



Regional Telehealth Learning Collaboratives Final Report

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Introduction

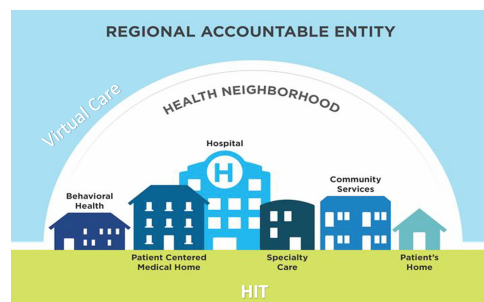
The COVID-19 pandemic has not only increased the use of telehealth but also highlighted the need for an interoperable statewide telehealth infrastructure in Colorado. Developing a telehealth infrastructure that uplifts and supports every Coloradan presents a significant opportunity to establish a standard of care that sets a benchmark beyond our state lines and around the country.

Colorado has a history of innovation and collaboration in the pursuit of progressive health care solutions for our communities. To that end, the Office of eHealth Innovation (OeHI), in partnership with Prime Health, established the Regional Telehealth Learning Collaboratives (RTLCS) to advance the statewide adoption and coordination of telehealth technologies. The initial effort included three geographic regions spanning urban, rural, and frontier areas, each served by a Regional Accountable Entity (RAE) that provided support and encouraged participation among providers and community partners alike.

Statewide telehealth infrastructure must be broad and inclusive of the community, as well as providers and state agencies, if it is to be sustainable. The RTLCS convened from April 2021 to June 2021, listening to hundreds of individuals and dozens of organizations statewide, gathering information, discussing models and services, collecting feedback, and determining priorities, concluding with the delivery of collaboratively developed recommendations for an equitable, impactful, and inclusive statewide telehealth infrastructure.

Purpose

The purpose of this report is to: highlight some of the key findings and feedback across Colorado healthcare stakeholders; identify examples of successful models to be studied, supported and leveraged; and gain a comprehensive sense of the current telehealth landscape in Colorado – where we've been, where we are today, and where we might go from here.



The purpose of Regional Telehealth Learning Collaboratives has been to advance the adoption, collaboration, and coordination of telehealth technologies statewide, starting with three geographic regions in Colorado that include urban, rural and frontier areas and are served by a Regional Accountable Entity (RAE). Prime Health is recognized as a subject matter expert in telehealth both locally and nationally. The Office of eHealth Innovation is leveraging Prime Health's expertise to increase the coordination, adoption, and use of telehealth technologies, and to inform the design and development of statewide telehealth infrastructure.

Health neighborhoods represent the various clinical-community partnerships and medical, behavioral, and social supports necessary to enhance health, with the Patient Centered Medical Home serving as the

patient's primary "hub" and coordinator of health care delivery. Colorado has established Accountable Care Collaboratives and Regional Accountable Entities to support and develop strong health neighborhoods for Coloradans. The RTLCs helped to map the virtual layer of the health neighborhood, looking for opportunities to streamline patient and provider workflows, leverage HIT infrastructure, and strengthen coordination and collaboration across partners.

The Partnership

The Office of eHealth Innovation partnered with Prime Health to improve the health and well-being of all Coloradans. OeHI and Prime Health brought together RAEs, providers, and community members and gathered comprehensive input to inform the resulting recommendations.

About The Office of eHealth Innovation

The Office of eHealth Innovation was formed as a direct result of a consensus between public and private stakeholders on the need for statewide health IT governance and coordination. OeHI is responsible for defining, maintaining, and evolving Colorado's health IT strategy concerning care coordination, data access, health care integration, payment reform, and care delivery. To ensure these efforts align with the wants and needs of Coloradans, OeHI has created and adheres to a [Health IT Roadmap](#)¹ to identify and prioritize strategic initiatives.

About Prime Health

Prime Health is a locally and nationally recognized expert in digital health and innovation. The organization is dedicated to technology-driven health reform in partnership with Colorado communities. Prime Health strives to improve the equity, access, quality, and cost of health care in Colorado through programs that are developed with, by, and for the communities and organizations it serves.

Participating Organizations²

¹ OeHI. (2019, December). [Colorado's Health IT Roadmap](#).

² [RTLC Member List](#)

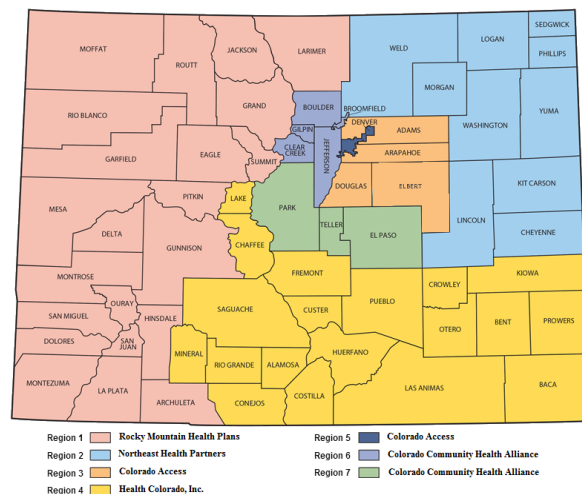
Access Care	Colorado Community Managed Care Network	Lincoln Community Hospital and Clinic
Access Health	Colorado Department of Health Care Policy & Financing	Marillac Clinic
AllHealth Network	Colorado Department of Human Services, Office of Behavioral Health	Mental Health Center of Denver
Arctaris Impact Investors	Colorado Department of Public Health & Environment	Mile High Health Alliance
Banner Health	Colorado Department of Regulatory Affairs, Division of Insurance	MindSprings Health
Care on Location	Colorado Health Foundation	North Range Behavioral Health
Carin' Clinic	Colorado Health Institute	Northeast Health Partners
Caring 4 Denver	Colorado Hospital Association	Colorado Office of BH, BH Task Force Working Group
CCIA- Colorado Commission of Indian Affairs, Lt. Gov Office	Colorado Rural Health Center	Colorado Office of eHealth Innovation
Centennial Mental Health Center	CORHIO	Colorado Office of Governor Jared Polis
Center for African American Health	CU Anschutz - Colorado Health Extension System	Colorado Office of Lieutenant Governor Dianne Primavera, Office of Saving People Money on Healthcare
Center for Improving Value in Health Care	Denver Health	Quality Health Network
Center for Primary Care Clinic	Developmental Disabilities Resource Center	Rocky Mountain Health Plans
Center for Care Innovation	Eastern Plains Healthcare Consortium	Salud Family Health Centers
CirrusMD	Family Physicians of Greeley	Servicios de la Raza
CIVHC	Haxtun Health	Sheridan Health Services
Clinica Colorado	Health Tech Solutions	State of Colorado, Medicaid
Clinica Tepeyac	Heart Centered Counseling	Stride Health
Colorado Access	Kiowa County Hospital District	Summit County Care Clinic
Colorado Broadband Office		The Children's Place
Colorado Cancer Coalition		Western Health Alliance
Colorado Coalition for the Homeless		Zoma Foundation
Colorado Community Health Network		

Parameters, Process, Topics, and Regions

Parameters

OeHI and Prime Health coordinated three RTLs in four RAE regions of Colorado - region 2 (northeast Colorado), region 1 (Western Slope), and regions 3 and 5 (Denver/Aurora metro area) - that represent urban, rural, and frontier populations. Each of these regions is supported by the RAE that likewise encourages community and local provider participation to gather collective and representative views on a regional level.

The goal of each RTL was to convene a diverse group of cross-sector and industry stakeholders representing different and important perspectives relevant to the development of a statewide strategy for sustainable telehealth adoption.



Process

The process called for RTLCS to evaluate and consider a standard statewide set of topics, as well as topics and challenges specific to the region. Each of the RTLCS shared information on current initiatives and barriers in their region, found opportunities to streamline patient and provider workflows, leveraged healthcare IT infrastructure, supported behavioral health initiatives, and strengthened coordination and collaboration across partners.

Convene

The first and primary objective of the RTLCS was to establish a forum for communication, coordination, and information sharing. This collaborative informed state telemedicine and broadband recommendations to maximize efforts, avoid duplication, promote accuracy, and increase the speed to solution.

Learn

Once established, participants of the RTLCS had the opportunity for peer learning, peer support, and knowledge sharing. This phase of the project aligned participants on the state of telehealth in Colorado today and created a natural environment in which partners identified opportunities for collaboration, partnership, program replication, and program scale.

Inform

Ultimately, each RTLCS provided insight, information, and feedback based on its collective understanding of both state and regional needs to consider in the development of a telehealth infrastructure. The outcome of these inputs is informing the development of a roadmap, conceptual framework, and action plan, that account for regional priorities and diverse perspectives.

Colorado Telehealth Survey

As part of the RTLCS process, multiple organizations and state agencies and departments collaborated with OeHI and Prime Health to develop and disseminate a statewide survey gathering perspectives from Colorado providers and healthcare professionals on telehealth experiences and sentiments. 1,357 individuals responded, representing a diverse array of backgrounds, geographic locations, professions, and demographics. Information gleaned from the survey is incorporated into this report, and a full analysis of this new data set is forthcoming in a separate report.

Goal

The goal of the RTLCS was to convene groups and facilitate discussions to inform the design and development of an equitable, inclusive, sustainable, and impactful statewide telehealth infrastructure. This goal was met. The RTLCS provided the state and local communities with recommendations for an interoperable and flexible statewide telehealth infrastructure. In support of this, Prime Health identified

and differentiated common statewide themes versus regionally specific needs and ensured the outcome reflects a diverse array of perspectives.

A note from the authors:

Many of the stakeholders in this process expressed concerns related to privacy in sharing information or perspectives that may be uncomfortable or controversial for other stakeholders to hear in the complex, interdependent community that comprises a statewide healthcare ecosystem with competing interests and priorities. Out of respect for the trust, vulnerability, and commitment of all stakeholders who participated in this process, quotes and information are not directly attributed to any one source. The RTLC process successfully collected a large body of information and evidence to substantiate claims and recommendations in this report. This report aims to accurately, fairly, and concisely represent a wide range of perspectives, challenges, calls for accountability, ideas, and opportunities.

For further information or detail on a specific area, please contact the authors who will be happy to provide additional context and supporting materials. Specific individuals or sources of information, however, will not be shared without the individual's or organization's permission.

Topics and Focus Areas

Each RTLC addressed the following topics:

- Mapping and coordinating existing programs and efforts
- Financial sustainability
- Broadband and technology infrastructure
- Provider resources and workforce
- Targeted population health goals and priorities
- Equity and patient access and experience
- Advancing and aligning with Colorado's Health IT Roadmap

Foundational Concepts

What is Telehealth?

Telemedicine in Colorado is defined as a means to deliver medical services, diagnosis, consultation, or treatment using interactive audio, video, or data communication.³ According to Health First Colorado, "Telemedicine is not considered a unique service, but rather, a means to provide services approved by Health First Colorado through live, interactive audio and video telecommunications."⁴ Telehealth also includes home health monitoring services by the member's home health agency.

In its broadest definition, telehealth includes five modalities:

³ HB21-1190 "Defining Telemedicine For Medical Practitioners". <http://leg.colorado.gov/bills/hb21-1190>

⁴ CO Department of Health Care Policy and Financing. ["Telemedicine Billing Manual," 11/20.](#)

Live video	Telephone/audio only	Remote patient monitoring	mHealth	Store & Forward (asynchronous consultation)
<ul style="list-style-type: none"> • Provider-patient • Provider-provider consult • Care teams • Navigation and care management services 	<ul style="list-style-type: none"> • Provider-patient • Provider-provider consult 	<ul style="list-style-type: none"> • Chronic disease • Behavioral health • Can be done with or without additional devices 	<ul style="list-style-type: none"> • "mobile" health e.g. apps • Patient engagement • Texting, messaging • Symptom trackers, condition management tools 	<ul style="list-style-type: none"> • Typically used for consultations with specialists

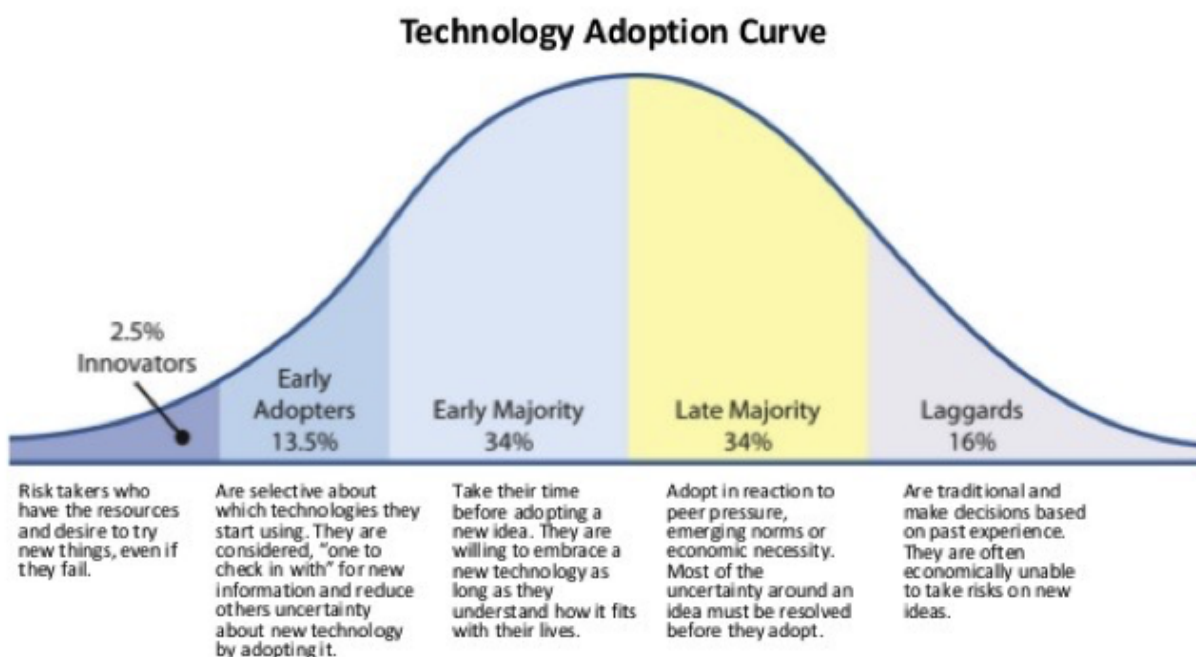
**Reimbursement and policy varies by modality and may not be available or allowable yet for all telehealth modality types.*

Telehealth Expansion

According to one study by Fair Health⁵, telehealth use increased by 3,060% nationwide in 2020. In Colorado for example, telebehavioral health use increased by 600%. Across the nation, and in Colorado, policy makers, payers, and providers recognized the value and benefit of leveraging telehealth to sustain healthcare during the Public Health Emergency (PHE) in response to the COVID-19 pandemic. Many providers started using telehealth technologies in response to the PHE, in some cases literally overnight.

In learning by doing, Colorado's healthcare community recognized telehealth as a valuable tool with many benefits to public health systems, payers, providers, and most importantly, patients. Various national and local patient surveys report that patient satisfaction with telehealth ranges on average between 86% - 98%. In another survey, 70% of patients stated that they would prefer telehealth visits over in-person visits for the majority of care to save time and cost. Providers surveyed across a number of studies, including the Colorado Telehealth Survey, reported favorably on telehealth, citing benefits to patients, increased efficiency, increased access to resources, increased flexibility, and improved coordination as some of the primary reasons why they'd like to keep using telehealth.

⁵ FAIR Health. (2020, October). Monthly Telehealth Regional Tracker, Oct. 2020. <https://www.prnewswire.com/news-releases/telehealth-claim-lines-increase-3-060-percent-nationally-w-hen-comparing-october-2019-to-october-2020--301201834.html>



But there's a learning curve.⁶ Patients, providers, payers, and policy makers all report challenges, barriers, and unanswered questions in navigating this rapidly changing telehealth landscape. This surge in adoption has sparked a telehealth renaissance, and now that the COVID-19 PHE is subsiding somewhat (as of the writing of this report), the healthcare community has turned its attention to sustaining and refining lessons learned during the PHE. This report seeks to summarize the current state of telehealth in Colorado and highlight key priorities, challenges, barriers, opportunities, success stories, opportunities, and recommendations for next steps.

Overview and Key Findings

Over the course of this process, several key findings surfaced as areas of strong consensus and potential next steps in developing sustainable statewide telehealth infrastructure. Those recommendations are outlined below.

1. Start with telebehavioral health services

Colorado has a persistent and prevalent need related to behavioral health services that is worsening. Behavioral health services and needs are present in all healthcare settings: primary care, hospitals, jails, schools and school-based health centers, and, of course, community mental health centers.⁷ As such, behavioral health is widely identified as a top priority across all stakeholders, and there is

⁶ Popularized by Everett Rogers in the book [Diffusion of Innovations](#), people tend to adopt new technologies at varying rates. Their relative speed of adoption follows a bell curve, with the primary difference being individuals' psychological disposition to new ideas.

⁷ Behavioral Health Task Force. (2020, September). [BEHAVIORAL HEALTH IN COLORADO: PUTTING PEOPLE FIRST](#). CDHS. Page 10.

alignment across State departments and agencies, State initiatives, payers, and provider organizations to improve behavioral health services. In response, Colorado established a new Behavioral Health Administration in 2021 to address challenges and barriers in delivering behavioral health services and improving mental health and well-being for Coloradans, including exploring digital health and innovation options for improving and maximizing accessibility, quality, equity, and cost of services.

Identifying a common thread of shared services allows for a starting point that connects all members of a health neighborhood or ecosystem. Best practices from implementation science, change management, project management, and experience implementing telehealth models and infrastructure suggest that starting with one achievable, focused, and shared goal allows for greater success by providing a clear and digestible pathway to success. Rather than focusing on multiple, or all, things at once, starting with Colorado's most pressing and urgent need of behavioral health – which also happens to be the easiest starting point for organizations, providers, and patients new to telehealth – lays a foundation that, once established, can be more rapidly, easily, and efficiently expanded upon.

2. Engage consumers in a human centered design process

Consumer digital health literacy and awareness is one of the top challenges cited by RTLC participants, however specific needs or solutions to address consumer barriers remain unclear and require further exploration. As a next step to address consumer access as a fundamental element of successful sustainable infrastructure that will be useful and impactful to consumers, Colorado should meaningfully engage consumers and community and patient advocates to listen to their needs and challenges, and collaborate with consumers to co-design effective solutions.

The community expressed consensus in their desire and support for a broad and robust consumer engagement process leveraging human centered design, user experience design (also known as "UX", a field of study and best practices in the innovation, technology and product design sectors), and shared decision making best practices to listen to, learn from, and co-design with consumers on user experience, access barriers, communication gaps, and service maximization. This process should include health equity considerations and give special attention to consumer accessibility and inclusivity.

3. Establish a Colorado Innovation Resource Center

Prime Health identified at least 28 different organizations disseminating telehealth information and training to Colorado safety net providers, almost none of whom were coordinating topics covered with one another or sharing resources, funding, and information. Prime Health also identified that several of these organizations were sharing incorrect or out-of-date information that was misleading or potentially harmful to providers.

Stakeholders, when asked, were not able to clearly identify or name a go-to resource in Colorado for telehealth information, training, and resources. In fact, many stakeholders reported difficulties in this area, citing confusion, duplicative programming, credibility questions, competing priorities, and time-consuming yet ineffective trainings as barriers.

Despite the numerous opportunities available, providers reported that most trainings and resources fell short or did not meet their needs, and expressed a preference for more hands-on, long-term, learning cohort style coaching and support over webinars. Providers also expressed a desire for other topics related to health innovation best practices, such as human centered design, trauma informed care, health equity, solution architecture, and implementation science.

It is recommended that Colorado establish a Colorado Innovation Resource Center to provide:

- Clear, up to date, centralized information on ever-evolving telehealth policy and regulations
- Guidelines and best practices
- Training and education
- Pilot development and implementation support
- Support for testing behavioral health innovation and innovative value-based payment models leveraging digital health
- Vendor procurement guidance, vetting, and support
- Funding streamlining, maximization, and braiding opportunities
- Streamlined and coordinated efforts to minimize duplication and maximize impact

4. Internet as a public utility, free wifi in urban areas, and strong federal advocacy for internet regulations

Another top barrier among rural and urban stakeholders alike is reliable, accessible, affordable internet. The community is passionate in its outcry against current broadband and internet infrastructure, citing a number of barriers and inequities outlined later in this report. Temporary subsidies for internet access for low-income individuals are inadequate and do not address fundamental barriers that cannot be solved without federal action and regulations for internet service providers.

Recognizing that federal reform takes time, it is recommended that Colorado take matters into its own hands, protect consumers, find independence from unregulated internet service providers where possible, and examine options such as internet as a public utility, free wifi services in urban centers such as Denver, Pueblo, and Grand Junction, or other emerging technologies to rapidly improve internet and cellular coverage and access.

5. Care coordination and data interoperability is a top priority

Care coordination and data interoperability continue to be top priorities for the Colorado health ecosystem, a need further highlighted by the COVID-19 pandemic. Fortunately, there is already significant progress being made in this area to be supported and expanded upon. The Social Health

Information Exchange (S-HIE) model, for example, supports care coordination and incorporates social determinants of health. S-HIE is a nationally innovative model aligned with federal initiatives and built with a flexible, scalable, and inclusive infrastructure that offers ongoing potential for expansion.

⁸

Further opportunities to connect and integrate large-scale infrastructure and key systems, such as S-HIE, the PEAK system, Connect 4 Health Colorado, health information exchanges (HIEs), RAEs, behavioral health providers – including private sector partners – should be explored and invested in.

Additional recommendations in this area include:

- Health information exchanges:
 - Drive integration of telemedicine-only providers into health information exchanges to mandate and support information sharing and care coordination with in-person providers be prioritized to maintain care continuity and patient-centered medical home models.
 - Providers strongly expressed a need for behavioral health and substance use data to be available through health information exchanges, in addition to a need for longitudinal and episodic record sharing.
- Procurement guidelines and best practices:
 - Establish best practices, guidelines, and expectations for digital health vendors as it relates to data ownership, interoperability, and information sharing, particularly those seeking eligibility as State vendors and contractors.

6. Maintain and enforce parity for telehealth services, including audio-only, at the same rate as in-person services

Parity for telehealth services has been in place in Colorado since 2017. In 2020, Colorado expanded parity further to include audio-only visits, Federally Qualified Health Centers, Rural Health Clinics, home health agencies, and others.

87% of healthcare professionals surveyed in the Colorado Telehealth Survey reported that they have been using telehealth for only 18 months or less.⁹ Most providers began using telehealth for the first time either in response to the public health emergency or because their organizations were newly eligible to begin seeking reimbursement for telehealth services. Providers and patients agree that telehealth is often the most accessible and affordable option for patients.

63% of providers agree or strongly agree that audio-only/telephone-based services are essential for their patients in accessing care.¹⁰ Some examples of patients who rely on audio-only services are:

⁸ Colorado Health Institute. (2020, January). [Advancing a Coordinated Ecosystem for a Social Health Information Exchange \(S-HIE\) in Colorado](#). Pages 8-9.

⁹ Prime Health and the Office of eHealth Innovation. (2021, June). [2021 Colorado Statewide Telehealth Survey](#). Question 12.

¹⁰ Prime Health and the Office of eHealth Innovation. (2021, June). [2021 Colorado Statewide Telehealth Survey](#). Question 58.

rural populations with limited or no internet access, populations with low income who may have limited access to devices, people experiencing homelessness who simply have no other way to access services, older adults and others unfamiliar with new technologies, and patients with stigma, privacy, and safety concerns such as LGBTQ+ individuals, veterans, or survivors of abuse and gender-based violence.

Peer-reviewed studies and literature, in addition to feedback from Colorado providers, suggest that not only is telehealth not a lesser version of care, in terms of quality, impact, or outcomes, it is in many cases a better option. Be that as it may, it is undeniable that with the majority of providers, payers, and policy makers still seeking to understand telehealth, we do not yet have a clear enough picture to make determinations about a separate pay scale for telehealth and audio services, nor has the community had time to do a full review of national best practices, guidelines, examples from other states, or how wide scale telehealth adoption in response to the pandemic has impacted our state.

The majority of providers do not believe and it has also not been proven that telehealth services cost less for an organization to provide and should therefore be reimbursed at a lower rate. Stakeholders widely reported that if Colorado were to reverse parity for telehealth services they would likely abandon telehealth and return to in-person services, despite the benefits they identified, as it would no longer be financially sustainable for their organization.

Colorado providers are still learning how to use and bill for telehealth. Reversing parity for telehealth and audio services in Colorado would add additional complexity to an already new and confusing space, disincentivize providers, and hamper the significant progress the community has made and is making in identifying innovative ways to leverage services to improve care and access while reducing cost.

It is also recognized that there are concerns in the payer landscape regarding increased costs, the role of national telemedicine-only companies, and fraud, waste, and abuse for example. As such, stakeholders recommend developing a plan for evaluation in 2021, conducting an evaluation of telehealth claims data, cost reports, and national best practices in 2022, and reevaluating parity legislation no sooner than 2023 once more information is available and telehealth adoption has stabilized.

Providers also widely reported challenges pertaining to confusion and inconsistent reimbursement from commercial payers. Barriers related to reimbursement from commercial payers lead to significant adoption barriers for safety net providers, as they often rely on reimbursement from commercial payers to sustain their practices, and complex billing practices can be costly and time consuming. In addition to maintaining parity for telehealth services, it is recommended that expectations and processes for commercial payers be clarified. The Colorado Division of Insurance (DOI) has issued a draft of proposed guidance on this topic that aims to address this need for additional guidance.¹¹

¹¹ Colorado Division of Insurance. (2021, July). [DRAFT Proposed Revised Bulletin No. B-4.89 Policy Directives for Telehealth](#).

7. Simplify and expand contracting and reimbursement for telebehavioral health providers interested in serving Medicaid and Indian Health Services (IHS) populations

Colorado has a provider shortage when it comes to behavioral health, especially behavioral health providers that take Medicaid and IHS patients, exacerbating the state's behavioral health and substance use epidemics. Additionally, providers tend to concentrate in urban areas, contributing further to rural health disparities and access barriers. Telehealth could be leveraged to significantly improve access to needed and lifesaving behavioral health services and expand Medicaid and IHS behavioral health provider networks statewide. However, eligibility requirements and reimbursement rates for behavioral health providers serving Medicaid are determined at the regional level and vary across the state, which providers identify as a barrier when seeking to serve patients across regions. To allow them to serve patients anywhere in the state, Colorado must (1) recruit independent behavioral health providers, community mental health centers, and other behavioral health and substance use providers and organizations in expanding their telebehavioral services and (2) simplify and expand contracting and reimbursement processes for behavioral health.

Behavioral health providers are credentialed at the RAE level, each with separate processes, utilization management, forms, prior authorization processes, and additional complexities, adding to administrative burden, duplicative work, and uncompensated services for providers. Streamlining credentialing and onboarding processes for Medicaid behavioral health providers will be extremely beneficial in enabling their participation in the behavioral health safety net.

8. Establish reimbursement pathways for eConsults, including telepsychiatry

Reimbursement models for eConsults are currently being explored by state agencies, and community stakeholders expressed strong support and desire for this work to continue and expand. eConsult models, particularly those for telepsychiatry, are well-established and demonstrate remarkable success, for example in the case of the NC-STeP model of North Carolina¹², which has demonstrated improvement to behavioral health outcomes, access to services in rural areas, psychiatric services and workforce capacity in rural hospitals, and significant cost savings to the state Medicaid program over the course of 10 years. Colorado already has several existing models for telepsychiatry eConsult services that are scalable and could be expanded to support patients and providers statewide.

¹² North Carolina Department of Health and Human Services . (2020, October 30). [Summary Report on SFY 2020 North Carolina Statewide Telepsychiatry Program \(NC-STeP\) Funds.](#)

9. Evaluate existing quality measures, guidelines, standards, and other literature available before implementing Colorado-specific changes to minimize duplication and meet or exceed national best practices

While there has been a massive surge in use of telehealth in response to the public health emergency, versions of telehealth in the United States have been documented as early as the 1920's when providers would use radio to communicate with rural patients in their homes. NASA, the military, and prison systems have been using telehealth for more than 40 years. MindSprings, a Colorado community mental health center on the Western Slope, has been using telebehavioral health for more than 20 years. Colorado is also home to nationally recognized telehealth early adopters, pioneers, and thought leaders, like psychiatrist Dr. Jay Shore, who participated in the establishment of the American Telemedicine Association in 1993. The American Psychiatric Association, American Medical Association, NCQA, and numerous other organizations, journals, and academic institutions have published guidelines, best practices, studies, quality measures, clinical protocols, and other such content related to the advancement and refinement of telehealth.

Colorado stakeholders interviewed were largely unaware of many of these resources, reflecting that 86% of Colorado health professionals across all sectors are relatively new to the field of telehealth.¹³ This body of research offers the community an opportunity to accelerate adoption and refinement of telehealth policies and practices, minimize duplication, avoid common pitfalls, and find opportunities to meet or exceed national best practices, thus continuing Colorado's legacy as one of the most innovative states in the nation for healthcare.

10. Identify, fund, scale, and support cohorts of safety net innovation success case studies and early adopter cohorts to pilot, test, and evaluate new models

One of the most exciting aspects of the RTLCs was discovering and learning about the numerous examples of outstanding innovation, success stories, and creative solutions stakeholders across all sectors were implementing to improve access, quality, and affordability of healthcare services through digital health innovation. 71% of health professionals stated that they are motivated to increase use of telehealth in their practice¹⁴, and this shows in the variety of models and modalities for telehealth being applied across the community. Colorado's safety net healthcare community is impressive in its innovation, willingness to try something new, and dedication to improving the health and well-being of Coloradans. Nurturing this community and its innovative spirit collaboratively will only advance Colorado's goals related to healthcare and further establish our state as a national leader in safety net health innovation. There is an appetite at the federal level, in

¹³ Prime Health and the Office of eHealth Innovation. (2021, June). [2021 Colorado Statewide Telehealth Survey](#). Question 12.

¹⁴ Prime Health and the Office of eHealth Innovation. (2021, June). [2021 Colorado Statewide Telehealth Survey](#). Question 60.

the private sector, with foundations, and at the state and local level to explore public-private partnerships, test value-based innovation, and pilot new models of care and collaboration. Investing in safety net health innovation and developing robust pathways and opportunities for providers to implement new solutions and models of care positions Colorado well to attract additional funding, resources, and investments from across the nation. This recommendation also addresses another barrier identified in the learning process, which is the fragmentation of funding and additional funding challenges outlined in the Office of eHealth Innovation's Sustainability Report.¹⁵

¹⁵ *Sustainability Recommendations Report*. (Coming Soon). [Progress & Overview presented in eHealth commission meeting June 9, 2021](#). Slides 25-51.

<https://oehi.colorado.gov/sites/oehi/files/documents/June%202021%20eHealth%20Commission%20Slides.pdf>

Internet and Technology

Internet and Cellular Access

Coverage

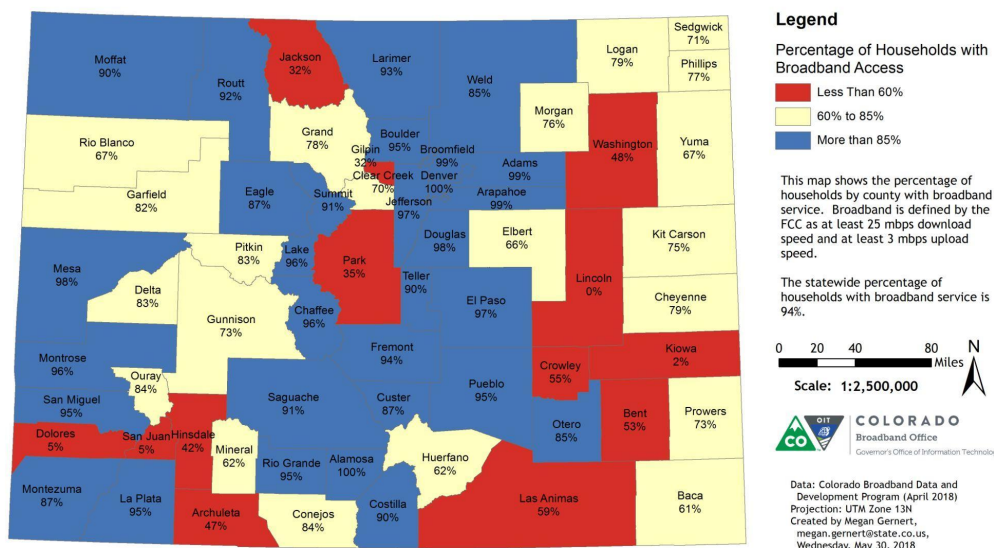
It is widely acknowledged and proven that Colorado has significant gaps and challenges related to adequate and equitable internet coverage and access. Challenges can be attributed to barriers including the large rural areas of the state with population volume not large enough to attract internet service providers, mountainous terrain, cost of infrastructure development, and difficulty related to regulating the internet service provider industry or implementing alternative solutions.

During the course of this process, in listening to healthcare professionals across the state, the challenges and impact this has on Colorado communities at large and across every area of life (economics, education, business and industry, safety, public services, and healthcare) cannot be understated, both in urban and rural areas. Not only does the lack of internet access and coverage deny Coloradans equitable access to health services, it denies entire communities equitable access to opportunity, education, and quality of life.

Below are several maps, demonstrating internet access by county in Colorado, along with maps indicating Medicaid enrollment by county.¹⁶ Health First Medicaid eligibility and enrollment in Colorado requires that individuals have low or very low income, of 138% of the poverty level for non-elderly

adults. Put differently, a household size of four (4) persons must have a total annual household income of \$35,245 or less to be eligible.¹⁷

BROADBAND SERVICE BY COUNTY - ALL HOUSEHOLDS



communities, it also

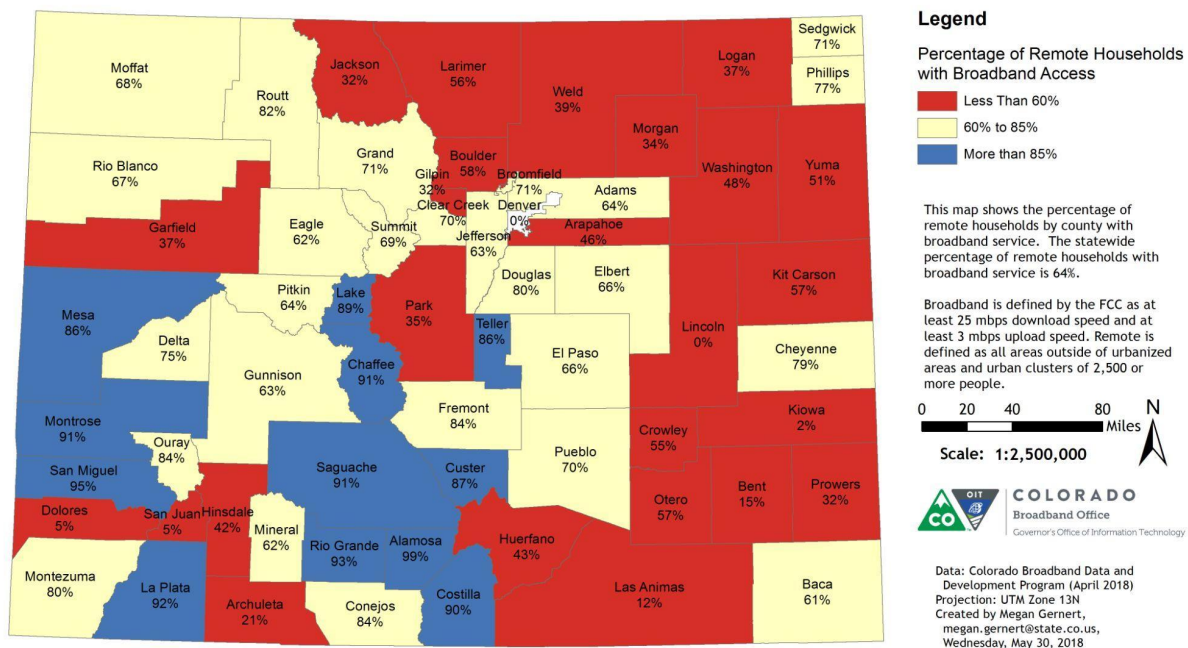
Cost
 What these maps demonstrate is that lack of internet coverage in addition to disproportionately impacting rural

¹⁶ Colorado Broadband Office. <https://broadband.co.gov/broadband-map-gallery/>

¹⁷ <https://www.benefits.gov/benefit/1621>

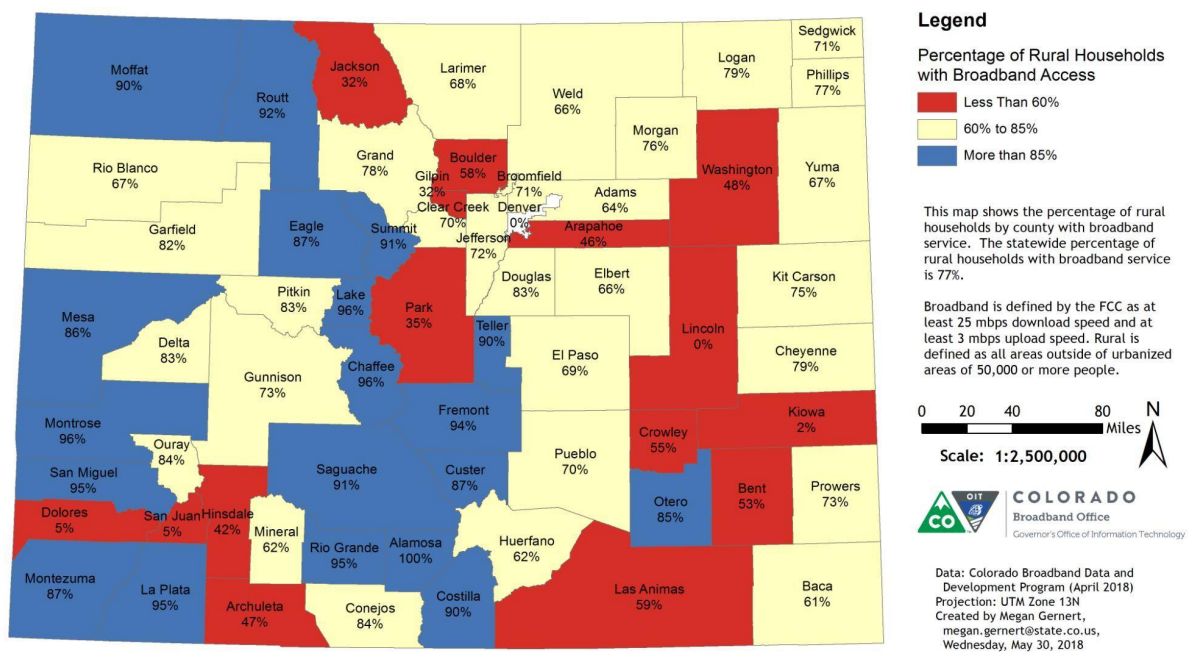
disproportionately impacts counties

BROADBAND SERVICE BY COUNTY - REMOTE HOUSEHOLDS



with the highest poverty levels. Additionally, internet services providers (ISPs) charge more for internet services in rural areas, adding additional financial burden to those who can often least afford it. Other pricing practices from ISPs, such as requiring a monetary deposit for individuals with poor credit, add-on charges, device rentals, and late fees and fines further financially impact consumers.

BROADBAND SERVICE BY COUNTY - RURAL HOUSEHOLDS

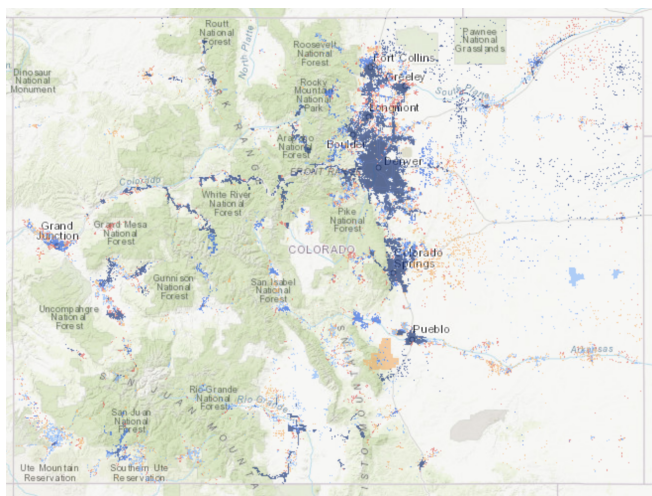


When examining why uptake in programs such as the Emergency Broadband Benefit subsidy or Lifeline program are lowered than expected, consumer advocates reported that these programs do not address that many low-income consumers have outstanding debts owed to ISPs that the subsidy program does not apply to, do not have the credit scores, funds, or permanent address to initiate services, or that services are simply not available in the consumer's area.

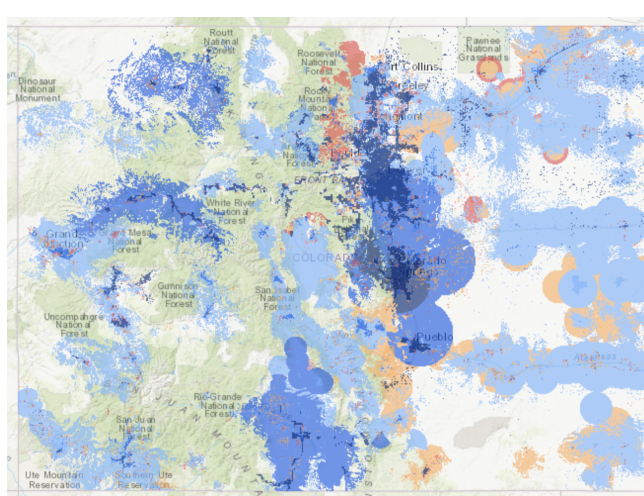
While ISPs have begun offering debt forgiveness programs and more affordable options for eligible consumers in response to COVID-19, such as the [Internet Essentials](#) program, consumers and community stakeholders appear to be largely unaware of these options or how to guide consumers with low-income through services and options available to them. Trust of ISPs was also low across all stakeholder groups, along with skepticism for the sustainability and durability of current relief programs.

Colorado Maps – Internet Coverage

All areas without Blue or Orange areas are **NO broadband**
Wireline



Fixed Wireless



Quality and Reliability

Low trust levels of ISPs among consumers and stakeholders may be attributed to the inconsistent quality of internet services, even for those in urban areas, and a general lack of reliability. This can in part be attributed to the overselling of internet capacity without improved infrastructure capacity.

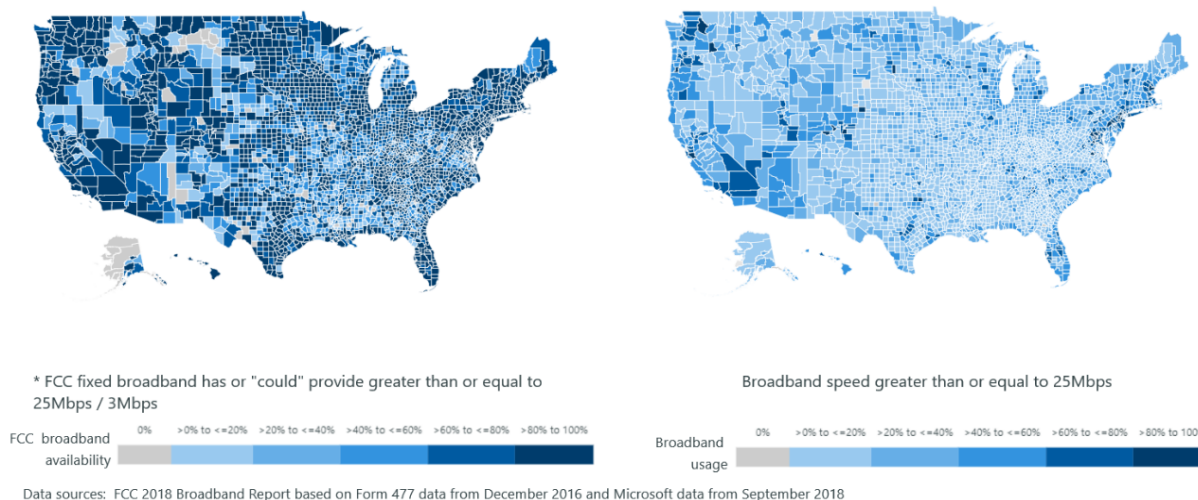
One stakeholder, a broadband and internet expert, described it as such, "Internet service providers oversell internet services in a way similar to how airlines oversell seats on a flight with the expectation that not everyone will show up. Their model relies on not everyone being on the internet at the same time as internet bandwidth is a finite amount shared by a covered neighborhood, not necessarily a dedicated line to a business or household. With increased demand on internet, you start to see internet shortages or crashes because infrastructure was not designed to support that kind of capacity."

There is also a need for internet infrastructure redundancies to be invested in. Urban and rural providers alike shared examples of when a line was cut and internet service to their entire organization and area went out, such as in the case of Estes Park that went without internet for several days in 2020 after a cable was cut, or a Denver practice that experienced something similar after nearby construction

inadvertently damaged a cable. Less catastrophic but still incredibly disruptive to healthcare professionals are internet updates and maintenance. Provider organizations across the state listed examples of internet services being rebooted or undergoing maintenance during business hours, rendering them without internet for hours or in some cases an entire day.

FCC indicates broadband is not available to 24.7M people

Microsoft data indicates 162.8M people do not use the internet at broadband speeds



Reliability also relates to the reliability of information on current state infrastructure. For example, reported internet coverage varies dramatically based on source. In one example, the FCC reported that 24.7 million people do not have internet coverage, whereas Microsoft conducted an independent study finding that the number of people without internet coverage is 162.8 million. This is based on whether or not the analysis is assessing *potential* internet coverage (FCC) versus *actual* internet coverage (Microsoft). One explanation for this difference in perspective is counting the potential coverage of "dark fiber", which is fiber laid for internet coverage but not "lit" due to the low population volume of the covered area.

Access

Access barriers also exist for consumers, providers and patients alike. Consumers living in apartments, for example, may only have access to limited subscription options. Cost barriers, outlined above, are another access barrier. Many consumers, particularly those with low income or who are housing insecure or experiencing homelessness, may not meet requirements such as having a permanent address, email address, or phone number.

In rural areas, internet and cellular coverage are simply not available to conduct telemedicine services or much else in the way of online services. Two critical access hospitals shared that the only place where their patients could access internet was in the parking lot of the hospital, meaning that patients were driving in some cases over two hours simply to park outside and speak with their doctor, which was still preferable due to COVID-19 exposure risk concerns.

In urban areas, spotty coverage, unpredictable outages, and limited service present barriers to businesses and individuals alike. Free public wifi hotspots are more readily available than in urban areas, however most of these require a phone number to receive a text message activation code, rendering them still inaccessible to those without internet or cellular access. Additionally, these free wifi hotspots are often in public areas inappropriate for those using internet to seek healthcare or other public services.

Cellular Coverage

In many cases, stakeholders cited that for patients especially, mobile or cellular coverage is often preferred, more reliable, and easier to access. Cellular coverage shows similar coverage equity and adequacy barriers to broadband coverage, with less robust coverage and infrastructure in rural areas.

Innovation Barriers

There are a number of alternative solutions available for exploration in addressing internet accessibility and affordability: local electric cooperative models, municipality-owned internet as a public utility, White Space Internet leverage radio frequencies and television infrastructure, emerging satellite technologies such as Starlink, OneWeb, Viaero Wireless, Google Fiber, Facebook Connectivity, and others. Many of these programs face barriers due to lobbying by the ISP industry at the federal level blocking the advancement of these services or lack of infrastructure funding available to properly invest in and test innovative solutions.

Recommendations

1. Strong, ongoing, federal advocacy for regulation of Internet Service Providers, to include:
 - a. Minimum up/down speed requirements,
 - b. Network adequacy requirements,
 - c. Permanent debt-forgiveness programs beyond the COVID-19 pandemic,
 - d. Permanent Internet Essentials/Lifeline/Emergency Broadband Benefit subsidy and financial assistance models for low-income Americans,
 - e. Pricing regulations for rural areas,
 - f. Dark fiber ownership regulations,
 - g. Business practice and network transparency requirements,
 - h. Allowance and support of innovative internet and cellular coverage models to enable an American culture of modernity, innovation, equity, and rural revitalization.
2. Explore any and all ways in which Colorado may implement similar policies at the state level and support innovative, urgent solutions to address internet access barriers.
3. Continue to invest in rural infrastructure development projects, especially those that target and prioritize frontier communities and underserved areas of the state.
4. Consider wifi as a public utility and offer state-funded free internet access in Colorado urban areas, and examine other successful examples around the nation for comparison and replication.
5. Expand and diversify internet and cellular service providers to include smaller, emerging companies or new entrants into the marketplace.

Technology

Providers reported several barriers related to technology infrastructure and how it impacts the ability to implement and leverage telehealth:

Electronic Medical Records (EMRs)

Many safety net provider organizations, particularly those in rural areas such as critical access hospitals, reported challenges related to using outdated EMRs that do not easily integrate new technologies or for which updates and add-ons such as patient portals, billing and quality reporting features, or HIE integration are incompatible. A large number of behavioral health providers report having no EMR at all.

EMRs are very expensive and labor intensive to upgrade or change, and stakeholders could not identify any funding available to support EMR modernization.

This prevents many critical safety net organizations, particularly in rural areas, from participating in critical care coordination and payment reform initiatives such as the Social Health Information Exchange (S-HIE) and the Hospital Transformation Program (HTP). In some cases, rural hospitals and clinics housed in the same building cannot coordinate care through the EMR across the hallway.

EMRs are a foundational, essential tool for providers. With so many pain points related to dysfunctional EMRs, stakeholders reported that it was difficult to consider prioritizing and investing in digital health technologies when fundamental priorities have not yet been resolved. Especially since outdated EMRs complicate digital health technology workflows for providers and staff.

Recommendations:

- Identify and publicize funding streams to support safety net providers, particularly rural and behavioral health providers, in modernizing EMRs.
- OeHI, Colorado Community Managed Care Network (CCMCN), and Colorado Rural Health Center (CRHC) are currently engaged in work to understand what is needed and identify solutions and strategies for rural providers. This work should be prioritized and supported to enable further telehealth and care coordination advancement.

Technology Solution Architecture

Many providers reported that digital health technologies were procured individually, and that many organizations are now juggling multiple different tools to support various elements of clinical workflow. For example, if a provider is doing in-home care with remote patient monitoring to support a patient's diabetes, they may be using an EMR, patient portal, patient engagement tool for messaging,

videoconferencing platform such as Zoom, a remote patient monitoring software, quality reporting tool, and billing software.

Providers also reported procurement challenges related to choosing which vendor is right for their organization and feeling overwhelmed sorting through the wide range of tools, vendors, and services in the digital health private sector. Providers also experienced procurement challenges related to budget and patient volume size, in that it can be difficult to attract or contract with vendors in smaller organizations. For example, a practice may only have 6,000 attributed patients total but their vendor of choice only contracts with organizations with a patient population of 20,000 or more. This can be a frustrating process for all involved, and is especially discouraging for rural partners.

Providers expressed a need for support with technical assistance and procurement support to streamline solution architectures and minimize the number of different tools provider staff are expected to use, especially as technology fatigue is identified as a key contributing factor to provider burnout and digital health adoption failure.

Recommendations

- Fund and support technical assistance and organizational capacity building services for provider organizations related to technology procurement and solution architecture.
- Issue recommendations and guidance for vendor best practices, procurement guidelines, questions to ask, examples of companies that meet these criteria, and additional resources to aid and streamline procurement.
- Support purchasing collaboratives for smaller organizations in urban and rural areas to enable access to desirable vendors at more competitive and affordable prices. Examples to reference here include the Western Health Alliance and Eastern Plans Healthcare Consortium models for collective purchasing agreements.
- More information on recommendations and resources needed for providers adopting new technology can be found in the Providers and Telehealth section.

Health Information Exchanges (HIEs)

HIEs are a powerful tool to support care coordination, continuity of care, assess and improve outcomes, and more, and are an essential, foundational component of the virtual health neighborhood. Both HIEs participated in the RTLC process and shared multiple examples of how they are leveraging their infrastructure to support and enhance healthcare. Stakeholders expressed support and interest in participating in Colorado's two HIEs - CORHIO and QHN, and offered recommendations and opportunities for HIEs to continue to evolve in service to the community's needs.

Key recommendations for HIEs related to supporting the virtual health neighborhood include:

- Both HIEs should offer bidirectional clinical history, longitudinal record sharing, and episodic record sharing. This is especially important in terms of care coordination with telemedicine providers who may be treating patients outside of the medical home. 58% of providers surveyed expressed concern about the presence of telehealth-only providers or digital health services disrupting the quality and coordination of care for their patients.

For example, in the case of a large national telemedicine provider offering on-demand acute care services direct to consumers or Regional Accountable Entities (RAEs) who have contracted with a

telemedicine provider company to provide after-hours services or meet network adequacy requirements.

- **Success Story:** QHN's model for sharing information bidirectionally with Rocky Mountain Health Plans, PCMPs, and telemedicine providers is an excellent example of leveraging HIEs to close care coordination loops, support health neighborhoods, local care, and medical home models, while also enabling patient convenience, access, and choice. Western Slope stakeholders can share data across physical and behavioral health in all care settings including telehealth. A contributing factor to success is that data sharing is required by Rocky Mountain Health Plans, the region's RAE, that contracts with in-person and telehealth providers. HIE participation is voluntary but the payers require data sharing for contracted providers, which benefits patients and the health neighborhood overall.
- When people talk of 'national telehealth providers' it's important to remember that these partners enter communities through payer and employer contracts. A very small percentage of services are direct-to-consumer telehealth. To advance care coordination and data interoperability, contracts with payers and employers to in-person and telehealth providers should include data sharing expectations.
- Some safety net organizations, particularly those in rural areas, found cost to be a barrier in participating in HIEs. Current initiatives to support rural HIE integration are seeking to address this.
- Behavioral health and substance use patient data is essential to provider stakeholders of all types, and meaningful care coordination cannot occur without these capabilities. HIE stakeholders expressed that current legislation related to protected information sharing under 42 CFR part 2 was a barrier to offering this service. In light of the [proposed rulemaking](#) issued by Health and Human Service (HHS) Office of Civil Rights in December 2020 in response to changes required by the Coronavirus Aid, Response, and Economic Security (CARES) Act, there is hope that these changes at the federal level will enable HIEs to implement these in-demand capabilities and enable behavioral health and substance use disorder information sharing.

Patient and Consumer Technology

Devices

Stakeholders reported that for many Medicaid members, access to devices remains a significant barrier. A patient may not have a device at all, or the device may be shared by multiple members of the same household, which can present privacy concerns.

Solutions: Providers implemented a variety of different approaches to addressing the lack of devices, such as purchasing and distributing smart phones with mobile hotspots or partnering with nonprofit organizations like PCs for People that distribute devices. Most of these solutions came with their own challenges, and the community is still working on ways to best address device barriers.

This is another area to be explored with a consumer engagement and human centered design process. More information on patient experience and telehealth technology can be found in the Patient Access and Equity section.

Audio-Only Services

There was strong consensus around audio-only services (telephone-based encounters) and the integral role audio-only services play in maintaining a healthy virtual neighborhood, supporting patient access, advancing health equity for various patient populations, supporting provider workforce adoption of telehealth, mediating broadband coverage and internet access challenges, and improving overall quality of care. 63% of surveyed providers agree or strongly agree that audio-only/telephone-based services are essential for their patients in accessing care.

Financial Sustainability

Financial sustainability is one of the driving factors and considerations for advancement, sustainment, and scale for safety net providers leveraging telehealth services. This section addresses policy, payers, and funding successes, gaps, and opportunities impacting providers.

Reimbursement for Telehealth Services

Colorado established payment parity for video visits from a patient's home in 2017 for Medicaid and private payers. Prior to the 2020 public health emergency, there was limited use of billing for telehealth encounters or applicable codes. The PHE waivers expanded allowable services, provider types and patient locations. Most of these changes were codified into state law with the passing of [Senate Bill 20-212](#) regarding the reimbursement of telehealth services.

Most notably, SB20-212 made the following changes permanent beyond the PHE:

“The act prohibits a health insurance carrier from:

- Imposing specific requirements or limitations on the HIPAA-compliant technologies used to deliver telehealth services;
- Requiring a covered person to have a previously established patient-provider relationship with a specific provider in order to receive medically necessary telehealth services from the provider; or
- Imposing additional certification, location, or training requirements as a condition of reimbursement for telehealth services.

The act specifies that, to the extent the state board of health adopts rules addressing supervision requirements for home care agencies, the rules must allow for supervision in person or by telemedicine or telehealth.

For purposes of the Medicaid program, the Act:

- Requires the Department of Health Care Policy and Financing (State Medicaid department, also known as HCPF) to allow home care agencies to supervise services through telemedicine or telehealth;
- Clarifies the methods of communication that may be used for telemedicine;
- Requires HCPF to reimburse rural health clinics, the federal Indian health service, and federally qualified health centers for telemedicine services provided to Medicaid recipients and to do so at the same rate as the department reimburses those services when provided in person;
- Requires HCPF to post telemedicine utilization data to the state department's website no later than 30 days after the effective date of the Act and update the data every other month through state fiscal year 2020-21; and
- Specifies that health care and mental health care services include speech therapy, physical therapy, occupational therapy, hospice care, home health care, and pediatric behavioral health care.”

Reimbursement and Policy Confusion

RTLC stakeholders aware of this bill widely expressed support for the amendments to Colorado’s existing parity legislation. However, it was found that many providers across the state remained unaware of this change in policy, its permanency beyond the public health emergency, and its impact on their organization. Stakeholders were also not aware of more specific changes such as a previously established in-person relationship with a patient no longer being a requirement for telehealth.

For those that are aware, despite expanded parity legislation, many providers reported complexities, challenges, and claims denials for unclear reasons when attempting to bill for telehealth, and particularly confusion when it came to contracts with commercial payers. Providers expressed uncertainty as to why their claims were being denied in some cases but not others, which services they are allowed to bill for, how claims need to be filled out, which codes or modifiers to use, among other more granular concerns.

Telehealth Tool	CMS	CO DOI Policy	CO HCPF	FQHC / RHC	PHE CMS	PHE HCPF	FQHC/RHC PHE
Text	No	No policy	No	No	No	Yes but need clarity	No
eVisit / secure email / digital E&M	Yes	No policy	No	Yes	No change	Yes but need clarity	Yes
Virtual Check In Telephone	Yes	No policy	No	Yes	Additional codes for audio only	Yes	Yes
Video	Rescinded to clinical and rural locations only	Yes, parity, home acceptable place of service	Yes, parity, home acceptable place of service	No	Yes home acceptable place of service, no geographic restrictions, additional CPT codes	Allowed phone only to be billed same as video visits	Yes
Remote Patient Monitoring (RPM)	Yes	No policy	Yes only home health agency	No	No change	No change	No change
Chronic Care Management (CCM)	Yes	No policy	??	Yes	No change	No change	No change
eConsult	Yes	No policy	No	No	No change	No change	No change
Behavioral Colab Care Model (CoCM)	Yes	No policy	??	Yes	No change	??	No change
Provider type	Limited set	No policy	Limited see notes	Not allowed to be provider	Added PT, OT, SP, Chiro	Added PT, OT, SP	All added as CMS
Network Adequacy Rules specific to telehealth	No	Yes	??	N/A	No	??	N/A

Table outlining policies researchers identified related to telehealth and where specific guidance does not exist, could not be found, or requires further clarification.

There is a need for ongoing guidance and clarification with both providers and commercial payers around what these policy changes mean in terms of allowable billable services, establishing patient relationships, and reimbursement expectations.

Quality Measures

Stakeholders were also largely unaware of recent changes to quality measures related to telehealth and implications on services. For example, in June 2020, the National Committee for Quality Assurance (NCQA) [amended 40 HEDIS measures](#) to update telehealth guidance and reflect the increased use of telehealth by providers.

Remote patient monitoring (RPM) - a modality of telehealth - is shown to be effective at helping to manage chronic disease and improve chronic disease related outcomes. RPM codes are reimbursable by Medicare and private payers, but barriers to reimbursement by Medicaid exist that require further exploration.

Network Adequacy

Stakeholders also expressed concerns regarding narrow networks and patient steering related to telehealth provider networks and commercial payers. For example, if a commercial payer is contracted with a large national telemedicine company such as Teladoc, MDLive, or AmWell, there is concern in the community that payers will steer members towards these contracted telemedicine services or prioritize them over telemedicine services offered by local providers and medical homes. This also relates back to care coordination and data sharing concerns outlined in the technology section of this report.

Colorado Division of Insurance (DOI)

The Colorado Division of Insurance (DOI) released a [draft of proposed rulemaking](#) to provide, “clarity around existing state requirements, to alleviate carrier, provider, and consumer confusion, and provide guidance to carriers regarding current and ongoing requirements for coverage of services appropriately delivered through telehealth.”

Behavioral Health Provider Contracting and Credentialing

There is a shortage of behavioral health providers in Colorado, particularly in rural areas and for providers qualified to serve more specialized conditions or populations. Telehealth has the potential to enable behavioral health providers to rapidly expand and accelerate access to care statewide.

However, behavioral health providers interviewed reported barriers around expanding their capacity and access for serving Medicaid patients due to complexities related to behavioral health contracting and reimbursement. Contracting for behavioral health providers hoping to serve Medicaid members is determined at the regional level by the RAE, and reimbursement rates and contracting requirements vary from region to region. These challenges are outlined in greater detail in the Behavioral Health Task Force report, and are one of the areas Colorado’s new Behavioral Health Administration will seek to address.

Does Telehealth Cost Less to Provide?

A recurring topic of discussion throughout the RTL process was whether or not telehealth services cost providers less than in-person services. While studies show that telehealth services can and do reduce costs over time, direct costs savings to providers are not immediate. Rather, offering telehealth services tends to cost providers more at the outset. Costs and potential savings to providers can be broken down into a few key areas: time and efficiency, capital costs such as technology, staff, or brick and mortar facilities, and potential revenue capture per encounter through reimbursement.

Time and Efficiency

Penn Medicine published a time study in April 2021 comparing in-person tasks for patient appointments with telehealth tasks. Telehealth correlated with an increase of 4.5 minutes per appointment. The perception that telehealth is less burdensome does not bear out in time studies, particularly for providers and organizations new to telehealth.

Comparison of select tasks and average time to complete (minutes)

Select Task	In-person	Telemedicine	Telemedicine incremental
Front desk check-in	2.5	4.0	1.5
Imaging support*		1.0	1.0
Patient rooming/nurse triage	5.0	6.0	1.0
Check-out/surgery sign-up/follow-up scheduling	2.0	3.0	1.0
Subtotal	9.5	14.0	4.5
Incremental staff cost per visit (compensation and benefits)†			\$2.40

* Telemedicine virtual triage/consultation estimated at an additional 30 minutes per visit for 5% of patients (30 minutes x 5% = 1.5 minutes per patient)

This can be explained by the extra time spent gathering patient information and supporting patients and providers with learning and troubleshooting new technologies and workflows. Telehealth programs in their first three years of maturity tend to require more administrative time, not less, to serve patients virtually.

Cost Increases and Cost Savings

In the case of telehealth, interviews and case studies suggest that cost savings or cost reductions due to telehealth implementation are often best observed at the system and patient levels, and cost savings are more impactful in certain areas compared to others, such as in the case of specialty care, behavioral health, or chronic disease management.

Provider Level Overview of Telehealth Potential Economic Impact

	Provider Cost Savings / New Revenue (Positive)	Provider Cost Unchanged (Neutral)	Provider Cost Increase or New (Negative)

Staffing	Provider organizations can leverage telehealth and work-from-home or remote work benefits as an employment incentive, a means to retain semi-retired providers, recruit specialists, employ partial FTE providers, or save on recruitment and relocation costs to rural areas.		Telehealth increases work and workflow complexity for care teams and many stakeholders expressed a need to hire additional staff to support telehealth programming specifically. For example, hiring a dedicated medical assistant to manage telehealth appointments and support providers and patients with telehealth utilization.
Capital Costs		Costs associated with maintaining buildings, cleaning and security services, and other costs tend to remain static as providers still need to maintain in-person facilities and do not decrease with telehealth.	Telehealth requires investment in new or upgraded infrastructure, software and hardware, such as EMR add-ons, videoconferencing software, cameras, etc.
Reimbursable Services	Telehealth offers providers the ability to offer new services (e.g. virtual cardiac rehab, specialty care, integrated care). Studies and interviews show that telehealth can significantly reduce no-show rates for patient appointments. ²⁹		Services typically only available in-person or that are added on to a visit, such as outpatient procedures or vaccinations, are not available through telehealth-only services.
Access and Geographic Reach	Telehealth may increase the reach and volume of existing services. Collaborations with telemedicine-only providers have been shown to be successful in expanding capacity and increasing billable services across several Colorado safety net case studies.	The ability to expand services and geographic reach does not apply to all provider organizations equally and may remain unchanged.	58% of surveyed providers expressed concern about the presence of telehealth-only providers or digital health services disrupting the quality and coordination of care for their patients. Additional concerns include narrowing of networks and patient steering negatively impacting volume.
Quality Measures	Telehealth can be leveraged to strategically and specifically target outcomes and measures for improvement, thus increasing potential revenue capture.		
Hospital-Based Care	Increased throughput, shortened length of stay, readmission reductions		Limited or no ability to bill for procedure codes, such as G0463, detailed below.

Payment comparison of in-person versus telemedicine services for Hospital Outpatient Departments (HOPD)

Medicare payment comparison: Level III established patient office visit

	HOPD		Non-HOPD	
	In-Person	Telemedicine	In-person	Telemedicine
Professional (99213)	\$71.33	\$71.33	\$97.78	\$97.78
Technical/facility (G0463)	\$105.98	\$0.00	\$0.00	\$0.00
Telehealth originating-site fee (Q3014)	\$0.00	\$26.65	\$0.00	\$0.00
Total	\$177.31	\$97.98	\$97.78	\$97.78

Use Case Success - eConsults

eConsults are one of the most powerful ways in which telehealth can be leveraged to reduce overall healthcare costs to a system while simultaneously increasing access to specialty care.

eConsult Versus In Person Cost Comparison					
		Non-HOPD		HOPD	
		In Person	eConsult	In Person	eConsult
Primary Care Referring Provider					
99452	Ntrprof ph1/ntrnet/ehr rfrl		\$36.64		\$36.64
Specialty Care Consulting Provider					
99449	Ntrprof ph1/ntrnet/ehr 31/>		\$73.28		\$73.28
99204	Office o/p new mod 45-59 min	\$169.93		\$148.09	
G0463	Technical/facility HOPD			\$105.98	
	Total Cost to HCPF	\$169.93	\$109.92	\$254.07	\$109.92
	Savings per patient		\$60.01		\$144.15
	Savings by using eConsults for unmet need 167,000 visits instead of in person		\$10,021,670		
Savings by using eConsults for unmet need 167,000 visits instead of in person					
If HCPF convert 167,000 visits to eConsults they save					
* Majority of speciality care providers are employed by hospital systems					
Another questions to answer what is HCPFs current # of specialty visits per year. If we convert 10 or 25% to evisits what is that volume # and cost savings					
MUST CLARIFY IS HCPF PAYS HOPD BASED CLINICS FACILITY FEES					
Financial assumption based on: 1) HCPF reimbursement rate for 99204 2) CMS reimbursement rate for 99452, 99449, G0463					

For example, North Carolina's NC-STeP model, which provides State-funded telepsychiatry econsult services to rural providers, reported in 2020 that they have achieved an estimated **\$32,891,400** in cumulative cost savings to the State⁶. "The primary method of cost savings from this program is the avoidance of unnecessary hospitalization through overturned unnecessary involuntary commitments. Of the 18,233 patients held under involuntary commitment and served by the program, 6,091 have been discharged for further treatment using community resources. This approach has reduced burden for patients and families and reduced cost to state psychiatric facilities, other hospitals, law enforcement agencies, government, and private payers."

Telehealth Financial Sustainability Recommendations

- Maintain reimbursement for audio-only telehealth services and ensure that this is both permanent and clearly communicated to providers and payers.
- Maintain telehealth reimbursement parity for Federally Qualified Health Centers and Rural Health Clinics.
- Efforts by DOI and HCPF to clarify requirements and provide guidance should be supported and maximized wherever possible to ensure that information is reaching both provider and payer audiences across the state.
 - Provide ongoing guidance and clarification to both providers and commercial payers around what policy changes mean in terms of allowable billable services, establishing patient relationships, and reimbursement expectations.

- Provide further guidance to clarify ‘real time chat’ reimbursement policy. Educate providers on criteria, tools for real time chat to be reimbursed, and integrate into the care continuum.
- Educate providers and payers on how quality measures from NQF & HEDIS have changed to incorporate telehealth.
- Partner with telehealth/in-person hybrid service safety net providers to replicate time studies to determine time required for telehealth versus in-person.
- Evaluate and share telehealth literature, resources, and research from the past 10 years on telehealth clinical efficacy.
- Reimburse for eConsults to address specialty care access, including psychiatry, and align with Centers for Medicaid and Medicare Services (CMS) Current Procedural Terminology (CPT) codes for ease of use for health care providers billing all payer types.
- Expand reimbursement for remote patient monitoring to all provider types.
- Require and support providers contracted with Medicaid to connect with HIE to share data. Support should include financial resources and incentives, technology upgrades, and technical assistance to be effective.

Providers and Telehealth

Providers quickly transitioned to virtual care in 2020. They’ve used the full range of tools from text, email, phone, and video. Unfortunately, most clinicians didn’t have time during the pandemic for much training or workflow integration. Additionally, reimbursement has shifted and varies across government and private payers.

With clinics reopening, more services are going back to in-person care. It’s easier for providers and services to go back to in-person. Change management is hard and if there’s not an easy way to do hybrid telehealth and in-person care then providers will go back to in person.

The pandemic forced providers to be innovative and do telehealth with patients. If you pay LESS for video or telephone, providers will do the same services in person because that’s what pays the most. Providers default to services they get paid for. If you want access and convenience for patients, payers must reimburse the same rate for telehealth and in-person care.

Key Challenges and Opportunities for Improvement

Challenges	Opportunities for Improvement
Lack of knowledge/understanding of reimbursement rules	<ul style="list-style-type: none"> ● Maintain and expand telehealth reimbursement parity ● HCPF align telehealth CPT codes reimbursement with Medicare and private payers ● Standardized billing practices

	<ul style="list-style-type: none"> ● Reimbursement education on an annual basis
Reduction of screening due to pandemic and lack of electronic tools to collect information	Leverage software solutions to provide screening tools to patients. Ensure multilingual access.
Lack of access to specialty care	Support and expand econsult services
Patient support and digital literacy	<ul style="list-style-type: none"> ● Support providers in identifying and leveraging resources for patient technical support ● Provide digital literacy tools to clinicians ● Utilize audio only, email, text, and other tools to connect patients with technology barriers in addition to video
Provider IT support	Organizations need to designate IT and technical support to providers for virtual care tools
Provider telehealth training	Virtual care training specific to workflow, clinical skills for telehealth, technology training, scripting for clinicians and office staff for patient recruitment to virtual care
Clinical workflow redesign for hybrid and in-person care models	Evaluate the continuum of care and incorporate all types of virtual tools to provide a full-service hybrid model. Implement workflows customized to hybrid virtual care model
Workforce Shortage	<ul style="list-style-type: none"> ● Utilize telehealth for 1-to-many services. ● Group visits, asynchronous, triage tools, evidence-based algorithms

Recommendations

- Establish a Colorado Innovation Resource Center
 - Provide clear, up to date, centralized information on ever-evolving telehealth policy and regulations
 - Guidelines and best practices
 - Training and education
 - Program development and implementation support
 - Test value-based behavioral health innovation models
 - Vendor procurement guidance and support
 - Funding support for operational implementation
 - Streamline and coordinate efforts to minimize duplication

- Provider Training for Virtual Care
 - Training series that include website manners, clinical demonstrations of telehealth customized to speciality area, back tech overview and support. Training conducted live for real time Q&A and recorded for later use
 - Template scripts for office staff and providers to recruit patients into telehealth
 - Creation of culturally competent digital literacy tools for patients and care givers
 - Reimbursement training for administrators and staff
 - Workflow redesign training to incorporate virtual care across the care continuum using human centered design

- Colorado Funding Support
 - Grants and funding mechanism for implementation and training are needed

OeHI Telemedicine Projects Successes and Barriers Report

When OeHI conducted kick-off meetings with each of their 34 safety net provider grantees implementing telehealth programs, they were able to identify some of the key successes that participating providers have experienced while utilizing telemedicine. Some of the key successes highlighted were a decreased no show rate to appointments (Clinica; Mind Springs), and in turn, higher frequency of visits (Montrose Memorial; IDEA; D. Vo). Many patients have reported to their providers that they prefer telehealth appointments over in person appointments, and plan to continue using telemedicine in the future even as the pandemic comes to an end for risk avoidance and convenience. Many clinics reported decreased exposure to COVID-19 for both providers and patients when able to use telehealth appointments rather than in-person appointments.

Throughout the COVID-19 pandemic, clinics have adapted to utilize telehealth for physical, mental, and behavioral health purposes.

Success Categories:

- | | |
|---|---|
| 1. Decreased no show rate | 7. Increased ability to assess behavioral health |
| 2. Higher frequency of patient visits | 8. Increased use of telemedicine to treat behavioral health |
| 3. More patients being seen | 9. Decrease of unnecessary ER visits |
| 4. Maximization of patients' and providers' time | 10. Decreased risk of COVID-19 exposure |
| 5. Increased convenience for patients and providers | |
| 6. Increased access to providers, especially for folks in rural areas | |

Barriers Summary:

OeHI identified a variety of key barriers to utilizing telemedicine for these providers, including but not limited to broadband and internet accessibility; language; technology literacy; access to technology; age;

income; consent; and security issues. At least ten participating health clinics reported that there is a high need for increased broadband connection and speed in order to implement telehealth services.

Barrier Categories:

- | | |
|-------------------------|-------------------------|
| 1. Connectivity | 5. Technology hesitancy |
| 2. Language barrier | 6. Income |
| 3. Technology literacy | 7. Consent |
| 4. Access to technology | 8. Security |

Patient Experience

Digital Navigation

Additionally, many consumers - and providers - struggle with using new and changing technology. Providers shared that consumers need support with things like setting up an email address, learning to use patient portals, downloading applications, navigating technology, or connecting to video visits. Providers do not have funding for adequate IT teams or dedicated staff currently to support patient training and digital navigation.

Solutions: Some providers are leveraging 15-minute targeted case management codes to support patients in getting set up with telehealth for the first time, and reported great success with this approach. This code is not reimbursable for FQHCs, however, despite FQHCs being the organizations that reported the greatest need in their patient populations for technology navigation and training support.

Colorado Access has an innovative model allowing care managers to refer to their internal telehealth team at AccessCare Services to provide technology support to members that has shown efficacy and success.

One potential option to consider is whether care management resources at RAEs or with contracted providers could be leveraged to provide digital navigation and support services to patients.

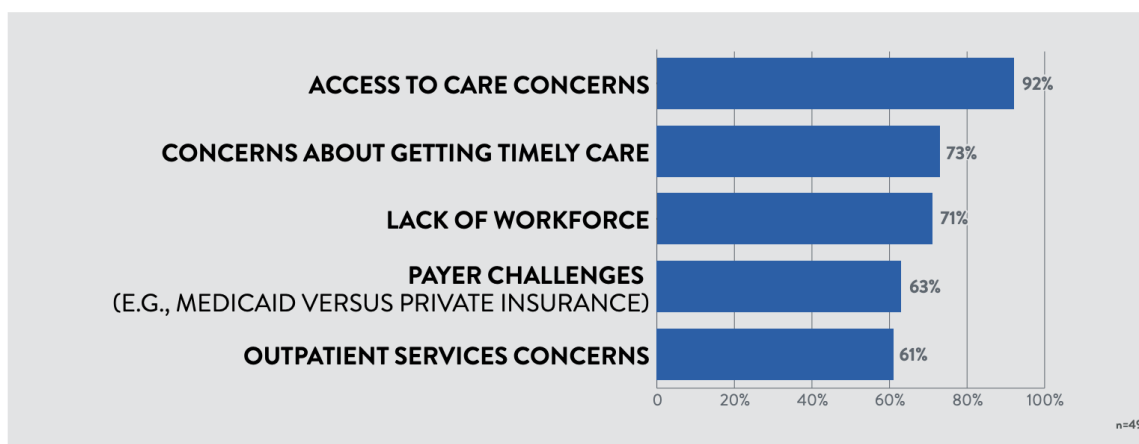
Many organizations reported that calling patients on the phone in advance of the telehealth encounter, particularly for patients new to or experiencing challenges with telehealth, was incredibly helpful and improved the quality of the video visit, along with provider and patient experience.

Another potential solution is to explore peer support and volunteer models locally and nationally that could be leveraged to support consumers peer-to-peer in learning and getting comfortable with new technologies. Stakeholders cited examples of senior volunteer programs, where seniors teach other seniors how to use new healthcare technologies.

Colorado providers quickly implemented telehealth services during 2020 but accessing healthcare services is a confusing maze of information and resources. With an influx of new Coloradans joining Medicaid due to job loss and the increased strain in people's mental health because of the COVID-19 pandemic, we need a clear and single point of entry for those in need of care. A whole person approach

that considers mental health as well as physical health is needed. Below is a summary table of findings that related to key themes about patient experience using telehealth.

TABLE 1. THEMES TASK FORCE MEMBERS HEARD FROM COLORADANS WHO SHARED THEIR STORIES



Key Challenges and Opportunities

Challenges	Opportunities for Improvement
Without a single point of entry the burden's on the person in need of services to determine where and how they can access their care	A single point of entry digital front door
Lack of access to specialty care	eConsults Specialty Care
Patients have struggled getting connected to technology, downloading apps, accessing patient portals. The lack of digital literacy challenges providers to broaden telehealth services	Digital literacy course through community engagement and digital front door with culturally competent instructions about accessing behavioral health, telehealth and other services
Different patients have different needs	Utilize S-HIE, care coordinators, in person, telehealth or hybrid models to provide whole person care
Digital divide leaving rural and unhoused patients without access to low cost internet and cellular coverage.	Continued alignment with OeHI broadband funding. Utilize community resources for programs that provide stipends and/or technology to patients
Need for more peer support models	Explore clinical innovation and community based

health models with technology

Without a single point of entry, the burden of determining where, how, and when to access services is placed on the consumer. A digital front door for identifying and accessing services, especially for Medicaid beneficiaries, could address many challenges simultaneously in one solution.

A digital front door supports all six pillars of a strong behavioral health system, and at least nine of the 19 recommendations in the Behavioral Health Task Force Report.¹⁸ Digital health technologies in general support all 19 recommendations in the report.



Digital Front Door	
Whole Person Care, Access, Local and Consumer Guidance	<p>Provide easy to use app with desktop available to locate provider and services through a consumer self-service portal for Colorado</p> <p>Access to a person's complete longitudinal information across payers and providers</p> <p>Insurance verifications, consents, preferences for service delivery in person, telehealth or hybrid</p>
Whole Person Care, Workforce, and Accountability	<p>Allow care coordinators in the back end of the software to create the 'regional support structure for care coordination that connects the dots on patient care. This will provide Coloradans with safer, more affordable and effective care.' Behavioral Health In Colorado A Blueprint, Sept 2020</p> <p>Care coordinators access statewide resources and address SDOH using S-HIE</p> <p>Using insurance information and real time authorization monitor where state funds are going to mental health. "Cross-agency data sharing, as well as consolidating non Medicaid funding and programs, could generate</p>

¹⁸ [Behavioral Health In Colorado: Putting People First. A Blueprint for Reform](https://drive.google.com/file/d/1IWVIG3IHPM8OUgVFgLuqWFn8waqgUseZ/view). (Sep 2020).
<https://drive.google.com/file/d/1IWVIG3IHPM8OUgVFgLuqWFn8waqgUseZ/view>

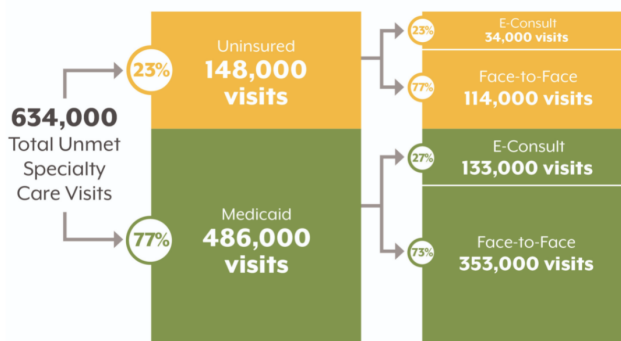
savings for the State due to reduced administrative costs. Having one entity responsible for consolidating and overseeing all of the State’s behavioral health funding beyond Medicaid could ensure that the changing needs and availability of services across Colorado are monitored” Behavioral Health In Colorado | A Blueprint, Sept 2020

eConsults For Access To Specialty Care

In 2019, the Colorado Health Institute found that 634,000 needed specialty care visits in Colorado went unmet.

CU School of Medicine, Kaiser Permanente, Colorado Access/Access Care Services and Denver Health have active eConsult programs and can serve as advisors to HCPF as they create the eConsult program. Additionally, the architects of North Carolina’s national recognized best-in-class econsult specialty care model participated in the RTLC process and have offered their support as well.

Figure 1. Unmet Demand for Specialty Care among Adults (19-64) Without Insurance and Those Enrolled in Medicaid, Colorado



Success Story: CU School of Medicine has 26 adult specialties and 22 pediatric specialties, conducting more than 10,000 eConsults since April 2018. 95% of PCPs reported high satisfaction with the eConsult services received from specialists. Alternatively, for in-person care most of these visits would have required a 30+ day wait time. Instead, PCPs received access to specialty care in 2-3 business days. One South Carolina study found that telehealth services reduced patient wait time to see a psychiatrist from 10 days to four hours. Additionally, eConsults support Patient Centered Medical Home models by keeping the patient in the primary care setting and maximizing primary care provider services and capabilities.

Coloradans want a hybrid model of in-person and telehealth options

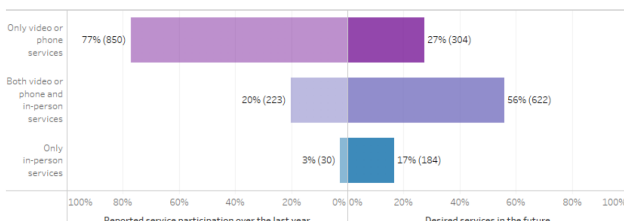
In the [Telehealth Impact: Patient Survey Analysis](#) national survey of 2,007 patients, 70% of patients reported that they would prefer virtual visits over in-person visits to save time.

Mental Health Center of Denver (MHCD) conducted their own patient survey⁷⁹, finding similar feedback from their patient population.

Desired services for the future

Of the 1,110 respondents who answered this question, 83% said they would like to receive some sort of video or phone services and 73% would like some sort of in-person services from MHCD. With most people (56%) wanting to have both types of services available to them.

Almost a third (27%) of respondents want to only receive virtual services in the future and a little over half (56%) want to participate in both virtual and in-person services. Seventeen percent of respondents want only in-person services when those are available.



Desired services for the future

When COVID restrictions are lifted, what MHCD services would you like to receive over **video or phone**?



- Therapy and psychiatric services
- Medication management
- Check-ins
- Groups

When COVID restrictions are lifted, what MHCD services would you like to receive **in-person**?



- Therapy and psychiatric services
- Case management

Saving People Money on Health Care

A significant contributing factor to patient preferences and high satisfaction rates with telehealth services, including audio-only services, is the significant cost savings associated with virtual visits. Telehealth enables consumers to save money on costs associated with missing work, childcare, transportation, and long distances to providers, sometimes requiring overnight stays and lodging expenses. Telehealth also enables faster access to services, leading to less sick time, faster treatment and relief, and increased compliance and adherence to treatment protocols.

Patient Cost to Receive In Person Care Average Appointment Time 15 - 30 minutes	
Time Off Work	\$15 per hour wages x 8 hr missed work = \$120 income loss AND percentage of weekly income/monthly income
Bus To/From Appointment	2.5 hours x round trip = 5 hour time loss
Child Care Cost if Needed	\$15 per hour wages x 7 hours = \$105 potential cost
Patient Cost to Receive Virtual Care Average Appointment Time 15 - 30 minutes	
Time Off Work	\$15 per hour wages x 1 hr missed work = \$15 income loss
Child Care Cost if Needed	\$15 per hour wages x 1 hours = \$15 potential cost
No Transportation Needed	No Time Lost
ADD above	Medical transport estimate - cost to HCPF

RECOMMENDATIONS

- Digital front door single point of entry for mental and physical health
- eConsultation reimbursement for HCPF
- Community engagement on human centered design for patients

Prioritizing Patient Needs

Barriers:

- With telehealth, patients have the ability to access their appointments anywhere.

- Providers have concerns that patients are completing their appointments while they drive, shop, etc. Providers are concerned that patients are not giving their full attention to the consult and they'd like for patients to meet them where they are so providers can use their best practices/preferences.
- How do we match the providers best practices/preferences to the patients' desires/needs? Leverage best practices from successful direct to consumer digital health companies with success in engaging patients, such as MISTR, NURX, Plume, and others.
- With the current payment models, practices are encouraged to overload activities into visits in order to meet the financial ends.
 - The overload of activities does not necessarily meet patients where they are.
 - There are payment requirements that require in person screenings and with telehealth, some of these screenings can't be met.
 - There is a need to discuss how to balance where patients are at and what they need specifically in relation to primary care.
- Clinics are already doing all the SDOH screening already even without any payment changes because it is the right thing to do for patients
 - Coding might not be done correctly, it's just being done.
 - There is an opportunity for reimbursement as related to coding.

Solutions:

- Creating human centered design models for care and services
- Create different standards/expectations for visits
- Let patients set their own health goals and priorities and find ways to capture that information while matching that to standards/expectations for visits

Access and Enrollment

Barriers:

- Lack of electronic documentation for certain waivers/documents/forms
 - *Example - an organization they had to physically drop off a large document to be reviewed and signed*
- Websites and Apps that are not user friendly
 - Conflicting information/workflows
 - Multiple steps to verify the submission of documents
 - Impractical contacts available to patients for troubleshooting
 - Information provided through tech support is very challenging to follow for users
 - Consumers are being kicked off of Medicaid for minor issue in the enrollment and verification process
 - The mobile apps are not as accessible as the browser versions

- Users are not aware of the services available to them and how to access them Accessing available services
- Lack of consumer awareness of what is available for access and where to look for them
- Non inclusive intake forms including gender, race and ethnicity, preferred name, language used
 - Respondents have felt offended by the last version of gender question
 - Website does not make their lists based on the primary target population therefore users don't feel that the website is inclusive
- A patient portal would be a tool to help some but it would not reach everyone

Solutions:

- The usage of technology in the enrollment process may improve some of these barriers
- Improve the consent process using a more standardized and centralized approach.
- HIE already has the agreements in place for the clinical data to provide access to the data. HIE has been working with the telehealth providers so that they can access the patient history. Providers need to have bidirectional access to the HIE.
- Centralization using a digital front door would allow for people to navigate to services that they want and need most.
 - Implementation of a master patient index and identifiers with the technology tools would be needed
- Short term solution for the PEAK. Since this is an existing system, it would be worth investing in improvements
 - All benefits should appear together to help customers keep track while updating their information
 - Fix broken links, make sure phone numbers are correctly posted
 - Improving the follow-up process of submitting documentation, checking communications and keeping track of and understanding status changes
 - Ensure consumers know how to expect communication and the tools for them to communicate
 - Email? Letter? Text? Phone/Voicemail? Secure portal message?
 - Create a mobile friendly version site or app. For many with low incomes, especially with jobs that do not require or provide a computer, mobile web access is often the best, or maybe even only, access point.
- Take cultural considerations for access points in the systems
- Create a regional digital front door within the RAE regions.
 - Keep the database current for who is accepting which insurance or services
 - Standardize databases across regions to ease training

Digital Literacy

Barriers:

- Access to technology and the level of success have been but not at the same level for all patients
- Connectivity issues are also a barrier
- It is challenging for patients to remember information related to technology
 - login, password, email, navigation, volume, microphone etc.

Solutions:

- The implementation of interpretive services
 - Spanish is the most common language
 - *MindSprings utilizes Stratus Video - medical language translation platform used.*
- Most providers in the behavioral health space have been giving out devices and info sheets and that deployment has been working well.
- A similar concept to the Nurseline has worked really well
- Implementation of self assessments
- Create a step before the step
 - Infuse a little more fun and get patients engaged with technology in a safe and non threatening way and before they are sick.
- Community care alliance does a lot of training with the care coordinators.
 - Check-ins with patients have been done mostly by phone and telehealth.
 - DDRC has been using the phone check ins with people the more accessible the better where a caregiver can assist them
 - Helped to decentralize the info from the provider to the patient
 - Telehealth has opened up the information and communication exchange.

Data Access

Barriers:

- Patients lack access to their own data/information
- Providers lack access to patient data with concerns about regulatory violations.
- Telehealth providers are missing patient history

Solutions:

- Allow patients access to their own data!
- OeHI as a level of coordination local or state regs to support the work
- Strengthen patient identification and verification and leverage CO digital cards.
- Federal level digital age with EHRs and HIE - digital footprint of the information adds the policy referenced 2 year ramp up/implementation period that requires all providers, vendors, clinics etc to comply.

Public Health Promotion

Barriers:

- Many people, especially those with chronic conditions, are unsure of where to start in finding information for services or providers.

Solutions:

- Give patients choice and give them a right to chose their care
- Billboards on buses or in the city and virtual billboards that are helpful
 - Implement them in rural areas
- Leverage current marketing and promotional tools including social media that exists to help educate the public
- CDPHE doing more public health education campaigns support the counties and campaigns on public education

- Expand public education regarding community resources
 - Ex - utilizing buses to access maternal health services etc. to other communities.

Access to Providers

Barriers:

- Access to care: pediatric psychologist supporting 11 clinics simultaneously vs 44 hours of drive time

Solutions:

- Partner with local health providers so they can access specialists
- How can we create virtual options to make it not so siloed

Regulatory Changes

Barriers:

- Federal regulatory changes are set to expire soon
- Process enrollment applications
- Websites and apps
- Streamlining communications
- Keep regulatory flexibilities

Solutions:

- CCDC would need to meet with them about the folks who specifically need the services
- Colorado health policy coalition
- Allowing phone visits to continue
- Can PH help to vet and validate the technology solutions to help address some of the issues that patients are experiencing?

Evaluation

Barriers:

- Websites, platforms, tools, and resources have not been adequately evaluated for their accessibility, user experience, language, and overall usability.

Solutions:

- Secret shoppers in the community could be used to evaluate different systems and elements
 - Would need to have tester Medicaid IDs
 - *AllHealth Network has a secret shopper program that is an outside agency.*
- Independent contractor for all of the state sites that are being accessed for services including cultural relevance and language accessibility

Care Coordination

Barriers:

- Financially sustaining care coordinators

- Are there clinics/hospitals that are interested that could help build a billable program
- The pops that we can find funding for are very siloed and employer groups mostly
- Some insurance plans allow to bill care coordination
- There is a need for more behavioral and mental health

Solutions:

- Find if there are specific codes that can stand out to better bill for services
- Regarding mental health some RAEs want to bill at the facility and some want them to bill at the non facility rate
 - HCPF did provide some guidance. What was the resolution?
- Telehealth plays a big role in home hospice, end stage, and palliative care
- Care coordinators have a compiled list of resources per region
- Implement the communication with patients regarding resources via telehealth
- Rocky mountain has set forward the tool essett to help coordinate the coordinators
- Have we resolved these issues with compliance?

Value Based Care

Barriers:

- Moving to value based care from widgets
- Reimbursement for behavioral health tied into coordinated care

Solutions:

- State has done a great job with opening codes for behavioral health
- The current RVU schedule has some flaws and policy improvements to be made which is good

Broadband & Technology

Barriers:

- Interwoven with broadband and internet access issues and device access
 - Example: patients had a hard time logging on while other people in their households were also logged on to school or something else
- Over 65% of the population really jumped on the bandwagon to use telehealth services in Haxtun, yet the facility does not yet have the ability to get beyond phone visits.

Connection to Human Services

How is the healthcare system working with the human services system and how can they symbiotically keep organizations sustainable

Behavioral Health

RMHP easy care platform from CirrusMD continually monitoring and patient enrollment is more simplistic.

Behavioral health moving towards measurement based care; multiple companies marketing psychometric tools but they don't integrate with EHR and how do you do that via OWL out of Tennessee

A problem that many providers have is around remote patient monitoring, there are now open codes but they still don't integrate into the EHR contain cost, less of a burden the cost of IT interfaces are so burdensome for organizations. They are forced to choose between providers and the cost of IT.

State Initiatives

Care coordination: standards for sharing across social agencies and providers

ECQM

Need to standardize across state

Statewide Governance

Information in the state governance guidebook

Physical & behavioral health data sharing in health crisis

What are we currently allowed to share - providers can actually share more than they have been.

Improve information sharing across the state

Resource:

<https://www.chhs.ca.gov/ohii/shig/>

Our Guidebook is based on the CA SHIG

Key Takeaways: What We Heard

Public Health Promotion

Barriers:

- Many people, especially those with chronic conditions, are unsure of where to start in finding information for services or providers.

Solutions:

- Give patients choice and highlight that patients have the right to choose their care
- Billboards on buses or in the city and virtual billboards that are helpful - already happening in more urban areas, is this as effective in rural areas?
- Leverage current marketing and promotional tools including social media that exists to help educate the public.
- CDPHE doing more public health education campaigns support the counties and campaigns on public education.
- Expand public education from progressive places that are already utilizing buses for how to access maternal health services etc. to other communities.

Access and Enrollment

Barriers:

- *Example - one org has to get people enrolled in different waiver programs; they had to physically drop off a large document to be reviewed and signed. Electronic documents greatly reduced the time to get patients enrolled.*

- Consumers lack awareness of what is available and where.
- There are problematic websites and apps.
 - workflows, conflicting information, you don't sign up one time you have to verify that documents are properly submitted, that it is very difficult to contact a person for help and oftentimes the information that they provide is very challenging.
- Consumers are being kicked off of Medicaid for minor issue in the enrollment and verification process
- The mobile apps should be just as accessible as the browser version.
- First barrier is of course awareness of available services, but accessing the services can be the next major barrier.

Solutions:

- Perhaps barriers can be eliminated using technology in the enrollment process.
- Improve the consent process using a more standardized and centralized approach.
- HIE already has the agreements in place for the clinical data to provide access to the data. HIE has been working with the telehealth providers so that they can access the patient history. Providers need to have bidirectional access to the HIE.
- Centralization using a digital front door would allow for people to navigate to services that they want and need most.
- Need to have a master patient index and identifiers and the technology tools to make that happen.
- Short term - bolster PEAK app still has a lot of challenges and this is an existing system that we can invest in.
 - Should have all benefits in the one app to help keep them on their benefits, update their info, shop services
 - simple, diligent quality control on things like making sure correct phone numbers are posted, links are not broken.
 - Preventing trapping users in circular logic chains goes a long way to making it easier for patients to gain access.
 - Improving the follow-up process of submitting documentation, checking communications and keeping track of and understanding status changes.
 - Ensure consumers know when to expect a message and through which channel. Email? Letter? Text? Phone/Voicemail? Secure portal message?
 - Create a mobile friendly version site or app. For many with low incomes, especially with jobs that do not require or provide a computer, mobile web access is often the best, or maybe even only, access point.
- Create user friendly access points on websites or platforms that we are using.
- Healthcare is a very culturally based service - need to take into consideration the different cultures and the access points in the system.

Data Access

Barriers:

- Patients lack access to their own data.
- Providers lack access to patient data and are concerned about regulatory violations.
- if you are a telehealth provider- the one piece that you are missing the patient history - anticipate many people participating in this

Solutions:

- Allow patients access to their own data!
- OeHI as a level of coordination local or state regs to support the work
- Strengthen patient identification and verification and leverage CO digital cards.
- Federal level digital age with EHRs and HIE - digital footprint of the information *add the policy referenced* 2 year ramp up/implementation period that requires all providers, vendors, clinics etc to comply.

Regulatory Changes

Barriers:

- Federal regulatory changes are set to expire soon
- process enrollment applications
- websites and apps
- streamlining communications
- keep regulatory flexibilities - what is it to include

Solutions:

- CCDC meet with them about the folks who specifically need the services
- Colorado health policy coalition
- allowing phone visits to stay
- Can PH help to vet and validate the technology solutions to help address some of the issues that patients are experiencing?

Evaluation

Barriers:

- Websites, platforms, tools, and resources have not been adequately evaluated for their accessibility, user experience, language, and overall usability.

Solutions:

- Secret shoppers in the community could be used to evaluate different systems and elements (would need to have tester Medicaid IDs)
- *Example - AllHealth Network has a secret shopper program that it is an outside agency.*
- Independent contractor for all of the state sites that are being accessed for services including cultural relevance and language accessibility

Key Takeaways: What We Heard

Patient Access to Services

Barriers:

- Complex and fragmented entry points into the healthcare system.
- Even if we had one digital front door - not sure what help they might need and who to ask.
- A patient portal would help many people but wont reach everyone.

Solutions:

- Create a regional digital front door within the RAE regions.
 - Keep the database current for who is accepting which insurance or services.
 - Give people choice.
 - Standardized across the regions which helps with training.

Digital Literacy

Barriers:

- *Example - DDRC just completed a survey and found that in their write in responses they identified access to technology and the level of success in the younger populations. Resource coordinators making sure that people have an emergency fund called the 25th hour and mostly being used for phones.*
- Connectivity issues come up a lot for people.
- It is challenging for patients to remember how to use the technology - login, password, email, navigation, volume, microphone etc.

Solutions:

- Interpretive services are available with telehealth.
 - Spanish is the most common
 - *Example - MindSprings utilizes Stratus Video - medical language translation platform used.*
- *Example - DDRC has been using the phone check ins with people the more accessible the better - many people have a caregiver that can assist them.*
- Most providers in the behavioral health space have been giving out devices and info sheets and that deployment has been working well.
- The Nurseline concept worked really well in this country in the past - perhaps a similar concept.
- Create self assessments that people could take.
- Create a step before the step - this is easy, it feels safe, I can get the info that I need. Infuse a little more fun and get patients engaged with technology in a safe and non threatening way and before they are sick.
- Community care alliance does a lot of training with the care coordinators.
 - Check ins with patients have been done mostly by phone and telehealth.
 - Helped to decentralize the info from the provider to the patient.
 - Have seen a significant impact of the care coordinators.
 - Telehealth has opened up the information and communication exchange.

Care Coordination

Barriers:

- Financially sustaining care coordinators
 - predominantly through insurance but if there is a clinic/hospital that is interested then they will help them set up a billable program
 - the pops that we can find funding for are very siloed and employer groups mostly
 - some insurance plans allow to bill care coordination
- want to see more behavioral and mental health

Solutions:

- Are there specific codes that stand out to better bills for services?

- for mental health some RAEs some want to bill at the facility and some want them to bill at the non facility rate. HCPF did provide some guidance. What was the resolution?
- home hospice, end stage, and palliative care - telehealth a big role in this
- care coordinators have a compiled list of resources per region
- being able to communicate with patients about these resources via telehealth
- rocky mountain has set forward the tool essett to help coordinate the coordinators
- there were some behavioral health policy issues that they encountered
- have we resolved these issues with compliance?
- internal care coordinators, integrative care, and community partners have access to the

Value Based Care

Barriers:

- Moving to value based care from widgets.
- Reimbursement for behavioral health tied into coordinated care.

Solutions:

- State has done a great job with opening codes for behavioral health
- The current RVU schedule has some flaws - policy improvements to be made which is good.

Successes and Case Studies

Reviewing Current Models and Work

CORHIO Telehealth Support

- want to see it scale and leverage the infrastructure in place
- Dr savage and care on location, simplify care summaries when they provide a service and send back to their PCP
- important to use different tools for data distribution
- relatively low implementation barrier with this Ako
- clinical providers - access consolidated care summary and so it can be shared, hyperlink through to specific data to make it easy to read
- meaningful use - EHR needs to have the functionality as mandated
- allows all providers, orgs both big and small, to access information
- not siloing telehealth encounters from any other visits that they may have
- Example: HealthONE receive registration from ER and send them back a consolidated patient history and extra step into their EHR system Meditech
- As long as using an EHR or solution that is capable of sending a direct message, the integration is relatively simple
- connection in the first time for each EMR
- can access through the portal or send messages
- works very well with cloud hosted or

PEAK

- PEAK is responsible for about half of all new members and $\frac{2}{3}$ applicants are coming through smartphones
- hole in the middle for smartphones - has been identified and working on addressing
- know they need the tool to be fully operational on all platforms before the PHE ends

- analytics have been able to show what the customers want
- anticipating that 60% to $\frac{2}{3}$ will
- 80% of revalidations through online portal which will free up the county offices to shift resources and deal with the more complex cases of long term care, appeals, evaluations etc.
- planning to expand into the other programs like snap
- conversations with DOC to make sure that their benefits are ready to go prior to them to reentering
- One of the reasons PEAK is still not the answer, is that the eligibility criteria differ. PEAK already CAN collect all the data for SNAP, WIC, LEAP, etc. However, SNAP requires an "interview" so someone cannot immediately be signed up and the interview process is awful even in "streamlined" counties. Now, if someone qualifies for SNAP, Medicaid should be an automatic signup.

RMHP and Cirrus MD

- on demand telehealth plan Medicaid, CHP++, and free to patients
- chat with a therapist platform currently being revamped and promoted through curated apps on Colorado Health First
- <https://www.easycareco.com/>
- 1700 outcomes resolved
- 22% diverted from urgent care
- seen increase in utilization
- Are you sharing with other RAEs? Are other RAEs doing this in some way? How is this affecting safety net clinics or FQs which HCPF cites as wanting to make sure they stay supported and this could reduce volume from them also, right?
- The platform is designed to be complementary to primary care. We also see the platform as a means for primary care practices to meet after-hours care needs.

Continuity of Care

- local provider inclusion
- KCHD wants to have their providers included
- in the plans want to include a tier that accounts for local providers
- The possible model could be that a telehealth provider must be and/or must have an agreement with a safety net provider and/or the attributed patient's provider to maintain continuity of care.
- There is an argument our clinics support that needs more work to determine if it is realistic or not that in Medicaid there is an increased need for holistic care because the wrap-around services needed by patients are not easily apparent and the trust built with the provider is what gets the patient the SDOH services they need to reduce healthcare costs. Telehealth by an independent provider disrupts this additional benefit in a clinic.
- One of the beefs with the Teledocs of the world is that sometimes (again, no data, just conjecture) there are calls that are made and then the person is told that they need to see a doctor. This is frustrating on so many levels. So, the idea that a telehealth-only provider will take all comers may be a problem if this is the majority of the calls. Are there efforts to discern this by any of the insurance carriers or RAEs?
- Usability should match the level of internet and broadband access
- At what point do we take control of the interface for telehealth and digital front doors?
- Decision trees need to be standardized and made
- Patient Centered Medical Home practices have been taught to "own" their patient. This flies in the face of that. What's HCPF's direction on that? Also, we would have to talk about disruption

of the attribution process. Medicaid has some internal conversations before going down this road. I'm also interested in the NON Medicaid population if we are solving for more than just Medicaid. Uninsured people should have access to telemed and since most uninsured right now are 20-45 years old, what can we do about that?

- Attribution needs to leave more room for culturally diverse populations

Data Connectivity with CCMCN

- data that they are reporting on the clinics would generally have to pay for
- some dashboards in development as a tool and have 3 years of additional funding to extend and expand that project
- EPHC collection of hospitals - how can they leverage each other and how do they collaborate and coordinate care
- WHA working with CRHC as well to see if they can leverage a group purchasing power working on the last 6 months

Acute Care/On Demand Vs Primary Care and Wrap Around Services

- **Examples of telehealth tools to deliver clinical care:**
 - Rural or urban patient home with smartphone, internet but no cell coverage
 - Low bandwidth video systems that run at 25 mbps
 - Video, telephone, text, email
 - Patient accesses virtual front door via internet desktop at home and on the app when has cell coverage
 - Patient Persona - rural, female, latinx, diabetic with depression, spanish speaking
 - Add payment as cost to consumer/patient, show out of pocket, insurance, copay, transportation for patient (own vs med transport)
 - Rural or urban patient home with smartphone, cell coverage but no internet
 - If unlimited data low bandwidth video systems that run at 25 mbps
 - Video, telephone, text, email
 - If data restrictions NO video
 - Telephone, text, email
 - Patient accesses virtual front door on the app when has cell coverage
 - Patient Persona - urban, male, transgender
 - Rural or urban patient home with no cell coverage and no internet and video visit is needed
 - School
 - Library
 - Church
 - McDonalds
 - Starbucks
 - The goal is to be close enough to the building to get wifi on your smartphone.
 - Patient accesses virtual front door on the app when has cell coverage (not at their home)
 - Patient Persona - urban, female, youth in foster care
 - Rural or urban patient home no smartphone but has the internet
 - Low bandwidth video systems that run at 25 mbps
 - Video if computer has camera
 - Telephone, text, email
 - Patient accesses virtual front door via internet desktop at home

- Rural or urban patient home no smartphone and no internet and no car
 - Telephone, text
 - Patient accesses the virtual front door via a telephone call to a human to help them. This can't be automated because there are too many steps and cannot be designed to a phone tree.
 - Virtual front door text confirmations and reminders can be sent to this patient
 - What are hours of service?
 - Patients need to be able to leave a message for return call
 - Patients can be given technology for specific services through care provider
 - Patient Persona - female, depression, single mom
 - Wait time to get services, crisis stabilization, MERU model, peer support/promotora services

Examples of powerful, effective, innovative models that patients like, that get great outcomes, and that there's currently no place for in the system

- E.g. Minecraft, Tbuddy, promotora, peer support, group therapy, virtual community spaces, etc
- These models are typically heavily human centered design and loved by consumers but no reimbursement pathway
- Innovation Lab should think of ways to test and pilot these models and new reimbursement/policy mechanisms to integrate these effective services in broader healthcare
- aligns with BHTF Report

Western Slope

- Rocky Mountain Health Plan (RMHP), Quality Health Network (QHN), and CirrusMD have an established telehealth model leveraging the Health Information Exchange (HIE) to support care coordination, care continuity, and data interoperability between the RAE, telemedicine provider, and local primary care medical providers (PCMP). This bidirectional model allows both PCMP and CirrusMD to have real time access to longitudinal clinical records, information regarding where clients may be receiving care elsewhere, and referral pathways for CirrusMD to direct clients to primary care for ongoing services and follow ups. RMHP is currently exploring adding behavioral health to this model in partnership with Heart Centered Counseling to expand access and coverage for behavioral health services in remote areas of the region.
 - to be mapped
 - Can be expanded by RAE
- Collaborative procurement and implementation models for rural hospitals
- Western Health Alliance is an alliance of 29 hospitals and clinics in western Colorado. WHA is in the process of exploring centralized procurement of telehealth solutions to be shared across its members. The RTLC will support WHA in this process and explore collaborative buying power as a means to support effective cost containment and resource maximization strategies.

Northeast Colorado

Region 2 has some of the most sparsely populated counties in Colorado. Lincoln County, for example, has two residents per square mile, serving a total population of approximately 6,000. The population of Ft. Collins alone is roughly 168,000 people. Frontier counties experience unique financial and workforce challenges, struggle to connect with the HIE, and have different technology and internet infrastructure, including electronic medical records, that often prevent data interoperability. Such wide variances in population density and resources within one RAE region must be taken into consideration when developing equitable statewide strategies for telehealth.

Alternative strategies for behavioral health

Region 2 has two Community Mental Health Centers (CMHC): Centennial Mental Health Centers and North Range Behavioral Health, both of whom provide behavioral health services and are part owners of Northeast Health Partners. Region 2 is also home to Heart Centered Counseling, a large behavioral health practice serving regions 1, 2, 3, and 5, and heavily engaged in telehealth statewide. Elsewhere in the region, several frontier hospitals in the Eastern Plains Healthcare Consortium have received grant funding to add their own telebehavioral health services onsite. Finally, North Range Behavioral Health, Adams County, and Northeast Health Partners are piloting an exciting and powerful model for telehealth-enabled care continuity for behavioral health for children in foster care. The RLTC will seek to map and understand telebehavioral health services, explore how these programs can improve access to care in the region, and work to coordinate these new behavioral health offerings to ensure seamless patient experience.

Denver/Aurora Metro Area

- Sustainable telehealth for Federally Qualified Health Centers (FQHC)
- Many FQHCs across the state expanded their use of telehealth or began offering services for the first time, including several in the Denver metro area of Regions 3 and 5. These partners have shared that they saw immense value in telehealth as an effective mechanism to care for and support their patient population and are committed to identifying pathways and strategies to keeping, expanding, and more deeply integrating telehealth into their regular services. For example, one FQHC shared that telehealth was so effective in overcoming access barriers for their population that despite having never done telehealth prior to February they are now striving to maintain 30% of services virtually.
- Alternative strategies for behavioral health
- Mental Health Center of Denver has partnered with Prime Health and the Office of eHealth Innovation to conduct a pilot with telebehavioral health solution Meru Health. This solution has the potential to increase access to care, maximize MHCD resources, improve outcomes and reduce costs through potential new payment models. AllHealth Network is another highly innovative mental health center with a number of active telehealth pilots. CMHCs have reported decreases in the no-show rate with the advent of telebehavioral health visits. The RLTC will

explore how this data can be shared to help make the financial case for increased use of telehealth among Medicaid members.

- Strategies to overcome the digital divide
- One of the big lessons learned in 2020 was that many of the assumptions related to technology access in urban areas were inaccurate. Providers in the Denver and Aurora metro region experienced significant barriers in care delivery via telehealth due to a lack of access to devices such as smartphones, tablets, or laptops, as well as a lack of internet access. In some cases, providers partnered with a nonprofit such as PCs for People or purchased their own devices to distribute. Sheridan Health Services, an FQHC in south Denver, is exploring a partnership with public libraries for device distribution and internet access. One goal of this learning collaborative is to identify regional and statewide strategies for access and distribution of devices and funding to support virtual care.

Colorado Access

- How Colorado Access and AccessCare are leveraging Salesforce health cloud
- virtual health care services
- accessing behavioral health
- using salesforce community - have given patients access to licenses so they can login and access all of their information
- had issues with calendar synchronization so have been using calendly to support
- have had a hard time trying to keep up with the demand for services - want to have this so they can communicate with them online
- comprehensive view of the patient - if they need a higher level of care then they connect them to the parent company Colorado access to get them what they need
- Delores project and catholic charity samaritan house projects 6-8 sessions and consider this brief intervention have a hard time getting them connected to further services when they have commercial insurance
- data that they gather can be shared out
- How S-HIE, PEAK, Colorado Access are all using salesforce health cloud
- in CA patient facing activity and coordinating people in operation access - had been using corona and they have now dropped it
- Is the functionality from Access Care replicable or transferable to other systems?

Alignment of telehealth initiatives with other state priorities

- Alignment with state priorities, infrastructure, and funding opportunities. Colorado's Health IT Roadmap, is the state's strategy for health IT infrastructure, information sharing/data sharing, and policy. This effort advances the Virtual Health and Broadband initiative outlined in the Roadmap. These activities and efforts will also align with other roadmap and state priorities as directed by OeHI and the eHealth Commission.
- Something explaining state initiative alignment OBH OIT etc
- HCPF Telehealth Strategy;
- Colorado's Health IT Roadmap;
- Affordability Roadmap;

- Behavioral Health Task Force;
- Colorado Health Institute Telehealth Analysis

Appendix and Additional Resources

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