Telehealth: In Response to COVID-19 and Beyond

Ryan Spaulding, PhD
Vice Chancellor, Community Engagement
Research Associate Professor, Department of Biostatistics and Data Science
Acting Director, Center for Telemedicine & Telehealth

Shawna Wright, PhD, LP
Associate Director, KU Center for Telemedicine & Telehealth
Clinical Assistant Professor, Dept. of Psychiatry and Behavioral Sciences
Learning Objectives

• Discuss COVID-19 related telehealth policy updates and identify useful telehealth policy resources.
• Review basic tenants of organizational/provider-level telehealth policy development
• Outline core elements of conducting a technology needs assessment and develop a plan for selecting appropriate telehealth technology.
<table>
<thead>
<tr>
<th>Pre-COVID</th>
<th>During COVID</th>
</tr>
</thead>
<tbody>
<tr>
<td>14% of physicians had done telehealth and 18% intended to try it in the next couple of years</td>
<td>TUKHS: Less than 5 televisits per week to over 1,800 per day by April 21st. Surpassed 50,000 telehealth encounters for 2.5 month period on May 29th</td>
</tr>
<tr>
<td>23% of patients had done video visits and another 57% said they were willing to try it.</td>
<td>Across all private insurers, telehealth claim lines increased 4,347% to 7.5% of all medical claim lines; 15,503% in the Northeast</td>
</tr>
<tr>
<td>1/3 of hospitals and 45% of outpatient providers offered telehealth</td>
<td>Direct to consumer telehealth providers reported an increase ranging from 70% to 158% depending on the company</td>
</tr>
<tr>
<td>CMS did not provide reimbursement for patients in metropolitan areas</td>
<td>CMS waives rural requirement and licensure requirements</td>
</tr>
<tr>
<td>No telephone visits were allowed except Medicare CheckIns</td>
<td>Telephone and consumer level video apps allowed by HHS and many state plans</td>
</tr>
<tr>
<td>Licensure laws prevented most providers from serving patients in other states via telehealth</td>
<td>Many states waived licensure laws for physicians, nurses and other health professionals</td>
</tr>
<tr>
<td>FQHCs and RHCs were not allowed to serve as distant sites</td>
<td>FQHCs and RHCs can be distant sites</td>
</tr>
<tr>
<td>Prior to PHE, approximately 13,000 Medicare beneficiaries used telehealth per week</td>
<td>Last week of April, 1.7 million beneficiaries received telehealth; 22% in rural and 30% in urban areas</td>
</tr>
<tr>
<td>Many providers inexperienced and unprepared for rapid telehealth implementation</td>
<td>Experience gained, many challenges, provider telehealth fatigue</td>
</tr>
</tbody>
</table>
Looking Ahead

- Most federal and state waivers continue at this time
- Anecdotally there are indications that telehealth activity is dropping as clinics and hospitals slowly return to normal operations
- Telehealth will likely fall somewhere between pre-COVID and during-COVID levels
- Survey of 300 practitioners, oncologists, specialists, and primary care providers April 17 and 22, 2020. Only 9% of their patient interaction was via telehealth prior to the pandemic; 51% during the pandemic period, expected to be around 21% after the pandemic ends.
- New physician and patient champions will likely drive some increased telehealth activity post-COVID
- Health systems and clinics that rapidly implemented will likely reassess goals and plan accordingly
- CMS will continue to assess 1) safety, 2) payment rates and 3) fraud during COVID before making any long-term changes

FierceHealthCare, April 2020; Bashur et al, *Beyond the COVID Pandemic, Telemedicine, and Health Care*. Telemedicine and eHealth Journal, August, 2020
2021 Physician Fee Schedule

• Indicates CMS will cut 74 of 83 telehealth codes created during COVID
• Will add 13 new codes to new Category 3 (through end of year that PHE ends)
• Category 1 codes will remain and Category 2 codes are the 74 that will be eliminated
• “CMS found no likelihood of clinical benefit after the PHE ends”
• Home visits, new patients, all levels
• Was open for public comment until **October 5, 2020** and public opinion could change these updates

<table>
<thead>
<tr>
<th>Service Type</th>
<th>HCPCS/CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9 Codes that will continue (Cat 1)</strong></td>
<td></td>
</tr>
<tr>
<td>Group Psychotherapy</td>
<td>90853</td>
</tr>
<tr>
<td>Domiciliary, Rest Home, or Custodial Care services, Established patients</td>
<td>99334-99335</td>
</tr>
<tr>
<td>Home Visits, Established Patient</td>
<td>99347-99348</td>
</tr>
<tr>
<td>Cognitive Assessment and Care Planning Services</td>
<td>99483</td>
</tr>
<tr>
<td>Visit Complexity Inherent to Certain Office/Outpatient E/Ms</td>
<td>GPC1X</td>
</tr>
<tr>
<td>Prolonged Services</td>
<td>99XXX</td>
</tr>
<tr>
<td>Psychological and Neuropsychological Testing</td>
<td>96121</td>
</tr>
<tr>
<td><strong>13 New Codes (Cat 3)</strong></td>
<td></td>
</tr>
<tr>
<td>Domiciliary, Rest Home, or Custodial Care services, Established patients</td>
<td>99336-99337</td>
</tr>
<tr>
<td>Home Visits, Established Patient</td>
<td>99349-99350</td>
</tr>
<tr>
<td>Emergency Department Visits, Levels 1-3</td>
<td>99281-99283</td>
</tr>
<tr>
<td>Nursing facilities discharge day management</td>
<td>99315-99316</td>
</tr>
<tr>
<td>Psychological and Neuropsychological Testing</td>
<td>96130-96133</td>
</tr>
</tbody>
</table>
Digital Divide

• 6.5% of Americans do not have access to broadband (21.3 million people)
• 26% in rural and 32% on tribal lands do not have access to broadband
• 1.7% in urban areas do not have access
• Connecticut (99.1%) highest and Arkansas (77.4%) lowest
• 26% of households with income of less than $30,000 annually are smartphone dependent (do not have broadband)
Tenants of Organizational/Provider-level Telehealth Policy

- Why
- When
- Where
- Who
- How

Policy
Organizational Strategic Plan

Telehealth Strategic Plan

Telehealth Goals and Objectives

Policy
Typical Telehealth Policies

• Why – describes purpose of the policy
• Where – telehealth locations for both distant and originating sites; providers
• Who – technical assistance, scheduling, required credentials
• How - documentation, required forms, appointment processes
• When – scheduled or PRN, after hours
KanCare Telemedicine Reimbursement Update
From Adam Proffitt, State Medicaid Director

The Division of Health Care Finance (DHCF) is working quickly to make necessary program changes to increase the scope of telemed services available to our KanCare members. Our goal is to encourage members to seek their care through virtual options when appropriate. As such, DHCF is writing a number of policies to add a more robust set of services to the list of approved telemed services. As new codes/services are approved, DHCF will post Kansas Medical Assistance Program (KMAP) bulletins for public consumption.

The reimbursement rates for distant sites for services delivered through telemed will be equivalent to identical services provided in person. The Medicaid fee-for-service fee schedule that is posted on the KMAP website will serve as the source of truth for reimbursement by code. There will be no change in reimbursement level for existing originating sites. In the instances that “home” is the originating site, then there will be no originating site fee paid for that claim.
Policy Development Process

1. Identify need
2. Assign responsible individual
3. Gather information
4. Draft policy
5. Review, Input, Edit
6. Implement
7. Evaluate
8. Revise as needed

Start with what you already know from in-person clinics
GINHER INFORMATION

Synthesize Information

• Form a committee
• Stakeholder interviews
• Environmental scan
• Surveys

Draft
Example

What forms are needed for a telehealth consultation and what is the process?
• What forms used in-person and are different ones needed for telehealth?
• Adapted consent to treat form to add telehealth language; different forms for different clinical departments
• Telehealth coordinator sends entire packet to originating site
• Patient completes, originating site sends back via secure email (if available)
• Telehealth coordinator forwards packet to clinical department
• Clinical department enters into electronic health record and completes the billing after the appointment
• Originating site also completes a “Record of Consult” form which telehealth department requires to complete the appointment
From Law to Practice
Kansas Telehealth Law
https://www.cchpca.org/

Medicaid Program: Kansas Medicaid
Program Administrator: Kansas Dept. of Health and Environment
Regional Telehealth Resource Center: Heartland Telehealth Resource Center www.heartlandtrc.org

Kansas Policy At-a-Glance

<table>
<thead>
<tr>
<th>MEDICAID REIMBURSEMENT</th>
<th>PRIVATE PAYER LAW</th>
<th>PROFESSIONAL REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIVE VIDEO</td>
<td>STORE-AND-FORWARD</td>
<td>REMOTE PATIENT MONITORING</td>
</tr>
<tr>
<td>✓</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>IMLC, EMS, NLC</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Missouri Telehealth Law
https://www.cchpca.org/

Missouri

Medicaid Program: HealthNet
Program Administrator: Missouri Dept. of Social Services
Regional Telehealth Resource Center: Heartland Telehealth Resource Center www.heartlandtrc.org

Missouri Policy At-a-Glance

<table>
<thead>
<tr>
<th>MEDICAID REIMBURSEMENT</th>
<th>PRIVATE PAYER LAW</th>
<th>PROFESSIONAL REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIVE VIDEO</td>
<td>LAW EXISTS</td>
<td>LICENSURE COMPACTS</td>
</tr>
<tr>
<td>STORE-AND-FORWARD</td>
<td>PAYMENT PARITY</td>
<td>CONSENT REQUIREMENT</td>
</tr>
<tr>
<td>REMOTE PATIENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MONITORING</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NLC, PTC, PSYPACT, EMS</td>
</tr>
</tbody>
</table>
Sample Policy and Procedure Template

<table>
<thead>
<tr>
<th>Title: Records Management</th>
<th>Policy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Developed By:</td>
<td>[Organization Name]</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>Next Review Date</td>
</tr>
</tbody>
</table>

**TITLE: Telemedicine Program**

I. Purpose/Expected Outcome:
   1. To provide telemedicine clinical diagnostics and treatments services to patients

II. Policy
   2.1 Billing: Billing for services must be in compliance with State and federal laws as well as in accordance with any third party payer's requirements. These laws and requirements vary by state.
   2.2 Confidentiality/Privacy: Transmitting Protected Health Information (PHI) including, but not limited to, patient records, diagnostic results, and videotapes must be secure on both the transmitting and receiving ends.
   2.3 Patient Consents: Patient Consents are required documentation prior to the encounter. The provider requesting the telemedicine services at the originating site must advise the patient about the proposed use of telemedicine, any potential risks, consequences, and benefits and obtain the patient’s or the patient’s legal representative’s consent.
   2.4 Medical Record Documentation: Providers must document all telemedicine services, provide that documentation to the originating site when applicable. Providers must maintain a copy in the facility’s medical record. The physical location of the patient as well as the physical location of the provider must be documented as well as everyone involved in the clinical encounter, including those who may be off camera. Additional documentation needs are dictated by the service or procedure performed.
For Healthcare Organizations

- Introduction to telemedicine
- References or additional resources about telemedicine
- Scope of telemedicine program
- Orientation/training of staff
- Using the equipment
- Confidentiality/privacy
- Video recording of telemedicine services
- Clinical record keeping
- Prescriptions
- Appropriate telemedicine services
- Reporting telemedicine statistics
- Technical quality of telemedicine
- Prioritization of clinical telemedicine
For Telemedicine Providers

Application or telemedicine platform
Overview of telemedicine program and scope
Reimbursement
Telemedicine services offered
Modifiers, codes, and explanation
Telephone calls
Internet services
Definitions
Q & A
Attachments
References
Three Core Components of Telehealth Policy

- Administrative Issues
- Clinical Issues
- Technology Issues
Common Administrative Policy Issues

- Privacy and confidentiality
- Federal, state, local, and other regulatory agency and ethical requirements
- Fiscal management
- Documentation, including use of electronic health records
- Patient and clinician rights and responsibilities
- Use of equipment, devices and technology including peripheral devices, network
- Quality management/improvement
Common Clinical Policy Issues

- Discipline guidelines/standard of care
- Orienting clients/patients to telehealth and understanding local resources
- Familiarity with telehealth software and devices used
- Client/patient consent
- Telehealth documentation
- Cultural sensitivity
Where can I find guidance about developing organizational/provider level telehealth policy?

American Telemedicine Association
www.americantelemed.org

National Consortium of Telehealth Resource Centers
www.telehealthresourcecenter.org

Center for Connected Health Policy
www.cchpca.org

Professional Trade Organizations

Regulatory boards
“Develop your program, then choose your equipment”

Steve North, MD, MPH, FAAFP, Health e Schools, North Carolina
Technology Assessment

- Technology Assessment – identifying the purpose of the technology, user needs, user preferences, requirements, and other details
  - Organizational Readiness Assessment
- Technology Selection – process of identifying available technologies that fulfill the technology assessment
- National Telehealth Technology Assessment Resource Center (TTAC)
- [https://telehealthtechnology.org/toolkits/](https://telehealthtechnology.org/toolkits/)
Technology Selection

Graphic Courtesy of the National Telehealth Technology Assessment Resource Center (TTAC)
Organizational Readiness

• Administrative and clinician support; champions
• Technical infrastructure – IT network, WiFi, bandwidth, current technologies, EHR?
• Environment – space available, good lighting, private, or current clinic space
• Centralized or decentralized model?
• Human resources – tech support, presenters
• Budget range
• Change management
• eSTART Tool
### C. ORGANIZATIONAL ASSESSMENT

<table>
<thead>
<tr>
<th>Your organization:</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has discussed organization readiness concerning telemedicine.</td>
<td></td>
</tr>
<tr>
<td>Organization accepts change (vs. wants to stay with the status quo).</td>
<td></td>
</tr>
<tr>
<td>Is mostly aware of any shortcomings and able to discuss them openly.</td>
<td></td>
</tr>
<tr>
<td>Has formed collaborative partnerships in the past and they’ve worked okay.</td>
<td></td>
</tr>
<tr>
<td>Has interactive video conferencing capabilities already, and is active using them.</td>
<td></td>
</tr>
<tr>
<td>Is aware of examples and evidence of telehealth being used in similar organizations/communities.</td>
<td></td>
</tr>
<tr>
<td>Has individuals working here who are champions for telehealth (clinical/provider, senior administration, or community champions).</td>
<td></td>
</tr>
</tbody>
</table>
Technology Assessment

Step 1: Establish Requirements
- Create needs assessment
- Create Position Statement
- Create User Profile List
- Create Use Case List
- Create Requirements
- SWOT Analysis

Must have Features
Nice to have Features

Graphic Courtesy of the National Telehealth Technology Assessment Resource Center (TTAC)
Technology Selection

Telemedicine Technology Assessment

Needs Assessment

Step 1: Establish Requirements
Step 2: Market Review

Testing

Step 3: Procure Devices
Step 4: Plan Tests
Step 5: Test the Plan

Deployment and Support

Step 6: Select Device
Step 7: Deploy

Graphic Courtesy of the National Telehealth Technology Assessment Resource Center (TTAC)
<table>
<thead>
<tr>
<th>System</th>
<th>One-time Cost Implementation</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Total 5 Year Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation Costs</td>
<td>11,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11,000</td>
</tr>
<tr>
<td>External License Cost (up to 5,000 users/25,000 TDM), included 5% uplift charge</td>
<td>13,131 13,788 14,477 15,201 15,961</td>
<td>72,557</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Customization Costs</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Storage Costs 500GB free, $12,000 per year for 1 TB. Do we need more than 500GB</td>
<td>13,131 13,788 14,477 15,201 15,961</td>
<td>72,557</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Module (per TLT, includes reporting functionality)</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Touchnet Implementation Cost BB/TDM (est. 20hrs)</td>
<td>5,000 1,349</td>
<td>5,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Touchnet Implementation Cost KU-L</td>
<td>1,349</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7,500</td>
</tr>
<tr>
<td>Touchnet Annual Cost KU-L</td>
<td>1,500 1,500 1,500 1,500 1,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7,500</td>
</tr>
<tr>
<td>Content Creation Costs</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Articulate (not required) $600 per license</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Implementation Costs (SABA micro site)</strong></td>
<td>59,985</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>59,985</td>
</tr>
<tr>
<td>Implementation Costs (Publisher) Depends on if we use it</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External License Cost: included 3% uplift increase each year</td>
<td>15,000 15,450 25,000 25,750 26,523</td>
<td>107,723</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Customization Costs (unknown until we know what customizations)</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Storage Costs (550 GB free, $500/yr 550-600GB, $1,500/yr for each 100 GB over 600)</td>
<td>2,000 2,000 2,000 2,000 2,000</td>
<td>10,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Module (included, no separate module to purchase)</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Touchnet Implementation Cost?</td>
<td>1,349</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7,500</td>
</tr>
<tr>
<td>Touchnet Annual Cost KU-L</td>
<td>1,500 1,500 1,500 1,500 1,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7,500</td>
</tr>
<tr>
<td>Content Creation Costs (One of the below options will be necessary, Articulate added as the low cost option)</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Publisher $1,700 per license</td>
<td>61,334 19,100 19,550 29,100 29,850 30,623</td>
<td>189,557</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Articulate $600 per license</td>
<td>600 600 600 600 600 3,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Support Personnel</strong></td>
<td>61,334</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>189,557</td>
</tr>
<tr>
<td>After Implementation:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instructional Designer 1 FTE ($55K plus fringe)</td>
<td>74,250 74,250 74,250 74,250 74,250</td>
<td>371,250</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>System Admin/App Admin/Customer Support 1 FTE ($45K plus fringe)</td>
<td>60,750 60,750 60,750 60,750 60,750</td>
<td>303,750</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Support (credit card revenue, invoicing) 0.125 FTE of current employee ($50K plus fringe)</td>
<td>8,438 8,438 8,438 8,438 8,438</td>
<td>42,188</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Implementation Costs (Publisher)</strong></td>
<td>61,334</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>189,557</td>
</tr>
<tr>
<td>Financial Support (credit card revenue, invoicing) 0.125 FTE of current employee ($50K plus fringe)</td>
<td>8,438 8,438 8,438 8,438 8,438</td>
<td>42,188</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Example

• **Needs Assessment** – Reduce unnecessary follow-up appointments in-person and transition to telehealth

• **Position Statement** – To transition 25% of outpatient appointments to telehealth

• **User profile list** – outpatient providers and patients ages 18-90

• **Use case list**
  ➢ see patients via telehealth in their homes
  ➢ quick follow-ups
  ➢ visual required
  ➢ no peripheral devices needed

• **Requirements** – WiFi capable, simple to use, provides video capability, HIPAA compliant, works on computer or mobile device
Example (con’t)

• Market Review/Environmental Scan – Search for companies or devices that meet your requirements; narrow down list if possible

• Have demonstrations – vendors cover features and walk through your use case scenarios

• Trial - Obtain a trial license or “sandbox” from vendor for your providers to try it on their own

• 5 year total cost of ownership analysis – covers all costs of owning the product including personnel costs

• References – ask vendor for other customers who have purchased the product and conduct reference calls or visits

• Select and Deploy
References


https://www.fsmb.org/advocacy/covid-19/
Questions?

Ryan Spaulding, PhD
Vice Chancellor, Community Engagement
Research Associate Professor, Department of Biostatistics and Data Science
Acting Director, Center for Telemedicine & Telehealth

Shawna Wright, Ph.D., LP
Associate Director, KU Center for Telemedicine & Telehealth
Clinical Assistant Professor, Dept. of Psychiatry and Behavioral Sciences