TELEHEALTH STARTUP GUIDE

Telehealth can be a cost-effective means of meeting patient need – especially when operating under fixed payment models. In fact, patients often prefer telemedicine visits for their convenience and timeliness as compared to office and home visits. This guide explains the key components of utilizing telehealth, especially in a home-based palliative care program.

Definition

Telehealth is the remote delivery of health care using telephones, smartphones, and mobile wireless devices with or without a video connection. For purposes of this guide, the term "telehealth" is broader in scope than telemedicine, covering remote healthcare services that are clinical and non-clinical; "telemedicine" refers solely to remote clinical services[*].

Using Telehealth in Palliative Care

Telehealth can be used in multiple ways, including:

- Live video (synchronous) with real time, two-way interaction between patient and provider, or provider and provider (see below)
- Store-and-forward (asynchronous), including recorded patient history, X-rays, photos shared with a clinician after it is collected/available
- Remote Patient Monitoring (RPM) using devices that send information to the clinical team, such as wireless blood pressure devices, glucometers, pulse oximeters, scales for weight
- Mobile health (mHealth), using smart phones either for synchronous or store-and-forward information-sharing, such as daily patient-reported symptom burden
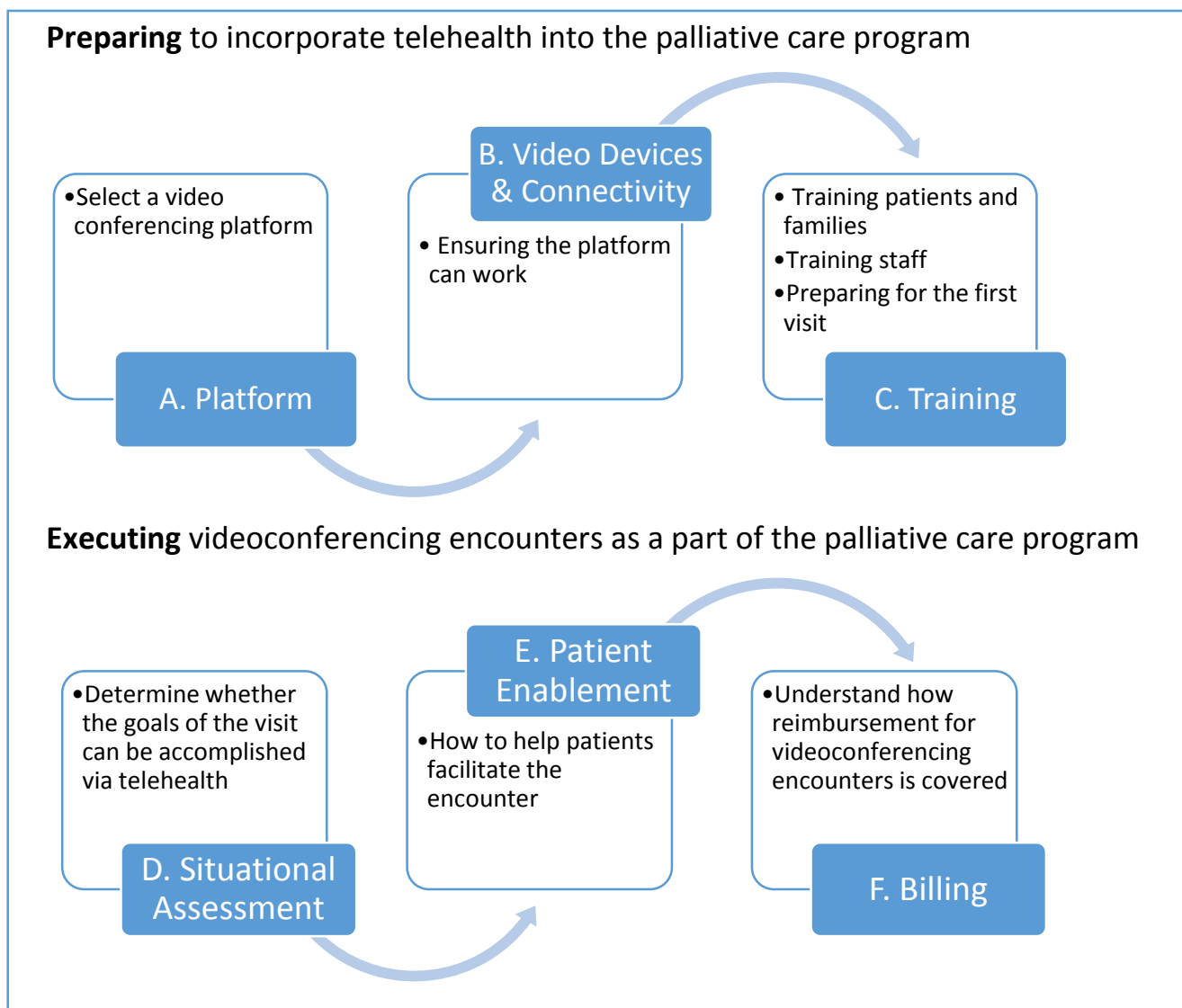- Telephone communication for direct care and assessment, as well as coordination

Telehealth in palliative care can be used for both patient-to-provider and provider-to-provider communication.

- Patient-to-provider communication: In palliative care, just-in-time telehealth can be used for patient-to-provider visits that involve acute issues (such as when a patient has a new symptom), for conversations on care plan changes and advance care planning, for regular check-ins to see how the patient and caregivers are doing, or for caregiver education and support. Telehealth can help the patient and family to feel more connected to their palliative care team, which assists with trust-building and the likelihood of being called when an issue arises

- Provider-to-provider communication: The use cases for provider-to-provider span:
  - Interdisciplinary team meetings
  - Home-visiting staff (or other providers, such as nurses and aides from a collaborating home health agency) can show video of the home environment to a remote physician or social worker, such as to demonstrate hoarding or an empty refrigerator
  - Consultations with other treating clinicians, such as Oncologists or Cardiologists

This guide describes six components for integrating telehealth into a palliative care program, as depicted in the figure below.

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[*] Note that the American Telemedicine Association (ATA) uses the two terms interchangeably, both encompassing remote healthcare.

Preparing to incorporate telehealth into the palliative care program

- Select a video conferencing platform

A. Platform

B. Video Devices & Connectivity

- Ensuring the platform can work

- Training patients and families
- Training staff
- Preparing for the first visit

C. Training

Executing videoconferencing encounters as a part of the palliative care program

- Determine whether the goals of the visit can be accomplished via telehealth

D. Situational Assessment

E. Patient Enablement

- How to help patients facilitate the encounter

- Understand how reimbursement for videoconferencing encounters is covered

F. Billing

A. **Video Platform**

Successful integration of telehealth into palliative care delivery depends on the quality and usability of the video conferencing platform. Simplicity/ease of use for patients and also for staff is the top criterion for selecting a platform.

Almost all platforms require a license from the vendor, and many require the patient to download software or an app to their smartphone or tablet. Some vendors provide the patient with a distinct device that is sometimes easier to use but may then require patients and families to re-enter information such as contacts.

It is also important to understand issues regarding HIPAA compliance. Any vendor to a covered entity that creates, receives, maintains, or transmits Protected Health Information (PHI) is a Business Associate. In order to work with a Business Associate and remain compliant with the law, a Business Associate Agreement (BAA) with the vendor is required. There are exceptions (known as part of the "conduit exception rule") such as the US Postal Service and internet service providers. Apple (FaceTime), while providing end-to-end encryption, has not been known to sign BAAs with providers, and therefore the use of FaceTime should be reviewed with your

compliance officer. Note that during the final quarter of 2014, the United States Department of Veterans Affairs (VA) gave FaceTime an "Approved w/ Constraints" rating.

There may also be state regulatory issues that impact platform selection and/or telehealth policies and procedures. Again, seek guidance from your compliance officer.

(Remember that telehealth can also be delivered via telephone. Especially in areas with unreliable internet connections, the best platform may be as simple as the existing telephone service, provided a system is in place to document the required information about the visit –review this option as well with your compliance officer.)

B. Video Devices & Connectivity

Video conferencing requires at least two devices equipped with front-facing cameras and adequate high speed internet or data connectivity. Hard-wired internet connections, secured wi-fi, and satellite broadband can all support videoconferencing. The required bandwidth is dependent on the chosen platform and may vary.

Quite often – particularly at the first videoconferencing encounter with an individual—technical troubleshooting by support personnel is required to deliver the best possible audio-visual experience for the patient and staff. Programs should be prepared for this when planning their staffing and the time allotted for video visits, especially initial visits.

C. Training

Videoconferencing encounters are fundamentally different from the usual experience of patients and providers interacting in an office or a home setting. For the purposes of building trust with the palliative care team, as well as to orient to the use of videoconferencing as a valuable communication tool, **it is advantageous to schedule the initial encounter as a face-to-face visit in the clinic or home**, while explaining that some or future encounters will be over videoconference. The biggest barriers to effective use of synchronous videoconferencing are psychological; i.e., how we relate to new and unknown experiences.

1. Patient & Family Training
    Once a patient/family agrees to participate, patient and family training can begin by telephone with an assessment of available connectivity, devices, and comfort with technology use. In addition to understanding the technology to be used, the staff members responsible for setting up the patient and family should be selected for their:
    - patience
    - clear (no jargon) unrushed, and detailed communication style
    - familiarity with the psychological barriers around acquisition of new technology skills.

2. Care Team Member Training
    As with patients, the staff must buy-in to using telehealth, and be educated on the benefits expected for both patients and the team. Given that palliative care professionals are experts in communication, engagement, and establishing trust, the training for staff must demonstrate the effectiveness of videoconferencing in establishing genuine presence. Techniques that take advantage of the medium for non-verbal communication are easily taught as minor adaptations of what is already well known to skilled palliative care professionals. Examples include:
    - matching one's image size to the patient's

- awareness of body language within the frame
- maintaining eye contact
- controlling when you move in or out from the camera/patient.

Effective training provides palliative care professionals with new awareness of and attention to background, position, lighting, distracting background sounds, and the maintenance and focus on active listening. Additional tips for staff training -- and to keep in mind when conducting video visits -- include:
- always remember that you can be seen--dress appropriately and do not multitask!
- create a professional or neutral background
- speak slowly and clearly, as audio/video can lag

When a videoconferencing encounter is home-based, staff should be trained to assess the visible home environment. They should ask to be shown where and how medications are organized, what the inside of the refrigerator looks like, or to scan the room(s) for safety issues and other relevant elements of the home.

3.   Preparing for the First Visit
The staff member preparing the patient/family for ongoing telehealth services should do so via an initial home visit, if possible. The critical first steps include ensuring that the device settings can support the platform and the future use, that programs/apps are downloaded successfully, and that communications are tested. All this can be done concurrent with enrollment and orientation to the overall palliative care program. Face-to-face testing and demonstration of the capabilities and benefits of synchronous videoconferencing prior to the first encounter will build the confidence of patients and families.

Some starting introductions for patients and families can be:
"Are you familiar with video conferencing for health care? We use it to make sure we can talk to each other easily and whenever needed. Because we can see and talk with you, it reduces the time we have to spend on the road, making more time available to spend with patients and families. It also reduces the amount of time you have to spend traveling and waiting. We can use it to help figure out any urgent problems that come up, like a new rash or symptom, so we don't have to rely only on a verbal description."

D. Situational Assessment – When Telehealth Should Not Be Used

Assessment of circumstances and goals for the visit must occur in preparation for each videoconferencing encounter. Direct clinical care via synchronous videoconferencing to patients may not be possible in all situations. Disabilities of speech, cognition, hearing, mental health, or impaired ability to manipulate the devices can all limit the use of videoconferencing, and staff presence in the home may be needed to fulfill goals of the encounter. **Examples of times when an in-home face-to-face visit should be used include**:
- Initial comprehensive assessment, as a general rule
- physical exam assessment for acute changes in condition
- wound care
- assessment of caregiving adequacy
- precision tasks such as helping to fill medication organizers
If working with a private health plan (see Billing, below), check the contract for requirements regarding in-home visits versus face-to-face encounters.

Even when staff are physically present at the home visit, videoconferencing can be used to involve and engage others on the team. For example, a nurse staff member in the home can assess the patient's wound and show it to a physician on the care team.

E. Patient and Family Enablement

A videoconferencing palliative care encounter can be initiated both by staff and by the patient themselves, a family member, or a caregiver. They should be encouraged to do so upon any change of condition or rising concern.

Some palliative care programs provide secure tracked loaner devices and/or broadband connectivity to patients and families that cannot afford them. This may be accomplished through grants or as a result of the spending flexibility advantages of alternative payment contracts.

F. Billing

Videoconferencing encounters connecting patients to "billable clinicians" (physicians, nurse practitioners, and/or physician's assistants who are Medicare-certified) are covered by Medicare Fee-for-Service when the patient is physically present in a *Qualifying Originating Site*[1]. These regulations are constantly changing, so check with your compliance officer and billing department to determine which encounters, if any, may be billed to Medicare.

For example, telehealth can be used for the face-to-face requirement for transitional care management (TCM) billing for CPT codes 99495 and 99496 through telehealth in accordance with existing Medicare regulations for telehealth services. Another example is advance care planning services, CPT codes 99497 and 99498.

Medicaid coverage of telemedicine varies by state, with 49 states and the District of Columbia providing reimbursement for some form of live video engagement.[2]

Private health plans, including Medicare Advantage plans and Medicaid Managed Care Organizations, may cover telemedicine to varying degrees. Increasingly, alternative payment contracts are enabling telehealth services as part of the contract. Each plan must be individually queried to determine the level of reimbursement and scope of benefits.

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[1] Eligible facilities that may serve as an Originating Site include provider offices, hospitals, rural health clinics, federally qualified health centers, skilled nursing facilities, community mental health centers, and dialysis centers

[2] Center for Connected Health Policy Report, SPRING 2018