A PRACTICAL GUIDE TO TELEHEALTH

IMPLEMENTING TELEHEALTH IN POST-ACUTE AND LONG-TERM CARE SETTINGS (PALTC)

IMPLEMENTING TELEHEALTH IN POST-ACUTE AND LONG-TERM CARE SETTINGS

By the year 2030, nearly 20 percent of Americans will be 65 or older. The gift of longevity and population growth will strain access to our already overburdened healthcare system. This is particularly true for older adults in post-acute and long-term care settings. The expanding senior population, shortages of providers, and skyrocketing costs will push our healthcare system to the breaking point. With the rise of telehealth, we have an extraordinary opportunity to build a more sustainable and more effective healthcare future.

Telehealth is one of the most exciting developments available to help increase access to care. By employing a cost-efficient care delivery model, telehealth improves care coordination and achieves positive health outcomes for older patients, while supporting medical providers. It allows seniors to receive care where they prefer—in their homes and communities—and, it enables medical providers to address changes in their patients' conditions in a timely manner.

Telehealth also brings specialty care and other health services that were previously inaccessible to seniors into long-term care settings. Ultimately, it offers a pathway to more comprehensive, patient-centered and accessible care that better serves our communities and protects our most vulnerable citizens.

Telehealth programs have the potential to completely change the game—but they need to be scaled, structured, fully-deployed and disseminated. Every healthcare organization that treats patients in post-acute and long-term care settings must begin planning for a future that implements telehealth using practices to improve patient outcomes. Every senior deserves effective, low-cost care, and with telehealth advances, every healthcare organization has the opportunity to provide it.

That's why West Health brought together the most knowledgeable experts and organizations to create this first-of-its-kind telehealth implementation manual. In the following pages, you will find information you need to successfully implement a telehealth program, including advice from experts at leading telehealth organizations in post-acute and long-term care settings.

We cover a range of topics in detail to help you understand the specifics of the technology's use, the broader landscape of telehealth, and how you can tailor these innovations to your organization's requirements. From needs and readiness assessments, to reimbursement models and performance monitoring, we have created a comprehensive guide for effective telehealth program implementation.

As our healthcare system undergoes a rapid and historic shift, telehealth offers a way for medical providers not only to evolve, but to thrive. We are proud to share this guide, and we are excited to partner with you as we take these vital next steps into the future of healthcare.

SHELLEY LYFORD
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Chief Medical Officer and
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JUST THE FACTS

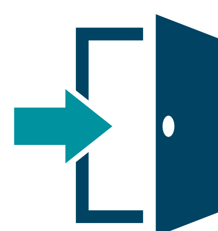
IS PROJECTED TO AGE SIGNIFICANTLY OVER THE NEXT 10 YEARS WITH **20%** OF ITS POPULATION AGE 65 AND OVER BY 2030[1]

AMONG PEOPLE WHO REACH AGE 65, **MORE THAN TWO-THIRDS** WILL NEED LONG-TERM CARE SERVICES DURING THEIR LIFETIME, AND THEY HAVE A 46% CHANCE OF SPENDING TIME IN A NURSING HOME[2]

MEDICARE SPENT NEARLY **60 BILLION** ANNUALLY ON POST-ACUTE CARE SERVICES, ROUGHLY 15%[3]

23% OF PATIENTS IN SKILLED NURSING FACILITIES (SNFS) ARE **REHOSPITALIZED WITHIN 30 DAYS**[4]

SNFS HAVE AN **8% RATE** OF POTENTIALLY AVOIDABLE READMISSIONS[5]



[1] www.census.gov/newsroom/press-releases/2014/cb14-84.html
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[3] www.medpac.gov/docs/default-source/data-book/jun18_databooksec8_sec.pdf?sfvrsn=0
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CHAPTER 1

NEEDS ASSESSMENT

AT-A-GLANCE

This chapter will guide your PALTC facility through the process of conducting an initial needs assessment. A needs assessment is a critical first step before launching any new initiative, and our goal is to lead you through this process with practical information.

WHAT:

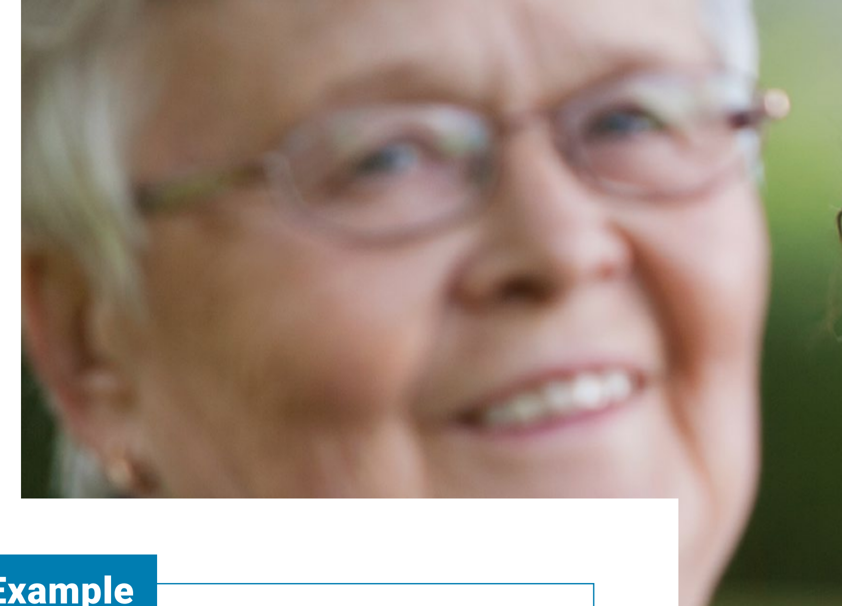
A needs assessment helps identify any unmet needs, examine their potential causes, and define priorities for future action. This assessment will also help inform how best to allocate available resources to provide value for your organization.

WHY:

In a PALTC setting, the purpose of a needs assessment is to identify unmet needs and how they may be addressed before considering any new services. Rollout of a new program can be complex, costly, and labor intensive. Conducting a needs assessment is critical to ensuring any new programs are designed with specific goals in mind to help identify potential challenges that may arise.

WHO:

Site leadership (e.g., administrators), clinical staff (e.g., medical director, nurses, social workers, nursing assistants), residents, and family members.



Real-world Example

Beatrice Winters is an 86-year-old resident at Sunny Hill Nursing Home. Last night, she had a low-grade fever, chills, and lower abdominal pain. Beatrice immediately alerted her nurse, Wendy. Wendy called the on-call medical provider, Dr. Jones, who returned the call an hour later.

Dr. Jones told Wendy that he had never seen Beatrice and felt that the best course of action would be to send Beatrice to the emergency department (ED). Beatrice did not want to go to the ED in the middle of the night, especially since her family would now get a call to come meet her at the hospital, but she reluctantly accepted.

Ten hours later, Beatrice was sent back from the ED to Sunny Hill. Upset with the entire experience, Beatrice complained of the uncomfortable ride that made her carsick, the hours she waited in the ED, and bruising from the IV. Beatrice was prescribed an oral antibiotic to treat a urinary tract infection and she was instructed to follow up with her primary care provider.

A few days later, the medical director at the facility, Dr. Walters, reviewed Beatrice's chart and realized she could have been treated in place. Beatrice's experience prompted Dr. Walters to conduct a quality review of all ED transfers.

She discovered that Sunny Hill Nursing Home had a three-fold increase in ED transfers over the past two years. Upon further examination, she found that a high percentage of these transfers happened after hours for acute change of condition.

A needs assessment generally includes three phases addressed in a set order. First, an environmental scan helps organizations better understand where there are unmet needs. Second, data collection and analyses focus on gathering and interpreting information about your organization's current operations. Third, alignment of needs with strategy focuses on how to determine the fit between identified needs and the resources necessary to operationalize a program. These phases are described in detail throughout this chapter, and an example Needs Assessment Questionnaire is provided in the Chapter 1 Appendix.

FIGURE 1: Needs Assessment Components

ENVIRONMENTAL SCAN

- Immediate needs
- Value
- Competitive landscape
- Organizational roles

DATA COLLECTION AND ANALYSIS

- Organizational details
- Data collection
- Root causes
- Summary report

ALIGNMENT AND STRATEGY

- Strategic plan
- Timeline
- Budget

PHASE I: ENVIRONMENTAL SCAN

The purpose of an environmental scan is to identify the needs of your organization based on input from multiple stakeholders. When conducting an environmental scan, it is important to avoid making assumptions about specific solutions or interventions to ensure you have an unbiased understanding of opportunities.

Immediate Needs
Identify your organization's short-term priorities based on importance and overall goals. For example, improving ease of access to a provider can reduce Potentially Avoidable Hospitalizations (PAHs). Understanding current PAH rates, determining how PAHs are defined, and setting appropriate goals for reducing PAHs will help define your organization's specific needs.

Although these needs will vary across organizations, when planning new services or programs within PALTC settings, the following are common areas to consider:

- Timeliness of care – How quickly can you access needed services?
- Staff satisfaction – Will the program reduce the burden on your staff?
- Provider satisfaction and efficiency – Will the program reduce workload and stress for medical providers?
- Access to care – Will the program offer your residents new specialty services?
- Cost – Will the program decrease costs?

TIP:

Timely access to care is one of the most common needs in PALTC, especially after hours when medical providers are often off-site or less available.

When assessing needs at your organization, the findings will likely include both clinical and nonclinical needs. To obtain the findings, it is necessary to elicit perspectives and information from multiple stakeholders such as:

- Administration and leadership;
- Direct care staff (e.g., RNs, LVNs, and LPNs);
- Information technology (IT) staff;
- Other ancillary staff (e.g., social services, consultant pharmacist, housekeeping, dietary);
- Residents, family, and caregivers;
- Community and local providers (e.g., local emergency departments and medical providers); and/or
- Pertinent local, state, and national professional organizations via guidelines, white papers, and position statements (e.g., Agency of Aging, American Heart Association, American Geriatrics Association).

Value
Once priorities have been identified, it is important to understand how your organization defines "value." When organizations define value with consideration given to the perspectives of residents, staff, and families, they can more effectively strike a balance between priorities and needs. For example, residents and family members may be most interested in access to specialty providers, whereas providers may value programs that reduce after-hours calls. Ultimately, determining whether any new initiative provides value is the best measuring stick for judging the concept. That is why it is important to define value up front and ensure all staff, especially leadership, understand how value is being defined. For example, in the case of readmissions and ED revisits, one way to define value may be in reducing the number of PAHs.

Competitive Landscape
Understanding market forces, such as services offered at nearby facilities, is another approach to identifying potential needs. Understanding local competitors will help uncover opportunities for your facility. The following strategies will allow you to compare how and where your organization stands:

- Understanding the market penetration of your facility.
- Understanding the local market, based on Center for Medicare and Medicaid (CMS) 5-Star ratings for your region's facilities.

Once competitors are identified, understanding the services they offer will help identify potential areas for your organization to consider. For example, your organization may determine that one way to secure market share is by establishing preferred partnerships with local, acute-care centers.

Organizational Roles
Each organization is likely to have differences in staff roles, despite similar titles, so understanding needs based on your organization's specific role responsibilities is critical. Below are common roles at most PALTC facilities and considerations for your needs assessment:

- Medical Director: How much time do they spend on administrative leadership versus clinical resident care?
- Nurses: What is the average nurse-to-resident ratio and the parameters of responsibility?
- Care Team Members: What are the responsibilities of various members (e.g., social worker, dietician, pharmacist) of the care team?
- Technology: What is the IT infrastructure in your building and community? What is your facility's IT support structure?
- Leadership: How open to change is the leadership team? What is the leadership team's relationship with the local provider teams and/or other health care organizations?
- Parent Organization: If your facility is part of a larger enterprise, what is the role of your PALTC setting in support of the overall organization?
- Medical Providers: How collaborative are they with other members in your organization?

PHASE II: DATA COLLECTION AND ANALYSIS

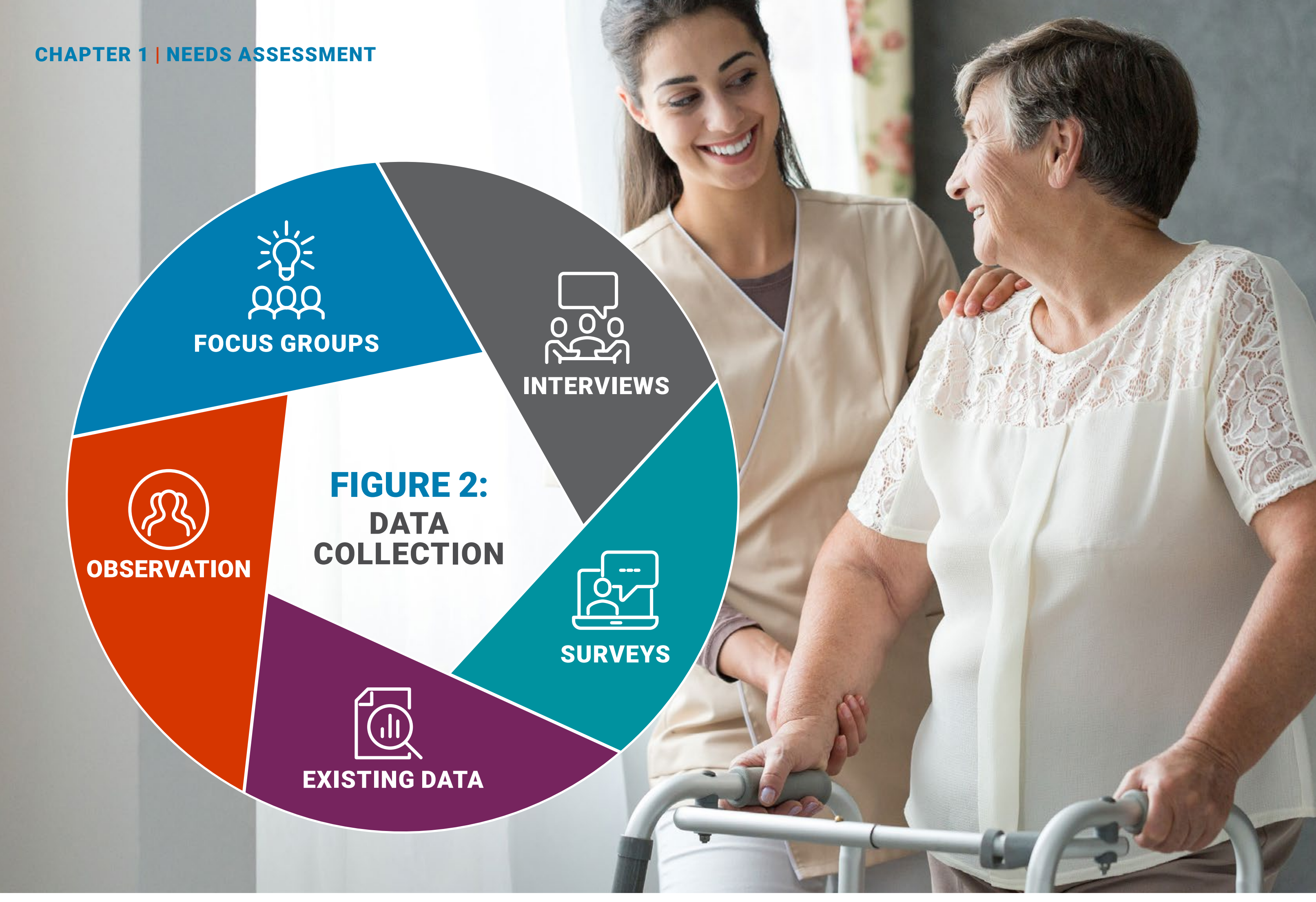
The goal of Phase II is to gather information to help understand current operational and administrative characteristics at your organization. Approaching this process strategically with focus on the areas outlined in the environmental scan will help identify current administrative and operational characteristics at your organization.

Organizational Details
Before capturing any data or collecting information, outline the basic organizational details to help put any additional information you gather into context. We recommend starting with the following standard metrics, which help provide a general profile of your organization:

- Provider- and nurse-to-resident ratios,
- Resident acuity,
- Nursing staff hours per resident per day,
- Number of beds at the facility and how many are occupied,
- Distribution of beds for long-term and short-term stays,
- Medical Provider hours,
- Specialty medicine availability,
- Number of hospital-preferred providers,
- Nurse-to-provider model variations ,
- Number of in-house and community providers, and
- Staff turnover rate.

Additional organizational details to consider:

- On-site access to supply of emergency medications (e.g., e-kit contents);
- On-site intravenous insertion capability and access to vendor or insertion of midline or PICC line;
- Pharmacy delivery turnaround time;
- On-site access to EKG, lab, or imaging services;
- Utilization of an electronic medical records;
- Length of stay by population (e.g., custodial, skilled nursing, transitional care, hospice, subacute);
- Feeder entities (e.g., hospitals, long-term acute care facilities, physician offices, EDs); and
- Payer mix, by population (e.g., Medicare, Medicaid, Accountable Care Organizations (ACOs), private insurers).



Data Collection
It is also important to gather information from your organization's staff, residents, and families. Consider using the following approaches, either individually or in some combination.

Focus Groups are small-group discussions lead by a facilitator that ideally create an open and safe environment so that participants feel free to express their honest opinions. These discussions can yield valuable information in a relatively short time. Examples of focus group forums are resident and family education nights and resident council meetings.

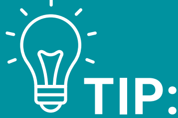
Interviews can be conducted with frontline staff, directors, current or past residents, resident representatives, or providers. Interviews should include a variety of open-ended questions to address emerging themes. For example, the interviewer may seek to better understand residents' needs rather than asking for solutions to problems. The following are example interview questions for residents:

- What health care needs do you (i.e., residents) wish someone would help you with?
- If you miss appointments, why (e.g., cost, arranging rides, discomfort with transport, other barriers)?
- Is your family or caregiver being appropriately informed of your care?

Surveys can be conducted individually with residents and families, in focus groups, and with staff to address remaining questions. Surveys typically have low response rates so keep them brief and simple to increase completion rates. The following are example questions, in this case for staff:

- I face challenges in providing care to residents. Yes or No?
- I oversee a manageable number of residents each day. Yes or No?
- I feel supported by leadership staff at my organization. Yes or No?

Existing Data Sources such as details gathered from resident charts and electronic record systems provide a rich source of information that can serve as indicators or metrics. For instance, understanding data such as ED transfers, PAHs, average monthly census, acuity levels, and specialty services will help pinpoint areas of need and those requiring attention.



TIP:

Utilize the Minimum Data Set (MDS), to help uncover potential unmet needs. The MDS includes an assessment of each resident's functional capabilities. Your MDS Coordinator should be able to help you access these reports from the Quality Improvement and Evaluation (QIES) Certification and Survey Provider Enhanced Reports (CASPER) system or utilize the Centers for Medicare & Medicaid Services (CMS) Five-Star Helpline (1-800-839-9290).

Observation is an inexpensive and useful data collection method that requires only staff time and note-taking skills. This approach is recommended for assessing technology infrastructure, clinical workflows, and resident satisfaction metrics. The downside of direct observation is that individuals may act differently when they are being observed.

Analysis

Once data are collected, the next step is to try to understand why some needs remain unmet. This is especially critical for needs that have existed for a long period of time. For example, when trying to understand ED or hospital transfer rates at your organization, it may be helpful to examine transfer rates by month to understand patterns in seasonal variation. Furthermore, you may find that transfer rates are consistently higher during the winter months, which may coincide with flu season or times when there is a higher frequency of visitors at your organization.

Attempting to understand the reason behind areas of unmet needs will help your organization know whether those needs can be addressed using existing resources or will require external support. This will also help set expectations in terms of how long it may take to address these needs. Some gaps in care or opportunities to improve service provision may be addressed with adjustments to existing workflows or improved communication, while others may warrant new services and take more time and resources.

Summary Report

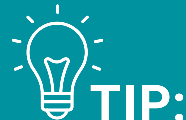
Following data collection and analyses, creating a needs assessment will provide key personnel and leadership with the necessary information to move to Phase III. The purpose of the final report is to convey your findings based on your interpretation of the information gathered and analyzed in Phase II. Once a final report is developed, set aside time with your leadership team to review findings from the needs assessment.

PHASE III: ALIGNMENT AND STRATEGY

The goal of Phase III is to align needs with solutions and develop a strategic plan, including developing a budget and timeline.

Strategic Plan

Using information from the environmental scan and data collection, you are well positioned to develop a strategic plan to help define needed services. Include descriptions of the potential solution(s), rationale, proposed timelines, and resource requirements. For example, consider your resource limitations (e.g., IT infrastructure) when determining the feasibility of potential solutions or services.



TIP:

Identify and incorporate state and local requirements while developing a strategic plan. The process of credentialing and licensing may vary across organizations and states.

When assessing your needs and developing a strategic plan for services, consider where services such as telehealth may be most beneficial, but also where it may not be appropriate. For example, areas where telehealth is most likely to provide benefit to your site may include:

- Avoidable hospitalizations;
- Change in condition consultations;
- Consultation with medical subspecialists;
- Quality of Care (e.g., falls protocol, diabetes management); and
- Other clinical needs, including:
    - Advanced directives,
    - Palliative care consultation,
    - Care coordination,
    - Care plan goals,
    - Case-based education, and
    - Family care conferencing.

Alternatively, telehealth may not be suitable for:

- Admissions review,
- Long-term narcotic prescribing, and
- Capacity assessments.

Budget and Timeline
Budget and an accompanying timeline are important elements of every strategic plan. When developing your budget, ensure that you consider external factors such as:

- Health Resources and Services Administration (HRSA) funding,
- State reimbursement policies, and
- Local payer funding.

For additional information on business models and financial considerations, please refer to Chapter 3. Ultimately, a strategic plan should outline an estimated timeline in alignment with your organization's budget and implementation goals.

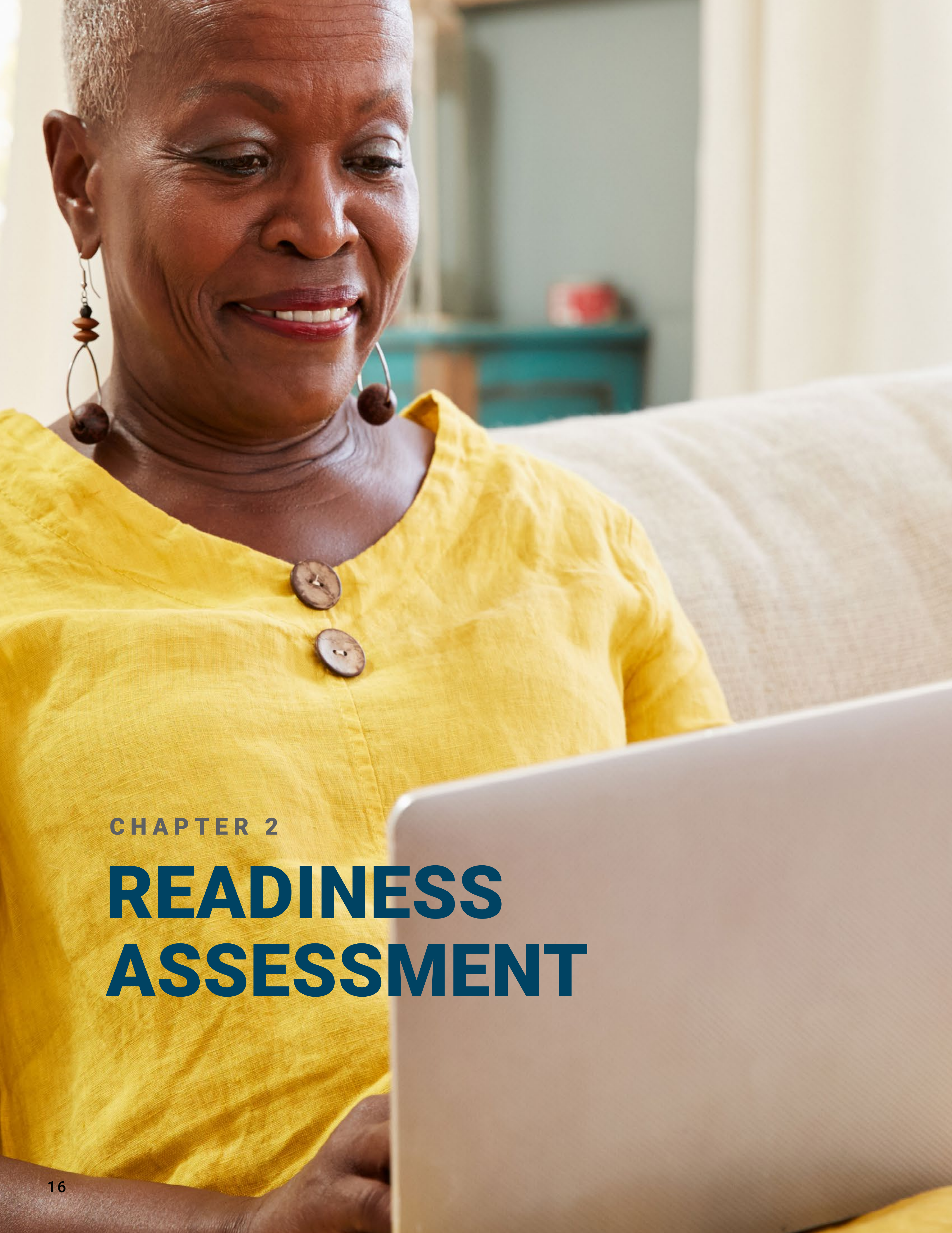
Summary
Assessing unmet needs prior to exploring potential solutions is a critical first step of any new initiative. After outlining areas of need, organizations should capture information on current operational and administrative characteristics. Completing these two steps will facilitate creation of a strategic plan that aligns needs with solutions prior to readiness and implementation.

APPENDIX

Needs Assessment Questionnaire

Stakeholder Groups	Questions
Resident, Family, and Caregiver Considerations	What unmet health care needs do those for whom you care experience?
	What are the most prevalent diagnoses among the residents for whom you provide care?
	Describe additional nonclinical needs of which you are aware. What additional nonclinical services have you seen being used?
	Which services do residents most often traveling to tertiary care facilities receive
	What is the rate of missed appointments? Why are appointments being missed?
	Are residents' family members and caregivers appropriately informed about their care?
	What is the resident's and their family's understanding and level of acceptance regarding advanced care planning?

Stakeholder Groups	Questions
Direct Care Staff, Medical Providers, and Leadership	What diagnoses arise that your facility does not have the time and/or expertise to manage effectively?
	What is you organization's provider-to-patient ratio?
	What are the medical provider hours at your facility? What is the after-hours coverage they provide? What is the accessibility of medical providers after hours? Are they readily available?
	What are the hours for your nursing staff? Typically, how many residents are cared for by each nurse?
	What additional resident services do you believe providers in your facility most want?
	What level of support and training is available to your providers?
Organizational Details	What, if any, resources are allocated by the organization to perform a needs assessment?
	What are the number of beds at your facility? On average, how many beds are occupied each quarter? What are the number of short-stay and long-stay residents at your organization?
	What are the average number of admissions, discharges, and transfers at your facility? What is the 30-day readmission rate for your facility and how is it calculated?
	Who are the hospital-preferred providers at your organization?
	How many in-house and community providers are at your organization?
	What is the staff turnover rate at your organization? Does this affect your ability to provide services at your facility?
	What is the rate of advance care planning that occurs on admission (e.g., Provider Order for Life-Sustaining Treatment (POLST) or health-care proxy designation)?
	What is the prevailing attitude toward change at your facility? How is technology perceived?
Payers	Does your organization have any existing agreements with payers?
	What kind of reimbursement approaches exist for your organization?
	Does the site collect data on procedures, diagnoses, and billing?
	Will private payers be willing to offer telehealth services at your site?
	Does your organization participate in bundle payments or ACOs?
	Does your organization participate in a narrow network or preferred provider network?



CHAPTER 2

READINESS ASSESSMENT

AT-A-GLANCE

Following a needs assessment, the next step is to consider the extent to which your organization is prepared to launch a telehealth program or service. This chapter will provide guidance on how your organization can determine its readiness and whether to move forward with implementation.

WHAT:

Organizational readiness is an assessment focused on the organization's ability to undertake change. This step identifies challenges that may arise when implementing new processes and considerations that affect the sustainment of a new initiative. A readiness assessment also helps align expectations of key stakeholders with the goals of your organization based on its culture, staff buy-in, leadership support, and technical infrastructure.

WHY:

A readiness assessment provides an opportunity for your PALTC community to assess strengths and areas of growth. Findings from your readiness assessment will also help your organization determine when telehealth should be implemented.

WHO:

Site leadership, clinical staff, and IT. A readiness assessment may be conducted in collaboration with a telehealth provider if one already has been identified.

Real-world Example

Dr. Walters was interested in learning more about Wendy and her colleagues' experiences since discovering the trend of patients being transferred to the ED.

After gathering input from the nursing staff, Dr. Walters determined a telehealth program providing consultative services during off hours would help address unmet needs at the facility. Wendy, being a new graduate, had learned a little bit about telehealth in her nursing program and was excited to have an alternative to calling the attending physician during off hours. Her colleagues, however, were more skeptical as last year they had attempted to implement e-prescribing. The program failed due to poor Wi-Fi signals and Sunny Hill had to return to faxing orders. If they could not get e-prescribing to work, how would telehealth services be successful? Her coworkers also were concerned with the training required to support a new service line and the time it would take away from resident care.

The following key areas impact an organization's readiness to implement initiatives: organizational culture, proactive senior leadership, staff buy-in, and technical infrastructure. Each of these domains is described in greater detail within this chapter, and a sample readiness survey is provided in this chapter's Appendix.

ORGANIZATIONAL CULTURE

One of the single most important factors in determining whether your organization is ready for telehealth services is its culture and comfort level with change. To gauge this, consider utilizing established surveys, such as "Organizational readiness for implementing change: a psychometric assessment of a new measure,"[1] as an initial assessment tool.

Survey of Organizational Readiness for Implementing Change:

1. We are committed to implementing this change.
2. We are determined to implement this change.
3. We are motivated to implement this change.
4. We want to implement this change.
5. We can manage the politics of implementing this change.
6. We can support people as they adjust to this change.
7. We can coordinate tasks so that implementation goes smoothly.
8. We can keep track of progress in implementing this change.
9. We can handle the challenges that may arise in implementing this change.

Look to the Past

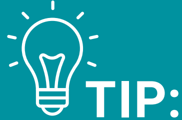
Another way to assess your organization's receptiveness to change is to draw from prior experiences, particularly those related to technology. One of the more significant changes that has occurred in PALTC is the adoption of electronic health records (EHRs), which offers lessons that also can inform organizational readiness. If applicable, drawing from your site's experience with EHR adoption may be a good indicator of how change is received at your organization. If your organization

does not currently use an EHR, other areas of considerations include staff adoption of new video conferencing software, smart phones, or other electronic workstations.

PROACTIVE LEADERSHIP

Messaging

Proactive and engaged leadership is key prior to launching and sustaining any new program. This requires that your organization has a firm understanding of where telehealth fits into its goals and clearly communicates that vision to staff. A key message is that telehealth adoption is an iterative process and may require adjustments along the way to ensure the organization's and residents' needs are being met. Be clear that while new telehealth-related protocols will be put into place, your organization may continue to update them and other existing protocols to ensure organizational goals are met. Such communication will help ensure that telehealth is viewed as an additive resource, as opposed to an additional responsibility.

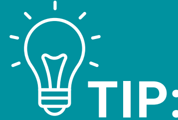


TIP:

Compare perspectives from the leadership team and direct-care clinical staff to gauge alignment on readiness to implement any new programs.

Community Engagement

To help alleviate perceptions that telehealth services at your facility may negatively impact medical providers in the community, consider sending a letter to local medical providers introducing the concept and benefits in addition to welcoming their feedback. Community medical groups and providers can contribute to the success of your organization's telehealth services by being able to inform residents of the benefits regarding timeliness and appropriate use of care that may be enhanced by technology. Telehealth may help medical providers reduce travel time and improve efficiency in treating residents.



TIP:

Consider organizing education opportunities (e.g., town halls) for medical providers from the broader community to learn about your plans to implement telehealth services, and if possible, include a demonstration of how telehealth works.

STAFF BUY-IN

Identify a Champion

Direct-care staff are critical not only to the successful implementation of a telehealth program, but also to sustaining and improving changes over time. Consequently, staff buy-in is a key component of readiness. To ensure perspectives from direct-care staff are captured and supported through advocacy, identify and establish a "change champion"—in this case, a "telehealth champion." This role is integral to the success of the program, as it provides direct-care staff with a representative they can contact to share concerns or input on any changes to workflow and other activities that impact the team.

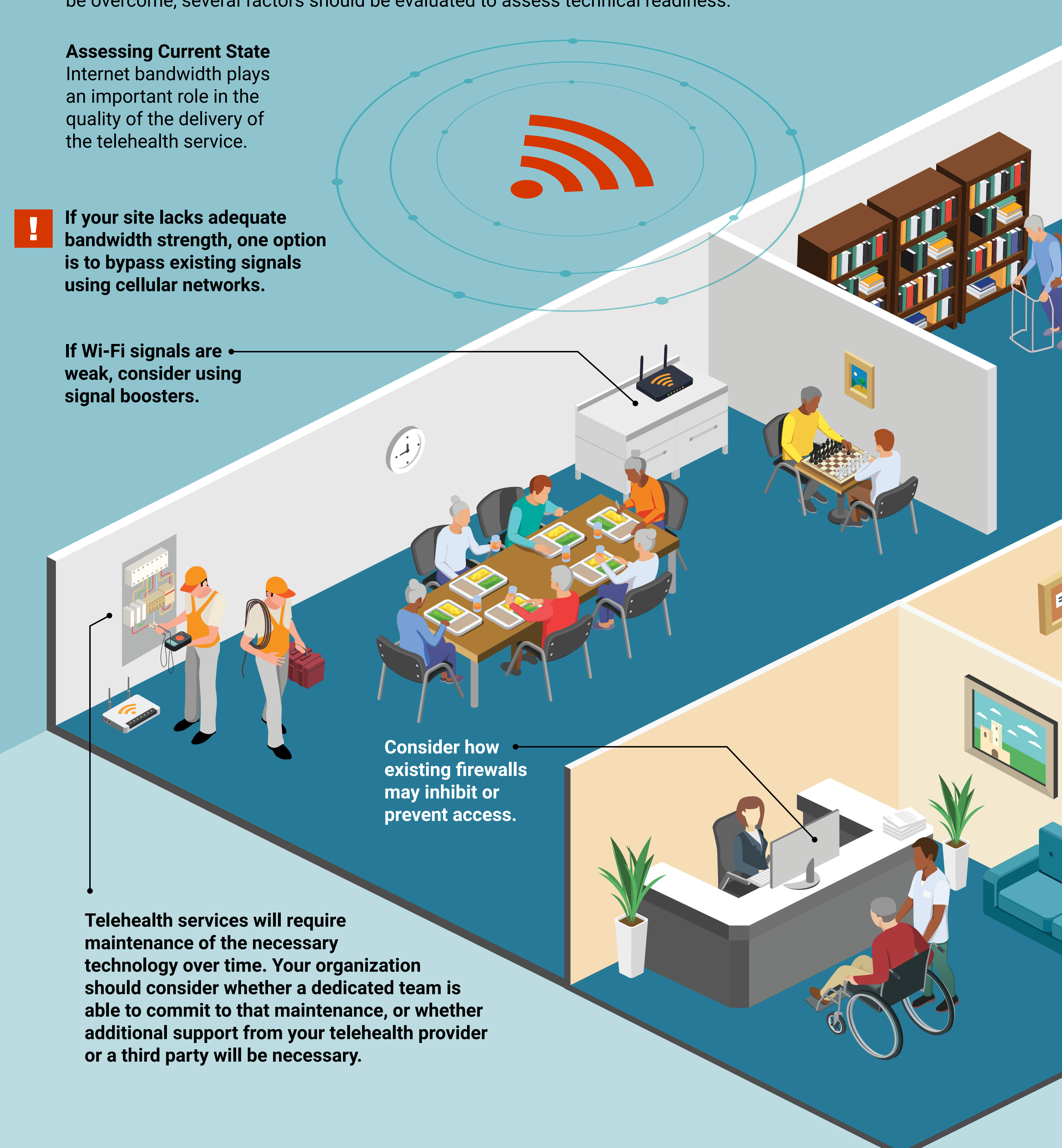
Additionally, champions become embedded spokespersons and motivators for change. Your telehealth champion can help address concerns around processes as well as workflow and training from a peer perspective. If your facility utilizes a large proportion of agency nursing staff, your telehealth champion should be a full-time employee to ensure continuity during times of agency staff turnover. Your telehealth champion can also help to keep your staff engaged and incorporate telehealth training into your existing onboarding or orientation process.

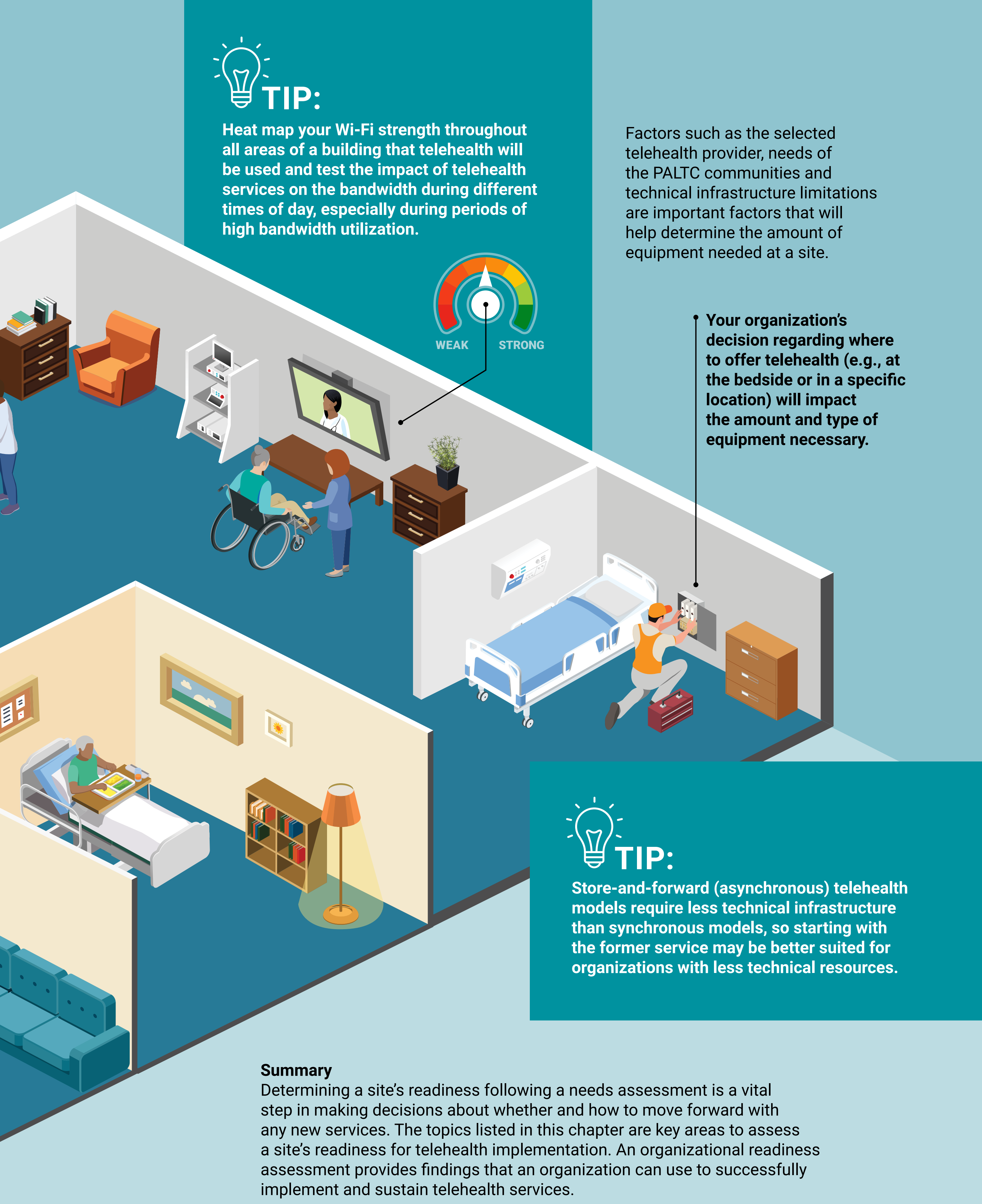
Staff Engagement

Leverage your champion to address concerns and ensure staff understand the benefits of telehealth services. Address staff concerns during all shifts, as staffing protocols may vary based on the time of day or day of the week. The most common initiator of telehealth is the nursing staff, so address the concerns of those who manage higher acuity residents who would benefit most from a telehealth service. For example, if during the needs assessment it was revealed that nursing staff have difficulty reaching a medical provider after hours, make sure it is clear how telehealth can serve as an alternative and that the telehealth provider can be available to nursing staff within a short period of time, particularly in change-of-condition situations.

FIGURE 3: TECHNICAL INFRASTRUCTURE

Technical capabilities are also a factor when assessing whether a site is prepared to move forward with a telehealth program. Your internal IT resources or external IT consultants are crucial in the assessment phase of telehealth deployment. While technical limitations can be overcome, several factors should be evaluated to assess technical readiness.





TIP:

Heat map your Wi-Fi strength throughout all areas of a building that telehealth will be used and test the impact of telehealth services on the bandwidth during different times of day, especially during periods of high bandwidth utilization.

Factors such as the selected telehealth provider, needs of the PALTC communities and technical infrastructure limitations are important factors that will help determine the amount of equipment needed at a site.

Your organization's decision regarding where to offer telehealth (e.g., at the bedside or in a specific location) will impact the amount and type of equipment necessary.

TIP:

Store-and-forward (asynchronous) telehealth models require less technical infrastructure than synchronous models, so starting with the former service may be better suited for organizations with less technical resources.

Summary

Determining a site's readiness following a needs assessment is a vital step in making decisions about whether and how to move forward with any new services. The topics listed in this chapter are key areas to assess a site's readiness for telehealth implementation. An organizational readiness assessment provides findings that an organization can use to successfully implement and sustain telehealth services.

APPENDIX

Readiness Assessment Questionnaire

Instructions: Use this questionnaire to assess your organization's level of readiness to implement telehealth. Answer the questions with "Yes," "Maybe," or "No." Use the "Maybe" and "No" responses to identify areas in need of improvement.

TECHNICAL INFRASTRUCTURE

Question	Answer		
My organization has a network that can support telehealth services.	Yes	Maybe	No
My organization has assessed bandwidth impact and Wi-Fi signals to ensure that telehealth services can be supported.	Yes	Maybe	No
My organization has a team dedicated to supporting technical services.	Yes	Maybe	No
My organization will need technical service support for telehealth troubleshooting.	Yes	Maybe	No

OPERATIONS AND LOGISTICS

Question	Answer		
My organization has a workflow that aligns with implementing telehealth.	Yes	Maybe	No
My organization uses electronic health records or medical charting systems.	Yes	Maybe	No
My organization can handle telehealth visit charting.	Yes	Maybe	No
My organization and its communities have established communication methods with each other.	Yes	Maybe	No
My organization has the time to commit to implementing telehealth.	Yes	Maybe	No

STAFFING

Question	Answer		
My organization's staff faces challenges in providing care to residents.	Yes	Maybe	No
My organization has enough staff to accommodate resident care.	Yes	Maybe	No
My organization has staff coverage during a variety of hours to support residents (e.g., after-hours coverage).	Yes	Maybe	No
My organization has staff dedicated to specific tasks (e.g., resident care, resident transport, custodial needs).	Yes	Maybe	No
My organization feels well-supported to accomplish daily expectations.	Yes	Maybe	No
My organization's staff feels confident about implementing telehealth.	Yes	Maybe	No
My organization feels that telehealth services will address staff recruitment and retention concerns.	Yes	Maybe	No
Staff within my organization believe that telehealth services will enhance their ability to deliver care to residents.	Yes	Maybe	No

OPERATIONAL STRATEGY AND COMMITMENT

Question	Answer		
Leadership can be directly engaged in telehealth implementation.	Yes	Maybe	No
Telehealth supports my organization's vision.	Yes	Maybe	No
My organization has the funding available to participate in telehealth.	Yes	Maybe	No
My organization has considered start-up costs for implementing telehealth.	Yes	Maybe	No
My organization has considered alternative funding sources to implement telehealth.	Yes	Maybe	No
My organization has considered potential barriers to implementing telehealth.	Yes	Maybe	No
Telehealth will be supported by local medical providers who work with my organization.	Yes	Maybe	No
My organization believes that other organizations should also use telehealth services.	Yes	Maybe	No

RESIDENT IMPACT

Question	Answer		
My organization has an idea of which telehealth services may benefit our residents.	Yes	Maybe	No
Telehealth can support the individuals my organization serves.	Yes	Maybe	No
My organization believes that telehealth services will reduce the number of resident readmissions and ED visits.	Yes	Maybe	No
Telehealth services are important to those whom my organization serves.	Yes	Maybe	No

CHAPTER 3

FINANCIAL AND REIMBURSEMENT MODELS

AT-A-GLANCE

This chapter will help navigate your PALTC organization through various financial, contractual, and reimbursement models and provide basic tips and guidelines for financial feasibility.

WHAT:

Financial and reimbursement models are explained in terms of identifying the value proposition for telehealth services and the most cost-effective and appropriate revenue model for your organization.

WHY:

By extending care through the adoption of telehealth, PALTC organizations may—in addition to improving resident care outcomes—differentiate themselves from competitors, reduce readmission rates, increase provider efficiency, empower nursing and other clinical staff, cut organizational costs, and increase reimbursement potential under value-based reimbursement programs.

WHO:

Site leadership (e.g., CEO, CMO, CFO, or VP) and medical providers involved in identifying the most appropriate and financially feasible revenue model for your organization's telehealth program.

Real-world Example

Sunny Hill actively seeks new ways to differentiate themselves from local competitors in the area and ensure they receive the highest Star Ratings. Dr. Walters originally thought about a telehealth program to improve care of residents by treating in-place for urgent/non-emergent conditions. Such a program also would favorably impact the facility's CMS five-star ratings, value-purchasing scores, and assist them in becoming a preferred nursing home. Additionally, the telehealth program would benefit patients like Beatrice and her family by increasing access to care when it is not available. The benefit of knowing that additional consultative services were available also improved the morale of the night shift nurses, resulting in an increased retention rate.

PALTC facilities require sound financial and reimbursement models to illustrate the value of telehealth, whether that be financial viability, sustainability, or enhancement of the organization's commitment to the community and its residents. When addressing the financial aspects of a telehealth service program, two key questions to ask are "What is the value proposition?" and "What is the expected return on investment?" In this chapter, we discuss considerations necessary to formulate those answers.

VALUE PROPOSITION

Telehealth may provide value to PALTC facilities, both directly and indirectly through clinical benefits and financial benefits.

Clinical Benefits

Telehealth can improve health outcomes and care management by providing three key clinical benefits: access to care, timeliness of care, and care coordination.

- **Access to Care:** Telehealth can increase the availability of care through on-site management of residents by remote providers. This includes using the telehealth platform to facilitate consultations between on-site staff and a residents' medical providers or specialists who assists with critical decision support at the point of care when it is needed. For example, incorporation of telepsychiatry services would enable support for mental and behavioral health issues in unplanned, urgent, and scheduled care episodes.
- **Timeliness of Care:** Traditionally, the schedules and availability of PALTC providers can hinder efficiency of resident assessment, treatment, and care management. Increased access to providers via telehealth promotes timely intervention. For example, telehealth allows PALTC staff to more quickly consult with a remote provider to conduct a resident assessment and determine whether an ED transfer is warranted. Such quick access can potentially reduce avoidable ED transfers and a resident's exposure to infections in a new setting.
- **Care Coordination:** Telehealth can facilitate more fluid communication, information sharing, and collaborative decision making in the course of care planning. For example,

telehealth may enhance engagement between the resident's family and the interdisciplinary care team, allowing for face-to-face engagement among multiple stakeholders, even if they cannot attend in person. For example, when engaging in complex conversations around advanced illness management and end-of-life care, participants tend to prefer face-to-face encounters, whether they are in-person or remote.

Indirect Financial Benefits

Another value proposition of telehealth is the positive impact it can have on your organization's position in the regional market, organizational strategy, and value to residents and staff.

- **Market Differentiation:** In a competitive marketplace, telehealth services may help set an organization apart from competitors. Telehealth services offer prospective families and residents options for convenient and accessible health care. Furthermore, telehealth may support resident education, counseling, and chronic-disease monitoring, which can be viewed as a "value-added" service that differentiates your organization as a preferred provider in your community.
- **Improved Culture and Staff Satisfaction:** Telehealth can help increase staff morale and reduce burnout by providing timely access to providers who can support the nursing staff on site with the resident. For instance, a remote care clinician can assist a nurse with care plan decision making, which reduces stress, especially when nurses are caring for multiple residents. In addition, availability of telehealth providers during night shifts can address trends of higher acuity when staffing is typically lower and on-site providers are not as available.
- **Resident Satisfaction:** The convenience that telehealth offers increases an organization's ability to engage residents while supporting their wellness, happiness, and independence. For example, residents typically wish to be treated "in place," or where they reside, whether that is a nursing facility or their home. By providing such treatment, residents can avoid disruptive transfers that can negatively affect their mental and physical health.

RETURN ON INVESTMENT

Return on Investment (ROI) is a key performance measure to evaluate any investment. Since implementing telehealth requires significant investment in terms of time, analysis, and resources understanding ways to define ROI are key. Three different ways to consider the ROI of your telehealth program include:

Clinical ROI	Operational ROI	Financial ROI
• Improved health outcomes and quality of care • Resident education • Timely interventions • Expanded access to care • Staff education and skillset	• CMS STAR ratings • Census stabilization • Resident satisfaction • Provider satisfaction • Decreased staff turnover rates • Preferred partnership establishment • Broader outreach and network (access) • Publicity and marketing opportunities • Stress relief for overburdened medical providers • Improved resident-to-provider ratios • Reduction of potential liability for your providers and organization	• Reductions in unnecessary and higher-cost ED visits and hospital readmissions • Lower costs of resident treatments for urgent/non-emergent conditions • Avoidance of penalties for readmissions • Reduction in transportation costs

CONTRACTUAL MODELS

There are various models that organizations implementing telehealth services may consider. The three most common models are:

- Business-to-Business Model (B2B),
- Payer Reimbursement/Fee-for-service Model (FFS), and
- Shared Risk or Value-Based Model.

Each of the three models has unique costs that must be considered in the context of ROI, in addition to whether the chosen contract model fulfills the desired value propositions.

Instructions: Use the table below as a starting point for identifying a contractual and compensation model that may fit your organization's goals and structure. If the consideration is applicable to your organization, place a check mark in the most appropriate contractual model.

Considerations When Selecting a Financial/Reimbursement Model

Considerations	B2B Model	FFS Model	Shared Risk or Value-Based Model
Are you a standalone organization?	✓		
Is your site in a rural or health professional shortage area?	✓	✓	
Are your providers willing to adopt outside contracted providers?	✓	✓	✓
Does any ACO or other similar relationship exist at your organization?		✓	✓
Do you bill directly for medical provider services?	✓	✓	
Do you have a billing expert or team?	✓	✓	
Does your organization have a capitated health plan driving your payer mix?	✓		✓
Are you part of a preferred network?	✓		✓

**check marks indicate recommended model*

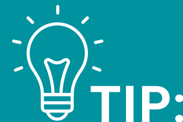
BUSINESS-TO-BUSINESS CONTRACTING MODELS

The most common contracting model for telehealth within the PALTC area are B2B services in which a PALTC facility directly works with a telehealth provider. In this model, the facility contracts with an external telehealth provider organization to augment its existing services and/or provider network. However, not all B2B arrangements look the same. The following are the three most common B2B arrangements:

Beginning-to-end Service Model
In a beginning-to-end arrangement, the telehealth provider supplies a turnkey operation, including the software, hardware, and professional providers, to your organization. This is the most common contracting model and is best suited for an organization that lacks the necessary technical capabilities or staff and/or would like to outsource care to a single telehealth provider. The technology services in this model most commonly include a software and technology platform license and some degree of maintenance and support services, such as:

- 24/7 coverage including urgent care: Best for organizations that have a large population and require quick assessments when local providers are not able to respond.
- After-hours or holiday coverage: Used when local or on-site provider availability is limited, such as nighttime, holidays, or weekends.
- Change of condition coverage/consultations: Often used to provide coverage during business hours where a telehealth provider can treat in place a resident's change in condition by assisting on-site nursing staff when local providers are unable to respond in person in a timely fashion.
- Specialist Coverage: Involves the provision of specialist services only. This is useful for organizations located in areas with a shortage of specialists or when the organization has a special resident population, such as an Ventilator Nursing Care Unit.

Common compensation methods (see Chapter 5 for more information) in the beginning-to-end arrangement include a fee-for-service model, subscription model, or a combination of the two, which is known as a hybrid model. The FFS model involves payment on a per-consult or per-service basis. This would be most fitting for change-in-condition coverage or specialist coverage. The subscription model involves the payment of a fixed monthly fee for the services and availability, regardless of volume of services. Accordingly, this compensation model would work well with a 24/7 or after-hours/holiday coverage arrangement. A hybrid model could be useful in agreements that incorporate all of the indicated offerings.



TIP:

In a true beginning-to-end service arrangement, fees paid to the telehealth provider will incorporate the costs of the technology. Be sure to confirm any additional fees for professional versus technical services.

Technology-only Model
A technology-only arrangement is appropriate for organizations that want to engage their own providers but outsource the software and IT platform. Such organizations may utilize theirexisting employees or contract new providers. From a technology standpoint, the organization engages a software and IT vendor to provide, build, and/or white label the software and IT equipment via license, lease, or purchase agreement. These agreements can incorporate a variety of fees for services, such as initial set-up, implementation, training, recurring licensing, maintenance, and support.

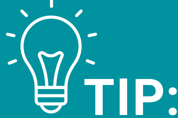
Staffing Model
In contrast to the technology-only arrangement, in a staffing arrangement the organizations provide their own technology platform and engage a telehealth provider for purposes of virtually staffing the program with clinical professionals. Organizations must ensure that medical providers who agree to provide remote services have access to and are familiar with the technology platform.

This model has the unique burden of credentialing new professionals to practice in your organization and state, unless a credentialing by proxy option is available. While this is also the case in the beginning-to-end model, the staffing model also requires orientation of an entirely new network of providers to a new technology platform. Such a process is often resource-intensive and any support or training would fall upon the organization.

PAYER REIMBURSEMENT MODELS

Fee-for-service Reimbursement

Telehealth adoption continues to grow as more telehealth-related services and policies are implemented at the state and federal level. Telehealth reimbursement varies depending on payer policies, which differ greatly in terms of services covered, patient location, and provider type. For PALTC settings, FFS reimbursement models are limited. For example, Medicare covers only Skilled Nursing Facilities (SNFs) in specific regions and for specific services, and often the fees and payments exchanged under the B2B arrangement are the only available compensation. Following is a summary of the most common Medicare telehealth reimbursement policies.



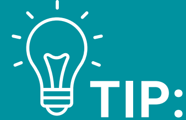
TIP:

A telehealth provider often will give (reassign) the facility "billing rights" so that your organization can bill for the services provided.

Qualifying Originating Site

A SNF is an eligible originating site if it is located in a qualifying geographic area.[2] While Assisted Living Facilities (ALFs) are not considered a qualifying originating site under Medicare, it may be possible for a Continuing Care Retirement Community to use its SNF unit as an originating site. Another option for PALTC facilities is to enroll in Medicare as a qualified practitioner's office, which is one of the eight eligible originating site facility types. This can be a viable option if the facility can meet the space and other operational requirements of Medicare enrollment.

Regarding geography, a qualifying area is either a county outside of a Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA) located in a rural census tract.[3] As such, the geographic location is commonly understood to be a qualifying rural area. HRSA and the Census Bureau update these rural areas annually.



TIP:

HRSA maintains a Medicare telehealth payment eligibility search tool to determine whether the location of an originating site is in a qualified rural area. Visit: https://data.hrsa.gov/

Covered Telehealth Services at SNFs

CMS annually publishes a list of telehealth services payable under the Medicare Physician Fee Schedule (PFS). The most commonly used services codes for covered telehealth services delivered to SNF residents are inpatient telehealth consultations and follow-up inpatient telehealth consultations.[4] Although the code descriptions utilize the term "inpatient," CMS defines telehealth consultation services to include consultations provided to residents of a SNF.

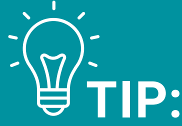
CMS regulations do not have a frequency limitation for inpatient follow-up telehealth consultation services at SNFs as long as the services themselves are reasonable and medically necessary.[5] In contrast, CMS policy limits subsequent SNF services delivered via telehealth to only once every 30 days. This limitation is due to CMS's "concerns regarding the potential acuity and complexity of SNF inpatients" and their desire to "ensure that these patients continue to receive in-person visits as appropriate to manage their care."[6]

While there is no frequency limitation for inpatient follow-up telehealth consultations at SNFs under Medicare, these inpatient telehealth consultation services cannot serve as a replacement for federally required in-person visits or routine follow-up evaluation and management services. This means that a Medicare-enrolled SNF, under current Medicare rules, cannot entirely outsource its services to become telehealth-only. Additionally, there are some important technical limitations and documentation requirements that must be followed to bill Medicare for inpatient follow-up telehealth consultations at SNFs.

SNF Billing of the Originating Site Facility Fee

The originating site facility fee is a separately billable Part B payment to which SNFs are entitled.[7] SNFs should submit the originating site facility fee claims to their Medicare Administrative Contractor (MAC).[8] SNFs who improperly bill the originating site fee could be exposed to audits, overpayment recoupments, and potential liability under the False Claims Act.

Resident Co-Payments and Financial Responsibility
The SNF cannot bill only Medicare for telehealth services; it must also bill the resident for his/her financial responsibility. SNFs cannot routinely waive resident co-payment obligations. Accordingly, SNFs should intend to bill and make a good-faith effort to collect copayment from a resident unless there is an individualized determination that payment of such amounts will otherwise cause financial hardship, made in accordance with a written financial hardship policy.

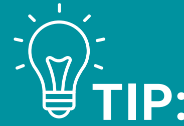


TIP:

Deductible and copay rules do not just apply to the professional telehealth services; they also apply to the originating site facility fee. A resident Medicare beneficiary is responsible to pay his or her 20% copay/deductible for both fees.[9]

Chronic Care Management and Remote Patient Monitoring
Medicare reimburses for both chronic care management (CCM) and remote patient monitoring (RPM). Because these codes are not specifically defined as telehealth services, they are not subject to the same restrictions as the services defined above (i.e., geographic and service restrictions). For more information on CCM service codes, visit: https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management.html.

CMS's Physician Fee Schedule: 2019 Changes
Each year, CMS issues proposed and finalized changes to the PFS. In 2018, final changes to the PFS for 2019 paved the way for new technologies, including asynchronous communications through the creation of a new set of virtual care codes. Changes include payment codes for virtual check-ins, asynchronous review of patient recorded data, and peer-to-peer consultations. For more information on the CMS's PFS, visit: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/.



TIP:

Similar to Chronic Care Management and Remote Patient Monitoring services, the new Physician Fee Schedule codes are not telehealth codes and therefore not subject to the Medicare telehealth limitations.

Medicare Advantage Reimbursement
While the current telehealth landscape for FFS beneficiaries is limited, primarily due to originating site restrictions, more flexibility is allowed in Medicare Advantage (MA) plans, which traditionally have been able to offer expanded benefits beyond those available in traditional FFS Medicare plans. For more information, please refer to your resident's MA plans.

Medicaid Reimbursement
State governments have established a variety of telehealth coverage policies for their Medicaid programs, with a total of 48 state Medicaid programs and the District of Columbia covering telehealth in some form. CMS does not limit the use of telehealth in Medicaid, which allows states to individually determine whether to cover telehealth and how to cover it. In addition to covering visits, Medicaid programs may provide a transmission fee to cover the cost of connecting the patient to the distant-site provider. However, compared with Medicare, more Medicaid beneficiaries are in managed care plans.

Elements of coverage that are relatively consistent across Medicaid programs include:

- Telehealth in urban areas,
- Telehealth using two-way video, and
- Tele-mental health services.

Elements of coverage that are less consistent across Medicaid programs include:

- RPM services and
- Asynchronous services, also known as store-and-forward.

For more information on Medicaid reimbursement, please refer to Chapter 6.

Private and Commercial Payer Reimbursement
The coverage of telehealth services by commercial insurance plans has generally been motivated by competitive pressure from employers and other insurers as well as anticipated cost reductions. Many national plans have embraced telehealth services and are steadily broadening coverage through partnerships with telemedicine organizations. Most commercial plans cover one or two types of telehealth services (e.g., basic evaluation and management physician visits), cover both urban and rural originating sites, and are often conducted through direct-to-consumer (DTC) models. In DTC models, telehealth is delivered by medical providers contracted through a telehealth vendor or employed by the managed care organization directly to act as an additional source of care.

When evaluating private and commercial payer policies, a key consideration is the existence of parity in the applicable state. Parity laws require commercial payers to cover telehealth services to the same extent as in-person services. However, laws must be closely analyzed to determine whether the parity requirements extend to both coverage and payment. Ideally, providers want to have both, but more important is for providers to understand the landscape, which can impact an organization's value propositions.

SHARED RISK OR VALUE-BASED MODEL

As value-based care becomes more prominent in health care, public and private payers are pushing providers to take on more financial accountability for their services through alternative payment models. In a FFS world, providers received reimbursement for every

test or procedure they performed without being penalized or rewarded if their services impacted patient outcomes and costs. In alternative payment models, such as shared risk or value-based models, providers become financially responsible for the care they provide. In this model, the organization and the payer share in health care savings if their services make care delivery more efficient and cost effective. Relevant to PALTC facilities is the Medicare Skilled Nursing Value-Based Purchasing Program (SNF VBP Program) in which SNFs can qualify for a bonus based upon avoiding medical complications resulting in a hospital readmission within 30 days of discharge.

For example, one SNF reportedly earned $150,000 in Medicare bonuses as a result of incorporating telemedicine, which they attributed to a reduction in hospital transfers and improved patient care and staff morale.[10]

Such programs can involve either one- or two-sided risk. In a two-sided risk model, providers may lose health care revenue if their care exceeds agreed-upon financial and clinical thresholds. Many providers prefer one-sided risk models in which they are not liable to repay any financial losses if care costs go over the budget or benchmark. For example, most Medicare ACOs are upside-risk-only.

The Next-generation Accountable Care Organization Model

In the next-generation ACO model, ACOs assume higher levels of financial risk (often referred to as two-sided risk) than is usual. Next-generation ACOs have a waiver to use telehealth services at urban-originating sites and from the patient's home. For next-generation ACOs, separate payments are made for each discrete service, and ACOs then receive a bonus payment if annual costs are lower.

Summary

Telehealth holds promise for PALTC care settings in a variety of ways. It can provide remote access to specialist care in both unplanned, urgent- or emergent- and scheduled-care episodes and assist with providing quality care management by monitoring the safety and wellness of residents. However, financial and reimbursement models remain extremely varied, so understanding the financial model most feasible for a specific organization will help ensure successful implementation.

CHAPTER 4

IMPLEMENTATION

AT-A-GLANCE

This chapter will outline key roles, responsibilities, tasks, and goals that are critical to your implementation process and success.

WHAT:

Implementation of telehealth services occurs after your organization has a strong understanding of its needs and readiness for change. Key components of implementation include preparing staff, installing the technology, and designing workflows and communication methods.

WHY:

Implementation is essential to the success of operationalizing any idea and plan. It signifies to all members of your organization and the community they care for that workflows and tools are being changed to support new objectives or goals.

WHO:

Site leadership, clinical and technical staff, the telehealth provider, and residents should all be engaged to some degree in the implementation stage.

Real-world Example

Wendy was designated as the telehealth champion as a result of her enthusiasm, interest in technology, and personal experience with caring for patients during off hours—something to which other staff members could relate.

During the readiness assessment, Dr. Walters discovered the Wi-Fi connectivity was weak and tended to drop in certain areas of the facility. Both Wendy and Dr. Walters knew that consistent Wi-Fi connectivity was necessary to provide after-hours, bedside care.

The IT support team was notified, and Wi-Fi system upgrades were made to assure the telehealth consultations could occur in the residents' rooms. Wendy and Dr. Walters also determined it would be best to assure all nurse trainers were comfortable with the telehealth service process, so they included them in the initial training. This assured that telehealth providers would be available to residents throughout Sunny Hill.

To help acquaint staff and families with telehealth, Wendy acted as the onsite liaison and collaborated with the telehealth provider to conduct mock consultations during staff training and with residents during resident and family council meetings.

Beatrice's family was especially supportive of the new services. They spoke with other family members about their late-night ED experiences and how they expected those events to decrease since onsite consultative services were now available.

Having a well-organized implementation plan is critical for the success of your telehealth program. The implementation plan is comprised of multiple steps, each of which builds off one another with implications for both timing as well as organization.

For instance, accounting for the length of time it will take to install new technology will influence the dates chosen to train staff. Other factors that may impact your plan includes the availability of the telehealth provider, the complexity of the new services, and organizational factors, such as changes in leadership and decision-making processes. This chapter will provide insight and important considerations as you develop your implementation plan.

IMPLEMENTATION PLAN AND TEAM

Identifying your tasks, timelines, approach, and goals are the core components of an implementation plan. The personnel that lead the execution of the plan are considered your team, often referred to as the project team. Although each team member is assigned a specific set of goals and tasks, it is crucial for the team to work together to ensure the plan is followed.

Depending on your needs and personnel composition, your organization may need to bring in additional help to assist in achieving the goals of the implementation plan. If your telehealth model includes working with an external telehealth provider, they will often offer to work alongside your team, providing subject matter expertise. Such an arrangement is advantageous for all by ensuring timeline and goals are met.

Key Members to Include in an Implementation Plan

Role	Stakeholder	Responsibilities
Administrative Lead	CMO and/or CEO	• Strategic guidance • Executive decisions on behalf of the organization
Technical Lead	IT Engineer or Analyst	• IT expertise regarding hardware and software • Escalations and repairs
Clinical Lead(s)	Medical and Nursing Directors	• Clinical guidance on workflows • Operational decision makers
Telehealth Lead	Medical Provider	• Insight on clinical workflows • Key communication representative for all staff
Telehealth Provider	Telehealth Company	• Subject matter experts on implementation • Education and training
Resident Representative	Resident and Family Member	• Feedback from the resident, caregiver, or family perspective
Project Lead	Project Manager or Coordinator	• Maintain timeline and budget

One way to make your implementation plan easier to follow is to create accessible visual reference documents. For example, creating a Gantt chart with dates, key tasks, and milestones will help assist with managing and adhering to timeline expectations. It is also important to strategically place key reference documents (e.g., Gantt chart) in locations frequented by staff and the project team. Staff not associated with the project team should be able to view reference documents as a means of added accountability and credibility.

COMMUNICATION STRATEGY

One of the most significant parts of an implementation plan is the communication strategy. On a regular day, ensuring that the right people receive the right message at the right time is a challenge for most organizations. This section will identify target audiences and describe methods to address common communication challenges. Your communication strategy should address the following questions:

1. Who do you need to get the message to?
2. What do you need to say?
3. Why do you need to say it?
4. When do you need it to be shared?
5. Where do you share it?
6. What do I need from you?

Staff Communication

Your initial target audience is your organization's staff. Building your staff's awareness of the new service, when it will be available, and the value it brings will equip them with the ability to discuss and answer questions. Enabling your staff to successfully address questions from residents, families, and external care providers will help avoid misinformation and decrease concerns. Engaging staff early in the process and providing formally scheduled updates establishes communication expectations for the new service line. As your organization approaches the go-live and full implementation of the service, information should be shared more frequently, such as at weekly meetings and during staff gatherings.

Live demonstrations of the new technology and service are especially informative and impactful. They provide an opportunity for staff to become more familiar with the tools, workflow, and expectations. Such demonstrations serve as teaching moments because they allow staff to ask questions while learning to use the new service.

Community Provider Communication

Engaging community providers requires a broad approach as levels of interaction between your organization and each provider may vary. In general, acceptance of telehealth differs among providers. When communicating with a community provider group, your organization will need to educate and highlight the value propositions for them and their residents. Some successful tactics include:

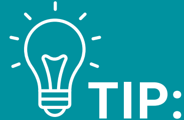
- Writing letters to local medical providers to communicate your organization's plan to implement telehealth.
- Inviting medical providers, primary care providers, and other relevant clinicians to demonstrations and informational sessions.
- Having your medical director serve as a liaison to the community providers, if applicable.

Resident Communication

PALTC settings tend to have a mix of residents, ranging from those who are well engaged with technology to those having no experience with technology. This variation could contribute to resident resistance to the new telehealth service.

For instance, technology may be considered impersonal, so it is important to emphasize the benefits of the service, particularly how it can help reduce transportation needs. Multiple outreach and communication methods help to ensure resident understanding of telehealth and how it may benefit them. We recommend reaching out to residents through:

- Information sessions,
- Town Halls,
- Meeting with family members during normal visits,
- Live telehealth service demonstrations, and
- Resident Council meetings.



TIP:

Know and utilize the various internal communication channels available within your organization, including:

- **All-Staff town halls,**
- **Daily stand-up meetings,**
- **Departmental meetings,**
- **Posters,**
- **Emails,**
- **Newsletters, and**
- **Intranet.**

When communicating about telehealth services, remember to highlight key benefits that residents can expect, such as:

- Increased access to timely care within their residence,
- Decreased need for transportation to EDs or clinics,
- Reduction in Potentially Avoidable Hospitalizations, and
- Decreased financial burden associated with being able to receive treatment in place.

Part of the resident education process includes outlining the value proposition for them and informing them about the telehealth service during their onboarding process. This is not only an opportunity to reinforce or clarify information with residents, but also with their families or caregivers. Some onboarding considerations include:

- How and when should existing residents sign-up for telehealth service?
- Can new residents be enrolled during the admissions process?
- Will your community use an opt-in or opt-out enrollment design?

Working with residents takes time and may feel redundant. Using the right terminology is important and may require adjustments over time. For example, "telehealth consultation" could be referred to as a "video visit" or other synonymous terminology that resonates well with your local resident population.

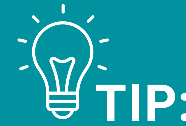
Marketing

Your organization may already have established protocols for marketing new products or services. Many of those existing marketing methods may be appropriate for marketing a new telehealth service, but we encourage your organization to consider a variety of outreach strategies, including:

- Posters throughout common areas in the facility,
- Press releases,
- National and regional conference presentations,
- Peer-reviewed literature,
- Facility newsletter (if available),
- Brochures at time of admission,
- Website and/or intranet,
- Social media,
- "On hold" phone message, and
- Interview/demo on local TV or radio health segment.

EDUCATION AND TRAINING

Regardless of your staff's level of familiarity with recent technologies, education and training is essential to ensure everyone feels like an expert in delivering telehealth services. Training your staff is one of the most important components of a successful implementation process and continued utilization.



TIP:

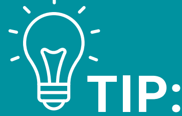
Consider including telehealth service training as part of the on-boarding process for new staff members. In an effort to ensure the highest utilization possible, all staff should be trained on their roles in delivering care via telehealth.

Clinical Staff Education

One way to test the telehealth service and simultaneously train staff is to utilize the actual equipment through which the telehealth services will be delivered. One benefit to internally conducting the training is that schedules may be more easily managed within your organization.

Training should be conducted for all relevant employees as close to implementation as possible to ensure that new information can be applied and retained. Refresher training sessions should also be available monthly to account for new employees or for addressing low utilization of the telehealth services. Once staff become comfortable with the training sessions and are using the devices, relying on a "train-the-trainer" model can boost confidence and empower staff to teach others. Training is also important to conduct when there is a change in workflow, technology, equipment, or platform.

The test of a successful training program is if your organization's staff feel comfortable independently facilitating a telehealth consultation from start to finish. Staff should be able to ensure the room is set up properly and that the device connects well for the duration of the visit. Staff should also know how to request post-visit summaries and communicate to the medical provider where those need to be sent.



TIP:

Make sure medical providers are made aware of basic telehealth etiquette, such as proper lighting, background, and camera angles, to ensure optimal visibility during the consultation.

Training Model Examples

In-person Training Sessions

In-person training sessions may be especially helpful when your organization's staff members have very limited experience with technology-related solutions. Such sessions can be conducted in large groups but convening smaller groups may build staff confidence in using the telehealth devices and/or equipment. In-person training is especially useful in improving your staff's perception of how telehealth may be useful to them and their residents.

Remote Training Sessions

A helpful way to rapidly expose your organization's staff to telehealth training is to conduct the session remotely using the actual on-site device and involving an operator originating the training from a distant location. This type of training can be particularly useful where organizational staff have had previous technology-related experiences and perhaps need less guidance, or when an organization's staff ratio makes it difficult to have all staff available in one setting, or when the telemedicine service requires few technological tasks from nursing staff. Practicing using the equipment in this way also encourages troubleshooting and promotes staff independence.

Telehealth Provider Training Sessions or Videos

Depending on your elected telehealth provider, they may provide telehealth training sessions directly to your staff. At a minimum, most telehealth service or equipment providers include training materials such as helpful "how-to" videos and tip sheets.

Mixed Training Sessions

For some organizations, using mixed training methods may be helpful. For example, your organization could start with in-person training sessions followed by remote training sessions. Using this approach can help ensure that all learning types are accommodated and that your organization's staff members have numerous chances to learn the new telehealth services. Mixing these two types of training also may help to address staff changes over time.

DOCUMENTATION

To ensure the best continuity of care for your organization's residents, the telehealth provider should have some resident information preceding the telehealth visit. Especially relevant are a resident's medical history, current medications, and chief complaint.

This information should be sent via predetermined methods approved by the Health Insurance Portability and Accountability Act (HIPAA). During the visit, and for your organization's protection, the medical provider should request resident consent to provide the consultation. Directly following a visit, the telehealth provider should send notes to your organization and to an individual's primary care physician.

If your organization uses an EHR, a telehealth provider may request read-only access to ensure the strongest continuity of their care for your residents. Finally, your organization should determine with your telehealth provider what the agreed-upon "turn-around" time is for receiving visit information. For example, it should be determined whether telehealth visit notes will be available via fax or the EHR within a designated time. Along those lines, orders, prescriptions, and other necessary information should be sent to the resident's direct-care staff within the agreed upon timeframe.

LICENSING AND CREDENTIALING

If your organization operates across state lines, the telehealth provider will need to be licensed and credentialed in applicable states. Licensing and credentialing processes take time to complete, which can impact implementation timelines. Licensure allows medical providers to practice in a state while credentialing is specific to health care organization and payers. For legal issues related to licensing and credentialing, please refer to Chapter 5.

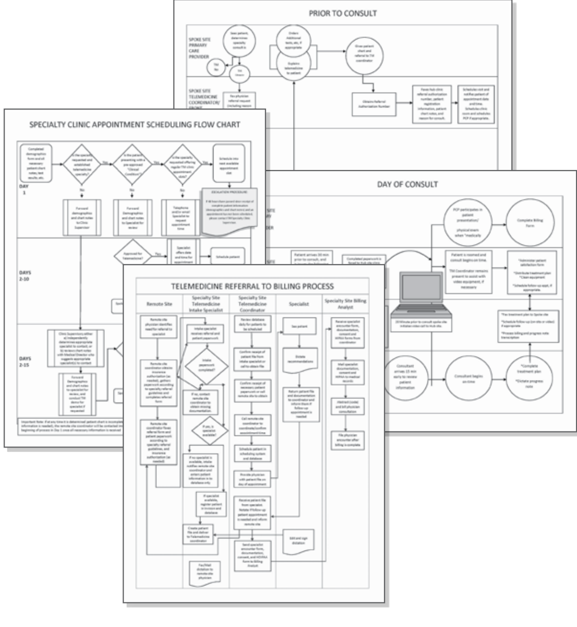
TIP:

Include a license and credentialing expert in your early discussions to determine an appropriate timeline, as this often takes several months to complete.

WORKFLOWS

Establishing a telehealth service workflow can be approached in a number of ways. However, it is important to begin by considering how telehealth best fits into your organization's current workflow to create the fewest modifications possible. The Telehealth Resource Centers (TRCs) can help tailor a workflow specifically to the needs and existing workflows within your organization or its facilities.

For more information visit: www.caltrc.org/wp-content/uploads/2018/07/Sample-Workflow.pdf



Establishing New Protocols
If during your needs and/or readiness assessment(s), it was determined that your organization needs to improve aspects of its workflow, it may be important to consider refining existing workflows or creating new ones. New protocols may have indirect effects on other workflows, and those implications should be thoughtfully considered to the greatest extent possible. A telehealth provider should collaborate with the site to assure the site's needs are met. Some important components of a new protocol include:

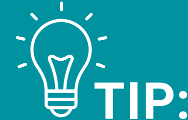
- When and how to engage with residents.
- What to do when the telehealth services aren't working.
- How to manage resident concerns (e.g., language barriers).

Communication Escalation
Processes or workflows may not anticipate all challenges to providing your organization's residents with quality telehealth services, which is why it is necessary to have troubleshooting mechanisms in place to address administrative, clinical, and technical challenges that may arise. Those engaging in the telehealth service should know who to call in the event of each type of challenge. For example, if there is a technical challenge affecting a telehealth consultation, the staff should know the most appropriate staff member to assist with resolving the concern.

Emergencies are yet another important example to consider. Staff should know how to handle a resident's situation and should know when to call emergency services rather than use telehealth services. Of further consideration is how to manage visits in the event of outages. Having contingency plans that address the following scenarios are essential:

- If an EHR system is down, would verbal orders be sufficient?
- If the telehealth services are malfunctioning, how should resident care situations be managed?

These communication escalation plans help ensure that everyone knows how to foresee potential areas of concern and that the best possible telehealth service is delivered to your organization's residents. For example, if your telehealth providers are not typically the ones who provide care to your organization's residents, it is important to work with existing medical providers to determine the appropriate level of support of shared residents.



TIP:

Some telehealth organizations monitor services remotely and can alert your organization to any issues such as expected downtime for services. In addition, backup plans should be in place for challenges that may arise.

SAMPLE CLINICAL WORKFLOWS

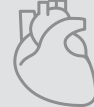
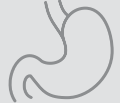
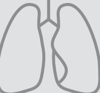
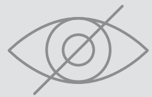
Change of Condition
Some telehealth services are engaged to specifically address a change in condition. For example, if a resident has a major, unexpected decline in health, telehealth services could be accessed to address that change. This is particularly useful for helping staff to feel supported in decision making regarding whether or not to keep a resident on-site or consider a transfer. To carry out this telehealth service model, your organization's staff would ideally call a triage line for guidance on how to proceed by either initiating a telehealth consultation or escalating the case to emergency services.

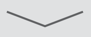
Specialist Consultations
In some areas, access to specialist providers may be limited. To bridge this gap, telehealth expands coverage for residents requiring specialty care. Specialist consultations can increase staff members' confidence in managing various clinical situations by providing them with additional external support.

Chronic Disease Management
Telehealth is also used to monitor chronic conditions such as diabetes and heart failure and increase residents' confidence in, and understanding of, their health care situation.

FIGURE 4: Sample Change of Condition Workflow

Detect Change
Signs / symptoms detected in resident (e.g. urination or bowl patterns, demeanor, etc)



Assess Acuity
Determine how severe symptom(s) is/(are)

EMERGENT

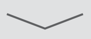
Symptoms requires the nurse to call for prompt or urgent action.

URGENT

Symptoms prompt attention, however is not serious enough to warrant an Emergency Department (ED) visit.

NON-EMERGENT

Symptoms do not require immediate attention.



Response Time
Depending on severity, nurse will respond

WITHOUT TELEHEALTH

WITH TELEHEALTH

Emergent:

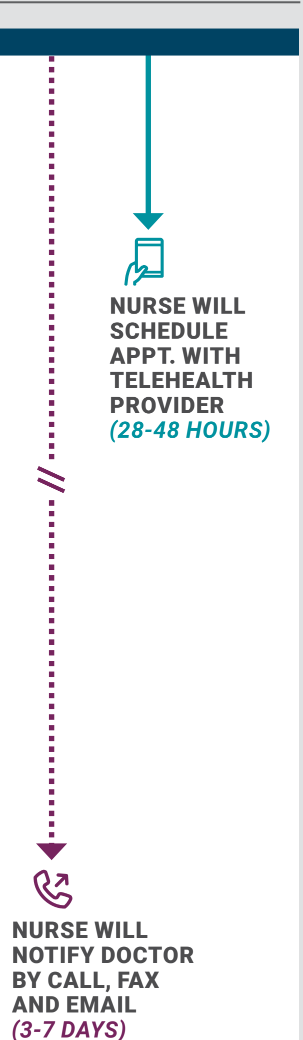
NURSE CALLS 911 AND DOCTOR RIGHT AWAY

Urgent:

NURSE INITIATES TELEHEALTH CONSULTATION *(10-15 MIN)*

NURSE CALLS DOCTOR RIGHT AWAY *(45-60 MIN)*

Non-Emergent:



NURSE WILL SCHEDULE APPT. WITH TELEHEALTH PROVIDER *(28-48 HOURS)*

NURSE WILL NOTIFY DOCTOR BY CALL, FAX AND EMAIL *(3-7 DAYS)*

FIGURE 5: Sample Implementation Timeline

INITIAL ASSESSMENT AND LEADERSHIP ON-BOARDING

INFORMATION GATHERING

IT ASSESSMENT

CONTRACT SIGNED

WEEKLY IMPLEMENTATION MEETINGS/CALLS

LICENSING AND CREDENTIALING COMPLETE

EQUIPMENT DELIVERY AND TESTING

MARKETING

EDUCATION AND TRAINING

GO-LIVE

POST GO-LIVE FOLLOWUP

TECHNOLOGY DEPLOYMENT

There are several key steps to consider when implementing any telehealth service. These components vary depending on your organization's location(s), floor plans, and readiness assessment results. This list is not exhaustive, but provides critical insight:

- Site expectations,
- Equipment location(s),
- Technical modifications,
- Simulations, and
- Monitoring.

Site Expectations

The telehealth champion can help determine the site expectations regarding equipment set up, the staff involved, and more. Staff already should be aware of the goals of the program and understand how the telehealth service can benefit residents. Your organization should be prepared to guide the telehealth service or provider in building new infrastructure based on your need. This ensures that telehealth services contribute to a high degree of efficiency and utility for your organization.

Equipment Locations

The telehealth team should first determine where the equipment will be stored and how it will be accessed. All telehealth service staff should have a firm understanding of where the equipment is located, how consultations are carried out (e.g., in resident rooms or a designated room), when and how the equipment will be accessed, and who will be able to access the equipment. For example, if you concluded during the readiness assessment that your organization's technical infrastructure was lacking, you should consider designating the equipment and consultations to a single room where the Wi-Fi bandwidth supports the service.

Technical Maintenance and Modifications

When implementing a new telehealth service, the technical service team, whether part of your organization or the elected provider, will need to make modifications to existing systems. These include tasks such as ensuring that telehealth equipment has sufficient connectivity and devices are working properly; setting up user accounts specific to the telehealth platform; assigning password instructions; conducting training and demonstrations; and maintaining applicable software updates, hardware updates, and general service maintenance. A key consideration in technical maintenance is whether and how the technical staff should be contacted if troubleshooting becomes necessary.

Simulations

As noted previously, prior to formal staff training, demonstrations with the new equipment or service can be beneficial. Demonstrations should include direct-care staff at your organization, medical providers who will be providing care, and residents. Conducting demonstrations with staff before launch ensures that concerns or technical difficulties are resolved in advance of resident demonstrations. Simulations can also help to establish mitigation strategies and troubleshooting communication strategies.

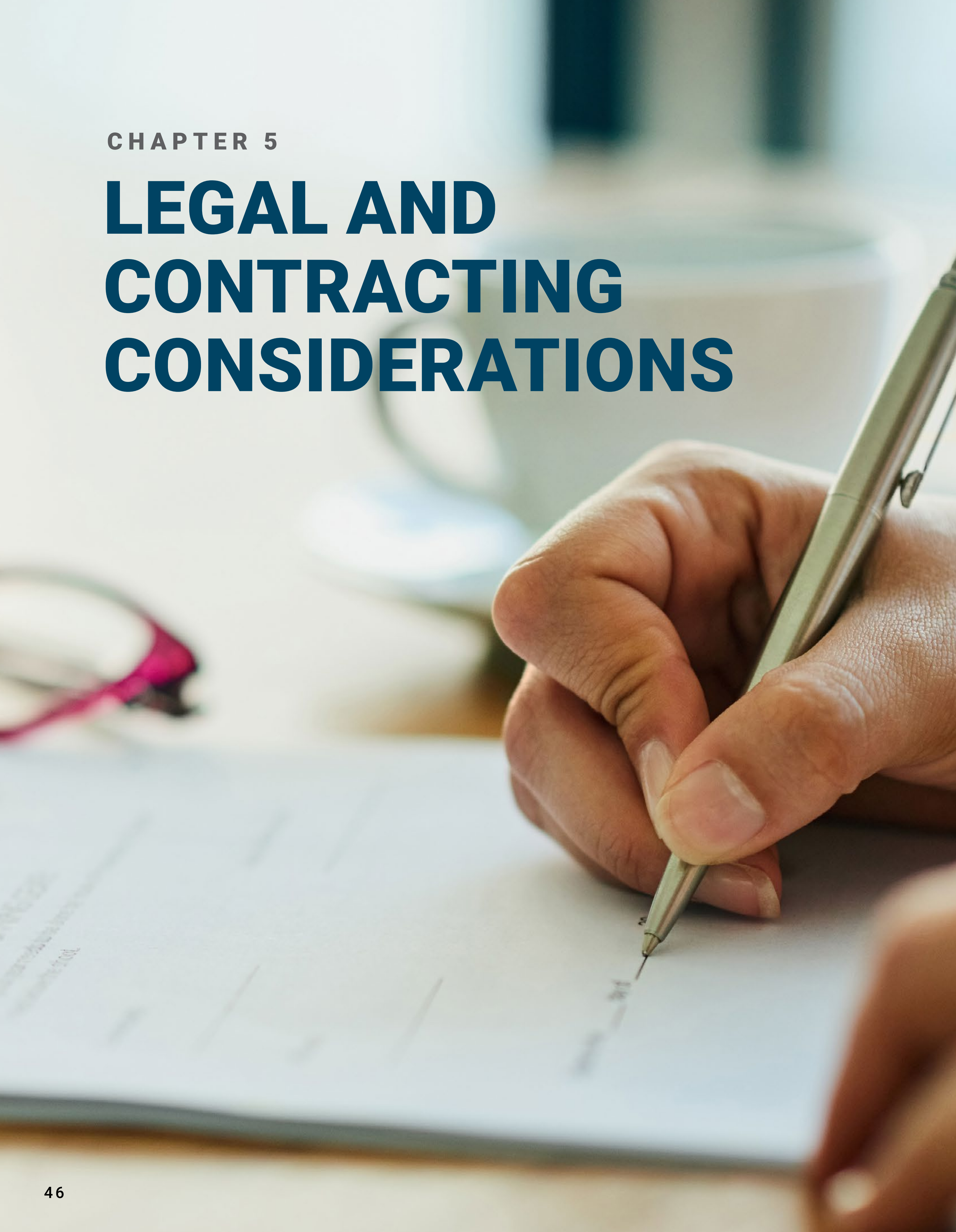
Go-live

The most important components of the "go-live" are to ensure that the equipment is in place and ready to use. The staff within your organization should be aware of the official "go-live" date and all trainings should be completed prior to that date to ensure the best possible first impression with the residents using the services. "Go-live" launches can last a single day or for as long as a week.

Leading up to and directly following the determined date or week, it is also important to maintain established communication methods to mitigate unforeseen challenges that arise and to ensure your organization's staff feel well supported in making the transition. Your organization, in conjunction with the selected telehealth provider, should determine which additional elements to include as part of the "go-live" day. One common approach for launch is to have practice sessions, especially in using the equipment, and to meet with the medical providers who will be providing care.

Summary

The implementation process is a critical part of any telehealth program and includes preparing staff via education and training, technology installation, workflow design and development, and establishing a communication strategy. Each step outlined in this chapter requires an interdisciplinary team advancing a process that takes an average of 16-20 weeks, or potentially longer if implementing across multiple sites.



CHAPTER 5

LEGAL AND CONTRACTING CONSIDERATIONS

AT-A-GLANCE

With a particular emphasis on Medicare rules and compensation methodologies, this chapter offers an overview of key legal and contracting issues for telehealth services at PALTC organizations.

WHAT:

Addressing legal and contracting issues, including fraud and abuse considerations, is essential when developing and negotiating telehealth professional service arrangements at PALTC organizations. To that end, this chapter explains telehealth services for PALTCs and includes sample contract language for compensation methodologies.

WHY:

Although there are many telehealth arrangements that fit both the clinical needs of PALTC facility residents and the business realities of building sustainable service contracts, the fact remains that one size does not fit all. Understanding the legal and regulatory landscape is essential to ensuring an arrangement makes good economic sense and is compliant with Medicare requirements and state and federal laws.

WHO:

PALTC leadership (e.g., CEO, COO, CFO, or VP) within organizations seeking to purchase or deliver telehealth services who are charged with strategic business and contracting decisions. This chapter will offer guidance on key legal and contracting issues to help build successful, sustainable telehealth arrangements.

Real-world Example

Dr. Ashton, the attending physician of Beatrice Winters, had concerns with the telehealth program, both in terms of the clinical quality and legal and security ramifications.

Dr. Walters informed Dr. Ashton that the telehealth providers were credentialed at Sunny Hill and were licensed to practice in the state. Concerning privacy and security risks, the technology utilized for the visits was HIPAA compliant and each patient was verbally informed of the privacy and security risks prior to enrolling in the program. In advance of each consult verbal consent is documented by the telehealth provider and is available in the after-visit summary, of which the attending physician would receive copies.

Just as telehealth in the PALTC setting requires its own tailored clinical approaches for residents, specific legal solutions and business structures are required to comply with complex state and federal laws. While it would be impossible to cover all telehealth legal, regulatory, and contracting issues in a single chapter, this chapter provides a discussion on three key areas applicable to telehealth arrangements at PALTC organizations:

1) Contracting for Telehealth Services at PALTC Organizations,
2) Licensing & Telehealth Services at PALTC Organizations, and
3) Health Care Fraud & Abuse Laws at PALTC Organizations.

CONTRACTING FOR TELEHEALTH SERVICES AT PALTC ORGANIZATIONS

Chapter 3 explores several different telehealth business models for consideration. This section offers sample contract language for:

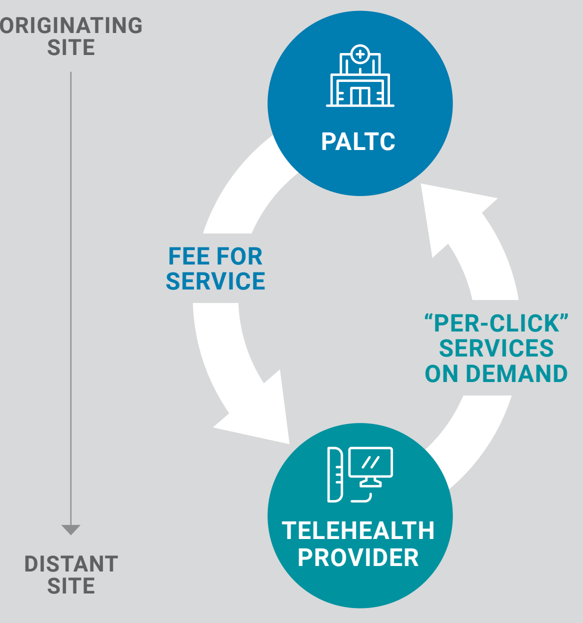
1. A pure FFS model,
2. A subscription fee model, and
3. A hybrid payment model.

Also discussed is the importance of whether the telehealth provider will reassign to the PALTC the right to bill and collect for the telehealth professional services. See the accompanying figures intended to visually illustrate these compensation methodologies and reassignment options.

Telehealth Compensation Methodologies and Accompanying Contract Language
Compensation methodologies under various PALTC telehealth contracts are limited only by the parties' imagination and applicable law. Some pure FFS models result in utilization of as little as 2%, whereas pure capitated or subscription models can result in utilization of 20%-30%.

This is due, in part, to telehealth's lack of in-person "face time" when compared to traditional on-site medical services. For adoption, the financial incentives and economic drivers are nearly as important as the quality and clinical benefits. Both parties to a PALTC telehealth contract must want it to be a success and want the residents to receive quality services that derive both short- and long-term benefits. Accordingly, PALTC organizations should spend sufficient time considering the impact various compensation methodologies will have on utilization.

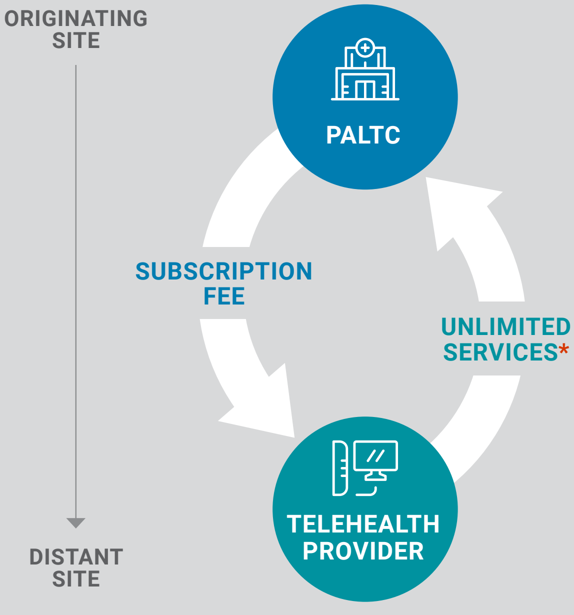
FIGURE 6: Pure Fee-for-service Model



Under a pure FFS model, the telehealth provider is paid each time a telehealth consult is provided. The FFS payment covers both the professional services and the technology delivered to the PALTC organization. Consider the following sample contract language for this payment methodology:

> *PALTC shall compensate Group for telehealth professional consults delivered to PALTC's residents on a fee-for-service basis at a rate of $____ per consult. This fee includes the cost of the telehealth professional consults, as well as the technology delivered by Group under this Agreement.*

FIGURE 7: Subscription Fee Model

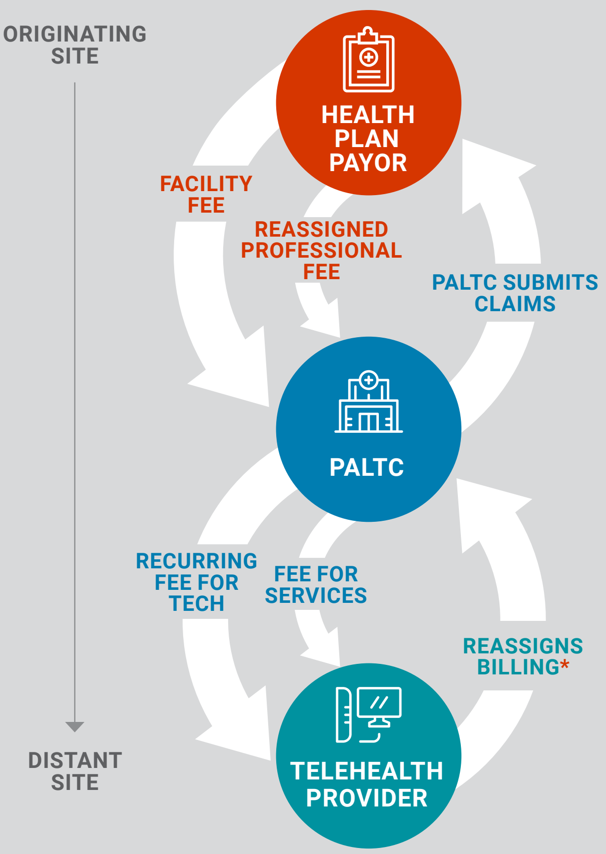


! *BUT MUST ASSESS STATE LAW INSURANCE RISK FACTORS DUE TO TELEHEALTH PROVIDER TAKING ON UNLIMITED UTILIZATION RISK.

Under a subscription fee model, the telehealth provider is paid a monthly recurring fee that covers both the professional services and the technology delivered to the PALTC facility. This can be a simple annual fixed fee, a per-resident-per-month (PRPM) capitated fee, or a variant of the two with adjusters to the PRPM rate depending on the extent of utilization of the services. Consider the following sample contract language for this payment methodology:

> *This annual fee is for the cost of the telehealth services, and covers the technology, availability, and professional services delivered to PALTC's residents. This fee does not include technology support services on-site at PALTC, which is PALTC's own responsibility. There are no limits on the number of telehealth professional consults PALTC may request under this Agreement, provided that the volume of requests does not exceed the current level of resources Group can devote, and that PALTC understands and agrees that Group is not responsible for unavailability of the services due to errors, delays, or failures in communication systems or equipment or unexpected volume beyond its control.*

FIGURE 8: Hybrid Fee Model



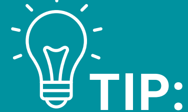
Under a hybrid fee model, the telehealth provider is paid a recurring monthly fee for the technology (and the availability of the distant-site professionals) plus an additional FFS payment each time a telehealth consult is provided. Consider the following sample contract language for this payment methodology:

> *This monthly access fee is for the cost of the network access and coverage availability, as well as the technology delivered by Group. However, the monthly access fee does not include compensation for the telehealth professional consults. PALTC shall compensate Group for telehealth professional consults delivered to PALTC's residents on a fee-for-service basis at a rate of $____ per consult.*

*UNDER THIS MODEL, THE PALTC IS RESPONSIBLE TO BILL AND COLLECT ALL RESIDENT COPAYS FOR THE PROFESSIONAL SERVICES.

The Importance and Effect of Reassignment on Compensation

Under any of the above compensation models, the parties must also consider reassignment of billing rights, as it is possible for a distant-site telehealth practitioner to reassign professional fee billing to the originating site facility under Medicare and many other payer rules.



TIP:

Reassignment can have important implications on the economics of the arrangement, as well as practical burdens and duties of billing and collection. It is a technical feature too often overlooked in many PALTC facility telehealth service agreements.

Consider the following language when the telehealth provider group does ***not*** reassign billing and collection rights to the PALTC:

> *Except to the extent inconsistent with federal or state law, Group and its physicians shall have the sole and exclusive right to bill and collect for the services from all residents, health plans, governmental agencies, third-party payers, and other financially responsible parties. PALTC shall not bill any resident, governmental agencies, or third-party payer for the services rendered to PALTC by Group and its physicians under this Agreement. Group and its physicians shall not reassign to PALTC the right to bill and collect for the services. To that end, PALTC shall reasonably cooperate in assisting Group and its physicians to obtain such payment, including providing necessary records or documentation related to the provision of services, and turning over to Group any payments PALTC receives for the services, if any. Subject to the foregoing, PALTC has the sole and exclusive right to bill any residents, health plans, governmental agencies, third-party payers, or other financially responsible parties for PALTC's own facility fees, technical fees, or other fees, excluding the telehealth services themselves.*

Consider the following language when the telehealth provider group ***does*** reassign billing and collection rights to the PALTC:

> *Except to the extent inconsistent with federal or state law, PALTC shall have the exclusive right and responsibility to bill and collect from all residents, health plans, governmental agencies, third-party payers, and other financially responsible parties as it deems fit in its sole determination. Group and its physicians shall not bill any resident, governmental agencies, or third-party payer for the services rendered to PALTC by Group and its physicians under this Agreement. Group and its physicians hereby reassign and grant to PALTC the right to bill and collect for the services, and shall complete or cause physicians to complete, all written agreements and reassignment forms necessary to effectuate this. In billing and collecting for the services, PALTC shall be responsible for all billing, coding, and collections associated with the services, including the determination of whether or not the services are covered by health plans, governmental agencies, third-party payers or other financially responsible parties.*

LICENSING AND TELEHEALTH SERVICES AT PALTC ORGANIZATIONS

In order to practice any licensed health care profession, via telehealth or otherwise, the individual must be licensed to practice the profession in the state where the resident is located at the time of the consult (or otherwise meet a licensure exception). For telehealth services provided to residents of PALTC organizations, that would be the state where the facility is located.

For example, a physician licensed in California and providing telehealth services to a resident located in a Colorado PALTC facility must have a license to practice medicine in Colorado (or otherwise meet a licensure exception).

Some states offer certain exceptions to licensure, allowing a doctor licensed in one state to deliver care (typically on a limited basis) to a resident in a state where the doctor is not licensed. Some exceptions include medical emergencies and disasters, neighboring/border states, follow-up care, free "curbside" consults, and peer-to-peer consultations.

While certain exceptions exist in every state, these exceptions vary and telehealth providers should carefully understand the requirements to avoid risk unlicensed practice of medicine. The same holds true for PALTC organizations seeking to have residents receive telehealth services from remote professionals.

Check and verify such licensure during the credentialing/contracting process or else the PALTC facility could face sanctions for engaging unlicensed health care professionals at its facility.

PALTC FRAUD AND ABUSE LAWS

Telehealth arrangements involving any federal health care program dollars (e.g., Medicare, Medicaid) must comply with applicable federal fraud and abuse laws, including the Stark Law and the Anti-Kickback Statute. The Stark Law prohibits a physician (or immediate family member) from referring Medicare and Medicaid patients for certain designated health services (DHS) to entities with which the physician (or immediate family member) has a financial relationship, unless the arrangement meets a specific exception under the law. If a telehealth arrangement or contract is subject to the Stark Law, it must meet an exception, as the Stark Law is a strict liability statute.

The federal Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by federal health care programs. The term "remuneration" includes the transfer of anything of value, in cash or in kind, directly or indirectly, covertly or overtly. The Anti-Kickback Statute has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals.

Violation of the Anti-Kickback Statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. The statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction. Violations also can trigger false claims liability for the purposes of the Federal False Claims Act. Conviction will lead to automatic exclusion from federal health care programs, including Medicare and Medicaid.

If a telehealth arrangement potentially implicates the Anti-Kickback Statute, the parties should determine whether the contract can be structured to fit within an applicable safe harbor. The safe harbor regulations define practices that are not subject to the Anti-Kickback Statute because such practices would be unlikely to result in fraud or abuse. The safe harbors include specific conditions that, if met, assure the parties will not be prosecuted or sanctioned for the arrangement. Safe harbor protection is afforded only to those arrangements that precisely meet all of the conditions in the specific safe harbor.

An arrangement that does not meet a safe harbor is not necessarily unlawful or illegal. Such arrangements require a detailed examination of the surrounding factual background and intent of the parties. Generally, the closer an arrangement mirrors safe harbor, the better. In addition, parties oftentimes build additional safeguards into the arrangement to reduce the risk of fraud and abuse and the likelihood of an enforcement action.

Telehealth contract models often involve the exchange of equipment (sometimes without cost) among providers to support implementation of the program. Further, some telehealth programs necessitate referral activities for follow-up care or emergent care and can involve the participation of laboratories and pharmacies. Depending on the method for aligning such referrals and structuring arrangements between health providers and pharmacies, these programs could be at risk under applicable federal and state fraud and abuse and anti-referral restrictions.

The Office of Inspector General (OIG) has evaluated certain telemedicine business models and issued five advisory opinions on them.[11] All five opinions have been favorable, and PALTC organizations are encouraged to read each in detail and understand the rationale as to why OIG supported the specifics of each arrangement.

State Fraud and Abuse Laws

Fraud and abuse compliance is not restricted to the Medicare and Medicaid Programs as more than 40 states have all-payer anti-kickback statutes, also known as "patient brokering statutes." These laws function like the federal Anti-Kickback Statute, but apply no matter the source of payment (e.g., commercial insurance, self-pay, cash). The primary purpose of these statutes is to prohibit payments for referrals of patients or health care items or services.

TIP:

Telehealth provider and PALTC facility cannot simply avoid anti-kickback issues by not accepting Medicare or Medicaid dollars.

For example, the Florida Patient Brokering Act prohibits any person, including any health care provider or health care facility to offer or pay any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral of patients or patronage to or from a health care provider or health care facility.[12] Unlike its federal counterpart, the Patient Brokering Act applies no matter the source of payment. This means that even if no federal health care program dollars are involved, the Patient Brokering Act can still apply.

Compared to OIG's enforcement of the federal Anti-Kickback Statute, state all-payer, anti-kickback statutes are not as frequently enforced by state regulators and attorneys general. Despite the relative lack of enforcement of these laws, there is a trend gaining traction in which commercial health plans are using these laws as grounds to file commercial unfair trade practices suits against providers who have been paid claims by the insurer when those claims have been generated by practices or arrangements violating state patient brokering laws.

Summary

There are a variety of telehealth arrangements that fit both the clinical needs of PALTC facility residents and the business realities of building sustainable service contracts, and one size does not fit all. Taking sufficient time to understand the legal and regulatory landscape will help ensure the providers' desired arrangement not only makes good economic sense, but also is compliant with Medicare requirements and state and federal laws.

CHAPTER 6

POLICY CONSIDERATIONS

AT-A-GLANCE

This chapter will educate your organization on the various state policy and legal issues PALTCs will encounter when implementing a telehealth program.

WHAT:

Provide information on state policy and legal issues commonly encountered by PALTCs starting and operating a telehealth program, and on potential routes that may be taken to address said issues.

WHY:

Your organization should be aware of potential legal issues that may arise when using telehealth to deliver services as understanding state laws and policies impacts the sustainability of any telehealth program.

WHO:

PALTC leadership (e.g., CEO, CMO, CFO, or VP) and administrative personnel as well as providers who are in a decision-making position and involved in key policy considerations.

Real-world Example

After seeing how beneficial telehealth was for her patients, Dr. Walters contacted her congresswoman by writing a letter of support for new telehealth legislation. The legislation would encourage the use of telehealth in value-based relationships, believing that nursing homes could benefit from taking on more risk because they are able to provide better care of their patients and, therefore, increase their reimbursement and Star Ratings.

Additionally, Dr. Walters has reached out to her state's Medicaid representatives to inform them of the increased outcomes and decreased costs as a result of telehealth within his nursing home.

Her goal in sharing this information is to help more providers receive reimbursement for services through telehealth, particularly specialty care services, such as dental and ophthalmology.

Navigating the telehealth policy landscape is complicated as policies differ from state to state and changes to policies related to the delivery of health services utilizing telehealth continue to evolve in a fragmentary fashion. A clear example of this is the inconsistent use and definition of the term "telehealth" or "telemedicine." The definition of the terminology used could have great impact on what is allowed for reimbursement. For example, Arkansas defines telemedicine as:

> *The use of electronic information and communication technology to deliver health care services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient. Telemedicine includes store-and-forward and remote patient monitoring. Telemedicine does not include the use of audio-only communication including without limitation interactive audio; a facsimile machine; text messaging; or electronic mail systems.*[13]

This definition encompasses the three modalities of telehealth, but it explicitly eliminates the use of phone, text, fax, and email only. Compare this definition to the one used in Connecticut which states "telemedicine means the use of interactive audio, interactive video or interactive data communication in the delivery of medical advice, diagnosis, care or treatment.

Telemedicine does not include the use of facsimile or audio-only telephone."[14] Unlike Arkansas, the definition in Connecticut only includes the modality of live video, as the definition includes the term "interactive." Therefore, in Connecticut, the options on what modality can be used and reimbursed are more limited.

Since 2016, there has been an uptick in introducing and adopting laws and regulations related to telehealth on both the state and federal levels. In general, the states far outpaced

federal policy in updating their laws and Medicaid policies to encourage greater utilization of telehealth. Although strides on the federal level have begun, recent changes may offer more opportunities for PALTC facilities to utilize technology to augment services.

REIMBURSEMENT

Most existing policies on telehealth focus on reimbursement and what and how services are paid. Reimbursement for telehealth-delivered services is usually dictated by policies that determine:

- What type of provider is reimbursed?
- What type of service is reimbursed?
- Where the patient is located—both geographically and exact site of location—when the interaction takes place?
- What is the telehealth modality used (live video, store-and-forward, or RPM)?

The answer to each question varies depending on jurisdiction and payer. Reimbursement in Medicare differs from reimbursement in Medicaid and varies among states. Adding to the complexity, health plans also may have different policies within their own available plan options and their telehealth policies also vary.

For example, a payer who offers both an MA plan and a Medicaid managed care plan in a state likely faces different requirements and/or allowances for what is reimbursed for telehealth-delivered services, causing the coverage policies for those services to be different.

Medicare

For more information on Medicare policies, see Chapter 3 and Chapter 5.

Medicaid
Each state Medicaid program has a different approach to how its telehealth policies are structured. Like Medicare, Medicaid programs may limit the reimbursement of telehealth-delivered services based upon the type of services they will reimburse, type of provider, originating site (where the patient is located), and what modality is used. Unlike Medicare, almost no states have a geographic limitation, such as restricting telehealth to rural areas.

Eleven states[15] currently explicitly allow an SNF to be an eligible, originating site when a telehealth interaction takes place. However, some states do not explicitly provide a list of eligible originating sites. For example, there may be no language regarding eligible originating sites[16] or vague language, such as "telemedicine services may only be offered in an inpatient, out-patient or office setting."[17]

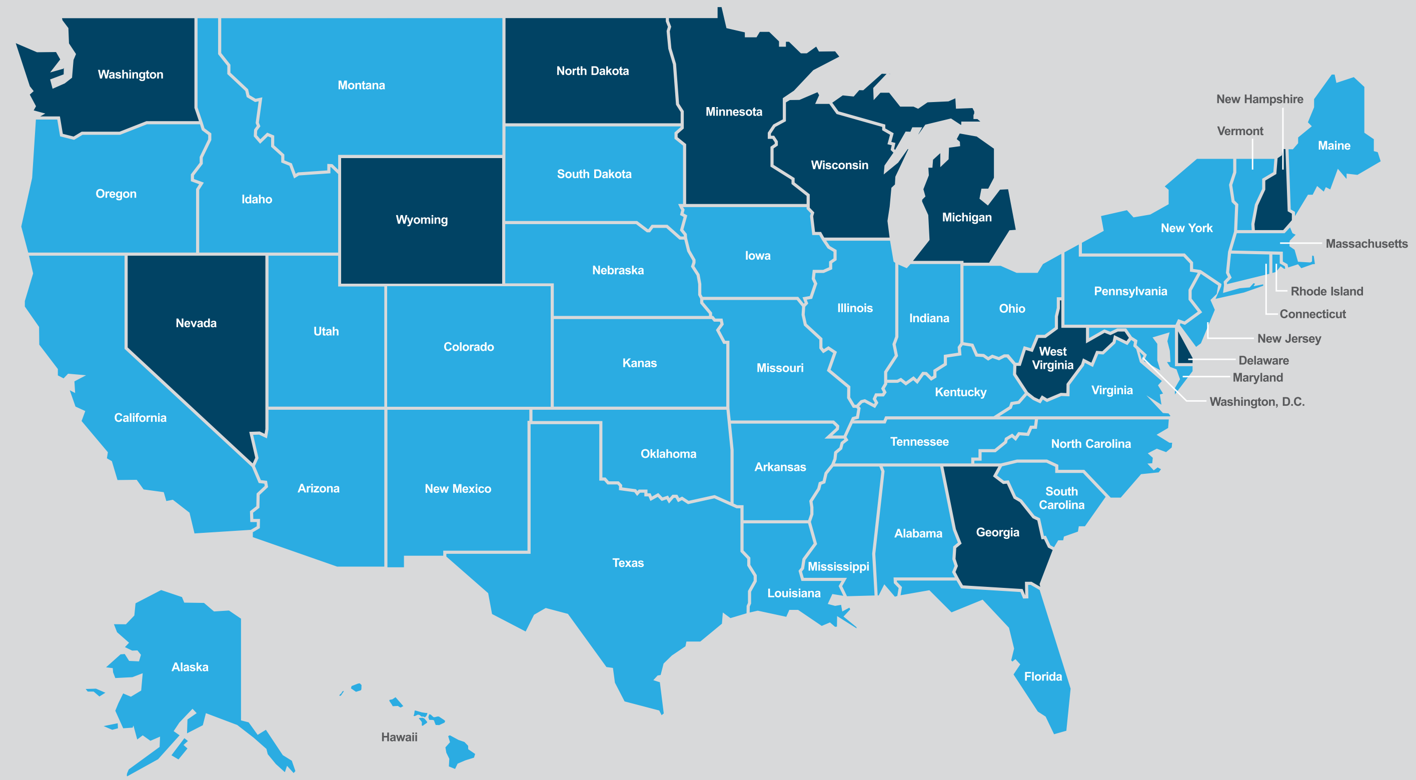
If a PALTC facility is primarily treating Medicaid patients, options for providing services via telehealth may be limited due to eligible site requirements. Even if a location is eligible to offer telehealth-delivered services, the type of services that are reimbursed may be limited.

Medicaid program may only reimburse for a specific list of services provided via telehealth. North Dakota's list includes:

- New and established office and other outpatient evaluation and management services,
- Psychiatric diagnostic evaluation,
- Individual psychotherapy,
- Pharmacological management,
- Speech therapy, individual, and
- Initial inpatient telehealth consultation.[18]

FIGURE 9: MEDICAID MAP

11 STATES
ALLOW SNFS TO BE ORIGINATING SITES



Other states are even more specific regarding what services they reimburse. Oklahoma lists exactly what service codes will be reimbursed if the services are provided via telehealth.[19] Some Medicaid programs offer a broader, but vaguer, policy, which makes it difficult to determine what services are reimbursable. The eligible services under telehealth in a Medicaid program may not correspond to the type of services an acute care facility is seeking to provide.

Private Payers

In addition to Medicaid policies, states also may require private payers to cover telehealth-delivered services. There are private payer laws in 39 states and Washington, D.C., that have various levels of reimbursement offered for telehealth-delivered services. However, because most of these laws allow payers to shape their own policies, they may not offer reimbursement for services in PALTC settings. Like Medicaid, private payers may limit reimbursement based on where a telehealth interaction takes place, the type of service, and the type of provider. Thus, it is necessary to inquire with each payer to determine whether a PALTC facility could act as an eligible originating site and what types of services could be reimbursed.

In addition, most Medicaid programs and private payers will reimburse only for live video. Store-and-forward and RPM policies are not as widespread, and programs that do reimburse for these modalities often have associated limitations. Therefore, even if a PALTC facility qualifies as an eligible originating site, it might be limited to only using live video.

Facility Fee/Transmission Fee

Most telehealth reimbursement policies, whether part of federal or state policies, focus on reimbursement for the distant-site provider. In most cases, the telehealth policy does not consider paying the originating site, or in this case the PALTC facility, a provider fee unless the originating site provider performs a separately billable service. Instead, to offset the costs incurred by the originating site, a facility fee and/or a transmission fee may be offered.

Of the 11 states that explicitly allow SNFs to act as an originating site, eight of them (e.g., Delaware, Michigan, Nevada, New Hampshire, North Dakota, Washington, West Virginia, and Wisconsin) offer a facility fee. Georgia, Minnesota, and Wyoming do not explicitly offer facility fees. While the facility fee is typically small, it does offer the originating site some monetary compensation. None of the 11 states that allow SNFs to be an originating site offer reimbursement for a transmission fee to help offset connectivity costs.

MALPRACTICE

While malpractice cases involving telehealth are rare, PALTC facilities should still ensure that their liability coverage includes protection for services provided via telehealth and that the distant-site telehealth provider also has such coverage. Finally, if a PALTC facility engages an out-of-state provider, that carrier's plan may not be viable in the PALTC facility's state.

TIP:

Check a payer's policies first to determine whether your site is an eligible originating site and then verify what services they will reimburse if provided via telehealth.

TIP:

Check to see that your malpractice coverage also covers services provided via telehealth.

Privacy
When starting a telehealth program, organizations often wonder how to address HIPAA requirements. The use of telehealth does not change an organization's obligations under HIPAA, nor does a specific type of telehealth equipment or software automatically make an organization HIPAA-compliant. HIPAA compliance involves a combination of human actions, policies your organizations have in place, and other factors that go beyond having the "right" equipment. A PALTC facility will need to adjust its internal policies and actions when using telehealth to ensure it is still compliant, even though its care goals remain the same. For example, entities outside of a PALTC facility who will have access to protected health information (PHI) will need to sign a business associate agreement (BAA) with the facility. When using telehealth, you would want a BAA with the telehealth provider.

Additionally, some states may have state health privacy laws that are much stronger than what is required in HIPAA. A state may have a technology or internet law that does not apply to any health service but does impact telehealth in some way simply because technology is being used to provide a service. For example, California medical privacy law applies to vendors of an individual's personal health record, whereas HIPAA applies only if the vendor is a business associate of a covered entity.[20] Another consideration is that states may have internet commercial laws that are not directed at health care, but that impact a telehealth program due to the use of connected technologies. For example, in Connecticut, if a person conducting business collects Social Security numbers, a privacy protection policy must be created and publicly displayed on a web page.[21]

Keep in mind HIPAA is a baseline that facilities must meet to protect patient information. Many states have other or higher requirements regarding the protection of information.

Consent
Approximately half of the states have some prior consent requirement that must be satisfied before a telehealth interaction takes place. Such policy may be found in a variety of places, including in Medicaid policies, but is frequently found in state law. Most have common requirements, such as explaining to the patient what telehealth is, who will be involved in the telehealth visit, and the patient's right to request an in-person visit. Some states allow verbal consent while others require written consent.

Patient-Provider Relationship
The patient-provider relationship has traditionally been established during a required initial in-person patient exam. Some states now allow a live video exam to suffice in establishing a patient-provider relationship. However, others have put limitations or conditions in place regarding what can be prescribed if the relationship has been established through telehealth. Most commonly, the limitations involve prescribing controlled substances as described later in this chapter.

LICENSING BOARDS

Licensing boards are another entity that often produce policies that impact the utilization of telehealth. They do this in the form of regulations or guidelines for the professionals they oversee. Following are some areas in which licensing boards have weighed in on telehealth:

Documentation and Record Keeping
Providers must abide by any laws and regulations regarding record keeping and documentation required to provide a health service. Specific record keeping laws or regulations directly related to telehealth are scarce except in the case of recording informed consent. As noted earlier, approximately half of the states have some type of informed consent policy and that consent is mandated to be recorded in the patient records. Some state boards in their guidelines or professional conduct rules do offer more specificity in what their licensees should do. While state boards' rules or guidelines typically mirror what is required in state law (e.g., the need to obtain informed consent), they may also place additional requirements on their licensees. For example, the following are guidelines issued by the Iowa Medical Board for their Standards of Practice for Telemedicine:

> *A licensee who uses telemedicine shall ensure that the following information is clearly disclosed to the patient:*
> *a) Types of services provided;*
> *b) Contact information for the licensee;*
> *c) Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services;*
> *d) Limitations in the drugs and services that can be provided via telemedicine;*
> *e) Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter;*
> *f) Financial interests, other than fees charged, in any information, products, or services provided by the licensee(s);*
> *g) Appropriate uses and limitations of the*

technologies, including in emergency situations;

h) Uses of and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;

i) To whom patient health information may be disclosed and for what purpose;

j) Rights of patients with respect to patient health information; and

k) Information collected, and passive tracking mechanisms utilized.[22]

Check to see what may be required of telehealth providers from your state's licensing board(s).

Clinical Standards

Most licensing boards only require their licensees to adhere to the same standards they would be required to meet had the service been provided in person, so there are very few specific examples of clinical standards for the use of telehealth to treat specific conditions. One of the few exceptions is the New York State Office of Alcoholism and Substance Abuse Services that as of December 2018 issued draft telepractice standards for its certified programs.[23] Given the purview of the agency, these draft standards are primarily focused on medication-assisted treatment (MAT).

Coordination of Care

While using telehealth to provide care coordination has benefits, there is still insufficient policy addressing important aspects of care coordination—most notably reimbursement. The most prominent example of a care coordination policy that includes telehealth is CMS's CCM codes. These codes cover some costs involved in coordinating care with home- and community-based clinical service providers, specifically the time spent coordinating care.

Unfortunately, as of December 2018, PALTC facilities are still not eligible to bill CMS for CCM services. Only physicians, physician assistants, clinical nurse specialists, nurse practitioners, certified nurse midwives, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Critical Access Hospitals (CAHs) are eligible providers under Medicare.[24] State Medicaid policies are even vaguer, with only one state, Indiana, noting that it will not reimburse care coordination services if the member is not present when telehealth is used.[25] Guidance on telehealth and care coordination may be found in regulations or guidelines issued by licensing boards, though these too remain fairly broad and focus primarily on ensuring the telehealth provider relays information about his/her visit back to the patient's primary care provider.

Prescribing Controlled Substances

The policy regarding the prescription of controlled substances comes under federal law, so there is very little that states can do in this area. The section directly addressing the prescription of controlled substances and telehealth is a part of the Ryan Haight Act.[26] This section of federal law specifically lists a limited set of scenarios in which telehealth can be used to prescribe a controlled substance without the prescriber conducting an in-person exam. Example scenarios include:

1. During a medical emergency.
2. While the patient is being treated by, and in the physical presence of, a DEA-registered practitioner.

An option for a PALTC facility, if the state it is operating in has an unclear or limited telehealth prescribing policy, is to have the provider located within the PALTC facility write the prescription based upon the recommendation(s) made by the distant-site provider.

A recent federal policy change will require the Drug Enforcement Agency (DEA) to create a telemedicine registry in 2019 that, theoretically, would allow a provider on the registry to prescribe controlled substances via telehealth without needing to meet one of the aforementioned exceptions or have an in-person exam.[27] While the DEA was charged with creating this registry, no parameters were given on what the registry would look like or the requirements that should be included. Therefore, the registry may not provide as much of an expansion as anticipated if providers find the necessary requirements too onerous to meet.

Summary

The last few years have indicated a policy trend toward increasing the use of telehealth and more fully integrating it into health systems. While policies on both the state and federal level continue to evolve, opportunities are opening for PALTC facilities to incorporate telehealth. Utilization of telehealth has the potential to increase access and timely care, but organizations should be aware of the intricacies of existing policies on the state and federal level that will impact the decisions and design of their telehealth program.

This awareness will help organizations create more effective and efficient programs to help meet their patients' needs while also minimizing telehealth-related complications.

CHAPTER 7

PERFORMANCE MONITORING AND SUSTAINABILITY

AT-A-GLANCE

This chapter will guide your PALTC leadership team through considerations important to building and sustaining a telehealth program and the components of monitoring its performance.

WHAT:

Performance monitoring is a process that evaluates the current management of your telehealth program's outcomes and impact. Such monitoring provides your organization with strategies for scaling and sustaining your telehealth program.

WHY:

It is important to monitor the performance and the impact of a new technology deployment to improve the application and service delivery of your telehealth program. When evaluating and monitoring your program, your organization will be able to optimize workflows and inform decision making in order to build a sustainable program.

WHO:

This chapter is designed for site leadership (e.g., CEO, CMO, CFO, VP, Administrator or Director of Nursing) who can utilize performance data and metrics to share insights with team members, optimize processes, and implement overall sustainability strategies for the organization.

Real-world Example

The staff at Sunny Hill have been using telehealth for over a year now, and in doing so, Wendy and Dr. Walters have identified some key findings. Residents and their families have accepted telemedicine well and now frequently ask if it is an option for care. Fewer residents are being transferred to the ED after hours and turnover of nurses on the night shift has decreased.

Wendy and Dr. Walters believe these findings are related to the introduction of telehealth. Because they are capturing trends over time, they can share these results with different audiences, including clinical and administrative leadership, frontline clinicians, families, and the telehealth providers to continue demonstrating value and ways to improve the program.

Providing high-quality care is paramount in a telehealth program. Organizations also must ensure their program is financially sustainable and meets expectations of organizational value and objectives. Formulating strategic objectives and aligning those objectives with investments is necessary to continue to grow and sustain your telehealth program. This chapter provides detailed guidelines for performance monitoring and for scaling and sustaining telehealth services in your organization.

PERFORMANCE MONITORING

When your organization is looking to improve the service delivery of a telehealth program, fundamental building blocks for an effective performance monitoring and sustainability strategy are key for understanding the maturity of your program and areas for improvement.

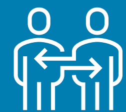
FIGURE 10: STEPS FOR EVALUATING QUALITY AND OUTCOMES

DATA COLLECTION

BENCHMARKING

SETTING ALERTS

ANALYZING DATA



SHARING RESULTS

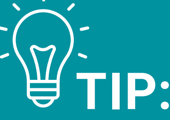
CONTINUOUS PERFORMANCE MONITORING

Data Collection
Any successful performance monitoring strategy starts with data collection. If you cannot monitor the program, you cannot continue to implement improvements or manage the services. When determining what data to collect, consider the goals for your organization's telehealth services. A telehealth provider often will collect data for your organization. However, if there are specific metrics or goals your organization is assessing, it is important to capture that information on an ongoing basis.

The purpose of data collection may be to create performance improvement initiatives that seek to achieve clinical excellence, improve care quality, or reduce costs. Data may also help your organization respond to health care and payment reforms. For example, often the most common objective for medical providers is to improve access to after-hours care. To evaluate the impact of this organizational objective, your organization can collect information on the number of consultations that occur after hours and the chief complaint of each visit.

Organizations also can utilize standardized metrics from the Agency for Healthcare Research and Quality (AHRQ), such as definitions for ambulatory care sensitive conditions. These metrics are indicators of medical care that can be treated in outpatient settings and should not require ED escalation. Other quality metrics to consider collecting data on include:

- Cost avoidance,
- Reduced avoidable ED visits and readmissions,
- Number of telehealth consultations,
- Reasons for telehealth consultations,
- Resident and family satisfaction metrics,
- Medical providers satisfaction metrics,
- Process improvement metrics, and
- Beer's Criteria (e.g., potentially inappropriate medication utilization in older adults).



TIP:

The same utilization and resident satisfaction metrics used to measure traditional face-to-face care delivery should also be used to assess the performance of a telehealth program.

Benchmarking
As part of your organization's needs assessment (see Chapter 1), data will be collected on organizational details, immediate needs, and the anticipated value of telehealth services. These data are also important in determining a benchmark for performance monitoring and determine meaningful change overtime.

For example, your organization's readmission and ED visit rates serve as a benchmark of what outcomes looked like prior to telehealth implementation. Then, after implementing telehealth, your organization will be able to assess the benefits of the services and whether they have improved based on collection and monitoring of data on avoidable ED visits and readmissions.

TIP:

The Long-Term care MDS and Interventions to Reduce Acute Care Transfers (INTERACT) may be useful benchmarks for sites to consider using. Visit: http://www.pathway-interact.com/

Setting Alerts and Measuring Engagement
Flag metrics based on certain deviations from benchmark performance, in addition to alerts for other metrics such as inappropriate utilization, low utilization, or workflow. These alerts will assist in understanding and mitigating issues that may arise after implementation.

For example, if utilization is low, this suggests that the staff may need additional education or a reminder of the incentives of the telehealth services. Automated alerts also can be useful in helping your telehealth provider know when equipment needs to be serviced.

Analyzing Data

The goal of performance monitoring is to find actionable information to optimize and improve performance. Analyzing data provides information necessary for informing decisions in scaling and sustaining the telehealth services. To optimize data analysis, have the data in one place so that it can be more easily maintained and queried to create reports as they are needed. Resident, family member, medical provider and staff surveys may also be helpful in assessing performance overtime and are often conducted by your telehealth provider.

Sharing Results

The last and most crucial step of performance monitoring is to share insights with team members and leadership. The shared results will determine areas for improvement and provide clarity on the strategy of the telehealth services. When sharing information, it is important to understand the audience and what value the data will provide them in building the telehealth program. Some of the components to consider including in a report are:

- 30-day outcomes,
- Trends of diagnoses,
- Education for certain conditions, and
- Additional equipment and support.

TIP:

Discussing reports at least quarterly with leadership and other key stakeholders will help provide further value to sustaining your telehealth program.

BUILDING A SUSTAINABLE PROGRAM

Aligning program goals with broader organizational strategic initiatives to improve performance and deliver more accountable care can facilitate progress. The following are common themes in evaluations on scaling telehealth programs:

- Promoting a culture of openness and preparedness.
- Utilizing a multidisciplinary, team-based approach.
- Establishing leadership support.
- Minimizing barriers to resident enrollment.
- Improving resident experience and staff satisfaction.

Technology

Developing a telehealth program does not necessarily involve significant investment in equipment and technology solutions. When starting a new telehealth program, it is best not to invest in every technological solution, but instead start with the core technology necessary to meet your strategic goals and immediate needs. For example, psychiatry and behavioral health services may require only basic technology, such as voice and video equipment. Then, the technology solutions and equipment can grow and evolve in tandem with your organization as your strategic goals advance.

TIP:

Consider leasing your equipment from the telehealth provider. This will allow you to gauge whether the technology solution works well for your needs and it guarantees timely software and hardware refreshes.

Financial Sustainability
As discussed in Chapter 3, defining a revenue model for telehealth programs may be challenging due to varying payment rules based on state laws and payer contracts. The most common financial model is a B2B contract where revenue is determined by traditional performance metrics. However, when building sustainable and scalable models, your organization will need more than just improved outcomes and cost avoidance.

An important component of financial sustainability is understanding how the telehealth program will affect cash flow. To understand cash flow, your organization will need to understand the resident mix, how services are being paid for, which residents are being targeted, operational expenses, and how your organization will manage the overall investment. This is especially important if your organization is interested in potential risk-sharing contracts with payers.

Summary
Successful programs take time to integrate technology into care delivery and allow staff and residents to adapt. Critical components of any sustainability model include structure, coordination, planning, and strategic vision. Aligning a program's goals with strategic initiatives will help improve performance and ensure accountability among staff.

Telehealth can have a positive impact on resident care when placed in the hands of motivated medical providers and staff. Such motivation can be achieved through open communication in your organization.

EXISTING RESOURCES

1. A systematic review of telemedicine services for residents in long term care facilities
Link: http://journals.sagepub.com/doi/abs/10.1177/1357633X13483256

2. Telemedicine Consultations for Patients in Long Term Care: A Review of Clinical Effectiveness, Cost-Effectiveness, and Guidelines
Link: https://www.ncbi.nlm.nih.gov/books/NBK326855/

3. Telehealth & Patient Satisfaction: a systematic review and narrative analysis
Link: http://bmjopen.bmj.com/content/7/8/e016242

4. American Telemedicine Association: Core operational guidelines for telehealth services involving provider-patient interactions
Link: https://southwesttrc.org/sites/southwesttrc.org/files/ATA%20Core%20Guidelines.pdf

5. Consortium for Telehealth Resource Centers (CTRC) telehealth program developer kit: a roadmap for successful telehealth program development
Link: https://www.telehealthresourcecenter.org/program-development

6. Leading Age: Telehealth and Remote Patient Monitoring for Long Term & Post-Acute Care
Link: https://philipsseniorliving.com/wp-content/uploads/2016/04/Telelhealth_Whitepaper.pdf

7. Washington State Telehealth Implementation Guide
Link: https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/DSHSTelehealthGuidebook.pdf

8. Telehealth Start-Up and Resource Guide
Link: https://www.integration.samhsa.gov/hit/telehealthguide_final_0.pdf

9. PrognoCIS: The Physician's Guide to Telemedicine in 2017
Link: https://prognocis.com/wp-content/uploads/2017/01/Telemedicine-Whitepaper.pdf

10. DoD Telemental Health Guidebook
Link: http://t2health.dcoe.mil/sites/default/files/TMH-Guidebook-Dec2013.pdf

11. Consortium for Telehealth Resource Centers (CTRC): Facilities at the Patient Site
Link: https://www.telehealthresourcecenter.org/toolbox-module/facilities-patient-site

12. Navigating Reimbursement for Telemedicine in Long Term Care News & Assisted Living
Link: https://www.mcknights.com/guest-columns/navigating-reimbursement-for-telemedicine/article/501688/

13. mHealth Intelligence: Telemedicine Gives Long-Term Care Facilities an Instant Link to Healthcare
Link: https://mhealthintelligence.com/news/telemedicine-gives-long-term-care-facilities-an-instant-link-to-healthcare

14. Telemedicine in LTC: Help for Patients with Multiple Chronic Conditions
Link: https://www.mcknights.com/marketplace/telemedicine-in-ltc-help-for-patients-with-multiple-chronic-conditions/article/649378/

15. Long Term Care: Telehealth – An Untapped Opportunity for Nursing Facilities
Link: http://www.todaysgeriatricmedicine.com/archive/MJ17p28.shtml

16. What is the role of telemedicine in long term care facilities?
Link: http://www.amdtelemedicine.com/blog/article/what-role-telemedicine-long-term-care-facilities

17. Conducting a Telehealth Needs Assessment
Link: https://link.springer.com/chapter/10.1007/978-3-319-08765-8_2

18. The UTAUT Questionnaire Items
Link: http://www.irma-international.org/viewtitle/9038/

19. Standards for the Use of Telemedicine for Evaluation and Management of Resident Change of Condition in the Nursing Home
Link: https://www.jamda.com/article/S1525-8610(18)30671-6/fulltext?dgcid=raven_jbs_etoc_email

20. Providing Rural Care, Remotely: Avera's eCARE Initiative
Link: https://www.caringfortheages.com/article/S1526-4114(15)00212-7/pdf

21. Impact of After-Hours Telemedicine on Hospitalizations in a Skilled Nursing Facility
Link: https://www.ajmc.com/journals/issue/2018/2018-vol24-n8/impact-of-afterhours-telemedicine-on-hospitalizations-in-a-skillednursing-Facility

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[2]CMS Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

[3]Social Security Act § 1834 Available at: https://www.ssa.gov/OP_Home/ssact/title18/1834.htm

[4]CMS, Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, § 190.3.1. (Medicare A/B MACs (B) pay for reasonable and medically necessary inpatient or emergency department telehealth consultation services furnished to beneficiaries in hospitals or SNFs …") Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

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GLOSSARY

Asynchronous technologies allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos. Asynchronous transmissions typically do not occur in real time and take place primarily among medical professionals to aid in diagnoses and medical consults, when live video or face-to-face patient contact is not necessary.

Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare, Medicaid, and Children's Health Insurance Program.

E-Prescribing is the act of offering medical prescriptions over the Internet. Often, e-prescriptions must be accompanied by a valid physician-patient relationship, which may or may not require an initial face-to-face interaction between the physician and patient, depending on the state.

Facility Fee (also known as Originating Site Fee) is a fee paid to the originating site to compensate for the cost of facilitating a telemedicine visit.

Health Professional Shortage Areas (HPSA) are designated by the Health Resources and Services Administration as having shortages of primary medical care, dental, or mental health providers, and may be geographic (a county or service area), demographic (low income population), or institutional (comprehensive health center, federally qualified health center, or other public facility).

Medicaid is a program that provides medical coverage for people with lower incomes, older people, people with disabilities, and some families and children. Medicaid is jointly funded by the federal government and individual states and is administered by the states.

Medicare is a health insurance for people age 65 or older, people under 65 with certain disabilities, and people of all ages with end-stage renal disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant.

Originating Site is the location of the patient receiving a telehealth service.

Remote Patient Monitoring (RPM) uses telehealth technologies to collect medical data, such as vital signs and blood pressure, from patients in one location and electronically transmit that information to health care providers in a different location. The health professionals monitor these patients remotely and, when necessary, implement medical services on their behalf.

Skilled Nursing Facility (SNF) is a facility that houses chronically ill, usually elderly patients, and provides long-term nursing care, rehabilitation, and other services.

Synchronous refers to the use of two-way interactive audio-video technology to connect users, in real time, for any type of medical service.

Transmission Fee is a fee paid to telemedicine providers for the cost of telecommunications transmission.

Definitions provided by Center for Connected Health Policy (CCHP)

NOTES

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TELEHEALTH

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