Comagine Health

Long-Term Services and Supports Telehealth Toolkit

Contents

Introduction

During the COVID-19 pandemic, there was an urgent need to provide remote services to continue uninterrupted health care service delivery to enhance access, support patients and families, and prevent spread of COVID-19. This resulted in a rapid increase in the delivery of remote health care services in just about every sector of health care, including in the long-term services and supports (LTSS) settings. This toolkit provides helpful guidance, checklists, resources and best practices to optimize and support telehealth and other virtual services in the LTSS settings, including long-term care (LTC) and assisted living facilities, home health services and hospice care.

Telehealth and Other Virtual Services Basics

As defined by the Health Resources & Services Administration (HRSA), telehealth encompasses more than telehealth as a health care service delivery modality, which many people use when they refer to telehealth. HRSA defines telehealth 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. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications."[1]

The Centers for Medicare & Medicaid Services (CMS) acknowledge that "The health care community uses the term ''telehealth'' broadly to refer to medical services furnished via communications technology." CMS further clarifies that while all kinds of services may fall into this broad use of the term telehealth, they use the term "Medicare telehealth services" to refer to the discrete set of services and codes for which Medicare makes payment, all of which can be furnished in person rather than by interactive, real-time telecommunication technology[2].

While there is some debate about whether health care services delivered only by phone are considered telehealth, our approach for this toolkit is to take a holistic view of remote service delivery options, which fall into two categories:

1. Telehealth services → the specific codes and services pertaining to the Medicare List of Telehealth Services[3]
2. Other virtual services → additional options to deliver health care services remotely (e.g., chronic care management (CCM), remote physiologic monitoring (RPM), virtual communication services (VCS), etc.).

[1] Telehealth Programs. *Health Resources & Services Administration.* https://www.hrsa.gov/rural-health/telehealth
[2] Calendar Year 2021 Physician Fee Schedule Final Rule. *Centers for Medicare & Medicaid Services*. December 28, 2020. https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf
[3] List of Telehealth Services. *Centers for Medicare & Medicaid Services*. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

TELEHEALTH SERVICES:

- Are defined by a discrete set of services and codes for which Medicare, Medicaid and other health plans make payment.
- Can also be furnished in person.
- Have a distant site (where the provider is) and an originating site (where the patient is)
- Must include both audio and video components (not required during the public health emergency)

OTHER VIRTUAL SERVICES include but are not limited to:

- Telephone Evaluation and Management (E/M) (only during PHE)
- Virtual Communication Services: virtual check-in and remote evaluation of pre-recorded patient information
- E-visits – Online Digital Evaluation Services
- Chronic and Principal Care Management
- Behavioral health integration and Psychiatric Collaborative Care Services
- Interprofessional consultation
- Remote physiologic monitoring

Promoting and supporting the use of telehealth and other virtual services in LTSS settings can:

- Reduce disruption to LTSS recipients
- Increase patient and staff satisfaction
- Reduce the use of personal protective equipment (PPE)
- Ensure timely, potentially life-saving interventions
- Reduce the number of unnecessary hospital transfers
- Expand access to care, including mental/behavioral health, wound care and advanced care planning

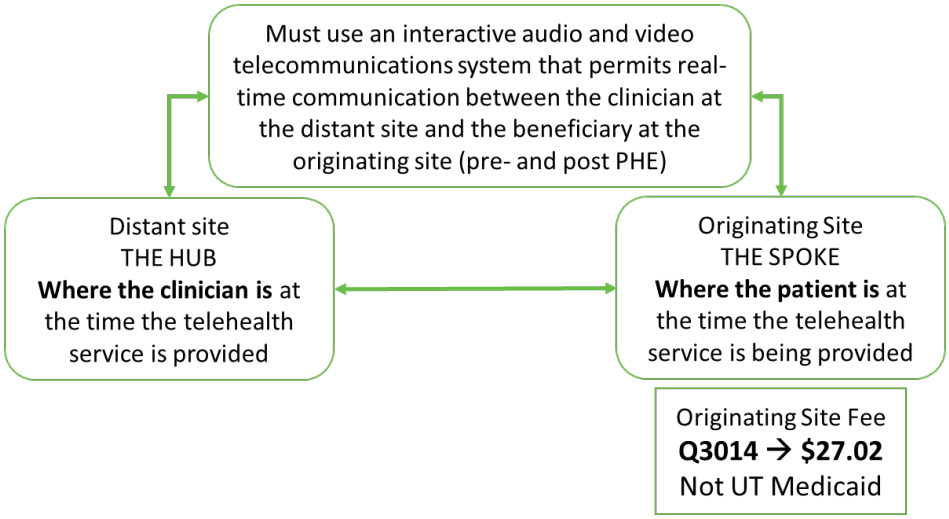
This document provides guidance to help LTSS staff promote and support remote health care service delivery to expand access, keep people safe, and offer additional options for patients and families.

Telehealth Services

Telehealth services can be delivered to residents at in all LTSS settings by clinicians under Medicare, Medicaid and other insurers. For Medicare beneficiaries, there are several requirements for delivering telehealth services, including the use of an interactive audio and video telecommunications system that permits real-time communication between the clinician at the distant site and the beneficiary at the originating site[4]. For each telehealth encounter, there is always a distant site – where the clinician is – and an originating site – where the patient is. For 2021, Medicare reimburses $27.02[5] for the originating site fee, but Utah Medicaid does not reimburse for the originating site fee.

[4] Telehealth Services Booklet. *Centers for Medicare & Medicaid Services.* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

[5] CMS Manual System Pub 100-04 Medicare Claims Processing. Transmittal 10505. Change Request 12071. December 4, 2020. https://www.cms.gov/files/document/r10505cp.pdf . Accessed December 21, 2020.



During the public health emergency (PHE), CMS has waived the requirement that initial visits to long-term care (LTC) facility residents must be performed in person and allows visits to be conducted, as appropriate, via telehealth options[6]. In addition, CMS revised the frequency limitation from one subsequent LTC facility visit every 30 days to permit one Medicare telehealth visit every 14 days[7]. In addition, initial LTC facility visits (i.e., following admission to the facility), all levels (CPT codes 99304–99306 Low, Moderate and High Complexity) are added to the telehealth codes on an interim basis during the PHE, and LTC facility discharge day management (CPT codes 99315–99316) are added to the telehealth codes through the year in which the PHE ends.

Long-Term Care and Assisted Living Facilities

In addition to telehealth specifics throughout this document, below are top 10 actions for LTC and assisted living facilities:

1. **Assign a telehealth champion**. Identify an internal telehealth "motivator for change" who can lead a small team of direct-care clinical care, IT staff and clinicians, preferably one currently utilizing telehealth in their practice, to prepare for, promote and support services.
2. **Know and correct any telecommunication weaknesses.** Assess bandwidth and Wi-Fi strength throughout the building. Pilot test capabilities to ensure glitch-free remote sessions.
3. **Select a telehealth solution.** While the current health crisis allows for immediate adoption of telehealth through options that are not compliant with the Health Insurance Portability and Accountability Act (HIPAA) (e.g., FaceTime), plan for a permanent solution that is HIPAA-compliant and provides interactive audio and video telecommunications that permits real-time communication between the clinician and the resident.
4. **Engage community clinicians.** Reach out to community clinicians to create a table listing all health care professionals who provide services to residents with an indication of whether they provide remote services and any special requirements or requests for setup ahead of or during the telehealth encounter.
5. **Educate/train facility staff.** Use a combination of in-person and/or remote training sessions, telehealth how-to videos and tip sheets to get staff up to speed quickly; refresher trainings are key to ongoing success.

[6] COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. *Centers for Medicare & Medicaid Services.* Page last modified December 1, 2020. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

[7] [7] Calendar Year 2021 Physician Fee Schedule Final Rule. *Centers for Medicare & Medicaid Services*. December 28, 2020. P. 84531. https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf

6. **Develop standard workflows.** Develop a pre-visit/call routine to have the resident ready to engage with the clinician. Discuss with clinicians any additional aspects of the visit that will be completed by facility staff (e.g., obtain and document consent) to facilitate the virtual visit.
7. **Establish expectations.** Ensure an agreed-upon turnaround time is in place for clinicians to provide visit notes, orders, prescriptions and additional required documentation for the electronic health record (EHR). Be clear on clinicians' expectations of residents and staff (e.g., ready to start remote visit promptly at scheduled time).
8. **Develop a communication strategy.** Include facility staff, community clinicians, residents and families in creative and repetitive ways (e.g., Quality Assurance & Performance Improvement [QAPI], department, resident council meetings and more). Direct message to clinicians and develop a system of feedback to improve the telehealth processes and patient/staff satisfaction.
9. **Monitor performance.** Work with the QAPI team to identify and track relevant metrics, especially those related to quality, safety, efficiency, and patient and staff experience.
10. **Take a broad view.** Brainstorm and ask questions to be sure something important is not forgotten. There's always more to consider!

Other Virtual Services

Listed below are additional virtual services that LTSS recipients may receive from clinicians. These virtual services do not have the required audio and video component that telehealth does, and there are no distant or originating site considerations as there are for telehealth services. Other virtual services describe a suite of services that expand options for enhanced service delivery for individuals receiving LTSS.

Do not hesitate to ask clinicians if they provide any of the following virtual services!

Remote Physiologic Monitoring

Remote physiologic monitoring (RPM) has the potential to decrease emergency department visits, hospital admissions and readmissions. Clinicians can receive reimbursement for providing these services to monitor physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate). There are ample opportunities for an LTSS provider to support an RPM program by providing the monitoring devices, sending information to the clinician and executing treatment plans based on readings when appropriate. CMS has not created materials around these services yet, but details may be found in the Comagine Health Remote Physiologic Monitoring Fact Sheet.

Chronic and Principal Care Management

CMS' Chronic Care Management (CCM) and Principal Care Management (PCM) services cover a broad range of care coordination, patient education, continuity and care plan elements that can be delivered to LTSS residents by clinicians, nurses and medical assistants (MAs). These services are typically provided by phone only but can include secure messaging or in-person components as well.

"Chronic care management is **care coordination services** done outside of the regular office visit **for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient**, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. These services are typically non-face-to-face and allows eligible practitioners to bill for **at**

least 20 minutes or more of care coordination services **per month**."[8] PCM provides the same monthly services to an individual with a single high-risk disease.

These services are an excellent option for those receiving LTSS who need ongoing care management to optimally manage their conditions, and it may be beneficial to know which clinicians provide these services and to request those services for certain individuals, especially in a home health setting. Note that there are some constraints around providing CCM/PCM to individuals in a nursing or assisted living facility, but clinicians will know whether they can provide the services based on those existing constraints. Additionally, these services are unlikely in hospice care situations but are quite likely to be used by clinicians providing services to those receiving home health services.

Behavioral Health Integration and Psychiatric Collaborative Care Model

Like the Chronic and Principal Care Management services noted above, the Behavioral Health Integration (BHI) services are for systematic assessment and monitoring and care plan revision for patients whose mental health condition is not improving adequately. The Psychiatric Collaborative Care Model (CoCM) services are also monthly services that are furnished to patients, but this set of services requires "A medical professional trained in psychiatry and qualified to prescribe the full range of medications,"[9] making this less likely for a clinician to be able to provide if they do not have access to a psychiatrist or other professional that fills the requirements. For individuals with more complex mental health issues, it may be worthwhile asking if a clinician or health care organization can offer CoCM services. Also similar to the above, it may be beneficial to know which clinicians can deliver these services.

Virtual Communication Services

Virtual Communication Services are short interactions with patients, usually 5-10 minutes, that are primarily used to prevent the need for an office visit (telehealth or in-person). There are two options – virtual check-ins and remote evaluations of pre-recorded patient information. These short interactions with patients cannot originate from a related evaluation and management (E/M) service (think office visit) provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment. (Office visits are often referred to as E/M services.)

1. **Virtual check-ins** – This option could be helpful for individuals in the LTSS and home health settings because it can be much easier than presenting for an in-person visit or arranging a telehealth visit. Use these check-ins to decide if an office visit is needed or whether other actions can be taken to address a given issue. Virtual check-ins are usually for 5-10 minutes, but there is an option – only on an interim basis for calendar year 2021 – for a check-in that is 11-20 minutes.

EXAMPLE: A patient calls the clinician to discuss some cold symptoms because she doesn't know if she needs to have an office/telehealth visit. After obtaining more information and ensuring that the patient has no fever nor shortness of breath, the clinician offers reassurance and advises to call if symptoms worsen or if she has any shortness of breath.

[8] Chronic Care Management – Health Care Professional Resources. Centers for Medicare & Medicaid Services. Page last modified September 11, 2020. https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/ccm/hcpresources

[9] Behavioral Health Integration Services. Centers for Medicare & Medicaid Services. Last updated May 2019. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

2. **Remote evaluations of pre-recorded patient information** – This option could also be very helpful, especially in the setting of skin-related issues (e.g., pressure ulcers, skin tears, etc.). LTSS or home health staff could help a resident take and send (securely) a picture of a skin lesion for remote evaluation.

Interprofessional Consultation

There are five services/billing codes for the consultative physician and one code for the treating clinician, making this option attractive and efficient for LTSS recipients, staff and clinicians. Knowing which clinicians participate in interprofessional consults is helpful, especially if the LTSS or client's home is in a rural area and/or has a shortage of specialists. Having the clinician engage in an interprofessional consultation or e-consult can save hours of driving and disruption of residents. If a referral is needed, ask the referring clinician if an interprofessional consultation or e-consult is possible. The LTSS or home health staff can facilitate the operational pieces of the interprofessional consultation process by sharing medical records and more.

E-visits – Online Digital Evaluation Services

E-visits provide online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days. These services are non-face-to-face, patient-initiated communications using online patient portals. These digital assessment services are for established patients who require a clinical decision that otherwise typically would have been provided in the office. While e-visits do offer another option for receiving health care services, e-visits may be more challenging than other virtual services to implement and adopt due to the patient portal requirement.

Virtual Visit Table

As noted above, it is helpful to know which clinicians offer which remote services. The table below features an option for tracking this information by health care provider. Alternatively, the LTSS can list each of the services along with clinicians or offices that offer any or all services.

Office or Clinician	Telehealth	CCM/PCM	RPM	BHI	CoCM	Virtual Check-In	Remote Eval of Info	E-Visits	IP Consult
Dr. Apple	Y	Y	Y	N	N	Y	Y	N	N
Dr. Banana	Y	N	N	Y	Y	N	N	Y	Y
ABC Health Center	Y	Y	N	Y	N	Y	Y	Y	N
BHI-Behavioral Health Integration, CCM-Chronic Care Management, CoCM- Psychiatric Collaborative Care Services, IP-Interprofessional, PCM-Principal Care Management, RPM-Remote Physiologic Monitoring									

Home Health

Home health agency (HHA) staff have utilized telehealth and other technology for many years to serve their clients. CMS encourages the use of telehealth and telecommunications technology to expand options for HHAs and their clients, allowing for provision of virtual services within the 30-day period of care, as long as those virtual services are part of patients' plan of care. However, CMS is also clear that virtual services do not replace needed in-person visits as ordered on the plan of care, and only in-person visits can be reported on the home health claim[10]. CMS cites remote physiologic monitoring as a service that can be furnished via a

[10] Home Health Agencies: CMS Flexibilities to Fight COVID-19. *Centers for Medicare & Medicaid Services.* Updated Nov 4, 2021. https://www.cms.gov/files/document/covid-home-health-agencies.pdf

telecommunications system to augment a home health plan of care without substituting for an in-person visit[11]. Note that the use of technology must be included on the home health plan of care along with a description of how the use of such technology will help to achieve the goals outlined on the plan of care. The required face-to-face encounter for home health can be conducted via telehealth during the public health emergency.

Depending on a client's health plan, telehealth and other virtual services are options for those receiving home health services, presenting an opportunity for HHA staff to help clients to engage in these options. Below is a list of actions that HHA staff can take to support the individuals they serve.

- Advocate for telehealth visits rather than in-person office visits when appropriate during the pandemic because clients may receive telehealth when they are in their home. Often if one does not request a telehealth visit, this option will not be offered when scheduling a visit.
- Beyond using telehealth instead of office visits, leverage telehealth for needed services, including for diabetes self-management education (DSME), education for chronic kidney disease, mental health and counseling, transitional care management and more. During the pandemic, physical therapy, occupational therapy and speech-language pathology services may be delivered by telehealth.
- Provide the requisite devices with mic and video to conduct a telehealth visit and provide additional support to facilitate the visit.
- Ensure that clients have the needed broadband or other connectivity to engage in telehealth.
- Know what each client's specific needs are during a telehealth visit and make sure clinicians and others make the necessary accommodations for clients with translation needs, hearing loss, cognitive impairment, etc.
- When needed and/or appropriate, on behalf of the client, request that family or other caregivers join telehealth visits.
- Understand which of the other virtual services listed above are options for each client and help them take advantage of those options in ways that work for them, including, but not limited to chronic and principal care management.

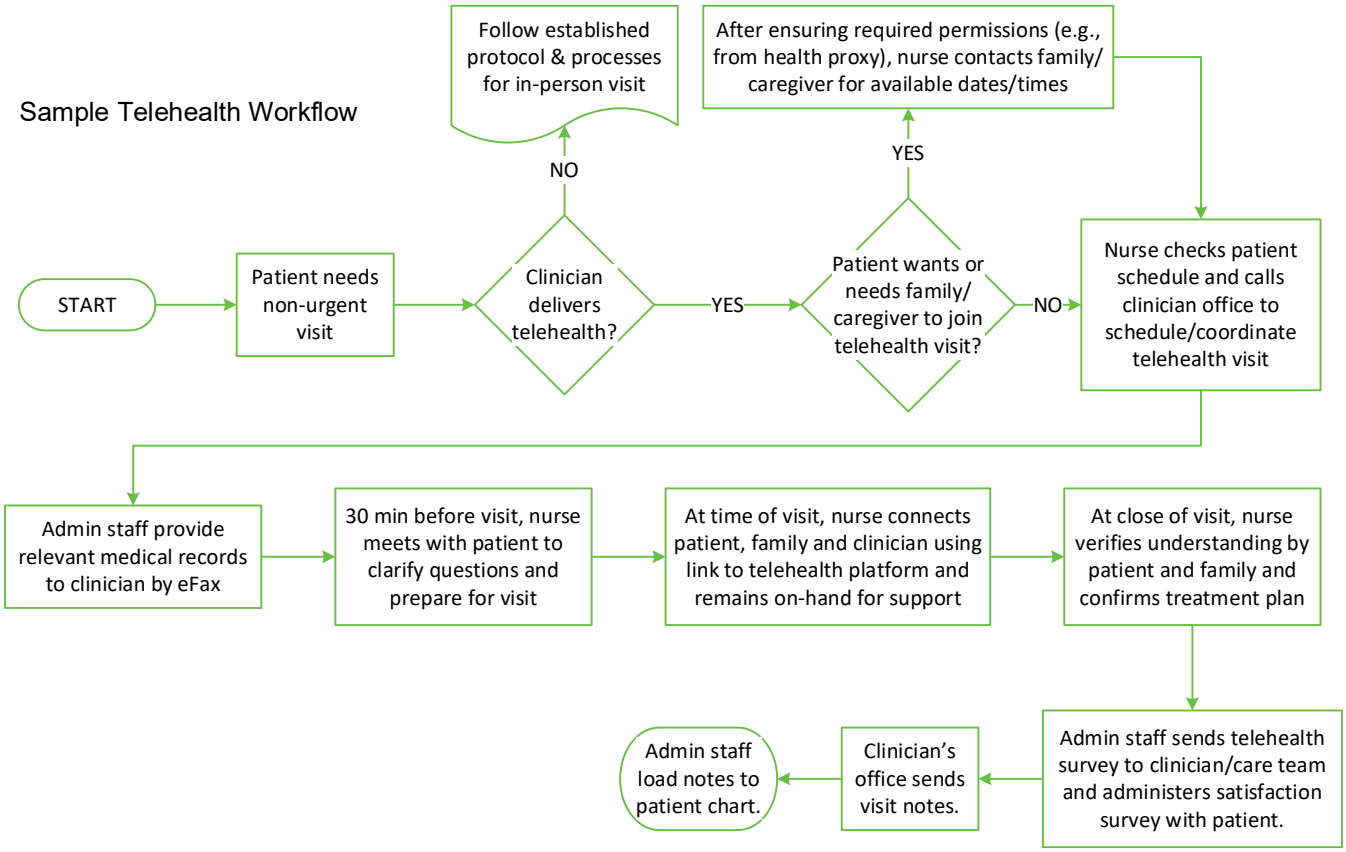
Hospice

Remote service delivery options and information for hospice care are similar to the information in the Home Health section above. For the duration of the public health emergency (PHE), CMS specifies that "when a patient is receiving routine home care, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patient's terminal illness and related conditions without jeopardizing the patient's health or the health of those who are providing such services during the PHE for the COVID–19 pandemic"[11]. Additionally, CMS will not pay beyond the per diem amount for the use of technology in providing services under the hospice benefit. Only in-person visits (except for social work telephone calls) can be reported on the claim. Hospices may use telehealth (must have audio and video) to satisfy the face-to-face encounter requirement but must include additional documentation (see details at COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) p. 145 https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf)

[11] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency Interim Final Rule. pp. 19247-52. *Centers for Medicare & Medicaid Services*. Apr 6, 2020. https://www.govinfo.gov/content/pkg/FR-2020-04-06/pdf/2020-06990.pdf

Workflow

As with in-person visits, having standard, efficient workflows are the key to having virtual visits run smoothly and ensuring patient safety. As virtual visits are being implemented, consider forming a small team of two to three individuals who are responsible for establishing, mapping, fine-tuning and continuously improving workflows. In the long-term care setting, this work will fall under the existing Quality Assurance and Performance Improvement (QAPI) program. Basic information on workflows can be found at the Agency for Healthcare Research and Quality website What is workflow?. The National Telehealth Research Center provides a 47-minute instructional video on Mapping and Designing Telehealth Clinic Workflows that covers the basics of workflow mapping. The California Telehealth Resource Center provides additional telehealth sample workflows.



Patient Safety

There are several potential patient safety issues with telehealth, which can be mitigated with care.

BEST PRACTICE: Have available each clinician's telehealth clinical pathway to determine when a virtual visit is acceptable and when an in-person visit is required.

Emotional and mood cues may be missed. Because the communication is different with telehealth and may not include a video component, facial cues are blunted, and clinicians may not see distress or tears if not using video.

Diagnoses may be missed or delayed. Telehealth is not always the right choice. Robust physical exams cannot be conducted that could reveal a serious condition. Some workflows for remote services have shifted from established workflows away from the way things are done for in-person visits, which may lead to patient safety issues. For example, it is more challenging to deploy team-based care virtually to conduct pre-visit planning and huddles to identify and address preventive and chronic gaps in care.

There is a potential increased risk for domestic abuse. While one hopes this never happens, some patients are at risk for domestic abuse due to potential abusers hearing part or all of the virtual visit. Additionally, patients, including children, may not have the privacy to let a clinician or other staff know if they are being neglected or abused.

Quality Assurance and Performance Improvement (QAPI)

From a performance improvement standpoint, consider a set of process and outcome measures to identify opportunities to improve remote health care services. A few examples (besides satisfaction surveys) include:

- Percentage of encounters that are telehealth visits vs. in-person visits
- Percentage of visits that start and end on time – include reasons why visits did not start or end on time (e.g., clinician running late, resident not ready on time, appointment time too short to cover issues, questions and concerns)
- Percentage of visits for which we receive notes for patient within two business days
- ED visits, admissions and readmissions rates over time

Quality assurance. Each person should have the same high-quality telehealth experience, regardless of several variables that may differ within the LTSS setting (e.g., workflows, devices, clinicians, support staff). Consider what your LTSS site can do to ensure the clinician experience is also of high quality (e.g., access to needed records well in advance, start time at or before the scheduled time). Create a process to collect, collate and respond to questions/items related to telehealth. Below is a starter set of questions to assess the patient, staff and clinician experience with virtual visits.

BEST PRACTICE: Keep surveys short, focused and easy to complete. Sometimes just asking two simple questions is all that is needed: "How was your visit? What could have gone better?"

Resident Telehealth Satisfaction Questions	Possible Responses
Overall, I am satisfied with my telehealth visit.	Strongly disagree (1) Disagree (2) Agree (3) Strongly agree (4)
The visit started on time.	
I could see the clinician clearly.	
I could hear the clinician clearly.	
The clinician listened carefully.	
The clinician explained things in a way that was easy to understand.	
What could have gone better?	Free text box
Facility Staff Satisfaction Questions	**Possible Responses**
The clinician's processes were easy to follow to begin the telehealth visit.	Strongly disagree (1) Disagree (2) Agree (3) Strongly agree (4)
The visit started on time.	
The clinician's credentials were clearly displayed.	
The clinician and other team members introduced themselves.	
The clinician and other staff spoke directly to the resident and were respectful and accommodating.	
The technology or telehealth platform was easy to use.	
What could have gone better?	Free text box
Clinician and Care Team Satisfaction Questions	**Possible Responses**
I was provided the patient information needed for the virtual visit well in advance.	Strongly disagree (1) Disagree (2) Agree (3) Strongly agree (4)
The visit started on time.	
The resident was prepared for the visit (e.g., on time to appointment, had questions and concerns ready).	
Facility staff were present to assist when needed during the visit (e.g., support/help patient, troubleshoot issues with technology, etc.)	
What could have gone better?	Free text box

Equity

While telehealth has great potential to expand access to health care services, it also worsens several existing health care inequities. In the LTSS setting, one would expect that possession of means to engage in telehealth (e.g., device, connectivity, data plan) is not a factor. However, it is important to have a high level of vigilance to ensure that all residents are treated equally well and have the same opportunities to access and use remote health care services.

BEST PRACTICE: Ensure that all individuals, regardless of cognitive functioning or other factors, have the same access and support to engage in telehealth.

Person-Centeredness

Telehealth and other virtual services are not always scheduled at times that are convenient to residents and LTSS staff. All efforts should be made to accommodate residents' preferences and to provide them ample notice and reminders about upcoming appointments. Residents may still like to dress and groom as though they are going to an in-person visit and should be supported in this preference as well. To ease anxiety, reassure residents that staff will help facilitate the technical and other portions of the visit. Provide residents with headsets or ear buds to ensure privacy and to accommodate any hearing loss. Look for additional opportunities to support residents in this new way of interacting with and receiving their health care services. Many person-centered supports will be specific to the resident, the clinician and many other factors, making it important to tailor support to the situation to ensure person-centeredness.

BEST PRACTICE: While frequently overlooked, telehealth provides an amazing new opportunity to include family and caregivers in the visits with two important caveats:

1. The resident or health proxy must provide permission.
2. The visit must still be focused on the resident without disruption from other participants.

Team-Based Telehealth

Team-based telehealth is probably practiced at the distant site – where the clinician is. However, there are also several opportunities to implement or improve team-based care at the originating site – where the patient/resident is. Depending on the telehealth platform that is used, LTSS staff can engage in the following activities and more:

- Share current vital signs
- Advise regarding the status of chronic and preventive care gaps (e.g., last A1C test, due for influenza vaccine, etc.)
- Add relevant family, social and surgical history
- Provide portions of the history of present illness
- Begin review of systems questions
- Act as scribe

Staff Training

Every LTSS setting should have a list of basic skills that are required by specific staff to understand and support receipt of remote health care services by residents. Additional training for telehealth can be provided internally to the organization or through available online options.

Consent

The clinician and the distant site care team is primarily responsible for documentation for telehealth, but LTSS staff can obtain and document consent in advance of the telehealth visit if coordinated with the clinician and team in advance.

Medicare and most state Medicaid agencies and other insurers require patients' informed consent for telehealth and other virtual services. While consent for Medicare beneficiaries is straightforward, other insurers, including state Medicaid agencies, have informed consent requirements that can be complex. Below are the consent requirements for Medicare and Utah Medicaid for telehealth and other virtual services. Check directly with other insurers for their specific requirements and guidance for informed consent.

Medicare Consent for Telehealth

Medicare requires beneficiary consent — verbal or written — for telehealth and other virtual services as well as notification of any applicable cost sharing, including potential deductible and coinsurance amounts. Consent must be documented in the patient's medical record.

Utah Medicaid Consent for Telehealth

Utah Medicaid has several additional components for consent for telehealth services[12] and must include the following.

- Additional fees for telehealth services, if any, and how payment is to be made for those additional fees if they are charged separately from any fees for face-to-face services provided to the patient in combination with the telehealth services
- To whom patient health information may be disclosed and for what purpose, including clear reference to any patient consent governing release of patient-identifiable information to a third-party
- The rights of patients with respect to patient health information
- Appropriate uses and limitations of the site, including emergency health situations
- The following information:
    - Affirming that the telehealth services meet industry security and privacy standards, and comply with all laws referenced in Subsection 26-60-102(8)(b)(ii)
    - Warning of potential risks to privacy notwithstanding the security measures
    - Warning that information may be lost due to technical failures, and clearly referencing any patient consent to hold the provider harmless for such loss
    - Disclosing the website owner/operator, location and contact information

Medicare – Chronic and Principal Care Management (CCM/PCM)

Medicare requires additional documentation of verbal consent for CCM/PCM in the medical record after informing the patient regarding availability of the services, that only one clinician can bill per month, the right to stop services effective at the end of any service period (i.e., end of any month), and that cost sharing applies (if no supplemental insurance).[13]

Billing and Revenue

Medicare, state Medicaid agencies and other insurers all have their own specifications, coding and reimbursement details for telehealth and other virtual services, making it challenging for the clinicians delivering telehealth and other virtual services to residents in LTSS settings. For the most part, keeping those billing and reimbursement details straight is the responsibility of the clinicians and their health care organization(s). However, it is reasonable to ask if there is anything that LTSS staff can do to streamline or support the related processes.

Both long-term care and assisted living facilities can bill for the originating site fee for Medicare beneficiaries when they receive telehealth services at the facility. However, that is not true when the people receive

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[12] Utah Administrative Code. R156-1-602. Telehealth - Scope of Telehealth Practice. *Utah Office of Administrative Rules*. https://rules.utah.gov/publicat/code/r156/r156-01.htm Accessed 2021.01.08

[13] Calendar Year 2020 Physician Fee Schedule Final Rule. (Pp. 62695-6) *Centers for Medicare & Medicaid Services*. November 15, 2019. https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

telehealth services in their homes. Note that this is only for telehealth and not for other virtual services. Medicare sets the reimbursement rate for originating site fees for HCPCS code Q3014 on an annual basis; for 2021, the reimbursement is 80 percent of the lesser of the actual charge, or $27.02. Medicare beneficiaries are responsible for any unmet deductible amount and Medicare coinsurance. Each state Medicaid agency specifies whether they do or do not reimburse for an originating site fee. For example, according to verbiage in the Utah Medicaid Provider Manual, Utah Medicaid does not appear to reimburse for the originating site fee: "The provider at the originating site receives no additional reimbursement for the use of telehealth services."[14] Because the originating site is defined as where the *patient* is not the *provider*, their verbiage is not entirely clear. For confirmation, it may be best to receive confirmation on the status of reimbursement directly from the state Medicaid agency.

Technology – Hardware and Software

While telehealth has been around for decades, its recent insurgence has increased awareness. Along with this awareness are concerns for the additional cost of delivering and/or receiving telehealth. The following are some of the hardware and software considerations related to telehealth and other virtual services.

Hardware

carts or "computers on wheels" (COWs) – These are frequently used in the LTSS setting to wheel the computer or device for telehealth from room to room.

Computers, laptops, tablets, etc. – Having a mobile option to take to where a resident is for a scheduled virtual visit is important and provides flexibility and efficiency. This may be the case for home health agencies and hospice providers.

Headsets or ear buds – Inexpensive options abound to protect patient privacy and to help residents with hearing options. During the pandemic, several facilities used disposable options to ensure infection prevention.

Telehealth peripherals – These include digital options for conducting portions of the physical exam or providing remote physiologic monitoring (e.g., digital stethoscope, otoscope or scale; Bluetooth®-enabled glucometer or O^2 monitor, etc.).

Software

There are several types of telehealth-related software, but the most common consideration is the telehealth platform that is used by the clinicians that provide services to the LTSS residents. Unfortunately, if several clinicians provide telehealth services to an LTSS recipient, it can be challenging to keep them all straight and become proficient enough to support patients.

HIPAA Privacy and Security: Telehealth Considerations

During the COVID-19 pandemic, there was a pressing need to expand telehealth, which was facilitated by several accommodations. The Notice of Enforcement Discretion published by the Office for Civil Rights states that "covered health care providers will not be subject to penalties for violations of the HIPAA Privacy, Security, and Breach Notification Rules that occur in the good faith provision of telehealth during the COVID-19 nationwide public health emergency." However, compliance with HIPAA is essential both during and after the public health

[14] Utah Medicaid Provider Manual - Section I: General Information, p. 50 (Jul. 2020). https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/All%20Providers%20General%20Information%20Section%20I/AllProvidersGeneralInfo_Section_1.pdf

emergency (PHE). The information below reinforces the HIPAA Privacy Rule in the setting of telehealth and provides a list of telehealth-related considerations to include in a security risk analysis (SRA) as required by the HIPAA Security Rule for all covered entities.

HIPAA Privacy

There are at least three aspects of patient privacy that need reinforcement when using telehealth.

Using a headset or earbuds: Because an exam room provides privacy for conversations between residents and clinicians, it is important to maintain privacy during virtual communication by using a headset or earbuds. On both ends of the virtual communication, it is essential that 1) patients and clinicians can speak freely without risk of being overheard by someone who should not or does not need to hear the conversation and 2) the computer mic is not used when there are others near who can hear either or both sides of the conversation.

Discussing patients: Conversations about patients, including medication and other treatment plan changes, often occur in the hallways or other nonprivate spaces in the LTSS setting. This results in other individuals overhearing residents' protected health information (PHI).

BEST PRACTICE: Dedicate a private place within the LTSS for people to discuss the care of residents.

Sharing medical records: If clinicians do not have access to the electronic medical record, LTSS staff often send records to clinicians in advance of telehealth visits. It is important to remember that the HIPAA Privacy Rule minimum necessary standard must be applied to ensure that PHI is not used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function.

HIPAA Security

Adhering to the standards and implementation specifications components of the LTSS security risk analysis (SRA) is required by the HIPAA Security Rule. The checklist below provides some relevant guidance based on some of the required component of the SRA. Note that this is not legal advice nor is this checklist comprehensive.

- ☐ Our designated Security Officer (required by HIPAA) has updated all relevant HIPAA standards and implementation specifications in our SRA to include changes we have made with telehealth.
- ☐ All devices (e.g., laptops, tablets, etc.) used for telehealth:
  - Are protected, using unique passwords for each user
  - Have current and functioning antivirus software
  - Are secured physically to prevent unauthorized access or removal
  - Terminate an electronic session after a predetermined time of inactivity
  - Include ability to encrypt/decrypt electronic PHI (ePHI) when deemed appropriate
  - Are included in the inventory of all devices that create, receive, maintain or transmit ePHI
- ☐ We have a security awareness and training program that includes telehealth-related security concerns for all employees (including management)
- ☐ Any telehealth platforms that we use are HIPAA-compliant, and we have signed business associate agreements (BAAs) for relevant persons or entities as described by the Office for Civil Rights[15]

[15] Business Associates. U.S. Department of Health & Human Services – Office for Civil Rights. Accessed Jan 4, 2021. https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/index.html

Top 10 Resources

Below is a curated list of resources for those in the LTSS setting that want to learn more about telehealth.

1. **A Practical Guide to Implementing Telehealth in LTPAC Facilities - March 2019** (West Health)
   This is a comprehensive toolkit that starts with conducting an initial needs assessment. This toolkit was created prior to the COVID-19 pandemic and most LTSS facilities no longer need to assess the feasibility of telehealth; it is an essential tool to delivery health care services to keep people safe and to expand access. However, the toolkit is chock full of excellent information and is a great adjunct to the material above.
   https://www.westhealth.org/resource/telehealth-paltc-guide/
2. **Keys to effective telemedicine for older adults**
   Short and pertinent blog from the Institute for Healthcare Improvement
   http://www.ihi.org/communities/blogs/the-keys-to-effective-telemedicine-for-older-adults
3. **Quality Improvement (QI) Essentials Toolkit**
   Great resource for QI tools
   http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx
4. **Telehealth Services for Medicare Fee-for-Service Providers**
   CMS fact sheet on telehealth
   https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf
5. **American Medical Association Telehealth Implementation Playbook**
   This is a fairly long document at 128 pages, but it is exceptionally complete and well done. Not all sections are relevant for the LTSS setting. However, it's worth scrolling through the document for the parts that are relevant such as Designing the Workflow and references to documentation.
   https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide
6. **Telehealth in PALTC from The Society for Post-Acute and Long-Term Care (PALTC) Medicine**
   Resources related to telehealth the PALTC settings.
   https://paltc.org/telehealth-paltc
7. **Health and Human Services Telehealth Homepage**
   Excellent telehealth resources.
   https://telehealth.hhs.gov/
8. **Rural Health Information Hub Rural Health Toolkit**
   Comprehensive set of telehealth resources – not just related to rural health
   https://www.ruralhealthinfo.org/toolkits/telehealth
9. **Center for Connected Health Policy**
   Resources related to telehealth policy changes, including comprehensive state-specific look-up tool with state Medicaid statutes and other information related to telehealth policy and allowances.
   https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies#
10. **Utah-Inclusive Telehealth Organizations**
    Northwest Regional Telehealth Resource Center (AK, ID, MT, OR, **UT**, WA, WY): https://nrtrc.org/
    Southwest Telehealth Resource Center (AZ, CO, NV, NM, **UT**): https://southwesttrc.org/
    Utah Education and Telehealth Network https://uetn.org/

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