Evergreen Council on Problem Gambling

Telehealth: Where are We Now, What Does the Future Hold?

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Learning Objectives:

- Review telehealth definitions and modalities.
- Describe legal and regulatory and billing & reimbursement issues that impact the delivery of telehealth services.
- Review common myths related to Telemental Health care.
- Discuss workflows, office set-up, HIPAA and privacy, and safety planning in delivering TeleBehavioral Health care

TELEHEALTH/TELEMEDICINE

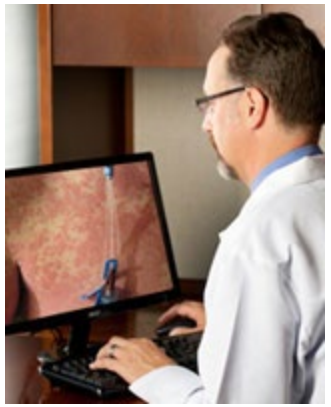
Definition:

- Telehealth = the use of a technology-based virtual platform to deliver various aspects of health information, prevention, monitoring, and health care services.

- Telemedicine = the delivery of health care services via a remote electronic interface, including provider-to-provider, patient-to-provider.

TYPES OF TELEMEDICINE

1. Real-time interactive consultation



2. Store and Forward

4. Case-based teleconferencing

3. Remote monitoring

5. mHealth

WHY DO TELEHEALTH/TELEMEDICINE?

WHY TELEHEALTH/TELEMEDICINE?

"Quadruple Aim"

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care
- Increase provider satisfaction.

COVID-19 Crisis

WHERE WE STARTED

In TV sessions, patients (posed by NPI staff) sit in V-formation so that therapist (on screen) can follow facial expressions on his own monitor.

HISTORICAL PERSPECTIVE 1970-2020

- 1970's
  - 15 federally funded telemedicine projects in the 1970s.
  - Cumbersome and expensive technologies .
- 1980's
  - Resurgence in the 1980s with widespread entry into computer age.
- 1990's
  - International telemental health applications (e.g. Australia).
- 2000's
  - Improved technology and internet access opens possibilities for multiple digital health modalities
  - Policies, billing, re-imbursement were lagging pre-COVID

MYTHS AND FACTS

- ***"Diagnoses are not valid"***
  - Hilty et al. Telemedicine Journal and e-Health. 2013;19:444-454.
  - Hubley et al. World Journal of Psychiatry. 2016; 22;6(2): 269-282

- ***"Treatment is not as good"***
  - Ruskin et al. Am. J Psychiatry 2004; Aug;161(8):1471-6.
  - Hailey et al. Can J Psychiatry 2008; 53(11):769-78.
  - Fortney et al. JAMA Psychiatry 2015;72(1):58-67.
  - Hubley et al. World Journal of Psychiatry. 2016; 22;6(2): 269-282

2004 – Comparable Outcomes with Tele-Mental Health and Face-to-Face Treatment for Depression

- Landmark study published in 2004, Paul Ruskin, MD, et al of the Baltimore VA
- Compared remote "telepsychiatry" treatment of depression to in-person treatment
- Comparable outcomes: Hamilton Depression Rating Scales, Beck Depression Inventory Scores, drop-out rates, satisfaction

- ***Ruskin*** *PE, Silver-Aylaian M, Kling MA, Reed SA, Bradham DD, Hebel JR, Barrett D, Knowles F 3rd, Hauser P. Treatment outcomes in depression: comparison of remote treatment through* ***telepsychiatry*** *to in-person treatment. Am J Psychiatry. 2004 Aug;161(8):1471-6).*

MYTHS AND FACTS

- ***"Elderly don't like it"***
  - Actually, elderly really appreciate the convenience of it.
  - Appreciate the improved access to providers.
  - Today's technology is not that complicated and easily taught.
  - Often has options to make it more user-friendly (e.g., large text).
  - Often have experience communicating with family.
  - More likely that education and income level predict internet use than age.

- *Loera. Telmedicine and e-Health. 2008; 14(10):1087-1090.*
- *Haluza et al. Health Communications 2016; 32(11): 1342-1349*

MYTHS AND FACTS

- ***"Patients and providers are not satisfied"***

  - More empathic possibly due to greater eye contact.
  - Patients report less anxiety; "white coat".
  - Better access to specialists.
  - Reduced travel time.
  - Decreased power relationship.
  - Virtual space seen as safer to both patients and providers (e.g. vulnerable populations).

  - Yellowlees et al. International Review of Psychiatry. 2016; 27(6): 476-489
  - Hubley et al. World Journal of Psychiatry. 2016; 22;6(2): 269-282

MYTHS AND FACTS

- ***"Only stable patients should be treated with CVT"***

- Clinical video telehealth (CVT) has the potential to deliver much-needed mental health services to individuals at risk for suicide who face access barriers.

- None of the literature, professional guidelines, and laws pertaining to the provision of mental health services via CVT suggest that high-risk patients should be excluded from this modality.

- Best practices for assessment and management of suicide risk can be feasibly performed by mental health professionals via CVT.

- Mental health professionals delivering services via CVT to high-risk patients would benefit from a multidisciplinary network of CVT providers for referral and consultation.

- McGinn et al. Psychiat Clin N Am. 2019; 42: 587-595

MYTHS AND FACTS

- ***"Ethically, it is too risky when compared to in-person care"***

  - Nice review of considerations to assure ethical care is being delivered:
    - Providing competent, safe care.
    - Ensuring informed consent.
    - Managing boundaries.
    - Ensuring continuity of care.
    - Addressing health equity.
    - Promoting privacy and confidentiality.

  - Sabin et al. International Review of Psychiatry. 2015; 27(6): 490-495

Core Components of a TMH CVT Program

- What type of services will you provide?
  - Types of patients, providers, services?
- What type of tech issues need to be addressed?
  - IT support, bandwidth, equipment?
- What secure software will you use?
- Where are you delivering services?
  - Center to Clinic, Center to community site, Center to home?
  - Safety planning?

TELEMEDICINE BILLING & REIMBURSEMENT - CMS

CMS before COVID ….during COVID

- Specified ~100 CPT/HCPCs codes… now 240+
- FQHCs & RHCs excluded as distant sites… now allowed
- Specified providers…
- Patient location/originating site:
  - Specified clinical sites… now includes patient home
  - ~~Required federally defined rural location~~
  - Originating (patient) site fee; facility fee
- Payment parity

Physicians
Nurse practitioners
Physician assistants
Nurse midwives
Clinical nurse specialists
Certified nurse anesthetists
Clinical psychologists
Clinical social workers
Registered dieticians/
Nutrition professionals

ST, OT, PT….all providers eligible to bill Medicare

TELEMEDICINE BILLING & REIMBURSEMENT - CMS

- **TECHNOLOGY-ENABLED SERVICES/**
- **COMMUNICATION TECHNOLOGY-BASED SERVICES** (CTBS)

for Medicare beneficiaries via:

- **Virtual Check-Ins:** synchronous (phone/video) & asynchronous (S&F)
- **eVisits:** "digital" visits through an online portal
- **eConsults:** interprofessional consults (phone/video/ internet/EMR/S&F)

CTBS ≠ "Telehealth/Telemedicine"

https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

WASHINGTON STATE TELEHEALTH/TELEMEDICINE LEGISLATION

- **2015 - SB 5175** Coverage parity; defined telemedicine (WAC 182-531-1730); excludes “home”; no rural requirements; no specified provider types; includes S&F; allows credential-by-proxy
- **2016 - SB 6519** Includes “home” as originating site; WS Telehealth Collaborative
- **2017 - SB 5436** “Home” definition
- **2020 - SB6061** – Effective 1-1-2021, a health care professional who provides clinical telemedicine services, other than an MD or DO, shall complete a telemedicine training.
- **2020 - SB5385** - Payment parity Effective ~~1/1/2021~~….immediately.
- **2021 - HB1196** – Payment parity for audio-only telemedicine services with established patients. Must obtain patient consent. Not email or fax, or audio-only services that are not customarily billed. Extends WSTC through 2023.
- **2021 - SB5423** - Concerning telemedicine consultation:

WASHINGTON STATE TELEHEALTH/TELEMEDICINE LEGISLATION

- Telemedicine definition
  - HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) or store and forward (S&F) technology
  - within scope of practice
  - to a client at a site other than the site where the provider is located
  - S&F requires an associated office visit between the patient and the referring health care provider
- Payment parity
- Provider must be licensed in WA
- Allows for payment of the originating site fee – not if patient is at “home”
- Did not include audio-only telephone, fax, or email…add telephone to definition of telemedicine?

WASHINGTON STATE TELEHEALTH/TELEMEDICINE LEGISLATION

For reference only:

RCW 70.41.020: Definitions.
RCW 48.43.735: Reimbursement of health care services provided through telemedicine or store and forward technology. : health plans.
RCW 41.05.700: Reimbursement of health care services provided through telemedicine or store and forward technology. : employer health plans.
RCW 74.09.325: Reimbursement of a health care service provided through telemedicine or store and forward technology—Report to the legislature.
RCW 74.09.658: Home health—Reimbursement—Telemedicine. : Medicaid managed care
RCW 70.41.230: Duty of hospital to request information on physicians, physician assistants, or advanced registered nurse practitioners granted privileges. : addresses specific elements of credential-by-proxy process for any physician, physician assistant, or advanced registered nurse practitioner providing telemedicine or store and forward services.
WAC 182-531-1730:
Telemedicine Guideline (MD2014-03)
Telemedicine & Continuity of Care (POL2018-01)

TELEMEDICINE BILLING & REIMBURSEMENT - WA

Washington State Medicaid

https://www.hca.wa.gov/assets/billers-and-providers/telehealth-brief-for-COVID-03-2020.pdf

Washington State Health Care Authority

Apple Health (Medicaid) telemedicine & telehealth brief

Introduction

In response to the COVID-19 pandemic, the Health Care Authority (HCA) and the Apple Health (Medicaid) managed care organizations are allowing the use of a variety of telehealth technologies to meet the healthcare needs of providers, clients and families. In the health care community the words telehealth and telemedicine are often used interchangeably. However for Apple Health, telemedicine is defined in a very specific way.

An overview of HCA's telemedicine policy

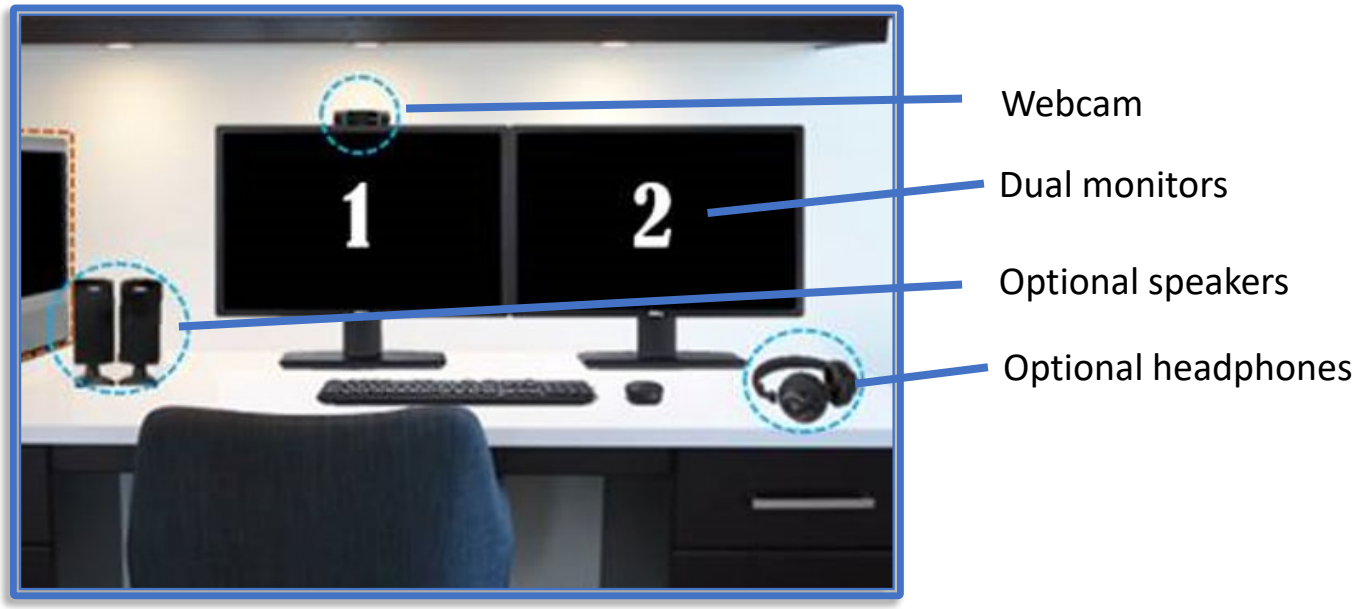
Telemedicine is a form of telehealth that supports the delivery of health care services. HCA has covered telemedicine for many years. HCA's policy for using telemedicine to deliver services is consistent with Medicaid state and federal requirements. RCW 74.09.325 defines telemedicine as the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

TELEHEALTH: LEGAL & REGULATORY

- **Licensure** – Licensure requirement is based on where the <u>patient sits at the time of health care appointment</u>
  - ✓ **Must be licensed in state where patients is located** (waived during PHE by CMS but not states!)
    - Interstate compacts for MDs/DOs √, nurses, psychologists, PTs √, EMS, Audiologists & Speech-Language Pathologists
  - ✓ Must abide by the laws and standards of care in the state where patient is located.
  - ✓ Must abide by telemedicine-specific laws in the state where the patient is located.
- **Malpractice** - policy valid in state where patient is located; covers telemedicine.
- **Credentialing & Privileging** - at provider (distant) site & patient (originating) site as required; credential-by-proxy (optional) – also approved by TJC & CMS
- **Ryan Haight** - changes re in-person visit requirement
- **Consent** - CMS (telehealth vs CBTS), WA State, Non-HIPAA compliant platforms, 42 CFR part 2, how and when/how often obtained, PHE relaxations –> best practice
- **HIPAA** - federal & state requirements - before (HIPAA/HITECH Acts), during (OCR waiver) and after PHE
- **Stark Law & Anti-kickback Statutes** - protect patients from unnecessary services or inappropriate referral for services.

Each state has policies re telemedicine, as well as special waivers/relaxations during PHE!

Telehealth Capable Workstation



Ideal station. Will depend on platform, access, internet connection, location

Setting up your professional space

Do:

1. Look at space where you will be providing care.
2. Make sure it is quiet and nobody can come into this space during a session.
3. Make sure you remove any potentially unprofessional material that could be seen.
4. Make sure lighting is good and you are not back-lit.
5. Do turn on your camera and look at yourself and your background. Do you approve?
6. Do set up your camera so that you are eye level.
7. Do where plain colored non-suggestive clothes “telehealth blue”.

Setting up your professional space

Don't:

1. Provide care in a busy place lacking privacy.
2. Have a busy background with personal or potentially offensive material within sight.
3. Don't wear clothes the blend into the background, avoid being a "Floating head".
4. Don't wear bright patterned cloths.
5. If using a self-screen, drag it to just below the camera.
    1. Impossible not to look at yourself.
    2. Number one complaint is provider did not make eye contact with the patient.
    3. Don't position camera so that you are looking down or up at the patient.

Workflow considerations

Do: consider step-by-step details related to workflow

1. How are referrals made?
2. How are appointments made?
3. How will the patient and provider be notified about the appointment?
4. Where is the patient going to be (home, clinic, other)?
5. Does the patient or clinic have HIPPA compliant software?
6. Does the patient know how to use the software?
7. Would they benefit from a tech call for set-up?

Workflow considerations

Do: consider details related to workflow

1. How do you plan to document in the EHR and will you need to document in multiple EHRs?

2. When the encounter is complete, how to you schedule f/u appts?

3. Do understand details related to your billing system and code appropriately.

4. If consultation is needed, do understand how and where to refer the patient for routine consults.

Workflow considerations

Don't:

1. Assume the patient will be automatically checked into the clinic room. Prior to clinic, check to see who you will be working that day and get their contact information.

2. Assume that all staff at a clinic is familiar with providing support for virtual appointments. As previously noted, check in prior to clinic with who will be supporting you to assure they are prepared and knowledgeable.

3. If providing home-based care, don't assume patient will be familiar with using the equipment. May want to build in extra time at first while the develop expertise.

Setting up your patient for their session.

Do:

-Get Informed Consent either in writing prior, or verbally at first session then clearly document.

-Main components of any Informed Consent include

- -Nature of the recommended intervention (Telehealth)
- -Capacity to make a decision
- -Benefits of intervention
- -Risks of intervention
- -Option to refuse the intervention

Don't:

Assume this is obvious. This is a recommended form of treatment. If you want to set the professional setting correctly, must set the professional tone from the start.

Setting up your patient for their session.

Do:

-Review specifics:

1. Expected benefits (e.g., access, decreased travel).
2. Risks (e.g., transmission over internet, so hacking), this low risk due to encryption, but need to review it esp. if not using HIPPA software.
3. Limits to confidentiality (Usual rules for disclosing medical information such as court order, medical urgency, threats, etc.).
4. Appt. is a professional meeting, so adhere to professional behavior (dress appropriately, no alcohol, MJ, drugs) Assure they have a confidential space prepared.
5. Set boundaries for communications outside of session (emails, phone msgs., etc.).
6. Review option to refuse and what other treatment options would then be available.

Setting up your patient for their session.

At start of each session:

Do obtain following information:

1. Location patient during the planned session.
2. Back-up phone number to be used if CVT session fails.

Don't assume they are in the same place every session esp. if providing home-based care.

Do have a non-emergent back-up plan.

For example:

1. If video fails, close session and prepare for provide to re-connect.
2. If unable to re-connect, provider will call by phone at a previously agreed upon phone number.
3. Can put this information into a header if easier to be cut and pasted into each note.

Setting up your patient for their session.

Don't:

1. Lose control of your boundaries (allow others to wander in an out of session, allow personal email and phone to be used for communication).

2. Allow them to record the session (though they will if they want).

3. Allow a non-professional space with poor lighting (help them get oriented), may want to help them with lighting and room presentation.

4. Don't allow smoking, drinking, or MJ use.
   -Yes, I know it is legal.
   -Yes, I know I already said this, but you will be surprised how often this comes up in session!

5. Don't panic if tech fails, assure patient this can happen and have a plan on what will happen in non-urgent and urgent settings.

Safety Planning when providing care to a clinic

Do:

1. Have an initial and follow-up Safety Plan.
2. Document, recommend using a standard header that can be pasted into each note and updated as appropriate for each session.
3. If providing care to a clinic, be sure to confirm the following:

   a. Location of the clinic

   b. Identified individual at clinic (Jane Smith IT) who can be contacted in case of tech failure, their number, and what do to if CVT drop (attempt to re-connect, call via phone at XXX-XXX-XXXX). Do routinely try these numbers to be sure they work. Will document each appt.

   c. Identified individual at clinic (John Smith RN) who can be contacted in case of clinical emergency, their number (XXX-XXX-XXXX). Do routinely try these numbers to be sure they work. Will Document each appt.

   d. Document use of e911 at 267-908-6605 and ask to be connected to emergency services for the location of the emergency.

   e. Document your location and number.

   f. Do review with clinic staff protocol to be used if someone needs to be admitted.

Safety Planning when providing care to home

Do:

1. Have an initial and follow-up Safety Plan.
2. Document, recommend using a standard header that can be pasted into each note and updated as appropriate for each session.
3. If providing care to home or another site, be sure to confirm the following:

   a. Location of the patient at time of session (address in case e911 is needed)

   b. If possible, identify and document an individual (John Smith family/friend) who would be willing to be contacted in case of clinical emergency and their number (XXX-XXX-XXXX).

   3. Document use of e911 at 267-908-6605 and ask to be connected to emergency services for the location of the emergency.

   4. Document your location and number.

Don't:

1. Forget to have an idea of general clinic, ER, other services in the area where care is being provided.

TELEMEDICINE: DOCUMENTATION

Tips for Documentation

- Date of the service, include start/stop tim[illegible] duration
- Consent:
  - Written, verbal, electronic
  - Who – provider or auxiliary staff
- Others present during the encounter
- How/why service delivered, platform, HIPAA-compli[illegible]
- Physical exam: self-reported or obtained under direction
- Provider location during encounter
- Patient location during encounter…safety plan
- **Billing code + telehealth modifier**
- **Place of Service code**

Please consult with your billing & coding experts, and compliance professionals!

TELEHEALTH/TELEMEDICINE IMPLEMENTATION

❑Evaluation & Metrics

- Who will be affected?
  - Patients
  - Clinicians & Staff
  - Healthcare Facilities
  - Payers
  - Healthcare system
  - Society-at-large

- How will they be affected?
  - Access
  - Efficiency
  - Satisfaction
    - Patient
    - Provider & staff
  - Clinical Outcomes
  - Financial

CHALLENGES FOR TELEHEALTH

- QA/QI work
  - How to share outcomes to impact legislation?
- Hybrid models
  - Determining who gets telehealth and who gets in-person care?
  - In-person/telemed ratio goals
  - Financial implications….may depend on legislation
- Uncertainty re PHE waivers
  - Billing is confusing
  - Rescind or maintain waivers? New legislation?
- Access & equity issues
  - Digital literacy
  - Tech access – devices and broadband
  - Rural & Urban
  - Language barriers, Cultural barriers

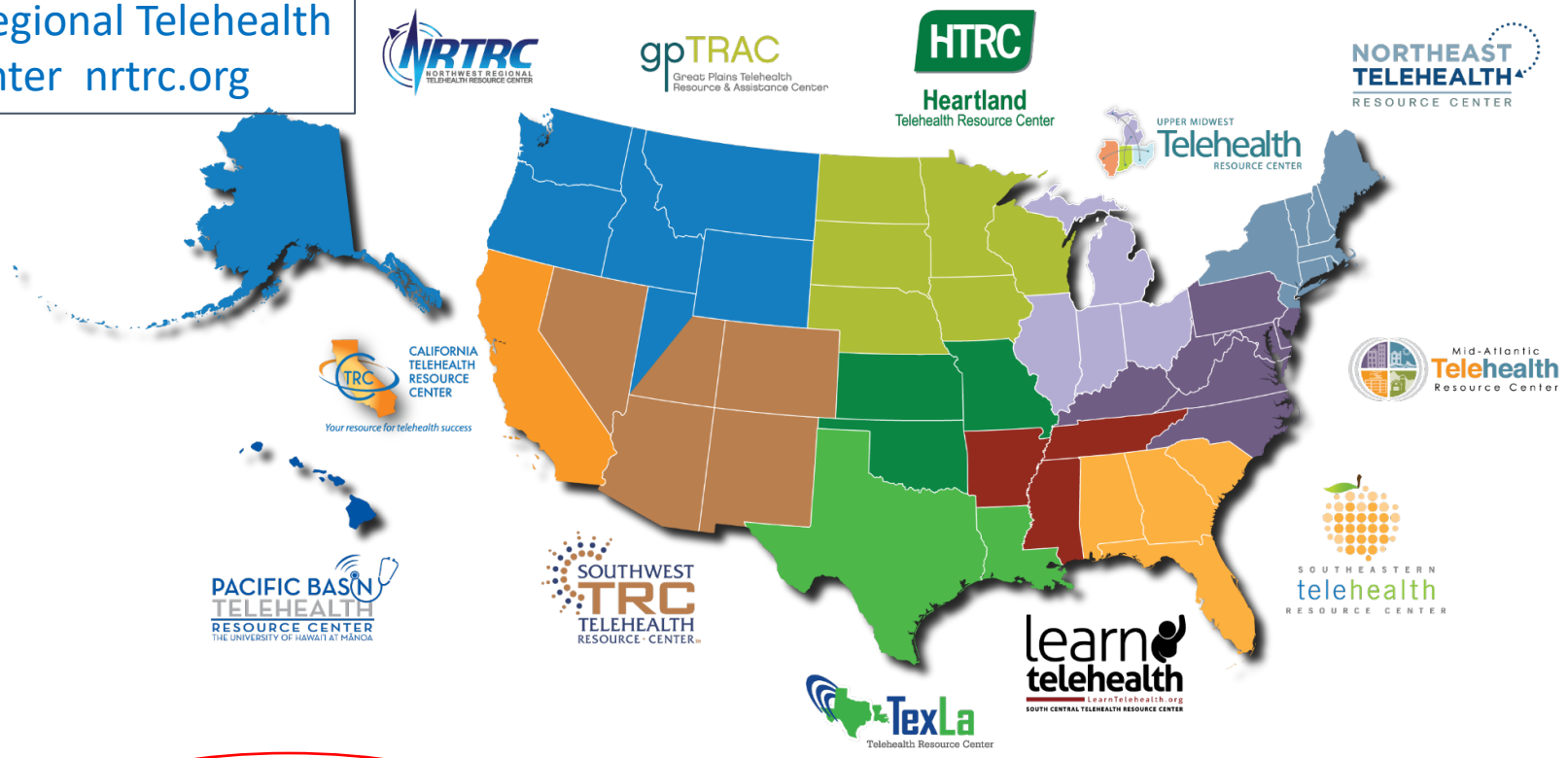
CHALLENGES FOR TELEHEALTH: DISCUSSION OF BARRIERS AND CHALLENGES. WHAT ARE YOUR THOUGHTS AND PLANS?

- Client Barriers and Facilitators
- Policy Barriers and Facilitators
- Administrative Barriers and Facilitators
- Provider Barriers and Facilitators

TELEHEALTH/TELEMEDICINE RESOURCES

TelehealthResourceCenters.org

Northwest Regional Telehealth Resource Center nrtrc.org



TTAC TelehealthTechnology.org
National Telehealth Technology Assessment Resource Center

Center for Connected Health Policy
The National Telehealth Policy Resource Center

2 National Resource Centers

NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

12 Regional Resource Centers