Incorporating Telehealth into Pediatric Practice

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Learning Objectives

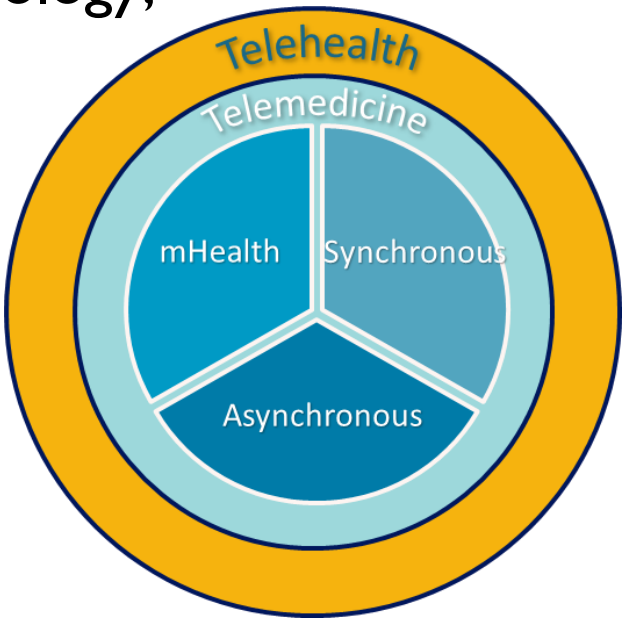
- Understand the regulatory, financial and legal considerations affecting telehealth practice today.
- Learn how to optimally use technology to facilitate clinical care from a distance.
- Identify ways that telehealth can be used to provide comprehensive, efficient and high quality care for children.

Disclosures

Neither the speaker, planner, nor anyone in control of content for today's CME Pediatric Partnership Course has any relevant financial relationships.

Definitions

- Telemedicine: patient care using telecom technology
- Telehealth: health care using telecom technology; includes patient care, health education, etc.



- Originating Site: patient location
- Distant Site: provider location

- Store-and-forward (asynchronous): non-real-time data transfer such as remote interpretation of a photo
- Synchronous: real-time data transfer such as a video conference
- mHealth: mobile technology health care applications

Why Use Telehealth?

- How many American patients will be using telehealth by 2018?

A. 500,000
B. 1 million
C. 2 million
D. 3 million
E. 4 million

- Answer: (D) – 3.2 million. This represents >1000% growth compared to 2013 data!

AAP Section on Telehealth Care (SOTC)

1998 Provisional Section focused on telephone care with 48 charter members

2002 Granted full section status

2008 Changed the name and extended scope beyond telephone care

2018- 400 members (doubled in the last 2 years)

Official liaison relationships with COCIT (2015), SOAPM (2017), SOECP (2018)

AAP SOTC Objectives

Educate pediatricians and others about the delivery of pediatric telehealth care: clinical, technical, regulatory, billing, reimbursement

Create resources to teach pediatricians and pediatric trainees how to deliver quality telehealth services

Provide mentorship

Promote research: access, quality, cost, and clinical outcomes

Promote best practices: documentation, communication with the pediatric medical home

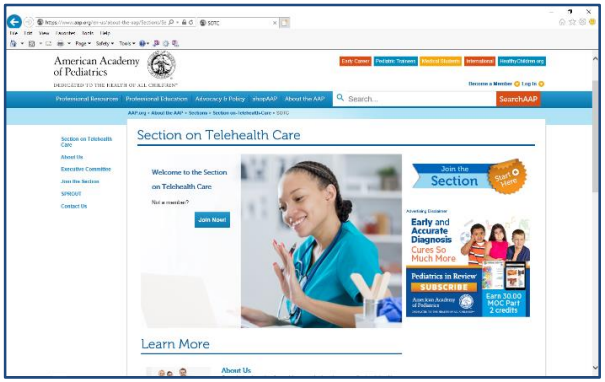
Participate in policy development

Proactively address concerns about **patient safety**, privacy and medicolegal risks related to telehealth care.

Advocate for appropriate use of, and payment for, telehealth care services.

AAP SOTC Solutions & Resources

- Website
  - Comprehensive educational compendium
  - Searchable directory of specialty telehealth services
  - Mentorship program
  - Advocacy action guides and resources
    - Telehealth services
    - Intrastate Medical Licensure Compact
    - State reimbursement policies/ parity legislation
- Listserv: networking, peer resource
- Telehealth Affinity Program
- Education:
  - NCE & PAS
  - Speakers' Bureau
  - Co-sponsor of PEDS 21: Leveraging New Technologies to Transform Child Health (NCE 2018 - Nov 2, 2018, 1:30-5pm)



https://www.aap.org/en-us/about-the-aap/Sections/Section-on-Telehealth-Care/Pages/SOTC.aspx

The 30,000' Medical-Legal Environment

- In-person standard of care = telehealth std of care
- Everything is based on the location of the patient at the time of the telehealth encounter

- Federal laws, state laws, licensing board policies, payer policies & accreditors affect telehealth practice
- Most laws & regulations enacted at the state level
- CMS guidance exists for Medicare but state Medicaid policies vary (and matter more for pediatrics)
- The Joint Commission isn't currently a major driver, but this could change
- HIPAA violation fines are real & expensive
- Few lawsuits: this is good, but little legal precedent

Licensure

- State licensure is required when practicing medicine, nursing, etc.
- Must be licensed in the state where the patient is during the telehealth encounter
- What is the practice of medicine?
  - Exceptions vary by state - read the licensing board policies
  - Provider-to-provider may be viewed differently than provider-to-patient
- Interstate Medical Licensure Compact for physicians
  - Utah is a member – issues licenses but not LOQs (may change soon)
  - Pathway to expedited licensure, NOT license reciprocity
- Enhanced Nurse Licensure Compact (eNLC)
  - Utah is a member
  - eNLC license works in all member states
  - APN compact is being discussed but not in effect

Credentialing & Privileging

- Joint Commission & CMS policies drive this
- Applicable to clinical care in hospitals/ hospital-based clinics
  - If it's required for similar in-person care, it's required for telemedicine
  - If not required for in-person care, shouldn't be required for telemedicine

- Credentialing by proxy (a.k.a. delegated credentialing)
  - Exclusively for telemedicine
  - Need a written agreement between 2 credentialing institutions for credentialing by proxy & written agreement to provide telemedicine services
  - Works for credentialing, privileging, or both
  - In effect, the originating site accepts the decisions of the distant site
  - Can credential/ privilege a slate of practitioners rather than one by one

Malpractice

- Ensure coverage for telemedicine at the patient's location
- Many find their current coverage works for telemedicine, but don't make this assumption
- Before talking with a malpractice provider, know:
  - Planned scope of telemedicine service
  - Patient location(s)
- Practitioners are responsible for obtaining enough data (history, exam, tests, etc.) to make appropriate and defensible medical decisions for a patient
  - If you can't do this with telemedicine, don't use telemedicine
  - This doesn't mean you have to duplicate the in-person exam
  - Have a plan in case an encounter turns into an emergency or becomes inappropriate for telemedicine

Questions for your Malpractice Provider

1. Does my liability insurance cover telemedicine services?
2. Do you cover all states where I plan to provide telemedicine services?
3. Are there tech standards or protocols that you recommend I follow?
4. Am I covered if there is a failure to use telemedicine when its use is alleged to be required under the applicable standard of care?
5. Are my policy limits adequate in each state? For example, if I practice in a state with a cap on damages, am I insured to the level of that cap?
6. What is your rating?
7. What has been your claims experience with distance care in my specialty in each state where I practice or plan to practice?
8. Do you offer a consent-to-settle clause? If so, is it offset by a "hammer" clause?
9. Do you offer any telemedicine-specific risk management advice?
10. Do you offer any discount if I take relevant CME or similar courses designed to reduce my risk, and therefore yours?

* Taken from http://utn.org/support/development/regulatory.shtml

Regulatory/ Compliance Odds & Ends

- Non-independent providers can be tricky, especially if crossing state lines (e.g. trainees, APPs)
- Controlled substances: Ryan-Haight Act, cross-state DEA registration
- Informed consent
  - Patients have the right to opt out of telehealth without penalty
  - Risks/ benefits
  - Specific requirements vary: licensing board & Medicaid policies are good sources
- Electronic security rules found in HIPAA & HITECH Act
- Risk is overall low if you take time to set up a compliant program in the beginning and reassess if/ when:
  - New state law, licensing board policy or Medicaid policy enacted
  - Crossing state lines
  - High risk or high profile services

Pediatric Telehealth Guidance

- AAP Technical Report on telemedicine (2015)
  - Covers: clinical practices, liability, patient safety, privacy, security, licensure & credentialing, research & education, equipment & infrastructure, costs & sustainability
- ATA Pediatric Operating Procedures (2017)
  - Endorsed by AAP & NAPNAP
  - Covers: patient privacy & confidentiality, informed consent, patient safety, parent/ guardian presence, emergency contingencies, mobile devices, encounters, equipment, environment, presenters & facilitators, provider considerations, legal & regulatory considerations
  - No specific clinical guidance
- AAP Policy Statement on non-emergency acute care outside the medical home (2017)
  - Primarily applies to ERs/ UCs, retail clinics & telemedicine programs

The Payer Environment

- Medicaid programs in our part of the country tend to be good about covering telemedicine
- Medicare, Tricare, self-funded plans & commercial plans originating outside the state rarely have to follow state laws
- Commercial payers may contract with providers for telemedicine -> talk with them
- If prior auth or referral is required for similar in-person care, it's required for telemedicine
- Covered benefit exclusions apply to telemedicine
- Live-video patient-to-provider encounters most likely to be covered; home-based telemedicine less likely to be covered
- Each state has a different payer environment
- Advise families to check their coverage!

Coding/ Billing

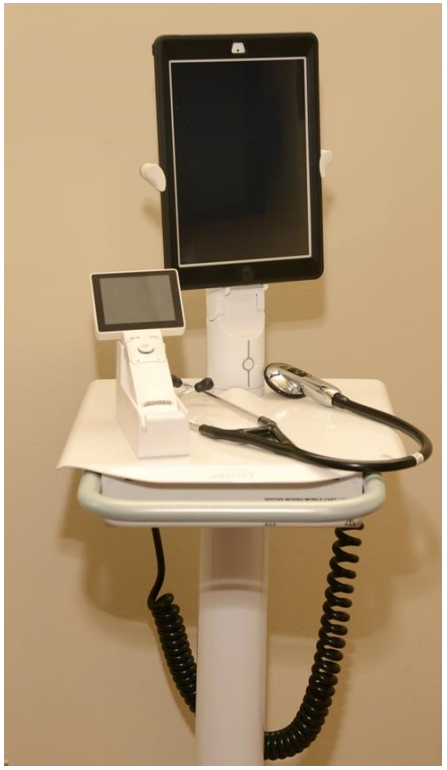
- Standard in-person coding + "02" Place of Service code
- Telehealth originating site fee
- Distant clinician bills professional fee (no facility fee)
- Use note templates for successful billing
- Telemedicine often heavy on counseling/ coordinating care – consider time-based billing if appropriate
- CPT codes for store-and-forward services can capture workload even if not paid
- It's illegal to selectively bill payers that cover telemedicine (e.g. Medicaid) and not bill for identical services provided to patients without coverage
  - You <u>can</u> offer a service to everyone and let patients "self-select" based on their financial situation.

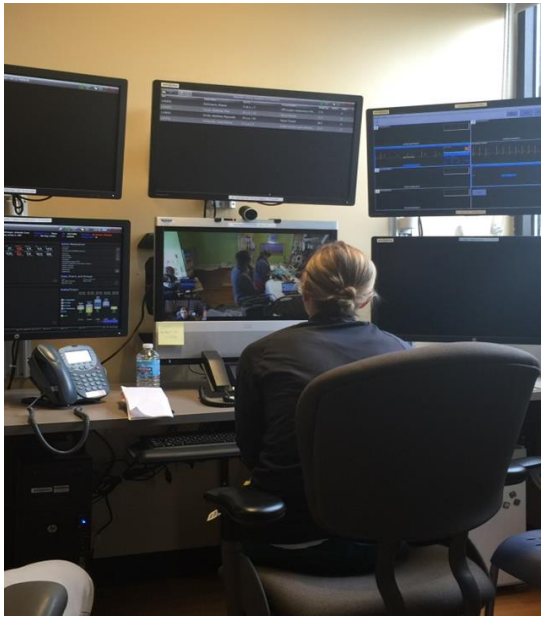
Return on Investment (ROI)

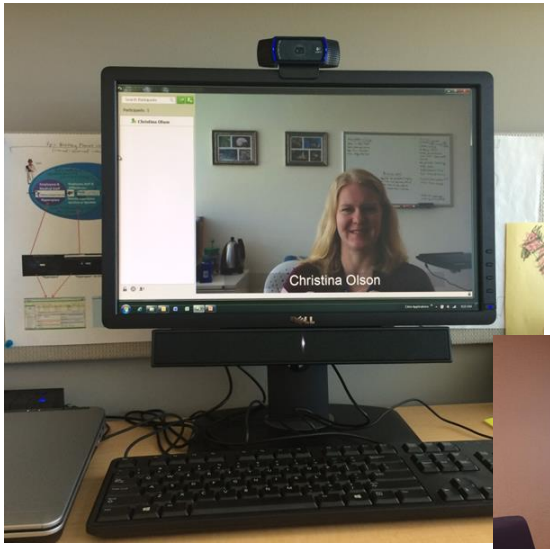
- "Dollars Out":
  - Technology & facility updates: startup & maintenance
  - Training
  - Staff time, new licenses, malpractice premiums, etc.
- "Dollars In":
  - Professional billing
  - Contract billing
  - Grants, donations, financial incentives from payers
- Less quantifiable:
  - Increased patient volume/ market share
  - Lower financial penalties from readmissions, etc.
  - Lower transfer rate
  - Lower costs (especially important in shared risk or bundled payment models)

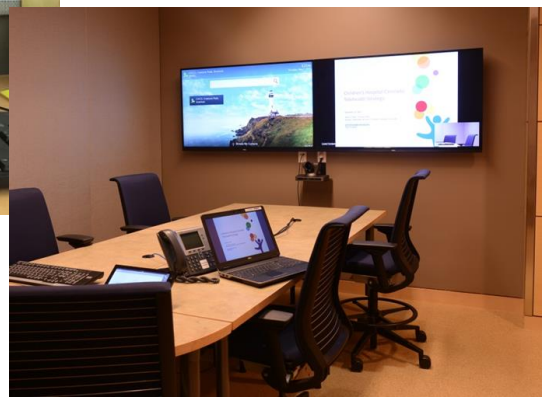
Technology Needs

- Connectivity: usually broadband internet
  - Cellular data can get expensive
- HIPAA-compliant platform…not FaceTime or SMS!
  - Vidyo, Jabber, InTouch & Polycom common at large institutions
  - AAP Affinity Program will utilize SnapMD
- Video visit basics: camera, speakers, mic & central device (anything from a desktop computer to a smartphone)
- Peripheral devices: stethoscope, otoscope, high-res camera, ultrasound, audiometry equipment, etc.
- Store-and-forward technology is highly variable & may be embedded in your EMR or PACS software
- Complete carts including maintenance & tech support available from several vendors





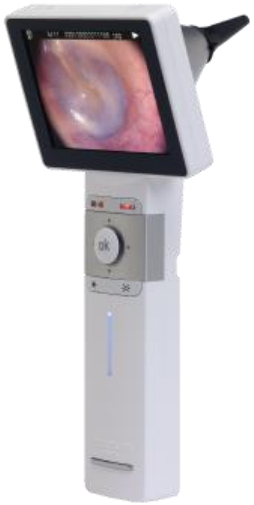




Hard-Wired Technology

Software-based Technology

Telemedicine Peripheral Devices



SnapMD

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Physical Exam Key Points

- Most clinicians find they can do more than they think with telemedicine equipment.
- Remote-controlled pan/tilt/zoom cameras are optimal but more expensive than webcams (cost coming down rapidly).
- Hybrid chronic disease models combining in-person and telehealth encounters may overcome exam limitations.
- Consider using the physical exam of another clinician at the patient's location.
- Doing a good telemedicine exam takes practice. Test runs and/or simulation are essential.

Ready, set…go!

- Where are the patients?
- Identify major patient needs in "health care deserts"
- Are there ED/ inpatient transfers that could have been avoided if "just one thing" were there?
- Ask patients and originating sites what they want
- Find clinicians who want to do telehealth and support their ideas…they'll spread the word
- Prioritize needs over "nice-to-haves". If there's an unmet need, patients/ clinicians are more forgiving of hiccups.
- Purchase technology based on anticipated use cases
- Crossing state lines adds a lot of complexity
- Start small to ensure success but plan for expansion

Children's Colorado Telehealth Program

- ~30 child health specialties using telehealth
  - Each one doing something different
- >2000 patient-provider encounters per year
- Interdisciplinary focus across the health care spectrum
- Innovative models including in-person/ telehealth hybrids
- Affiliated with ECHO Colorado + new ECHO-Lite model
- Research & QI

- Lessons learned as the medical director:
  - Executive sponsorship, flexibility and good internal/ external reputations are essential
  - Tailor services to your patients, financial environment & geography rather than copying what others are doing
  - Offer pilots & use physician champions to overcome hesitation
  - Change can be stressful but this is absolutely worth doing ☺

Moving Beyond Classic Telemedicine

- E-consults
- Photo- and video-based triage
- Remote monitoring
- Medication adherence
- Project ECHO
- Research project support
- Education: providers, patients, caregivers, school nurses, video-conferenced courses, etc.
- Virtual support groups
- Care coordination & transitions of care
- Extended-family-centered care
- Humanitarian/ disaster response

Imagine if…

Rash at preschool?
- Triage nurse evaluates by video & reassures daycare staff; parents stay at work

URI at 10pm?
- PCP evaluates by video, reassures & review returns precautions in patient's home; no ER/ UC visit

New onset seizures?
- Pediatric neurologist provides tele-visits in the PCP's office; family doesn't travel to children's hospital

Status epilepticus in a small non-pediatric ER?
- Distant PICU attending provides real-time support to local provider; seizure resolves

Forgetting meds?
- Cap sensor detects when pill bottle is opened; parent gets text if bottle not opened on schedule

These aren't hypothetical cases!

Be on the lookout for unexpected opportunities…

Quality, Evaluation & Research

- Use in-person care standards as the guide
- Be deliberate
- Collect data and periodically evaluate telehealth services
- Consider 360 degree evaluation: patients, clinicians, IT, administration, ancillary staff
- Periodic billing audits
- Literature on pediatric telehealth services very limited => Publish!
- SPROUT: national pediatric telehealth research network affiliated with the AAP

SPROUT

Summary

- The ROI might not make sense if you only look at short-term dollars-in vs. dollars-out, but there are a lot of other factors.
- Telehealth is good for families with satisfaction rates >90%.
- There's a learning curve, but it's shorter than you'd expect.
- The technology is more available & cheaper than the staffing & processes.
- Work within existing processes as much as possible.
- Telehealth is a new way of providing care, not a new type of care.
- Telehealth is no longer experimental…the future is now and the opportunities are endless!

Online Resources

- Center for Connected Health Policy http://cchpca.org
- Utah Telehealth Network http://utn.org/
- AAP Section on Telehealth Care https://www.aap.org/en-us/about-the-aap/Sections/Section-on-Telehealth-Care/Pages/SOTC.aspx
- ATA/ AAP-endorsed Pediatric Telehealth Operating Procedures https://www.aap.org/en-us/Documents/ATA_Pediatric_Telehealth.pdf
- CMS Telehealth Guidance https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf
- HIPAA for Professionals https://www.hhs.gov/hipaa/for-professionals/index.html?language=es
- State Laws and Reimbursement Policies http://cchpca.org/state-laws-and-reimbursement-policies
- Telehealth Medicaid and State Policies http://www.cchpca.org/telehealth-medicaid-state-policy
- Telehealth Resource Centers http://www.telehealthresourcecenter.org

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Additional Slides:

SPROUT's national pediatric telehealth program assessment

SPROUT

SUPPORTING PEDIATRIC RESEARCH ON OUTCOMES AND UTILIZATION OF TELEHEALTH

- Established in 2015-2016
- Affiliated with AAP SOTC in 2017
- Applied to NIH for funding to address telehealth research barriers
  - if awarded, would link SPROUT with the CTSA network
- Network:
  - 104 Institutions
  - 170 members
  - 38 states

Vision: Children receive the best healthcare: Anywhere, Anytime

Objectives:

•Establish network to do collaborative research in pediatric telehealth

•Determine the impact of telehealth on healthcare quality

•Identify best practices for implementation of pediatric telehealth

National Infrastructure Assessment

Goals:

- Establish a database/registry of existing and developing pediatric telehealth programs across the country
  - Assess program characteristics: technology, funding, services, barriers
- Facilitate collaborative multi-center research studies
  - Develop Research Interest Groups (RIGs) on specific telehealth services
  - Use the registry to recruit and collect further data from programs providing or developing those specific services
  - Identify, study, and disseminate best practices in pediatric telehealth
  - Facilitate advocacy for safe and effective pediatric telehealth practice

* Details from SPROUT's national infrastructure assessment were published in *Pediatrics*: "The Current Pediatric Telehealth Landscape", March 2018 issue

National Infrastructure Survey – Service Lines

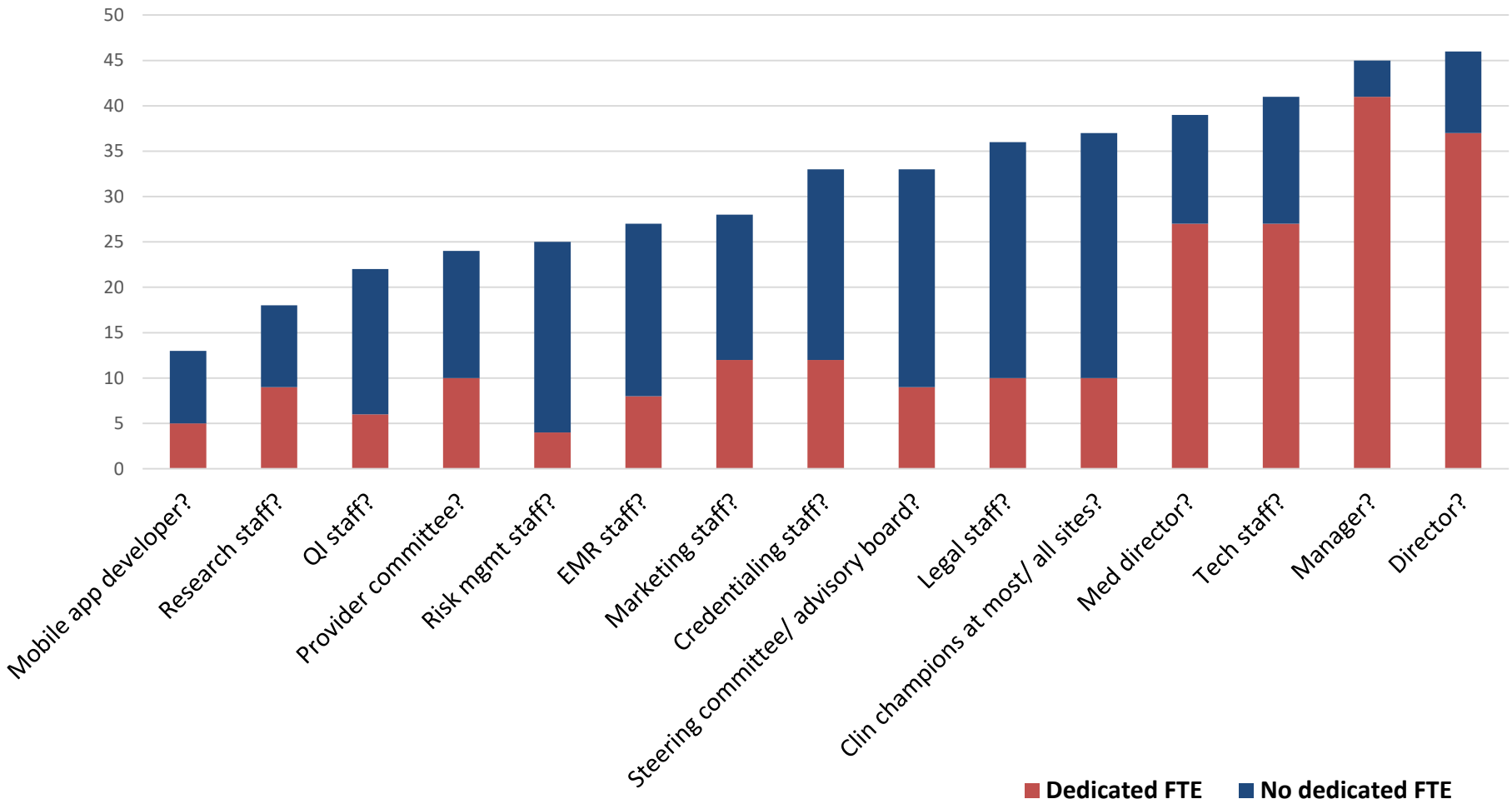
Top 5 - Established Phase

- Neurology
- Psychiatry
- Cardiology
- Neonatology
- Critical Care

Top 5 – Pilot Phase

- Endocrine – Diabetes
- Developmental/Behavioral Pediatrics
- Psychiatry
- Adolescent Medicine
- School Health

National Infrastructure Survey - Staffing



National Infrastructure Survey – Barriers (severity weighted)