Texas Health and Human Services (HHS) e-Health Advisory Committee

As Required by
Title 1, Part 15, Texas Administrative Code, Section 351.823(d)

e-Health Advisory Committee
December 2022

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Disclaimer

This report is not authored by and does not necessarily reflect the views and opinions of the Texas Health and Human Services system, its component agencies, or staff. For a full roster of representatives who contributed to this report, please see Appendix A.

Executive Summary

The Texas Health and Human Services Commission's (HHSC) e-Health Advisory Committee (eHAC) was established under Texas Government Code, Section 531.012 to advise the Executive Commissioner and Health and Human Services system agencies on strategic planning, policy, rules, and services related to the use of health information technology (HIT), health information exchange systems (HIE), telemedicine, telehealth, and home telemonitoring services.[1]

As directed by Title 1, Part 15, Texas Administrative Code (TAC), Section 351.823(d), the Committee is making several recommendations, which fall into three categories:

Task 1 (Section 351.823. eHAC): Advises HHS agencies on the development, implementation, and long-range plans for health care information technology (IT) and HIE, including use of:

1. Electronic health records (EHR), computerized clinical support systems, HIE systems for exchanging clinical and other types of health information, and
2. Other methods of incorporating health information technology in pursuit of greater cost-effectiveness and better patient outcomes in health care and population health.

Task 2 (Section 351.823. eHAC): Advises HHS agencies on incentives for increasing health care provider adoption and usage of an electronic health record and HIE systems.

Task 3 (Section 351.823. eHAC): Advises HHS agencies on the development, use, and long-range plans for telemedicine, telehealth, and home telemonitoring services, including consultations, reimbursements, and new benefits for inclusion in Medicaid telemedicine, telehealth, and home telemonitoring programs.

The eHAC includes health and human services stakeholders concerned with the use of HIT, HIE, telemedicine, telehealth, and home telemonitoring services. eHAC membership includes representation from the Texas Medical Board, the Texas Board of Nursing, the Texas State Board of Pharmacy, the Statewide Health Coordinating Council, managed care organizations (MCO), representatives from the

[1] See TAC Section 351.823(a) and (b).

pharmaceutical industry, academic health science centers, an expert on telemedicine, an expert on home telemonitoring services, a consumer of health services through telemedicine, a Medicaid provider, a representative from the Texas Health Services Authority (THSA), a representative from a local or regional HIE, and representatives with expertise in implementation of electronic health records, computerized clinical support systems, and HIE systems for exchanging clinical and other types of health information. The committee also includes ex-officio representatives from HHSC and an ex-officio representative from DSHS. For a full roster of representatives, please see Appendix A.

The remainder of this report includes recommendations on the three tasks listed above, as well as other information as required under TAC Section 351.823.

Introduction

The eHAC is established under Texas Government Code, Section 531.012 and governed by Texas Government Code, Chapter 2110 and TAC Section 351.823.

Pursuant to TAC Section 351.823, "by December 1 of each even-numbered year, the committee files a written report with the Executive Commissioner and the Texas Legislature covering the meetings and activities not covered in its most recent report filed with the Executive Commissioner and Texas Legislature through September 30 of the even-numbered year the report is due to be filed." The report includes:

(A) a list of meeting dates;

(B) the members' attendance records;

(C) a brief description of actions taken by the committee;

(D) a description of how the committee accomplished its tasks;

(E) a summary of the status of any rules that the committee recommended to HHSC;

(F) a description of activities the committee anticipates undertaking in the next fiscal year;

(G) recommended amendments to this section; and

(H) the costs related to the committee, including the cost of the HHSC staff time spent supporting the committee's activities and the sources of funds used to support the committee's activities. "

Please note that a full list of acronyms used in this report is available on page 33.

This report provides a background for eHAC's recommendations, as well as information on each criterion listed above.

Background

TAC Section 351.823, requires the eHAC to address three tasks:

Task 1: Advises HHS agencies on the development, implementation, and long-range plans for health care information technology and HIE, including use of:

- Electronic health records, computerized clinical support systems, HIE systems for exchanging clinical and other types of health information, and
- Other methods of incorporating health information technology in pursuit of greater cost-effectiveness and better patient outcomes in health care and population health.

Task 2: Advises HHS agencies on incentives for increasing health care provider adoption and usage of an electronic health record and HIE systems.

Task 3: Advises HHS agencies on the development, use, and long-range plans for telemedicine, telehealth, and home telemonitoring services, including consultations, reimbursements, and new benefits for inclusion in Medicaid telemedicine, telehealth, and home telemonitoring programs.

Definitions Unless stated otherwise in this report, the terms below shall have the following definitions:

"Electronic Health Record" (EHR) means "an electronic record of aggregated health related information concerning a person that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized health care providers across two or more health care organizations" (see Texas Government Code, Section 531.901(1)).

"Electronic Medical Record" (EMR) means "an electronic record of health-related information concerning a person that can be created, gathered, managed, and consulted by authorized clinicians and staff within a single health care organization" (see Texas Government Code, Section 531.901(2)).

"Health Information Exchange" (HIE) means an organization that:

> (1) Assists in the transmission or receipt of health-related information among organizations transmitting or receiving the information according to

nationally recognized standards and under an express written agreement with the organizations;

(2) As a primary business function, compiles or organizes health-related information designed to be securely transmitted by the organization among physicians, other health care providers, or entities within a region, state, community, or hospital system; or

(3) Assists in the transmission or receipt of electronic health-related information among physicians, other health care providers, or entities within: (A) a hospital system; (B) a physician organization; (C) a health care collaborative, as defined by Section 848.001, Insurance Code; (D) an accountable care organization participating in the Pioneer Model under the initiative by the Innovation Center of the Centers for Medicare and Medicaid Services; or (E) an accountable care organization participating in the Medicare Shared Savings Program under 42 United States Code, Section 1395jjj (see Texas Health & Safety Code, Section 182.151; see also Texas Health & Safety Code, Section 481.002(54); see also Texas Government Code, Section 531.901).

"Home telemonitoring service" means "a health service that requires scheduled remote monitoring of data related to a patient's health and transmission of the data to a licensed home and community support services agency or a hospital, as those terms are defined by Texas Government Code, Section 531.02164(a).

"Telehealth service" means "a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state [Texas] and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology" (see Texas Occupations Code, Section 111.001(3); see also Texas Government Code, Section 531.001(7)).

"Telemedicine medical service" means "a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license, to a patient at a different physical location than the physician or health professional using telecommunications or information technology" (see Texas Occupations Code, Section 111.001(4); see also Texas Government Code, Section 531.001(8)).

eHAC Meeting Dates

The eHAC met on the following dates in fiscal year 2021-fiscal year 2022:

- December 7, 2020
- March 5, 2021
- June 21, 2021
- December 6, 2021
- March 7, 2022
- June 6, 2022
- September 16, 2022

Brief Description of Actions Taken by the Committee and Member Attendance

Below is a high-level list of actions taken by the committee at each meeting.

- *Prior* fiscal *year reporting period*- July 17, 2020 voted to amend rules to change reporting frequency from annually to biennially. This rule became effective September, 2021.

December 7, 2020 (90 percent member attendance)

- New Chair elections were held. George Gooch was elected Chair; Mari Robinson was elected Vice-Chair.
- HHSC staff updated the Committee on the novel coronavirus (COVID-19) telehealth flexibilities, currently filed legislation being tracked by HHSC staff, Senate Bill (S.B.) 670, 86th Legislature, Regular Session, 2019; House Bill (H.B.) 1063, 86th Legislature, Regular Session, 2019; and H.B. 1697, 85th Legislature, Regular Session, 2017.
- HHSC staff provided an update regarding H.B. 4533, 86th Legislature, Regular Session, 2019, which requires that HHSC enroll and revalidate Medicaid and Children's Health Insurance Program (CHIP) providers using National Provider Identifiers.
- HHSC staff provided an update regarding the Delivery System Reform Incentive Payment (DSRIP) Program Transition Plan Telemedicine and Telehealth Assessment Milestone.
- Mr. George Gooch, eHAC member, provided overview of the December 2020 Texas Health Services Authority HIE-Texas Disaster Response Report.
- HHSC staff provided an update regarding ImmTrac2, the Texas Immunization Registry, including the Registry Content and Electronic Affirmation.
- HHSC staff presented regarding the Public Health Reporting Update.

March 5, 2021 (85 percent member attendance)

- Recruitment and designation of Dr. Magoon as Interoperability Subcommittee Chair.
- HHSC staff updated the Committee on the COVID-19 telehealth flexibilities, currently filed legislation being tracked by HHSC staff, S.B. 670, H.B. 1063, and H.B. 1697.

- HHSC staff updated the committee on interoperability matters, including Emergency Department Encounter Notification (EDEN), Patient Unified Lookup System for Emergencies (PULSE), the Strengthen the Technical Advancement and Readiness of Public Health via Health Information Exchange (STAR-HIE), and the Situation Awareness for Novel Epidemic Response Project (The SANER) projects. There was also presentation and discussion regarding health data and the possibility of central exchange.

June 21, 2021 (100 percent member attendance)

- Staff from the eHealth Alliance presented legislative summary from the 87th legislature.
- HHSC staff updated the COVID-19 telehealth flexibilities and H.B. 1697.
- HHSC staff updated the committee on interoperability matters, including the Centers for Medicare and Medicaid Services (CMS) interoperability requirements, and the ImmTrac2, PULSE, STAR-HIE, and SANER projects.
- The board participated in the required ethics training as presented by HHSC staff.

September 17, 2021

- *Meeting cancelled.*

December 6, 2021 (89 percent member attendance)

- New Chair elections were held. Mari Robinson was elected Chair; Phil Beckett was elected Vice-Chair.
- Revised and approved Bylaws to adjust the reporting frequency of the committee to be consistent with the rule changes adopted at a prior meeting.
- HHSC staff updated the committee on the implementation of H.B. 4, 87th Legislature, Regular Session, 2021, S.B. 670, and H.B.
- Staff from the Rural Telementoring Training Center a national Health Resources and Services Administration funded center, presented to the committee on use and benefits of telementoring.
- HHSC staff updated the committee on the implementation workflow to allow the eHAC to offer assistance to fellow committees within HHSC.
- HHSC staff updated the committee on interoperability matters, including HHSC Environmental Scan and State Medicaid Health IT Plan, the HIE Connectivity Project, and disaster response.

March 7, 2022 (95 percent member attendance)

- HHSC staff updated the committee on the implementation of H.B. 4, H.B. 1697, and the DSRIP Program transition plan as it related to telehealth/telemedicine.
- HHSC staff updated the committee on interoperability matters, including 2022 Interoperability Report, the HHSC Environmental Scan and State Medicaid Health IT Plan, the HIE Connectivity Project, and disaster response.
- HHSC staff presented on the United States Core Data for Interoperability and US@ (Address Information).
- Mr. George Gooch, eHAC member. Mr. Gooch provided a presentation and handout titled *Disaster Response in Health IT.*

June 6, 2022 (70 percent member attendance)

- Discussion was held concerning the extension of the eHAC. The committee approved the recommendation of an extension of eHAC beyond December 31, 2023 abolish date.
- Discussion was held concerning the HHSC's adoption of the US@ address standards and service – standardization of address format and content will improve the accuracy of patient matching across disparate system, improve efficiency and accuracy of health care operations, notification requirements, etc. The committee approved the recommendation that HHSC adopt the recommended standardization.
- HHSC staff updated the committee on the implementation of H.B. 4, S.B. 670, and H.B. 1697.
- HHSC staff provided updates on the following projects: The Final State Medicaid Health IT Plan, The HIE, Interoperability for Texas: Powering Health 2022 Report
- HHSC staff provided updates provided updates on Department of State Health Services (DSHS) Program Area Activities, as well as Data and Interoperability Standards Technology Development Collaboration with HHSC.
- Mr. George Gooch, Chief Executive Officer, Texas Health Authority Services Authority and eHAC member presented to the committee regarding THSA – Disaster Response in Health Information Technology.
- Representatives from the Texas Medical Association and from Sen. Nathan Johnson's office, District 16 (Dallas) presented on interoperability from a legislative perspective and on Interoperability Challenges for Physicians.

September 16, 2022 (60 percent member attendance)

Recommendations from eHAC to HHSC and the Legislature

As noted in the Background section the Committee has tasks in three primary areas to include in this report. These tasks are being addressed within the three sections below, as determined by the eHAC Subcommittees. The Interoperability Subcommittee report and recommendations discusses Tasks 1 and 2. The Telemedicine, Telehealth, & Telemonitoring Subcommittee considers Task 3. Behavioral Health Subcommittee covers all three Tasks within the realm of behavioral health. Historical recommendations and their status are included at the conclusion of this section. In addition to the recommendations below, the committee also recommends the continuation of the eHAC, which is especially important given the expansions in this area during the COVID-19 public health emergency (PHE).

Interoperability Subcommittee

This Subcommittee report was developed by the Texas HHS eHAC Subcommittee on Interoperability and is intended to support the eHAC in the development of its annual report as required by TAC Section 351.823. As discussed below, this report (1) lays out the charge of the Subcommittee; (2) provides a definition of interoperability; (3) provides an overview of the items discussed by the Subcommittee this year; (4) discusses interoperability at the regional, state and national levels; and (5) provides recommendations on interoperability to the eHAC.

Charge of the eHAC Subcommittee on Interoperability

The purpose of the Interoperability Subcommittee is to address Tasks 1 and 2 in the eHAC's enabling rule *TAC Section 351.823*.

Task 1. The eHAC advises HHS agencies on the development, implementation, and long-range plans for health care information technology and HIE, including use of:

- Electronic health records, computerized clinical support systems, HIE systems for exchanging clinical and other types of health information
- Other methods of incorporating health information technology in pursuit of greater cost-effectiveness and better patient outcomes in health care and population health.

Task 2. The eHAC *a*dvises HHS agencies on incentives for increasing health care provider adoption and usage of an electronic health record and HIE systems.

What is Interoperability?

According to section 4003 of the federal 21st Century Cures Act (Cures Act), the term "interoperability," with respect to health information technology, means such health information technology that:

> (A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user;

(B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law;

(C) does not constitute 'information blocking'[2] as defined in section 3022(a).[3]

Overview of Items Discussed by the Interoperability Subcommittee This Year

The Interoperability Subcommittee met several times throughout the year to discuss interoperability issues as they relate to the work of eHAC. The interoperability Subcommittee provided a full report of its meetings at each scheduled eHAC meeting.

These discussions of the Subcommittee included, but were not limited to (1) the value of interoperability for physicians and the medical community; (2) an update on regional HIE efforts across Texas, including their work during the COVID-19 PHE; (3) an update on the HHSC Interoperability Center of Excellence, and how it relates to the Texas Medicaid Health IT Strategic Plan;[4] (4) an update on the Texas Immunization Registry, now known as "ImmTrac2," as well as the syndromic surveillance system; (5) expert testimony on the United States Core Data for Interoperability and (6) expert testimony on the US@ Standards, a project to move health care in alignment with United States Postal Service address standards (US@ Standards), such that by utilizing a common address format across the health system, there will be improved patient matching and coordination of service.

Regarding the US@ Standards, there was significant interest expressed in voluntarily promoting the US@ standards for improved patient matching. The

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[2] The Cures Act defines information blocking as "a practice that . . . is likely to interfere with, prevent, or materially discourage access exchange, or use of electronic health information." The Cures Act goes on to apply this definition to not only health information technology developers, exchanges, and networks, but also to healthcare providers. In addition to laying out certain practices that do constitute information blocking, the Act also provides seven exceptions to what constitutes information blocking. More information is available for review in the Cures Act, as well as the Notice of Proposed Rulemaking at 84 Fed. Reg. 7424 (proposed March 4, 2019) (to be codified at 45 C.F.R. pts. 170 and 171).

[3] "21t Century Cures Act, Public Law 114-255, https://www.congress.gov/bill/114th-congress/house-bill/34/text. Retrieved October 10, 2019.

[4] https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/health-it-strategic-plan.pdf

Interoperability Subcommittee wrote a recommendation for eHAC committee consideration for submission to HHS through the new recommendation process.

Background Information on Interoperability at the Regional, State, and National Levels

Interoperability at the regional level

Regional HIEs in Texas offer services to health care systems, providers, payors and hospitals to share health care information primarily for the purposes of payment, treatment, and other healthcare operations. These regional HIEs are non-profit organizations and offer integrated interoperability services with the aim of helping drive participant costs down and/or participants revenues up. Regional HIEs also collaborate at the local, state, and national levels so that systems that cover multiple regions can have a single connection.

All of the regional HIEs use standard, secure connections with strong encryption so that patient data is secure. The HIEs integrate with health care providers' electronic health record systems where possible so that the access and exchange of the data is accessible within the user's normal workflow. Each participant in an HIE signs a business associate agreement defining responsibility for protecting the data and its approved use. Texas does not have a required opt-in or opt-out model, and the HIEs have different models based on local governance, but all patients in any regional HIE have the option to opt out at any participating facility.

Interoperability at the state level

Pursuant to Chapter 182, Texas Health and Safety Code, the THSA is responsible for statewide HIE. Formed by the Texas Legislature as a public-private partnership, THSA partners with state agencies, regional HIEs, as well as others engaging in the exchange of health information across Texas.

THSA is also responsible for implementing the Texas State HIE Plan, originally created by the HHSC and THSA for submission to the Office of the National Coordinator in 2010. THSA's governor-appointed board of directors supplemented the state HIE plan in 2014 to reflect the changing HIE market, and specifically how interoperability was being addressed in the public and private sectors.

Also relevant to state-level HIE is public health reporting and HIE with programs such as those provided by the Texas DSHS including, but not limited to Electronic

Laboratory Reporting, the Texas Immunization Registry/ImmTrac2, Texas Syndromic Surveillance, and the Texas Cancer Registry. Another example of a public health system that exchanges data with the private sector is the prescription monitoring program (PMP) which is operated by the Texas State Board of Pharmacy.

Pursuant to Texas H.B. 2641, 84th Legislature, Regular Session, 2015, certain registries maintained by DSHS may bidirectionally exchange health information via electronic HIEs. This legislation also required "the commission and each health and human services agency establish an interoperability standards plan for all information systems that exchange protected health information with health care providers."[5]

Interoperability at the national level

National HIE generally refers to information exchanged through or pursuant to (1) the eHealth Exchange, (2) CommonWell, (3) the Carequality framework, (4) the Civitas Patient Centered Data Home, and/or (5) the Sequoia Project.

The eHealth Exchange is "the largest query-based, health information network in the country. It is the principal network that connects federal agencies and non-federal organizations, allowing them to work together to improve patient care and public health."[6]

The Commonwell Health Alliance (Commonwell) is "a not-for-profit trade association devoted to the simple vision that health data should be available to individuals and caregivers regardless of where care occurs. Additionally, access to this data must be built into health IT at a reasonable cost for use by a broad range of health care providers and the people they serve."[7]

Carequality is "a public-private, multi-stakeholder collaborative developed to create a standardized, national-level interoperability framework to link all data-sharing networks."[8] Carequality implementers are "the adopters of the Carequality Interoperability Framework, and their clients."[9]

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[5] *See* bill text at https://capitol.texas.gov/tlodocs/84R/billtext/pdf/HB02641F.pdf#navpanes=0
[6] www.ehealthexchange.org
[7] www.commonwellalliance.org/about
[8] www.carequality.org
[9] www.carequality.org/members-and-supporters/

The Civitas Patient Centered Data Home (PCDH) is a "national collaborative representing HIEs and their business and technology partners." The PCDH is "a cost-effective, scalable method of exchanging patient data among HIEs. It's based on triggering episode alerts, which notify providers a care event has occurred outside of the patient's 'home' HIE and confirms the availability and the specific location of the clinical data, enabling providers to initiate additional data exchanges to access real-time information across state and regional lines and the care continuum."[10]

The Sequoia Project is an "independent, trusted advocate for nationwide HIE. In the public interest [the Sequoia Project] steward[s] current programs, incubates new initiative[s,] and educate[s] our community."[11] In 2019, ONC selected the Sequoia Project as the Recognized Coordinating Entity for the Trusted Exchange Framework and Common Agreement (TEFCA). The Cures Act requires ONC to convene stakeholders to develop a trusted exchange framework and a common agreement among existing, disparate health information networks (HINs) to exchange electronic health information. TEFCA is designed to scale electronic HIE nationwide and help ensure that HINs, healthcare providers, health plans, individuals and many more stakeholders have secure access to their electronic health information when and where it is needed.

Recommendations

As recommended in previous annual reports, Texas HHS System agencies should leverage the existing EHR and HIE infrastructures described in this report, and should avoid developing duplicate infrastructure, to a) better assist healthcare entities in complying with the interoperability regulations and initiatives described in this report; b) drive down healthcare costs; c) improve population health; and d) reduce the burden of reporting for both healthcare providers and public health through structured, secure, electronic data exchange.

Furthermore, Texas HHS System should adopt the US@ Standards, as referenced above, and submitted to Texas HHS through its newly adopted recommendation process. Finally, the Interoperability Subcommittee recommends that the full eHAC should continue in existence beyond its Sunset date currently scheduled for December 31, 2023, and instead should be extended to December 31, 2027.

[10] Civitas Networks for Health Announces Grant Award to Lead Implementation and Dissemination of Gravity Project® SDOH Standards (civitasforhealth.org)
[11] www.sequoiaproject.org

Telemedicine, Telehealth & Telemonitoring Subcommittee

This Subcommittee report was developed by the Texas HHS eHAC Subcommittee on Telemedicine, Telehealth & Telemonitoring. The focus of this section is on Task 3 of the eHAC's enabling rule *TAC Section 351.823*.

*Task 3. A*dvises HHS agencies on the development, use, and long-range plans for telemedicine, telehealth, and home telemonitoring services, including consultations, reimbursements, and new benefits for inclusion in Medicaid telemedicine, telehealth, and home telemonitoring programs.

The Subcommittee focused on four main points during the reporting period:

- Survey of the current landscape of tele-services
- Examination of tele-services beyond traditional telemedicine
- Feedback and discussion surrounding the implementation of HB 4
- Discussion of possible assistance and expansion efforts for telemedicine, telehealth, and telemonitoring

Prior to the COVID-19 PHE, the Subcommittee conducted a survey regarding the use of tele-services in Texas. However, the pandemic drastically changed the use of tele-services throughout the state, making the prior information less relevant to current practice. The Subcommittee thus created and executed an updated survey, the full results of which can be viewed in Appendix B. Some of the highlights of the results include:

- The majority of survey respondents were clinics, followed by individual practitioners, with the number of patients seen per year ranging from 0-1.5 million.
- Ninety-nine percent of respondents provide telemedicine/telehealth services, with the most common modality being that of audio-video services (81 percent).
- One hundred percent of respondents bill for telehealth services, with 92 percent offering telehealth services to all patients regardless of payment method.
- Over 92 percent provide telehealth services using their own clinicians.

- With practice areas, behavioral health was the most frequently offered service follow by primary care. Additionally, 83 percent of respondents offer telemonitoring/remote monitoring for their patients, most commonly for hypertension and diabetes. Only hospitals (50 percent) and Federally Qualified Health Centers (67 percent) offered telemonitoring or remote monitoring, with no clinics or individual practitioners offer this service.

As these results illustrate, tele-services are a very common and likely permanent part of the medical landscape. The current challenges will be to ensure that current progress is not lost at the conclusion of the current PHE, and that technology is leveraged to allowed for even better medical services within the state.

In addition to the survey, the Subcommittee explored available services beyond traditional telemedicine. In particular, the committee receive a presentation from the newly formed Rural Telementoring Training Center.[12] The presentation informed committee discussion about how telementoring may fit within the healthcare landscape of the state, especially the possible utilization of the Project Extension for Community Healthcare Outcomes (ECHO) model, a telementoring model that links primary care clinicians with specialists via teleconferencing technology.[13]

Following the passage of H.B. 4, work began on the rules to implement the new standard surrounding reimbursement for tele-services. The committee acted in a resource stakeholder role and met with HHSC staff to offer review and feedback over the course of the rules process.

Recommendations

As noted above, the fourth item of the committee's focus was discussion of possible assistance and expansion efforts for telemedicine, telehealth, and telemonitoring. Based on the information received over the course of the year, the Subcommittee makes the following recommendations:

- Explore and fund options for educational and support opportunities for teleservices within the state. Examples include:
    - Establish a shared telemedicine and telehealth tech support pool that could provide a combination of onsite and virtual services for rural and underserved areas in Texas.

[12] https://ruraltelementoring.org/
[13] https://hsc.unm.edu/echo/

    - Create trainings and educational classes to inform policy makers, fellow HHSC appointees, and healthcare providers around the state about tele-services guidelines and technology advancements that could improve care for Texas patients.
- Enable and fund targeted pilot projects to insert tele-service solutions in appropriate care settings to improve healthcare outcomes and access within the state. Potentially pilots could include:
    - Medicaid financing options for Project ECHO and other telementoring models;
    - Funding for teleservices options for technology enabled physical exams for children within the foster care system;
    - Creating studies to evaluate the best use of teleservice with a patient care setting.

Behavioral Health Subcommittee

The Behavioral Health Subcommittee considered all three task areas described able through the lens of behavioral health and shares the below recommendations.

With the passage of the 21st Century Cures Act, healthcare providers must ensure that sharing client data among providers occurs seamlessly and patients have access to their electronic health information as quickly and efficiently as possible to provide literacy and transparency in outcomes and cost. Unfortunately, the exclusion of behavioral health (BH) in federal electronic medical record incentive dollars in 2009 has put the provider technology adoption rate woefully behind that of medical providers.

The eHAC's BH Subcommittee has been reviewing the needs and barriers to sharing digital health information among behavioral health providers and stakeholders. Most of this work was able to be completed through support of HHSC's implementation of S.B. 640, 87th Legislature, Regular Session, 2021 which requires HHSC to conduct a survey to assess the interoperability needs and technology readiness of behavior health providers in Texas. Based on survey results, HHSC is to produce a report and include a state plan, with timeline, for aligning the interoperability and technological capabilities in the provision of BH services with applicable law. BH Subcommittee members assisted with development and distribution of the legislated survey to appropriate stakeholders, evaluating the survey data for possible trends and recommendations, and reviewing the HHSC report, *Interoperability Needs and Technology Readiness of Behavioral Health Service Providers (August 2022).* This report describes the survey tool development and findings, presents the state implementation plan and timeline, and offers recommendations. Survey results identified gaps in the use of EHRs HIEs by some BH providers. Key takeaways from the report are:

- Most local mental health authorities (LMHAs) and state hospitals do have an EHR; in fact, the majority of these organizations use the same platform vendor. However, these organizations report they still use mail/fax as the primary mode of sending and receiving patient information.
- Most freestanding psychiatric hospitals have not implemented an electronic health record reportedly due to implementation and recurring costs. Those freestanding psychiatric hospitals that have implemented an EHR report they do not send/receive patient information electronically due to lack of connected

partners. Psychiatric departments that are part of a medical/surgical hospital have technology as part of their hospital system platform.

- Cost of these technologies, both initial implementation and recurring/ongoing fees, were considered a significant barrier to adoption.
- There is concern and confusion about the consent and security of sharing behavioral health information digitally, especially as it relates to substance use and the Title 42 Code of Federal Regulations, Part 2 rules.

Along with the S.B. 640 report, the Subcommittee reviewed other substantial references such as the Report to Congress on Medicaid and CHIP Medicaid and CHIP Payment and Access Commission (MACPAC)[14] and the American Hospital Association IT Survey (2020), to name a few.

Texas is moving forward with health IT strategies that will increase patient access, improve quality of care, and lower costs through technology, but the state needs to ensure behavioral health has the same opportunity for digital platforms and interoperability. As patients have more access to their health information through the Cures Act, there will be an increase in health literacy and transparency. Without the appropriate behavioral health information included, patients do not have a holistic picture to make appropriate healthcare decisions.

With Medicaid/managed care being the largest payer for behavioral health care in Texas, there will continue to be fragmentation in information, care coordination and appropriate treatments unless behavioral health has parity in this area. Historically, behavioral health has lower reimbursement rates making it difficult to overcome the operational investment the technology, training, and billing disruption a platform implementation requires without financial incentives. The state needs to work to remove any barriers that continue to lead to low adoption of these technologies or this sector may miss future incentive dollars, quality measure payments and waiver opportunities. With these considerations in mind, the BH Subcommittee puts forth the following recommendations.

[14] "Report to Congress on Medicaid and CHIP", Medicaid and CHIP Payment and Access Commission, June 2022; https://www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf

Recommendations

LMHAs and State Hospitals

The heavy lift for the state has been achieved by having these organizations implement and actively use their digital platforms.

- Recently, the LMHAs began a new Directed Payment Program that requires them to measure a connection to an HIE. HHSC needs to build a timeline, with targets, to hit the full objective of interoperability by the end of fiscal year 2025.
- With most of the LMHAs and state hospitals using the same electronic health platform, work with the vendor to develop a plan to interconnect all the LMHAs and state hospitals at a volume discount.
- Incentivize those LMHAs and state hospitals that become early connectors to realize the cost savings sooner.
- Leverage health IT funds through SAMHSA, or other federal agencies, to defray some of the connection costs.

Freestanding Psychiatric Hospitals

The legislature is currently in discussions around expansion of psychiatric bed capacity in the state. With such a focus on behavioral health, the state should consider the technological infrastructure as part of that strategic planning.

The freestanding psychiatric hospitals are in a new Directed Payment Program, Comprehensive Hospital Increase Reimbursement Program (CHIRP), which measures connections to an HIE; however, a low HIE measure may not reveal the underlying lack of a EHR platform. Until hospitals across Texas are digitally connected, there is not a true, holistic view of the patient, nor solid decision-making data points for future considerations in behavioral health technology needs.

- Develop a one-time capital grant opportunity, or a rider in the budget, to allow for freestanding psychiatric hospitals to purchase and implement an EMR platform with connectivity to an HIE. Appropriate implementation timelines and outcome measures must be required as part of the award. Look for federal matching opportunities in health IT funding to supplement.

- HHSC should develop an incentive program, as a supplement to CHIRP and its HIE measure, for recipients that connect to an HIE by the end of FY'25 improve overall statewide interoperability and compliance with the Cures Act.
- Consider developing a new directed payment program for EHR adoption. The MACPAC report suggests that "CMS guidance on state directed payments within managed care notes that EHR incentive payments for providers that were ineligible for incentives through HITECH is an allowable use of directed payments".[15]
- The MACPAC report also states that an 1115 demonstration waiver could be considered to support interoperability and integration as part of the systems of care of the serious mental illness and serious emotional disturbance population.[16] HHSC should see if this is an option with our current system of care and state health IT strategic plan.

High volume and rural provider groups

The S.B. 640 report showed approximately three-fourths of the Medicaid-volume provider group respondents had an EHR; of those that did not report, cost was the biggest factor. And while rural providers were not specifically segmented in any of the studies and reports, it is consistently known or stated that technology costs are an impediment/barrier to these providers for telehealth. The State can leverage that so many providers now have technology post-covid by offering assistance for further technologies and connectivity.

- Consider budget allocation similar to the one-time Community Mental Health Grants. Allow different funds for a) providers that need to implement a technology platform and b) those that have a platform but need to become interoperable.
    - Determine the definition of "high volume" for providers and the populations they serve that gets the state quick return on investment and broadens the behavioral health technology readiness. Use the current TAC definition of "rural" providers.
    - Include appropriate timelines and outcome measures for the award.

[15] "Report to Congress on Medicaid and CHIP", pg. 89.
[16] "Report to Congress on Medicaid and CHIP", pg. 89.

- Incentivize interoperability with reimbursement models that reward outcomes appropriate for interoperability (such as reduced duplicate tests, closed loop referrals)

Consent and security

- Enable sharing of digital consent through national standards [Health Level Seven (HL7 V2), (Extensible Access Control Markup Language (XACML), Fast Healthcare Interoperability Resources (FHIR-4)] and opportunities to manage consent/authorization through patient portals/applications.
- Standardize e-consent process by addressing the lack of uniformity and clarity around how patient consent is collected, for both treatment and sharing purposes. The system's inability to appropriately share data creates patient safety risks and keeps patients from being truly empowered and engaged in their own healthcare. These improvements will enable providers to integrate consent management into their workflow.
- Develop educational opportunities for stakeholders clarifying rules and laws as it pertains to the electronic consent and sharing of behavioral health information and Title 42 Code of Federal Regulations, Part 2 considerations.
- Ensure that state laws related to data sharing, data collection, and patient data privacy are aligned with federal law whenever possible and address any conflicts around these issues in state statutes.
- Provide incentives for compliance with state and federal consent and security laws by state contractors.

Prescription Digital Therapeutics (PDTs)

PDTs are clinically validated, digital treatments approved by regulatory bodies and prescribed by a physician or other licensed healthcare prescribing provider, to treat a health condition. PDTs have been approved for the treatment of cognitive, psychological, and behavioral health conditions. PDTs are an especially important treatment option for patients with mental health conditions because PDTs empower patients to take personal responsibility for their own mental health well-being by taking an active role in their own treatment and recovery.

- Given the current crises in mental health, both in terms of workforce and access to services, Texas Medicaid should expedite access to Federal Drug Administration-approved prescription digital therapeutics and allow providers to

prescribe these treatments, as part of a broader course of treatment, for patients as indicated by the standard of care.

- PDTs provide physicians and other health care professionals another flexible treatment option for patients. PDTs can be particularly beneficial for those patients who might not otherwise be able to access treatment regularly or in-person.

State Initiatives

- Change the managed care contracts to include requirements set forth by the CMS Interoperability and Patient Access[17] final rule. Develop metrics to measure success and consider expansion of the ombudsman office to take patient/provider concerns and complaints.
- Connectivity interoperability to state required platforms such as Clinical Management for Behavioral Health Services (CMBHS), Texas Health Care Information Collection, and the Star Health platform to prevent duplicative data entry, and possible errors, in multiple systems.
- Develop a common strategy to collect and share data as it relates to social determinants of health that can be shared with agencies, stakeholders, and platform vendors.
- Leverage existing infrastructure while allocating new resources in ways that encourage accountability, across all settings of care in the healthcare ecosystem.

[17] https://www.cms.gov/newsroom/fact-sheets/interoperability-and-patient-access-fact-sheet, March 2020.

Prior Recommendations

As noted above, the HHS eHAC is making recommendations across several areas for which it is responsible. The tables below present the committee's previous recommendations from earlier reports and related information from HHS agencies regarding the status of each recommendation.

Committee Recommendation	Status	Action Needed
Revise Texas Medicaid Medical Policy including updating the definition of telemedicine.	Complete	Process is in place for on-going review and revision of policy to stay current industry change in telemedicine application.
Recommend removal of the requirements for site presenters.	Complete	No further action needed at this time.
Remove the requirement for an initial in-person consultation.	Complete	No further action needed at this time.
Add guidelines surrounding electronic prescribing during a telemedicine encounter.	Complete	Medicaid providers can generate a valid electronic prescription from a telemedicine encounter. All federal and state law and rule requirements would need to be met.
Ensure all Medicaid MCOs include reimbursement for virtual services covered same as in-person	Complete	Process for on-going review and revision of policy to stay current industry change in telemedicine application.
Continue remote patient monitoring benefit.	Complete	Continued via S.B. 670 and H.B. 1063.
Recommend expansion of coverage to include substance abuse treatment (recovery services, counseling, e-prescribe)	Ongoing	Scope included in implementation of S.B. 670, as well as H.B. 4.
National data standards work for Texas, and state health agencies should not create or recommend standards that deviate from national standards	Complete/Ongoing	State health agencies, to date, have not recommended standards that deviate from national standards. This should continue into the future.

Committee Recommendation	Status	Action Needed
HHS agencies should use HIETexas, when appropriate, to exchange messages with trading partners and collaborate with the state's HIEs to increase participation by health care providers	Complete/Ongoing	HHSC signed a contract with THSA to incorporate HIETexas into the HIE Connectivity Project. This project will be implemented over the next several years.
Change requirement for ImmTrac2, the Texas immunization registry from opt-in to opt-out.	Incomplete	Current state law specifies that the state immunization registry operates on an opt-in basis. Legislative action is required to change the registry to an opt-out system.
Encourage data sharing of behavioral health data from LMHAs through HIEs across the State as needed within legal constraints	Ongoing	eHAC is working with HHSC on implementation of S.B. 640.
Review all data streams from providers into the HHS System in order to identify opportunities for consolidated reporting and administrative simplification process platforms (MCOs, public health, etc.).	Ongoing	The connections established between providers and HHS through the current HIE Implementation Advance Planning Document (IAPD) will allow for the consolidation of the number of connections required by health care providers. The EDEN system, also included in the IAPD, will enable the exchange of Admit, Discharge, and Transfer (ADT) messages that may be used by Texas Medicaid and public health to support a variety of programs.

Committee Recommendation	Status	Action Needed
Provide a complete inventory of inbound or outbound streams of clinical data between HHSC and Texas health care providers, how much data is flowing in each, what data and transport standards are in use for each, whether there are existing national/industry standards that could be used for each type of data, and what the plan is to move toward those standards.	Complete/Ongoing	Much of this material is contained in the Powering Texas report. In 2020, the eHAC's Interoperability Subcommittee will review the report to see if it fully meets the intent of this recommendation or if changes are needed.
Provide incentive payments for certain services (new patient, emergency) when patient health record was utilized in the provision of the service to that patient (proof of compliance would be summary of care document or health record number).	Discontinued	Due to the special terms and conditions of the 1115 waiver related to requiring data sharing among Medicaid providers who are treating the same patient for the same condition, this recommendation is being discontinued.
Create payment incentive for Medicaid providers to engage with HIE if available in their area.	Ongoing	This is being accomplished through Strategy 1 of the Medicaid HIE IAPD.
Since HIEs are allowed by statute to receive PMP data, direct the State Board of Pharmacy to facilitate a cost-effective integration for data sharing with HIEs within statutory constraints.	Ongoing	HHSC does not have this authority. The PMP is managed by the Texas Board of Pharmacy. Legislative action would be required.
Include HIEs as a standard component in disaster relief planning.	Ongoing	Planning for this activity is referenced in the draft version of the Health IT Strategic Plan.
Expand bi-directional interoperability for electronic data submission.	Ongoing	The connection between HHS and HIETEXAS, established as part of the HIE IAPD, will enable easier bi-directional data flows between providers and HHS agencies. DSHS is working to enhance interoperability for systems supporting newborn screening.

Costs Related to eHAC

The following eHAC support-related time and cost information is reported by the Office of e-Health Coordination's designated Committee liaison. Costs reflect staff time and related supplies and materials purchases. eHAC Committee members are not reimbursed for travel or any other Committee participation-related expenses. For this reporting period, one HHS agency staff assisted in supporting the eHAC at a cost of approximately $40,000. All eHAC activities were supported using HHS appropriated funds.

List of Acronyms

Acronym	Full Name
BH	Behavioral Health
CHIP	Children's Health Insurance Program
CHIRP	Comprehensive Hospital Increase Reimbursement Program
CMS	Centers for Medicare and Medicaid Services
Commonwell	The Commonwell Health Alliance
COVID-19	Novel Coronavirus
DSRIP	Delivery System Reform Incentive Payment
DSHS	Department of State Health Services
ECHO	Extension for Community Healthcare Outcomes (Project ECHO)
EDEN	Emergency Department Encounter Notification
eHAC	e-Health Advisory Committee
EHR	Electronic Health Record
EMR	Electronic Medical Record
FHIR-4	Fast Healthcare Interoperability Resources
H.B.	House Bill
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HIE	Health Information Exchange
HIT	Health Information Technology
HIN	Health Information Networks
HL7	Health Level 7
IAPD	Implementation Advance Planning Document
ImmTrac2	Updated Texas Immunization Registry
IT	Information Technology
LMHA	Local Mental Health Authority
MACPAC	Medicaid and CHIP Payment and Access Commission
MCO	Managed Care Organization
PCDH	Civitas Patient Centered Data Home
PDT	Prescription Digital Therapeutics
S.B.	Senate Bill
STAR-HIE	Strengthen the Technical Advancement and Readiness of Public Health via Health Information Exchange
TAC	Texas Administrative Code
TEFCA	Trusted Exchange Framework and Common Agreement
THSA	Texas Health Services Authority
US@	United States Postal Service address standards
XACML	Extensible Access Control Markup Language

Appendix A. HHSC e-Health Advisory Committee - Membership

Category	Selection	Business organization	City	Region, Race & Gender
Representative from **HHSC** (ex-officio member)	Deanna Naranjo	HHSC	Austin	7, White, Female
Representative from **HHSC** (ex-officio member)	Vacant as of 9/3/2021			
Representative from **DSHS** (ex-officio member)	Steve Eichner	DSHS	Austin	7, White, Male
Representative from **Texas Medical Board**	Christopher M. Palazola	Texas Medical Board	Austin	7, White, Male
Representative from **Texas Board of Nursing**	Vacant as of 11/4/2022			
Representative from **Texas State Board of Pharmacy**	Todd Unruh, R.Ph.	Texas State Board of Pharmacy	Austin	7, White, Male
Representative from **Statewide Health Coordinating Council**	Vacant as of 09/2022			
Representative of a **managed care organization**	Tracy Rico, RN	Superior Health Plan (Centene Corporation)	Austin	7, White, Female
Representative of the **pharmaceutical industry**	Melissa McEwen	Otsuka America Pharmaceutical, Inc.	Spicewood	7, White, Female
Representative of a **health science center in Texas**	Mar Robinson, JD	The University of Texas Medical Branch	Galveston	6/5S, White, Female
Expert on **telemedicine**	Brett A. Moran, MD	Parkland Health Hospital System	Dallas	2/3, White, Male
Expert on **home telemonitoring services**	Vacant as of 10/15/2021			

Category	Selection	Business organization	City	Region, Race & Gender
Representative of **consumers of health services provided through telemedicine**	Vacant as of 08/30/2022			
Medicaid provider or child health plan program provider	Vacant as of 07/2021			
Representative from **Texas Health Services Authority**	George Gooch, JD	Texas Health Services Authority	Austin	7, White, Male
Representative of a local or regional **health information exchange**	Phil Beckett, PhD	Healthcare Access San Antonio	San Antonio	8, White, Male
Representative of a local or regional **health information exchange**	Sheila M. Magoon, MD	South Texas Physicians Alliance/Buena Vida y Salud, LLC	Harlingen	11, White, Female
Representative with **expertise related to the implementation of electronic health records, computerized clinical support systems, and health information exchange systems for exchanging clinical and other types of health information**	Christine Bryan	Clarity Child Guidance Center	San Antonio	8, White, Female

Category	Selection	Business organization	City	Region, Race & Gender
Representative with **expertise related to the implementation of electronic health records, computerized clinical support systems, and health information exchange systems for exchanging clinical and other types of health information**	Stephanie W. Dixon, MBA	The University of Texas Health Science Center – Houston	Houston	6/5S, Black Female
Representative with **expertise related to the implementation of electronic health records, computerized clinical support systems, and health information exchange systems for exchanging clinical and other types of health information**	Vacant as of 11/10/2022			

Appendix B. Telemedicine, Telehealth, and Telemonitoring Subcommittee Survey Results

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e-Health Advisory Committee Telemedicine, Telehealth, and Telemonitoring Survey

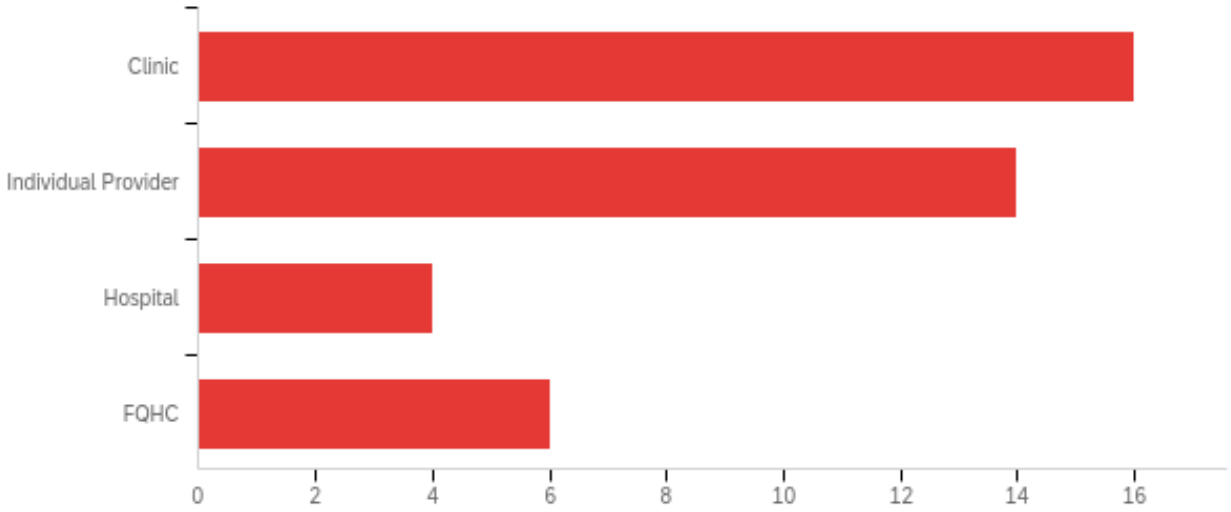
November 17th 2022, 1:53 pm MST

Q1 - What is the name of your organization?

- Centro San Vicente
- Waco Family Medicine
- Waco Family Medicine
- Los Barrios Unidos Community Clinic
- Preventative Care Health Services
- Parkland Health
- Texas Children's Hospital
- Tyler County Hospital District
- Waco Family Medicine
- Sidd Medical Associates
- Torp Counseling
- Donald R. Fulsom MD PA
- Haydee Te Nievera MD PA
- Lagniappe Counseling & Community Service PLLC
- Rebound Sports & Physical Therapy
- SAENZ MEDICAL CENTEER
- Logos Counseling
- HLN Physicians Inc
- Valley Psychological Services
- RAUL LOAISIGA MD PA
- West Texas Centers Little Lives ECI
- Peoples Community Clinic

- Creative Counseling
- Michael Hawkins LPC
- Robert G Szewc MD
- Clarewood Clinic
- Electra Hospital District
- UT Health McGovern Medical School
- "UT Physician McGovern Medical School"
- Laura Montes MD
- Palo Pinto General Hospital
- Treehouse In Home Psychological Services
- Eastland Memorial Hospital District
- Adult and Adolescent Counseling Center
- UT Health/UT Physicians
- UT Physicians
- UTP
- RiverKids Pediatric Home Health
- United Regional Physician's Group
- Methodist Health System

Q2 - What is your organization type?



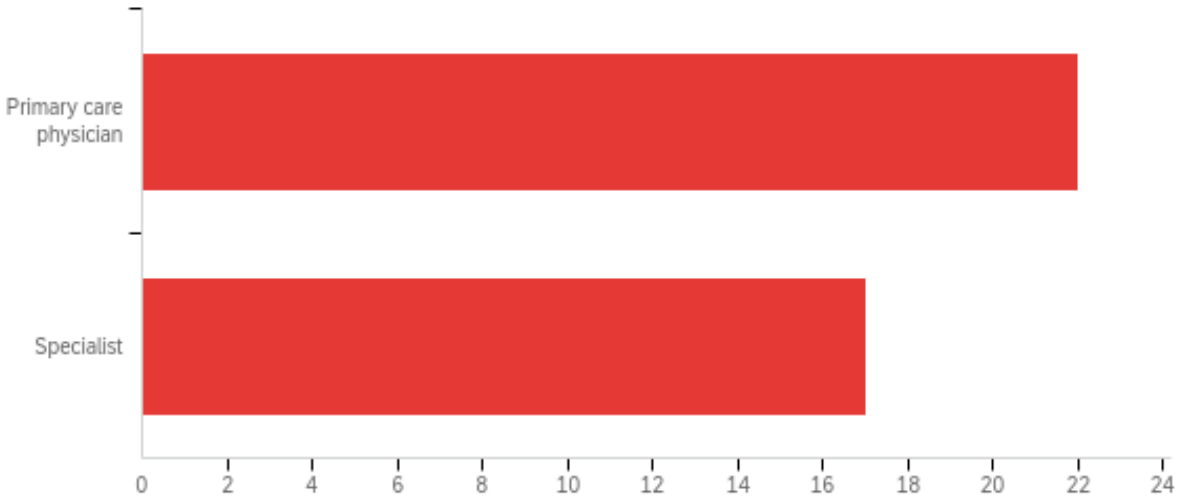
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	What is your organization type?	1.00	4.00	2.00	1.05	1.10	40

#	Answer	%	Count
1	Clinic	40.00%	16
2	Individual Provider	35.00%	14
3	Hospital	10.00%	4
4	FQHC	15.00%	6
	Total	100%	40

Q3 - Number of patients seen per year?

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Number of patients seen per year?	0.00	1481117.00	71676.00	247589.93	61300774637.89	37

Q4 - Provider type



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Provider type	1.00	2.00	1.44	0.50	0.25	39

#	Answer	%	Count
1	Primary care physician	56.41%	22
2	Specialist	43.59%	17
	Total	100%	39

Q5 - City/Town Location

- El Paso
- Waco
- Waco
- Dallas
- Alpine
- Dallas

- Houston
- Woodville
- Waco
- Denton
- Mexia
- Tyler
- Brownsville
- Wylie
- Denison
- La Joya
- Hilltop Lakes
- Edinburg
- Brownsville
- Sweetwater
- Austin
- San Antonio
- Kerrville
- San Antonio
- Houston
- Iowa Park
- Houston
- Houston
- McAllen
- Mineral Wells
- Dallas
- Eastland
- El Paso
- Houston

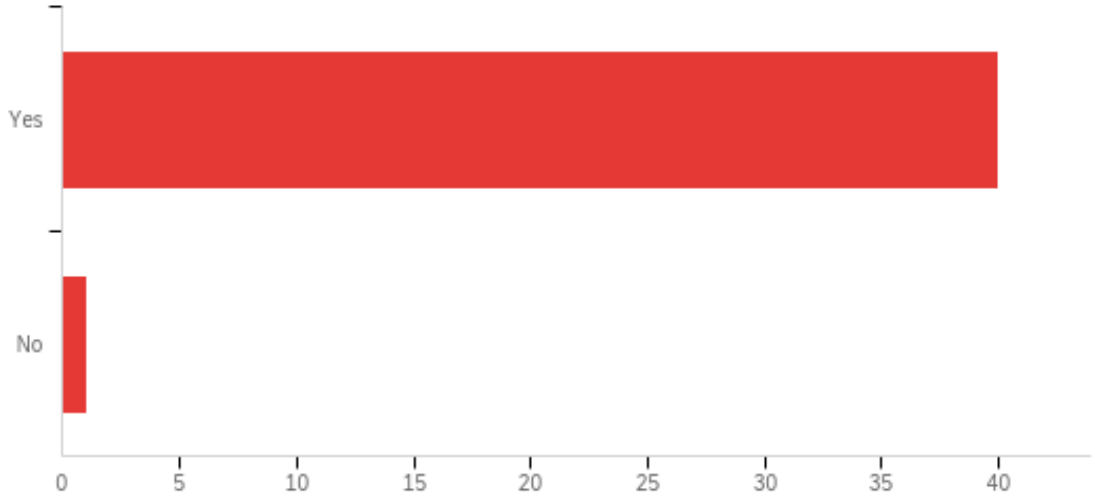
- Houston
- Amarillo
- Houston
- Pearland
- Wichita Falls
- Dallas

Q6 - Zip Code

- 79915
- 76712
- 76707
- 76244
- 79830
- 75235
- 77030
- 75979
- 76707
- 76201
- 76667
- 75702
- 78526
- 75098
- 75020
- 78560
- 77871
- 78539
- 78526
- 79556
- 78752

- 78228
- 78028
- 78204
- 77036
- 76367
- 77030
- 77030
- 78504
- 76067
- 75206
- 76448
- 79903
- 77054
- 77059
- 73109
- 77030
- 77581
- 76367
- 75203

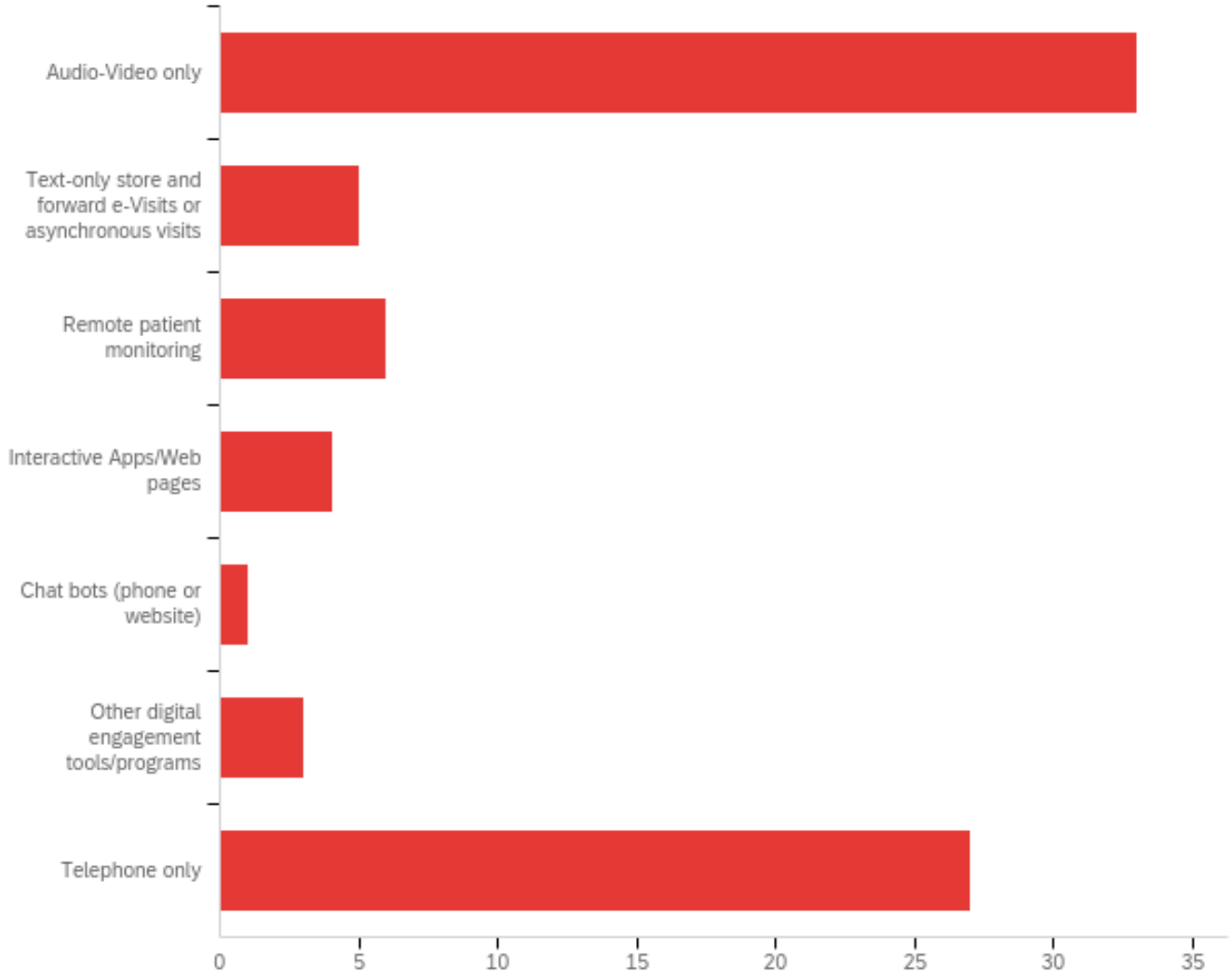
Q7 - Do you provide telemedicine/telehealth services to your patients?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you provide telemedicine/telehealth services to your patients?	1.00	2.00	1.02	0.15	0.02	41

#	Answer	%	Count
1	Yes	97.56%	40
2	No	2.44%	1
	Total	100%	41

Q8 - Which methods do you offer (check all that apply)?



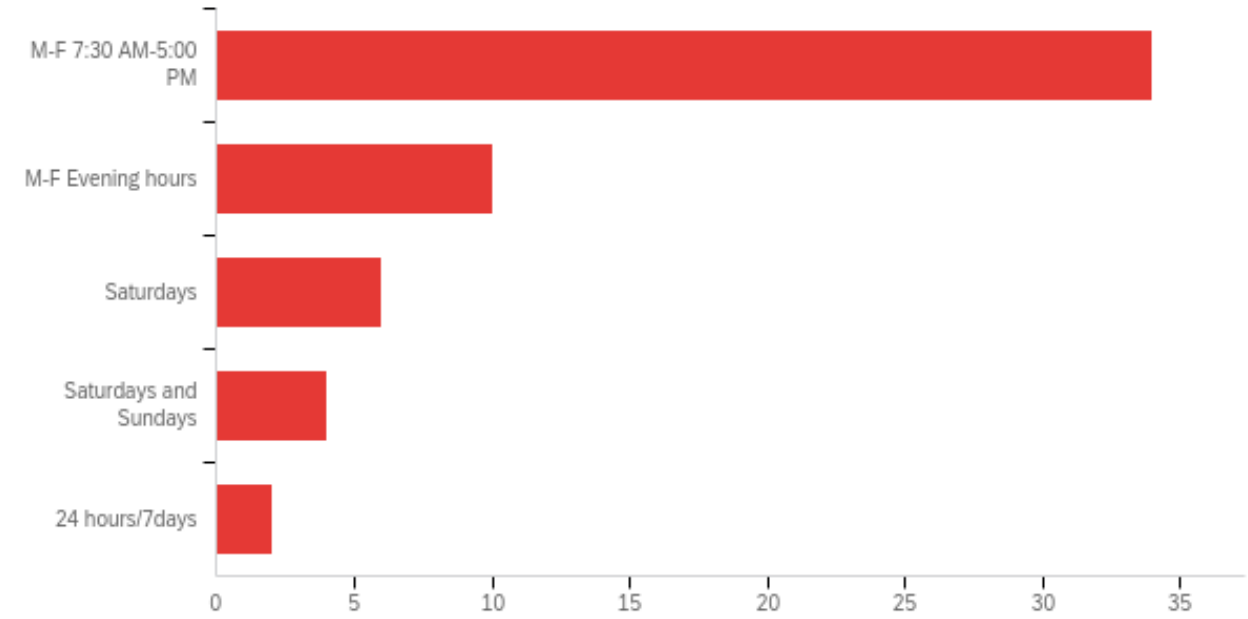
#	Answer	%	Count
1	Audio-Video only	41.77%	33
2	Text-only store and forward e-Visits or asynchronous visits	6.33%	5
3	Remote patient monitoring	7.59%	6
4	Interactive Apps/Web pages	5.06%	4
5	Chat bots (phone or website)	1.27%	1

#	Answer	%	Count
6	Other digital engagement tools/programs	3.80%	3
7	Telephone only	34.18%	27
	Total	100%	79

Q9 - Add comment details for other digital engagement tools/programs:

- Add comment details for other digital engagement tools/programs:
- Tyto Care
- centralized video visit support center
- Apple Tablet

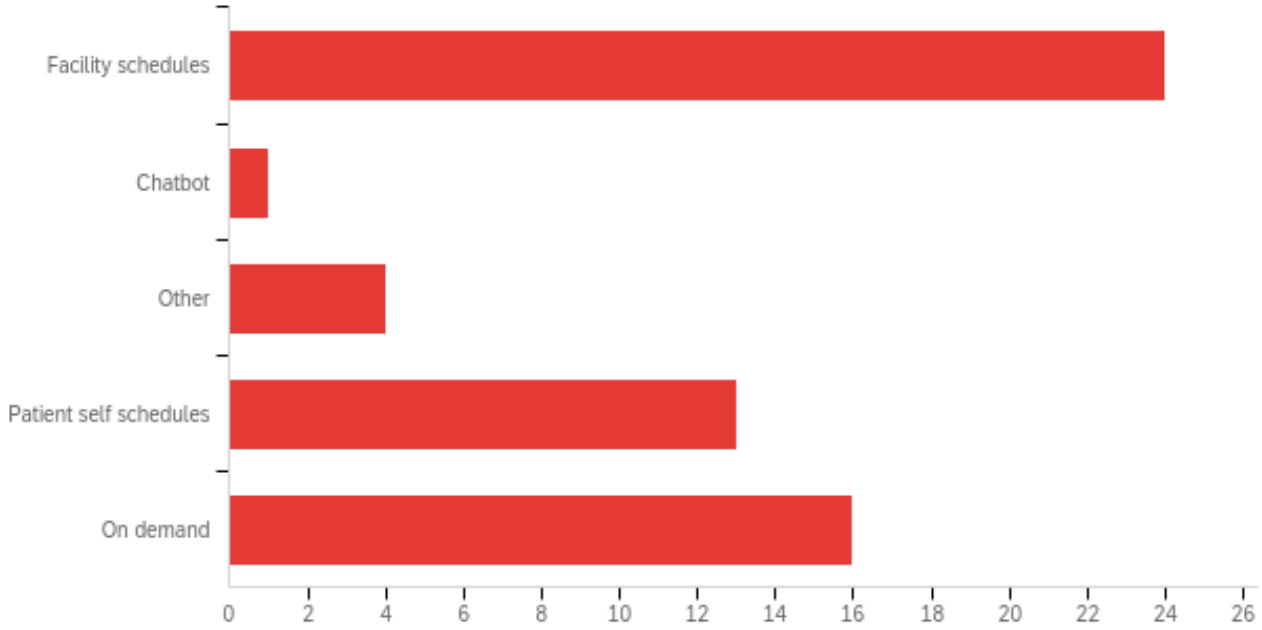
Q10 - If you provide telemedicine/telehealth services, what hours/days do you offer them?



#	Answer	%	Count
1	M-F 7:30 AM-5:00 PM	60.71%	34

#	Answer	%	Count
2	M-F Evening hours	17.86%	10
3	Saturdays	10.71%	6
4	Saturdays and Sundays	7.14%	4
5	24 hours/7days	3.57%	2
	Total	100%	56

Q11 - How are these services accessed?

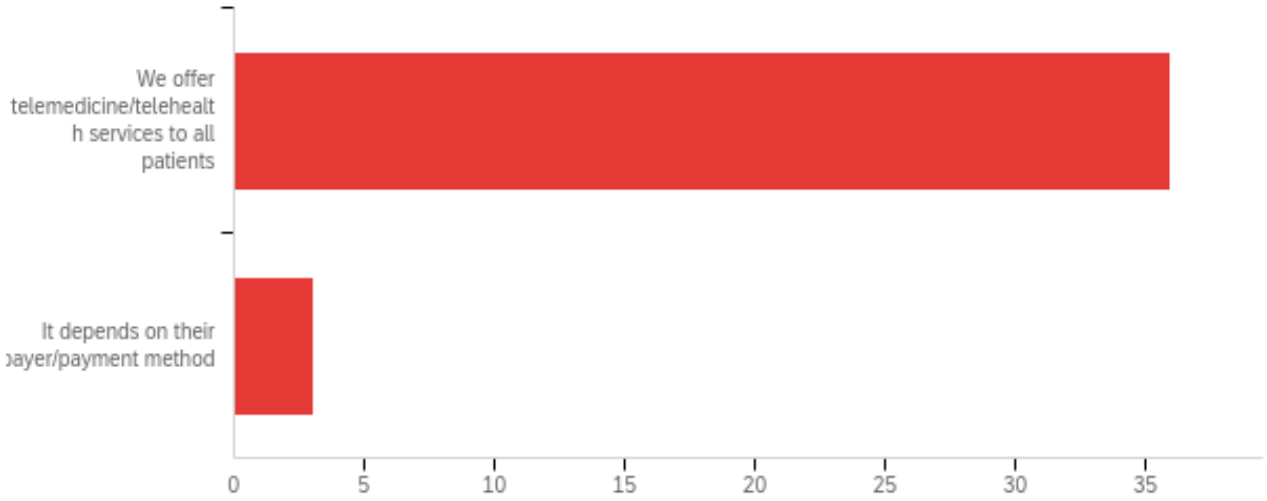


#	Answer	%	Count
1	Facility schedules	41.38%	24
2	Chatbot	1.72%	1
3	Other	6.90%	4
4	Patient self schedules	22.41%	13
5	On demand	27.59%	16
	Total	100%	58

Q12 - Clarify "other" for services accessed:

- "e-Consults are received and completed by specialty providers within 5 business days no scheduling required"
- provider schedules with client
- Therapist schedules with family

Q13 - Do you offer telemedicine or telehealth services to all patients or does it depend on their method of payment or an alternative payment model contract?

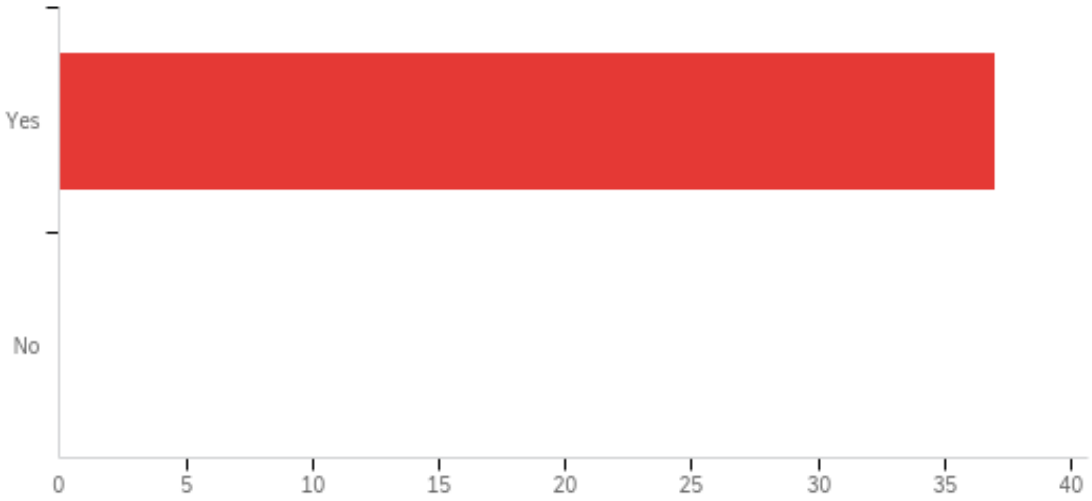


#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you offer telemedicine or telehealth services to all patients or does it depend on their method of payment or an alternative payment model contract?	1.00	2.00	1.08	0.27	0.07	39

#	Answer	%	Count
1	We offer telemedicine/telehealth services to all patients	92.31%	36

#	Answer	%	Count
2	It depends on their payer/payment method	7.69%	3
	Total	100%	39

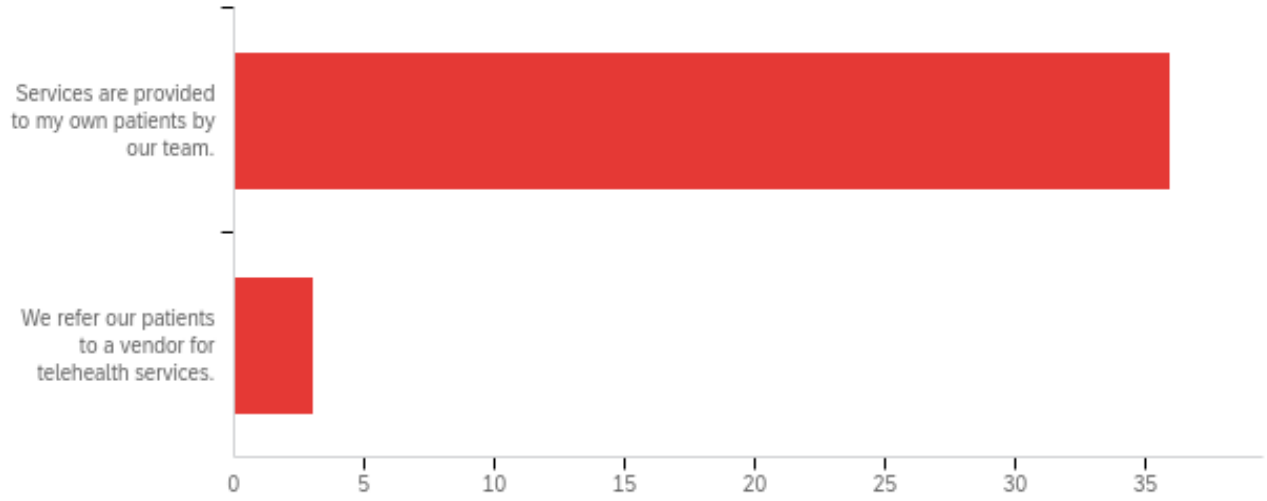
Q14 - Do you bill for Telehealth services?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you bill for Telehealth services?	1.00	1.00	1.00	0.00	0.00	37

#	Answer	%	Count
1	Yes	100.00%	37
2	No	0.00%	0
	Total	100%	37

Q15 - Do you provide telehealth services for your own patients utilizing your own clinicians or refer them to a vendor or contractor (i.e. Teladoc MD Live etc.)?



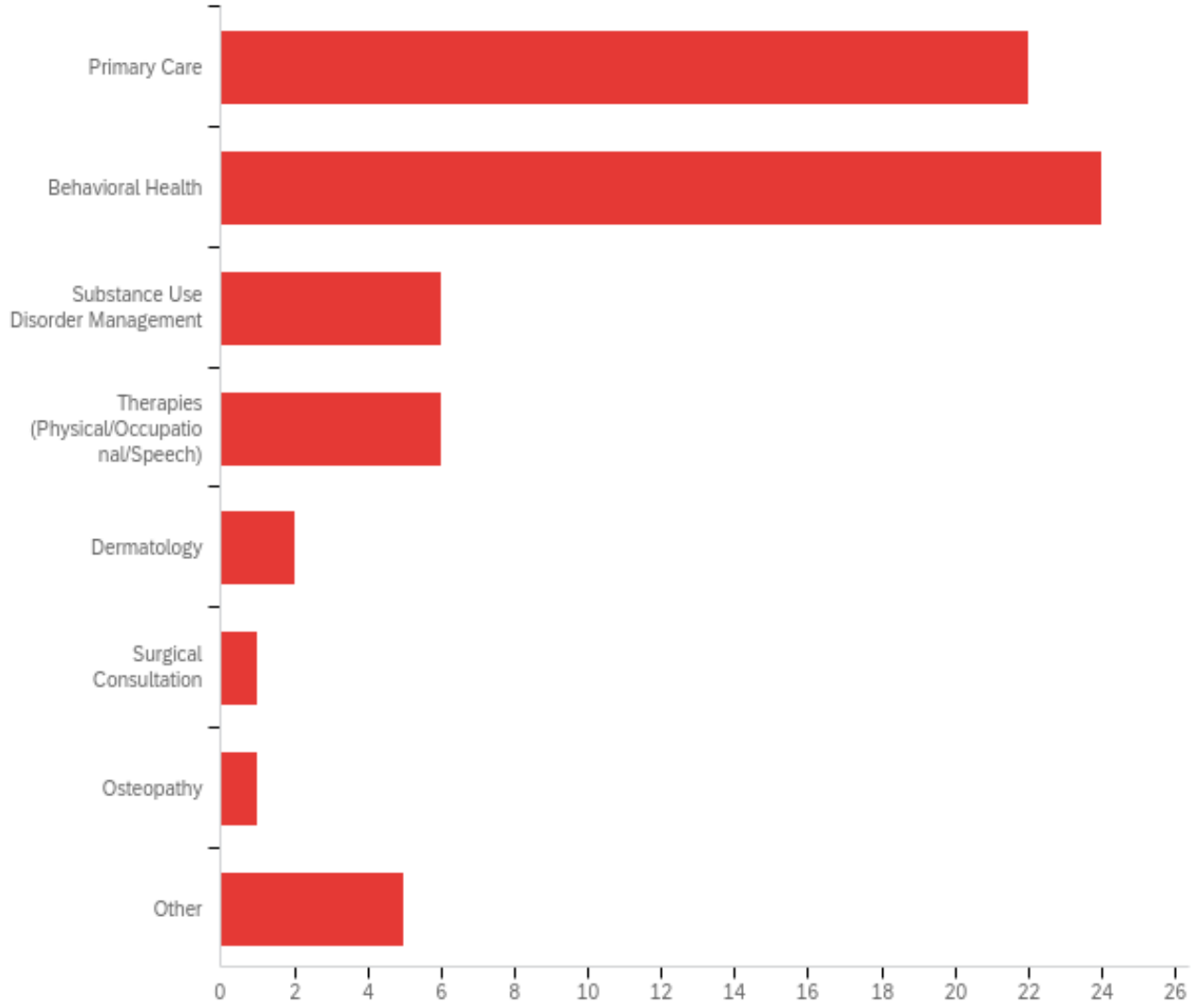
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you provide telehealth services for your own patients utilizing your own clinicians or refer them to a vendor or contractor (i.e. Teladoc MD Live etc.)?	1.00	2.00	1.08	0.27	0.07	39

#	Answer	%	Count
1	Services are provided to my own patients by our team.	92.31%	36
2	We refer our patients to a vendor for telehealth services.	7.69%	3
	Total	100%	39

Q16 - Which Telehealth vendor do you use?

- All Heal
- SOC Telemed

Q17 - List the virtual services offered by your telehealth services:



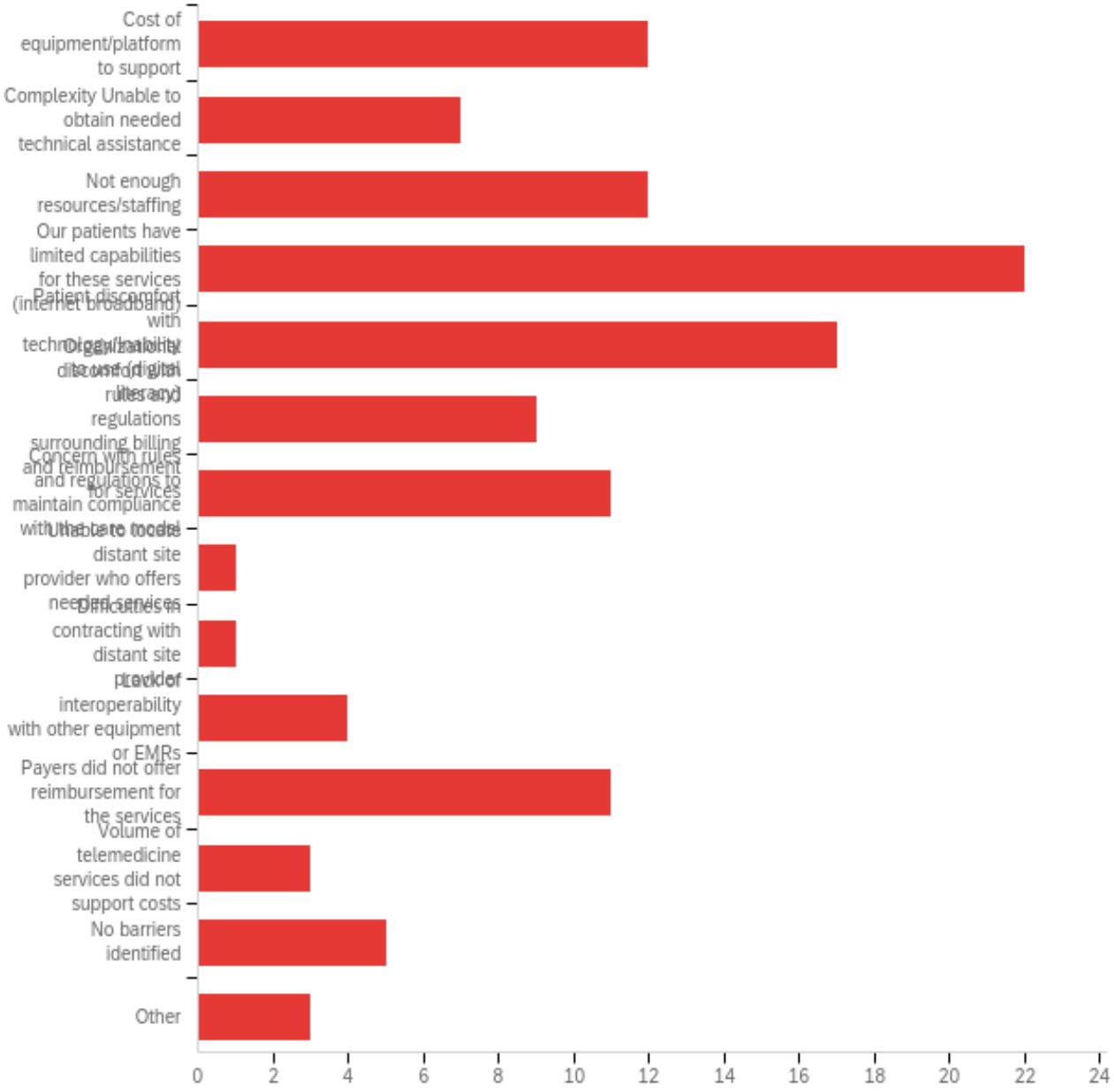
#	Answer	%	Count
1	Primary Care	32.84%	22
2	Behavioral Health	35.82%	24
3	Substance Use Disorder Management	8.96%	6
4	Therapies (Physical/Occupational/Speech)	8.96%	6
5	Dermatology	2.99%	2

#	Answer	%	Count
6	Surgical Consultation	1.49%	1
7	Osteopathy	1.49%	1
8	Other	7.46%	5
	Total	100%	67

Q18 - Give details on the other telehealth services offered:

- Care Management
- "Gynecology Clinic social work pharmacy nutrition numerous APP staff in a variety of specialty clinics and some virtual classes"
- Specialized Skills Training (SST) and Targeted Case Management (TCM)
- IP Tele-Pulm IP Tele-Infectious Disease IP Tele-Intensivist IP Tele-Nocturnist and OP Tele-Pulm Clinic
- Post-surgical specialties

Q19 - What barriers have you experienced with any telemedicine/telehealth services?



#	Answer	%	Count
1	Cost of equipment/platform to support	10.17%	12
2	Complexity Unable to obtain needed technical assistance	5.93%	7

#	Answer	%	Count
3	Not enough resources/staffing	10.17%	12
4	Our patients have limited capabilities for these services (internet broadband)	18.64%	22
5	Patient discomfort with technology/Inability to use (digital literacy)	14.41%	17
6	Organizational discomfort with rules and regulations surrounding billing and reimbursement for services	7.63%	9
7	Concern with rules and regulations to maintain compliance with the care model	9.32%	11
8	Unable to locate distant site provider who offers needed services	0.85%	1
9	Difficulties in contracting with distant site provider	0.85%	1
10	Lack of interoperability with other equipment or EMRs	3.39%	4
11	Payers did not offer reimbursement for the services	9.32%	11
12	Volume of telemedicine services did not support costs	2.54%	3
13	No barriers identified	4.24%	5
14	Other	2.54%	3
	Total	100%	118

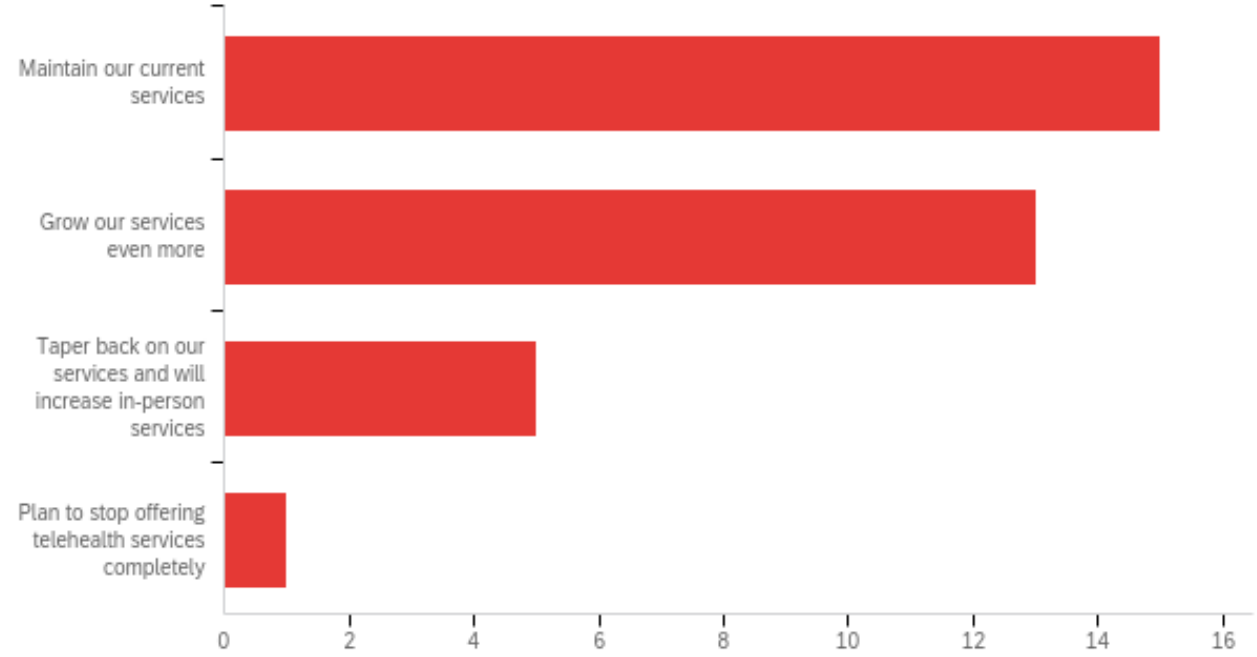
Q20 - Please expand on other barriers to telemedicine/telehealth services:

- Inclusion of interpretation service options
- Payers keep trying to limit patients access by requiring proprietary programs etc.

Q21 - Please estimate the % of your overall patient services which are completed using telehealth modalities

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Click to write Choice 1	1.00	100.00	33.54	35.42	1254.52	37

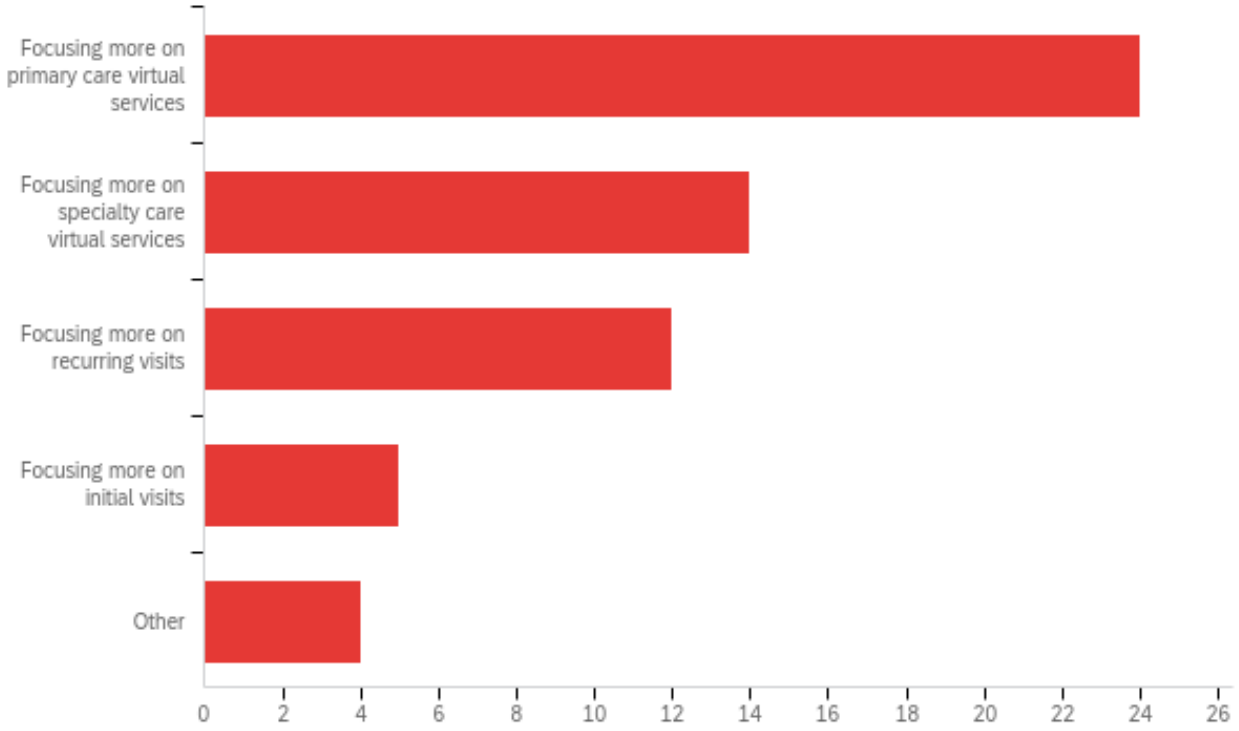
Q22 - What are your plans post-pandemic regarding telehealth services?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	What are your plans post-pandemic regarding telehealth services?	1.00	4.00	1.76	0.81	0.65	34

#	Answer	%	Count
1	Maintain our current services	44.12%	15
2	Grow our services even more	38.24%	13
3	Taper back on our services and will increase in-person services	14.71%	5
4	Plan to stop offering telehealth services completely	2.94%	1
	Total	100%	34

Q23 - What kinds of modifications are you planning with your telehealth programs in the future?

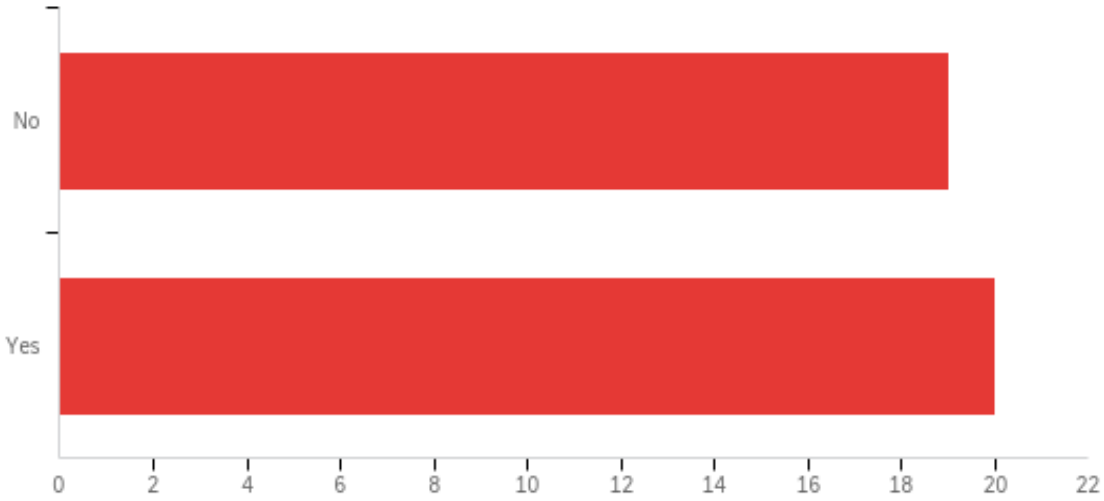


#	Answer	%	Count
1	Focusing more on primary care virtual services	40.68%	24
2	Focusing more on specialty care virtual services	23.73%	14
3	Focusing more on recurring visits	20.34%	12
4	Focusing more on initial visits	8.47%	5
5	Other	6.78%	4
	Total	100%	59

Q24 - Clarify other modifications for future planning:

- Tailoring telehealth visits to best-use areas (behavioral health school-based care)
- Urgent Care and staring tytocare for targeted populations
- Stop offering
- letting patient know options

Q25 - Do you capture patient and clinician preferences for virtual care opportunities?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you capture patient and clinician preferences for virtual care opportunities?	1.00	2.00	1.51	0.50	0.25	39

#	Answer	%	Count
1	No	48.72%	19
2	Yes	51.28%	20

#	Answer	%	Count
	Total	100%	39

Q26 - How do you capture preferences?

- MyChart clinician survey
- We ask patients how they would prefer to be seen. Providers are asked as well.
- "Patient preference is captured discretely in the EHR while the provider preference is capture non-discretely in the EHR."
- Patient Web Site
- Interview
- Gathering information on intake
- By Calling them
- Survey
- We took a team approach to identifying the right partners and what services were mission critical to add
- verbal feedback
- Ask Patient
- Survey
- Survey
- EMR

Q27 - What are the barriers to using telemedicine/telehealth services?

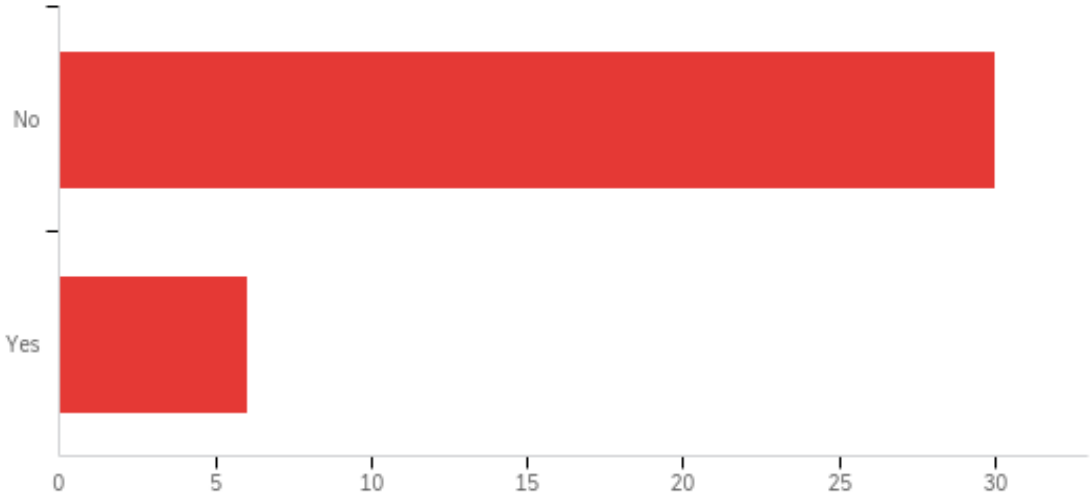
#	Answer	%	Count
1	Cost of equipment/platform to support	50.00%	1
2	Complexity Unable to obtain needed technical assistance	0.00%	0
3	Not enough resources/staffing	0.00%	0
4	Our patients have limited capabilities for these services (internet broadband)	0.00%	0

#	Answer	%	Count
5	Patient discomfort with technology/Inability to use (digital literacy)	0.00%	0
6	Organizational discomfort with rules and regulations surrounding billing and reimbursement for services	0.00%	0
7	Concern with rules and regulations to maintain compliance with the care model	0.00%	0
8	Unable to locate distant site provider who offers needed services	0.00%	0
9	Difficulties in contracting with distant site provider	0.00%	0
10	Lack of interoperability with other equipment or EMRs	0.00%	0
11	Payers did not offer reimbursement for the services	0.00%	0
12	Volume of telemedicine services did not support costs	0.00%	0
13	No barriers identified	50.00%	1
14	Other	0.00%	0
	Total	100%	2

Q28 - Clarify other barriers to telehealth services:

- Clarify other barriers to telehealth services:

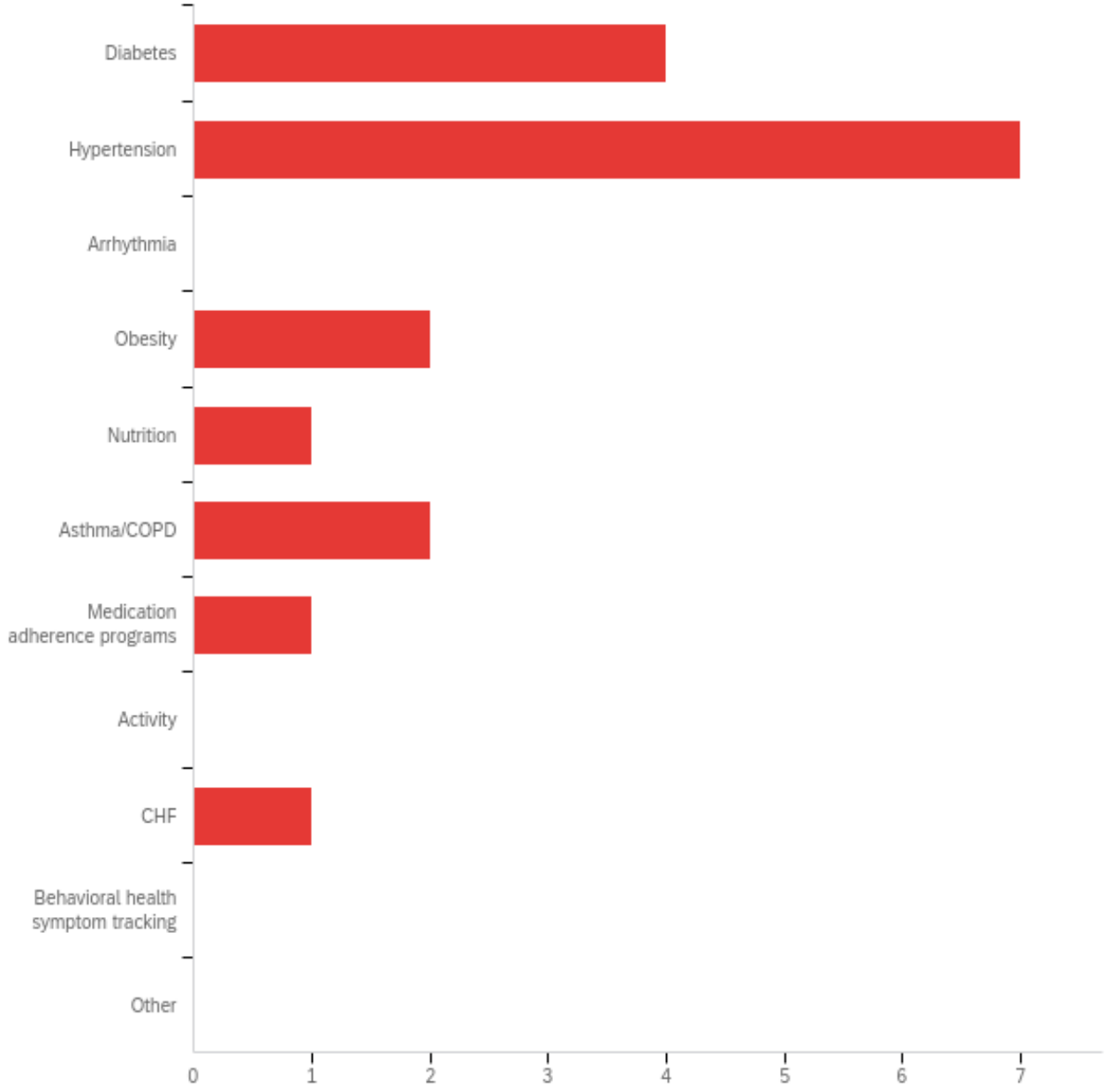
Q29 - Do you offer telemonitoring/remote monitoring to your patients?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you offer telemonitoring/remote monitoring to your patients?	1.00	2.00	1.17	0.37	0.14	36

#	Answer	%	Count
1	No	83.33%	30
2	Yes	16.67%	6
	Total	100%	36

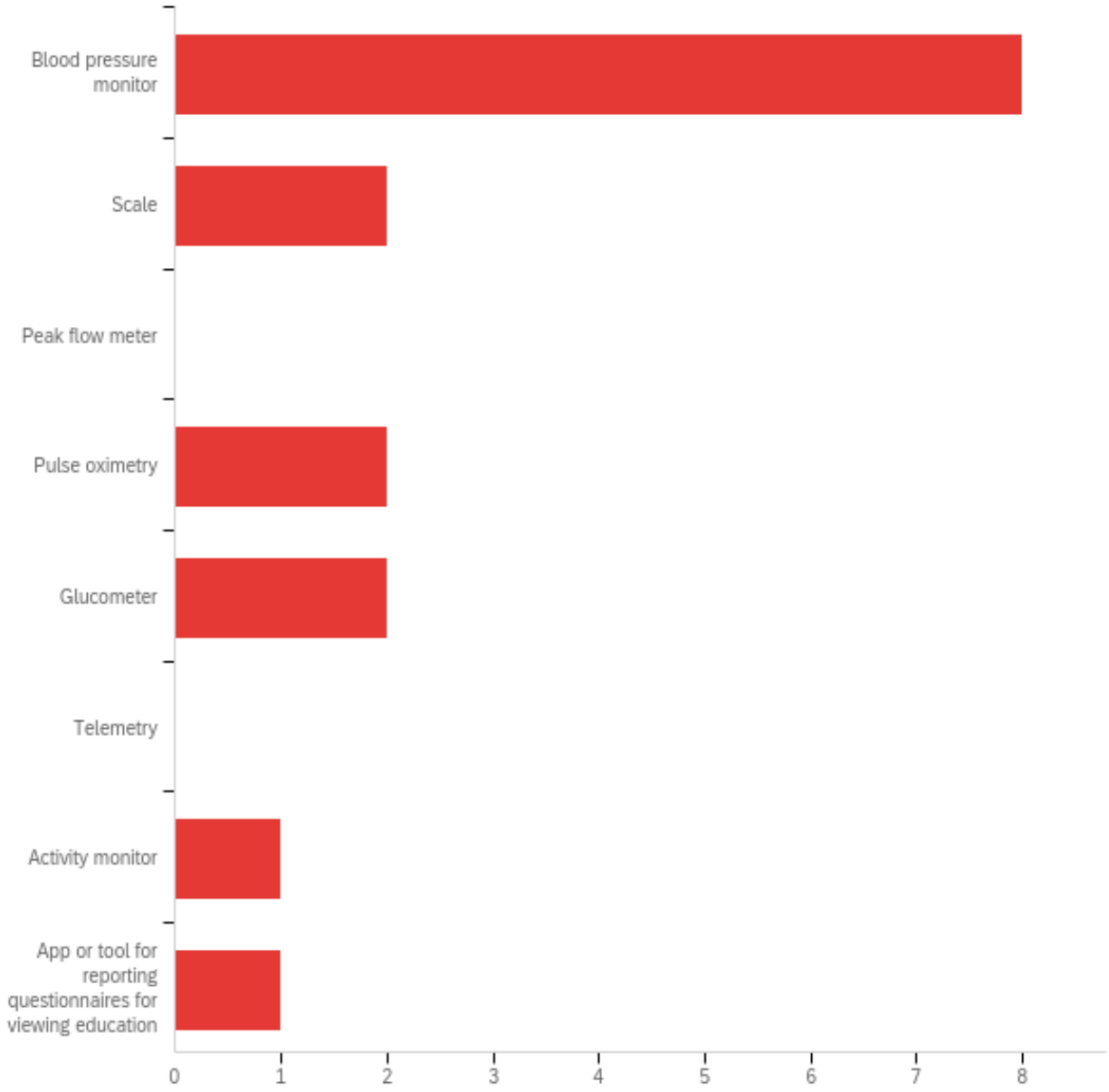
Q30 - What are you primarily monitoring (check all that apply)?



#	Answer	%	Count
1	Diabetes	22.22%	4
2	Hypertension	38.89%	7

#	Answer	%	Count
3	Arrhythmia	0.00%	0
4	Obesity	11.11%	2
5	Nutrition	5.56%	1
6	Asthma/COPD	11.11%	2
7	Medication adherence programs	5.56%	1
8	Activity	0.00%	0
9	CHF	5.56%	1
10	Behavioral health symptom tracking	0.00%	0
11	Other	0.00%	0
	Total	100%	18

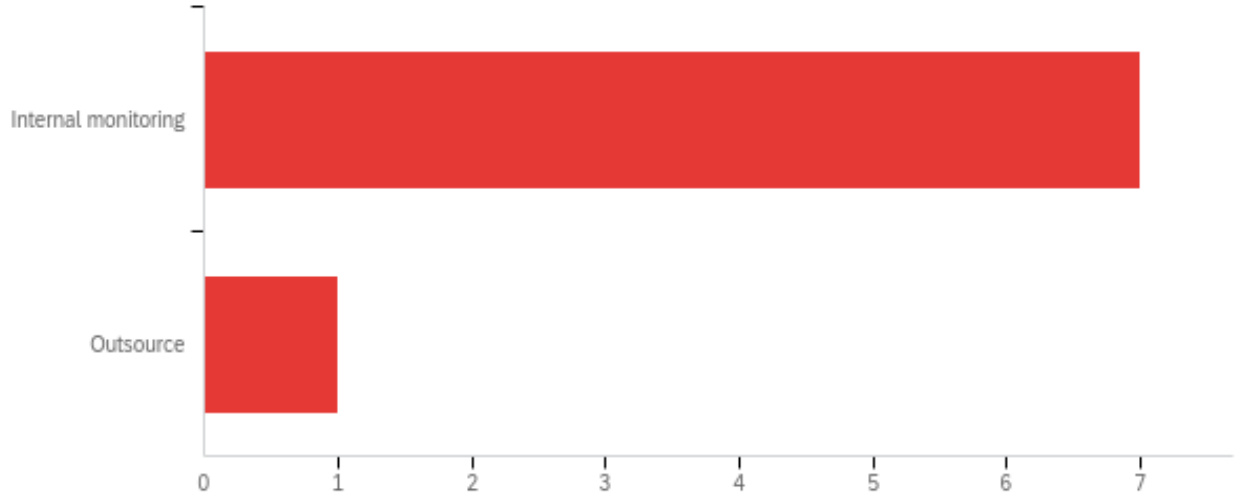
Q31 - What equipment for remote monitoring do you offer?



#	Answer	%	Count
1	Blood pressure monitor	50.00%	8
2	Scale	12.50%	2
3	Peak flow meter	0.00%	0

#	Answer	%	Count
4	Pulse oximetry	12.50%	2
5	Glucometer	12.50%	2
6	Telemetry	0.00%	0
7	Activity monitor	6.25%	1
8	App or tool for reporting questionnaires for viewing education	6.25%	1
	Total	100%	16

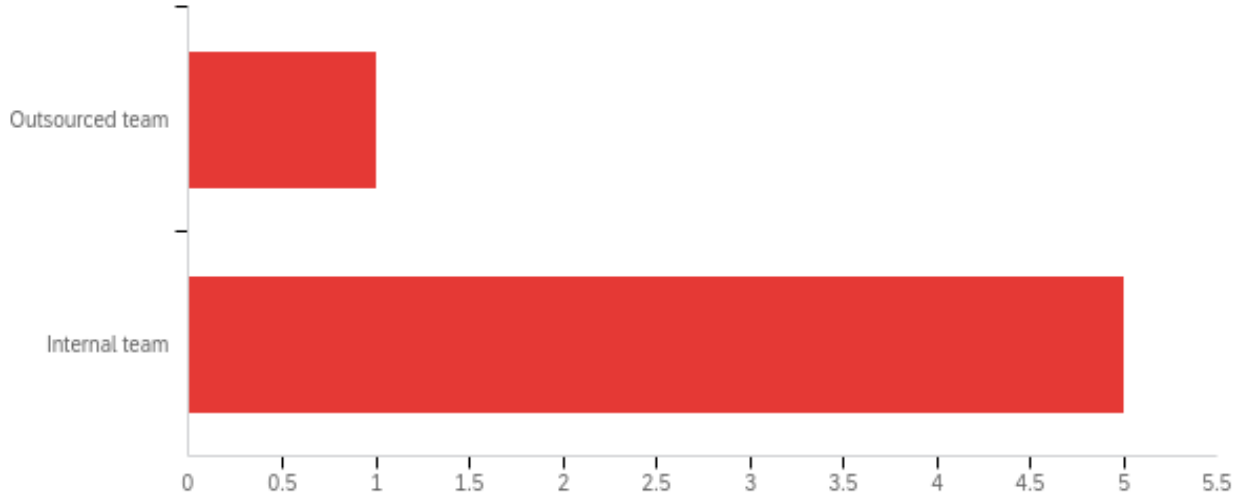
Q32 - Do you provide monitoring services internally or outsource the monitoring?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you provide monitoring services internally or outsource the monitoring?	1.00	2.00	1.13	0.33	0.11	8

#	Answer	%	Count
1	Internal monitoring	87.50%	7
2	Outsource	12.50%	1
	Total	100%	8

Q33 - Who is responsible for monitoring and notifying critical remote values to your clinicians?

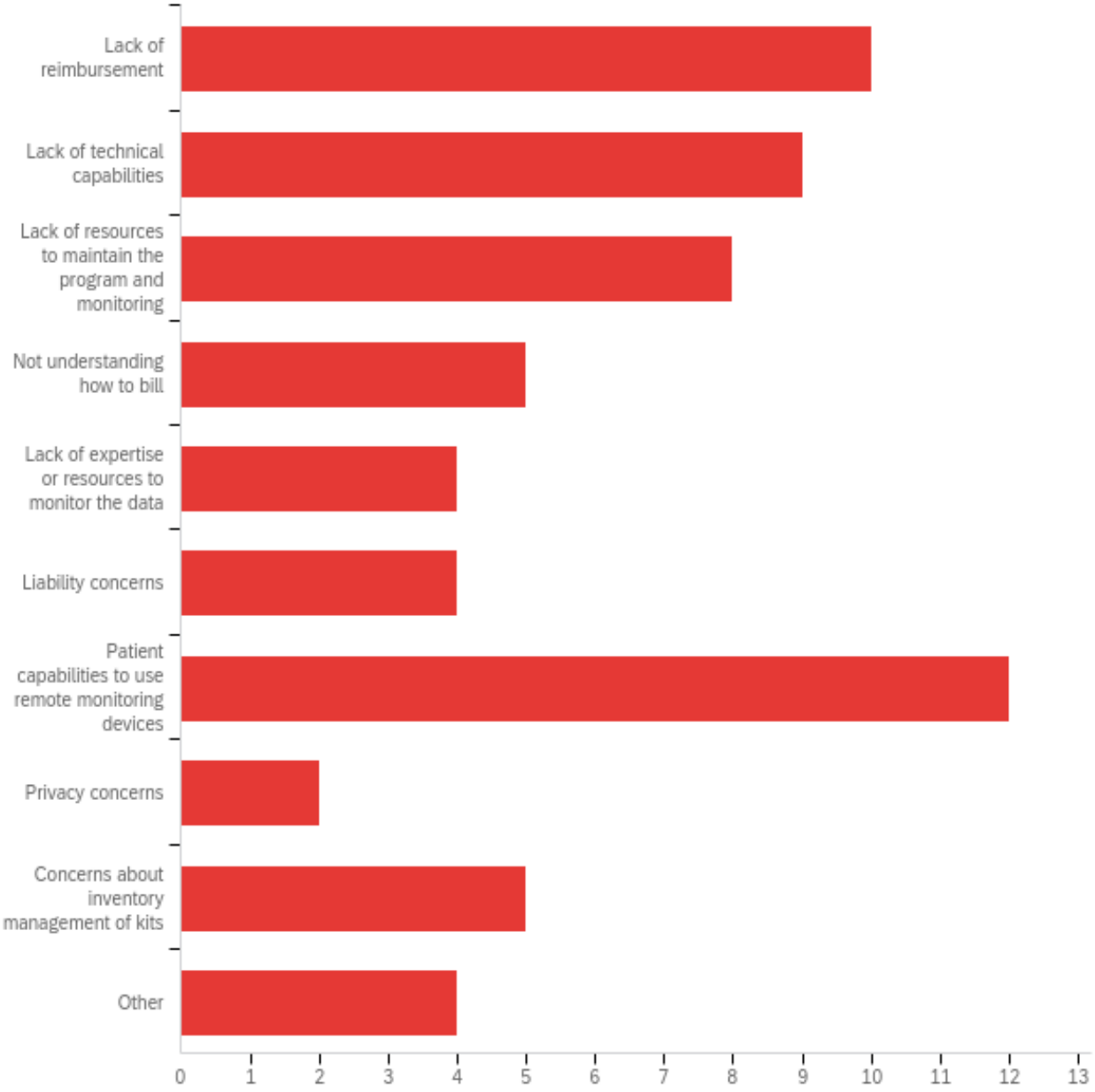


#	Answer	%	Count
1	Outsourced team	16.67%	1
2	Internal team	83.33%	5
	Total	100%	6

Q34 - If internal team, please provide details as to org structure

- Nursing and community health workers review flags with patients then bring in providers as needed.
- Employee

Q35 - Please select any barriers you have encountered to deploying and sustaining telemonitoring services for the patients you serve:

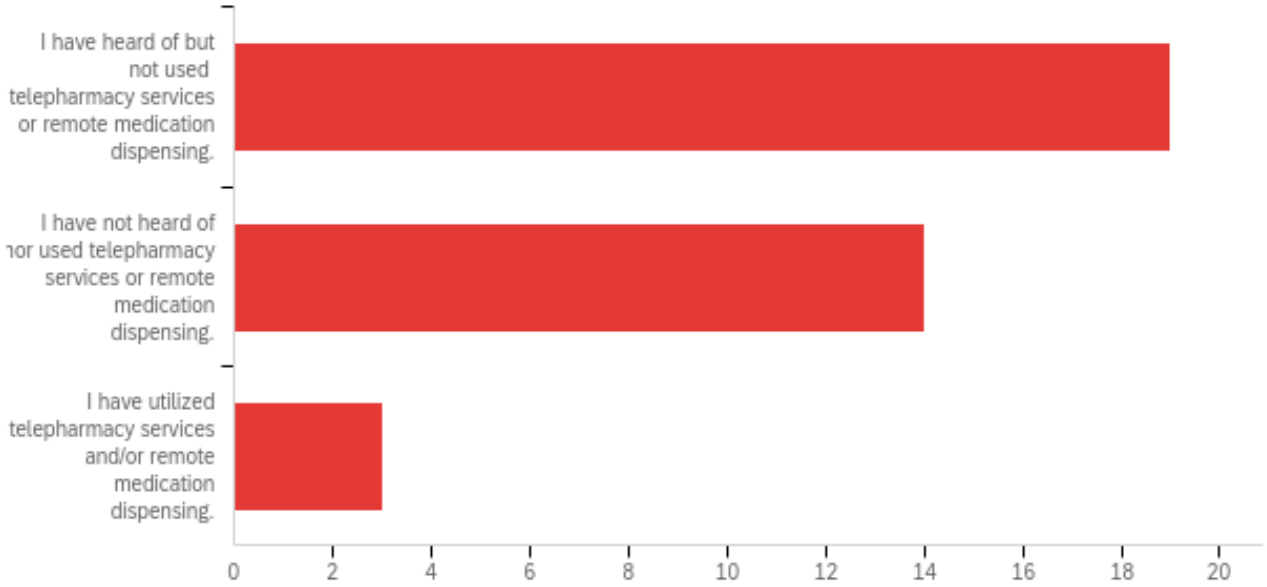


#	Answer	%	Count
1	Lack of reimbursement	15.87%	10
2	Lack of technical capabilities	14.29%	9
3	Lack of resources to maintain the program and monitoring	12.70%	8
4	Not understanding how to bill	7.94%	5
5	Lack of expertise or resources to monitor the data	6.35%	4
6	Liability concerns	6.35%	4
7	Patient capabilities to use remote monitoring devices	19.05%	12
8	Privacy concerns	3.17%	2
9	Concerns about inventory management of kits	7.94%	5
10	Other	6.35%	4
	Total	100%	63

Q36 - Clarify other barriers for deploying and sustaining telemonitoring services:

- Just starting this initiative
- As a rural health clinic I am unaware if this is reimbursable
- Do not use in this practice
- no ROI for cost involved

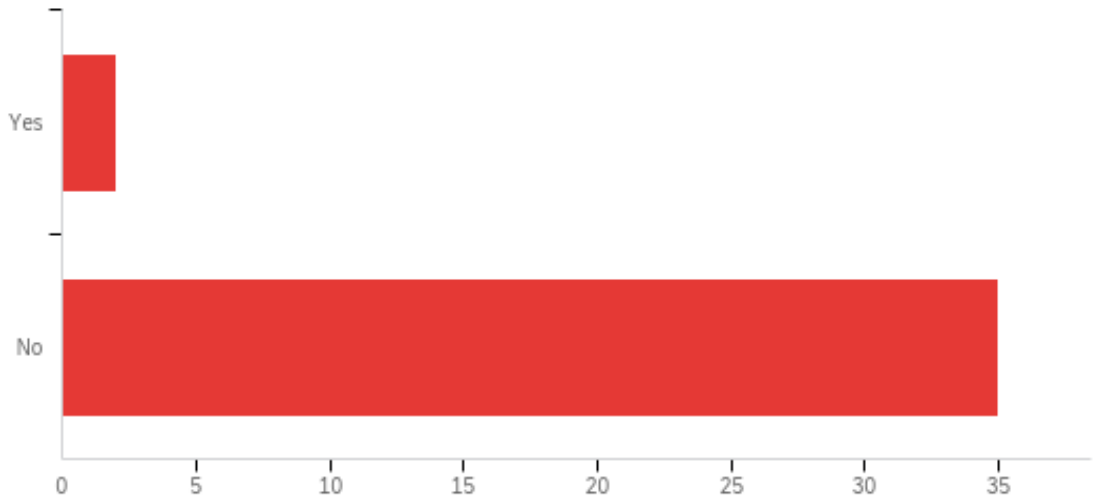
Q37 - Have you heard of or utilized telepharmacy services or remote medication dispensing?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Have you heard of or utilized telepharmacy services or remote medication dispensing?	1.00	3.00	1.56	0.64	0.41	36

#	Answer	%	Count
1	I have heard of but not used telepharmacy services or remote medication dispensing.	52.78%	19
2	I have not heard of nor used telepharmacy services or remote medication dispensing.	38.89%	14
3	I have utilized telepharmacy services and/or remote medication dispensing.	8.33%	3
	Total	100%	36

Q39 - Do you offer telepharmacy services or remote medication dispensing for your patients?



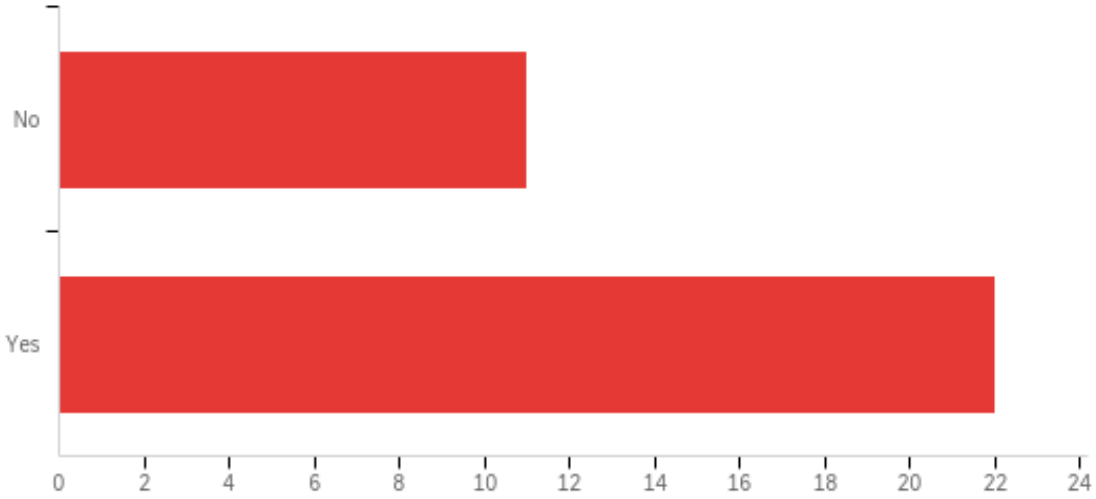
#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you offer telepharmacy services or remote medication dispensing for your patients?	1.00	2.00	1.95	0.23	0.05	37

#	Answer	%	Count
1	Yes	5.41%	2
2	No	94.59%	35
	Total	100%	37

Q38 - What % of your pharmacy services are completed using telepharmacy?

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Click to write Choice 1	5.00	100.00	52.50	47.50	2256.25	2

Q40 - Do you feel a pharmacist home-monitoring patient therapy would improve adherence and outcomes?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you feel a pharmacist home-monitoring patient therapy would improve adherence and outcomes?	1.00	2.00	1.67	0.47	0.22	33

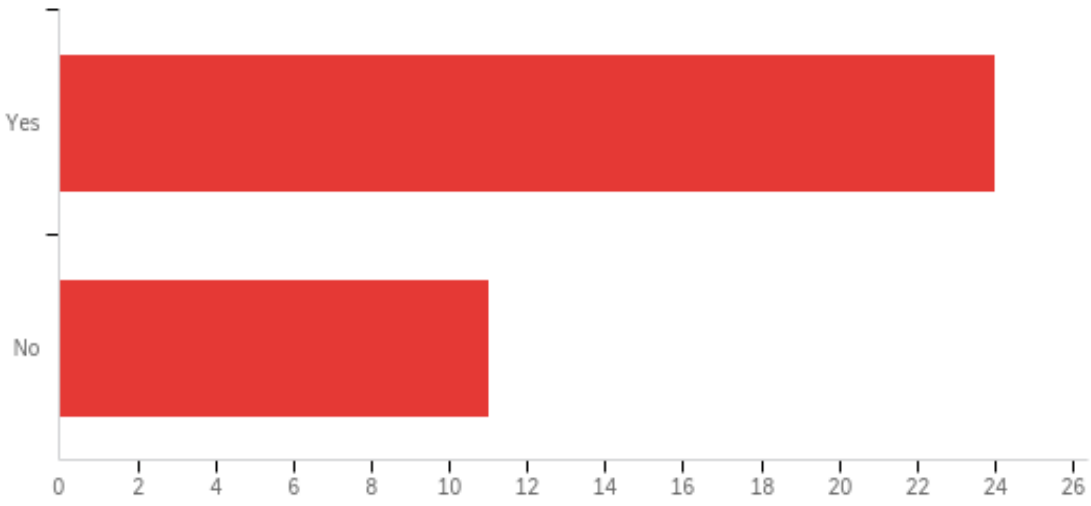
#	Answer	%	Count
1	No	33.33%	11
2	Yes	66.67%	22
	Total	100%	33

Q41 - Please explain your affirmative answer:

- Patient focused care
- Gas is expensive for patients and it is difficult for them to get off work
- "This assists with patient engagement, compliance, and education."
- additional monitoring option
- "For patients who lack assistance at home this could be beneficial to them"

- if they have a 3 month rx and are do for more rx they still have rx left they are not taking it as directed
- some cannot get to pharmacy until script has run out and get delays in treatment.
- Accountability for everyone around
- Any type of monitoring would likely improve adherence and therefore outcomes.
- pharmacist counseling and titration of blood pressure and diabetes meds would be helpful
- I am interesting in learning more about this for some more remote parts of our County
- Oversite is critical.
- Maybe. For most it won't matter because they are compliant.
- Helps patients understand the medication does and regimen

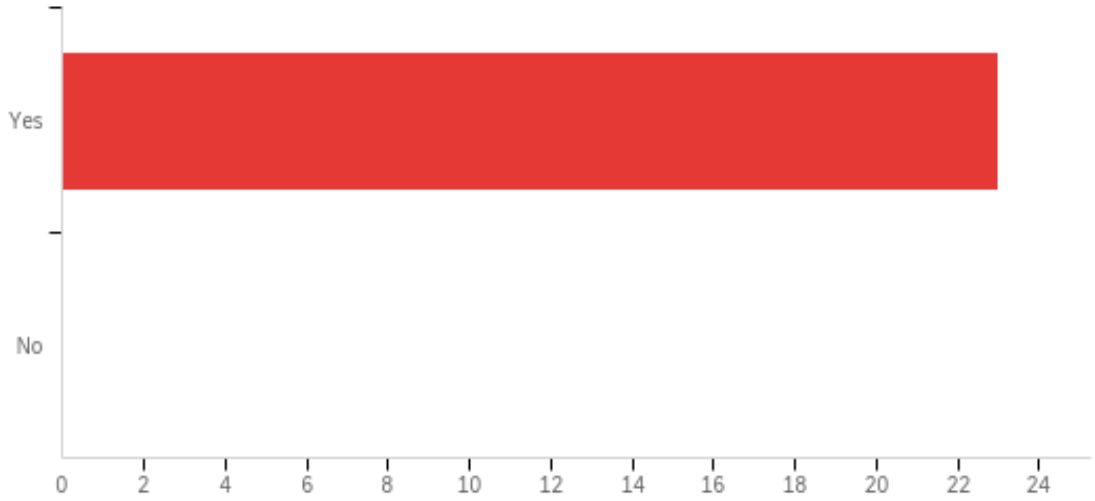
Q42 - Do you treat any patients who have challenges or hardships in accessing their pharmacy?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you treat any patients who have challenges or hardships in accessing their pharmacy?	1.00	2.00	1.31	0.46	0.22	35

#	Answer	%	Count
1	Yes	68.57%	24
2	No	31.43%	11
	Total	100%	35

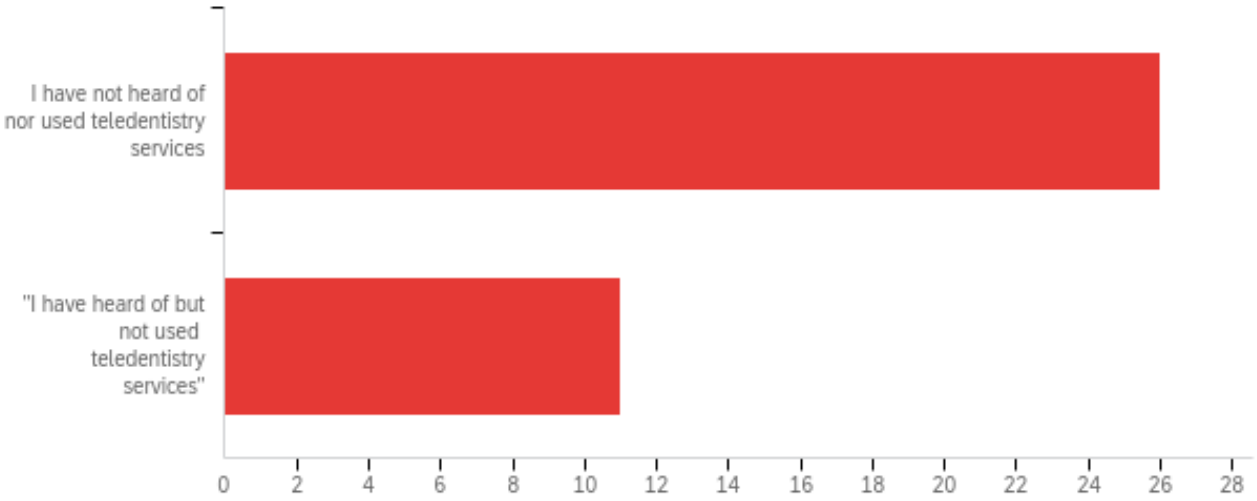
Q43 - If yes, would allowing patients to access a pharmacist remotely ease some of these hardships?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	If yes, would allowing patients to access a pharmacist remotely ease some of these hardships?	1.00	1.00	1.00	0.00	0.00	23

#	Answer	%	Count
1	Yes	100.00%	23
2	No	0.00%	0
	Total	100%	23

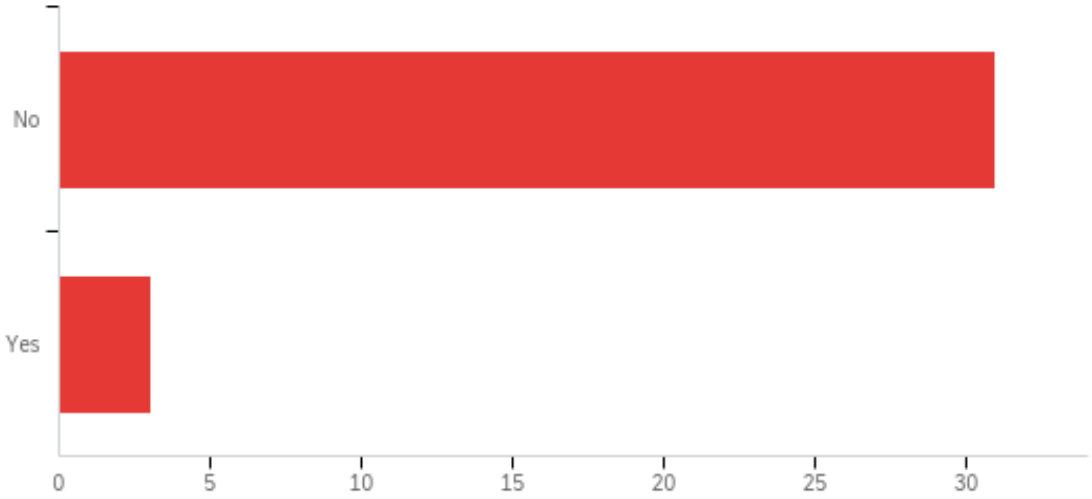
Q44 - Have you heard of or used teledentistry services?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Have you heard of or used teledentistry services?	1.00	2.00	1.30	0.46	0.21	37

#	Answer	%	Count
1	I have not heard of nor used teledentistry services	70.27%	26
2	"I have heard of but not used teledentistry services"	29.73%	11
	Total	100%	37

Q45 - Do you feel teledentistry would improve adherence and outcomes?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you feel teledentistry would improve adherence and outcomes?	1.00	2.00	1.09	0.28	0.08	34

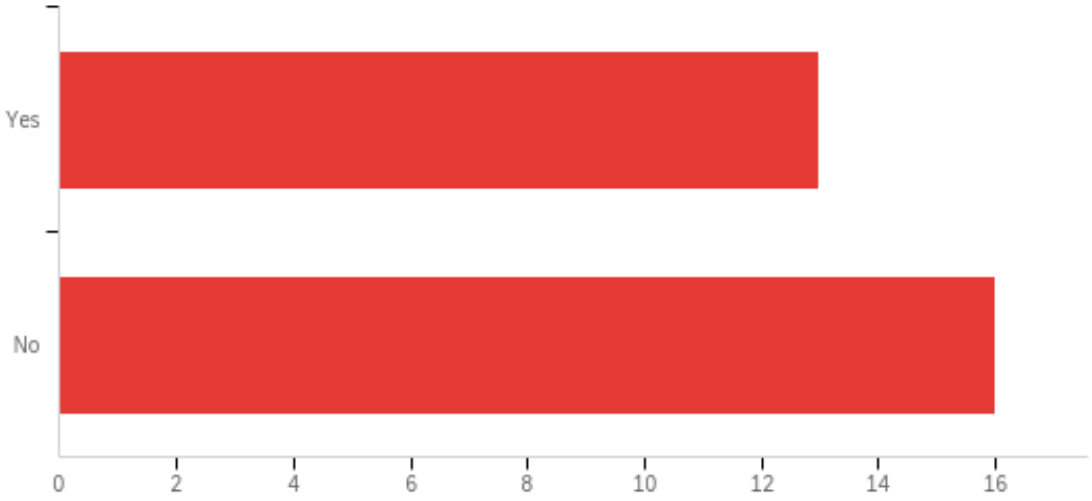
#	Answer	%	Count
1	No	91.18%	31
2	Yes	8.82%	3
	Total	100%	34

Q46 - Please explain your answer regarding adherence and outcomes:

- Can't speak on this because of no experience in this area
- Only be able to provide education
- If patients has question their response would be given
- Do not have an informed opinion.

- Not a dentist
- Dentistry patients should be in person visit

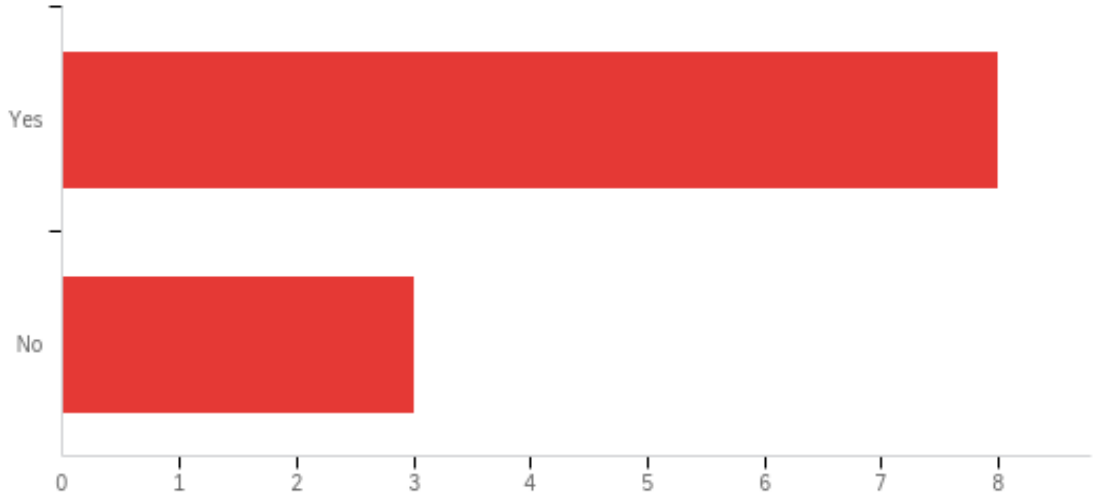
Q47 - Do you treat any patients who have challenges or hardships in accessing their dentist?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Do you treat any patients who have challenges or hardships in accessing their dentist?	1.00	2.00	1.55	0.50	0.25	29

#	Answer	%	Count
1	Yes	44.83%	13
2	No	55.17%	16
	Total	100%	29

Q48 - If yes would allowing patients to access a dentist remotely ease some of these hardships?



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	If yes would allowing patients to access a dentist remotely ease some of these hardships?	1.00	2.00	1.27	0.45	0.20	11

#	Answer	%	Count
1	Yes	72.73%	8
2	No	27.27%	3
	Total	100%	11

Q49 - Please provide any additional comments you have regarding telemedicine/telehealth, telemonitoring, telepharmacy or teledentistry:

- It's not the panacea that is hyped. It is only good for certain visits in primary care and has numerous limitations.
- We have learned to have community health workers teach patients how to use the electronic remote patient monitoring first and then send it home with them. They did not do well when the equipment was just sent home.
- Reimbursement parity is important.
- Any opportunity to provide services to individuals who would not otherwise receive them is beneficial.
- Telemed over the last two years has had significant positive impact on patients and provider convenience. We must not lose ground. e
- Need physical contact to examine most things in teeth
- N/A
- We would prefer to continue telemedicine/ telehealth services. We have a lot of out-of-town patients and this helps them. We also have fewer no-show appts than when in person.
- been in the area for 35 year; patient are older. this is new to majority of them add or daycare /home health should teach patients what new for them to assess care
- Reimbursement needs to be same as in office as the overhead is the same as this service is provided form our office. Also, some clients have been served who have never been served before because of fear of getting out to services. They are now functioning better. This also helps with patient who have transportation issues which is half our patient population.
- We appreciate Texas Medicaid approving ECI therapies in March 2020 for reimbursement. Physical therapy was the only ECI therapy not approved for reimbursement but has been through the pandemic. Hopefully with HB4 physical therapy reimbursement will be permanent for ECI. We would also like Targeted Case Management to be approved for permanent telehealth

reimbursement. Currently we are reimbursed for phone and in person with telehealth only during the PHE. Telehealth Targeted Case Management is a great alternative to phone so we would appreciate continued reimbursement for that service.

- Resourceful
- Yes, but there still needs to be a onsite person to assist
- Telehealth has given us an opportunity to serve an even larger rural population that did not previously have access to our services. Patients love the convenience.
- Follow-up for meds and treatments
- Must overcome simple resistance to change.