Telehealth Update

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Resources

Medical Practice:

- Covid-19: a remote assessment in primary care (BMJ open access journal)
- Why the Telemedicine Physical is Better Than You Think (Jud Hollander, MD, Jefferson Health)
- Telemedicine: Conducting an Effective Physical Exam (JeffConnect CME course)

Other Resource Lists:

- CMS COVID-19 FAQ (35+ pages) AND New Medicare MLN Guidance - April 30, 2020
- www.matrc.org/ (click on COVID-19 link)
- www.telehealthquickstart.org (Presentations with tips and other resources)
Four Domains of Telehealth

- **Hospital & Specialty Care**
  - Specialists see and manage patients remotely

- **Integrated Primary Care**
  - Specialists (often MH) integrate services into primary care environment

- **Remote Monitoring for Transitions and Maintenance**
  - Physiological and behavioral monitoring to maintain best function in least restrictive, least expensive, or most preferred environment

- **Direct to Consumer Services (Primary/Urgent Care)**
  - Convenient access to needed/desired services; popular among younger, busier, and generally healthier patients
Conceptual Framework

TELEMEDICINE IS A DELIVERY MECHANISM, NOT A SERVICE

- Providers need **no new certification or credentials**
- All regulations **apply equally to telehealth**
Regulatory Environment

FEDERAL REGULATIONS

- All federal legislation covering healthcare
- **Prescribing Controlled Substances** (Ryan Haight Act)
  - In person visit required before prescribing controlled substances (or use consultation model)
  - Telemedicine exemption (undefined)
- Medicare (reimbursement)
Regulatory Environment

STATE REGULATIONS

- Licensing Boards (many are silent regarding telehealth)
- State laws/regulations regarding healthcare
- Medicaid (reimbursement)
- Commercial payer regulations (reimbursement)
The Realities of Telehealth Billing

1. Telehealth Reimbursement Varies by Payer
   a. Medicare, Medicaid (each state), Commercial (each plan)

2. Telehealth Billing Policies Vary by Payer
   a. There is no “right way” to bill for telehealth
   b. There are many ways, one for each payer
   c. Some payers mimic Medicare; others don’t
   d. CHCs/RHCs almost always have a completely different method (by state)
   e. Every payer is changing/adapting to current situation
Cross-border Medical Practice ([link - FSMB](https://www.fsmb.org))

Cross-border practice is regulated by the foreign states’ licensing boards (and state governments)

The Federation of State Medical Boards (FSMB) maintains a list of all states’ current policies regarding cross-border practice. ([link](https://www.fsmb.org))

All of Wisconsin’s bordering states temporarily allow cross-border practice

For other disciplines (e.g., nursing, psychology, counseling, social work), see each state’s licensing board website.
POLICIES

Informed Consent
Patient Appropriateness, Location & Safety
Broken Calls
Documentation
Emergencies
Informed Consent

You must document patient consent for telehealth. It can be verbal (for now).

**Main reason:** It’s a chargeable service, but wasn’t before.

Important points to include:

- Calls are not recorded.
- What to do if the call drops (reconnect, or call this number ______).
- There are confidentiality risks; how to minimize them.
- Connect from a quiet, private, safe place, with minimal distractions.
- Only use approved software and links provided.
- The patient portal and video are not an emergency contact method.
Patient Appropriateness

Document any concerns regarding the appropriateness of telehealth for this patient or at this time. Concerns may include:

- Difficulty using the equipment effectively
- Lack of access to adequate connectivity or private space
- Inability to collect necessary medical information from patient or perform an adequate exam
- History of or current difficulty managing patient behavior

**NOTE:** Clinical needs and/or urgency may outweigh concerns
Emergency Procedures

As part of the consent/initial session:

- Discuss emergency procedures and any foreseeable risks
- Collect numbers for local fire, police, and other emergency contacts

In an emergency situation:

- Maintain contact and work to transfer care to appropriate onsite responders and/or caregivers
- Document the event and the transfer of care
- Make any mandated reports
PROCEDURES

Front Desk/Medical Assistants
Opening Script
Presentation & Examination
Disposition & Follow up
Documentation
Use Front Desk/MA Staff Effectively

- Allow front desk to schedule encounters, make initial connections, and then “transfer” sessions to providers.
- Front desk and MA staff may virtually “room” and orient patients.
- Develop a “supplemental technical support” pathway or resource for patients who have difficulty connecting.
- Deploy “on site ePPE” as needed
  - Provider in one room, patient in another (billed as a regular visit)
  - Patients on WiFi in parking lot (or at local business partner locations)
1. Hello [pt]. Can you see and hear me clearly? [Adjust for lighting, sound.]
2. As you know, I’m [Provider]. Can you confirm your name and date of birth for me, please?
3. Can you confirm your location, please?
4. Are you in a private place? Is anyone else in the room or within earshot?
5. Do you have any questions about the privacy of this call or anything else before we begin?
6. If we get disconnected, please reconnect using the same link. If that fails, I will call you at ________. Is that the correct number?
Presentation & Examination

- Maximize capabilities provided in the Patient Portal (separate product or through EHR) to collect symptom information and/or complaints
- Use functional questions or other non-contact techniques to assess medical conditions (assume no ability to physically examine the patient)
- Recognize when a physical examination is required for the condition or presentation, and make appropriate arrangements for an exam
- If decisions are made with inadequate information due to urgency, document these decisions and reasons

http://www.telemedmag.com/article/telemedicine-physical-better-think/
Documentation

Document encounters as usual for the billing code, including ...

- Patient's location (“Home” is OK, as long as address is on file)
- Provider's location (“Clinic” or “Provider home, via secure clinic portal”)
- That the encounter was conducted via telehealth
- Encounter start and stop times
- That the patient consented (unless clearly documented elsewhere)
- Any other people or providers involved, including any presenters

Optional... Provide a reason for using telehealth (medical or otherwise)
PRACTICE

PRACTICE, PRACTICE, PRACTICE

Take some time to gain familiarity and comfort with equipment and software before your first “real” telehealth encounter. Debrief and compare notes if things don’t go as planned, or you need to adjust things.

COMMUNICATE WITH COLLEAGUES AND WORK AS A TEAM
EXPANDING TELEHEALTH SERVICES

Strategies
Platform & Configuration
High Potential Services
Implications & Strategies

● "Telehealth/Virtual Care strategies" have now become a critical part of your overall strategy
  ○ Short term: Get people seen
  ○ Medium term: Post-COVID overall practice patterns

“We are all telehealth providers now.”
Near Term Considerations

Billing and reimbursement will continue to settle unevenly

● Medicare will (attempt to) lead, hampered by political crosscurrents
  ○ The bulk of CMS’s TH policies were enshrined in statute; in the absence of new telehealth legislation, there was a discernible movement at CMS toward defining new services outside the domain of traditional TH (Virtual Check-Ins, eVisits, CCM/CoCM)

● State payers will vary in speed and pattern of response

● Service models will coalesce around locally reimbursable “sweet spots”
“Outside the Domain of Traditional Telehealth”

“Telehealth” for Medicare means:

- Live video
- Originating site and distant site
- Fee for service reimbursement under Part B

Non-traditional services include:

- Virtual Check-Ins
- eVisits
- *CCM/CoCM

No rural restrictions
Few technology limitations
*No encounter-based billing
Considerations for Strategic Planning

- TH regulations and practice will NOT return to the previous state, and the new policies will not be well defined (at least at first)
- Organizations that embrace telehealth will find their patients and providers readily adopt it and experience unforeseen benefits
- Equipment costs will be lower than expected; time/complexity costs will be buried in the general chaos of the coronavirus response
- Care pathways or “channels” will multiply (phone, text, photo, video) along with billing codes (CCM, eVisits, RPM, intra-practice, etc.)
Patient Portals and Other Communication Channels

The Patient Portal is CRITICAL. You need it to:

- Set and confirm scheduled appointments
- Send links and passwords for video calls
- Collect patient information before a call
- Conduct an eVisit

It should be easy to find, easy to set up, simple, clear, and USABLE.

You need ONE PLACE patients can connect with you and stay connected.
Website - Leading Patients In

Enhance your website. Let patients know that you’re there and you are responding appropriately.

Help them contact you.
Push Notifications via SMS (Texting)

Many texting companies are offering free introductory deals. Consider them as a way to reach out to patients.

Other “channels”:
- Outdoor banners
- Other community-based outreach channels
Choosing Technology Platforms - The Spectrum

**Standalone Video**
- Operates independently of your EMR
- “Dual systems” - video on one screen, EMR on the other (or split windows)
- Configuration and generating “meetings” left up to the user (provider); done via staff process or auto-generated

**“eVisit” Platforms**
- Conducted via patient portal or separate eVisit platform
- Supports scheduling, text, images
- Separate from EHR, but may feed it or interact with it
- Support billing “eVisits” (per Medicare definition)

**Fully Integrated EHR**
- All scheduling, communication, and texting within EHR
- Expensive & complex
“eVisit” Platforms

Dozens of potential products exist. Lots of confusion and non-standard feature sets. Necessary features include:

- Patient portal (secure 2-way text communication)
- Image uploads
- Symptoms reporting/histories
- Signatures (informed consent)
- Scheduling
- (Optional) Live video calls

Encounters using these platforms are billable as “eVisits” for Medicare
Evaluating Platforms

Comparison Sites:

http://telehealthtechnology.org/toolkit/clinicians-guide-to-video-platforms/ (TTAC)
https://vsee.com/telemedicine-platform-reviews (VSee)
Mozilla Foundation - Video App Security

No “Consumer Reports” comparison exists
CONFIGURE YOUR SOFTWARE

- Enable encryption
- Use passwords
- Disable recording
- Control screen sharing
- Control chat (= PHI)
- Other optional settings

Assign IT + clinician to audit configuration settings and summarize/report on them
Home Monitoring

RPM can be billed for any patient (during PHE)

- Added interface for provider
- Cost

Limited (but useful) data:

- Oxygen Saturation
- Pulse Rate
- Steps/Falls (activity)

Much more complex systems available
Home Exams

Patient initiated encounters
- Accuracy
- Cost ($300 for pt; much more for Doc)

Limited (but useful) data:
- Live images (ear, throat, skin)
- Stethoscope
- Temp

Network business model
Some General Considerations

1. **Services legally occur at the patient’s physical location.** The provider must be licensed (and credentialed) to provide services at that location.

2. **Telehealth services are often more demanding** physically/mentally/emotionally than in-person care. Take breaks, slow down, debrief, adjust.
Potential Technical Pain Points

Keeping encounters private (separate video products, only).

- Ensuring each client/patient has a secure (unique) link
- “Locking” rooms; using passwords
- Using virtual waiting rooms

Providing technical support to clients/patients who have difficulty.

Alternatives for patients with no cell phones, computers, or connectivity.
Contact

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