feedback below is not an endorsement by RAND.

* Health centers and health plans generally were very pleased with the initiative and the TA they have received. The majority only had positive comments about their interactions with the TA team and the grantee meetings held to date, with only minor suggestions for improvement.
* A couple of health center participants felt that the baseline period was not clearly communicated and, as such, were concerned that they may not get credit for activities that began prior to the official start.
* Several health center participants felt that reporting telehealth utilization was time consuming when they first started reporting.
* According to one health center participant, there were multiple point persons at the beginning of the initiative. This health center needed equipment for telehealth and received divergent opinions on how to obtain and pay for this. Furthermore, some of the ideas for funding did not pan out. This same health center commented that it would have been helpful if funding for equipment had been part of the grant or if resources had been directed to support purchasing of equipment.
* According to one health plan participant, there was some confusion regarding the role of health plans in the initiative (e.g., whether they were to help sites buy equipment, find a coordinator).

## 2.2 Health Center and Health Plan Recommendations for Improving SMTSN Technical Assistance

* *Information about SMTSN*
  + Provide clear guidance on start dates and end dates to inform volume goal setting. Allow start time to correspond to when work on increasing volume began rather than when the contract was officially signed.
* *TA Activities and Resources*
  + Provide more TA on “how to use readily accessible and inexpensive technology and hardware-agnostic software to expand the scale of your program without a lot of costs and without danger of what you have quickly becoming obsolete.”
  + Provide more resources on telehealth billing. This is a knowledge gap.
  + Provide more resources on how to improve telehealth no-show rates as well as experiences of best performers.
  + Provide more resources on telehealth contracting (e.g., how to write a contract, what is a reasonable cost per hour, how you can you get your PPS rate). As stated by one participant, “*There is no standard everyone is following yet. These resources may not influence your individual contract but could give you some insights into what is possible*.”
  + Provide example patient surveys health centers could adapt for their use/QI activities. As one participant shared, “*We've got a survey from TeleMed2U for the patient to fill out. We ask them: Is this your first experience, rate on a scale of 1 to 5, about your experience today, physician communication, and do you believe this is effective of receiving access to specialty medical care? But I wished that we had some sort of a survey that the patient could fill out that incorporated some questions on how easy was it for you to get this referral? Do you feel like you've got your appointment scheduled in a timely manner? Just general, overall questions about their whole experience with telemedicine from the start of talking with their provider*.”
  + Share how others are doing with respect to telehealth volume and growth to facilitate sharing of promising practices.
  + Conduct a survey of specialists to inform quality improvement. As explained by a health center representative, “*We do get a set of criteria of stuff they want for each visit, and we try to send that all to them, but sometimes that changes when the patient gets in the room, so I don't know how often that's a frustration to the specialist*.” Knowing more about how the specialists are experiencing telehealth could help inform quality improvement efforts.
  + Share more stories and impacts of telehealth programs in narrative form (e.g., handwritten notes from patients).
  + Make grantee meetings more interactive and allow time for health centers to network amongst themselves; make future meetings more like the first meeting than the second.
* *Health plan transparency* 
  + Provide information on how much credit telehealth should get for HEDIS incentives from CA Health and Wellness. Health plans’ providing more transparency on linking financial rewards with the services provided as it relates to telehealth would help program implementation.

## 2.3 RAND Recommendations for Technical Assistance

1. Consider publishing monthly visit data or growth rate data for all grantees to see. Sharing this information could promote accountability, facilitate sharing of promising practices, and motivate under-performers.
2. Ask health centers currently doing patient surveys of telehealth users to share those with the other health centers. Encourage health centers to modify the example surveys and use them with their patients to inform quality improvement activities.
3. Future grantee meetings should allow for more time for interactions among health centers to share common problems and potential solutions. Consider pairing each clinic with a “sister clinic” that faces similar challenges and has a similar telehealth model.
4. Develop a survey for providers that can be used for quality improvement activities. (RAND proposes to prepare this survey for the health centers.)
5. Provide technical assistance to financial officers. Help them figure out how to financially sustain telehealth. Consider having profitable health centers from within and outside of California present their strategies at future grantee meetings.
6. Consider having a three-month average (rather than total for one month) prior to the start of the initiative be the baseline for goal setting. One month may not be representative of the trend prior to the start of the initiative.

## 2.4 RAND-Identified Challenges for the SMTSN Evaluation

In conducting wave 1 interviews, RAND identified multiple sources of variation in clinic characteristics and use of telehealth that need to be addressed in the analysis. Health centers varied with respect to the following (further detail is provided in Table 2):

* Types of telemedicine offered
* Maturity and volume of telehealth program prior to initiative
* Telehealth model (contracting with third parties (originating site only) or serving own sites (originating and distant site)
* Whether all sites at health center vs. select sites offer telehealth (e.g., CDS- not available at all clinic locations)
* Whether health center had a telehealth coordinator before the initiative
* Staffing model of telehealth (i.e., total number of staff with telehealth roles and their responsibilities)
* Position that is being funded by initiative
* Specific tasks of telehealth coordinator/how role is scoped

**Table 2: Sources of Variation Across Clinics that Could Affect Evaluation Outcomes\***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Clinic** | **Types of Telehealth Offered** | **Start of Telehealth** | **Telehealth Model** | **Position funded by Initiative** | **Coordinator before Initiative** | **Staffing Model for Telehealth** | **Role of Telehealth Coordinator** |
| Clinicas de Salud | * Psychiatry * Diabetic retinopathy * Dermatology | Early 2000s | Contracts with third party | Fund two part-time staff (techs?) in three new sites | Yes (had telehealth manager) | Telehealth manager and 3 telehealth technicians | Oversee and train telehealth technicians (who run the schedules)  Work on expansion  Address no shows |
| Chapa De | * Psychiatry * Psychotherapy * Endocrinology * Rheumatology * Neurology * Dermatology * ID * Nephrology * Pulmonology * GI * Cardiology | 2016 | Contracts with third party | Telehealth site coordinator | No | Telehealth coordinator and telehealth site coordinator | Visit logistics (booking appointments, sending referral to vendor, scheduling)  Maintain equipment  Reporting  Obtaining and tracking authorizations with payers who require it  Send info to specialist (labs, PCP office visit info)  Make sure specialists sends notes and PCP follows recommendations |
| Open Door | * Psychiatry * Endocrinology * Rheumatology * Neurology * Pulmonology * Nutrition   GI | Early 2000s | Contracts with third party |  | Yes |  | Visit logistics (get vitals, get  patient seated in front of  camera, schedule follow-up,  make sure tests ordered before  next appt, send info to  specialist, follow-up with  provider regarding specialist  recs). |
| Borrego | * Psychiatry * Psychotherapy | 2009 | Own network | Telehealth coordinator |  | Telehealth coordinator then individuals at each site | Promoting program  Educate staff at each site so  that each site manager is aware  Educate patient population  (create materials to distribute)  Monitor if there is a dip in  visits  If no shows, identify why and  work with clinic site manager to  address |
| Neighborhood | * Psychiatry * Diabetic retinopathy | 2013 | Own network | Telehealth coordinator | No | Telehealth coordinator and unknown | Understand each site’s workflow and standardize process across sites  Train staff on new workflow  Review reporting and assess why volume isn’t as high as it could be  Train MAs on how to use new carts |
| El Dorado | * Psychiatry * Endocrinology * Rheumatology * Neurology * Dermatology * Diabetic retinopathy | 2015 | Contracts with third party | Telehealth coordinator | No (but development director and MA did coordination) | Telehealth coordinator and telehealth medical assistant | Liaison with vendors and with payers  Work out billing  Coordinate with vendors on how scheduling occurs  Ensure that with vendor scheduling and site scheduling, schedule is always full  Make sure vendors specialist getting everything they need  Work with telehealth medical assistant who conducts actual visits.  Coordinator makes sure there is a patient in the room and does the follow-up |
| Ampla | * Psychiatry * Diabetic retinopathy | 2004 | Contracts with third party | New staff member with IT experience |  | Telehealth advisor and certified medical assistants (to room patient, take vitals) | Data reporting  Training new staff  Building relationships with vendors  Contracting  Point of contact for providers  Address any challenges that arise in program  Focus on expansion across sites |
| West County | * Rheumatology * Psychiatry * Endocrinology * Dermatology | 2014 | Contracts with third party |  | No | 3-person team of promoter, scheduler, and roomer (coordinator, front office patient services rep, and MA) | Promote program within  health center  Instruct providers what it is,  how it works |
| Shasta | * Rheumatology * Psychiatry * Endocrinology * Neurology | 1999 | Contracts with third party | New Telehealth MA | Yes | 3 FTEs in telemedicine (2 telehealth MAs, 1 telehealth manager) | Contracting with new specialists  Visit logistics (scheduling, making sure tests ordered)  Process invoices  Assess compliance |

*\*All SMTSN stakeholders will be asked to review and correct Table 2 to ensure accuracy. A table like this will be included in RAND’s final report*

# Section 3: Summative Evaluation: Baseline Findings

In the section below we present an overview of the baseline data we collected on barriers, the role of health plans in supporting telehealth, and perceptions of the sustainability of telehealth. After wave 2 data are collected, we will conduct a more formal analysis of findings from both waves, and we will examine change in themes between wave 1 and wave 2.

## 3.1 Barriers

We asked interviewees to identify barriers to implementing telehealth. We show all barriers discussed in Table 3 as well as themes across sites in Table 4.

**Table 3. Detailed Barriers by Organization**

|  |  |
| --- | --- |
| **Health Center** | **Barriers** |
| Health Center 1 | Funding to cover cost of equipment and extra staff  Providers- they are liable and need to overcome new requirement; they are conflicted over having a  new provider step and provide care to their patient.  Workforce shortages/difficulty hiring qualified person for telehealth |
| Health Center 2 | Telemedicine across county lines has been an issue for payers |
| Health Center 3 | Getting all the payers on board  Carts don’t always meet their needs; have to create own cart  Lack of permanent space for telehealth |
| Health Center 4 | No shows  Incorporating nurses into workflow: telehealth is a separate department so telehealth is not  part of every nurse’s responsibilities and there is sometimes lack of clarity regarding  who is responsible  In areas where there are local specialists, providers may be less enthusiastic because  telehealth requires more work for them than referring out (e.g., doing biopsy in derm) |
| Health Center 5 | Insurance is the biggest barrier: we are in a pilot program with CHW and so our patients have to have  CHW to be seen  Providers don’t refer as often as they could; also, don’t read the consult note before the patient’s next  visit |
| Health Center 6 | None mentioned |
| Health Center 7 | Physical space (only two rooms enabled)  Staff time (for every 5 hours of telemedicine visits, need 10 hours of staff time)  Limited funds to pay specialists.  Due to low volume, can’t negotiate big blocks of time for specialist. Not worth it to the specialist to contract  Workforce shortages/difficulty hiring qualified person for telehealth  Contracting is very time consuming; takes a long time to identify specialist, train them on EHR, credential them  Turnover of specialist after time investment to credential them  Limited availability of specialist even when a contract is in place. Significant problem with new providers.  Specialists may not have a great IT team so technical issues on their end can be hard to solve |
| Health Center 8 | No show rate |
| Health Center 9 | Getting providers used to a new way of working |
| Health Center barriers (according to health plans) | Turnover in health centers  No shows  Lack of knowledge capital on how to bill and on compliance  Space: clinics quickly outgrow existing space  Specialist availability  Broadband  Lack of patient comfort with seeing a specialist through a video screen  Time consuming to build a program and get patients to agree  Lack of space  Time consuming to manage logistics of telehealth visit  Technology costs (although these are dropping)  Provider buy-in because they don’t feel it is their responsibility to provide specialist care and telehealth requires more of them than just referring  Reimbursement |
| Health plans | Time consuming to contract with and credential a telehealth provider  Need to rethink referral processes to allow for virtual options |

**Table 4: Frequency of Barriers**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Theme** | **Health Center 1** | **Health Center 2** | **Health Center 3** | **Health Center 4** | **Health Center 5** | **Health Center 6** | **Health Center 7** | **Health Center 8** | **Health Center 9** | **Payer view of Health Center** |
| Physical Space/Equipment | X |  | X |  |  |  | X |  |  | X |
| Technology Issues |  |  |  |  |  |  | X |  |  | X |
| Workflow/Logistics |  |  |  | X |  |  |  |  | X |  |
| PCP Support/ Buy-in | X |  |  | X | X |  |  |  |  | X |
| Telehealth Staffing/ Turnover | X |  |  |  |  |  | X |  |  | X |
| Specialist Staffing |  |  |  |  |  |  | X |  |  |  |
| Specialist Contracting |  |  |  |  |  |  | X |  |  |  |
| Specialist Availability |  |  |  |  |  |  | X |  |  | X |
| Reimbursement/ Insurance/Payer issues |  | X | X |  | X |  | X |  |  | X |
| Technology Costs |  |  |  |  |  |  |  |  |  | X |
| No Shows |  |  |  | X |  |  |  | X |  | X |
| Patient Reluctance to Use Telehealth |  |  |  |  |  |  |  |  |  | X |

## 3.2 Roles and Motivations of Health Plans

In Table 5, we present perspectives on health plan motivations to participate in the initiative and on the role of health plans in promoting telehealth.

**Table 5: Health Plan Roles and Motivation**

|  |  |  |
| --- | --- | --- |
| **Health Plan** | **Role of Health Plans in Promoting Telehealth** | **Motivation for Participation** |
| **Heath Plan 1** | Most limited role is administering benefits and paying claims.  Educate providers on differences between Medicare and Medicaid and broadly implement programs so that they touch as many members as possible  Help health centers navigate what to do when different patients have different plans and telehealth benefits  Help health centers to develop sustainable financial models | With our specialty care network and footprint, it was going to be hard to meet the standards the state has developed for us with respect to time and distance and access, and network adequacy. |
| **Health Plan 2** | Set aside a large chunk of money (“strategic use of reserves”) so that we can pay the coordinators. We are paying the health centers money to help supplement their coordinators’ costs. Give them a $10,000 grant up front when they start the program and we pay them based on a tiered model for telehealth utilization  Pay for e-consult platform and we pay the specialists’ cost  Don’t provide funds for equipment but help provide info on where to get grant funding | Eliminate transportation time to an appointment  Now focus is on timely access and eliminating the 45-60 day wait to see a specialist  Want to meet benchmarks on access as a health plan |
| **Health Plan 3** | We contract, we credential, we pay, and we report  Potential role: We could provide incentives (health plans have incentive programs) for virtual visits at some point if they align with good clinical outcomes  Potential role: We could increase consumer demand through outreach to members/direct marketing  We have been communicating to our FQHCs whether they would be open to members assigned to other PCPs getting their specialty services virtually through the health centers that offer telehealth | Goal to see improvements on some of the measures we are monitored on (e.g., wait times for behavioral health visit)  Improve members and provider experience |

## 3.3 Sustainability

Below we present a summary of participants’ comments about the sustainability of their telehealth programs after the initiative ends.

* + Most health centers felt that once they get their numbers up, they could continue to fund programs with internal funding because telehealth would prove itself, and the health center would not want to discontinue services serving a critical need. Also, visits are billable.
* Several health centers noted that telehealth aligned with their strategic plans and priorities.
* Several health centers felt that solving the no-show problem was key to making programs sustainable.
  + One health center is hoping to have vendors agree to charging per visit (rather than by hour) so they don’t take a hit for no shows
  + Health Plan 2’s strategic use of reserves is still in place for a few more years.