GETTING YOUR TELEHEALTH PROGRAM STARTED:

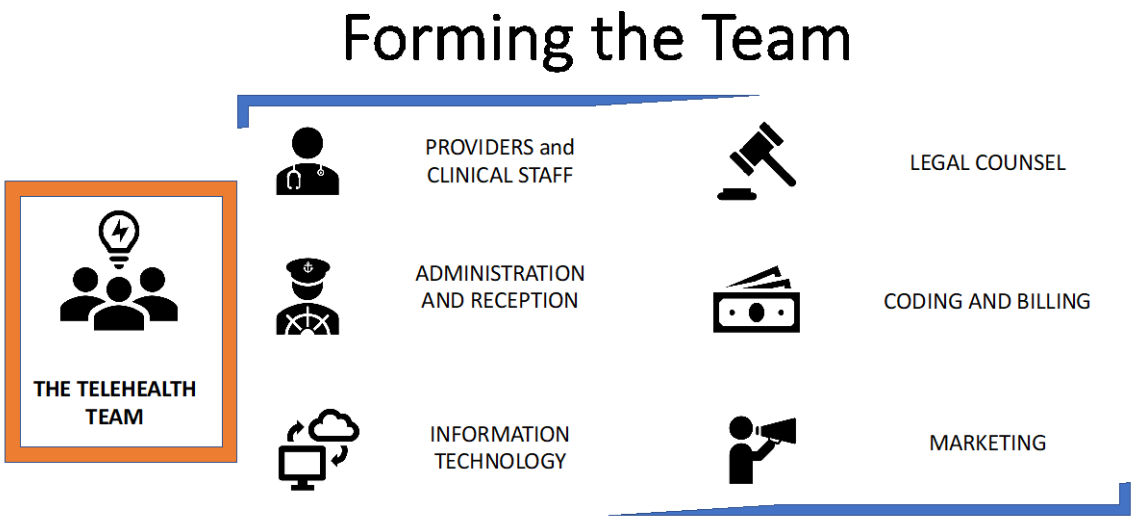
The primary goal of this guide is to provide information specific to telehealth in WV. A quick summary specific to Mercer Medical Group's experience is given below. Instead of reinventing the general process, the following are links to two excellent references for starting a telehealth program, not specific to West Virginia:

American Medical Association: AMA Telehealth Implementation Playbook:
https://www.ama-assn.org/system/files/2020-04/ama-telehealth-playbook.pdf
American Academy of Family Practice: A Toolkit for Building and Growing a Sustainable Telehealth Program in Your Practice
https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf
National Consortium of Telehealth Resource Centers:
https://telehealthresourcecenter.org/resources/toolkits/covid-19-telehealth-toolkit/
Health and Human Services: Telehealth for Providers:
https://telehealth.hhs.gov/providers/

General Structure from AMA TELEHEALTH IMPLEMENTATION PLAYBOOK

Identifying a NEED: This was easy during the pandemic. Outside of the pandemic, starting a telehealth program may by for different reasons. In WV, it is likely you will want to give patients an option to see you from their home for certain appointments, especially if they have difficulty with transportation. During times of staff quarantine, you may need to utilize providers/staff away from your office setting. Your hospital may lose neurology coverage and require a Tele neurology or Tele stroke program to keep patients at your local hospital.

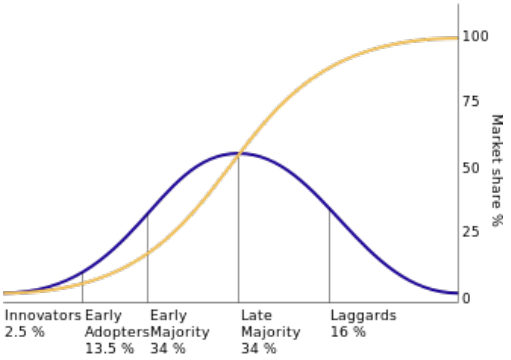
Forming a Team: Choose committed key players from diverse backgrounds in your organization who are knowledgeable, positive, energetic and ready for a challenge.



Define Success: Determine your goals. Best to start with smaller goals and then scale up. Small successes are necessary to boost team moral. Is the goal one telehealth visit per clinic, or per provider? Is it a percentage of visits?

Check your malpractice coverage: Make sure your telehealth visits are covered under your malpractice umbrella. If there is ambiguity, ask for specific clause regarding telehealth.

Making the Case: Political and Financial Buy-in
Clear the project with the administration and providers and make sure all are on-board. Present the project to those who will be involved. Evaluate interest and support. Ask for opinions and ideas from those who will be using the system. Anticipate who will create barriers and where problems will likely originate. Work on involving those people from the ground up to gain buy in. According to Everett Rogers **Diffusion of Innovation Theory** of change, people adopt change at different rates. It takes a critical mass to make a project move forward.
Diagram from Wikipedia: https://en.wikipedia.org/wiki/Diffusion_of_innovations



Decide on Your Audio Video Vendor: Anticipate that you will require a HIPAA compliant healthcare platform for telehealth once the PHE ends.
Here there are significant decisions best described in the AAFP Toolkit with excerpt noted below:

Stand-alone Product

Pros:
Low cost
Easy to implement
Low commitment

Cons:
Not connected to patient chart

EHR-Integrated Application

Pros:
Provider experience is seamless and integrated, enabling workflow efficiencies

Cons:
May require patient to create an account and login, which may require support
Can be costly and extend your EHR contract

STAND ALONE PRODUCT: Practices can partner with a third-party vendor such as those listed below to provide a HIPAA compliant platform connecting your patients to you for AUDIO-VISUAL visits. The most practical and user-friendly way to accomplish this is with patient on one screen and the EHR on a second screen allowing the provider access to chart at same time as maintaining contact with the patient. The EHR or practice management software continues to provide the scheduling, documentation, and billing aspects of care. The possibilities in the audio-visual vendor market are numerous and growing. Each facility must do their own search and choose an appropriate vendor. **BEWARE of companies requiring patients to fill out numerous forms, templates, and questionnaires before each visit. These can be time consuming and a turn-off for both patient and providers. Often the practice will be required to design special templates, questionnaires and forms ahead initiating your telehealth project which can become a barrier to getting started. Also be sure that vendor has option to switch to AUDIO only if the AUDIO-VISUAL visit is compromised in some way.**

Examples of possible vendors: ***there is no certain order of preference, is not comprehensive and is not meant to imply preference or bias. **NOTE: IT IS SUGGESTED TO START WITH A HIPAA COMPLIANT PLATFORM SUCH THAT NO CHANGES WILL BE NECESSARY POST PHE.**

- DoxyMe
- Doximity
- Teledoc

- ZOOM for Healthcare
- Team Meetings
- Cisco WebEx
- WebMD
- FaceTime
- EHR Portal Access
- There are many more…

DO NOT USE FRONT FACING SOFTWARE such as TikTok, Facebook Live etc. as this is not compliant with Office of Inspector General (OIG) and Office of National Coordinator (ONC).
*** AAFP TELEHEALTH TOOLKIT PROVIDES an excellent checklist for use when choosing a vendor. See page 23 of https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf

EHR INTEGRATED PLATFORM: Start with your EHR vendor. Ask them if they have telehealth audio-visual visit module managed through your portal. If not, ask if they have any special capabilities with third-party audio-visual vendors allowing you to access your EHR record at the same time as having visual contact with the patient. Ask if the demographic information and the documentation will flow seamlessly into your record.

*** **Mercer Medical Group decided to use both options** as patients preferred different methods. We used both a third-party vendor for audio-visual capability. Providers used their laptop to connect to the patient and a second monitor, laptop or desktop to access the record simultaneously. We also had the option of booking the visit directly through our portal. Unfortunately, this was not as well liked by our providers as our EHR vendor could not give access to the full chart at the same time as visual contact with the patient. NO MATTER WHAT YOU CHOOSE BE AWARE THAT KEEPING THINGS AS SIMPLE AS POSSIBLE WITH THE LEAST CLICKS POSSIBLE FOR BOTH PATIENTS AND PROVIDERS/STAFF TENDS TO WORK BEST.

HIPAA LAW:

- Telehealth provision or use does not alter a covered entity's obligations under HIPAA, nor does HIPAA contain any special section devoted to telehealth. Therefore, if a covered entity is utilizing telehealth that involves Personal Health Information (PHI), the entity must meet the same HIPAA requirements that it would if the service was provided in-person.
- Best to acquire an Audio-Visual platform with HIPAA compliance **and use a BAA (Business Associate Agreement) such that that company is also bound by HIPAA compliance**

Contracting: audio-video vendor, software, hardware. Define costs, negotiate contract with vendors. Evaluate and make a choice. Negotiate a Business Associate Agreement to protect HIPAA requirements.

- **Audio-Visual Telehealth Visits**: Most providers find it easier to navigate a telehealth visit with **access to video of the patient at the same time as access to the EHR chart.** Some systems allow for patient video feed at the top of screen with the EHR chart underneath. This is best as the provider is able to maintain eye contact most of the time. Other systems do not allow this. Discuss this issue with your EHR vendor or your third-party video platform vendor. Your hardware needs are largely dependent on this issue.
- **Hardware**: Your technical support will greatly appreciate a decision to have all providers and staff use the same hardware for your telehealth program. This simplifies fixes and switch-outs as needed. The following scenarios are possible:
    - 2 screens can be achieved with a second computer monitor attached to a desktop with camera and headset with microphone
    - 2 laptops: one for audio-visual platform and one for the EHR

    - 1 laptop with video feed of the patient at the top of screen and the EHR open to patient chart below. Beware: Often there are limitations of view and function in the EHR when choosing this method.
- **Camera and Sound:** The quality of the experience is often related to the quality of the sound and picture. It is worthwhile to invest in a good camera and headset for a desktop or invest in a laptop with a good camera and microphone. Test before you buy. Make sure the end users are comfortable with what you are choosing. A headset is imperative if there is any noise in the background in area where visit will occur (not ideal).
- **Digital timer:** Many providers find a digital kitchen timer helpful to quantify time spent on a telehealth visit.
- **Originating Site Equipment:** If your clinic plans on being an originating site (RHC and FQHCs), you may want to consider designation of an exam room to become a "Video Room" with extra audio-visual equipment such as a tele-otoscope and tele-stethoscope.
- **Patient hardware and software:** Patient device such as smart phone, tablet or computer connected to Wi-Fi or cellular network will be necessary. If accessing a visit through the EHR portal, they will need access to your portal and instruction before the first telehealth visit. If access is through a third-party vendor for audio-visual platform, most vendors require download of an application from "app store" in order to be able to connect. If patients do not have access to devices, "loaning" devices with mobile Wi-Fi units or establishing a secure virtual kiosk at your community library to provide a device with internet access might be a good community project. If you feel this is not possible yet a AUDIO-VISUAL visit is still necessary to protect patient or provider from infection, a video room in your clinic where patient can access audio-video could allow completion of the visit. (Note: this example is not a telehealth visit as both patient and provider are at the same location. It is a regular office visit.)
- **Audio only visit:** Nothing much is required other than a cell phone or land line phone for both parties. There are no HIPAA requirements here.

  IN SUMMARY:

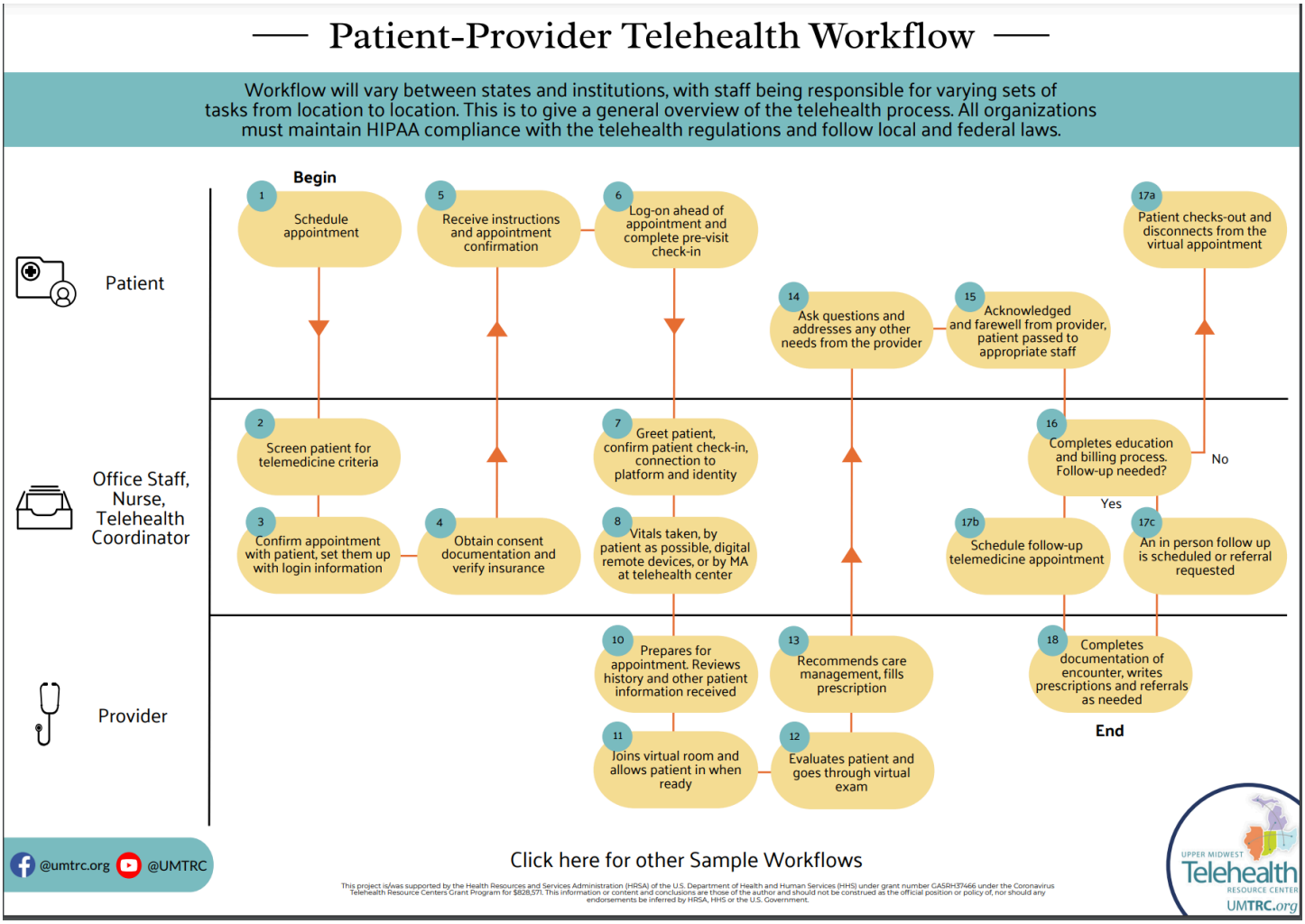
  FOR PROVIDERS:
    - Desktop/camera/microphone, consider dual monitor
    - Laptop with quality camera/microphone, consider second laptop or desktop for viewing EHR
    - Consider headphones with microphone for better sound quality and decreased background noise
    - Digital kitchen timer
    - Preferably quiet place to conduct visit
    - Good background and lighting above and in front of face, not behind.
    - Door which locks or sign on door "In Session" to ensure someone does not enter room and show up on the patient's screen.

  FOR PATIENTS
    - Tablet with camera +/- microphone
    - Laptop
    - Desktop, camera, microphone
    - Smartphone
    - Telephone if using audio only
    - Access to internet via Wi-Fi or cellular
    - Private place to conduct visit

Evaluate Your Internet and Cellular Network: High speed internet with at least 3 mbps up and 3 mbps down is minimum necessary for a decent conversation. More is definitely better in this department. Consider upgrade in speed if possible. Remember it is important to assess your internet or broadband access and the patient's as well. This will play a huge role in the success of your telehealth program. **NOTE: DSL dial up is unlikely to be sufficient.** You can **evaluate internet and cellular plans/speed availability in your area by accessing website**: www.broadbandnow.com

Assess Your Office Space: Providers and clinical staff will need **convenient, quiet, private, well-lit areas** to digitally connect with patients. Best lighting is overhead with soft desk lighting directed upward on the face of the provider. There should be a lock on the door and an appropriate background free of clutter and distractions. A sign on the door for when telehealth in process works well to prevent disruptions. Prevent family and pets from casually entering the room. It is preferrable to exclude windows in the background. If an appropriate background is not available, artificial backgrounds are available on most vendor websites.

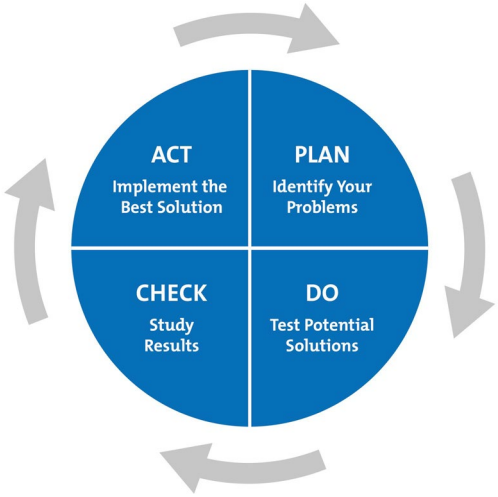
DESIGNING THE WORKFLOW:
Swim Lane Diagram Resource from National Consortium of Telehealth Resource Centers:
https://telehealthresourcecenter.org/resources/fact-sheets/telehealth-workflow/



PLAN/DO/STUDY/ACT stepwise iterative approach works well here. Start with the workflow suggested above. Spend time to make changes to fit your unique office situation as these details and make or break your telehealth program. Providers will become easily frustrated if this is not carefully organized beforehand. Use a staff member as a test patient in the EHR and run through the whole process. Test, tweak, test again. When you feel you have it running smoothly, pick a few of your tech savvy patients and do a test run with them, asking for feedback after the experience.

Image from MindTools:

Figure 1: The Plan-Do-Check-Act Cycle



Example: TELEHEALTH VIDEO-AUDIO PLATFORM SET-UP

AV Platform	SET UP BAA WITH AUDIO VISUAL VENDOR HIPAA Compliant
SET UP	SET UP AUDIO VISUAL ACCOUNT FOR EACH PROVIDER
SHARE	SHARE the User-Name (usually a designated email account) and Password with the Receptionists and Nursing staff so they can book Audio-Visual sessions.
SEND	SEND EMAIL TO THE PATIENT ON BEHALF OF THE PROVIDER inviting patient to the Audio-Visual SESSION and include LINK.

Start with the following:

1. **Patient Selection**: What patient problems/complaints are suitable for telehealth? Which ones are not appropriate? (see section "Information for Clerical Staff" for more guidance on this topic.)
2. How will your staff and providers be able to **identify a telehealth apt** vs a face-to -face appointment in the EHR schedule? Different color, wording? How will the provider know if this is an audio only visit vs an audio-visual visit? Which phone number does the patient want to use? Is the visit on the portal or is it on the audio-visual platform?
3. **Scheduling**: Will you allow telehealth to be mixed in with other appointments during the day or will you set aside certain time slots for telehealth appointments? Mercer Medical Group decided to mix telehealth with regular appointments and did not find this to be a significant issue and provided more flexibility for providers and patients.
4. Is the **check-in and check-out process** different for telehealth vs other visits? Who will collect the co-pays and deductibles?
5. Who will contact the patient to **initiate the visit**? Should this be the medical assistant or the LPN? NOTE: best to limit the number of phone calls to a patient on the day of the telehealth visit. Limit the number of staff member interactions with the patient if possible. Patients find endless phone calls before the telehealth visit to be a burden. Does the LPN obtain consent, enter the patients home vitals, chief complaint, medication reconciliation and brief review of systems? Is this portion of the process done with audio only or will the nurse use audio-visual capability as well? **NOTE: For CMS Quality**

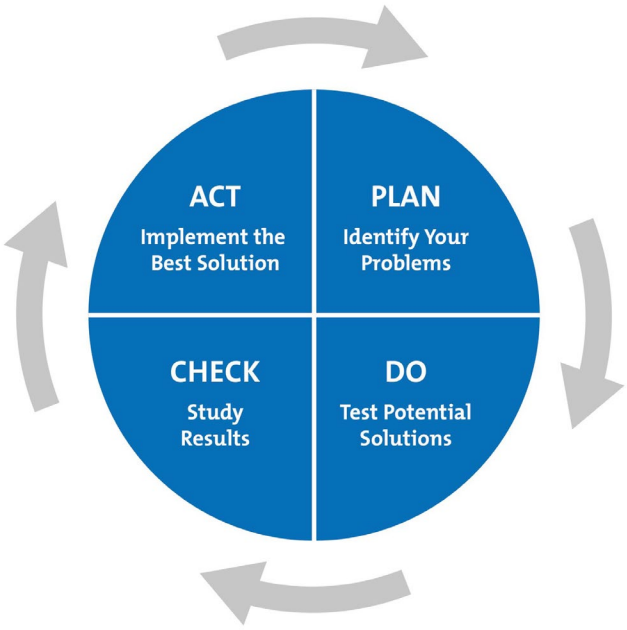
Payment Program, patient's home vitals cannot be used for meaningful use unless they are ELECTRONICALLY UPLOADED directly from the patient's device to your EHR. This information cannot be manually recorded for this purpose. You can add the BP and the weight reported by the patient, but these values cannot be used to satisfy meaningful use requirements.

6. How will the **hand off** from nurse to provider occur? How does the nurse let the provider know the patient is online and is ready to be seen? Who sets up the visit in the audio-visual platform? Does your EHR have capability to show this transfer without verbal notification?
7. Who is responsible for getting a **patient set up** with the portal or the appropriate app prior to the first telehealth visit? Is this done by the nurse on the first visit?
8. **Meaningful Use/Promoting Interoperability**: This is still required for each CMS telehealth visit if the coding applied requires it. During the PHE, the audio-visual visits are seen as the same as face-to-face visits and therefore meaningful use criteria apply. Remind your staff to collect your quality measure information, for example: the Flu status, smoking status, fall risk, depression screening, BP (if electronically capable) etc.
9. **Discuss with provider**: Do they plan to document the visit in real time while on video/phone with the patient or do they plan to perform the visit and document afterwards? Reminder: **All CMS AUDIO ONLY telehealth visits (99441-99443) are based on TIME SPENT during the PHE. There must be a time recorded on each of the audio only visits for coding.** For audio-visual visits, the provider has the option to code according to medical decision making. It may be advantageous to record time in audio-visual appointments as well to give the coder the chance for maximal reimbursement for work done. How will the hand off back to LPN, medical assistant or receptionist occur when the telehealth visit is completed by the provider?
10. **EHR Documentation**: Documentation must be distinctly different from regular office visits. It may be best to develop a **"Telehealth Template"** for your EHR set to require certain elements. There must be documentation of the following:
    a. Labelling as a "telehealth visit"
    b. Verbal or written consent from patient for visit
    c. Inform patient that telehealth cannot do everything that an in-person visit can do
    d. Location of the patient, including state
    e. Location of the provider, including state
    f. Licensure of the provider in the state where patient is physically present
    g. Audio Only Visits: Time Spent during the visit

    NOTE: It may be helpful to set certain EHR template elements as "required" such that the note cannot be "signed" until certain required elements are completed. This would include coding if required by your organization.

Prepare the Care Team: Once your team has details of these 10 elements of workflow achieved, it is time to TEST, TWEAK and TEST again using the PLAN>DO>STUDY>ACT process until things are running smoothly.

Figure 1: The Plan-Do-Check-Act Cycle



Partnering with your Patients: With patient needs in mind, consider a **marketing program** (Flyers with billing, online videos, Facebook announcements, on hold announcements, virtual waiting-room videos, mailing cards, TV/Radio announcements) to inform your patients of your telehealth project. Inform them of their options and responsibilities. Consider adding a few tech-savvy patients to your Telehealth Team to receive feedback and suggestions. Start by asking a few select patients to do trial telehealth visits.

Implementing: GO SLOW and BUILD!!! Start with one provider or pod. Learn from the issues you find. When things are working better, roll out to other providers and locations.

Evaluating for Success: Look at the goals you set at the beginning. Did you achieve them? What are the barriers? How can barriers be overcome? Were the goals unrealistic? Consider developing a Patient Telehealth Survey to evaluate some of your questions. Do you need to or want to set new goals?

Scaling: What is next in your project? Do you want to tackle Transitional Care Visits via telehealth and help prevent hospital readmission? How about identifying your most non-compliant diabetic patients and arranging for Medical Nutritional Therapy via telehealth? Consider having providers use telehealth visits to handle problems identified through on call service on the weekends and nights to help prevent patient visits to the ER and Urgent Care. Perhaps these problems could be handled via telehealth on nights and weekends instead to improve access to care?