



EDUCATIONAL RESOURCES



HOME HEALTH



HOSPICE

TELEHEALTH IN HOME HEALTH & HOSPICE: NEW NORM, NEW OPPORTUNITY

Presented by:

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LEARNING OBJECTIVES

- Review current regulations directing the use of telehealth and remote patient monitoring in home health and hospice.
- Review telehealth and remote patient monitoring coverage and reimbursement.
- Learn about recommended telehealth/remote patient monitoring guidelines and ACHC standards for distinction in telehealth.
- Review steps necessary for successful development and implementation of telehealth program in home health and hospice.

WHAT IS TELEHEALTH?

- **Telehealth** is defined by the U.S. Health Resources and Services Administration as “the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.” (Reference #9)
- Telehealth also includes three modalities. (Reference # 9)
 - **Live video (synchronous telehealth)** -the use of a secure, real-time video between a patient and a provider.
 - **Store-and-forward (asynchronous telehealth)**, allows patients and providers to electronically share data, images and videos followed by a subsequent interpretation or response to the information, such as a medical/surgical consultation.
 - **Remote patient monitoring** - continuous monitoring of a patient for a period of time with the provider in a different location.

WHAT IS TELEHEALTH?

- **Telemedicine** is the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data or education related to health care services using interactive audio or video communication instead of in-person contact. (Reference # 5)
- **Remote Patient Monitoring** refers to remote collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) that is digitally stored and/or transmitted by a healthcare professional. (Reference # 5)
- **Home Telehealth** –refers to “remote care delivery or monitoring between a health care provider and a patient outside of a clinical health facility, in their place of residence (home or assisted living residence).” (Reference # 2)

Note: Definitions may vary from Medicare to Medicaid, from insurance plans to individual state laws and reimbursement policies, but overall, the terms refer to patient-provider encounters performed utilizing telecommunication technologies with a goal to establish, implement or change the plan of care.



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TELEHEALTH

Before COVID-19 public health emergency

TELEHEALTH BEFORE THE PUBLIC HEALTH EMERGENCY

- Audio-visual modality only
- Incentive payment for select procedure codes
- Limited to just a few types of providers (i.e. outpatient speech therapy, home health remote patient monitoring) under Medicaid/State Laws
- Medicare Reimbursement for RPM Under CPT 99091 effective January, 2018 and additional CPT codes effective 2019. (5)

Note: this proposal was initially introduced in 2002

CPT 99091: Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days.

TELEHEALTH BEFORE THE PUBLIC HEALTH EMERGENCY

DEFINITION

48 states and the **District of Columbia** have a definition for telehealth, telemedicine, or both

LOCATION

a few states have required a certain amount of distance between the provider and patient

In New Hampshire, Medicaid patients must be located in a rural area, as defined by Medicare

In South Dakota, an originating site and a distant site cannot be in the same community

MEDICAID REIMBURSEMENT

48 states & DC reimburse for live video through Medicaid	22 states reimburse for remote patient monitoring
13 states reimburse for store and forward	2 offer reimbursement through their Department of Aging Services
states rarely view email/phone/fax as acceptable forms of service delivery	31 states reimburse for a transmission/facility fee

CONSENT

29 states include some sort of informed consent

ONLINE PRESCRIBING

Internet/online questionnaires are not adequate; states may require a physical exam prior to a prescription

PRIVATE PAYER LAWS

34 states and the **District of Columbia** have active laws

CROSS STATE LICENSURE

9 states issue special licenses or certificates for telehealth

Center for **Connected Health Policy** www.cchpca.org
March 2017

TELEHEALTH BEFORE THE PUBLIC HEALTH EMERGENCY

40 states have some form of coverage for home telehealth: Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, and Wisconsin. (Reference #5)

22 states are authorized to cover remote patient monitoring: Alabama, Alaska, Arizona, Colorado, Connecticut, Hawaii, Indiana, Kansas, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New York, North Dakota, Pennsylvania, South Carolina, South Dakota, Texas, Vermont, and Washington. (Reference #5)



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TELEHEALTH

During COVID-19 public health emergency

TELEMEDICINE DURING COVID-19 PUBLIC HEALTH EMERGENCY

Medicare: Flexibility Waivers/Home Health:

- “Home health agencies are able to furnish services using telecommunications technology during the PHE as long as such services do not substitute for in-person visits ordered on the plan of care. This can include telephone calls (audio only and TTY), two-way audio-video telecommunications that allow for real-time interaction between the patient and clinician (e.g., FaceTime, Skype), and remote patient monitoring. It would be up to the clinical judgment of the home health agency and patient’s physician/practitioner as to whether such technology can meet the patient’s need. The use of telecommunications technology in furnishing services under the home health benefit must be included on the **plan of care and the plan of care must outline how such technology will assist in achieving the goals outlined on the plan of care.**” (Reference #6)
- “Only in-person visits are to be reported on the home health claim submitted to Medicare for payment. On an interim basis, HHAs can report the costs of telecommunications technology on the HHA cost report as allowable administrative and general (A&G) costs.” (Reference #6)

TELEMEDICINE DURING COVID-19 PUBLIC HEALTH EMERGENCY

Medicare: Flexibility Waiver/Home Health:

- **Face-to-Face:** “The face-to-face encounter..... can be performed via telehealth in accordance with the requirements under 1834(m)(4)(C) of the Social Security Act. Under the expansion of telehealth under the 1135 waiver, beneficiaries are able to use telehealth technologies with their doctors and practitioners from home (or other originating site) for the face-to-face encounter to qualify for Medicare home health care.” (Reference #6)

Note: two-way technology must be utilized

- **Initial Assessment:** CMS has waived the requirements at 42 CFR §484.55(a) to allow HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely, by phone, or by record review. (Reference #6)

Note: when asked if telehealth could be used for comprehensive assessment, CMS stated that it could be an option.

TELEMEDICINE DURING COVID-19 PUBLIC HEALTH EMERGENCY

Medicare: Flexibility Waivers/Hospice:

- “Hospices are able to furnish services using telecommunications technology during the PHE when a patient is receiving routine home care. This can include **telephone calls (audio only or TTY)**, two-way audio-video telecommunications technology that allow for real-time interaction between the patient and clinician (e.g., FaceTime, Skype), and remote patient monitoring. It would be up to the clinical judgment of hospice as to whether such technology can meet the patient’s/caregiver’s/family’s needs and the use of technology should be included on the plan of care for the patient and family.” (Reference #6)
- “Only in-person visits (with the exception of social work telephone calls) are to be reported on the hospice claim submitted to Medicare for payment. For purpose of service-intensity add-on (SIA) payments, only in-person visits performed by registered nurses and social workers provided during routine home care during the last seven days of life are eligible for these add-on payments.” (Reference #6)

TELEMEDICINE DURING COVID-19 PUBLIC HEALTH EMERGENCY

Medicare: Flexibility Waiver/Hospice:

- Face-to-Face: "Hospices are allowed to use 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and the clinician (e.g., FaceTime, Skype) to satisfy the face-to-face encounter requirement, which is required for the third benefit period (after the patient has typically been receiving hospice for six months) and each subsequent 60-day benefit period thereafter. An explanation of why the clinical findings from the hospice face-to-face encounter support that the patient still has a life expectancy of six months or less is required as part of the recertification narrative. We do not believe that telephone calls (audio only or TTY) would provide the necessary clinical information for a hospice physician to determine whether the patient continues to have a life expectancy of six months or less. As such, telephone calls (audio only or TTY) cannot be used to satisfy the hospice face-to-face encounter requirement." (Reference # 6)

TELEMEDICINE DURING COVID-19 PUBLIC HEALTH EMERGENCY

Medicare: Flexibility Waiver/Hospice:

- Initial and comprehensive assessments: “Assuming that the patient is receiving routine home care during the initial and comprehensive assessment timeframe, furnishing services using telecommunications technology (e.g., using two-way audio-video telecommunications technology that allows for real-time interaction between the clinician and the patient, like FaceTime or Skype, or using audio-only or TTY telephone calls) would be compliant if such technology can be used to the extent that it is capable of resulting in a full assessment of the patient and caregiver’s needs to inform an individualized plan of care. ...During this PHE, we expect in most, but not all, situations that the initial and comprehensive assessment visits would be done in person.” (Reference # 6)

TELEMEDICINE DURING COVID-19 PUBLIC HEALTH EMERGENCY

Medicaid/State Laws: Flexibility Waivers Home Health & Hospice

- States have made four primary changes to their telehealth policies (Reference#10):
 1. Loosened restrictions on allowable originating and distant sites
 2. Reduced the requirements for eligible technologies or modalities through which telehealth services may be delivered, including by allowing telephonic-only communication.
 3. Allowed the establishment of a patient-provider relationship through telehealth.
 4. Expanded the types of services delivered through telehealth.
- To facilitate the safe delivery of health care services during the COVID-19 state of emergency, multiple states authorized temporary changes to their existing telehealth policy and included home health and hospice on the list of providers eligible to deliver services via telehealth, including therapy services, nursing initial and comprehensive assessments, CNA observation, supervision, and evaluation.
- Payment Parity: services provided via telemedicine are reimbursed at the same rate as in-person services.

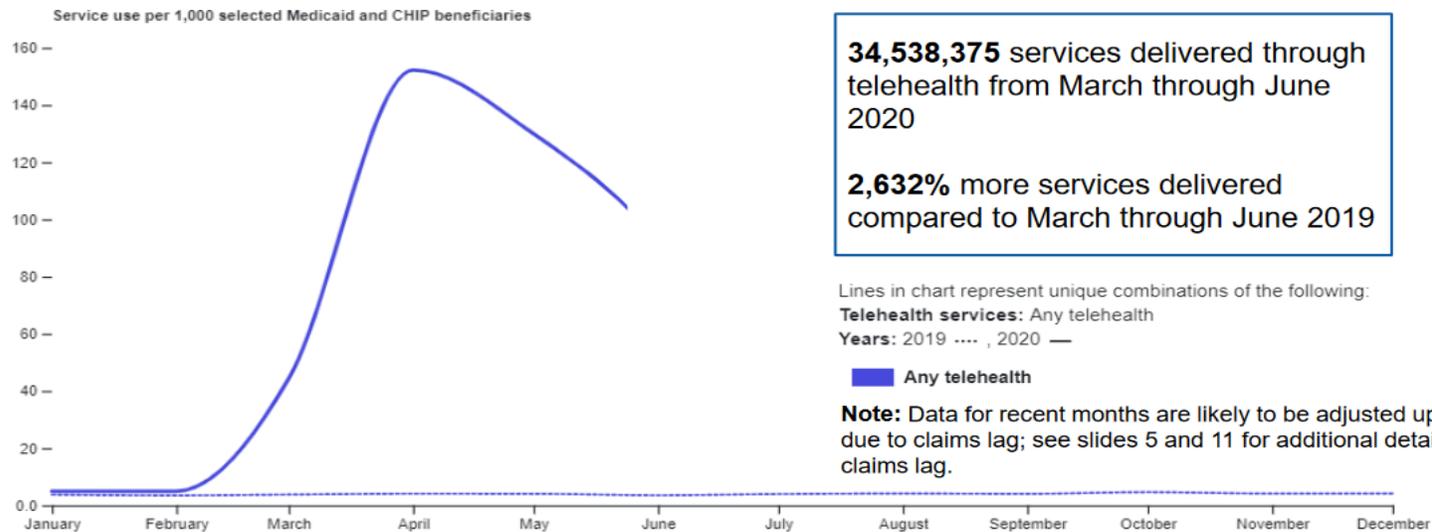
TELEMEDICINE DURING COVID-19 PUBLIC HEALTH EMERGENCY

Trends:

- **US Consumer use of telehealth:** increased from **11%** in 2019 to **46%** using telehealth to replace in-person encounters with healthcare providers. Of the 47.8 million Americans over the age of 65, **24.85 million** were willing to use telehealth. (Reference # 3,4)
- **Provider use of telehealth:** providers are seeing **50 to 175** times the number of patients via telehealth than they did before. (Reference # 4)
- **76%** of respondents surveyed in April 2020 by McKinsey and Co indicated that they were highly or moderately likely to use telehealth after PHE and **74%** reported high satisfaction with telehealth. (Reference # 4)
- **Revenues:** revenues of US telehealth players were an estimated \$3 billion, with the largest vendors focused on the “virtual urgent care” segment. With accelerated adoption of telehealth in multiple areas of healthcare, it is estimated that up to **\$250 billion** of current US healthcare spend could potentially be virtualized, including up to **35%** of regular home health services. (Reference # 4)

TELEMEDICINE DURING COVID-19 PUBLIC HEALTH EMERGENCY

Preliminary data suggest that services delivered via telehealth increased from February through April 2020



Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on August T-MSIS submissions with services through the end of July. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because data for July are mostly incomplete, results are only presented through June.

6

Source (7): CMS. *Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries During COVID-19: Preliminary Medicaid & CHIP Data*



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TELEHEALTH

After COVID-19 public health emergency

TELEMEDICINE AFTER PUBLIC HEALTH EMERGENCY

Medicare: CY 2021 Home Health Final Rule

- “We believe that the use of telecommunications technology in furnishing services in the home has the potential to improve efficiencies, expand the reach of healthcare providers, allow more specialized care in the home, and allow HHAs to see more patients or to communicate with patients more often.” (Reference # 8)
- CMS permanently finalized the PHE rule related to use of telecommunications technology in home health and cost reporting of telehealth/telemedicine as allowable administrative cost.
- The use of the technology must be related to the skilled services being furnished and included on the plan of care, along with a description of how the use of such technology is tied to the patient-specific needs as identified during the comprehensive assessment. Information regarding how such services will help to achieve the goals outlined on the plan of care must be documented in the patient’s medical record.

TELEMEDICINE AFTER PUBLIC HEALTH EMERGENCY

Medicare: CY 2021 Home Health Final Rule

- HHA cannot discriminate against any individual who is unable or unwilling to receive home health services that could be provided via telecommunications technology.
- Access to telecommunications technology must be inclusive, especially for those patients who may have disabilities where the use of technology may be more challenging.
- Telemedicine/telehealth will remain to be a service that is not covered by Medicare Home Health benefit and cannot be considered a home health visit for the purpose of eligibility or payment for home health.
(Reference #8)

TELEMEDICINE AFTER PUBLIC HEALTH EMERGENCY

- Multiple states that introduced PHE flexibility to allow home health and hospice services to be provided via telehealth/telemedicine are implementing permanent rules that duplicate the public health emergency rules.
- ACHC pioneered a distinction in Telehealth for multiple provider types (ambulatory clinics, home health, hospice, private duty, behavioral health, palliative care and renal dialysis). (Reference #1)
- On October 23, 2020, U.S. Senators Susan Collins (R-Maine) and Ben Cardin (D-Md.) introduced the Home Health Emergency Access to Telehealth (HEAT) Act, a bipartisan bill to provide Medicare reimbursement for audio and video telehealth services furnished by home health agencies during the COVID-19 emergency. (Reference #3)
 - ❖ To ensure that the Medicare home health benefit does not become a telehealth-only benefit, Medicare reimbursement would only be provided if the telehealth services account for no more than half of the billable visits made during a 30-day payment period.

TELEMEDICINE AFTER PUBLIC HEALTH EMERGENCY

- On October 23, 2020 CMS proposed a Bill to expand telehealth benefits in Medicare Advantage, making it easier for beneficiaries to access these services from home rather than a health care facility. If the bill passes, it will impact how telehealth benefits are financed (accounted for in payments to plans) making it more likely that MA plans will offer telehealth services and that more enrollees will be able to use the benefits.(Reference # 3)

TELEMEDICINE AFTER PUBLIC HEALTH EMERGENCY

- In October, 2020 United Healthcare provided the following updates:
 - Originating Site Expansion (applies to home health only): Any originating site requirements that apply under original Medicare are temporarily waived, so that home health telehealth services provided through live interactive audio-video can be billed for members at home or another location. UnitedHealthcare will extend the expansion of telehealth access for in- and out-of-network providers through the national public health emergency period, currently scheduled to end Jan. 20, 2021.
 - For contracted care providers, all home health and hospice telehealth claims should be billed using the code(s) that would be used if you were in the home performing the service; include place of service code 12 and modifier 95, as applicable. Non-contracted providers should follow Centers for Medicare & Medicaid Services (CMS) guidance on telehealth protocols. All visits must be performed using synchronous virtual care (live interactive video-conferencing) that involves the presence of both parties at the same time and a communication link between them that allows a real-time interaction to take place. (Reference #12)



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WHAT IS NEXT?

“One of the instructive experiences from COVID-19 has been the vastly expanded role of telehealth ... We went from about 14,000 virtual visits and Medicare fee for service each week before the pandemic to nearly 1.7 million virtual visits a week at the peak. There’s no undoing this revolution.”

— U.S. Health and Human Services Secretary Alex Azar

WHAT ARE THE BENEFITS OF TELEHEALTH

- Innovative approach to care
- Improved access to care
- Consumer choice empowerment
- Improved patient engagement
- Improved practice efficiency (staffing, scheduling, travel time)
- Proactive care = improved chronic disease management= improved outcomes

Note: 3 out of 4 Medicare beneficiaries have 2 or more chronic conditions (Reference #10)

- Reduction in hospital admissions/re-admissions and ER room utilization

Note: recent study showed that with telemedicine, patients had 38% fewer hospital admissions, 31% fewer hospital re-admissions, and 63% more likely to spend fewer days in the hospital (Reference #10)

- Improved clinicians experience (work-life balance, reduced fatigue and burnout, reduced turnover rate)

CASE STUDY #1- CENTURA HOME HEALTH AT HOME

Centura Health at Home-provides services in home, hospice, senior and palliative care.

The purpose of the Centura Health at Home project (telehealth program):

- to decrease 30-day rehospitalization rates
- to increase older adult quality of life
- to increase number of patients served in the telehealth program by a minimum of 200 per year after year one.

CASE STUDY #1- CENTURA HOME HEALTH AT HOME

Outcomes:

- over a 30-day period following the initial hospital stay, hospitalizations related to heart failure, chronic obstructive pulmonary disease (COPD) and diabetes were reduced by **62%**. (11)
- re-hospitalization rates for patients receiving telehealth home care (**6.28%**) were significantly lower than those for traditional home care patients (**18%**). (11)
- emergency department (ED) utilization **decreased** from 283 visits in the year preceding the study to 21 ED visits. (11)
- frequency of home RN visits reduced from 2-3 visits per week during a 60 day episode of care in a traditional home care model to approximately three (2.69) visits over the entire 60-day telehealth care management period. This resulted in **cost savings between \$1,000 and \$1,500** per patient per episode.

CASE STUDY #2- ENJOY LIFE!

EnJOY Life! provides patient health monitoring, diabetes education, weight management, case management, healthy lifestyle education, management, and coaching.

The **purpose** of the telehealth program: to evaluate if telehealth/telemonitoring helped patients manage their diabetes. (11)

Participants: patients with dx of diabetes were given a blood glucose meter, blood glucose strips, and the supporting equipment needed to wirelessly send their blood glucose readings to EnJOY Life! Some patients were also provided with a blood pressure monitor.

Outcomes:

- Efficiency: time-saving to obtain patients' blood glucose and blood pressure readings in one place, in a format that allowed effective patient education.
- Reporting: accurate reporting of results (BG, BP) on a regular/consistent basis.
- Patients reported easy to use process; "much easier than keeping a blood glucose/blood pressure log of their own."
(Reference #11)

CASE STUDY #3- VNA HOME HEALTH HOSPICE

VNA Home Health Hospice provides home health and hospice at home services in South Portland, Maine.

The **purpose** of the telehealth program: to improve patient care and communication by giving physicians the ability to monitor their patients' health status and "to form a broader "circle of care" around each patient by improving overall care coordination through the engagement of the patient's physicians – ensuring everyone involved in the patient's care plan could track and monitor the daily vital signs of patients from one clinical dashboard."

Outcomes:

Increase in staff efficiency – including a major reduction in paperwork and the time related to it. "When we implemented the system of physician standing orders and gave physicians access to the patient records through LifeStream View [telehealth provider], we quickly realized we'd put an end to almost 90 percent of our paperwork. A key area of success was that faxing was no longer required."

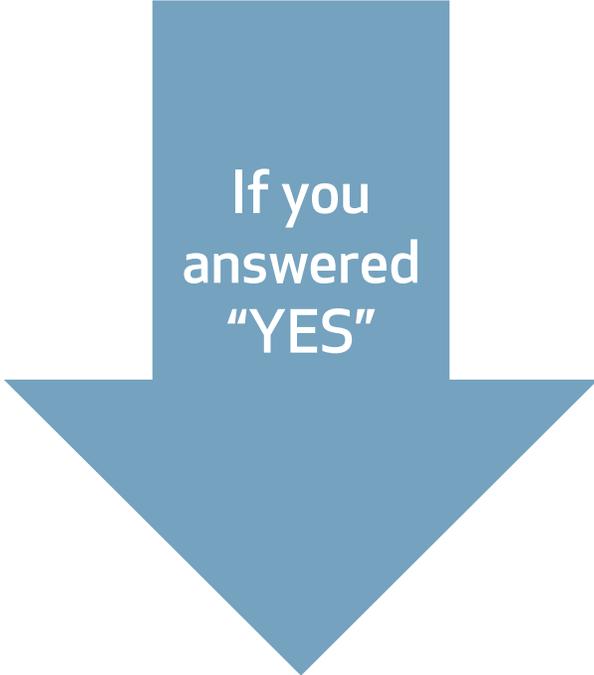
(Reference 13)

WHAT ARE THE CHALLENGES OF TELEHEALTH

- Gaining buy-in from:
 - Leadership
 - Staff
 - Physicians
 - Patients
- Not having a clear vision, business plan and model with quantifiable return on investment (ROI).
- Integrating the telehealth data with the organization's EHR/EMR.
- Equipment cost
- Environmental barriers
- Reimbursement barriers

WHAT IS NEXT?

- Determine if implementing a telehealth/RPM program within your organization is something that you would like to explore.



If you
answered
"YES"

WHAT IS NEXT?

- Select a project leader
- Establish community partnership: work with the telehealth partner (ACHC, consultant, solution provider) to establish a telehealth program design that will have maximum clinical and financial impact and to develop a communication strategy regarding the benefits of the telehealth program for stakeholders and referral sources.
- Choose a telehealth system: choose a system that is simple, reliable, easy to use, easy to maintain and affordable to providers and patients to assure buy-in and sustained use.
- Create a business plan: analyze financial data and perform return on investment analysis/projections.
- Develop set of standards, rules and guidelines. It is critical in setting up a formal telehealth program to assure high quality of care and successful clinical outcomes.
 - As Medicare, Medicaid state programs and MA plans continue to adopt new telehealth policies and expand reimbursement for telehealth services, it can be expected that use of telehealth in home health and hospice will become another heavily regulated area.

WHAT DO I NEED TO IMPLEMENT A SUCCESSFUL TELEHEALTH PROGRAM?

- Establish written policies and procedures for telehealth program
- Designate a dedicated telehealth authority within the organization
- Establish admission/eligibility criteria for patients
- Establish clinical protocols/parameters
- Establish documentation requirements
- Establish procedures to monitor and review collected data (in case of RPM)
- Establish staff education/telehealth competency program
- Establish telehealth/telemonitoring equipment requirements

WRITTEN POLICIES AND PROCEDURES

Written P&P at a minimum must include the following:

- Written detailed description of telehealth services (Reference #1,2)
 - What services are available via telehealth (i.e. virtual visits, RPM).
 - How are services managed after-hours
 - Instructions regarding type of services appropriate for a patient
 - Financial obligations related to telehealth services, if applicable
- Patient inclusion and exclusion criteria (Reference #1,2)
 - Detailing who is eligible and appropriate for each type of technology
 - Inclusion criteria (patients with chronic conditions, hx of multiple hospitalizations, ER visits, patients able to effectively and safely utilize technology)
 - Exclusion criteria (patient's environment is not conducive to use of telehealth technology, non-compliance, etc.)
- Process of assessment and development of patient plan of care (Reference #1,2)
 - Disciplines eligible to perform face-to-face comprehensive assessment for eligibility/inclusion criteria, adequate environment for use of telehealth equipment, etc.
 - Development of Plan of Care that meets patient's needs and is directed to positive clinical outcomes and decrease in utilization of resources, such as acute care hospitals/ER

In accordance with [American Telemedicine Association guidelines](#) and [ACHC Telehealth Standards](#)

WRITTEN POLICIES AND PROCEDURES

- Process of obtaining informed consent for the use of telehealth (Reference #1,2)
 - Providers are expected to obtain written and/or verbal consent from the patient prior to initiation of telehealth service
 - Note: 29 states require some form of consent; follow your state consent requirements. (5)
 - Consent must be documented in patient's record
 - Note: some states require that contact with the provider to request services to be delivered via telehealth must be initiated by the patient/caregiver (5)
- Patient rights when receiving services via telehealth (Reference #1,2)
 - Right to make decision about participating in telehealth program
 - Right to privacy (especially critical if utilizing video-audio capabilities)
 - Right to participate in telehealth program without being discriminated on the basis of language or physical barriers

WRITTEN POLICIES AND PROCEDURES

- Policies in regard to securing and releasing confidential and PHI information as r/t receiving services via telehealth (Reference #1,2)
 - Patient has the right to a confidential record and privacy while receiving telehealth services
 - Release and/or access to the patient information/record r/t telehealth
 - Note: Temporary changes in HIPAA compliance allow a wider-array of non-public facing electronic communication methods during the public health emergency. However, providers should make every effort to use HIPAA compliant technologies even during the public health emergency.
- Provision of telehealth services in accordance with the patient's POC (Reference #1,2)
 - POC to reflect patient's specific needs and refer to how utilization of telehealth will allow to meet the needs
 - Include specific frequency and duration for telehealth/RPM services, mode of telehealth delivery (virtual visits vs. RPM), orders/parameters/protocols.

WRITTEN POLICIES AND PROCEDURES

- Process of care coordination (communication with the patient, patient's physician or other providers) as related to patient's participation in telehealth program (Reference # 1,2)
 - Coordinate with patient's physician to inform of the use of telehealth and develop patient specific monitoring parameters, order set and protocols, as may be applicable
- Referral process (external/internal) for a patient to participate in telehealth program (Reference # 1,2)
 - What information is required for a referral to telehealth program
 - Referral log

WRITTEN POLICIES AND PROCEDURES

- Patient/Caregiver education related to participation in telehealth program (Reference #1,2)
 - Written instructions and return demonstration on how to operate equipment
 - Written instructions as to whom to call in case of technical problems or after-hours
- Policies in regard to standard of care provided via telehealth (Reference #1,2)
 - Care provided via telehealth must meet the same standards as care provided in-person
- Process of integrating telehealth program in organizational QAPI (Reference #1,2)
 - Track effectiveness of telehealth program
 - Track quality outcomes associated with the use of telehealth

ADDITIONAL GUIDELINES

- Designate a dedicated telehealth authority to oversee telehealth program (Reference # 1,2)
 - Telehealth Manager (as suggested by ACHC standards)
 - Define qualification, requirements, responsibilities
 - Develop job description
- Establish admission/eligibility criteria for patients (Reference # 1,2)
 - Detail who is eligible and appropriate for each type of technology
 - Inclusion criteria (patients with chronic conditions, hx of multiple hospitalizations, ER visits, patients able to effectively and safely utilize technology)
 - Exclusion criteria (patient's environment is not conducive to use of telehealth technology, non-compliance, etc.)

ADDITIONAL GUIDELINES

- Establish clinical protocols/order sets/parameters (applies to RPM)
 - Develop process to obtain order set indicating patient's parameters and protocols for monitoring and reporting monitoring data.

<input type="checkbox"/> Blood Pressure			
Normal	120 / 80 mmHg	Notify me if Systolic BP is < ___ or > ___ mmHg consec X ___ Notify me if Diastolic BP is < ___ or > ___ mmHg consec X ___	
<input type="checkbox"/> Pulse			
Normal	60 - 80 bpm	Notify me if < ___ bpm or > ___ bpm consec X ___	
<input type="checkbox"/> Weight			

- Develop process of reviewing, responding and communicating findings outside of physician acceptable parameters, as well as plan of action and timeliness of response when the collected physiological data (HR, BP, etc.) is outside of the parameters.

ADDITIONAL GUIDELINES

- Establish documentation requirements (Reference #1,2)
 - Consent, telehealth program enrollment form, telehealth assessment, physician orders, visit notes, etc.
 - Documentation of services performed via telemedicine must be easily identified as such.
 - Telehealth documentation requirements must comply with general organization's documentation standards.
 - Monitored data (data collected via RPM) must be included in patient's record and should be appropriately dated and timed.

ADDITIONAL GUIDELINES

- Establish procedures to monitor and review collected data (in case of RPM)
 - Determine what type of physiological data will be monitored
 - Determine method, frequency and timing for monitoring each data element (e.g. will blood pressure data be uploaded daily, weekly, etc.)
 - Determine who is responsible (call center vs. dedicated RN) for monitoring and responding to the collected data during business hours and after-hours.
- Establish staff education/telehealth competency program Develop staff education process to ensure that staff is oriented to and is educated on organization's telehealth program. Education may include, but not limited to use of equipment, troubleshooting, interpreting data, policies and procedures, patient admission criteria, etc.
 - Implement staff competency assessment process that allows to validate ability of staff to provide care using technology that organization is utilizing to deliver care via telehealth/ RPM.
- (Reference #1,2)

ADDITIONAL GUIDELINES

- Establish telehealth/telemonitoring equipment requirements When selecting telehealth/telemonitoring equipment/solutions, consider:
 - HIPPA compliant technology
 - User friendly and safe technology
 - Cost effective technology
 - Environment conducive to support the use of technology
 - Connectivity requirements
 - Maintenance, quality control and cleaning requirements
 - Equipment installation process, if applicable
 - Support and reporting capabilities
 - Equipment tracking process
 - *Choose a telehealth system that is simple, reliable, easy to use, easy to maintain and affordable to providers and patients to warrant buy-in and sustained use.*
 - (Reference #1,2)

ADDITIONAL GUIDELINES

- Incorporate your telehealth program into organizational marketing strategies.
 - Formal telehealth program with clear vision, purpose, and outcomes may differentiate you from other providers in the area, and may increase your referral base
- Share clinical outcome data with all applicable practitioners and referral sources across the full care continuum.
 - Take a credit for your positive outcomes/achievements
 - Make sure your referral sources know about positive outcomes/success stories
- Think about opportunities for growth

QUESTIONS?



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THANK YOU!



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