CASE STUDY: CARE ANYWHERE

# Expanding Access and Building Engagement in Rural Wisconsin

## *Introduction*

**Security Health Plan of Wisconsin, Inc.**, part of the Marshfield Clinic Health System, is a not-for-profit health maintenance organization providing coverage to more than 219,000 members across Wisconsin. Security Health Plan offers health care benefits to large and small businesses, individuals and families, and Medicare and Medicaid beneficiaries. Security Health Plan is the fifth largest health plan in Wisconsin by membership.

The Marshfield Clinic Health System's mission is to enrich lives through accessible, affordable and compassionate health care. The health system serves Wisconsin and Michigan's Upper Peninsula with more than 1,400 providers comprising 170 specialties, health plans and research and education programs.

Marshfield Clinic Health System and Security Health Plan provide coverage and care for a large rural population across the state. Telehealth offers critical access to services for farmers, foresters and others who live and work in these large rural service areas—communities challenged by barriers to care including distance, transportation, workforce shortages, broadband access, poor health literacy and social stigma.

## *History of Telehealth at Marshfield Clinic Health System*

### Pre-Pandemic Telehealth Infrastructure

Prior to the COVID-19 pandemic, a significant portion of the Marshfield Clinic Health System patient population did not have the option to receive care at home, a truth for many patients across the U.S. Older Americans, who often access health care at a higher rate, faced additional challenges in terms of virtual care access. Prior to 2020, for Medicare beneficiaries to access telehealth and for the health plan to receive payment, patients had to travel—sometimes driving for hours from rural or frontier county homes—to facilities known as originating sites for appointments.[1]

## *Marshfield Clinic Health System Pre-Pandemic Investment Timeline*

**1997**

- Development of telehealth team and video telehealth visits begin through originating sites.
- Marshfield develops telehealth exam rooms across the system to connect specialists to patients at local clinics.

**2014**

- Marshfield launches Care My Way, Low Acuity Episodic Care (audio-only care).

**2017**

- Increasing telehealth volumes allowed hiring of dedicated virtual providers.
- Marshfield partners with Amwell to add Care My Way® video visits.
- Marshfield changes appointment process and hires dedicated telehealth appointment coordinators to expand access.

**2018**

- Workplace-based telehealth pilot begins.

**2019**

- Infrastructure and other improvements lead to a 43 percent increase in originating site telehealth visits since 2017.

1. An originating site is the location where a Medicare patient gets physician or practitioner medical services through a telecommunications system. Authorized originating sites include: Physician and practitioner offices, Hospitals, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Hospital-based or CAH-based Renal Dialysis Centers (including satellites), Skilled Nursing Facilities (SNFs), Community Mental Health Centers (CMHCs), Renal Dialysis Facilities, Patients with End-Stage Renal Disease (ESRD) getting home dialysis and Mobile Stroke Units. More details at: https://achp.pub/MLN-Telehealth

## *A Single Virtual Platform*

As noted in the Investment Timeline, MCHS and Security Health Plan expanded virtual care through the Care My Way® virtual care platform, using MCHS nurse practitioners to diagnose and prescribe treatment by phone or video chat. The service provides members coverage for common health concerns such as flu symptoms, sinus infections, seasonal allergies, pink eye, urinary tract infections, behavioral health triage and more.

Care My Way® @ Work expands the original platform to employers, offering an onsite, virtual care clinic that brings a provider virtually to the workplace. Paired with The Care My Way® @ Work device, employees can take their own vitals and be guided through an exam, with results generated immediately and shared with the virtual provider.

To address this barrier, Marshfield Clinic Health System began making foundational investments in its telehealth program. These investments allowed Marshfield to expand services across all lines of business and eligibility to a wider population. As a result, from 2017 to 2019, Marshfield Clinic Health System saw a 43.4 percent increase in the total number of originating site telehealth visits.

Before March 2020, telehealth visit volume was low as compared to 2021 and 2022 numbers, but still notable, for both Security and the health system. Although fewer than 1 percent of health system visits were conducted via telehealth in 2019, 1 percent of 3 million visits equates to 30,000 annual visits.

### Pandemic Shift in Utilization

Early in the pandemic, non-essential in-person appointments significantly slowed due to perceived risks associated with in-person care—accelerating the need and demand for increased telehealth access. Due to both previous foundational investments in a robust virtual care program, as well as support from the federal government in easing virtual care restrictions, Marshfield was quickly able to adapt in the face of the PHE, expanding telehealth offerings across all lines of business and populations.

The Centers for Medicare and Medicaid Services (CMS) waivers issued under the PHE removed originating site requirements for telehealth payment in Medicare. Without this requirement, telehealth visits could be conducted anywhere, including from the safety and comfort of a patient's home, for all Medicare beneficiaries — including those in Medicare Advantage plans. The waivers also allowed health plans to rely on out-of-state providers to help accommodate the increased demand for virtual care. This federal government support immediately expanded Marshfield's ability to serve older and at-risk patients across their service area.

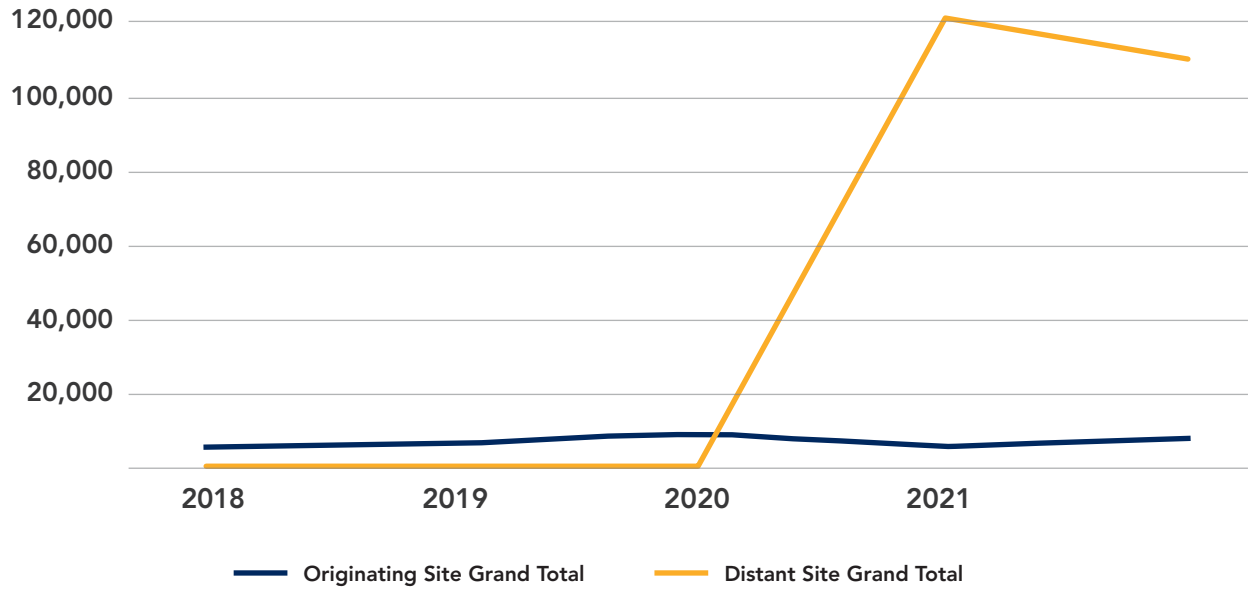
Outside of Medicare, other lines of business faced fewer regulatory barriers to telehealth. This enabled Marshfield and Security to quickly build on existing telehealth infrastructure to expand benefits and access in response to pandemic demand for services. In addition, the transition to telehealth was partly eased by additional federal regulatory action. The Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency enabled providers and plans without telehealth infrastructure to quickly begin offering virtual services through non-typical modalities.[2]

2. "Notification of Enforcement Discretion for Telehealth," Department of Health and Human Services., January 20, 2021, https://achp.pub/CMS-Waiver.

## *GRAPH 1: Originating Site vs. Distant Site*

**The distant site telehealth volumes averaged 13,473 per month in 2020 and 9,195 per month in 2021. The grand total for distant site data in 2020 was 121,258 visits compared to 110,341 visits in 2021. This slight drop-off is consistent with national trends showing decreased telehealth utilization as offices, clinics and other in-person care facilities reopened.**

**Visits in 2019 did not include certain services including Support Service Telehealth, which includes certain pharmacy-related services, advance care planning and end-of-life planning. These are essential components of patient care that are not identified with claims and are therefore difficult to capture in data.**




*This graph compares visit volumes between originating site and distant site telehealth from 2018 to 2021. Due to the shift in telehealth access, Security and Marshfield tracked telehealth differently since patients were no longer coming to originating sites for their virtual care. Instead, providers were able to deliver virtual care at distant sites to patients anywhere.[3] This is an important distinction when reviewing this graph as it explains the zero value for distant site data prior to 2020 and the slight drop-off in originating site data as explained by in-person care services closing due to the pandemic.*

3. The PHE telehealth waivers also waived the requirement that physicians licenses in a state may only treat patients in that same state, allowing providers to offer telehealth services across state lines.

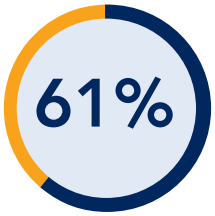
### *Telehealth Patient Satisfaction*

- Nearly 50 percent of respondents agreed or strongly agreed that they would choose a telehealth visit for their next appointment over an in-person visit if given the option, while an additional 25 percent were neutral.
- Nearly 70 percent of respondents agreed or strongly agreed that the technology required to complete a telehealth appointment was easy to use.
- A majority of patients agreed or strongly agreed that telehealth visits improved their access to care, saved them time and helped monitor their health condition.

Marshfield Clinic Health System and Security Health Plan were able to quickly accommodate the increased demand for virtual care due to two decades of investments in telehealth infrastructure and resources. As part of the pivot in April 2020, Marshfield and Security Health Plan launched an intensive nine-day transition period at the start of the PHE to train half of the 1,300 providers across 86 specialties in telehealth modalities to meet patient needs. In addition, provider champions played a key role by assisting and advising colleagues on how to adapt to a virtual practice environment.

Due to this shift in accessibility, Marshfield Clinic Health System and Security Health Plan saw a staggering increase in telehealth visits (see Graph 1), with behavioral health and primary care as the most common visit type. Total telehealth visits in 2020 increased by 12 times the number of visits in 2019—even though the pandemic did not disrupt in-person care until three months into 2020. From March 15, 2020, to June 1, 2020, 22 percent of MCHS visits were conducted via telehealth, a 1,700 percent increase over 2019. In 2020, approximately 22,000 MCHS patients utilized telehealth, amounting to nearly 200,000 video visits, compared with 15,000 in 2019.[4] Telehealth visits decreased slightly in 2021 due to a return to in-person visits but remained over 11 times higher than 2019 telehealth visits.

## Community Impact of Telehealth




*61.47 percent of Primary Care Health Professional Shortage Areas were in rural areas, according to March 2021 data*

In December 2020, Marshfield Clinic Health System conducted a telehealth patient survey to gauge general satisfaction with telehealth use and identify potential barriers to expanding services. The results showed that patients were generally satisfied with telehealth appointments and found them easy to navigate. Some patients noted the comfort and privacy of conducting appointments at home as a positive aspect of telehealth visits—particularly for mental health visits; other patients indicated that they may not have used behavioral health services if they needed to travel to a provider's physical office. The results also echoed larger national concerns about technology access issues, particularly for patients with older devices and/or poor broadband internet service.

## Mental and Behavioral Virtual Health Care Utilization Soars

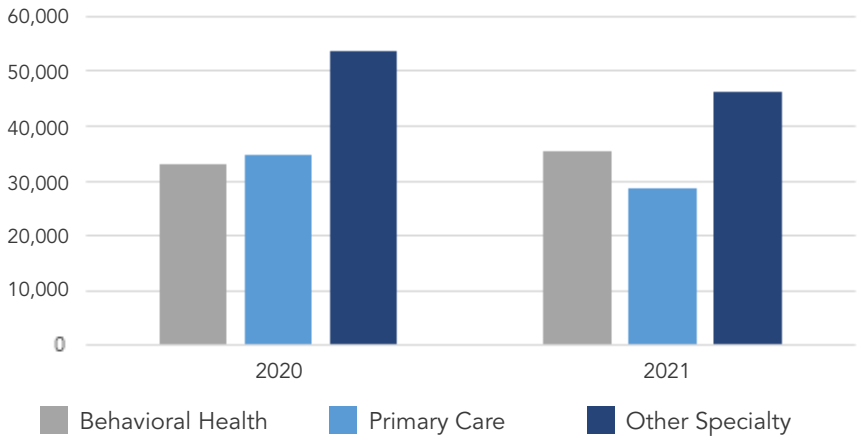
Prior to the pandemic, Marshfield Clinic Health System conducted a negligible number of mental health visits via telehealth. But improved access to these services virtually greatly increased utilization and patient comfort

4. Total visits in 2019 equaled 66,622, but around 50,000 were tele-pharmacy visits, the remaining approximately 15,000 were non-pharmacy related virtual care services.

with accessing these services from their own homes. In 2020 and 2021, over 30,000 virtual mental health visits occurred each year (see Graph 2).

While virtual care provided by primary and other specialty physicians decreased slightly in 2021 (between 13 to 17 percent), virtual mental and behavioral health care surpassed volumes by nearly 7 percent compared to 2020. Additionally, of all clinical specialties, Security Health Plan's rural members utilized virtual mental health services the most.

### GRAPH 2: Distant Site Total by Speciality




## Case Studies

### Marshfield Clinic's Heart Failure Improvement Clinic (HFIC)

Since 2014, Marshfield Clinic's Heart Failure Improvement Clinic (HFIC) has successfully increased survival rates, reduced hospital admissions and improved quality of life for patients with heart failure. With around 1,600 patients enrolled in the HFIC program, this program leveraged virtual care to provide participants with more frequent contact with their health care team and personalized visits to meet patients' needs. This program served as an early use case for the value of telehealth embedded in patient care plans showing tangible health outcomes.

### *The HFIC program led to:*

**36.8%**
decrease in the 12-month mortality rate

**20.7%**
decrease in the rate of ER visits

**21.7%**
in the rate of inpatient hospitalizations

**22.3%**
decrease in the rate of inpatient readmissions

### Utilizing Out-of-State Providers for Specialty Care

Marshfield Clinic Health System successfully utilized out-of-state providers to offer specialized care via telehealth. For example, Marshfield's single child behavioral care specialist moved out of state but continued to treat patients via telehealth, preventing the health system from having to hire a new provider. In this instance, when offered the option to transition to virtual visits or switch providers, only one patient of this provider did not choose the virtual option.

Marshfield's use of tele-pharmacy has also significantly expanded access. The tele-pharmacy program is a provider-to-provider consult model in which a PharmD supervises pharmacy technicians at rural sites, allowing a single PharmD to supervise multiple sites. This model reduces operational costs by preventing Marshfield from having to hire a PharmD to be physically located at each rural site. Marshfield conducts about 70,000 tele-pharmacy visits annually. Marshfield has also expanded oncology care through tele-pharmacy, offering oncology infusion at double the number of sites than would be possible without the program.

**Tele-Pharmacy Encounters by Year**

| Year | Encounters |
|---|---|
| 2017 | 52,807 |
| 2018 | 54,021 |
| 2019 | 52,389 |
| 2020 | 57,757 |
| 2021 | 71,682 |

## Conclusion and Recommendations

The early investments in telehealth infrastructure and the national policy changes due to the pandemic significantly assisted Marshfield Clinic Health System and Security Health Plan's ability to provide robust access to telehealth during the pandemic.

Marshfield and Security Health Plan will continue to expand the use, scope and coverage of telehealth systemwide following recent success in scaling virtual care services. The health system is expanding telehealth at its facilities with tele-hospitalists at two system hospitals and plans to expand to a third later this year, with the potential to add four additional sites between 2023 and 2024. Every patient room in critical access and micro-hospitals, covering cardiology, hospitalist, neurology and support services (e.g., spiritual, pharmacy, family visits), will also incorporate telehealth solutions.

One notable challenge from a telehealth evaluation standpoint is the shift of data collection between originating sites and distant sites. Originating site data provided a clearer picture of the patient, whereas distant site data reflects provider location rather than patient location – making it challenging to assess geographic utilization trends. This highlights a second challenge, ensuring payers get the right information from providers since they are largely dependent on claims data. Collectively, these represent a significant hurdle the industry will face in collecting, aggregating and analyzing telehealth data prior to, throughout and after the pandemic.

### Recommendations

As the nation continues to manage the COVID-19 pandemic, it is vital that the Administration and Congress:

- Update coverage and reimbursement policies for telehealth to expand access to virtual coverage and care.
- Improve telecommunication infrastructure to mitigate the digital divide.
- Develop incentives and guidelines for virtual care to ensure payers and providers continue to make these services available.

Additional Resources:

Chris Meyer, Florence Becot, Rick Burke & Bryan Weichelt (2020) Rural Telehealth Use during the COVID-19 Pandemic: How Long-term Infrastructure Commitment May Support Rural Health Care Systems Resilience, Journal of Agromedicine, 25:4, 362-366, DOI: 10.1080/1059924X.2020.1814921.

"Rural Health Information Hub," Healthcare Access in Rural Communities Overview, August 18, 2021, https://www.ruralhealthinfo.org/topics/healthcare-access.