American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

March 25, 2022

Dr. Alondra Nelson
Director, White House Office of Science and Technology Policy
1600 Pennsylvania Ave
Washington, DC 20500

Re: Request for Information (RFI) on Strengthening Community Health Through Technology

Dear Director Nelson:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to provide comments on the "Request for Information (RFI) on Strengthening Community Health Through Technology." In the RFI, the White House Office of Science and Technology Policy (OSTP) is seeking information and comments about how digital health technologies are used, or could be used in the future, to improve community health, individual wellness, and health equity. Community health, defined as the collective influence of socioeconomic factors, physical environment, health behaviors, and availability of quality clinical care services, serves as one of the most important drivers of health and wellness for all Americans.

Though we as emergency physicians have integrated telehealth and other digital health technologies into emergency care delivery more substantially over the past several years, the COVID-19 pandemic has accelerated our utilization of these technologies as supplemental tools for providing care. Having more regulatory and legal flexibility to use telehealth, for example, has enabled emergency physicians to provide essential services to patients during this pandemic without patients having to travel or risk exposure. Beyond the pandemic, digital health technologies have a lasting place in health care, and certainly should be explored as a key component of community health strategies.

With that context in mind, ACEP provides the following responses to the request for information.

Successful Models in the U.S.

As emergency physicians, we have been using digital technologies for years to help manage care for patients with complex needs. One such tool that ACEP supports is the Collective Medical Technologies' (CMT) Edie™ (a.k.a. PreManage ED) software. Edie™ is an information exchange that provides critical information on patients, such as how many emergency department (ED) visits patients have had in the last year, where they presented, their drug history, other providers who are involved in patients' care,

WASHINGTON, DC OFFICE
901 New York Ave, NW
Suite 515E
Washington DC 20001-4432

202-728-0610
800-320-0610
www.acep.org

and finally, whether there is a patient-specific care management plan that could guide treatment. The platform improves patient care by allowing emergency physicians to make more informed clinical decisions and better direct a patient's follow-up care. It also lowers health care costs through a reduction in redundant tests and better case management that reduces hospital readmissions. Through a partnership with CMT, ACEP has seen this system mature in approximately 17 states. In the first year alone, the state of Washington experienced a 24 percent decrease in opioid prescriptions written from EDs, a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than $32 million.[1]

Some EDs across the country are attempting to create care coordination and case management programs that help improve follow up appointment scheduling from the ED and target social interventions and primary medical care to high ED utilizers. One such program in Maryland applies mobile technology to use paramedics in a community health worker role to follow up on discharged patients at risk for readmission.[2] Many of these patients are Medicare beneficiaries. Another program in the East Bay, California has a help desk for health-related social needs with four integrated medical-legal partnerships, called Health Advocates, to help patients navigate housing and transportation challenges, immigration challenges, and benefit eligibility.[3]

Further, emergency telehealth programs have used technology to help ascertain key clinical information from patients, ensuring that emergency physicians are able to rapidly diagnose patients during a telehealth encounter. Emergency physicians are able to provide examinations using video communications systems and have found to be able to provide key elements of the physical exam. It also is useful to measure blood pressure, heart rate, and oxygen saturation, if available, but those tools are typically only needed for higher acuity patients. Wireless medical telemetry systems (WMTSs), such as those offered by VIOS, GE Healthcare, Edan, Medeia, and Philips, can be used for real-time monitoring of patients.

ACEP is also continuing to explore other innovative ways our physicians can help coordinate care for high-risk patients, including through participation in alternative payment models. We have developed a physician-focused payment model (PFPM) called the Acute Unscheduled Care Model (AUCM), which the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended to the Secretary of the U.S. Department of Health and Human Services (HHS) for full implementation in 2018. The AUCM provides incentives to participants to safely discharge Medicare beneficiaries from the ED by facilitating and rewarding post discharge care coordination. Under the model, a Medicare beneficiary who presents to the ED will undergo a safe discharge assessment (SDA) concurrent to receiving clinical care to identify socioeconomic factors and potential barriers to safe discharge back to the home or community, needs related to care coordination, and additional assistance that may be necessary. If the participating emergency physician, in collaboration with the primary care physician or designated specialist, determines that the patient is a candidate for discharge, the information captured during the SDA will be used to generate unique patient discharge instructions, including identifying symptoms that would require rapid reassessment and return to the ED. After the initial ED visit, the patient will receive appropriate follow-up care from the ED physician, his or her primary care physician, and other specialists as needed. One method for this follow-up care that is particularly emphasized in the model is telehealth, and we envision that the model would include a telehealth waiver similar to the waivers used

[1] https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/
[2] For more information on the Maryland Mobile Integrated Health Care Programs, please go to https://www.miemss.org/home/LinkClick.aspx?fileticket=w-K7gG-8teo%3D&tabid=56&portalid=0&mid=1964
[3] For more information on the Health Advocates Program, please go to http://www.levittcenter.org/ed-social-welfare-in-collabor/.

in other Centers for Medicare and Medicaid Innovation (CMMI) models. ACEP is excited about the limitless possibility this model has in terms of improving care for Medicare beneficiaries and is eager to work with HHS on implementation.

Uses of Telehealth During the Pandemic

The COVID-19 public health emergency (PHE) has changed the landscape of telehealth. While the Centers for Medicare & Medicaid Services (CMS) has made substantial changes to telehealth policies, there are a few that particularly affect emergency medicine. The most significant policy, which applied to all telehealth services, was CMS' use of its 1135 waiver authority to temporarily waive the Medicare originating site and geographic restrictions, allowing health care practitioners to provide telehealth services to patients regardless of where the clinicians or the patients are located—in both urban and rural areas. Congress, in the *Consolidated Appropriations Act, 2022*, recently extended this waiver for 151 days past the end of the PHE. Further, CMS clarified that the medical screening exams (MSEs), a requirement under Emergency Medical Treatment and Labor Act (EMTALA), could be performed via telehealth. Finally, CMS temporarily added all ED evaluation and management (E/M) codes, the observation codes, and critical care codes to the list of approved Medicare telehealth services through the end of 2023. These are the codes that emergency physicians typically bill.

With these flexibilities granted during the pandemic, emergency physicians provided telehealth services in the following three different clinical situations-- all of which added clinical value to patients:

1. ***Helping patients distinguish between urgent and acute care needs.*** Individuals who had urgent medical needs, but were unsure if they were having a medical emergency, were able to contact their EDs and have a telehealth visit with an emergency physician to assess whether the patient could stay at home, go to an urgent care clinic, or visit the ED. Emergency physicians are trained in rapid diagnosis and evaluation of patients with acute conditions, so they are particularly capable of providing these type of telehealth services. We are able to provide treatment to patients with minor illnesses and injuries completely via telehealth.

2. ***Providing MSEs to patients who came to the ED.*** As stated above, CMS released guidance stating that physicians (or other qualified medical persons) can perform MSEs via telehealth and where appropriate meet the MSE requirement without an in-person examination. Hospitals are temporarily allowed to set up alternative locations "on campus" for patients to receive an MSE other than in the ED. For example, patients presenting with possible symptoms of COVID-19 and meeting certain criteria (i.e., vital sign parameters) can be sent to a negative-pressure tent, where they are seen by an in-person nurse and a physician via telehealth (video and audio) who determines if the patient can be discharged from the tent or needs to be seen in the ED. After completing this process, a low percentage of patients need ED evaluation.

3. ***Ensure appropriate follow-up care after ED discharges.*** Emergency physician groups have set up systems and protocols to follow up with patients once they are discharged from the ED, ensuring that patients are taking their medications appropriately or are seeing their primary care physician or specialist if needed. These follow-up services have helped enhance care coordination efforts and avoid trips back to the ED or inpatient admissions. In addition, for patients under investigation for COVID-19, the treating ED group has been able to follow up with the patient to make sure their COVID symptoms are not progressing. Some groups have

sent patients home with portable pulse oximeters and followed up to check their general status and oxygen levels.

Being able to provide emergency services via telehealth initially helped preserve personal protective equipment (PPE) when supplies were limited and has helped reduce unnecessary exposure to COVID-19 for physicians and patients alike. Emergency physicians in particular have been at increased risk of contracting COVID-19 due to frequent and close physical interactions among patients and other health care workers. Having the ability to provide telehealth services has reduced face-to-face contact without compromising care, and patients have been able to safely receive services either from their home, the ED, or an alternative location within the hospital.

EDs across the country have also integrated their telehealth programs into their existing quality improvement initiatives, setting targets and metrics to ensure that the quality of care that is delivered is maintained and improved over time.

ACEP is still gathering data on the effectiveness of providing emergency telehealth services during the pandemic, but we expect to see improved health outcomes. For example, telehealth has the potential to improve care coordination and limit avoidable trips to the ED or hospital. Further, it allows for screening examinations that do not need to be done in person, thereby reducing the chance of exposure to COVID-19. Finally, it improves access to care for beneficiaries, a clear clinical benefit, by connecting patients with clinicians from any location in a timely manner. Some EDs have been able to track data that could be used to evaluate clinical outcomes, such as monitoring whether a patient required an additional medical visit after the telehealth visit and determining the percentage of patients who avoided an ED or urgent care visit for the illness or injury.

Barriers and Proposed Government Action

As hospitals and emergency physician practices have invested in new telehealth platforms to serve patients during the pandemic, one concern many emergency physicians share is how to sustain these investments if the underlying funding and reimbursement for telehealth services do not continue. As noted above, starting in 2024, the codes that emergency physicians typically bill—including the ED E/M codes, some observation codes, and critical care codes—may be removed from the list of approved Medicare telehealth services. It is also unclear whether Congress will continue to extend or make permanent the originating site and geographic restrictions beyond the 151-day extension it just provided. While CMS does not have the legal authority to lift the originating site and geographic restrictions, it does have the regulatory authority to extend certain telehealth policies past the end of the PHE without congressional action. We urge the Biden Administration to explore all these policies and extend those that will allow telehealth to remain a financially viable method for providing high-quality care going forward.

Another significant barrier is state licensing. Currently, there are regulatory barriers that restrict the ability for physicians to get licensed and credentialed in multiple states so they can provide telehealth services to patients across state lines. During the PHE, CMS issued a temporary waiver to allow physicians who are licensed in one state to provide services to a patient another state. This waiver only applies to Medicare and Medicaid patients. Further, for the waiver to be effective, the state where the physician is performing the telehealth service must also waive its licensure requirements. While many states have allowed this flexibility during the PHE, it is not clear whether they will continue doing so once the PHE ends.

Finally, ACEP believes that telehealth should continue to be available to treat patients with opioid use disorder (OUD). The Drug Enforcement Administration (DEA) adopted protocols to allow DEA-registered practitioners to prescribe controlled substances to their patients without having to interact in-person with their patients. Under the DEA's policy (which became effective on March 31, 2020), authorized practitioners can prescribe buprenorphine over the telephone to new or existing patients with opioid use disorder (OUD) without having to first conduct an examination of the patient in person or via telehealth. This flexibility is scheduled to be terminated once the PHE ends.

Health Equity

While there is significant potential to help improve access to care for vulnerable populations using digital technologies, unfortunately, in the short-term, telehealth may not be an effective tool by itself to reduce health care disparities. There are many structural barriers in place—particularly the lack of access to broadband in lower-income and rural communities and the disparities in smartphone and compatible device ownership—that should be addressed when discussing advancement in telehealth. According to a Pew Research Center survey, while 79 percent of suburban households and 77 percent of urban households reported having broadband internet connection, only 72 percent of rural households reported having broadband internet connection. This disparity is even more pervasive in terms of race and ethnicity – while 80 percent of white adults report having broadband internet at home, only 71 percent of Black adults and 65 percent of Hispanic adults say they have broadband internet at home. Further, 89 percent of suburban and 84 percent of urban American adults own smartphones, whereas only 80 percent of survey respondents in rural areas reported the same.[4] Americans over the age of 65 are approximately 24 percent less likely than the general population to own a smartphone.[5] As decreased access to technological devices correlates with lower "tech readiness," vulnerable populations who experience inequities in access to technology may also experience difficulties in access to, comprehension of, and proper usage of telehealth innovations. All in all, we must grapple with and attempt to correct the unfortunate reality that those in most significant need of these services are the ones who have the most trouble accessing them.

ACEP therefore supports efforts, such as the Federal Communication Commission's (FCC's) Connected Care Pilot Program, that cover the costs of broadband connectivity, network equipment, and information services necessary to provide telehealth and other remote care services to patients in rural and underserved communities, as well as other efforts to reduce and eliminate existing gaps in access for other vulnerable or in-need populations.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory and External Affairs, at jdavis@acep.org.

Sincerely,

Gillian Schmitz, MD, FACEP

Gillian R. Schmitz, MD, FACEP
ACEP President

[4] https://www.pewresearch.org/fact-tank/2021/08/19/some-digital-divides-persist-between-rural-urban-and-suburban-america/
[5] https://www.pewresearch.org/internet/2017/05/17/technology-use-among-seniors/