Critical Access Hospital Telehealth Guide

August, 2021

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This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UB1RH24206, Information Services to Rural Hospital Flexibility Program Grantees, $1,009,120 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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Acknowledgments:

This report is prepared for the National Rural Health Resource Center Technical Assistance and Services Center (TASC) through a partnership between the Northwest Regional Telehealth Resource Center (NRTRC) and Trudy Bearden, Senior Consultant at Comagine Health. This project was funded under the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under G22RH31114 Telehealth Resource Center's Grant Program in conjunction with HHS under grant number UB1RH24206, Information Services to Rural Hospital Flexibility Program Grantees, $1,009,120 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

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Feedback on the Critical Access Hospital Telehealth Guide:

If you have feedback, suggestions, or corrections, please let us know at info@NRTRC.org

Introduction

Telehealth has been used as a modality to deliver health care services for over six decades, but its potential to expand access and keep people safe came sharply into focus during the COVID-19 pandemic when using telehealth became an imperative. Critical Access Hospitals (CAHs) have multiple options to expand and optimize telehealth service to meet the quadruple aim[1].

- *Improve patient health and outcomes* by better disease management, monitoring, and timely care
- *Reduce health care costs* by fewer emergency department (ED) visits, admissions, and readmissions
- *Enhance the patient experience* by expanding access, improving convenience, coordinating care, and building relationships
- *Enrich the work-life of staff* by providing more options to optimize health care service delivery, enhancing flexibility in work locations and schedules, and serving patients in ways that are better for everyone

The CAH Telehealth Guide provides practical guidance on implementing and sustaining telehealth to optimize health care delivery, expand access, and enhance care coordination. Note that this is not an all-inclusive policy guide for telehealth. Just as health care organizations strive to take a person-centered approach to health care, this guide seeks to take a CAH-centered approach to telehealth that keeps the patient and community at the forefront. The target audience is any individual, team, or organization seeking to implement or expand telehealth services in the CAH setting. The guide primarily focuses on Medicare outpatient telehealth services but includes Medicaid coverage and remote services that may not strictly be considered telehealth.

Readers are encouraged to review state-based telehealth policy details at the Center for Connected Health Policy (CCHP), which provides detailed state Medicaid agency telehealth details with helpful links to each states' relevant resources, manuals, statutes, etc.

Because telehealth policy is currently in flux, when appropriate, the guide identifies temporary allowances resulting from the public health emergency declaration (PHE) in gray callout boxes. There is broad support by health care industry leaders,

[1] Bodenheimer T, Sinsky C. *From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider*. Ann Fam Med. 2014; 12(6): 573-6.

including the American Medical Association[2], to maintain many of the flexibilities allowed under the PHE. Additionally, in their March 2021 Report to the Congress: Medicare Payment Policy, the Medicare Payment Advisory Commission (MedPAC) presented a policy option that includes many recommendations reflected by industry leaders. Check CCHP's Telehealth Legislation & Regulation site to track telehealth state legislation and regulation across the nation for the current legislative session.

The Potential of Rural Telehealth

The full potential of telehealth in rural settings has yet to be realized primarily due to intermittent broadband availability. Telehealth has great promise to deliver health care to the right populations at the right place and time – efficiently, when feasible. Additionally, community-based solutions have yet to be optimized and opportunities to enhance care coordination by communication with shared care partners. Regardless, below are several potential telehealth benefits and opportunities for CAHs, their rural health clinics (RHCs), patients, families/caregivers, clinicians, care teams, and the community.

Enhance access. By acting as an originating site, CAHs can expand the range of specialty services and access to those services by health care professionals, patients, and the entire community. This is a fantastic service and benefit to patients, families, caregivers, and the community. In addition, consider CAHs' current use of telestroke programs to access neurologists and other specialists to optimize timely stroke interventions and care; teledermatology to evaluate and treat skin conditions, including decubitus ulcers, rashes, bites, and more; telepharmacy to optimize medical management; telebehavioral health for mental health; telehealth for substance use disorder; teleradiology for expert radiologists to render readings of images; teleophthalmology, primarily to ensure individuals with diabetes receive recommended retinal eye exams; teledentistry in areas with oral health provider shortages; use of telemedicine for the requirement that a medical doctor (MD) or doctor of osteopathic medicine (DO) must be immediately available for emergency services[3]; and a full range of additional specialists.

[2] AMA calls for action to help telehealth flourish post-pandemic. *American Medical Association*. Published online on June 14, 2021.
[3] Critical Access Hospital (CAH) Emergency Services and Telemedicine: Implications for Emergency Services Condition of Participation (CoPs) and Emergency Medical Treatment and Labor Act (EMTALA) On-Call Compliance. *CMS.* 2013.

Deliver supportive services for long-COVID. Resulting from the burden of COVID-19 infection – both on a national and individual level, the health care system sees the long-term impacts and chronic illnesses that linger after the disease has abated. Many patients will need long-term medical and chronic illness management as well as self-management support. Telehealth and other virtual services (e.g., Chronic Care Management Services) are essential to expanding options and access to support these individuals to optimize health and wellbeing.

Provide telehealth support for patients, families, and caregivers. For patients in the surrounding communities, CAHs' acting as an originating site provide access to specialists but also offers the opportunity to provide the support needed for patients to engage in a telehealth visit, including but not limited to a device with audio and video capabilities, adequate bandwidth, technical support for those with limited digital proficiency, a quiet and safe space in which to engage in a telehealth visit, and an option that is closer to home.

Expand behavioral health. Telebehavioral health was well-established before the pandemic but will be even more critical in the post-pandemic period as people emerge with lingering depression, anxiety, substance use disorder, and other mental health issues, including those associated with long COVID.

Elevate patient convenience. Many patients in rural areas travel several hours for specialists and other appointments for services unavailable in their rural town or county. This can often create an immense burden, especially for individuals without reliable transportation, those for whom mobility is challenging, those who cannot take needed time off from work, or for those who are caregivers and must either find coverage or bring the people for whom they provide care to a visit. Telehealth can decrease the out-of-pocket costs created by these burdens and can be a lifesaver, especially when time is of the essence.

Flex staff options. When conducting telehealth visits, members of the virtual care team may participate in the visit regardless of their location. While some staff may need to be at the CAH originating site, other members of the care team (e.g., medical assistant (MA), receptionist, social worker) may not need to be onsite for the telehealth visit and can be at their home, a different clinic site or essentially anywhere as long as they have the required tools (see Virtual Care Team Considerations). This option can be helpful – for example – when travel to the clinic is dangerous due to weather, staff cannot arrange

During the PHE, clinicians may provide telehealth from their home.

childcare, transportation to the clinic is problematic, or a staff member has a mild illness (especially if it is a contagious illness).

Preserve and capture revenue. Ensuring a full suite of telehealth services, including remote physiologic (patient) monitoring (RPM) and other virtual services, can help maintain the annual average length of stay of 96 hours or less for acute care patients by enhancing access to specialists and services as noted above and by providing telehealth service and RPM for patients in their homes when safe and appropriate. This can also lead to fewer transfers to other hospitals. While the originating site fee is small, those charges add up. Any cost savings are significant in value-based payment models, like accountable care organizations (ACOs). Lowering costs and improving quality are crucial for financial success through incentives and risk reduction.

Decrease staffing costs. Evidence shows that tele-ED physician backup for advanced practice providers decreases staffing costs, sometimes upwards of $100,000, and improves physician recruitment and retention.[4,5] Using tele-ED physician backup reduces costs by sharing salary costs; a CAH can pay a part-time or on-call salary for a physician rather than having to pay a full physician salary. Additionally, paying the salary for a nurse practitioner or physician assistant to cover the ED with physician backup by telehealth is less costly than paying for full physician coverage of the ED.

Telehealth Basics – Medicare

The Health Resources & Services Administration (HRSA) definition of telehealth is accurate and comprehensive: "…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". This guide primarily focuses on the "**support long-distance clinical health care**" portion of the definition, focusing on Medicare.

Per the Centers for Medicare & Medicaid Services (CMS), telehealth requires interactive audio and a video telecommunications system that permits real-time communication between the clinician at the distant site and the patient at the originating site. The exceptions are Alaska and Hawaii, where asynchronous

[4] Ward, M, et al. *Use of Telemedicine for ED Physician Coverage in Critical Access Hospitals Increased after CMS Policy Clarification*. Health Aff. 2018. 37(12) 2014; 12(6): 2037-44.
[5] Potter, A, et al. *Effect of Tele-emergency Services on Recruitment and Retention of US Rural Physicians*. Rural Remote Health. 2014; 14(3): 2787.

technology or store and forward — defined as the transmission of medical information to the distant site and reviewed later by the physician or practitioner — is permitted in federal telemedicine demonstration programs. CMS further narrows telehealth service delivery by the ~ 110 services and codes in the CMS List of Telehealth Services. See Appendix A - 2021 Category 1 Telehealth Code Summary Table in appendices for an accurate list of the permanent telehealth codes and services. All of these services can be delivered in person. Most state Medicaid agencies follow the exact telecommunication requirements, but some states also allow audio-only telehealth with or without contingencies (e.g., only if a video is impossible). Many state Medicaid agencies do not reimburse for the full range of telehealth services, and CAHs may need to check which telehealth codes are covered by Medicaid.

During the PHE, the list of telehealth services has expanded to ~ 250. Some will remain on the list until the PHE ends, others will be available through the year in which the PHE ends. Select telehealth services can be delivered using audio only during the PHE.

While this section focuses on telehealth from the Medicare perspective, many state Medicaid agencies and other commercial/private health plans follow Medicare's lead for their definitions of telehealth, including for distant and originating sites and service and payment parity. Several states also have permanent allowances for audio-only telehealth. Medicare, most state Medicaid agencies, and other health plans require patient/family consent to engage in telehealth. See the Consent section below for additional details. Below are several telehealth-related terms.

Originating site (where the patient is). CAH/RHCs are authorized to act as originating sites as noted in CMS' Telehealth Services MLN Booklet for services provided to Medicare beneficiaries and are eligible to receive reimbursement for the originating site fee, using Healthcare Common Procedure Code System (HCPCS) reimbursement code Q3014. More information is in Billing & Reimbursement below.

When a CAH acts as an originating site, the patient receives telehealth services from a distant site provider. There are several conditions of participation for this agreement. See Title 42 of the Code of Federal Regulations (CFR) §485.616 Condition of participation: Agreements to ensure compliance if applicable to the hospital. Note the requirement for written agreements with distant site providers.

"In the case of **distant-site physicians and practitioners** providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, the distant-site telemedicine entity is **not required**

to be a Medicare-participating provider or supplier." CFR §485.635 Condition of participation: Provision of services

A **distant-site hospital** providing telemedicine services **must be a Medicare-participating hospital**. CFR §485.616 Condition of participation: Agreements

To identify if an address is eligible for a Medicare telehealth originating site payment, enter the originating site address into the Medicare Telehealth Payment Eligibility Analyzer. Three important exceptions include[6]:

1. There are no geographic location limitations or originating sites where acute stroke telehealth service can be furnished.[7]
2. Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removes the originating site geographic conditions and adds an individual's home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder
3. There are no geographic location limitations for hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis ESRD-related medical evaluations. Independent Renal Dialysis Facilities are not eligible for originating sites.

During the PHE, geographic restrictions have been lifted, meaning that the originating site – where the Medicare beneficiary receives telehealth services – does *not* need to be in a county outside a Metropolitan Statistical Area or a rural Health Professional Shortage Area in a rural census tract. There is pending legislation that will permanently lift these geographic restrictions.

Distant site (where the clinician is). CMS does not currently list CAHs or their RHCs as distant sites, meaning that Medicare cannot reimburse these organizations for delivering the telehealth services listed in CMS' List of Telehealth Services. See Billing & Reimbursement below for the two situations when a CAH can be a distant site. The list of telehealth codes can also be found in Appendix P of a Current Procedural Terminology (CPT®) codebook, and a star symbol also indicates telehealth codes throughout the codebook.

During the PHE, RHCs may act as distant sites, and there is pending legislation to make this permanent.

[6] Telehealth Services Factsheet – MLN Booklet. *CMS*. This booklet include MUST READ information when delivering telehealth services to Medicare beneficiaries.
[7] New Modifier for Expanding the Use of Telehealth for Individuals with Stroke – MLN Matters. *CMS*. Effective Jan 1, 2019.

Hospitals do not technically bill for Medicare telehealth services as a distant site. However, the Medicare Claims Processing Manual Chapter 12 states that "If the physician or practitioner at the distant site is located in a CAH that has elected Method II, and the physician or practitioner has reassigned their benefits to the CAH, the CAH bills its regular A/B/MAC (A) for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply."

Providers at the distant site who are eligible to receive payment for telehealth services include:

- Physicians
- Nurse practitioners
- Physician assistants
- Nurse-midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical psychologists and clinical social workers (may not bill for psychiatric diagnostic interviews or E/M services)
- Registered dietitians or nutrition professionals

During the PHE, physical and occupational therapists as well as speech language pathologists may also provide telehealth services.

Consent. Medicare, most state Medicaid agencies, and other insurers require patients' informed consent for telehealth. While consent for Medicare beneficiaries is straightforward, other insurers, including state Medicaid agencies, have informed consent requirements that can be complex and are along the lines of consent for procedures – risks, benefits, and alternatives. Below are the consent requirements for Medicare. Check directly with other insurers for their specific requirements and guidance for informed consent. Obtaining and documenting consent to receive telehealth services can be obtained by the care team.

Medicare Consent for Telehealth

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

State Medicaid Agencies' Consent for Telehealth

Each state has its requirements for consent for telehealth. The best place to identify state-specific consent requirements is at the Center for Connected Health Policy (CCHP) site Current State Laws & Reimbursement Policies. Select "State" at the top of the page → , select state of interest → , select "Professional Requirements," → select "Consent Requirements."

Obtaining consent is primarily the responsibility of the distant site provider, but the originating site care team can help facilitate obtaining consent, too. Consent for telehealth can be streamlined by developing a standard script and creating a template in the EHR that ensures compliance with the relevant consent requirements.

Resource: Pre-Registration & Telehealth Consent Form Strategy. *Access*. Jun 2020. Great resource with sample consent forms to download.

Store and forward. The asynchronous, electronic transmission of or access to patient information - usually images - to evaluate, diagnose and guide treatment. Examples include teleradiology, where images are sent to a radiologist to assess and render findings; teledentistry, where a dental hygienist will obtain dental images to send for interpretation by a dentist; and teleophthalmology, where a retinal scan is sent to an ophthalmologist to determine if there is any pathology or change in eye health.

Peripherals. Equipment used at the originating site to collect patient physiologic information to share the data with the provider at the distant site. Some peripherals allow the distant site provider to gather the information usually collected during an in-person exam. Examples of peripherals include blood pressure monitor, pulse oximeter, fetal heart doppler, glucometer, incentive spirometer, lighted tongue depressors, digital otoscope, scale(s), stethoscope, or thermometer. (See Peripherals section at Home Telehealth Overview at the National Telehealth Technology Assessment Resource Center (TTAC)).

Telepresenter. A health care professional who is trained to facilitate a remote exam with or without telehealth peripheral equipment, collect vital signs, and provide additional assistance or patient evaluation at the originating site for the provider at the distant side. See this short video on telepresenting.

Resources:

1. What is telehealth? *CCHP*. Excellent set of definitions for telehealth and related terms and a one-pager – A Framework for Defining Telehealth. https://www.cchpca.org/what-is-telehealth/
2. CMS Telehealth Services Booklet. *CMS.* Excellent resource with the details of telehealth service delivery for Medicare beneficiaries.
3. CMS List of Telehealth Services. *CMS.* Complete list of telehealth services and codes frequently updated during the COVID-19 pandemic but usually just updated annually.
4. Physician Fee Schedule Look-Up Tool. *CMS.* Use this tool to search pricing amounts for billing codes.

5. Current State Laws & Reimbursement Policies. *CCHP*. Telehealth policy changes, including comprehensive, state-specific look-up tool with state Medicaid statutes and other information related to telehealth policy and allowances.
6. Billing for Telehealth Encounters – An Introductory Guide on Fee for Service. *CCHP*. March 2021. Excellent information about telehealth billing and reimbursement.
7. American Medical Association Telehealth Implementation Playbook. *American Medical Association.* This is a long document at 128 pages, but it is exceptionally complete and well done. Recommend scrolling through the document for the parts that apply, such as Designing the Workflow and references to documentation.
8. National Consortium of Telehealth Resource Centers – Provides trusted consultation, resources, and news at no cost to help you plan your experience. Start here to find the HRSA-funded Telehealth Resource Center representing your state.
9. Telehealth Services for Medicare Fee-for-Service Providers CMS telehealth fact sheet; also applies to CAH/RHC.
10. TELEHEALTH.HHS.GOV Excellent telehealth resources from HRSA.
11. Medicare Telehealth Payment Eligibility Analyzer *CMS.* Use this analyzer to check if an address is eligible for a Medicare telehealth originating site payment, noting that the address is not in a metropolitan statistical area (MSA) OR if it does fall in an MSA, the address must be in a rural area and be a primary care or mental health geographic Health Professional Shortage Area (HPSA). It is unclear if these constraints will continue with pending legislation (as of May 2021).
12. The Telehealth Explainer Series: A Toolkit for State Legislators. Not just for state legislators – includes clearly articulated telehealth basics.
13. Great Plains Telehealth Resource and Assistance Center – Telehealth Quick Start. Great resources can be found here.
14. Rural Healthcare Surge Readiness: Telehealth. Materials on implementation of telehealth/telemedicine including coding and billing practices, integration of telehealth into provider workflows, and remote or virtual health care services
15. MATRC Telehealth Resources for COVID-19 Toolkit. Includes an immense amount of information with links to many resources.
16. Telehealth Essentials. Not a toolkit by itself but a nice concise sheet.
17. AHA Recommendations for the Implementation of Telehealth in Cardiovascular and Stroke Care. Not a toolkit by itself but good info

18. Resources for Telehealth at Safety Net Settings. *University of California San Francisco – Center for Vulnerable Populations.* Some excellent resources to peruse.

COVID-19 Resources:

1. Telehealth in the hospital setting-including critical access hospitals. *Heartland Telehealth Resource Center*. Listen to this webinar for a comprehensive discussion of the telehealth PHE allowances for hospitals.
2. Rural Crosswalk: CMS Flexibilities to Fight COVID-19. *CMS.* Telehealth and Other Virtual Services – crosswalks among FQHCs, RHCs, CAHs, hospitals, and SNFs. It appears that CMS created this resource to capture the information more efficiently, but it does make it a bit more challenging to pull out exactly what is specific to CAH/RHCs.
3. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. *CMS.*
4. COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. *CMS.* Note section M "Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)."
5. New & Expanded Flexibilities for RHCs & FQHCs during the PHE. *CMS.* An excellent resource for billing telehealth for Medicare beneficiaries. CMS updated in Feb 2021 to include the 2021 reimbursement rate of $99.45 for telehealth services and $23.73 for G0071.

The number of telehealth visits are currently decreasing, but it is here to stay as is COVID-19 and other communicable diseases (e.g., flu). Many state emergency declarations are already expired, and the national PHE will likely expire on Dec 31, 2021. Legislation is pending to keep many of the allowances, including RHCs and FQHCs as distant sites; geographic restrictions lifted permanently; audio-only is an option; and patients may receive telehealth when in their home.

Virtual Services

While telehealth has tremendous opportunities to enhance access, keep people safe, and capture reimbursement, there are several additional virtual services – listed below - for CAHs and their RHCs to consider adding to the suite of options for remote health care service delivery. Virtual service delivery includes telehealth (as defined by the CMS List of Telehealth Services) and any health care service delivery that does not require that the patient be seen in person. From a delivery and reimbursement standpoint, virtual service delivery is usually constrained to

services. There is a billing code, reimbursement, and service details, generally found in the full CPT or HCPCS code description, CPT® codebook, or factsheets/websites provided by Medicare.

Remote Physiologic (or patient) Monitoring (RPM).

CMS considers RPM services covered by the RHC all-inclusive rate (AIR). Many RHCs use Chronic Care Management services to provide RPM.

RPM is the one virtual service with the most significant potential to reduce ED visits, admissions, and readmissions. For example, Medicare notes that sepsis is a top diagnosis for hospital 30-day readmission rates amongst Medicare beneficiaries and that monitoring appetite, mental changes, biometrics, etc. through software platforms or apps with virtual daily check-ins to monitor for potential issues can be helpful, especially if specific care instructions and reminders regarding hygiene and medications are included[8]. RPM is an excellent addition to self-management support for patients, and RHCs often have and bill for these services as part of Chronic Care Management. Check the fee schedules of your state Medicaid agency to see if RPM codes are listed as covered services. See Remote Physiologic Monitoring (RPM) resource for more details.

There are at least three versions of RPM to keep distinct.

1. RPM, as defined by Medicare, includes five billing codes and has several conditions and requirements. These RPM services require that "the medical device should digitally (that is, automatically) upload patient physiologic data (that is, data are not patient self-recorded and self-reported),"[9] which is not the case for the 2 and 3 below.
2. Medicare reimburses for other RPM services (e.g., self-measured blood pressure monitoring and continuous glucose monitoring (CGM) and ambulatory blood pressure monitoring) that don't technically fall under their RPM definition from 1 above.
3. Remote patient monitoring that may or may not be "physiologic" can be an excellent adjunct for chronic disease and other self-management and may include regular check-ins, reminders, diet logs, and so much more. With the explosion of patient health apps, the possibilities continue to expand.

[8] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency. Interim Final Rule. CMS. April 2020. p. 19249.
[9] Calendar Year 2021 Physician Fee Schedule Final Rule (CY 2021 PFS FR) p. 84543

CAHs should be able to bill for specific RPM codes. While Medicare has reimbursed for RPM since 2019, RHCs may not receive reimbursement for the five RPM services/codes for Medicare beneficiaries, and few state Medicaid agencies reimburse for RPM. However, this does not mean that CAHs and their RHCs should not provide RPM services for lack of reimbursement reasons.

CAHs should be able to bill codes 99453 and 99454 on the UB-04 and receive cost-based reimbursement. The other three codes are only billable as professional codes. The status indicator assigned to these codes is B (not allowed to be submitted on an outpatient hospital Part B bill type). Professional work could be billed out of the hospital setting if that is where it occurred. As this is outpatient, if Method II, it would be billed on the UB. Method I would be billed on the 1500 form.[10] Check with your Medicare Administrative Contractor (MAC) for confirmation and guidance, and see the resource below.

This Remote Physiologic Monitoring guide – provides additional guidance on implementing the RPM services and codes.

Virtual Communication Services.

For all of the three Virtual Communication Services below:

- Use G0071
- Obtain consent, which must be documented in the medical record
- Adhere to "7/24" rules: cannot be billed if they originate from a related Evaluation & Management (E/M) provided within the previous seven days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.
- Must be patient-initiated

Reimbursement for G0071 is $23.73 through Dec 31, 2021 and will likely decrease to closer to $14 in 2022

1. VIRTUAL CHECK-INS – PHONE CALL. Five to ten minutes of medical discussion described as a brief communication technology-based service (audio-only real-time telephone interactions) by a physician or other qualified health care professional who can report evaluation and management services. This is a great option to determine if a patient needs a virtual or in-person office visit.
2. STORE AND FORWARD - REMOTE EVALUATION OF RECORDED VIDEO AND IMAGES. Includes interpretation with follow-up with the patient within 24

[10] CAHs, FQHCs and RHCs, Oh My! See section *RPM billed from CAH?* 20:00-23:00. Carol Yarbrough, Business Operations Manager, UCSF Medical Center. 2021. https://swtrc.wistia.com/medias/31fxvtppxk

business hours. This option is great for wound management, post-operative follow-up of a surgical site, dermatologic complaints, and more.
3. E-VISITS are online digital evaluation and management services provided over seven days and are non-face-to-face, digital communications using a secure patient portal. Patients who use this option tend to like it, but use may be limited due to going through the patient portal.

Resources:

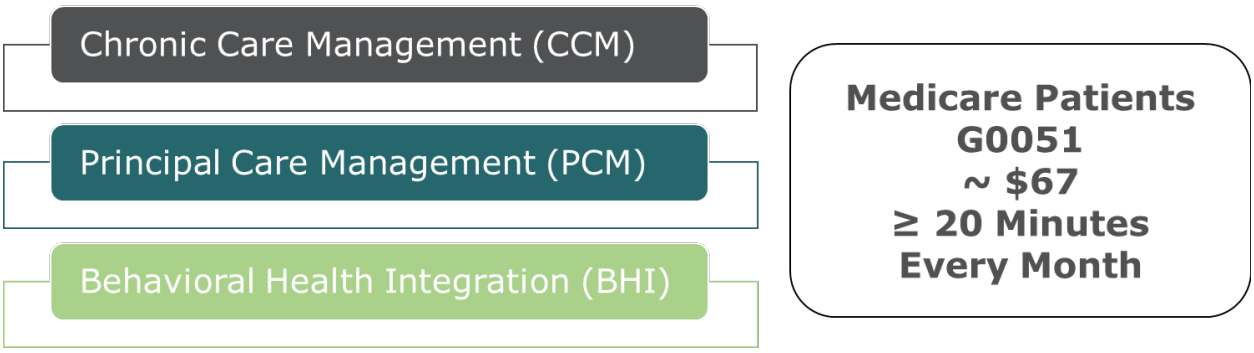
1. Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions. *CMS.* 2018. While a bit outdated most if not all information is still relevant.
2. CMS Virtual Check-In Patient Page. *CMS.* Great information for patients and staff alike.

Chronic/Principal Care Management and Behavioral Health Integration (CCM/PCM and BHI)

A large proportion of health care expenditures are spent on a small proportion of high-risk patients, making care management and care coordination increasingly important, especially in the post-pandemic era. There are at least three excellent, frequently underutilized options for CAHs and their RHCs. Additionally, CCM/PCM services lead to enhanced reimbursement, including team-based care and work that the care team is already performing.

Unless there is a compelling reason why an RHC cannot provide these services, every effort should be made to implement CCM, PCM, and BHI. Implementing BHI can be challenging due to the requirement of a psychiatric consultant. Still, the psychiatric consultant does not need to be available in person, and efforts can be made to find the fitting addition to the team to ensure BHI services. This is becoming increasingly important as the demand for behavioral health support rises due to the COVID-19 pandemic. Providing CCM and PCM can be a good source of revenue, too, as Medicare estimates that two-thirds of Medicare beneficiaries qualify for these services at some time.

An in-depth discussion on these opportunities to provide care management and support patients virtually is beyond the scope of this guide; additional details are found in resources below and this resource: Chronic & Principal Care Management Services: Implementation Guidance.



Resources:

1. Cheat Sheet on CMS Medicare Payments for Behavioral Health Integration Services - Federally Qualified Health Centers and Rural Health Clinics. *University of Washington AIMS Center*. 2019.
2. Behavioral Health Integration Services – MLN Booklet. *CMS*. Updated March 2021.

Interprofessional Consults (ICs). This patient-centered option for referrals for consults is underutilized and is an excellent option for clinicians and their patients living in rural areas, as long as the patient does not need to be seen in person. Medicare does not reimburse RHCs for any interprofessional consultation codes. Still, it is a great option to expand access and serve patients. Consider whether an IC is most appropriate for each specialist and ascertain if the specialist is willing to engage in an IC. See Interprofessional Consultation – A Patient-Centered Referral Option.

Tippah County Hospital – Telehealth Spotlight

Tippah County Hospital (TCH) is a county-owned critical access hospital in Ripley, MS, including a rural health clinic (RHC). They offer a complete set of services and supports to their area residents, consisting of a range of specialty services through telehealth. TCH began their process of implementing and expanding telehealth with the goal of:

- Increasing use of telemedicine to fill service gaps and access to care
- Enhancing coordination of care and developing a community care coordination plan
- Strengthening the local health care delivery system to position for population health management

Read more about their **keys to success** and **accomplishments** in the Tippah County Hospital – Telehealth Spotlight.

Engaging Key Stakeholders

The list of potential stakeholders that can impact the success of a telehealth program can be long, but this shouldn't be a deterrent to implementing telehealth. Think of stakeholders as potential partners to ensure the success of the telehealth program.

Stakeholders	Considerations
Leadership	Must have engagement through endorsement and commitment of time and resources; include relevant boards.
City, municipal, and county service districts	Because these entities may have a vested interest or even own the CAH, these agencies should be included in discussions to implement and expand telehealth and may be essential partners for finding solutions to limited access.
Staff – clinical and non-clinical	Without buy-in to both the concept and operational aspects of telehealth, success may be in jeopardy.
Vendors	Navigating the technical, functional, and budgetary requirements and concerns can be challenging, as can ensuring the CAH/RHC needs are met through vendor transparency.
Patients, families, and caregivers	Communicating effectively about telehealth services and how to access those services, paying keen attention to superb customer service, and providing value defined by patients are only a few of the critical considerations.
Specialists and other distant providers	The willingness of these individuals and organizations to provide telehealth services is vital and often needs to be fostered and facilitated.
Medicare, Medicaid & other insurers	Understanding and complying with documenting, billing, and coding are essential for reimbursement, as is communication with the Medicare Administrative Contractor (MAC).

Stakeholders	Considerations
The community	CAHs are an integral part of their community, which has incredible possibilities to support telehealth, primarily to provide a telehealth-ready device with broadband in a quiet, safe space – think about community-based organizations, senior centers, libraries, farm organizations, employers, and more that can be partners in expanding access for patients.
Schools	CAHs can work with schools to implement school-based telehealth to support students, staff, and parents. These programs may decrease unnecessary absences, increase access to care and chronic disease management, provide mental health services, and support school nurses.

Ten Tips for Engaging Stakeholders

Successfully engaging with stakeholders is more than just sending an FYI email. It requires some thoughtful pre-work to lay the groundwork for strong relationships, positive dialogue and partnerships, and continued collaboration to implement, expand and sustain telehealth in CAHs and their surrounding communities.

1. Make an initial list of key stakeholders. Check in with others at the CAH (and possibly beyond) to double-check the list for accuracy and completeness; add, delete or modify the list based on feedback. Include the entity name and contact information at a minimum.
2. Clarify - on the list and in writing - the stake each has in the potential changes related to telehealth implementation, expansion, or sustainability. There's a reason we call them stakeholders; we should be clear on precisely what stake they hold.
3. Consider adding the current and desired engagement. For example: Do they know about us/the telehealth program? Are we likely to run into resistance from them? Or are they neutral or supportive? What is the nature of support, if supportive (e.g., financial, staff, services)?
4. Identify what it is that each entity needs to know. Are they just being kept in the loop? Will they lose or gain anything? Will they need to make any changes?

5. Consider drafting SBARs for each entity - Situation-Background-Assessment-Request or Recommendation. Putting this information together can also help when reaching out by email. It's possible that a concise one- or two-pager with information would also be helpful.

   While SBARs may feel awkward at first, they get easier and quicker with practice.

   Short SBAR example – the SBAR headings do not need to be included when sending to stakeholders:

   Situation: We are reaching out to find partners who can help provide telehealth access in our community.

   Assessment: Our community, especially in our rural and underserved areas, needs more access to engage in telehealth. More than 65% of our local community lacks access to adequate bandwidth and a device to engage in telehealth, further widening health care disparities. We know that we have community resources that can provide patients with what is needed to access health services by telehealth.

   Background: We are expanding telehealth services to enhance access and provide more services, especially for our underserved and marginalized populations, and serve those with mental health issues and those suffering from long COVID. From demonstration projects from around the country, we know that libraries can be an excellent solution!

   Request/Recommendation: We would like to partner with the ABC Library to create a safe and private place for patients to participate in telehealth visits. If we provide an iPad with a mic and headphones, are you willing and able to give the space for a safe, private "Telehealth Booth" using your Internet connection?
6. Learn about each entity - do your homework - even if you think you know them. Check their website, if possible, including any information on mission, vision, and values. When you connect with the entity, it shows commitment to the relationship.
7. Choose the right person at the CAH to conduct initial outreach and possibly ongoing communication. Focus on existing connections and relationships and consider titles and positions. Sometimes contact from one CEO to another is essential, even if it is to conduct a warm handoff to a different person at the CAH. When engaging a new specialist, physician-to-physician outreach can be high yield.
8. If possible, keep track of the touches (i.e., calls, emails, meetings) and results in a shared document. For example, "Unable to connect by phone or email after multiple tries.", "Said yes to purchasing iPad for a school nurse.", "Gave me a hard NO to request to set up telehealth station in the library."

9. Manage expectations and be clear about roles and responsibilities. Consider using a responsibility assignment matrix, if appropriate, especially early in the engagements. The RACI (Responsible-Accountable-Consulted-Informed) model is commonly used and clarifies who is responsible for completing tasks, who is accountable for completing a task, who will be consulted on their opinion or expertise, and who will be consulted will be informed on progress or completion of a task or deliverable.
10. Be organized and be a good communicator! Send short agendas embedded in meeting invites. Take real-time notes using a shared screen, if possible, to keep everyone on the same page. Send a follow-up email with notes and with any action items - who will do what by when. Thank people for and be respectful of their time. Send brief emails; it may be essential to review some emails to stakeholders before they are sent. While this may sound like micromanagement, it is also a way to 1) mitigate risk from poorly worded emails with misinformation and 2) provide feedback and guidance on sending cogent, well-crafted emails that reflect well on the organization.

Initial Steps to Begin or Reassess a CAH Telehealth Program

1. Conduct a telehealth readiness/current state assessment like the NRTRC's Telehealth Program Assessment, Appendix C (additional options are in Resources below), including but not limited to:
    - Know and assess the range of options for delivery and reimbursement and make early decisions about what is most feasible for the CAH, including any associated RHCs
    - Assess strengths that are promotors of successful adoption of a telehealth program (e.g., engaged and committed leadership, positive telehealth perspective)
    - Clarify barriers to implementing and sustaining a telehealth program and identify potential solutions (e.g., insufficient buy-in (staff and patients) or change tolerance, EHR or other system limitations – no telehealth platform, staff challenges, lack of community trust in telehealth)
    - If partnering with a vendor, consider asking if they have a readiness assessment/checklist, too
2. Reach out to other CAHs that have already implemented telehealth to learn from their experiences and to explore opportunities to collaborate
3. Form a telehealth team (See Forming the Team in the American Medical Association Telehealth Implementation Playbook)

- Select a telehealth and virtual care champion. The telehealth champion is often a clinician but does not need to be as long as the champion is a well-respected leader with a passion for telehealth. Additional practical attributes include good communication and organizational skills and a track record of being a potent change agent.
- Select representatives from IT, operations, and administration/leadership, if possible, to form the telehealth team
- Consider adding a member(s) of the community to the team (e.g., (city council, chamber, school board, principal, etc.)

4. Clarify, enumerate, and describe possible telehealth opportunities, including estimates of revenue for each opportunity
    - As an originating site – list the services already being received by patients from specialists and others and identify new possibilities by reviewing the complete set of telehealth services and codes that can be delivered
    - As a distant site – list the services that can be delivered to patients, which may depend on billing Method, outpatient options, and whether RHCs can act as remote sites post-pandemic
5. Develop a work plan or "punch list"
6. Assess broadband or connectivity within the physical confines of the CAH and RHC to understand whether the speed and reliability are sufficient to support telehealth. For example, broadband may be adequate, but Wi-Fi is not strong enough in certain rooms, requiring additional nodes. If deficits are noted, the next step is to determine the etiology and look for solutions, which may exist beyond the confines of the physical structure. The Federal Communications Commission identifies a speed of ≥ 25 Mbps download/3 Mbps upload for fixed broadband as a minimum performance benchmark. There are many resources for checking broadband speed, including the speed test option from the Utah Education and Telehealth Network. Where possible, it is good practice to maintain two internet connections to the CAH or RHC from separate telecommunication providers for redundancy. This is especially true when your EHR system is cloud-based.
7. If able/available, assess the broadband capability of the geographic region in which the CAH's attributed patients live
8. List additional needs and capacity to meet those needs, including but not limited to:
    - Staffing – Note that CAHs are more likely to add new responsibilities than hire new telehealth staff[11].
    - Staff training
    - Quiet, private, and safe location to engage in a telehealth visit
9. Identify technology needs – hardware and software, including a telehealth platform – and build a budget to understand anticipated financial outlays, understanding that a device, connectivity, and a solution to ensure audio and video telecommunication are the basic requirements for a telehealth program.

[11] Haque, S, et al. *Factors Influencing Telehealth Implementation and Use in Frontier Critical Access Hospitals: Qualitative Study*. JMIR Form Res. 2021. 5(5): e24118. https://formative.jmir.org/2021/5/e24118/PDF

- Devices – computer on wheels (COW), laptop, or tablet with camera and microphone and speaker (purchase or lease)
- Headsets, if needed, for privacy
- Telehealth platform – identify technical and functional specifications

10. Select a HIPAA-compliant telehealth platform
    - Identify desired technical and functional requirements
    - Clarify the budget – upfront and ongoing costs.
    - Feedback from the front lines suggests that integration with the EHR, minimizing the need for multiple programs, screens, and clicks, is desired by clinicians. However, if access is challenging for patients (e.g., must download an application or access through the patient portal using the link in an email), uptake may be challenging.
    - If the CAH or RHC will only act as an originating site, there is likely no need for a telehealth platform because the care team will interact with providers using their platform. (See Evaluating the Vendor and Contracting in the American Medical Association Telehealth Implementation Playbook) Even when acting as an originating site only, the CAH will still require a computer/monitor, webcam, speakers, microphone, and connectivity.
    - It may be best to choose well-established telehealth platform vendors.
    - Never purchase a telehealth platform if the vendor is not willing to sign a Business Associate Agreement (BAA), which helps ensure that the platform is HIPAA-compliant and that the vendor is adhering to the HIPAA Security Rule, including the requirement to notify you if they suffer a security incident or breach. (For information on BAAs and definitions, see Business Associate Contracts – Sample Business Associate Agreement Provisions from the U.S. Department of Health & Human Services – Office for Civil Rights)
11. Consider internal processes for drafting, reviewing, and approving policies and procedures (P&Ps); existing P&Ps need to be reviewed to include telehealth, and new P&Ps need to be generated as the telehealth program begins. Know how this will unfold and share any changes or new P&Ps as it can be a matter of patient and staff safety.

Resources

1. American Medical Association Telehealth Implementation Playbook. *American Medical Association*. 2020.
2. Telehealth Readiness Assessment Toolkit. *Maryland Health Care Commission*. Thorough and long (54 pages), there is also an online version.

Vendor Selection and Guidance

Below are several considerations when selecting a telehealth platform. Make sure that clinicians and other staff involved in telehealth visits have input into selecting the telehealth platform. (See also the excellent resources in Evaluating the Vendor appendices in the AMA Telehealth Implementation Playbook pp. 90-100.)

1. **Clarify technical and functional requirements as well as budget constraints**, including but not limited to:
   - EHR integration – This can be an essential factor for clinicians. However, if it is convenient for clinicians and staff but inconvenient to connect with patients, they will not engage in telehealth.
   - Multiple participants can sign in at the same time to join a visit. Some free or reduced cost solutions only allow two connections to the telehealth visit, which is not ideal if the care team is working virtually or essential for other individuals to join (e.g., specialist, family, and caregivers).
   - Interpretation services – Some vendors have slick solutions to provide interpretation, but feedback from the field indicates that there are currently opportunities for improvement.
   - Workflow to access the telehealth visit – The patient workflow is one of the most important predictors of uptake! If accessing a telehealth visit requires a patient portal and email address, this may exacerbate health inequities and curtail use. It should be easy, or at least easy to learn, for the patient.
   - Online web link without the need to download an app/software – The option to have a URL for access is more straightforward than performing downloads and updates.
   - Technical support – If the CAH or RHC has a strong, readily available, capable IT team or telehealth coordinator/director, technical support may not be as important. Know whether the vendor can/will provide support for patients and be clear on exactly what that entails – real-time as needed or by appointment only or something else
   - Initial and ongoing costs – This information can usually be obtained online. Still, vendors can use proprietary information and require contact information before sharing fees, leading to aggressive follow-up and marketing.
2. **Choose an initial five to seven established vendors**
3. **Compare functional and technical requirements as well as cost and ongoing fees** among the top contenders

4. **Schedule a demo if needed.** Vendors often show the best features – the bells and whistles. A few tips on demos include:
    - Ensure that it is not a canned demo and that the team has ample time for questions and requests
    - Have a list of features the team wants to see and be prepared with the top eight to 10 questions; try not to ask YES/NO questions (e.g., Do you have interpretation services vs. Please demonstrate how we arrange interpretation services?)
    - Invite clinicians and other staff to the demo
    - Create several scenarios to see (e.g., scheduling, patient notification of appointment and sign-in information (email, text?), a process for a patient sign-on, process for clinician sign-on, support (if any) for real-time documentation, in-session communication options for patient and care team (chat?), interpretation (the team does not want to figure out the process and kinks later or on the fly))
    - Schedule an immediate post-demo debrief (consider a standard rubric for scoring or evaluating the vendor and the platform)
5. **Contracts** (See also Contracting in the American Medical Association Telehealth Implementation Playbook)
    - Involve the legal team/experts early in the process
    - Secure approvals early in the process and know who needs to approve any contracts/negotiations
    - Understand whether any patient protected health information is stored at any time by the vendor as this poses potential security risks and needs a plan for disposition if/when the contract ends (for whatever reason)
    - Require documentation that the solution is HIPAA-compliant and append to the contract
    - Know the details if leasing any equipment as well as keeping software and hardware updated
    - Sign a business associate agreement
    - Have clear language on conditions for canceling; know the time needed to provide notice and whether payments will continue beyond the cancellation date.

Adoption & Sustainability – Key Factors

Several key factors contribute to the success of telehealth programs, including but not limited to buy-in, infrastructure and cost, provider availability, and more[12]. Below are several critical considerations with recommendations to help ensure a smooth implementation and adoption.

Buy-In

Without buy-in from staff and patients, it may be impossible to implement and sustain telehealth.

- Listen to what staff say about telehealth and understand what their telehealth perspective is. It's a plus when staff generally have positive "telehealth talk." It is a good sign if staff see telehealth as a permanent option going forward rather than a stopgap until the COVID-19 pandemic is over. There's also a big difference between "We can do telehealth if…" and "We can't do telehealth because…"
- Include staff in the implementation plans
- Recognize that change can be difficult
- Assess the engagement and commitment from leadership as their support is one of the keys to success
- Clearly define and share the expected resources that are needed, including the estimated budget
- Outline goals of the telehealth program and how it will contribute to the organization
- Demonstrate alignment of telehealth with the mission, vision, and values of the CAH and RHC – enhancing access, serving patients and the community, being person-centered, providing excellent care services, etc.

[12] Haque, S, et al. *Factors Influencing Telehealth Implementation and Use in Frontier Critical Access Hospitals: Qualitative Study*. JMIR Form Res. 2021. 5(5): e24118.
Ward, M, et al. *Use of Telemedicine for ED Physician Coverage in Critical Access Hospitals Increased after CMS Policy Clarification*. Health Aff. 2018. 37(12) 2014; 12(6): 2037-44.

Financial Considerations

Implementing and sustaining telehealth is often less expensive than anticipated. The primary financial outlays include but are not limited to:

- Staff – In general, organizations do not need to hire additional staff to implement telehealth and usually provide existing staff with training. However, several organizations are hiring telehealth directors or coordinators to ensure continued efficiency and use.
- Staff training – There are ample free, online telehealth training opportunities, but attending them and learning on the job does take time, and time can be costly. The California Telehealth Resource Center Telehealth Course Finder is a great place to start and includes the host of the training, information on credits, and cost if any.
- Fees for the initial purchase and ongoing maintenance/service for the telehealth platform. Plan for updates and ensure the equipment is on a routine update schedule; double-check the technology after updates are completed for new or changed functionality to ensure smooth operations with no unpleasant surprises or hiccups during telehealth visits.
- Revenue – Although the reimbursement is small at ~ $27, originating site fees can add up. Revenue for performing distant site services depends on staff with the requisite training, licensure, and credentials. Review the 2021 Category 1 Telehealth Code Summary Table appendices to identify potential revenue-generating services that the CAH and the RHC can deliver.

Calculation of potential RHC telehealth distant site revenue may hinge on whether RHCs can be distant sites after Dec 31, 2021.

Leadership and Staff Engagement & Education

Leadership endorsement and commitment are essential. If leadership is not entirely convinced with moving forward with a telehealth program, the program may be doomed. For guidance on making the case to leadership, see Making the Case in the AMA Telehealth Implementation Playbook. Leadership demonstrates engagement by signaling a desire to be included and updated with the planning, dedicating the staff, time, and finances needed to launch and sustain the program, ensuring that telehealth is on meeting agendas, talking to people at the front lines

to understand buy-in and other vital factors, and reaching out to colleagues to learn best practices, etc.

Information technology (IT) staff may need to master additional skills to support telehealth. If the CAH/RHC has insufficient or part-time IT staff, other staff may need to take on new roles and responsibilities. Some organizations are now seeking telehealth directors or coordinators either as a new position or to add to existing staff roles and responsibilities. Roles and responsibilities include but are not limited to:

- Act as telehealth champion and telehealth team lead
- Take responsibility for all external-facing telehealth communication and promotion (i.e., website, social media)
- Be available in real-time to assist clinicians, the care team, patients, and others as tech support to ensure smooth and effective telehealth visits.
- Collaborate with HIPAA Security Officer to ensure all telehealth-related risks are identified, addressed, and mitigated for the security risk analysis.
- Ensure that all devices used for telehealth have a microphone and camera.
- Assess and troubleshoot broadband availability in general to the extent possible and ensure connectivity in areas where telehealth visits occur for the organization either as distant or originating sites (e.g., install additional nodes).
- Work with the community to identify places where patients can engage in telehealth (e.g., library, senior center, employers)
- Communicate with telehealth platform vendor when needed.
- Address patient barriers to and solutions for engaging in telehealth.
- Create cheat sheets, create/modify EHR templates to support telehealth and telehealth documentation,
- Assist in workflow mapping and process improvement related to telehealth and virtual services
- Ensure structured data capture for key telehealth parameters (e.g., billing codes, no show rates, clinical quality measures, types of visits – audio and video/audio-only, completed vs. incomplete holidays)
- Act as telehealth subject matter expert
- Work with senior and billing/coding staff to ensure the organization is current on regulations and requirements.

Staff – Training should be in place for all staff until each has reached an acceptable level of proficiency with the technology, workflows, techniques, documentation, requirements, etc. While there are several online training

options, some training is specific to the organization. Consider these elements for training.

Triage protocols – Written triage protocols that are easily accessible by all staff on which patients or patient issues are appropriate for telehealth and which need to be seen in person.

Technology and troubleshooting – Specific to the organization, staff should know how to navigate the technology and troubleshoot when issues arise during the telehealth visit.

HIPAA Privacy and Security – As noted in the relevant section of this guide, privacy and security training is essential. Some say it is not a matter of *if* but rather a concern of *when* an organization will have a security incident or breach. Well-trained employees provide a good measure of prevention and risk reduction.

Telepresenting – If staff will telepresent, they can be trained internally by clinicians to a certain extent. Still, there are formal telepresenter training programs available that are easily found with an online search.

Coding and billing – This is a complex and essential aspect of required telehealth expertise, as noted in other places of the guide. Again – there are online options for this training, but it is not too complex for a dedicated individual to grasp the details and stay current.

Consent – Many organizations gloss over and do not adequately document consent. Each staff member involved in telehealth visits and other virtual services needs to know whether consent needs to be obtained, how often it needs to be obtained, how it should be documented, who can obtain it, and what the requirements are based on patients' insurance and or visit type.

Workflows – Many organizations implement standard workflows but fail to ensure 1) that staff knows the workflow and 2) are using the established workflow, either of which can compromise the safety, quality, efficiency, revenue capture, and patient experience. Ensure workflows are mapped and readily available to staff. Perform spot checks or measure to ensure workflows are being followed.

Patient safety – Part of the training should include how to keep patients safe. See also the Patient Safety section of the guide.

Documentation – All staff should be trained on any telehealth-related documentation to ensure patient safety, quality, and revenue capture. Otherwise, documentation is the same as for in-person visits. See also the Documentation section of the guide.

Person-Centered Telehealth

Engagement & Education

Promote telehealth. Patients need to know that telehealth is an option. Here are a few high-leverage ways to get the word out.

Staff, clinicians, and patient partners - Messaging from clinicians and staff is vital! Often it begins with a call to schedule an appointment. Reception staff should offer either telehealth or in-person visit to everyone calling for an appointment. Clinicians can promote telehealth during an in-person visit. "Next time, if you don't want to drive to the clinic for a visit, we can do a telehealth visit if it's easier for you." The CAH/RHC can also enlist patient partners to promote telehealth by offering testimonials, joining select patient calls, and including in newsletters or convenings.

Website and on-hold message - Promote telehealth on the CAH/RHC website with need- or good-to-know information. Include telehealth as an option on the on-hold message.

Provide exceptional customer service. This is an essential key to success. Have a plan for accomplishing this, know the individual(s) who will be responsible, and measure to ensure exceptional service (e.g., satisfaction survey).

Assess and improve digital proficiency. Many patients avoid telehealth because they are unfamiliar with the technology, online experience, or electronic navigation required for a telehealth visit. Conduct test visits with patients so they can become more proficient and comfortable with the digital knowledge and skills to participate in a telehealth visit. This can help alleviate patients' apprehension about an upcoming medical appointment and reduce stress for those unfamiliar with telehealth.

Identify and address health inequity. Telehealth expands access but can also exacerbate health inequity. Whenever possible, identify and address barriers to

engaging with telehealth. Below are several well-known barriers with some potential solutions. Each CAH/RHC will have specific solutions as well.

Health Equity - Barriers and Potential Solutions

As noted above, while telehealth can expand access, it also exacerbates health inequity. Virtual care teams are part of the solution to ensure equity by helping patients access and engage in virtual health care delivery. Lack of access to virtual care services and telehealth should be considered a social determinant of health, documented as structured data, and addressed through innovative and creative ways.

BEST PRACTICE:
Ensure that all individuals have the same access and support to engage in virtual care and telehealth.

One of the most innovative, person-centered, and community-based options can enhance access and equity by finding community-based solutions for individuals. The CAH/RHC can convene potential partners and build a community network to support individuals' access to and use virtual care and telehealth. To engage in telehealth, patients need the following:

- Private, quiet, safe space
- A device with a camera and microphone
- Stable internet with adequate bandwidth
- Someone to help those with limited digital proficiency

Unfortunately, too many people do not have some or all of the above. Envision and execute community-based solutions; likely partners include libraries, senior centers, places of worship, employers, community centers, homeless shelters, and more. Below is a starter set of barriers and potential solutions; add/modify the barriers and possible solutions below specific to the CAH/RHC, location, and patient population.

Connectivity – lack of internet connection or data plan

- Identify federal or state programs to help pay for internet (e.g., FCC Lifeline Support for Affordable Communications or Emergency Broadband Benefit, EveryoneOn, National Digital Inclusion Alliance)
- Provide prepaid phones
- Dispense prepaid data or internet/wireless service cards
- Provide mobile hot spots
- Work with the local partners to find community-based solutions that can provide connectivity and more (e.g., library, senior center, places of worship, employers)

Connectivity – lack of broadband in patient's location

- While this may be a difficult barrier to overcome until reliable, high-speed broadband is available in the patient's location, consider lack of broadband as a social determinant of health and document as structured data for future reference (e.g., we do not keep offering telehealth visits if in the same location) and for possible reports
- Develop a broadband availability map using available sources for the majority of the geographic area served by the health center

Lack of phone/data plan to talk on the phone

- Provide prepaid phones and data plan cards
- Call patients at the beginning of the month/cycle when they are likely to still have minutes – with their permission to use those minutes for the call, we are making
- Use a mobile or landline phone at a community-based option. We already have many audio-only options to support patients, including chronic and principal care management, behavioral health integration, the Collaborative Care model, virtual check-ins, and more. Most people have phones, but not everyone does, nor does everyone have a data plan that allows them to engage in virtual care services.

Lack of reliable transportation

- Have a list of transportation options with the cost for patients to travel to the CAH/RHC or other originating site locations

Lack of device with camera and microphone

- Have staff deliver the device to patients' homes (and help with navigating technology) Off-Site Video Collaboration (three-minute video on how this can work)
- Consider a mail-to-patient option that provides an easy opportunity for the patient to return the device
- Direct the patient to community-based locations that have agreed to help/host with telehealth visits

Low digital proficiency

- Offer practice virtual visits
- Make allowances (e.g., more time) – reassure the patient that it will get easier with time
- Send clear, easy-to-read/understand instructions in advance by mail
- Provide training if the patient is interested
- Send staff (e.g., community health worker, promotora) to the patient's location to help navigate technology
- Direct the patient to nearby community-based locations that have agreed to help/host telehealth visits
- Ask if family/caregivers can help

Cognitive impairment and those with intellectual/developmental disabilities

- Request having family/caregiver join
- Consider whether virtual service is the best option if a patient can make it to an in-person visit
- Speak slowly and clearly – send post-visit notes and treatment plans by mail

Language/translation needs

- Know and connect with translation services; have arranged and ready to go at the time of call (e.g., Process to Add Interpreter to Zoom)
- Arrange American Sign Language (ASL) translation services for individuals who are deaf, when appropriate and available
- Note that this can be a significant barrier, and depending on the patient population, arranging and coordinating translation services can be complex and time-consuming
- How to Ensure Quality Language Translation and Interpreting in Medicine – Excellent information from the Arizona Telemedicine Program April 2021

Hearing-impaired

- Speak clearly and help the patient turn up the volume; ask the patient if speaking louder is helpful
- Ensure the patient has a headset with a noise-canceling feature to block out ambient noise; send the patient a headset if they do not have one
- Check with the patient beforehand if telehealth is the best option and what other accommodations can be made

Private, quiet place that is safe

- Talk to the patient about safe options, and if there are none, the team may need to accommodate the best the patient can do
- If possible, direct the patient to nearby community-based locations that have agreed to help/host telehealth visits

Homelessness

- Bring the device to people who are homeless to engage in telehealth visits. (Recognizing that some patients may distrust technology or have privacy concerns, make sure patients can clearly see your credentials and check in frequently on the patient's comfort level.)

Patient Safety

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

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

Diagnoses may be missed or delayed. Telehealth is not always the right choice. Comprehensive physical exams cannot be conducted that could reveal a serious condition. Some workflows for remote services have shifted established workflows away from how 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. Some states and other regulations require periodic in-person visits or that patients are seen in person before initiating telehealth visits to ensure patient safety, accommodate physical exam findings, including those that are impossible with telehealth (e.g., smell), foster connection, strengthen therapeutic relationships, and more.

There is a potential increased risk for domestic abuse. While one hopes that 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 provider or other staff know if they are neglected or abused. See this article for additional guidance: Responding to Intimate Partner Violence During Telehealth Clinical Encounters.

Know the physical location/address where the patient is. Suppose emergency medical services need to be called for the patient. In that case, it is a crucial aspect of patient safety to know and document the specific location of the patient and any numbers relevant to their site. See also this article: 3 Tips for Using Telehealth for Suicide Care.

Communication & Support

Communication among everyone touching telehealth processes is critical for success. A few best practices include:

- Mapped communication tree or table to identify who needs to know what, when, and how (e.g., CAH-RHC communications, staff, departments, revenue cycle team, IT, etc.)
- Readily available cheat sheets for troubleshooting, who to call, how to bill, etc.
- Reliable resource or number to call for help with the telehealth visit

- Information exchange can be a barrier when facilitating telehealth visits. Best practices include:
    - Only exchange information electronically in compliance with the HIPAA Security Rule (i.e., encrypted)
    - Adhere to the minimum necessary component of the HIPAA Privacy Rule and only share information that is required to complete the telehealth visit
    - Use e-faxing when possible, and if HIPAA-compliant
    - Know which providers may have access to the electronic medical record (EHR) to access patient information

Workflows

Workflows can either make or break a telehealth program! Workflows ensure that work is done in a standard and efficient way, creating a system-based approach or solution rather than relying on a few people working harder and smarter to ensure a successful telehealth program that works for everyone. See Appendix B – Sample Telehealth-Related Workflows and the resources below for examples of workflows. As with in-person visits, having standard, efficient workflows is key to having virtual visits run smoothly and ensure patient safety. As virtual visits are being implemented, consider forming a small team of two to three individuals responsible for establishing, mapping, fine-tuning, and continuously improving workflows, especially those that impact quality, safety, efficiency, or patient/staff experience.

Feedback from the field suggests that it is essential for each department, team, staff member, etc., to know exactly where to find the workflows that pertain to them. People should not have to search for workflows; regardless of whether they are paper or electronic, the workflows should be adequately labeled and accessible.

Find a solution for pre-visit planning and huddles. Unfortunately, some telehealth or virtual visit workflows no longer include pre-visit planning to identify and address chronic and preventive gaps in care, which is a risk management and patient safety issue. The care team must establish a standard process to identify and address gaps in care. Huddles are a well-established practice in primary care that is the antidote to the chaos in the clinic, inefficiency, and missed opportunities (i.e., we saw them in the clinic and neglected to address an issue and chronic or preventive care that was due). Some huddles are held clinic-wide, and others may be held between the clinician, an MA, nurse, or others on the care team – use the link to primary care example. Huddles are also used in the hospital setting. See the hospital example here from Kaiser Permanente.

Many teams have found asynchronous ways to huddle. If huddles are used to convey information specific to a particular group and do not include patient information, email works well, as do other bulk messaging options. Include in huddles who is on the team today and where they are located. Each organization needs to find a solution that works for them and their staff concerning available resources.

Identify and address gaps in preventive and chronic care. Unfortunately, this important piece of primary care service delivery is often skipped with telehealth, placing the patient at risk for missed and delayed diagnoses and services.

Clarify who will document what in the patient chart and how while optimizing team-based care. The provider needs to complete the history of present illness (HPI) (or confirm what another team member has entered for the HPI), document physical exam findings, develop the assessment and treatment plan, and; prescribe medications. Recognizing that the provider has complete responsibility, any other aspect of the visit may be delegated to someone else on the team as long as it complies with federal, state, local, and organizational regulations, requirements, protocols, etc. Of course, the individual must also have the requisite skills, licensure, training, and comfort level.

Streamline all patient-facing workflows – test and test again to ensure everything is as easy as possible for patients to schedule and participate in a telehealth visit. In some cases, workflows are not easy to modify. For example, for teams using Epic, patients need to have an active MyChart account to participate in telehealth. This may be an issue for patients without an email address.

Identify situations where handoffs are likely to occur and outline the step-by-step process. Ensure that the process does not leave a provider or care team member without an option to keep working. For example, handing a device during a telehealth visit from a provider to a behavioral health specialist without another opportunity for the provider to keep working or see the next patient is not ideal.

Resources

1. Remote Visit Workflow. Nicely done example.
2. Telehealth and Telephone Visits in the Time of COVID-19: FQHC Workflows and Guides. *Center for Care Innovations.* Also applicable to RHCs.
3. Telehealth Workflows. *California Telehealth Resource Center*. Several well-done telehealth workflows.

4. Mapping and Designing Telehealth Clinic Workflows. *National Telehealth Research Center*. 47-minute instructional video
5. What is workflow? *Agency for Healthcare Research and Quality*. Basic information on workflows.

Billing & Reimbursement

The importance of implementing telehealth in rural communities seems like a foregone conclusion but billing correctly to receive reimbursement is a critical factor. While complex, once the details for each service and insurer are established, it is just a matter of updating the information as needed. This may require some research and communication with payers. Medicare billing requirements and details for telehealth services are the same across the country. There are readily available resources, and when in doubt, CAH/RHCs can contact their MAC. Each state Medicaid agency and health plan has its specifications for telehealth.

CAH/RHCs can act as an originating site, provided they meet the geographic requirements. See Originating site above for additional details.

For example, in 2021, reimbursement for code Q3014 (*Telehealth originating site facility fee)* is set at $27.02, and for CAHs, the payment is 80% of the fee (~$21). The originating site facility fee helps defray the CAH's costs of supporting the patient to participate in a telehealth visit (e.g., clinical staff, supplies, and equipment/technology). It is a separately billable Part B payment (see Originating Site Facility Fee Payment Methodology on pp. 149-52 Medicare Claims Processing Manual Chapter 12 for additional CAH-related specifics, including originating site fees for renal dialysis centers). "If a distant site practitioner furnishes a telehealth service to a registered hospital outpatient, and hospital staff provides administrative and clinical support, the hospital may bill for the originating site facility fee (Q3014)."[13]

"There are two situations in which an institutional facility may bill for **distant-site services**: (1) the facility is a CAH that elected the Method II payment option,[11] and the practitioner reassigned his or her benefits to the CAH, or (2) the facility provided medical nutrition therapy (MNT) services."[14]

[13] COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. *CMS*.
[14] CMS Paid Practitioners for Telehealth Services that Did Not Meet Medicare Requirements. *Department of Health and Human Services Office of Inspector General*. April 2018

For eligible providers who have reassigned billing rights to a CAH that elected for the Method II payment, the CAH may bill for telehealth services on an institutional claim using the GT modifier (via interactive audio and video telecommunications systems). The payment amount is 80% of the Medicare Physician Fee Schedule (PFS) for telehealth services. Follow local Medicare Administrative Contractor (MAC) guidance on billing. Additionally, check state-specific allowances and limits for telehealth services, billing, and reimbursement for Medicaid beneficiaries.

During the PHE, CAH Method II claims for telehealth distant site services should continue to use modifier GT.

Until Dec 31, 2021, RHCs can act as distant sites and provide and bill for telehealth services using G2025 with payment rate of $99.45. There is pending legislation to permanently allow RHCs to be distant sites.

When researching state Medicaid agency telehealth allowances at CCHP, consider the following (also for other insurers):

Service parity. Are all of the codes covered by Medicare listed in the CMS' List of Telehealth Services reimbursed by the state Medicaid agency? If not, which ones are covered, and are there any stipulations?

Payment parity. Are the codes/services reimbursed at the same rate as the same visit provided in person?

Distant site. Can the CAH or RHC act as a distant site? If yes, are there any restrictions or conditions?

Originating site fee. Does the state Medicaid agency reimburse the CAH and the RHC for Q3014 and, if yes, how much is the reimbursement?

Consent. What are the specific requirements for obtaining consent for telehealth services? Medicaid requirements are usually more complex than what is required by Medicare.

Audio-only. Are there any provisions for reimbursement for audio-only visits?

Remote physiologic (patient) monitoring (RPM). Most states do not currently reimburse for the five RPM codes, but it is worth checking as some do.

Many private payers follow Medicare, but it is essential to check individual health plans' details regarding which services they cover, how much the reimbursement is, and specific billing or documentation requirements.

Resources

1. Telehealth. *Noridian Healthcare Solutions*. This is an excellent summary with concise billing guidance, including for CAHs. You can choose your specific jurisdiction, but the information is the same.
2. Telehealth Expansion Benefit Enhancement Under the Pennsylvania Rural Health Model (PARHM) – Implementation. *CMS.* Updated Dec 2020. This information may only be relevant to select CAHs that submit claims under the PARHM.
3. Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program – Interim Final Rule. *CMS*. May 2020. This information will likely be outdated at the close of the PHE but includes information regarding billing the originating site fee when a patient receives services in the home (pp. 27565-6)
4. Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency – Interim Final Rule. *CMS*. April 2020. CMS alludes to the importance of remote monitoring.
5. Hospital Outpatient Therapeutic Services That Have Been Evaluated for a Change in Supervision Level. *CMS*. May 2020. Note that several of the table codes are telehealth codes (e.g., most of the psychotherapy codes, smoking cessation, and transitional care management).
6. Rural Health Clinic MLN Fact Sheet. *CMS*. 2019. A short section called Payment for Telehealth Services confirms that RHCs can serve as originating sites if located in a qualifying area.
7. Billing for Telehealth Encounters – An Introductory Guide on Fee-for-Service. *Center for Connected Health Policy*. 2021.

Resources – COVID-19

8. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. *CMS*. Updated May 2021. "CMS is waiving the provisions related to telemedicine at 42 CFR §482.12(a) (8)– (9) for hospitals and §485.616(c) for CAHs, making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care."

9. COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. *CMS*. For telehealth information relevant to CAHs, see Section H, I, M (RHCs), N (RHCs), P, LL (all FAQs and flow diagram for Hospital Billing for Remote Services), an MM. This set of FAQs has some PHE-specific information but also permanent information.
10. Coronavirus waivers & flexibilities. *CMS*. One-stop shopping to track the waivers and flexibilities for the PHE.

Documentation

Documentation for telehealth visits requirements is mostly the same as for in-person visits. Still, it should also include that the visit was conducted by telehealth, patient consent, locations of the originating and distant sites, start and stop times, names and roles of all individuals participating or observing at the originating and distant sites, back-up and emergency plan if the technology fails or patient requires emergency medical services (EMS), and if treating a minor, documentation that parent/guardian was present.

- Consider creative ways to complete and document the physical exam and vital signs. For example, some clinicians have the patient use stairs to check breathing.
- Know what needs to be documented for the type of visit (same as in-person visits, mostly) but see the list above
- Know where the documentation will occur – directly in the EHR, in a document, on paper, etc.
- Who will document - clinician, scribe, cross-trained MA?

Virtual Care Team Considerations

Recognizing that care teams will almost certainly be working virtually, here are a few considerations to ensure the virtual care team members have the essentials needed to do their jobs.

Virtual Care Team – Essential Tools of the Trade

High-performing virtual care teams need a shortlist of essentials to be successful. Consider how best the CAH/RHC can provide the following.

Laptop/mobile device. If the virtual care team is working from home or another offsite location, they need a mobile device provided and maintained by the CAH/RHC. This creates a security risk if devices are lost or stolen, but there are safeguards to put in place, which is an essential tool.

Access to the electronic health record. To be effective, the virtual care team needs access to patient information, recognizing the inherent technical, security, and privacy issues. Providing secure access through a virtual private network (VPN) may be a solution, but IT staff will know the best way to accomplish this.

Privacy screen. When virtual care teams work from home, there is always the risk that friends or family can see a patient's information. Providing a privacy screen for the monitor/screen prevents purposeful or inadvertent viewing of patient information.

Teleconference and videoconference capability. One solution may cover both requirements (e.g., Zoom).

Reliable, high-speed broadband. For interacting with patients and the rest of the virtual care team, a reliable connection is a MUST.

Strong phone connectivity. This is a perennial problem in rural areas, and while 5G holds promises, it is not here yet. Solutions include boosters, using an internet-based phone solution (e.g., WhatsApp) if the internet is adequate, or having the team member work in a place with better phone service if the home is not an option.

Readily available technical support. Some organizations have strong IT teams that can provide tech support, while others may have that one individual who just seems to have the knack for finding solutions. Either way, the team needs to have support when the technology is not working.

Care Coordination with Telehealth & Care Management

Perhaps one of the most exciting possibilities is supercharging care coordination with telehealth and other virtual services. The following are intriguing ways to

enhance care coordination for Medicare beneficiaries. Check with state Medicaid agencies and other health plans for coverage of these and other services. Some state Medicaid agencies may require in-person visits to be reimbursed.

Transitional care management (TCM). There are two codes, and due to poor utilization of these services, CMS increased reimbursement for 2021. See 2021 Category 1&2 Telehealth Code Summary Table. This is a great way to support patients for post-discharge follow-up when travel can be challenging for the patient and receive reimbursement by providing these services through telehealth visits. Imagine a TCM visit that includes CAH staff, the patient and family/caregiver, the primary care provider (PCP), pharmacist, home health aide, specialist, and a nurse or MA! Timely and appropriate post-discharge visits can reduce ED visits and 30-day readmissions, making this an attractive option. The CAH may provide these services or ensure the patient is scheduled – either in-person or by telehealth – for a TCM visit during discharge planning.

Telebehavioral health and substance use disorder. There are many telehealth and virtual options for providing virtual services for those with acute and ongoing behavioral and mental health issues; the same is valid for supporting and coordinating individuals with substance use disorder. See 2021 Category 1&2 Telehealth Code Summary Table.

Chronic and principal care management (CCM/PCM). CCM is a mix of chronic disease management, care management, and care coordination, depending on patients' needs for those with two or more chronic conditions. PCM is specifically for patients with one chronic severe condition expected to last between three months and one year, or until the death of the patient, which **may have led to a recent hospitalization** and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline"[15].See CMS Chronic & Principal Care Management Services: Implementation Guidance in appendices.)

Remote physiologic (or patient) monitoring (RPM). See RPM discussion above and RPM resource in appendices.

[15] CY 2020 Physician Fee Schedule Final Rule published November 15, 2019.

Quality Improvement & Quality Assurance

As health care moves closer to the value-based care (VBC) model, it is clear that VBC is inextricably connected to population health, empanelment, and quality improvement. Improving the community's health through empanelment for RHCs and by attribution for CAHs may be a new concept. Because telehealth can have some impacts and unintended adverse consequences on VBC, it's essential to look at how telehealth impacts:

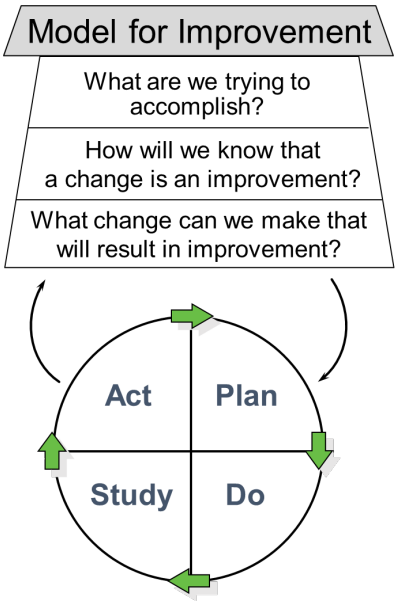
- **Population health and in-reach/in-person and outreach efforts** to identify and address chronic and preventive gaps in care as well as care management needs
- **Empanelment** to
  - Assume responsibility for the target population/empaneled patients
  - Ensure their health care needs are met regardless of whether they seek care
  - Know (and reach out to) those individuals who may be unseen or unknown
- **Quality improvement and critical outcome and process measures** that affect quality, safety, efficiency, cost, patient experience, and work-life of staff

Quality Improvement (QI)

"Every system is perfectly designed to achieve exactly the results it gets." ~ Arthur Jones[16] This quote encapsulates why healthcare organizations take QI seriously, although some are more successful at it than others.

[16] Attribution is disputed. Like Magic? ("Every system is perfectly designed…"). Institute for Healthcare Improvement. 2015. http://www.ihi.org/communities/blogs/origin-of-every-system-is-perfectly-designed-quote

From a performance improvement standpoint, consider a set of process and outcome measures aligned with the CAH/RHC goals. In addition to satisfaction surveys, clinical quality measures, and other measures, consider the suggestions below.



- Percent of encounters that are telehealth visits vs. in-person visits
- Percent of visits that start and end on time – include reasons why visits did not start or end on time (e.g., provider running late, patient not ready on time, appointment time too short to cover issues, questions, and concerns)
- Successful completion rate of telehealth visits and reasons for unsuccessful completion of the visit (do not include any no-shows)
- ED visits, admissions, and readmissions rates over time
- Clinical quality/other measures (e.g., vaccine and cancer screening rates, A1Cs, blood pressure control)

Quality Assurance

Each person should have the same high-quality telehealth experience, regardless of several variables (e.g., workflows, devices, clinicians, support staff). 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, clinician, and virtual care team experience.

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?"

Surveys help identify issues, but the best way to ensure quality assurance is to have a tele-partner, who is skilled at telehealth, attend and observe a few telehealth visits per clinician/care team and provide suggestions for improvement following the visit – or plus, minus, delta → What went well? What did not go well? What should/could change? Nota bene – This does require a degree of trust.

Patient Telehealth Satisfaction Questions	Possible Responses
Overall, I am satisfied with my telehealth visit.	Strongly disagree (1) Disagree (2) Agree (3) Strongly agree (4)
The process to sign on and begin the telehealth visit was easy.	
The visit started on time.	
The clinician's credentials were displayed.	
The clinician and other team members introduced themselves.	
I could see the clinician.	
The clinician listened carefully.	
The clinician explained things in a way that was easy to understand.	
What could have gone better?	Free text box

Clinician Satisfaction Questions	Possible Responses
The telehealth visit went smoothly; I had the support I needed for any glitches.	Strongly disagree (1) Disagree (2) Agree (3) Strongly agree (4)
The visit started on time.	
The virtual care team performed well and completed all pre-visit tasks.	
What could have gone better?	Free text box

Legal and Risk Management Considerations

Credentialing and licensing. Here is a checklist for CAHs to consider that may impact telehealth service delivery.

- Ensure that every provider of telehealth to a CAH patient is:
  - Working within their scope of practice, which may be defined by the CAH, local, state, and federal requirements.
  - Licensed in the state of the originating site (where the patient is) or that licensing reciprocity or a compact is in place
- Know the state, local, federal, etc. considerations in cases of delegated credentialing that may surface around telehealth and other virtual services delivery by providers
- Understand cross-state licensure requirements by checking this page from TELEHEALTH.HHS.GOV. Many states participate in interstate compacts, but

each CAH/RHC should know the requirements if they will provide distant site services to Medicaid beneficiaries and other patients in another state.
- Know whether advanced training is required for delivering telehealth. For example, in Washington, all providers except MDs and DOs must take an approved telehealth training course.
- Check to be sure a provider is an approved provider type based on patients' insurance plans
- Carefully review the medical staff bylaws to ensure they are aligned with telehealth and virtual service delivery and do not act as an impediment to the telehealth program

Malpractice coverage. Consider whether the CAH needs to know which providers' malpractice coverage includes telehealth services and have a backup plan if not. This may be challenging for CAH/RHCs because much of their telehealth is provided by distant site providers. It may be challenging to know beforehand who has telehealth malpractice coverage and who does not.

Missed and delayed diagnoses. Many medical malpractice settlements result from missed and delayed diagnoses, and the nature of telehealth may increase the risk. See additional information under Patient Safety.

Audits. CMS is concerned with the potential of fraud with telehealth and virtual services and may conduct audits of these services in the future. Consider random internal audits of medical records to CMS chronic ensure compliance.

Resources

1. Northwest Regional Telehealth Resource Center. Offers four telehealth training opportunities. The Washington State Healthcare Professional Telemedicine Training is required for all clinicians (except physicians) that will deliver telehealth services in WA. However, it is not just WA-specific and is an excellent training
2. New York State Telehealth Training Portal Excellent telehealth training offered by the Northeast Telehealth Resource Center – not just specific to NY. Must sign up for a free account to access the training opportunities. Currently not offering CME/CEU.

HIPAA Privacy & Security

Many organizations overlook the privacy and security considerations when implementing telehealth. These issues are compounded when the care team and others work virtually. Below are essential issues to address.

During the PHE, restrictions on using a HIPAA-compliant solution were lifted.

HIPAA Privacy

Use a headset or earbuds. This is a recommendation for patients and their families and caregivers, clinicians, and care team members. An exam room provides a space for private conversations for all involved; it is vital to maintain a similar level of privacy during virtual communication. 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. Using a headset or earbuds can help alleviate this privacy issue.

Display signage when a telehealth visit is in progress. This helps prevent accidental exposure of patient-protected health information (PHI) either by seeing information on the screen or from overhearing the conversations.

Protect patient's protected patient information – additional recommendations.

- Use a privacy screen so others cannot read patients' information, especially if working from home
- Do not let family or friends use your work device
- Share the minimum necessary information for others involved in the care of the patient. This is especially true for CAHs and RHCs that act as originating sites and send patient information to specialists and other shared care partners in advance of telehealth visits

HIPAA Security & the Security Risk Analysis

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

- Our designated Security Officer (required by HIPAA) has updated all relevant HIPAA standards and implementation specifications in our security risk analysis to include the changes we have made with telehealth and other virtual services
- The Security Officer has provided telehealth-specific training to all members delivering, supporting, or participating in telehealth and virtual services. Ongoing security awareness training is required as part of the HIPAA security rule. It is the responsibility of the designated Security Officer to ensure it happens.
- We have a security awareness and training program that includes security concerns specific to the care team members working virtually
- All devices (e.g., laptops, tablets, etc.), including those used by care team members working virtually:
    - Are protected, using unique passwords for each user.
    - Have current and functioning antivirus software.
    - Terminate an electronic session after a predetermined time of inactivity.
    - Include the 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.
    - Can be remotely wiped and disabled (in the event of theft or loss of the device(s)).
    - They are protected by a firewall whenever possible.
    - Have updated security software.
- 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[17]

Resource:

Mobile Device Privacy and Security from HealthIT.gov. Provides specific guidance on protecting and securing health information when using a mobile device.

Covered Entity Decision Tool. Helps to identify entities, including individuals that need to comply with HIPAA.

Business Associate Agreements (BAAs)

BAAs should be signed with any vendors or other associates that fulfill the definition of a business associate. "A "business associate" is a person or entity, other than a member of the workforce of a covered entity, who performs functions or activities

[17] Business Associates. U.S. Department of Health & Human Services – Office for Civil Rights. Accessed Jan 4, 2021.

on behalf of, or provides certain services to, a covered entity that involves access by the business associate to protected health information." – a solid recommendation to read the full text at the source of this information - Business Associates from U.S. Department of Health & Human Services.

Rules, Regulations & Keeping Current

Using select resources and subscribing to a few high-value newsletter lists, it is possible to stay in the know on telehealth rules and regulations. Here are a few recommendations:

1. Subscribe to CMS' Electronic Mailing Lists
    - **"Your MAC's Electronic Mailing List:** Subscribe to your Medicare Administrative Contractor's (MAC) mailing list for national and local Fee-for-Service (FFS) program news from your MAC, MLN Connects® newsletter content, and MLN Matters® Article and Medicare Learning Network (MLN) product updates.
    - **MLN Connects Newsletter:** Subscribe to the weekly MLN Connects newsletter for all national FFS program news, events, and MLN Matters Article and MLN product updates. Learn more and read the current edition of the MLN Connects newsletter."
2. Subscribe to the Center for Connected Health Policy emails. Scroll down to "Telehealth policy updates delivered straight to your inbox." Enter your information and subscribe.
3. Go to your state Medicaid agency website and subscribe to updates. Do the same for any other health plans serving your patients if email updates are offered.
4. Peruse the next Calendar Year Physician Fee Schedule (CY PFS) Proposed (published ~ July) and Final Rules (published ~ Nov). If you subscribe to the MLN Connects Newsletter and CCHP updates, you will be alerted when these are available. These documents are several hundreds of pages long, but using the search feature can make focusing on what is relevant to CAH/RHCs much easier. The proposed rule provides a sense of what is to come and includes details and discussions not always included in the final rule. Current and past CY PFS rules can be found here.
5. Review the Resources to Bookmark below.

Resources to Bookmark

1. Center for Connected Health Policy. Provides detailed state Medicaid agency telehealth policy with helpful links to each states' relevant resources, manuals, statutes, etc.
2. Using Telehealth to Expand Access to Essential Services during the COVID-19 Pandemic. *Centers for Disease Control and Prevention*. Includes short descriptions of telehealth modalities, benefits and potential uses of telehealth, strategies to increase telehealth uptake, telehealth reimbursement, and safeguards and potential limitations of telehealth. Updated June 2020.
3. Critical Access Hospitals (CAHs). *Rural Health Information Hub*. Provides excellent information about CAHs, including a comprehensive set of FAQs.
4. National Telehealth Technology Assessment Resource Center. An excellent resource for anything related to telehealth technology. Highly recommended learning opportunities include:
    a. Toolkit: Clinician's Guide to Video Platforms. Each of the 18 web pages includes a short YouTube video and well-organized accompanying text with additional detail.
    b. Technology Assessment 101. Includes a nice flow diagram with seven key steps.
5. Telehealth Services Factsheet – MLN Booklet. *CMS*. This booklet includes MUST READ information when delivering telehealth services to Medicare beneficiaries.
6. CMS' List of Telehealth Services. *CMS*. Complete list of telehealth services and codes frequently updated during the PHE but usually just updated annually.
7. TELEHEALTH.HHS.GOV. *Health Resources & Services Administration*. Excellent telehealth resources and guidance for patients and providers.
8. Medicare and Medicaid COVID-19 Program Flexibilities and Considerations for Their Continuation. *United States Government Accountability Office – Testimony Before the Committee on Finance, U.S. Senate*. May 2021. Relevant findings include that 1) enhanced telehealth flexibilities reduce obstacles to care, and 2) while telehealth utilization is slightly higher in urban areas than rural areas, the proportion using telehealth is similar across racial and ethnic groups.
9. Telehealth Topic Guide. *National Rural Health Resource Center.* This collection of critical resources is explicitly curated for rural health providers and regularly updated.
10. Rural Telehealth Toolkit. *Rural Health Information Hub.* Excellent resource with topics ranging from introduction to telehealth to funding and sustainability.
11. § 410.27 Therapeutic outpatient hospital or CAH services and supplies incident to a physician's or nonphysician practitioner's service: Conditions. Helpful information to have on hand.

Appendices

Appendix A - 2021 Category 1&2 Telehealth Code Summary Table

Category 1&2 telehealth services can be added to the permanent list by request and are promulgated in the Calendar Year Physician Fee Schedule (CY PFS) proposed (published ~ July) and final rules (published ~ November). Traditionally there are only a few additions every year; time will tell whether that is true in the post-pandemic period. See your CPT® Professional codebook for full descriptions and additional requirements. The table below includes all of the current (as of 2021) telehealth codes, grouped and with brief descriptions and CMS prices for CAHs and RHCs to review. The reimbursement for CAHs/RHCs will undoubtedly be different from what is in the table but having the prices may be helpful when discussing partnership with specialists.

- When a code notes "face-to-face" in the table below, telehealth provides a face-to-face encounter, different from an in-person encounter.
- The eight codes in italics were added to the list as of Jan 1, 2021. The CY 2021 PFS Final Rule permanently added nine billing codes to the Medicare telehealth services list. However, the Consolidated Appropriations Act, 2021 — passed Dec. 21, 2020 — delays the permanent addition of HCPS code G2211 until 2024.
- The national payment amount for the non-facility price (or facility price if no non-facility option) from the Physician Fee Schedule is included only as an indication of the value of each code, which may help with deciding which codes to implement even if this is not the reimbursement rate for CAHs and RHCs. Additionally, it can be helpful to have this information when connecting with specialists to expand services if the CAH/RHC acts as an originating site. CMS prices fluctuate but rarely by much.
- Most of the references included in the table have billing guidance for CAHs.
- The table's HCPCS/CPT Category 1 telehealth codes are reconciled with the CMS List of Telehealth Services updated April 7, 2021, and accessed June 26, 2021.

Service	HCPCS/CPT Code(s)
Hospital, Critical Care Consult & Nursing Facility Services	
Telehealth consultations, emergency department or initial inpatient	G0425($101) G0426($136) G0427($200)
Inpatient telehealth **pharmacologic management**, including prescription, use, and review of medication with no more than minimal medical psychotherapy	G0459($43)
Subsequent **hospital care services**, with the limitation of 1 telehealth visit every three days	99231($38) 99232($72) 99233($103)
Subsequent **nursing facility care services**, with the limitation of 1 telehealth visit every 30 days	99307($44) 99308($69) 99309($91) 99310($135)
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or skilled nursing facilities	G0406($38) G0407($72) G0408($103)
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; **first hour** (list separately in addition to code for inpatient E/M service) (99356) and **each additional 30 minutes** (list separately in addition to code for prolonged service (99357)	99356($91) 99357($92)
Telehealth Consultation, Critical Care, **initial**, physicians typically spend 60 minutes communicating with the patient and providers via telehealth (G0508), and **subsequent**, physicians typically spend 50 minutes communicating with the patient and providers via telehealth (G0509) Added in 2017 to "…report an intensive telehealth consultation service, initial or subsequent, for the critically ill patient, for example, a stroke patient, under the circumstance when a qualified health care professional has in-person responsibility for the patient, but the patient benefits from additional services from a distant-site consultant specially trained in furnishing critical care services." CY 2017 PFS FR p. 80198	G0508($210) G0509($191)
Post-Discharge Services	
Transitional care management (TCM)services with **moderate medical decision complexity** (face-to-face visit **within 14 days** of discharge) (99495) and with **high medical decision complexity** (face-to-face visit **within seven days** of discharge) (99496) If you are the surgeon or provider who performed a procedure on the TCM patient, you cannot bill TCM within the procedure's global period. Conversely, if you are the PCP or hospitalist who	99495($208) 99496($282)

Service		HCPCS/CPT Code(s)
discharged the TCM patient, you can bill within 30 days of discharge.		
Evaluation & Management (E/M) Visits		
Office or other outpatient visits	99202($74) 99203($114) 99204($170) 99205($224)	99211($23) 99212($57) 99213($92) 99214($131) 99215($184)
Prolonged **E/M or psychotherapy services** in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (99354) and each additional 30 minutes (99355)		99354($129) 99355($96)
Prolonged preventive service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (G0513) and each additional 30 minutes (G0514) CY 2018 PFS FR p. 53079		G0513($66) G0514($66)
Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. This code and service, which is an add-on code for 99202-99215, can be a gamechanger for primary care, especially in rural communities. It captures work that is not captured in existing E/M codes – from the CY 2021 PFS FR: "…G2211 could recognize the resources inherent in holistic, patient-centered care that integrates the treatment of illness or injury, management of acute and chronic health conditions, and coordination of specialty care in a collaborative relationship with the clinical care team." To read the entire fascinating discussion, see Comment Solicitation on the Definition of HCPCS Add-On Code G2211 in the CY 2021 PFS Final Rule pp. 84569-72. HCPCS Code G2211 is a Bundled Service & Not Separately Paid Under Section 113 of the Consolidated Appropriations Act; HHS is not paying for this code under the Physician Fee Schedule until January 1, 2024. HCPCS code G2211 is a bundled service. Medicare Administrative Contractors will automatically reprocess claims that were paid. "Practitioners may report this code for qualifying visits furnished on or after January 1, 2021, although we assigned a PFS payment status indicator of "B" (Bundled) until 2024." Fact Sheet - Physician Fee Schedule		*G2211($0)*

Service	HCPCS/CPT Code(s)
(PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits. CMS. Jan 2021.	
Prolonged office or other outpatient E/Ms beyond the maximum required time of the primary procedure, which has been selected using total time on the date of the primary service; each additional 15 minutes – add-on code for 99205 and 99215	G2212($34)
Chronic Kidney Disease (CKD) and End-Stage Renal Disease (ESRD)	
Individual and group kidney disease education services Coverage of Kidney Disease Patient Education Services. CMS. Updated Jn 2013.	G0420($114) G0421($27)
ESRD-related services included in the monthly capitation payment ESRD billing can be complex and is beyond the scope of this guide. There is either no record found or no price on the Physician Fee Schedule for the seven codes listed on the right, although they are the CMS list of telehealth services.	90951($1,199) 90952 90954 90955 90957 90958 90960 90961
ESRD-related services for **home dialysis** per full month, for patients < 2 years of age (90963), 2-11 years of age (90964), and 12-19 years of age (90965) to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90963($620) 90964($532) 90965($512)
ESRD-related services for **home dialysis** per full month, for patients ≥ 20 years of age	90966($300)
ESRD-related services for dialysis less than a full month of service, per day; for patients < 2 years of age (90967), 2-11 years of age (90968), 12-19 years of age (90969), and ≥ 20 years of age (90970)	90967($18) 90968($18) 90969($17) 90970(($10)
Behavioral and Mental Health Must-Have Resource: Medicare Mental Health. CMS. Updated June 2021.	
Individual psychotherapy	90832($78) 90833($71) 90834($103) 90836($90) 90837($152) 90838($119)
Psychiatric diagnostic interview examination	90791($181) 90792($202)
Neurobehavioral status examination (clinical assessment of thinking, reasoning, and judgment) – includes face-to-face time and interpreting test results and preparing the report, the first hour (96116) *and each additional hour (96121)*	96116($97) *96121($82)*

Service	HCPCS/CPT Code(s)
Psychoanalysis	90845($98)
Family psychotherapy (without the patient present)	90846($99)
Family psychotherapy (conjoint psychotherapy) (with patient present)	90847($103)
Group psychotherapy (other than of a multiple-family group)	*90853($28)*
Psychotherapy for crisis	90839($145) 90840($69)
Interactive complexity add-on (for psychotherapy codes) See Commonly Used CPT Codes section in Medicare Mental Health. CMS. Updated June 2021.	90785($15)
96156 Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making) 96159 Health behavior intervention (HBI), individual–Each additional 15 minutes (list separately in addition to 96158, which is not a Category 1 code but is listed as a temporary code during the PHE) 96164 HBI, group (2 or more patients), face-to-face; initial 30 minutes 96165 HBI, group - each additional 15 minutes (list separately in addition to code for primary services) 96167 HBI, family (with the patient present), face-to-face; initial 30 minutes 96168 HBI, family (with the patient present)-each additional 15 minutes (list separately in addition to code for primary services)	96156($97) 96159($23) 96164($10) 96165($5) 96167($71) 96168($25)
Substance Use Disorder (in addition to Behavioral/Mental Health above)	
G2086: Office-based treatment for a substance use disorder (SUD), including developing the treatment plan, care coordination, individual therapy, and group therapy and counseling; at least 70 minutes in the first calendar month. G2087: Office-based treatment for (SUD), including care coordination, individual therapy, group therapy, and counseling; at least 60 minutes in a subsequent calendar month. G2088: Office-based treatment for (SUD), including care coordination, individual therapy, and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes Note that the facility price for the three codes is lower: $287, $281, $34, respectively. For a full discussion of these codes and services, see Bundled Payments Under the PFS for Substance Use Disorders (HCPCS Codes G2086, G2087, and G2088) in the CY 2021 PFS FR (pp. 84642-3)	*G2086($395)* *G2087($351)* *G2088($66)*

Service	HCPCS/CPT Code(s)
Level 1 (99334) or Level 2 (99335) established patient domiciliary, rest home, or custodial care visit. *Level 1 (99347) or Level 2 (99348) established patient home visit.* *The CY 2021 PFS FR (p. 84505) states that "the patient's home cannot serve as an originating site" and that "because the home is not generally a permissible telehealth originating site, these services could be billed when furnished as telehealth services only for the treatment of a SUD or co-occurring mental health disorder," citing the SUPPORT Act.*	99334($60) 99335($96) 99347($55) 99348($84)
Patient Self-Management, Education, Wellness and Lifestyle Changes	
Individual and group medical nutrition therapy	G0270($32) 97802($38) 97803($32) 97804($17)
Individual and group diabetes self-management training (DSMT) services, with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training American Diabetes Association's 2020 Standards of Medical Care in Diabetes states that "all people with diabetes should participate in diabetes self-management education" and "all individuals with diabetes should be referred for individualized MNT." Medicare Reimbursement Guidelines for DSMT. Centers for Disease Control and Prevention's (CDC). Accessed June 2021. Medicare Preventive Services - Diabetes Self-Management Training. CMS. Accessed June 2021.	G0108($56) G0109($16)
Smoking cessation services Tobacco Use Prevention and Cessation Counseling. American Academy of Family Physicians. 2017.	99406($16) 99407($29)
Alcohol **and substance (other than tobacco)** abuse structured assessment and intervention services Screening, Brief Intervention, & Referral to Treatment (SBIRT) Services. CMS. Updated Feb 2021	G0396($36) G0397($68)
Annual alcohol misuse screening, 15 minutes (G0442) and brief face-to-face behavioral counseling for alcohol misuse, 15 minutes (G0444)	G0442($19) G0443($27)

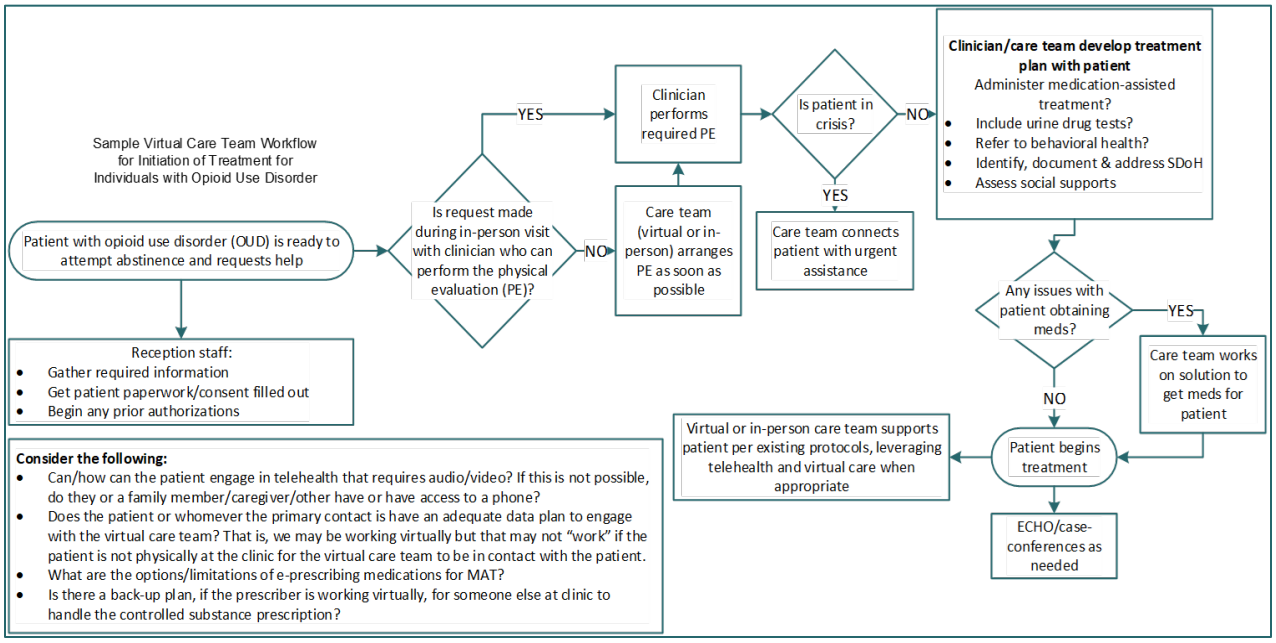
Service	HCPCS/CPT Code(s)
Annual depression screening, 15 minutes Screening for Depression in Adults. CMS. Updated March 2012.	G0444($44)
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes education, skills training, and guidance on how to change sexual behavior; performed semi-annually, 30 minutes Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs. CMS. Updated May 2012.	G0445($28)
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD). CMS. Updated March 2021.	G0446($27)
Face-to-face behavioral counseling for obesity, 15 minutes	G0447($27)
Annual Wellness Visit includes a personalized prevention plan of service (PPPS) first visit (G0438) and subsequent visit (G0439) Medicare Annual Wellness Visits. CMS. Accessed June 2021.	G0438($169) G0439($134)
Advance Care Planning, 30 minutes (99497) and each additional 30 minutes (99498) Advance Care Planning Fact Sheet. CMS. Updated 2020.	99497($86) 99498($74)
Counseling visit to discuss the need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT). CMS. It was updated in June 2017. For a decision tree and lung cancer screening guidelines across organizations, see Lung Cancer Screening Guidelines Implementation in Primary Care: A Call to Action. Ann Fam Med. 2020.	G0296($29)
Health Risk Assessment: administer a questionnaire to help identify a specific health risk to a patient (96160) or a patient's caregiver (96161), analyzes the results, assigns a score, and documents the findings.	96160($3) 96161($3)
Comprehensive assessment of and care planning for patients requiring chronic care management Chronic Care Management Services. CMS. 2019.	G0506($62)

Service	HCPCS/CPT Code(s)
Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian in the office or other outpatient, home or domiciliary or rest home with all required elements (~ 50 minutes face-to-face with the patient and family or caregiver)	99483($283)
• The national payment amount for the non-facility price from the Physician Fee Schedule Search as of June 25, 2021, rounded to the nearest dollar provided only to assess potential revenue if code is used. Do not rely on these. Have your biller/coder double-check. • A physician, NP, PA, or CNS must furnish at least one ESRD-related "hands-on visit" (not telehealth) each month to examine the beneficiary's vascular access site.	

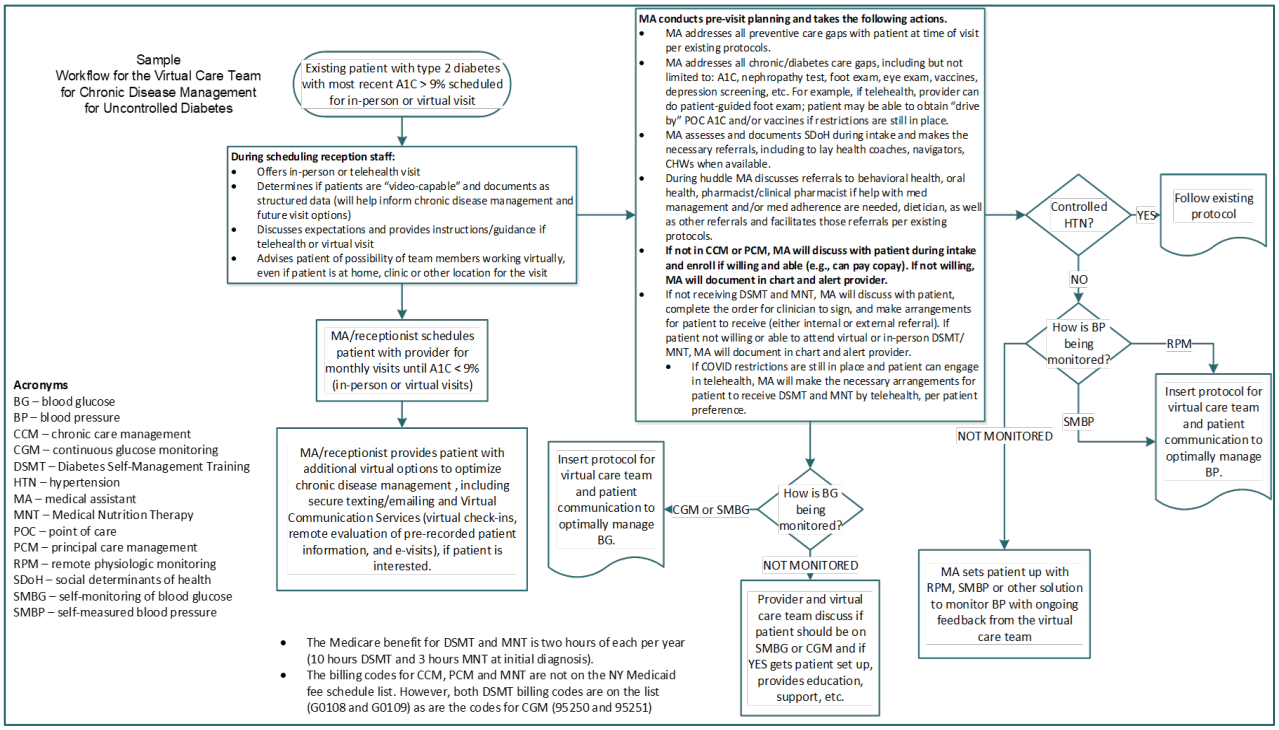
Appendix B – Sample Telehealth-Related Workflows

There are several ways to document telehealth workflows. The following flow diagrams were created in Visio.

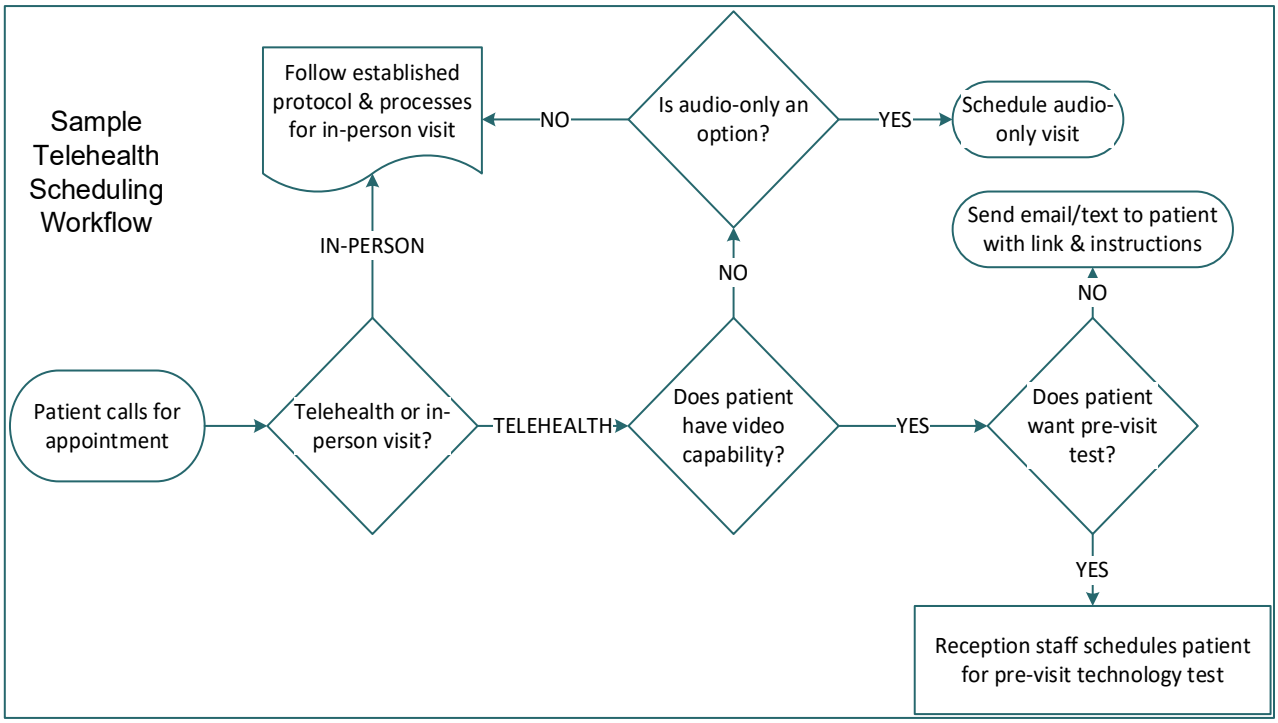
Workflow 1



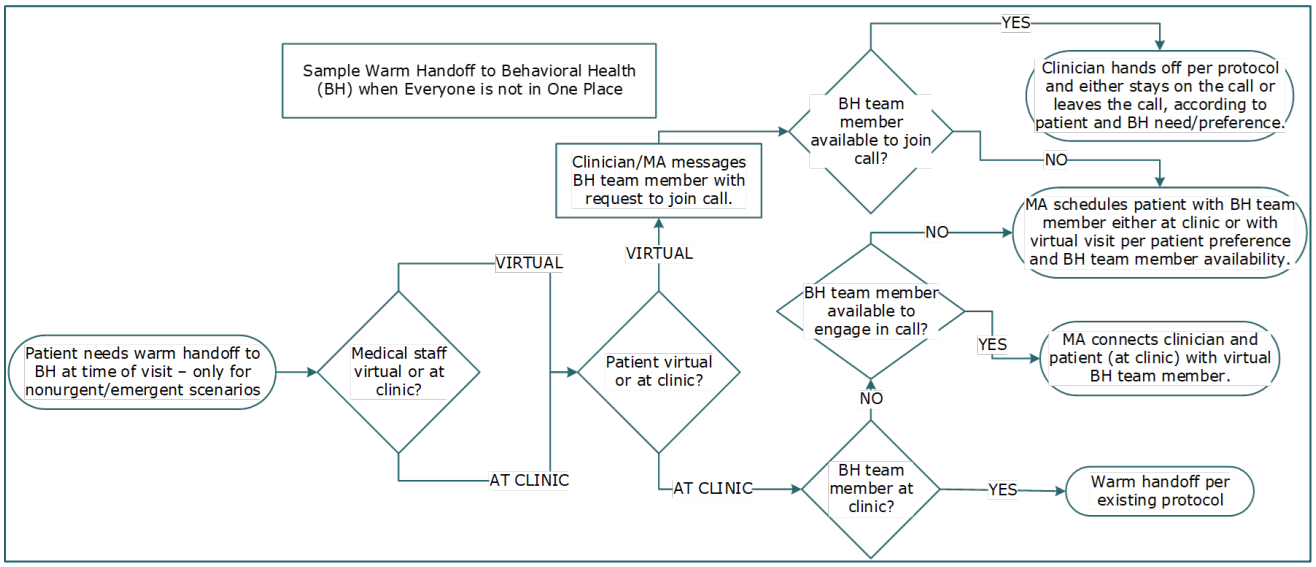
Workflow 2


Sample
Workflow for the Virtual Care Team for Chronic Disease Management for Uncontrolled Diabetes
Existing patient with type 2 diabetes with most recent A1C > 9% scheduled for in-person or virtual visit
During scheduling reception staff:
Offers in-person or telehealth visit
Determines if patients are "video-capable" and documents as structured data (will help inform chronic disease management and future visit options)
Discusses expectations and provides instructions/guidance if telehealth or virtual visit
Advises patient of possibility of team members working virtually, even if patient is at home, clinic or other location for the visit
MA/receptionist schedules patient with provider for monthly visits until A1C < 9% (in-person or virtual visits)
MA/receptionist provides patient with additional virtual options to optimize chronic disease management , including secure texting/emailing and Virtual Communication Services (virtual check-ins, remote evaluation of pre-recorded patient information, and e-visits), if patient is interested.
MA conducts pre-visit planning and takes the following actions.
MA addresses all preventive care gaps with patient at time of visit per existing protocols.
MA addresses all chronic/diabetes care gaps, including but not limited to: A1C, nephropathy test, foot exam, eye exam, vaccines, depression screening, etc. For example, if telehealth, provider can do patient-guided foot exam; patient may be able to obtain "drive by" POC A1C and/or vaccines if restrictions are still in place.
MA assesses and documents SDoH during intake and makes the necessary referrals, including to lay health coaches, navigators, CHWs when available.
During huddle MA discusses referrals to behavioral health, oral health, pharmacist/clinical pharmacist if help with med management and/or med adherence are needed, dietician, as well as other referrals and facilitates those referrals per existing protocols.
If not in CCM or PCM, MA will discuss with patient during intake and enroll if willing and able (e.g., can pay copay). If not willing, MA will document in chart and alert provider.
If not receiving DSMT and MNT, MA will discuss with patient, complete the order for clinician to sign, and make arrangements for patient to receive (either internal or external referral). If patient not willing or able to attend virtual or in-person DSMT/ MNT, MA will document in chart and alert provider.
If COVID restrictions are still in place and patient can engage in telehealth, MA will make the necessary arrangements for patient to receive DSMT and MNT by telehealth, per patient preference.
Controlled HTN?
YES
Follow existing protocol
NO
How is BP being monitored?
RPM
SMBP
NOT MONITORED
Insert protocol for virtual care team and patient communication to optimally manage BP.
How is BG being monitored?
CGM or SMBG
Insert protocol for virtual care team and patient communication to optimally manage BG.
NOT MONITORED
Provider and virtual care team discuss if patient should be on SMBG or CGM and if YES gets patient set up, provides education, support, etc.
MA sets patient up with RPM, SMBP or other solution to monitor BP with ongoing feedback from the virtual care team
Acronyms
BG – blood glucose
BP – blood pressure
CCM – chronic care management
CGM – continuous glucose monitoring
DSMT – Diabetes Self-Management Training
HTN – hypertension
MA – medical assistant
MNT – Medical Nutrition Therapy
POC – point of care
PCM – principal care management
RPM – remote physiologic monitoring
SDoH – social determinants of health
SMBG – self-monitoring of blood glucose
SMBP – self-measured blood pressure
The Medicare benefit for DSMT and MNT is two hours of each per year (10 hours DSMT and 3 hours MNT at initial diagnosis).
The billing codes for CCM, PCM and MNT are not on the NY Medicaid fee schedule list. However, both DSMT billing codes are on the list (G0108 and G0109) as are the codes for CGM (95250 and 95251)

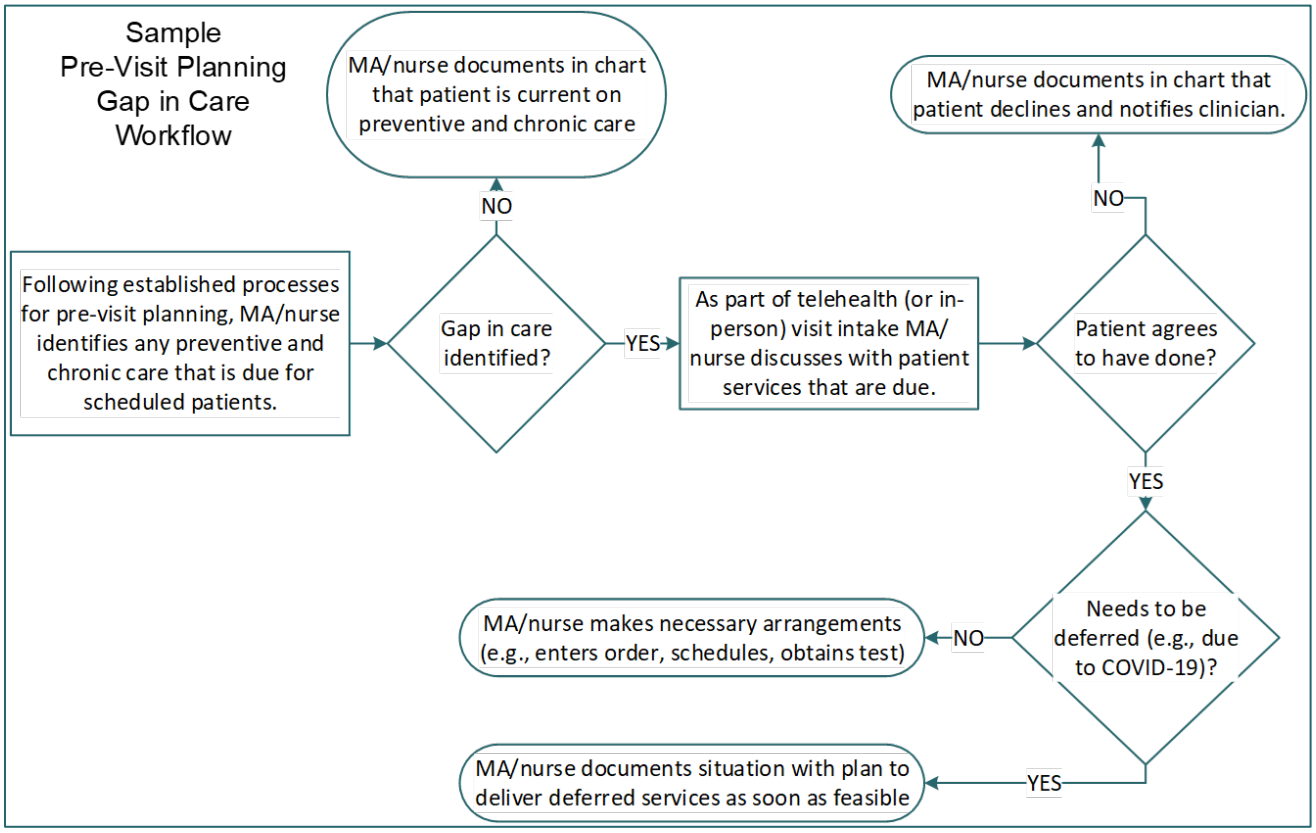
Workflow 3


Sample Telehealth Scheduling Workflow
Patient calls for appointment
Telehealth or in-person visit?
IN-PERSON
Follow established protocol & processes for in-person visit
TELEHEALTH
Does patient have video capability?
NO
Is audio-only an option?
NO
YES
Schedule audio-only visit
YES
Does patient want pre-visit test?
NO
Send email/text to patient with link & instructions
YES
Reception staff schedules patient for pre-visit technology test

Workflow 4


Sample Warm Handoff to Behavioral Health (BH) when Everyone is not in One Place
Patient needs warm handoff to BH at time of visit – only for nonurgent/emergent scenarios
Medical staff virtual or at clinic?
VIRTUAL
AT CLINIC
Patient virtual or at clinic?
VIRTUAL
Clinician/MA messages BH team member with request to join call.
BH team member available to join call?
YES
Clinician hands off per protocol and either stays on the call or leaves the call, according to patient and BH need/preference.
NO
MA schedules patient with BH team member either at clinic or with virtual visit per patient preference and BH team member availability.
AT CLINIC
BH team member at clinic?
YES
Warm handoff per existing protocol
NO
BH team member available to engage in call?
NO
YES
MA connects clinician and patient (at clinic) with virtual BH team member.

Workflow 5


Sample
Pre-Visit Planning
Gap in Care
Workflow
MA/nurse documents in chart that patient is current on preventive and chronic care
MA/nurse documents in chart that patient declines and notifies clinician.
NO
NO
Following established processes for pre-visit planning, MA/nurse identifies any preventive and chronic care that is due for scheduled patients.
Gap in care identified?
YES
As part of telehealth (or in-person) visit intake MA/ nurse discusses with patient services that are due.
Patient agrees to have done?
YES
Needs to be deferred (e.g., due to COVID-19)?
MA/nurse makes necessary arrangements (e.g., enters order, schedules, obtains test)
NO
MA/nurse documents situation with plan to deliver deferred services as soon as feasible
YES

Appendix C – Telehealth Program Assessment

The Telehealth Program Assessment can also be found on the NRTRC website under CAH Telehealth Guide and Tools.

Telehealth Program Assessment

Introduction

While many organizations, clinicians and care teams have been delivering telehealth and other remote services for many years, others are new to the telehealth table and are in the early stages of fully implementing and adopting a robust telehealth program. The following assessment provides the opportunity to assess gaps or areas to improve while also recognizing the investment of time and effort that has brought the organization to its current state of remote health care service delivery. Celebrate the items for which the organization has a high score!

The assessment is specific to outpatient health care clinic organizations that primarily deliver telehealth services, acting as a distant site, but may also act as an originating site when specialists or other clinicians deliver telehealth services to a patient that is at the organization/location.

This assessment can be completed by one individual who knows the organization and the state of telehealth well. However, consider completing the assessment together with individuals representing several roles in the organization – leadership, clinicians, medical assistants, nurses, reception staff, etc. Choose the response that best fits the current state even if a response does not perfectly match how things are at the organization; make notes to reflect what the actual current state is.

Intake (only if administering to a group of organizations)

Name and role:
Email address and phone number:
Organization:
Type of organization:
Using an electronic health record (EHR)?
☐ Yes – please enter the EHR(s) used:
☐ No

Organization is located in a/an…
☐ Urban area (≥ 50,000 or more people)
☐ Rural area (< 50,000 people
☐ Both
Assessment was completed by:
☐ One individual
☐ Team with responses derived by consensus
If completed as a team, list team names and roles:

Telehealth Maturity Model

This assessment is based on this very simple progression or maturity model; prior to taking the assessment, most organizations, teams and individuals will know where they fall along the continuum. Use the assessment to identify the current state and then retake the assessment in three to six months to highlight progress and perhaps to clarify remaining work to reach mature implementation and adoption to sustain telehealth service delivery.

Scoring

Level of Telehealth Implementation & Adoption	Score
Level 1 – Contemplation & Preparation	0 – 15
Level 2 – Early Implementation & Adoption	16 – 50
Level 3 – Mature Implementation & Adoption	51 – 78

*Note that scores have not been validated to ensure high fidelity with the levels in the maturity model.

Terminology

While telehealth is an all-encompassing term, when it comes to health care service delivery, the ability to bill and collect reimbursement using a billing code constrains the options for remote service delivery to sets of codes and services. Those fall into two categories: 1) the discrete set of Medicare telehealth services and 2) other virtual services. This Telehealth Program Assessment uses the term telehealth to refer to the discrete set of Medicare telehealth services[1].

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

Note that there are typically three types of telehealth that are described:

1. Real-time or synchronous interactive communication using audio and video
2. Store and forward, using electronic transmission of images, data, sound, or video (e.g., radiology images, electrocardiograms (ECGs), pictures of skin problems or injuries) for review or evaluation
3. Remote physiologic (or patient) monitoring (RPM) through collection and transfer of health data collected at a patient's home or other location for surveillance and response or management as needed

[1] List of Telehealth Services. *Centers for Medicare & Medicaid Services*. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Organizational Readiness

Systemwide awareness, commitment, and planning signals readiness to implement telehealth and is key to its sustainability. If leadership is not fully engaged and supportive, the success of the telehealth program is at stake.

Our organizational perspective on telehealth is:

☐	We will provide telehealth as needed but only during the COVID-19 pandemic. (1)
☐	We will support telehealth permanently for clinicians, care teams and patients who are interested in it but have not or will not implemented it across the entire organization. (2)
☐	We are committed to permanently offering telehealth as a modality to deliver our health care services for all patients, clinicians, care teams, and locations and have or will implement it across the entire organization. We are all in! (3)

Leadership is engaged and has demonstrated engagement by actions such as identifying an implementation or dedicated telehealth team, supporting learning activities, including telehealth in strategic planning, considering budgetary and other impacts and more.

☐	There is little or no leadership engagement. (0)
☐	Leadership generally supports telehealth but has not taken specific actions to demonstrate engagement. (1)
☐	Leadership has indicated robust support of telehealth and has taken specific actions to demonstrate engagement. (2)

Our degree of overall degree of buy-in and endorsement of telehealth by our staff – inclusive of clinicians and care teams - is:

☐	Low – most are not onboard with implementing telehealth for the long term. (0)
☐	Medium – we have a mix of those who support it and are excited about the possibilities but also have several who either refuse to deliver telehealth or do it only reluctantly. (1)
☐	High – we have broad and almost complete buy-in and support by everyone. (2)

Training and Expertise

Training is important and purposeful practice through repeated telehealth visits builds expertise for clinicians, the care team, and others. Focusing on the needed skills and working to improve them over time is key but people need to learn the correct fundamental skills first.

Our telehealth training is:

☐	Nonexistent. (0)
☐	Ad hoc – we only provide training when we think it is needed. (1)
☐	In progress (internal) – we are working on developing an internal program. (2)
☐	In progress (external) – we are searching for a comprehensive, affordable/external free training program. (2)

Our method of assessing expertise, including comfort with navigation, workflows and the technology is:

☐	Nonexistent. (0)
☐	Provided when we hear there is a problem. (1)
☐	Provided when requested. (1)
☐	Assessed prior to implementation of any telehealth offering. (2)
☐	Provided until individuals are comfortable with their telehealth expertise and proficiency. (2)

Resource: The Northwest Regional Telehealth Resource Center has several high-quality and free online trainings.

Policy and Procedure

Creating policies and procedures (P&P) around telehealth ensures that those services are high-quality, safe, and equitable. Strong and well-done policies and procedures can also serve as training materials when onboarding new staff.

We have a telehealth policy and procedure in place.

☐	No. (0)
☐	No – but we are working on one. (1)
☐	Yes – but it is not broadly available to everyone. (2)
☐	Yes – and it is broadly available to everyone with review and updates on an annual basis. (3)

Each organization has a process for drafting, reviewing and approving P&Ps. Existing P&Ps (and possibly job descriptions) need to be reviewed to include telehealth, and new P&Ps need to be generated as the telehealth program begins. Know how this will unfold and how to share any changes or new P&Ps as it can be a matter of quality and patient and staff safety.

We have reviewed and updated existing P&Ps to ensure telehealth and virtual services considerations are included. We have developed the new and relevant P&Ps to ensure quality and safety.

☐	No. (0)
☐	No – but we are in the process of doing so. (1)
☐	Yes. (2)

Telehealth Triage

Not all visits are appropriate for telehealth visits. To keep patients safe, each organization needs a written triage protocol for which diagnoses, symptoms and other issues a telehealth visit is appropriate vs. those for which an in-person visit is required.

We have a telehealth visit triage protocol in place.

☐	No. (0)
☐	No – but we are working on one. (1)
Yes – and it is (choose all that apply):	
☐	Readily available to all staff (1)
☐	Made available to patients (e.g., handout, on website, shared by social media) (1)
☐	Approved by medical staff (1)

Patients

A poorly designed, inefficient telehealth program results in lack of use and high no show rates. It is important to know how your patients' telehealth experience and to continually improve with the important Lean principle top of mind: define value from our customers' perspective.

We have support in place to help patients easily engage in telehealth visits, including offering test telehealth visits to reduce apprehension and build proficiency.

☐	No. (0)
☐	No – but we are working on one. (1)
☐	Yes – but we do not have a system of feedback from our patients, families, and caregivers on how we need to improve. (2)
☐	Yes – and we have an easy way for people in our telehealth program – those receiving (and delivering) telehealth – to provide feedback that we act upon to continually improve the telehealth experience. (3)

To engage in telehealth, patients need the following:

- Private, quiet, safe space
- Device with camera and microphone
- Stable internet with adequate bandwidth
- Help for limited digital proficiency

With creativity, innovation and community-based solutions, organizations can help overcome patients' barriers to telehealth.

☐	We are not currently working to find solutions to patients' barriers to engage in telehealth visits. (0)
We have or are working to find solutions for patients for the following barriers (choose all that apply):	
☐	Private, quiet, safe place to engage in a telehealth visit (e.g., library, place of worship, employer) (1)
☐	Device with camera and phone (e.g., telehealth kiosk within the community, staff bring device to patient) (1)
☐	Stable internet with adequate bandwidth (e.g., free, or reduced fee options for internet, community-based solution, mobile hot spot) (1)
☐	Help with limited digital proficiency (e.g., staff or community health workers go to where patient is) (1)
☐	Back-up plan or protocol if telehealth visit is scheduled, and patient, provider or care team is unable to engage in telehealth visit (1)

We keep track of which patients are or are not able to engage in telehealth, including what their specific barrier(s) is/are, in similar fashion to how we track social determinants of health. Best practice is to capture this information as structured data. Ideally an organization will run data on their telehealth-enabled patients and work to improve the percent that are able to engage in telehealth (provided that is the preference of the patient).

☐	No. (0)
☐	No – but we are working on finding a solution to do this. (1)
☐	Yes. (2)

Resource: See Northwest Regional Telehealth Resource Center Patient Resources for a Patient Telehealth Checklist and more.

Suite of Telehealth Services

The organization or team needs to outline the telehealth service delivery "package" or list of specific services that will be delivered to patients. An additional consideration is for scenarios when the organization or clinic sites will act as originating sites (where the patient is) for receiving telehealth services.

As a distant site (where the provider is). We have carefully reviewed the current and full set of telehealth services and codes listed on the Centers for Medicare & Medicaid (CMS) List of Services and have a selected from that list the set of services that align with the same or similar in-person visits/services that we offer.

☐	No. (0)
☐	N/A because we cannot act as a distant site. (0)
☐	No – we *can* act as a distant site but don't currently offer telehealth; we are in the process of implementing telehealth and assessing the full set of telehealth services that we can offer. (1)
☐	Mostly – we offer telehealth services but have not assessed if there are additional codes/services that we can deliver by telehealth. (2)
☐	Yes. (3)

As an originating site (where the patient is). We have identified the full range of possible telehealth visit options that our patients could receive – either at one of our clinic sites, in their homes or if the patient is located elsewhere. (See list below for guidance or inspiration.)

☐	No. (0)
☐	No – but we are in the process of doing so. (1)
☐	Yes. (2)

We have assessed which, if any, insurers will reimburse an originating site fee (~ $27) when our organization is the originating site for a telehealth visit (e.g., visit with a specialist).

☐	No. (0)
☐	N/A because we cannot act as an originating site. (0)
☐	No – but we are in the process of doing so. (1)
☐	Yes. (2)

The current health care services that we offer by telehealth are (check all that apply) – note that a comprehensive list is included to accommodate as many options as possible but also to demonstrate the range of possibilities for telehealth.

- ☐ Addiction medicine (substance use disorders)
- ☐ Allergy and/or Immunology
- ☐ Audiology
- ☐ Autism
- ☐ Bariatric medicine
- ☐ Burn/Wound care
- ☐ Behavioral/mental health
- ☐ Cardiology
- ☐ Chronic disease management
- ☐ Dementia
- ☐ Dentistry
- ☐ Dermatology
- ☐ Emergency medicine
- ☐ Endocrinology/Diabetes
- ☐ Gastroenterology
- ☐ Genetics/genetic counseling
- ☐ Geriatrics
- ☐ Gynecology/Women's Health
- ☐ Hematology
- ☐ Hepatology
- ☐ Home health/care
- ☐ Hospice/palliative care
- ☐ Hospitalist
- ☐ Infectious disease
- ☐ Integrative medicine
- ☐ ICU (intensive care unit)
- ☐ Internal medicine
- ☐ Long-term care
- ☐ Medication-assisted treatment
- ☐ Microbiology
- ☐ Mobile health (mHealth)
- ☐ Neonatology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuro-psychological testing
- ☐ Nursing
- ☐ Nutrition/obesity
- ☐ Obstetrics
- ☐ Occupational medicine
- ☐ Oncology
- ☐ Ophthalmology
- ☐ Orthopedic surgery
- ☐ Otorhinolaryngology (ENT)
- ☐ Pain management
- ☐ Pathology
- ☐ Remote patient monitoring
- ☐ Pediatrics
- ☐ Pharmacy
- ☐ Physical/occupational therapy
- ☐ Podiatry
- ☐ Primary care
- ☐ Psychiatry
- ☐ Psychology
- ☐ Pulmonology
- ☐ Radiology
- ☐ Rehabilitation
- ☐ Rheumatology
- ☐ School-based services
- ☐ Speech-Language pathology
- ☐ Sleep medicine
- ☐ Stroke
- ☐ Surgery
- ☐ Toxicology
- ☐ Trauma
- ☐ Urgent care
- ☐ Urology
- ☐ Other

Billing and Reimbursement

We have identified the places of service, modifiers and other telehealth billing requirements for the telehealth codes we are using for each of our patients' insurers (e.g., Medicare - CMS List of Services , state Medicaid agency – refer to Center for Connected Health Policy state pages for state-specific billing information, private/commercial insurer).

☐	No. (0)
☐	No – but we are in the process of doing so. (1)
☐	Yes. (2)

Workflow

Efficient, person-centered workflows are one of the most important aspects of a successful telehealth program and it is also the aspect that most organizations and teams struggle to streamline, standardize, and continually improve.

We have standard workflows in place for

- **Before the visit** (e.g., scheduling, ensuring patients have what's need for a telehealth visit),
- **During the visit** (e.g., completing intake by MA/nurse, documenting in the medical record, ensuring technology is working and back-up plan if not), and
- **After the visit** (e.g., sending written plan to patient/caregiver, coordinating follow-ups, sending referral information). We have identified and put in writing (e.g., Word, Visio, PowerPoint) our key workflows for all individuals involved from scheduling to billing and for every person/role, including reception staff, clinicians, care team, patient and family.

☐	No. (0)
☐	No – but we are working on workflows. (1)
☐	Yes – but not everyone can easily access them to ensure the workflow is consistently and sustainably implemented across all care teams. (2)
☐	Yes – and we have made sure we review the workflows; they are easily accessible to everyone, and; we monitor to ensure staff adhere to workflows and adjust based on feedback from those whom the workflows impact (including patients). (3)

Documentation

While documentation for a telehealth visit should include all of the same components of the equivalent in-person visit, there a few additional key components, including but not limited to:

- **Start and end times.** Because physical exams are difficult (but not impossible for certain anatomy), most telehealth office visits – evaluation and management visits – will likely be billed by time rather than medical decision-making complexity. Note the new time-based determinations for office or other outpatient services (including when they are delivered by telehealth visits), starting Jan 1, 2021.
- **Patient exact location/address.** Important in case patient suffers an adverse event and emergency services need to be called.
- **Consent.** Medicare, most state Medicaid agencies and other insurers require patients' informed consent for telehealth.
- **Participants.** All participants on the telehealth visit should be documented in the medical record, including patients, family, care givers, clinician(s), care team members, and more. (This will be increasingly important for risk management in the future.)

We have identified standard processes for documentation during a telehealth visit with assigned roles and responsibilities for the above at a minimum.

☐	No. (0)
☐	No – but we are in the process of doing so. (1)
☐	Yes. (2)

Hardware

We have all the devices with camera and microphones (with headsets, if needed) for our clinicians, care teams and others who will participate in telehealth visits.

☐	No. (0)
☐	No – but we are in the process of doing so. (1)
☐	Yes. (2)

Peripherals. Peripherals are devices that are used to collect patient biometrics and physical exam information between and/or during a telehealth visit. Examples include stethoscopes, fetal dopplers for babies' heart rate, otoscopes, lighted tongue depressors to visualize the oropharynx and more.

We have assessed the need for peripherals and budget needed to purchase what our clinical staff would like to have, or we already have in place what is needed.

☐	No. (0)
☐	No – but we are in the process of doing so. (1)
☐	Yes. (2)

Software

Selection of a telehealth "platform" does not need to be complicated or expensive, nor does it need to be a platform per se or be integrated into the EHR as long as clinicians have easy access to patients' medical records and can document easily (i.e., they may need a second screen).

We have selected a HIPAA-compliant telehealth solution that works well for all parties involved in our telehealth visits. Note – the assumption is that the organization has signed a Business Associates Agreement (BAA) if the solution is HIPAA-compliant. (For information on BAAs and definitions please see Business Associates Contracts – Sample Business Associate Agreement Provisions from the U.S. Department of Health & Human Services – Office for Civil Rights)

☐	No. (0)
☐	No – but we are in the process of doing so. (1)
☐	Yes. (2)

Broadband and Connectivity

We have ensured that our broadband speed and reliability is sufficient to support both audio and video for a glitch-free telehealth visit, regardless of whether we are the distant or originating site, throughout all locations, including for clinicians and care teams not onsite that will engage in telehealth.

☐	No. (0)
☐	No – but we are in the process of doing so. (1)
☐	Yes. (2)

We have a process to assess whether each patient has (or has access to) broadband or a data plan to support both audio and video for a glitch-free telehealth visit (ideally captured in the patient chart for future reference).

☐	No. (0)
☐	No – but we are in the process of doing so. (A good rule of thumb is that connectivity is adequate if the patient can watch live-streaming videos.) (1)
☐	Yes. (2)

Resource: The Federal Communications Commission identifies a speed of ≥ 25 Mbps download/3 Mbps upload for fixed broadband as a minimum performance benchmark. There are many resources for checking broadband speed, including the speed test option from the Utah Education and Telehealth Network.

Communication about Telehealth

We have multiple ways for patients to learn about telehealth (e.g., messaging when they call to schedule a visit, website, social media)

☐	No. (0)
☐	No – but we are in the process of getting the word out in multiple ways. (1)
☐	Yes. (2)

We have a strong system of communication within our organization to ensure effective communication about the telehealth program to providers and other staff.

☐	No. (0)
☐	No – but we are in the process of developing communication methods that work for our staff. (1)
☐	Yes. (2)

Quality Assurance

Each person should have the same high-quality telehealth experience, regardless of several variables (e.g., workflows, devices, clinicians, support staff). Monitoring the quality of telehealth visits (e.g., patient/staff satisfaction surveys, peer-review of the telehealth session to provide constructive feedback) and acting on improvement opportunities is one of the keys to ensuring quality assurance.

We have a process in place to ensure that everyone has a high-quality telehealth experience within the confines of what we can control

☐	No. (0)
☐	No – but we are in the process of doing so. (1)
☐	Yes. (2)

Quality Improvement

We have a set of process and outcome measures in place to monitor the safety, quality and effectiveness of telehealth.

☐	No. (0)
☐	No – but we are in the process of doing so. (1)
☐	Yes. (2)

HIPAA Privacy and Security

There are several unique and new privacy and security concerns when implementing telehealth services. However, HIPAA also requires that health care organizations have a dedicated Privacy Officer and Security Officer (sometimes the same individual), who should be diligent about identifying and mitigating any risks. Note that this is not legal advice nor is this checklist comprehensive by any means.

HIPAA Privacy

Telehealth and audio-only interactions can occur in areas that risk others overhearing either one or both sides of a conversation, especially if there is not a dedicated, private space like an exam room for these encounters. Note that a best practice is to post a sign to ensure patient privacy (e.g., "Telehealth Session in Progress").

Clinicians and other staff have headset or earbuds to ensure conversation cannot be heard by others.

☐	No. (0)
☐	No – but we are in the process of purchasing what is needed to ensure clinicians and all other staff engaged in virtual care have headsets/earbuds. (1)
☐	Yes. (2)

Privacy screens are provided to clinicians and other staff working from home or other offsite locations.

☐	No. (0)
☐	No – but we are in the process of assessing who needs the screens and/or are in the process of providing them. (1)
☐	Yes. (2)

HIPAA Security

Implementing telehealth opens new vulnerabilities that need to be identified and addressed. Security is further complicated when clinicians, care teams and others work from home or other locations. Below is somewhat of a check to ensure that necessary provisions and analyses are in place, but ultimately it is the responsibility of the designated Security Official at the health care organization.

Check all that apply (1 point each).

☐	Our designated Security Officer (required by HIPAA) has updated all relevant HIPAA standards and implementation specifications in our security risk analysis to include changes we have made with telehealth and other virtual services.
☐	The Security Officer has provided security training to all staff with additional training for individuals delivering or supporting telehealth offsite.
☐	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[2]
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.

[2] 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

☐	Can be remotely wiped and/or disabled (in the event of theft or loss of device(s)).
☐	Are protected by a firewall whenever possible.
☐	Have updated security software.

Score = 0

As a reminder, here are the levels of telehealth implementation and adoption that are associated with your score.

Level of Telehealth Implementation & Adoption	Score
Level 1 – Contemplation & Preparation	0 – 15
Level 2 – Early Implementation & Adoption	16 – 50
Level 3 – Mature Implementation & Adoption	51 – 78

Additional Virtual Services

While the sections above are very specific to telehealth – the discrete set of codes and services defined within the CMS List of Services, there are additional opportunities to expand the suite of virtual services to enhance access, meet patients' needs, optimize care, and capture revenue. This bonus section includes some but not all of those opportunities. The scores from this section of the assessment are not included in the calculations because they do not technically fall into what we traditionally call telehealth.

Virtual Communication Services

There are three opportunities that fall under virtual communication services. The information below is specific to RHCs and FQHCs. For all of the three Virtual Communication Services below:

- Use G0071
- Obtain consent, which must be documented in the medical record, which can be obtained at the time of services and by staff under the general supervision of the FQHC provider (only during the PHE for the latter two)
- Adhere to "7/24" rules noted above in Telephone-Only E/M services
- Must be patient-initiated

1. **Virtual Check-Ins – Phone Call**. Five to ten minutes of medical discussion described as a brief communication technology-based service (audio-only real-time telephone interactions) by a physician or other qualified health care professional who can report evaluation and management services. This is a great option to determine if a patient needs a virtual or in-person office visit.
2. **Store and Forward - Remote Evaluation of Recorded Video and/or Images**. Includes interpretation with follow-up with the patient within 24 business hours.
3. **E-Visits** are online digital evaluation and management services that are provided over a 7-day period and are non-face-to-face, digital communications using a secure patient portal.

☐	We are unfamiliar with these services.
☐	We know what these services are but have not explored the details or requirements to implement and capture reimbursement.
☐	We have explored the details of these services but have decided not to implement them because (insert reason):
☐	We are in the process of implementing or have partially implemented these services.
☐	We have fully implemented these services.

Resources:

1. Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions. CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf
2. CMS Virtual Check-In Patient Page. CMS. https://www.medicare.gov/coverage/virtual-check-ins
3. New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE. CMS. See "Expansion of Virtual Communication Services". Information current through Dec 31, 2021. https://www.cms.gov/files/document/se20016.pdf

Chronic and Principal Care Management Services

Chronic and principal care management services are an excellent way for health care organizations to provide and be reimbursed for care management and care coordination for certain patients. Medicare reimburses for these services for beneficiaries that fulfill the requirements. Some state Medicaid agencies and private insurers also provide reimbursement for these services. These services are provided on a monthly basis and can be billed once the required time is reached for the respective billing code.

☐	We are unfamiliar with these services.
☐	We know what these services are but have not explored the details or requirements to implement and capture reimbursement.
☐	We have explored the details of these services but have decided not to implement them because (insert reason):
☐	We are in the process of implementing or have partially implemented these services.
☐	We have fully implemented these services.

Resources:

1. Chronic Care Management (CCM). CMS. https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management
2. Principal Care Management (PCM) Services in RHCs and FQHCs. CMS. https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center
3. Care Management (also Advance Care Planning, Behavioral Health Integration and Transitional Care Management). CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment PhysicianFeeSched/Care-Management
4. Chronic & Principal Care Management: Implementation Guidance https://nrtrc.org/resources/resources.shtml#cah
5. CCM Services CMS. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
6. Care Coordination Services and Payment for RHCs and FQHCs. CMS. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10175.pdf
7. Care Management Services in RHCs and FQHCs – FAQs. CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Behavioral Health Integration & Psychiatric Collaborative Care Services

These two services are very similar to the CCM and PCM services above but are focused on providing mental health services.

☐	We are unfamiliar with these services.
☐	We know what these services are but have not explored the details or requirements to implement and capture reimbursement.
☐	We have explored the details of these services but have decided not to implement them because (insert reason):
☐	We are in the process of implementing or have partially implemented these services.
☐	We have fully implemented these services.

Resources:

1. Cheat Sheet on CMS Medicare Payments for Behavioral Health Integration Services - Federally Qualified Health Centers and Rural Health Clinics. University of Washington AIMS Center. 2019. https://aims.uw.edu/sites/default/files/CMS_FinalRule_FQHCs-RHCs_CheatSheet.pdf
2. Behavioral Health Integration Services – MLN Booklet. CMS. Updated March 2021. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Interprofessional Consultation

This patient-centered option for referrals for consults is underutilized and is a great option for clinicians and their patients, living in rural areas, as long as the patient does not need to be seen in person. Medicare does not reimburse RHCs or FQHCs for any of the interprofessional consultation codes, but it is a great option to expand access and serve patients. For each specialist, consider whether an IC is most appropriate and ascertain if the specialist is willing to engage in an IC.

☐	We are unfamiliar with these services.
☐	We know what these services are but have not explored the details or requirements to implement and capture reimbursement.
☐	We have explored the details of these services but have decided not to implement them because (insert reason):
☐	We are in the process of implementing or have partially implemented these services.
☐	We have fully implemented these services.

Resource:

Interprofessional Consultation – A Patient-Centered Referral Option. NRTRC and Comagine Health. https://nrtrc.org/resources/resources.shtml#cah

Remote Physiologic (or Patient Monitoring) (RPM)

RPM is the one virtual service that has the greatest potential to reduce emergency department visits, admissions and readmissions. Monitoring appetite, mental changes, biometrics, etc. through software platforms or apps with virtual daily check-ins to monitor for potential issues can be helpful, especially if specific care

instructions and/or reminders regarding hygiene and/or medications are included[3]. RPM is a great addition to self-management support for patients. While Medicare does not currently reimburse RHCs and FQHCs, these organizations can often include and bill for these services as part of Chronic Care Management. Check the fee schedules of your state Medicaid agency to see if RPM codes are listed as covered services.

There are at least three versions of RPM to keep distinct.

1. RPM as defined by Medicare, includes five billing codes and have several conditions and requirements. These RPM services require that "the medical device should digitally (that is, automatically) upload patient physiologic data (that is, data are not patient self-recorded and/or self-reported)"[4], which is not the case for the 2 and 3 below.
2. Medicare reimburses for other RPM services (e.g., self-measured blood pressure monitoring and continuous glucose monitoring (CGM), and ambulatory blood pressure monitoring) that don't technically fall under their RPM definition from 1 above.
3. Remote patient monitoring that may or may not be "physiologic" can be a great adjunct for chronic disease and other self-management and may include regular check-ins, reminders, diet logs and so much more. With the explosion of patient health apps, the possibilities continue to expand.

☐	We are unfamiliar with these services.
☐	We know what these services are but have not explored the details or requirements to implement and capture reimbursement.
☐	We have explored the details of these services but have decided not to implement them because (insert reason):
☐	We are in the process of implementing or have partially implemented these services.
☐	We have fully implemented these services.

Resources:

1. Remote Physiologic Monitoring. NRTRC and Comagine Health. https://nrtrc.org/resources/resources.shtml#cah
2. American Medical Association Digital Health Implementation Playbook (aka Remote Patient Monitoring Implementation Playbook) https://www.ama-assn.org/system/files/2018-12/digital-health-implementation-playbook.pdf

[3] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency – Interim Final Rule. CMS. April 2020. p. 19249.
[4] Calendar Year 2021 Physician Fee Schedule Final Rule (CY 2021 PFS FR) p. 84543