CARE TRANSFORMATION COLLABORATIVE OF RHODE ISLAND (CTC-RI) PCMH KIDS COLLABORATIVE AGREEMENT SCOPE OF SERVICE/WORK
Primary Care Telehealth Initiative
Phase 1: Participative Agreement: Primary Care Telehealth Practice/Patient Needs Assessment
Practice Name: <<Account_Name>>
Consisting of 26 pages

1. **Background:** UnitedHealthcare (UHC) has provided funding to Care Transformation Collaborative of RI (CTC-RI) to implement a Primary Care Telehealth Project consisting of two phases described below. This "Phase 1: Participative Agreement: Primary Care Telehealth Practice/Patient Needs Assessment" outlines practice responsibilities for completing the Practice and Patient Needs Assessment. The Rhode Island Department of Health (RI DOH) has additionally provided funding for Care-Community-Equity (C-C-E) practice/patient needs assessment participation. Up to 53 adult and pediatric primary care practices are invited to complete the Practice/Patient Needs Assessments.

   A Planning Committee (including Northeast Telehealth Resource Center representation) will develop and implement an educational webinar series based on review of practice and patient needs assessment findings and recommendations, and design and implement a 6-month webinar series. Timeline for Phase 1: July 1, 2020—March 2021).

2. **Phase 1: Telehealth Practice/Patient Needs Assessment and Six Month Learning Webinar Series:** Practices that complete practice needs assessment and patient engagement surveys (including patients using and not using telehealth are eligible to receive financial support ($2,000 per practice site).

   Telehealth Practice Needs Assessment: The practice telehealth needs assessment will request practice feedback via survey monkey on: telehealth operational policies, patient/staff experiences, services offered, integration with in-person visits, financial impacts, technology requirements, use of remote patient monitoring and identification of health equity, access to care, and community solutions.

   Telehealth Patient Engagement Surveys: Practices will obtain patient experience information from at least **five** patients using telehealth and **five** patients not using telehealth. Surveys will help inform practices and this initiative on patient identified barriers/needs/solutions.

   Information on Phase 2: Pilot Telehealth Learning Collaborative: CTC-RI will select and fund up to seven (7) * primary care practice teams that are part of systems of care and are interested in participating in a 12-month best practice learning collaborative to test the use of telemedicine services to improve care for patients with a selected chronic condition (i.e. ADHD, hypertension, diabetes, CHF). Practices would be provided with infrastructure and incentive funding payments, practice facilitation technical support and a quarterly best practice sharing learning series.
   Community health teams, adult and pediatric practices will be eligible to apply. Timeline for Phase 2: November, 2020-December 2021).

*number is subject to change based on potential availability of CARES ACT funding.

Practice participation in Phase 1: Telehealth Practice/Patient Needs Assessment does not obligate a practice to participate in Phase 2: Pilot Telehealth Learning Collaborative. CTC-RI/PCMH KIDS will issue a "Telehealth Call for Applications" and interested practices may apply.

Strategic Goals for Phase 1 Primary Care Telehealth Practice/Patient Needs Assessment:

Goals for gathering telehealth practice/patient needs assessment information:

1. to design and offer a 6-month educational webinar series on telehealth that will address the specific needs of RI primary care practices;
2. to design a 12 month learning collaborative for primary care practices that are interested in using telehealth to assist patients with managing chronic health conditions;
3. to provide practices with patient information that can be used to improve patient telehealth experience;
4. to help inform RI health care policy on primary care practice/patient telehealth needs.

Practice Responsibilities:

A. Phase 1: Primary Care Telehealth Participative Agreement and W-9

1. Practice is responsible for signing and returning Phase 1: Participative Agreement Primary Care Telehealth Participative Agreement Practice/Patient Needs Assessment by **September 4, 2020**.
2. Practice is responsible for submitting W-9 to Deliverables@ctc-ri.org by **September 4, 2020.**

B. Phase 1: Primary care Telehealth Practice Needs Assessment

1. Each practice is responsible for completing one Phase 1: Primary Care Telehealth Practice Needs Assessment (Appendix A: Practice Needs Assessment).
2. It is recommended that the practice identify one person who is responsible for obtaining input from practice team members and returning the Phase 1: Primary Care Telehealth Practice Needs Assessment via survey monkey by **September 22, 2020.** Practices may determine best way to gather input from team members; input is recommended from provider, practice manager, nurse care manager, behavioral health clinician, medical assistant, pharmacist and billing staff (as applicable).

C. Phase 1: Primary Care Telehealth Patient Engagement Surveys

3. Practice is responsible for identifying up to 5 patients who have used telemedicine services within the last six months using survey monkey link with consideration given to patients who represent diverse needs of practice population; Practices may determine best way to gather this input from patients (such as patient portal). Information is to be submitted using survey monkey link. (Appendix B: Patient Survey for Patients Using Telehealth).
4. Practice is responsible for identifying up to 5 patients who have not used telemedicine services with consideration given to diverse needs of practice population; Practice may determine best way to gather this input from patients. Information is submitted using survey monkey link. (Appendix C: Patient Survey for Patients Not Using Telehealth; Appendix D: Patient Survey for Patients Not Using Telehealth: Spanish)

5. All Patient surveys are due back via survey monkey by **September 25, 2020.**

Practice Compensation:

CTC will provide payment of $2,000.00 to practices within 30 days after receiving completed Practice Needs Assessment and Patient Engagement Surveys.

Please Provide Invoice Address:

Street:

City:

State:

Zipcode:

Care Transformation Collaborative of RI

Practice name: **<<Account_Name>>**

_____

Signature: Debra Hurwitz, MBA, RN
Executive Director, CTC-RI

_____

Signature of authorized staff:
Name:
Positon:

Appendix A: Phase 1 Primary Care Telehealth Practice Needs Assessment
Survey Monkey Link: https://www.surveymonkey.com/r/N9SCYCY

Practice Telehealth Needs Assessment

Due to the COVID-19 crisis, we at Care Transformation Collaborative of Rhode Island (CTC-RI) are looking to better understand practices' needs with regards to telehealth as well as practices' interest in an upcoming Telehealth Webinar Learning Series. Please review this survey within your practice, solicit feedback from your team and complete this online survey by September 15, 2020. One survey will be submitted per practice. Thank you for your participation.

A. General Practice Information (*Suggested to be filled out by the Practice Manager*)
   1. Practice name (<free text box>)
   2. Health System name (<free text box>)
   3. Organization Affiliation/Company (<free text box>)
   4. Physical address of practice (<free text box>)
   5. Website of practice (<free text box>)
   6. Electronic Health Record (EHR) used (Drop-down menu: Epic, Athena, Amazing Charts, e-Clinical Works, NextGen, Greenway, Cerner, Meditech, Other – free text)
   7. Which of the following best describes the practice? (Choose all that apply; Drop-down menu)
      a. Federally Qualified Health Center
      b. Primary Care
      c. Internal Medicine
      d. Family Medicine
      e. Pediatric Medicine
      f. Geriatric Medicine
      g. Practice includes onsite Behavioral Health
      h. Other (<free text box>)
   8. Who is helping to fill out this survey? Please check off participants and role(s) at the practice. (List of roles at practice with check box for each Ex. Clinician (MD, DO, NP, PA, RN, RPh) Medical Assistant/ Practice Manager / Front Desk Staff / Other (<free text box>))
   9. Since March 2020, what percentage of your primary care work has been performed by telehealth (video or phone)?
      a. 0-20%
      b. 21-40%
      c. 41-60%
      d. 61-80%
      e. Greater than 80%
   10. Since March 2020, what percentage of your behavioral health work has been performed by telehealth (video or phone)?
      a. 0-20%
      b. 21-40%
      c. 41-60%
      d. 61-80%
      e. Greater than 80%
   11. Does your practice have an on-site pharmacy services?
      a. Yes
      b. No
   12. Since March, 2020 what % of your pharmacy services work has been performed using phone/video visits?

a. 0-20%
b. 21-40%
c. 41-60%
d. 61-80%
e. Greater than 80%

13. What is the estimated payer mix of your practice's current patient population?
    a. Medicare % (<free text box>)
    b. Medicaid % (<free text box>)
    c. Private Insurance % (<free text box>)
    d. Self-pay/Uninsured % (<free text box>)

B. Provider Information: (*Suggested to be filled out by the Practice Manager*)
1. How many FTE primary care providers (MD, DO, NP, PA) practice at this Practice? (<free text box>)
2. How many FTE behavioral health specialists practice at this Practice? (<free text box>)
3. How many FTE practice staff work at this Practice? (<free text box>)
4. How many FTE pharmacists practice at this practice?

C. Clinical/Administrative Service Needs and Telehealth Workflow: (*Suggested to be filled out with feedback from the Practice Manager, Clinical and Support staff)*
1. Does this Practice currently utilize telehealth (either video or phone) as a part of its practice? If the answer is "Yes," continue to question 2. If the answer is "No," skip to question 23.
    a. Yes
    b. No
2. When did the program begin? (<free text box>)
3. Does the Care Team/Providers prefer video or phone telehealth visits?
    a. Video
    b. Phone
4. On average, how much time do you spend with each patient during a telehealth visit?
    a. Telephone visit (audio only) (Drop-down menu)
        i. Less than 10 minutes
        ii. 10 – 19 minutes
        iii. 20 – 29 minutes
        iv. 30 – 39 minutes
        v. 40 – 49 minutes
        vi. More than 50 minutes
    b. Audio/Video visit (Drop-down menu)
        i. Less than 10 minutes
        ii. 10 – 19 minutes
        iii. 20 – 29 minutes
        iv. 30 – 39 minutes
        v. 40 – 49 minutes
        vi. More than 50 minutes
5. On average, in what percentage of your telehealth visits (video or phone) does a family member or caregiver participate with the patient? (Drop-down menu)
    a. Less than 20%
    b. 20 – 29%
    c. 30 – 39%

    d. 40 – 59%
    e. 60 -79%
    f. More than 80%
6. Please list the barriers that patients have experienced with telehealth. (Please rank the following with #1 being the top barrier and so on)
    a. Patient didn't know how to use a phone for a medical visit
    b. Patient didn't know how to use video for a medical visit
    c. Patient does not have a phone
    d. Patient does not have a computer/tablet for videos
    e. Patient does not have sufficient minutes on cell phone
    f. Patient's cell phone service is unreliable
    g. Patient's computer internet service is unreliable or patient has no internet service
    h. Patient is concerned about privacy for a phone or video visit
    i. Patient needs deaf/hearing impaired services to use the phone or video visit
    j. Patient does not speak English and needs a language interpreter
    k. Patient has cognitive limitations and needs a person with them
    l. Other (< free text box>)
7. What types of phone/video visits does your practice offer? (Choose all that apply)
    a. Annual check-up
    b. Well Child Visit
    c. Sick visit
    d. Routine follow up for chronic condition management
    e. Behavioral health visit
    f. Medication management
    g. Nurse care manager check-in
    h. Visit before an Operation or procedure (Pre-OP)
    i. Visit after an Operation or procedure (Post-OP)
    j. COVID-19 concerns
    k. Pharmacy
    l. Other (<include free text box>)
8. What steps are included in your workflow associated with a telehealth visit (phone or video)? (choose all that apply)
    a. Scheduling/triaging an in person, phone or video appointment
    b. Screening patient for technology/digital literacy
    c. Screening patient for preventive services (such as depression, anxiety, substance abuse disorder)
    d. Obtaining patient consent
    e. Preparing the patient so they know what to expect for their appointment
    f. Staff does pre-visit planning (obtains any clinical information in preparation for the actual visit)
    g. Patient will use a "virtual waiting room"
    h. Schedules patient for next visit
    i. Other (<free text box>)
9. How does your practice integrate new telehealth services with existing in-person services? (<free text box>)
10. How do you get electronic documents from patients (electronic signatures, documents, etc.?) (Choose all that apply)
    a. Secure email
    b. Patient Portal
    c. Fax

    d. US Postal Service
    e. We do not get electronic documents from patients
    f. Other (free text)
11. What are workflow challenges associated with telehealth? (choose all that apply)
    a. Sending invitations to patients
    b. Difficulty getting electronic documents from patients
    c. EHR integration
    d. Referrals to specialists
    e. Translation services
    f. Staff training/competency
    g. Patient training/competency
    h. Other
12. Since March 2020, which of the following video platforms have you used to deliver a telehealth visit? (Choose all that apply)
    a. My EHR (<free text box>)
    b. Zoom
    c. Doximity
    d. Doxy.me
    e. Skype for Business
    f. Facetime
    g. Google Hangouts
    h. Other (<free text box>)
13. Can you list the advantages of any or all of the above programs? (<free text box>)
14. Can you list the disadvantages of any or all of the above programs? (<free text box>)
15. If you were purchasing the video platform, which of the following features would you pay for? (Choose all that apply)
    a. Chart function
    b. Virtual background
    c. Ability to record the visit
    d. Enhanced control of the microphone
    e. Enhanced control of the video
    f. Waiting room function
    g. Security
    h. Other functions you would pay for, please specify: (<free text box>)
16. Has telehealth improved your work experience?
    a. Yes
    b. No
17. On a scale of 1-5, how satisfied are providers/clinicians with the current telehealth program?
    (1 = very dissatisfied, 2 = dissatisfied, 3 =Neutral, 4 = satisfied, 5 = very satisfied) & (<free text box>)
18. On a scale of 1-5, how satisfied are non-clinical practice support staff with the current telehealth program?
    (1 = very dissatisfied, 2 = dissatisfied, 3 =Neutral, 4 = satisfied, 5 = very satisfied) & (<free text box>)
19. If you answered “No” to question 1, please indicate which of the following reasons why your office did not partake in telephone or video visits. If you answered “Yes” to question 1, please skip to “Existing Technology Infrastructure and Equipment Inventory”. (Drop-down menu)
    a. My practice did not promote telehealth visits
    b. I was not trained on how to provide telehealth visits

    c. I tried it and found it frustrating to use
    d. I did not have office staff to support my telehealth use
    e. I don't believe telehealth is a valid way to evaluate patients
20. If you have not yet, do you plan to implement telehealth services in the next 12 months?
    a. Yes
    b. No
21. Which telehealth services does your practice wish to implement? (Drop-down menu)
    a. Live phone or video (communicate with a client/patient in *real-time*, or *live)*
    b. Store and forward (technology to collect/store patient's data in secure cloud-based platform; later retrieved by another treating professional)
    c. Remote patient monitoring (record/monitor a patient's health data remotely)
    d. Other (please specify)

Sections D. through G. suggested to be filled out with feedback from the Practice Manager, IT, Clinical and Support staff)

D. Existing Technology Infrastructure and Equipment Inventory:
1. Who is your internet service provider? (Free response)
2. Do you have access to technical support that is available locally and/or on-call? If yes, please specify how you are receiving your technical support.
    a. Yes (please explain – free response)
    b. No
3. For which of the following telehealth services do you currently have telehealth equipment (i.e. carts, video cameras, web cameras, etc.) available at your Practice? (Choose all that apply)
    a. Live phone or video (communicate with a client/patient in *real-time*, or *live)*
    b. Store and forward (technology to collect/store patient's data in secure cloud-based platform; later retrieved by another treating professional)
    c. Remote patient monitoring (record/monitor a patient's health data remotely)
    d. Other (please specify)

E. Live Video Assessment (Complete only if your practice currently utilizes or wishes to implement this form of telehealth services)
1. Do you conduct live video assessments using cellular or internet?
    a. Cellular
    b. Internet
    c. Both
2. Do you have trouble with video quality when connecting with patients?

(Scale – 1 – 5) Need to anchor the likert scale. Is 1= trouble all the time and 5= trouble none of the time

3. How do you get video connection to patient?
    a. Text
    b. Email
    c. Patient portal message
    d. Other (free text)
4. Do you have any of the following telehealth peripherals? (Choose all that apply)
    a. General examination camera
    b. Electronic stethoscope
    c. Otoscope
    d. Dermascope

    e. Nasopharyngoscope
    f. Pulse Oximeter
    g. Scale
    h. Other (free text)
    i. Not Using any

F. Store and Forward Assessment (technology to collect/store patient's data in secure cloud-based platform; later retrieved by another treating professional - Complete only if your practice currently utilizes or wishes to implement this form of telehealth services)
   1. For which specialties do you/would you utilize store and forward technology? (Free response)
   2. What software do you/would you use? (Free response)

G. Remote Patient Monitoring (RPM) (Complete only if your practice currently utilizes or wishes to implement this form of telehealth services)
   1. Please describe your active RPM program, if applicable. (Free response)
   2. Has the practice selected a RPM Vendor?
      a. Yes (Please list which vendor and rationale for selection – (Free response)
      b. No
   3. Please indicate which health conditions you monitor using RPM? (Choose all that apply)
      a. Hypertension
      b. Diabetes
      c. Chronic Obstructive Pulmonary Disease (COPD)
      d. Cardiovascular Disease
      e. Asthma
      f. Other (please specify) (free text)
   4. What hardware do you/would you used? (Choose all that apply) + other questions (in notes)
      a. Blood glucose monitor
      b. Digital thermometer
      c. Blood pressure monitors
      d. Pulse Oximeter
      e. Digital scale
      f. iPad/tablet
      g. Other (please specify)
   5. Who monitors the RPM patients/data? (*suggested to get input from Nurse Care Manager and/or Pharmacist*)
      a. Practice
      b. Vendor
      c. Hybrid
   6. Does the practice have RPM data integrated with their EHR?
      a. Yes
      b. No
      c. Use separate platform to track RPM

   7. The practice receives reimbursement for RPM services? (Choose all that apply)
      a. Medicaid
      b. Medicare
      c. Commercial
      d. Practice does not receive reimbursement for RPM services
   8. The practice receives reimbursement for RPM equipment? (Choose all that apply)

    a. Medicaid
    b. Medicare
    c. Commercial
    d. Practice does not receive reimbursement for RPM equipment

9. What are challenges you have faced with RPM?
10. Do you have any solutions to share relating to RPM? (free text)

Sections H. through J. to be filled out with feedback from the Practice Manager and Clinical Staff)

H. Funding
    1. How are you currently funding your RPM? (free text)
    2. How are you currently funding your telemedicine program? (free text)

I. Practice Benefits and Barriers
    1. Which of the following (if any) do you perceive to be barriers to implementing and sustaining your telehealth program? (Choose all that apply)
        a. High level buy-in
        b. Competition
        c. Confidentiality
        d. Lack of medical staff
        e. Lack of dedicated coordinator staff
        f. Lack of technical staff/
        g. Technology issues
        h. Lack of specialty care access
        i. Licensure access
        j. Medical staff concerns
        k. Start up and/or ongoing costs
        l. Reimbursement
        m. Time commitment
        n. Training
        o. Other (please specify)
    2. Please expand upon barriers selected above. (Free response)
    3. Please describe the level of clinical provider buy-in at your Practice. (add scale 1- 5) (Free response)
    4. What are the benefits of telehealth for your practice? (choose all that apply)
        a. Increased patient access
        b. Improved relationships with patients
        c. Improved specialty provider relationship
        d. Increased volume of patient visits/ increased revenue
        e. Reduction in no-show appointments
        f. Ability to bill for on call services
        g. Ability to work from home
        h. Other (free text)

J. Best Practice Sharing, Assistance and Resources
    1. Would you participate in an upcoming Telehealth Webinar Learning Series – add more details 6 months, 1 topic per month? (anticipated to start in October 2020)
        a. Yes
        b. No
    2. What topics would you like to see offered in this Learning Series? (Drop-down menu and free response for comments)

    a. Remote patient monitoring
    b. Reimbursement
    c. Workflow
    d. Ethics/Legal /Regulatory
    e. Privacy and Security
    f. Patient engagement
    g. Behavioral Health
    h. Other (please specify – free response)
3. Would you be willing to share your best practices in telehealth? If so, please share in the response box below.
    a. Yes (please explain – free response)
    b. No
4. Does the practice have any recommendations for community solutions to help improve telehealth and or remote patient monitoring? (free response)

Thank you for your time in completing this important survey!

Appendix B: Phase 1 Primary Care Telehealth Patient Engagement Survey for Patients that **HAVE** used Telehealth Services

Survey Monkey Link: https://www.surveymonkey.com/r/RM9N8KP

Patient Telehealth Survey – Patients who HAVE had a Phone or video visit

Due to the COVID-19 pandemic, medical practices want to better understand how our patients feel about scheduled healthcare visits done by telephone or video. These are scheduled phone or video appointments with anyone on your healthcare team (which may be your primary care provider, a nurse care manager, behavioral health clinician or other clinician).

Your healthcare office has identified you as a patient who has had at least one phone or video appointment in the past 6 months.

Please complete the survey for yourself or a patient for whom you are a caregiver. If you are age 13 or under, a parent or other caregiver should complete this survey for you. [The caregiver should fill this survey out for only one child who has had a scheduled phone or video visit, even if there are more children in the home.]

Thank you. This survey will take about 10 minutes.

Primary Care Provider's Name/ or Medical Practice Name: (<include free text box>)

Town where the medical practice is: (<include free text box>)

Patient Information:

1. Are you filling this survey out for yourself, an adult patient for whom you are a caregiver, or a patient age 13 or under who you care for? (Choose one)
    a. For myself
    b. For an adult patient for whom I am a caregiver
    c. For a patient age 13 or under
2. Gender of patient (Choose one)
    a. Male
    b. Female
    c. Other
    d. Prefer not to say
3. Primary language of patient
    a. English
    b. Spanish
    c. Other (<include free text box>)
4. Age of patient (Drop-down menu)
    a. 0-4
    b. 5-13
    c. 14-18
    d. 19-24
    e. 25-34
    f. 35-44
    g. 45-54
    h. 55-64
    i. 65-74
    j. 75-84
    k. 85-94
    l. 95 and older

Insurance Information:

5. What type of health insurance do you/the patient have? (Choose all that apply) (Drop-down menu)

a. Commercial insurance (Aetna, Blue Cross Blue Shield, Cigna, Neighborhood Health Plan, UnitedHealthcare, Other)
b. Medicare
c. Medicaid (State of RI Insurance/RIte Care, including Tufts Health Plan, Neighborhood Health Plan of Rhode Island, and UnitedHealthcare Community Plan)
d. No health insurance
e. Other (<include free text box>)

Phone or video visit Information:

6. **Now please think about all of the phone/video visits you have ever had.** What were the reason(s) for your/the patient's phone or video visit(s) (Choose all that apply)
    a. Annual check-up
    b. Well Child Visit
    c. Sick visit
    d. Behavioral health visit
    e. Medication management
    f. Nurse care manager check-in
    g. Visit before an Operation or procedure (Pre-OP)
    h. Visit after an Operation or procedure (Post-OP)
    i. Ongoing care
    j. COVID-19 concerns
    k. Pharmacy check-in
    l. Other (<include free text box>)
7. Did you/the patient ever have a scheduled phone appointment before the COVID-19 pandemic?
    a. Yes
    b. No
8. Did you/the patient ever have a scheduled video appointment before the COVID-19 pandemic?
    a. Yes
    b. No
9. Have you/the patient had one or more scheduled healthcare visits over a phone or video after the COVID-19 pandemic? (Choose one)
    a. Yes, just one
    b. Yes, more than one
    c. No

10. If a phone or video appointment had not been available to address your healthcare concern(s), what would you/the patient have done instead? (Drop-down menu)
    a. Gone to see the clinician in person
    b. Gone to the Emergency Room at a local hospital
    c. Gone to a local urgent care/walk-in center
    d. Gone to a CVS MinuteClinic
    e. Not been seen by any clinician
    f. Other (<include free text box>)

11. During the COVID pandemic did you have any in-person visits?
    a. Yes
    b. No
12. If Yes to question 11, how did you get to your in-person visit? (Drop-down menu)
    a. Driven your/the patient's own car
    b. Taken a free ride in someone else's car
    c. Paid for a taxi, Uber or Lyft
    d. Taken a bus or other public transportation
    e. Taken MTM (RI Non-Emergency Medical Transportation - NEMT)
    f. Called an ambulance
    g. Other (<include free text box>)

13. How much do you agree with the following statement? The phone or video visit was able to address what was bothering me/the patient.

Strongly Disagree	Disagree	Agree	Strongly Agree	Prefer Not to Say
What comments or suggestions do you have about what could have been done better? (<include free text box>)				

14. How much do you agree with the following statement? Overall, I/the patient was satisfied with the phone or video visit.

Strongly Disagree	Disagree	Agree	Strongly Agree	Prefer Not to Say
What comments or suggestions do you have about what could have been done better? (< (<include free text box>)				

15. Would you/the patient be willing to have a phone visit again in the future?
    a. Yes (If your answer is "Yes," please choose all the reasons that apply)
        i. Did not have to leave home for a phone visit
        ii. Phone visit takes less time
        iii. I will not need transportation for a phone visit
        iv. Phone visit allows more time with my healthcare clinician
        v. Phone visit is safer than an in-person visit during COVID-19 pandemic
    b. No (If your answer is "No," please choose all the reasons that apply)
        i. Uncomfortable using a phone for a medical visit
        ii. Do not have a phone
        iii. Cell phone service is unreliable
        iv. Have concerns about privacy during a phone visit
        v. Need deaf/hearing impaired services to use the phone
        vi. Do not speak English and need a language interpreter
        vii. Phone visit with the healthcare clinician is too short
        viii. Other (< free text box>)

16. Would you/the patient be willing to have a video visit again in the future?
    a. Yes (If your answer is "Yes," please choose all the reasons that apply)
        i. I do not have to leave my home for a video visit
        ii. Video visit takes less of my time
        iii. Video visit does not require transportation
        iv. Video visit gives me more time with the healthcare clinician
        v. Video visit is safer than an in-person visit due during the COVID-19 pandemic

b. No (If your answer is “No,” please choose all the reasons that apply)
    i. Uncomfortable using video for a medical visit
    ii. Do not have a computer/tablet for video visit
    iii. Cell phone or computer internet service is unreliable
    iv. Have concerns about privacy during video visit
    v. Need deaf/hearing impaired services to have a video visit
    vi. Do not speak English and need a language interpreter
    vii. Video visit with the healthcare clinician is too short.
    viii. Other (< free text box>)

17. Which type of medical visit do you prefer? (Choose one)
    a. Phone visit
    b. Video visit
    c. In-person visit
18. What can make a phone or video appointment better? Do you have any other comments? (<include free text box>)

1. Do you have a suggestion for how the community (such as government, social services, churches, schools, YMCA, media, neighborhoods, etc.) could make phone or video appointments better? (<Include free text box>)

Thank you for your time. Please click “Submit” to complete the survey.

Appendix C: Phase 1 Primary Care Telehealth Patient Engagement Survey for Patients that have **not** used Telehealth Services

Survey Monkey Link: https://www.surveymonkey.com/r/M9X3TCM

Patient Telehealth Survey – Patients who HAVE NOT had a Phone or video visit

Due to the COVID-19 pandemic, medical practices want to better understand how our patients feel about scheduled healthcare visits done by telephone or video. These are scheduled phone or video appointments with anyone on your healthcare team (which may be your primary care provider, a nurse care manager, behavioral health clinician or other clinician).

You have been identified as a patient who has NOT HAD a phone or video visit since COVID-19 pandemic began.

Please complete the survey for yourself or a patient for whom you are a caregiver. If you are age 13 or under, a parent or other caregiver should complete this survey for you. (The caregiver should fill this survey out for only the child identified, even if there are more children in the home.)

Thank you. This survey will take you about 5 minutes.

Primary Care Provider's Name/ or Medical Practice Name: (<include free text box>)

Location / or Town of Practice: (<include free text box>)

Patient Information:

2. Are you filling this survey out for yourself, an adult patient for whom you are a caregiver, or a patient age 13 or under who you care for? (Choose one)
    a. For myself
    b. For an adult patient for whom I am a caregiver
    c. For a patient age 13 or under
3. Gender of patient (Choose one)
    a. Male
    b. Female
    c. Other
    d. Prefer not to say
4. Primary language of patient
    a. English
    b. Spanish
    c. Other (<include free text box>)
5. Age of patient (Drop-down menu)
    a. 0-4
    b. 5-13
    c. 14-18
    d. 19-24
    e. 25-34
    f. 35-44
    g. 45-54
    h. 55-64
    i. 65-74
    j. 75-84
    k. 85-94
    l. 95 and older

Insurance Information:

6. What type of health insurance do you/the patient have? (Choose all that apply) (Drop-down menu)
    a. Commercial insurance (Aetna, Blue Cross Blue Shield, Cigna, Neighborhood Health Plan, UnitedHealthcare, Other)
    b. Medicare
    c. Medicaid (State of RI Insurance/RIte Care, including Tufts Health Plan, Neighborhood Health Plan of Rhode Island, and UnitedHealthcare Community Plan)
    d. No health insurance
    e. Other (<include free text box>)

Phone or video visit Information:

7. If you/the patient have not had a scheduled phone or video visit, please tell us why not. (Choose all that apply)
    a. Phone or video visit was not offered for the type of appointment needed (such as a vaccination/shot)
    b. Did not need healthcare since March 2020
    c. Was not needing healthcare since March 2020
    d. Offered a phone or video appointment, but chose an in-person visit instead
    e. Offered a phone or video appointment, but chose to go to a local Emergency Room instead
    f. Offered a phone or video appointment, but chose to go to a local urgent care center instead
    g. Offered a phone or video appointment, but chose not to get healthcare at all
    h. Uncomfortable using the phone or computer for a medical visit
    i. Do not have access to a phone or computer for a medical visit
    j. Cell phone or computer internet service is unreliable
    k. Concerned about privacy when using the phone or computer
    l. No deaf/hearing impaired services were offered as part of the phone or video visit
    m. No interpreter was offered for non-English speaking patients
    n. Phone or video visit is too short
    o. Other (<include free text box>)
8. Would you/the patient consider having a phone visit when needing healthcare in the future?
    a. Yes (If your answer is Yes, please choose all the reasons that apply)
        i. Will not have to leave home for a phone visit
        ii. Phone visit will take less time
        iii. Will not need transportation for a phone visit
        iv. Phone visit will allow more time with the healthcare clinician
        v. Phone visit is safer than an in-person visit during COVID-19 pandemic
    b. No (If your answer is NO, please choose all that apply)
        i. Still uncomfortable using the phone for a medical appointment
        ii. Still do not have access to a phone
        iii. Cell phone service is still unreliable
        iv. Concerned about privacy when using the phone for a medical visit
        v. No deaf/hearing impaired services offered as part of the phone visit
        vi. No interpreter offered for non-English speaking patients
        vii. The phone visit will be too short
        viii. Other (<include free text box>)
9. Would you/the patient consider having a video visit when you need healthcare in the future?
    a. Yes (If your answer is Yes, please choose all the reasons that apply)
        i. Will not have to leave my home for a video visit
        ii. Video visit will take less time
        iii. Will not need transportation for a video visit

iv. Video visit will allow more time with the healthcare clinician
v. Video visit is safer than an in-person visit due during the COVID-19 pandemic

b. No (If your answer is NO, please choose all that apply)
   i. Still uncomfortable using the computer for a medical appointment
   ii. Still do not have access to a computer
   iii. Cell phone or computer broad band service is still unreliable
   iv. Concerned about privacy when using the computer for a medical visit
   v. No deaf/hearing impaired services offered as part of the video visit
   vi. No interpreter offered for non-English speaking patients
   vii. Video visit will be too short
   viii. Other (<include free text box>)

10. What can make a phone or video appointment better? Do you have any other comments? (<include free text box>)

11. Do you have a suggestion for how the community (such as government, social services, churches, schools, YMCA, media, neighborhoods, etc.) could make phone or video appointments better?
(<Include free text box>)

Thank you for your time. Please click "Submit" to complete the survey.

Appendix D: Phase 1 Primary Care Telehealth Patient Engagement Survey for Patients that **HAVE** used Telehealth Services (Spanish Version)

Survey Monkey Link: https://www.surveymonkey.com/r/FS2W97M

(Spanish Version)

Encuesta de Asistencia Médica Telefónica – Pacientes quienes HAN tenido una cita telefónica o por video

Debido a la pandemia por el COVID-19, los centros médicos buscan comprender cómo se sienten sus pacientes con las citas médicas programas realizadas por teléfono o video. Estas son citas programadas por teléfono o video con alguna persona de su equipo médico (puede ser su prestador de asistencia primaria, una jefa de enfermeras, un médico clínico especialista en salud del comportamiento u otro médico clínico).

Su cobertura médica lo ha identificado como un paciente que ha tenido al menos una cita telefónica o por video en los últimos 6 meses.

Por favor complete la encuesta respondiendo por usted o por algún paciente de quien usted es su acompañante. Si usted es menor de 13 años, sus padres u otro acompañante deberán completar la encuesta por usted. [El acompañante deberá completar la encuesta solo por un niño que haya tenido una cita telefónica o por video programada, aunque tenga más niños.]

Gracias. Esta encuesta le tomará alrededor de 10 minutos.

Nombre del prestador de asistencia primaria/o Nombre del centro médico: (<Incluir casilla de texto libre>) Ciudad donde se encuentra el centro médico: (<Incluir casilla de texto libre>)

Información sobre el paciente:

1. ¿Usted está completando esta encuesta por usted, por un paciente adulto de quién usted es su acompañante, o por un paciente menor de 13 años de quién usted es su acompañante? (Elija uno)
   a. Por mí mismo
   b. Por un adulto de quién soy su acompañante
   c. Por un paciente menor de 13 años
2. Sexo del paciente (Elija uno)
   a. Masculino
   b. Femenino
   c. Otro
   d. Prefiero no aclarar
3. Primer idioma del paciente
   a. Inglés
   b. Español
   c. Otro (<Incluir casilla de texto libre>)
4. Edad del paciente (menú desplegable)
   a. 0-4

b. 5-13
c. 14-18
d. 19-24
e. 25-34
f. 35-44
g. 45-54
h. 55-64
i. 65-74
j. 75-84
k. 85-94
l. 95 o más

Información sobre su cobertura médica:

5. ¿Qué tipo de cobertura médica posee usted/el paciente? (Elija todo lo que aplique) (menú desplegable)
   a. Cobertura comercial (Aetna, Blue Cross Blue Shield, Cigna, Neighborhood Health Plan, UnitedHealthcare, Otra)
   b. Medicare
   c. Medicaid (Cobertura estatal de Rhode Island/RIte Care, incluyendoTufts Health Plan, Neighborhood Health Plan of Rhode Island, y UnitedHealthcare Community Plan)
   d. No poseo cobertura médica
   e. Otro (<Incluir casilla de texto libre>)

Información sobre la cita médica telefónica o por video:

6. **Ahora por favor piense en todas las citas médicas/por video que haya tenido.** Cuáles fueron los motivos de su cita médica telefónica o por video/ o los del paciente (Elija todo lo que aplique) a. Chequeo anual
   b. Visitas periódicas por control infantil
   c. Visitas por enfermedad
   d. Visitas por salud del comportamiento
   e. Administración de medicación
   f. Facturación de la gerente de enfermería
   g. Visita antes de una operación o procedimiento (Pre-OP)
   h. Visita después de una operación o procedimiento (Post-OP)
   i. Atención permanente
   j. Preocupaciones debido al COVID-19
   k. Facturas de farmacia
   l. Otro (<Incluir casilla de texto libre>)
7. ¿Ha programado usted/el paciente alguna una cita telefónica antes de la pandemia por COVID-19? a. Sí
   b. No

8. ¿Ha programado usted/el paciente alguna una cita por video antes de la pandemia por COVID-19? a. Sí
   b. No
9. ¿Ha programado usted/el paciente una o más visitas médicas telefónicas o por video luego de la pandemia por COVID-19? (Elija uno)
   a. Sí, solo uno
   b. Sí, más de una
   c. No

10. Si no lograba agendar una cita telefónica o por video que abordara sus preocupaciones de salud, ¿qué hubiera hecho usted/el paciente en ese caso? (Menú desplegable)
    a. Dirigirme al consultorio médico en persona
    b. Dirigirme a la Emergencia de un hospital
    c. Dirigirme a un centro de urgencias local/sin turno previo
    d. Dirigirme a CVS MinuteClinic
    e. No atenderme con ningún médico
    f. Otro (<Incluir casilla de texto libre>)

11. Durante la pandemia por COVID, ¿tuvo alguna visita en persona? a. Sí
    b. No
12. Si responde sí a la pregunta 11, ¿cómo se acercó a la visita en persona? (Menú desplegable)
    a. Manejó su auto/el del paciente
    b. Le llevó otra persona en su auto
    c. Pagó un taxi, Uber o Lyft
    d. Tomó un autobús u otro transporte público
    e. Tomó MTM (transporte médico de Rhode Island para casos ambulatorios - NEMT) f. Llamó a una ambulancia
    g. Otro (<Incluir casilla de texto libre>)

13. ¿En qué grado está de acuerdo con estas afirmaciones? La cita telefónica o por video pudo resolver lo que me afectaba a mí/al paciente

No concuerdo en absoluto	En desacuerdo	De acuerdo	De acuerdo totalmente	Prefiero no responder
¿Qué comentarios o sugerencias haría para que la atención hubiera sido mejor? (<Incluir casilla de texto libre>)				

14. ¿En qué grado está de acuerdo con estas afirmaciones? En líneas generales, Yo/el paciente estuvimos conformes con la cita telefónica o por video.

No concuerdo en absoluto	En desacuerdo	De acuerdo	De acuerdo totalmente	Prefiero no responder
¿Qué comentarios o sugerencias haría para que la atención hubiera sido mejor? (< (<Incluir casilla de texto libre>)				

15. ¿Estaría usted/el paciente dispuesto a tener otra cita telefónica nuevamente en el futuro?
    a. Sí (Si su respuesta es "Sí," por favor elija todos los motivos que aplican)
        i. No tengo que salir de casa par una cita telefónica
        ii. Las citas telefónicas llevan menos tiempo
        iii. No necesitaré usar transporte para la cita telefónica iv. Las citas telefónicas me permiten pasar más tiempo con mi médico clínico
        v. Las citas telefónicas son más seguras que las citas en persona durante la pandemia por COVID-19
    b. No (Si su respuesta es "No," por favor elija todos los motivos que aplican)
        i. Es incómodo usar el teléfono para una cita médica
        ii. No tengo teléfono
        iii. El servicio telefónico no es confiable iv. Me preocupa la privacidad durante una cita telefónica
        v. Necesito los servicios para sordos/discapacitados auditivos para utilizar el teléfono
        vi. No hablo inglés y necesito un intérprete
        vii. Las citas telefónicas con el médico clínico son demasiado breves
        viii. Otro (<Incluir casilla de texto libre>)

16. ¿Estaría usted/el paciente dispuesto a tener otra cita por video nuevamente en el futuro?
    a. Sí (Si su respuesta es "Sí," por favor elija todos los motivos que aplican)
        i. No tengo que salir de casa par una cita por video
        ii. Las citas por video llevan menos tiempo
        iii. Las citas por video no requieren el uso de transporte iv. Las citas por video me permiten más tiempo con mi médico clínico
        v. Las citas por video son más seguras que las citas en persona durante la pandemia por COVID-19
    b. No (Si su respuesta es "No," por favor elija todos los motivos que aplican)
        i. Es incómodo usar el video para una cita médica
        ii. No tengo computadora/tablet para realizar una cita por video
        iii. El servicio telefónico o de Internet no es confiable iv. Me preocupa la privacidad durante una cita por video
        v. Necesito los servicios para sordos/discapacitados auditivos para utilizar el video
        vi. No hablo inglés y necesito un intérprete

vii. Las citas por video con el médico clínico son demasiado breves viii. Otro (<Incluir casilla de texto libre>)

17. ¿Qué tipo de cita médica prefiere? (Elija uno)
    a. Cita telefónica
    b. Cita por video
    c. Cita en persona
18. ¿Qué mejoraría una cita telefónica o por video? ¿Tiene algún otro comentario? (<Incluir casilla de texto libre>)

1. ¿Tiene alguna sugerencia para que la comunidad (tales como el gobierno, servicios sociales, iglesias, escuelas, YMCA, medios, vecindarios, etc.) mejore las citas telefónicas o por video? (<Incluir casilla de texto libre>)

Gracias por su tiempo. Por favor haga clic en «Enviar» para completar la encuesta.

Appendix E: Phase 1 Primary Care Telehealth Patient Engagement Survey for Patients that have **not** used Telehealth Services (Spanish Version)

Survey Monkey Link: https://www.surveymonkey.com/r/FSNKRP7

(Spanish Version)

Encuesta de Asistencia Médica Telefónica – Pacientes quienes NO HAN tenido una cita telefónica o por video

Debido a la pandemia por el COVID-19, los centros médicos buscan comprender cómo se sienten sus pacientes con las citas médicas programas realizadas por teléfono o video. Estas son citas programadas por teléfono o video con alguna persona de su equipo médico (puede ser su prestador de asistencia

primaria, la jefa de enfermería, un médico clínico especialista en salud del comportamiento u otro médico clínico).

Usted ha sido identificado como un paciente que NO HA tenido una cita telefónica o por video desde el comienzo de la pandemia por COVID-19.

Por favor complete la encuesta por usted o por un paciente de quién usted es su acompañante. Si usted es menor de 13 años, sus padres u otro acompañante deberán completar la encuesta por usted. (El acompañante deberá completar la encuesta solo por el niño identificado, aunque haya más niños en el hogar.)

Gracias. Esta encuesta le tomará alrededor de 5 minutos.

Nombre del prestador de asistencia primaria/o Nombre del centro médico: (<Incluir casilla de texto libre>) Domicilio/o ciudad donde se encuentra el centro médico: (<Incluir casilla de texto libre>)

Información sobre el paciente:

2. ¿Usted está completado esta encuesta por usted, por un paciente adulto de quién usted es su acompañante, o por un paciente menor de 13 años de quién usted es su acompañante? (Elija uno)
   a. Por mí mismo
   b. Por un adulto de quién soy su acompañante
   c. Por un paciente menor de 13 años
3. Sexo del paciente (Elija uno)
   a. Masculino
   b. Femenino
   c. Otro
   d. Prefiero no aclarar
4. Primer idioma del paciente
   a. Inglés
   b. Español
   c. Otro (<Incluir casilla de texto libre>)
5. Edad del paciente (menú desplegable)
   a. 0-4
   b. 5-13
   c. 14-18
   d. 19-24
   e. 25-34
   f. 35-44
   g. 45-54
   h. 55-64
   i. 65-74
   j. 75-84
   k. 85-94

l. 95 o más

Información sobre su cobertura médica:

6. ¿Qué tipo de cobertura médica posee usted/el paciente? (Elija todo lo que aplica) (menú desplegable)
    a. Cobertura comercial (Aetna, Blue Cross Blue Shield, Cigna, Neighborhood Health Plan, UnitedHealthcare, Otra)
    b. Medicare
    c. Medicaid (Cobertura estatal de Rhode Island/RIte Care, incluyendo Tufts Health Plan, Neighborhood Health Plan of Rhode Island, y UnitedHealthcare Community Plan)
    d. No posee cobertura médica
    e. Otro (<Incluir casilla de texto libre>)

Información sobre la cita médica telefónica o por video:

7. Si usted/el paciente no ha tenido una cita telefónica o por video programada, por favor díganos por qué.
   (Elija todo lo que aplica)
    a. No se sugirió cita telefónica o por video por el tipo de cita que se necesitaba (tal como vacuna/inyección)
    b. No necesitaba asistencia médica desde marzo de 2020
    c. No estaba necesitando asistencia médica desde marzo de 2020
    d. Me ofrecieron una cita telefónica o por video, pero elegí una cita en persona
    e. Me ofrecieron una cita telefónica o por video, pero elegí ir a una Guardia
    f. Me ofrecieron una cita telefónica o por video, pero elegí ir a un centro de urgencias local
    g. Me ofrecieron una cita telefónica o por video, pero elegí no ir a ningún centro
    h. Me siento incómodo utilizando el teléfono o la computadora para una cita médica
    i. No tengo acceso a un teléfono o computadora para tener una cita médica
    j. El servicio de telefonía celular o de Internet no es confiable
    k. Me preocupa la privacidad cuando uso el teléfono o la computadora
    l. No me ofrecieron servicios para sordos/discapacitados auditivos como parte de la cita telefónica o por video
    m. No me ofrecieron intérprete para pacientes que no hablan inglés
    n. Las citas telefónicas o por video son demasiado breves
    o. Otro (<Incluir casilla de texto libre>)
8. ¿Consideraría usted/el paciente utilizar una cita telefónica cuando necesite asistencia médica en el futuro?
    a. Sí (Si su respuesta es “Sí,” por favor elija todos los motivos que aplican)
        i. No tengo que salir de casa par una cita telefónica
        ii. Las citas telefónicas llevan menos tiempo
        iii. No necesitaré usar transporte para la cita telefónica iv. Las citas telefónicas me permiten pasar más tiempo con mi médico clínico
        v. Las citas telefónicas son más seguras que las citas en persona durante la pandemia por

COVID-19

b. No (Si su respuesta es “No,” por favor elija todos los motivos que aplican)
    i. Es incómodo usar el teléfono para una cita médica
    ii. No tengo acceso todavía a un teléfono
    iii. El servicio de telefonía celular no es confiable
    iv. Me preocupa la privacidad cuando uso el teléfono o la computadora
    v. No me ofrecieron servicios para sordos/discapacitados auditivos como parte de la cita telefónica
    vi. No me ofrecieron intérprete para pacientes que no hablan inglés
    vii. Las citas telefónicas son demasiado breves viii. Otro (<Incluir casilla de texto libre>)

9. ¿Consideraría usted/el paciente utilizar una cita por video cuando necesite asistencia médica en el futuro?
    a. Sí (Si su respuesta es “Sí,” por favor elija todos los motivos que aplican)
        i. No tengo que salir de casa par una cita por video
        ii. Las citas por video llevan menos tiempo
        iii. No necesitaré usar transporte para la cita por video iv. Las citas por video me permiten pasar más tiempo con mi médico clínico
        v. Las citas por video son más seguras que las citas en persona durante la pandemia por
        COVID-19
    b. No (Si su respuesta es “No,” por favor elija todo lo que aplica)
        i. Es incómodo usar el teléfono para una cita médica
        ii. No tengo acceso todavía a una computadora
        iii. El servicio de telefonía celular o de Internet no es confiable iv. Me preocupa la privacidad cuando uso la computadora para una cita médica
        v. No me ofrecieron servicios para sordos/discapacitados auditivos como parte de la cita por video
        vi. No me ofrecieron intérprete para pacientes que no hablan inglés
        vii. Las citas telefónicas son demasiado breves viii. Otro (<Incluir casilla de texto libre>)

10. ¿Qué mejoraría una cita telefónica o por video? ¿Tiene algún otro comentario? (<Incluir casilla de texto libre>)
11. ¿Tiene alguna sugerencia para que la comunidad (tales como el gobierno, servicios sociales, iglesias, escuelas, YMCA, medios, vecindarios, etc.) mejore las citas telefónicas o por video? (<Incluir casilla de texto libre>)

Gracias por su tiempo. Por favor haga clic en «Enviar» para completar la encuesta.