

PREPARED BY

ADAM LAN, CLARE HUDOCK, DIANA RUBIN, SABA
RAWJANI AND SAMANTHA RUSSO

FACULTY ADVISOR

MARTHA WOLFGANG

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REPORT DESIGNED BY

SARAH BACIO

Caring for New York's School Children: The Potential of Telehealth.

**Report to the New York School-Based
Health Foundation (NYSBHF)**



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II. INTRODUCTION

Across New York State, 262 school-based health centers (SBHCs) serve nearly 250,000 K-12 students. SBHCs provide a safety net for communities that face barriers to accessing quality mental and physical health services. The clinics are placed in K-12 schools and offer care regardless of a patients' ability to pay. When New York State directed all schools to close on March 18, 2020, students, teachers, and clinicians transitioned to a home-learning environment. Although telehealth was not widely used by SBHCs before this year, virtually all SBHCs were forced to quickly adopt the mode of care in response to virtual schooling.

SBHCs are defined as a health clinic that 1) is located in or near a school facility of a school district or board, or of an Indian tribe or tribal organization; 2) is organized through school, community, and health provider relationships; 3) is administered by a sponsoring authority; and 4) provides primary health services to children in accordance with state and local law, including laws relating to licensure and certification. A sponsoring facility can be a hospital, a public health department, a community health center, a non-profit health care agency, a local educational agency, or a program administered by the IHS or tribal organization.

This report was commissioned by the New York School-Based Health Foundation (NYSBHF) to examine the transition to telehealth in New York State's SBHCs, anticipate the future outlook of telehealth in SBHCs, and identify areas of opportunity for using telehealth in SBHCs. A team of five student consultants at the Columbia University Mailman School of Public Health interviewed 19 key stakeholders for input, including nine SBHCs in New York; SBHC experts from Connecticut, North Carolina, and Colorado; the New York City Department of Education; Greater New York Hospital Association (GNYHA); Healthcare Association of New York State (HANYS); Community Health Care Association of New York State (CHCANYS); and the national School Based Health Alliance. Unfortunately, the New York State Department of Health did not reply to requests for an interview.

For a comprehensive overview on SBHCs in New York State, please refer to a 2009 paper prepared by the New York State Coalition for School-Based Health Centers.

III. SECTION 1: POLICY

1.1 Definitions

At the onset of the New York State of Emergency declaration, the New York State Department of Health updated their definitions of telehealth, telemedicine, originating site and distant site under Medicaid guidance to reflect the needs of patient and provider populations during COVID-19. Under Executive order 202, these new definitions will remain until the State of Emergency is over (NYSDOH, 2020).

An interview with a telehealth policy consultant revealed that it is imperative for organizations to have a common understanding of these relevant definitions, as New York's definition of telehealth is not universal. Syncing definitions among staff becomes imperative when aligning services with billing and coding practices, especially in smaller organizations without centralized billing departments. This ensures that claims do not get rejected so each SBHC will get fully reimbursed for all services performed.

Today, New York State School Based Health Centers have an opportunity to play a role in what definitions of telehealth, telemedicine, originating site and distant site will look like at the end of the State of Emergency. SBHC's should consider how they understand these definitions and if any changes should be made. Then with a common understanding of current definitions and desired changes, they can begin advocating and influencing the future of telehealth in New York State.

Appendix 2 contains New York State Definitions of telehealth, telemedicine, originating and distant sites, and changes made during the public health emergency.

1.2 Telehealth Modality & Provider Restrictions

Under Executive Order 202.1, for the duration of the COVID-19 State of Emergency, an expanded list of eligible modalities and providers has been authorized by the Medicaid program. New York's Public Health Law 2999-cc(4) modalities now includes:

- Telemedicine
- Store and Forward Technology
- Remote Patient Monitoring
- **Telephonic communication (audio-only)**

Eligible providers for FQHCs offsite Licensed Practitioner services includes:

- Physicians
- NPs

- PAs
- Midwives
- Other Licensed Practitioners who have historically been billed under rate code 4015 for SBHCs including social workers and psychologists
- **Dentists**
- **School supportives**

1.3 HIPAA, Confidentiality & Consent

Laws governing consent and confidentiality were relaxed during the State of Emergency to allow for flexible use of telehealth services. The practitioner is not required to obtain written consent, however it is expected that the patient's identity is confirmed and they are provided with information on the services the patient will be receiving via telehealth. For providers in SBHC's, patients who cannot legally give consent must obtain verbal consent from a legal guardian (DOH, 2020).

While it is still expected that services performed via telehealth are in compliance with HIPAA and other relevant privacy laws, the enforcement of such laws at this time is relaxed. The Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency allows providers to perform telehealth services using non-compliant platforms, however they are encouraged to inform the patient of the associated risks. In good faith, the Office for Civil Rights (OCR) and the Department of Health and Human Services (HHS), which serve as the enforcement body, will not impose penalties on providers for noncompliance (HHS, 2020).

These relaxations allow for flexible use to telehealth services during times of uncertainty. **Interview insights revealed that post COVID-19, the government is likely to crack down on noncompliance causing organizations using platforms such as phone calls and basic zoom accounts to suffer. Organizations are urged to invest in compliant platforms before these regulations change.**

1.4 Policy Outlook

School Based Health Centers must carefully monitor the Center for Medicare and Medicaid Services (CMS) policy changes related to telehealth, as state Medicaid agencies often mirror CMS decisions. CMS has been carefully assessing key telehealth trends to determine which regulations should remain and which should be altered post COVID-19. These assessments have been focused on access, health outcomes, Medicare spending, impact on health care delivery and protection from misuse (Verma, 2020). While the rapid adoption of telehealth by providers has made it clear to CMS that telehealth is here to stay, there still remains a huge degree of political uncertainty.

IV. SECTION 2: REIMBURSEMENT

2.1 SBHC Medicaid Reimbursement Background

SBHCs are not a recognized Medicaid facility benefit. However, SBHCs may qualify as a Medicaid facility if they meet the requirements of the clinic benefit or the Federally Qualified Health Center (FQHC) benefit. Some states have taken the step to enroll SBHCs as Medicaid providers. New York State has considered doing this but has not yet taken the step of putting SBHCs under the managed care umbrella. However, New York State has laid out a plan to transition the provision of SBHC services into the Medicaid Managed Care benefit package beginning January 1, 2021. This is unlikely to occur given the current focus on the COVID-19 pandemic.

2.2 COVID-19 Reimbursement Changes

During the COVID-19 emergency, federal policy changes were made to improve access to telehealth. At the federal level, several changes were made to billing and reimbursement of telehealth services under Medicaid, but the majority of changes happened at the state level.

As part of the COVID-19 policy response, states had the option to reimburse telemedicine services the same way and in the same amount that they paid for face-to-face services. If they did this, they did not need to get approval from the Federal government. However, if they wanted to provide reimbursement differently for telemedicine than for face-to-face services, states must submit a separate State Plan Amendment (SPA). Keeping the rates equivalent was the path of least resistance in a time where capacity was extremely stretched. In New York, telemedicine services are currently being reimbursed in the same way and amount that in-person visits were reimbursed under Medicaid.

For the duration of the State Disaster Emergency declared under Executive Order 202, New York State Medicaid will reimburse evaluation and management services delivered via telephone and telehealth in cases where face-to-face visits are not appropriate. These services will be covered when provided by any qualified practitioner or service provider and must be documented as appropriate for payment purposes in Medicaid Fee-for-Service or Medicaid Managed Care. For FQHCs specifically, the full Medicaid wrap rate/PPS rate will be paid for telehealth and telephonic services. Of note, there is no difference in the way that telephone and televideo services are currently being reimbursed. Additionally, capital costs for telehealth equipment are not currently reimbursable by Medicaid. All of these enhanced Medicaid reimbursement rates for telehealth in New York will expire when the State Disaster Emergency Declaration ends.

2.3 Reimbursement Implications

The enhanced reimbursement rates have truly allowed SBHCs in the state to continue to provide essential care to patients despite a virtual environment. One provider from an independent SBHC noted, “In order to continue to provide a high level of service via telehealth, video and phone reimbursement rates have to remain equivalent to in-person visits.” This sentiment was echoed by a provider at an upstate SBHC, noting, “Without the current level of reimbursement, I don’t know how we would carry on providing telehealth services.” As long as the state of emergency continues, these enhanced reimbursement rates are likely to stay. However, once students and providers are back in the schools full-time, reimbursement changes will follow. Providers noted that telehealth is a powerful tool, but if reimbursement is lower for telehealth than in-person, it will be impossible to rationalize taking time out of a clinician’s schedule for telehealth when that time could be used for an in-person visit. The new reimbursement flexibilities have also allowed providers to bill for services previously provided for free, such as provider follow up calls.

2.4 Reimbursement Policy Outlook

It is unlikely that telehealth will continue to be reimbursed at the enhanced levels of 2020, beyond the COVID-19 pandemic. However, the value of telehealth has been made clear during the crisis, and this should be reflected in future policy changes. One interviewee from a large sponsoring SBHC organization noted that they anticipate video but not audio-only telehealth sessions to continue to be reimbursable. Interestingly, multiple policy advocacy groups in New York State noted a concern that increased access to telehealth services would lead to overutilization of care and increased healthcare costs. There has yet to be an analysis of the impact of telehealth reimbursement changes on costs yet, so the direction of the change is to be determined. However, all SBHC providers noted a clear decline in utilization of services after switching to telehealth. Once these cost analyses are performed, it is not expected that the state will find an increase in costs.

V. SECTION 3: CODING & BILLING

3.1 Key Considerations

Although reimbursement levels for telehealth visits were on par with in-person visits during the COVID-19 public health emergency, coding and billing for telehealth visits provided its own challenge. Coding for telehealth visits remains different from in-person visits and proper coding will be crucial to optimizing an SBHC’s telehealth performance and to maximizing revenues. Telehealth claims billing requires **1) a Place of Service (POS) code equal to what would have been used in-person and 2) a modifier to indicate the service took place over telehealth.**

Additionally, telephone visits and audio-only telehealth were made reimbursable for certain services during the public health crisis. These audio-only visits are coded differently than audio-video visits and present an additional challenge to the billing process. Coding for evaluation and management services provided by phone differ for visits of varying lengths (eg. 5-10 mins, 11-20 mins, 21+ mins). Telephonic services were reimbursed on par with tele-video services during the public health crisis, though it's important to note that these changes are expected to be temporary and CMS is establishing new billing guidelines and payment rates to use after the emergency ends.

3.2 Training

SBHCs have indicated that figuring out coding and modifiers was the biggest learning curve as part of telehealth implementation. Additionally, the dynamic nature of Medicaid reimbursement policies can lead to confusion with billing amongst providers. Thus, proper and continuous training will be imperative to the success of the telehealth program. It is recommended that SBHCs have their centralized billing office conduct best-practice training with providers to help staff understand coding and modifier usage to ultimately maximize reimbursements per visit. Furthermore, for smaller SBHCs without centralized billing, it is recommended to have one experienced Medicaid biller assigned to SBHC telehealth. Proper training will be crucial in the event of visit complexities such as if technical difficulties arise, and the visit shifts from audio-visual to audio-only.

VI. SECTION 4: SERVICES

4.1 Traditional SBHC Services

A select list of traditional SBHC services is outlined below. The services are categorized by their current suitability for telehealth. It is important to note that although some services are not yet suitable for telehealth, advancements and additional technology can make these services suitable for telehealth in the future.

Suitable for Telehealth

- Mental & Behavioural Health
- Chronic Disease Management (eg. Asthma & Diabetes)
- Reproductive Health
- Social Work
- Nutrition
- Substance Use Counselling
- Health Education
- Prescriptions
- Primary Care Services

Not Yet Suitable for Telehealth

- Physicals
- Vision & Dental
- Acute Illness Treatment
- Immunizations
- Blood & Urine Collection

4.2 Primary Telehealth Services

The most commonly offered telehealth services at SBHCs are mental & behavioural health, reproductive health, and chronic disease management (Appendix 3). Mental health and behavioural health were the top telehealth services and comprise the vast majority of telehealth visits at interviewed SBHCs. Reproductive health and chronic disease management also remain popular as routine follow-ups and prescription refills are easily conducted via telehealth. The key implication is that telehealth tends to work better for existing patients rather than new patients as it's challenging to establish an initial rapport and comfort virtually. With wider adoption of telehealth going forward, it is recommended to have students attend their visits in-person initially, utilizing telehealth for follow-up purposes.

4.3 Opportunities

Screening: Screening and self-assessments can be used to evaluate whether an in-person visit is needed. Some SBHCs have been using phone screens before an appointment is made to triage students between in-person and telehealth.

Parental Involvement: Telehealth allows for providers and social workers to better support and connect with parents. A significant number of SBHCs indicated that telehealth allowed the parent to be involved in mental health consults. This allows providers and social workers to increase coordination and provide parents with additional resources to help the student. A Medicaid waiver has currently made meetings with parents billable.

Peripheral Devices: Peripheral devices are devices and attachments that share diagnostic data with providers. Peripheral devices may expand the scope of a providers' ability to perform assessments virtually. Initial reviews from SBHCs on the use of peripheral devices were mixed. Further research will need to be conducted on the peripheral device cost compared to the expanded diagnostic abilities.

VII. SECTION 5: TELEHEALTH SYSTEMS

4.1 Traditional SBHC Services

Selecting a telehealth system platform that consists of a multitude of features and offers a variety of services, while also being cost efficient and user friendly, is critical for maintaining positive user experience and a sustainable virtual practice. There are numerous modalities that have been used across various SBHC's (Appendix A3)

There are 3 major pricing models to be considered when selecting telehealth system platforms:

1. **Commercial Open Source:** Software purchase by the customer and maintenance of this software is the sole responsibility of the customer. This kind of model refers to a dual licensing contract. There are no major upfront costs but there are high recurring costs due to ongoing maintenance.
2. **Subscription:** Software accessed over the internet and partnership with a third party is critical. Subscription is the most common pricing model utilized by SBHC's. There is a low upfront cost and a high recurring cost due to ongoing maintenance.
3. **Perpetual License:** Owning the software for a fixed term and premise installment. There is a high upfront cost with a single fee but low recurring since maintenance is internal and the program can be used indefinitely.

While speaking with and surveying various SBHCs, many pointed out similar sentiments towards what to consider when deciding upon a telehealth system to use:

- **HIPAA compliance**
- **Price**
- **Telephonic and video features**
- **Translation options:** Since SBHC's serve a high number of non-English speaking families/students, it is important to consider telehealth systems that offer their services/have the potential to offer their services in another language, such as Spanish.
- **Peripheral device options:** As telehealth services continue to advance and become a fundamental aspect of SBHC platforms, thinking about the use of peripheral devices and which telehealth systems could support this extension would be beneficial as services begin to expand.

VIII. SECTION 6: OPERATIONS/STAFFING/ TRAINING

4.1 Traditional SBHC Services

School based health centers must be cognizant of the training they provide staff members on the virtual platforms. In our interviews with various institutions, it became very apparent that time spent towards training caregivers on navigating through telehealth system platforms is essential for not only the efficiency of the appointment but also crucial for the patient's experience. Time spent towards training for the various features of the system, engaging in cross-training of other caregiver workflows (Appendix A4), providing bedside manner within a virtual platform and offering ongoing in-service training can lead to effective telehealth platform use. It is also highly recommended to ensure there are experts on site who have received rigorous training in using the telehealth system so that they can troubleshoot any issues that may occur.

IX. SECTION 7: BARRIERS TO ACCESS

In conversation with numerous School Based Health Centers, four major barriers to access in telehealth services came to surface; domestic privacy, network reliability, device accessibility and patient reimbursement.

7.1 Domestic Privacy

While engaging in telehealth services from home, students have had to take their appointments in privacy, away from family members and from parental surveillance. Students have taken appointments in the bathroom or leave their homes to go to a nearby park. This is especially prevalent with mental health services, as some students prefer not to keep their family informed of their engagement in such services.

7.2 Network Reliability

An uptake in more individuals staying at home has resulted in that much more internet use. This has resulted in an inability to access a high speed, stable internet connection, which impedes the ability to have steady and consistent appointments. Not only does this serve as an issue with access, but also compromises patient experience and having a meaningful, virtual experience. Family's could invest in high internet speed but this comes at a cost that many cannot afford. School based health centers are therefore encouraged to seek partnerships with telecommunication companies that have started offering system-wide deals for multiple members to enroll.

7.3 Device Accessibility

Access to devices such as smartphones, tablets, laptops and computers have served as major barriers for several students since they are sharing one device between various family members. The inability to access these devices impede the students' ability to engage in their telehealth appointments and unfortunately, students who utilize school based health centers come from families that cannot afford multiple devices for every family member.

7.4 Patient Reimbursement

There is a lack of widespread coverage and reimbursement for telemedicine services across states and insurers with low to no cost sharing for patients. Therefore, SBHCs must strategize towards finding a balance between telehealth and video health visits with in-person visits to ensure reimbursement, especially for new patients.

X. SECTION 8: EVALUATION

8.1 Evaluation Program Usage

Due to the rapid adoption of telehealth during the COVID-19 public health crisis, SBHCs had limited time and resources to perform extensive program evaluation. Although a handful of SBHCs had metrics to measure patient satisfaction, there continues to be a lack of evaluation in aspects of utilization, efficiency, and completion. Moving forward, it will be crucial for SBHCs to monitor and evaluate their telehealth programs to determine whether they are successfully meeting program objectives.

8.2 Key Areas for Evaluation and Recommended Indicators (Appendix 6)

Six primary areas were identified for evaluation: utilization, completion, technical disruption, reimbursements, time and duration, and satisfaction.

1. *Utilization*: evaluates the overall utilization of telehealth visits as a proportion of in-person visits and by type of service.
2. *Completion*: evaluates the proportion of scheduled telehealth visits that are ultimately completed and the proportion of visits that don't require an in-person follow-up.
3. *Technical Disruption*: evaluates the technical infrastructure and systems performance.
4. *Reimbursements*: evaluates telehealth claims data against in-person claims data.
5. *Time and Duration*: evaluates visit length and scheduling to optimize staffing and efficiency
6. *Satisfaction*: evaluates overall patient and provider satisfaction

Nine preliminary evaluation indicators have been recommended for measurement (Appendix 6). Although it is recommended that all SBHCs adopt these indicators into their evaluation programs, SBHCs may wish to incorporate additional metrics that meet their individual program needs.

XI. SECTION 9: CROSS-STATE TRENDS

No two states are alike in how telehealth is defined and regulated, making the policy environment for SBHC's difficult to navigate. While federal policies are important to understand, especially during a pandemic, understanding how New York State's policies impact the opportunities and constraints of SBHCs is even more critical. In order to provide recommendations on how to navigate the rapidly changing political environment, the team looked at telehealth policies across all 50 states, concentrating on a few states that displayed notable developments in telehealth implementation for SBHCs. Cross-state trends and unique state highlights are described below.

9.1 Policy Changes Pre/Post Public Health Emergency (PHE)

States continue to exert a great deal of flexibility around their adoption of telehealth services. After all, states have the option to choose which services will be covered, how the services will be implemented, what types of providers can deliver these services, and how they will code them for tracking and reimbursement. Therefore, the success of telehealth implementation is extremely geographically sensitive. According to a 2017 report by the American Telemedicine Association, 23 states had addressed telehealth in schools through some sort of legislative action (CMS, 2020). With the arrival of COVID-19 in the spring of 2020, all 50 states now have policies in place allowing telehealth to become reimbursable by Medicaid and other payers (CMS, 2020). As states quickly adjust their telehealth legislation, it becomes extremely important to understand which flexibilities will stay and what opportunities they will offer for the expanded role of telehealth in SBHCs.

A comprehensive review of state telehealth laws and reimbursement policies from the Center for Connected Health Policy (CCHP) provides rich information for health advocates and policymakers who are trying to understand telehealth implementation across America. Findings suggest that, in general, most states view telehealth positively and are considering extending some or all of the flexibilities adopted during the COVID-19 pandemic (CCHP, 2020). Thirty-three states are now reimbursing either a transmission, facility fee, or both, but only nineteen state Medicaid programs explicitly allow the home to serve as an originating site. Similarly, sixteen state Medicaid programs reimburse for store-and-forward, but only eight states, including New York, allow an out-of-state licensed provider to render services via telehealth (CCHP, 2020). Reimbursement policy is not the only variance across states. Privacy and confidentiality laws (HIPAA and FERPA), Children's Health Insurance Programs, funding, SBHC policies, local school-board policies, and many other factors are important to consider when analyzing telehealth initiatives for SBHCs in New York.

9.2 State Spotlights: Exploring Key Findings from Colorado, Connecticut, and North Carolina

In order to offer the Foundation a list of recommendations for New York State telehealth implementation in SBHCs, the team chose three states with progressive telehealth models in place to examine; Colorado, Connecticut, and North Carolina. Interviews with SBHCs in all states and telehealth consultants were conducted, as well as extensive secondary research to capture key findings. This next section will examine the varied approaches and strategies that the states have developed, highlighting successful practices and perceived barriers.

Colorado SBHCs have experienced multiple challenges and triumphs during the pandemic. Prior to COVID only two SBHCs had telehealth capabilities whereas today all centers now offer some sort of telehealth service (MacLean, 2020). The state sees telehealth as an extremely important role in increasing access for rural communities and their updated policy reflects that (Gostlin, 2020). After enacting the Colorado State Bill 215 in May 2020, changes to existing Medicaid laws and billing requirements have provided financial incentives for SBHCs to expand telehealth, particularly their behavioral health services. Colorado's hybrid approach to telehealth allows for some in-person visits to remain, delivering a full range of primary and specialty services between both models of care. The Colorado Association of School-Based Health Care created a resource compilation for SBHCs regarding billing information, staff support, community resources, and more to aid individual centers in their response to COVID and their reopening processes (MacLean, 2020).

In contrast to Colorado's hybrid model, Connecticut is operating under an exclusively telehealth approach for their Community Health Center (CHC) sponsored SBHCs. CHC is a statewide Federally Qualified Health Center (FQHC) in Connecticut that sponsors nearly 180 SBHCs across the state (Masselli, 2020). Prior to the PHE, SBHCs in Connecticut were already utilizing telehealth for behavioral health services and other small pilots. Therefore, when COVID hit they quickly transitioned all services to telehealth except dental care, where patients were referred out to clinics (MacLean, 2020). Since dental care was outsourced, SBHCs restrained those staff members to work in other sectors and services, such as working in call centers or taking temperatures (CT.gov, 2020). Some of the addressed challenges in Connecticut provide great lessons learned. For example, contact with students was problematic in the beginning, and therefore investing in Zoom Phone allowed them to have caller ID so patients knew who was calling. Access problems were addressed as well, as many districts handed out Google Chrome books to students without devices (WTNH, 2020).

North Carolina proved to be an interesting state to observe due to their utilization of funding streams. As a state, North Carolina had historically placed a large emphasis on improving child health, and the state's academic affiliations with institutions such as Duke University, UNC, and others proved to be key in their transition to telehealth for SBHCs. Additionally, in January 2020, the North Carolina Integrated Care for Kids (InCK) Model received a multi-million-dollar grant from the Center of Medicaid and Medicare Services (CMS) to improve child health and the integration of care in schools and communities (Sprigg, 2020). Therefore, the state seemed to demonstrate a mature and smooth transition to telehealth services during the pandemic.

9.3 Commonalities in telehealth implementation success across states

Some of the differences in state telehealth approaches are highlighted above. With all

three states being pioneers for SBHCs across the US, many similarities between states were found as well. For example, all states mentioned an expansive role for their SBHCs to serve as resource hubs for both patients and parents of the community. Two states even expanded their websites to not only include COVID-19 information, but also resources addressing social determinants such as housing, food insecurity, job postings, etc (CASHBSC, 2020). As a result they mentioned that providers and staff seemed engaged with the community in new ways (MacLean, 2020). Additionally, all states noted repeatedly that audio-only visits were one of the most important factors of telehealth success during the PHE, especially in rural areas. As far as services, all states found a significant increase in the need for behavioral health services, some even offering virtual group therapy in the SBHC to keep up with demand. Similarly, all states expressed concerns about confidentiality, particularly with behavioral health services and non-HIPAA compliant platforms such as FaceTime. Lastly, all states recognized the need for improvement on capturing quality measures and noted the critical importance demonstrating measurable results, a capability that many SBHCs are not equipped to currently measure.

XII. SUMMARY OF RECOMMENDATIONS

Policy

- SBHCs should establish common state-wide definitions
- Important to invest in the HIPAA compliant platform now before regulations change
- Nudge patients from audio only to audio-visual services
- Continue to develop and codify telehealth capabilities regardless of future reimbursement policy changes

Training

- Conduct training so staff understand the usage of modifiers in telehealth billing
- Encourage cross training so that all stakeholders are aware of each others' workflow and responsibilities

Evaluation

- SBHCs should implement evaluation programs to monitor and improve their telehealth program

System

- The chosen system should be HIPAA compliant, contain both video and telephonic features and be user-friendly from the patients' and providers' side
- A subscription payment model is ideal as it is more flexible and enables adaptations, changes and developments along the way.



XIII. NEXT STEPS & OPPORTUNITIES

COVID-19 has forced swift action on telehealth adoption. Prior to this year, many SBHCs and providers in general had placed telehealth implementation on the back burner. However, telehealth now has the world's attention. Telehealth has been a powerful tool for SBHCs, and as a result, there are several key areas of advocacy that SBHCs may focus on.

Advocacy Priorities:

- Permanent expansion of telehealth Medicaid coverage
- Push for reimbursement rates for telehealth to be as close to in-person rates as possible
- Continued flexibility for phone-only visits in order to protect access for high-risk students
- Expanded internet access for students at home via increased funding and/or partnerships with broadband providers
- Coordination with the American Telemedicine Association, Alliance for Connected Care, and the National Committee for Quality Assurance (NCQA), who are spearheading the “Taskforce on Telehealth Policy” to lobby for permanent policy changes to telehealth reimbursement

Beyond advocacy for continued protections of telehealth access for SBHCs, the Foundation may look into future applications of telehealth. The potential for telehealth utilization in SBHCs was largely untapped until this year, and the opportunities are vast. For one, peripheral devices could be implemented so that more services can be amenable to telehealth. Additionally, a hub and spoke model using telehealth could greatly expand access to care for New York students. In this model, providers in SBHCs can use telehealth to connect students with specialists who may not be available at the clinic. This could have vast implications for rural patients and patients who face barriers to specialized care.

XIV. CONCLUSION

This paper, written for the New York School Based Health Foundation by the Columbia Mailman School of Public Health Consulting Workshop, provides valuable insights and recommendations on school-based health center implementation of telehealth services during COVID-19. This report compiles knowledge from interviews with SBHCs, policy and advocacy organizations and a review of the literature to uncover information on policy, reimbursement, coding and billing, telehealth systems, operations/staff/training, access and evaluation. In addition, the report includes a section on next steps and opportunities for the New York School Based Health Foundation and SBHC organizations alike to engage in advocacy efforts to push for maintaining appropriate telehealth regulations and reimbursements.

Telehealth offers a unique solution for SBHCs to continue to provide needed care for an underserved population during a global pandemic. Successful implementation of telehealth will allow the opportunity to better serve students and engage parents when schools are not in session, now during COVID-19 and in the future.



XIV. APENDIX

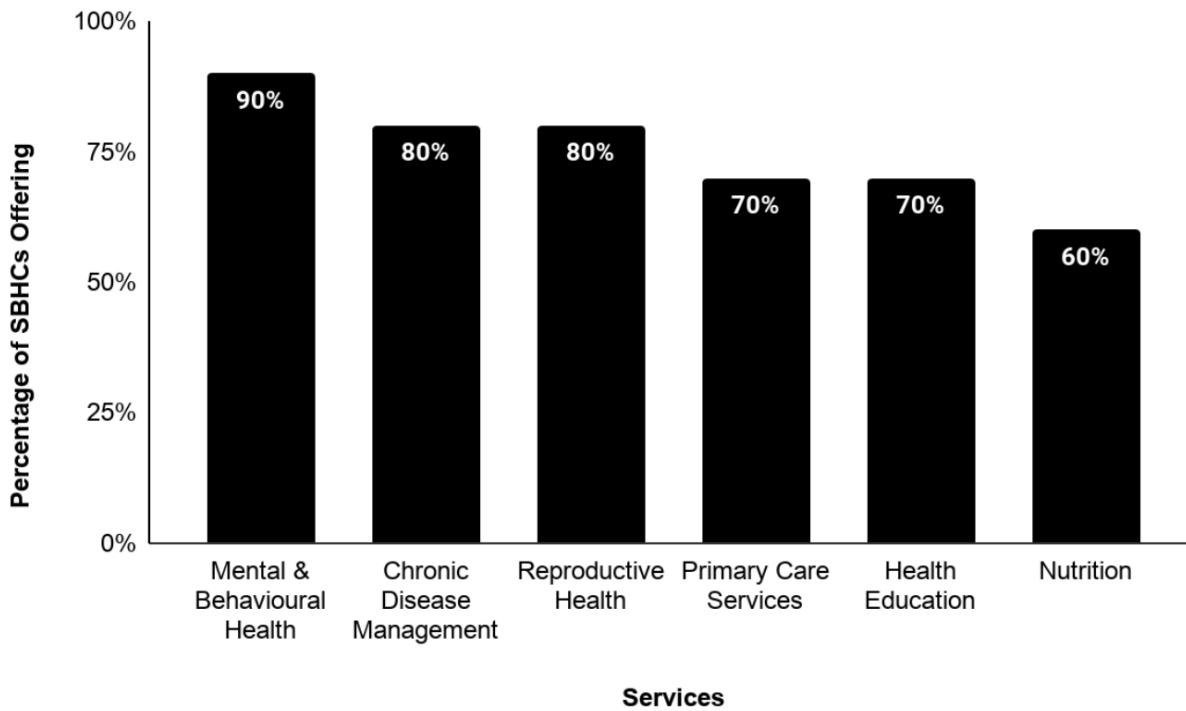
A1. Interview Guide Questions

Stakeholder	Questions
School Based Health Centers	Systems: What kind of telehealth system does your organization have implemented and how did you choose?
	Services: Tell us about the services and types of visits delivered via telehealth, how they have shifted with COVID, and what can't be delivered via telehealth?
	Challenges: What challenges did you face using telehealth? Were there any regulatory barriers? What would you have done differently?
	Equipment: What kind of telehealth equipment did your organization acquire? What was the capital cost of this equipment?
	Staff/Operations: Who is permitted to offer telehealth services? What kind of support staff is required? What kind of training is required? How did workflows change?
	Billing: Did telehealth coding and billing practices differ from in-person services?
	Access: Have you encountered issues regarding patient access to telehealth (eg. internet, devices, environment, etc)?
	Evaluation: Have you conducted evaluations on the effectiveness of telehealth vs. in-person service visits? If so how?
Policy/ Advocacy Organizations	Regulations: Many Medicaid and other regulations are relaxed during the COVID-19, which relaxed regulations are essential to the sustainability of SBHC telehealth services going forward? What is the outlook for these changes becoming permanent?
	Reimbursement: Reimbursement rates were enhanced for telehealth visits, what is the nature and extent to these enhancements? Are these rates sustainable for telehealth services? What is the outlook of these changes becoming permanent?
	Systems: What are the leading, compliant, reimbursable telehealth systems? Do you recommend any?
	Internal Changes: What internal practice changes are required for successful telehealth implementation (e.g., changes in staff roles, responsibilities, workflow, training)?
	Coding, Billing & Revenue: How does coding and billing for telehealth visits differ from in-person visits? What burdens does this impose on the provider?
	State SBHC Telehealth Models: Some states are highly advanced in SBHC telehealth services (particularly North Carolina). What have they done in terms of policy and implementation?
	Access: Providers have encountered issues regarding patient access to telehealth (eg. internet, devices, environment, etc), how do you suggest mitigating these access barriers?

A2. New York State Definitions (NYSDOH, 2020)

Term	Definition	Changes During COVID-19
Telehealth	<p>The use of electronic information and communication technologies to deliver health care to patients at a distance.</p> <p>Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Medicaid member.</p>	During the State of Emergency, telehealth includes telephonic services, in addition to telemedicine, store and forward, and remote patient monitoring.
Telemedicine	Two-way electronic audio-visual communications to deliver clinical health care services to a patient at an originating site by a telehealth provider located at a distant site.	Telemedicine includes teledentistry.
Originating Site	Where the member is located at the time health care services are delivered to him/her by means of telehealth.	During the State of Emergency can be anywhere the member is located including the member's home or out of state.
Distant Site	The site where the telehealth provider is located while delivering health care services by means of telehealth.	During the State of Emergency, any site within the fifty United States or United States' territories, is eligible to be a distant site for delivery and payment purposes, including Federally Qualified Health Centers and providers' homes, for all patients including patients dually eligible for Medicaid.

A3. Commonly Offered Telehealth Services



A4. Telehealth Platforms

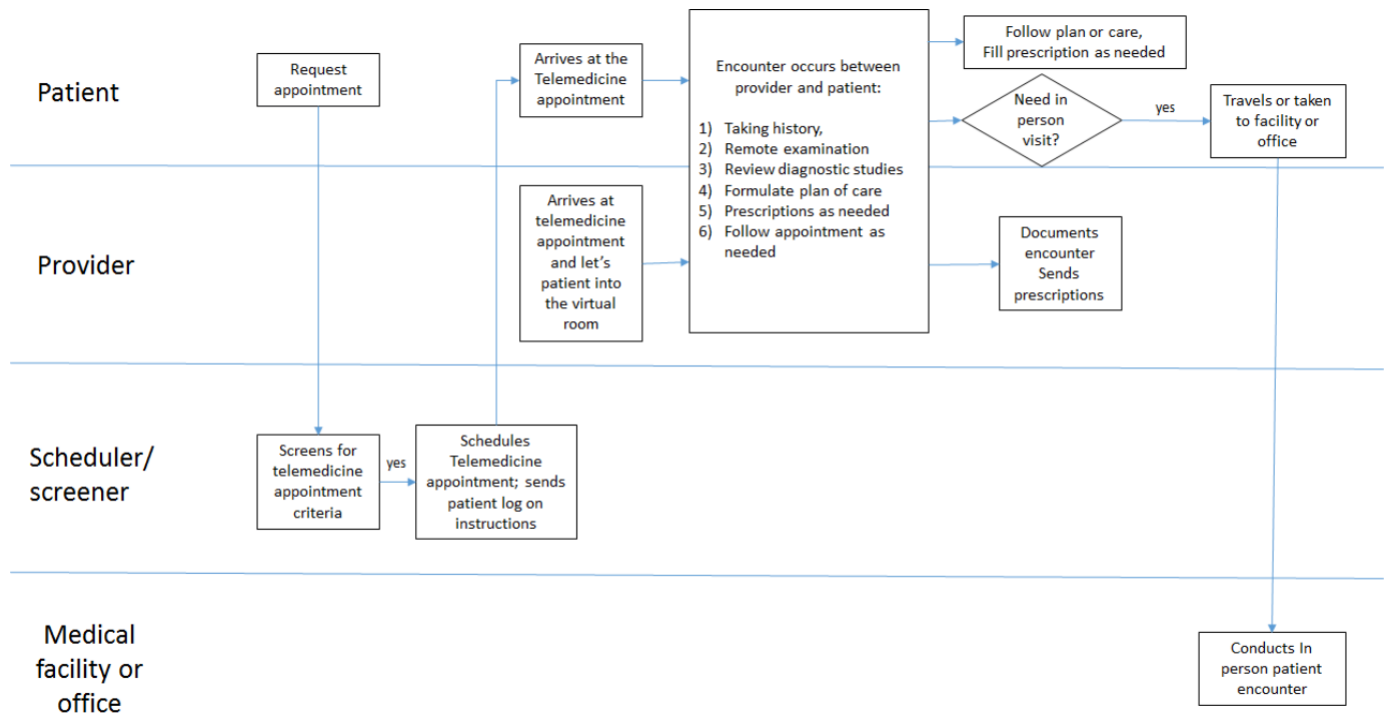
System	HIPAA Compliant	Telephonic features	Video features	Translation	EMR Integrated
Doximity	✓	✓	✓	✓*	✓
MyChart Connect	✓	✓	✓	✓	✓**
Zoom	✓	✓	✓		
Amwell	✓	✓	✓		✓
Curogram	✓	✓	✓		✓
Microsoft Teams	✓***	✓	✓		
Google Hangout	✓***	✓	✓		
Phone/Facetime		✓	✓		

*Translation available only with Epic

** Integrates with Epic only

***With the purchase of Business associate agreement

A5. Caregiver Workflow



A6. Recommended Evaluation Indicators

Indicator	Data Needed	Purpose
Utilization		
1. % of all services performed using telehealth: total and by specific service type	<ul style="list-style-type: none"> ● Services provided through telehealth <ul style="list-style-type: none"> - Total number, total by service type ● Non-telehealth services <ul style="list-style-type: none"> - Total number, total by service type 	Indicates overall utilization of telehealth at the SBHC
Completion		
2. % of scheduled telehealth visits completed	<ul style="list-style-type: none"> ● Telehealth visits scheduled <ul style="list-style-type: none"> - Total number, total by type ● Telehealth visits completed <ul style="list-style-type: none"> - Total number, total by type 	Low completion rates may indicate issues around patient no shows, home privacy concerns, and patient technical/equipment problems
3. % of telehealth visits that were followed by an in-person visit	<ul style="list-style-type: none"> ● Total number of telehealth visits ● Total number of telehealth visits with no subsequent in-person required 	Provides information on how often telehealth visits completely replaced the need for an in-person visit
Technical Disruption		
4. % of telehealth visits impacted by a technical issue	<ul style="list-style-type: none"> ● Visits with technical issue reported <ul style="list-style-type: none"> - Total reports - Total by specific reason 	Performance improvement measures can be implemented to address dropped calls, poor video quality, poor audio quality, etc
Reimbursements		
5. Actual telehealth reimbursements as a % of expected reimbursements and as a % of in-person reimbursements	<ul style="list-style-type: none"> ● Expected telehealth reimbursements ● Actual telehealth reimbursements ● Actual in-person reimbursements 	Helps to evaluate the long-term financial viability of telehealth services
Time and Duration		
6. Most frequent times for telehealth services delivery	<ul style="list-style-type: none"> ● Visit start time 	Provides insight to identify optimal staffing patterns for telehealth visits and opportunities to extend service hours
7. Average time per telehealth visit (including prep and charting); all services and by specific service type	<ul style="list-style-type: none"> ● Start time of visit ● End time of visit ● Specific service type 	Provides information on total encounter time that can be useful to optimize scheduling
Satisfaction		
8. % of patients indicating overall satisfaction with telehealth visits compared to in-person visits: by total and by visit type	<ul style="list-style-type: none"> ● Feedback responses collected <ul style="list-style-type: none"> - Telehealth - In-person ● Feedback responses collected that indicate satisfaction <ul style="list-style-type: none"> - Telehealth - In-person 	Identifies overall patient satisfaction. Reasons for differences in satisfaction can include <ul style="list-style-type: none"> - Efficient use of time - Reliability in technology - Patient comfortability
9. % of providers indicating overall satisfaction with telehealth visits compared to in-person visits: by total and by visit type	<ul style="list-style-type: none"> ● Feedback responses collected <ul style="list-style-type: none"> - Telehealth - In-person ● Feedback responses collected that indicate satisfaction <ul style="list-style-type: none"> - Telehealth - In-person 	Identifies overall provider satisfaction. Including and incorporating provider feedback can improve staff buy-in.

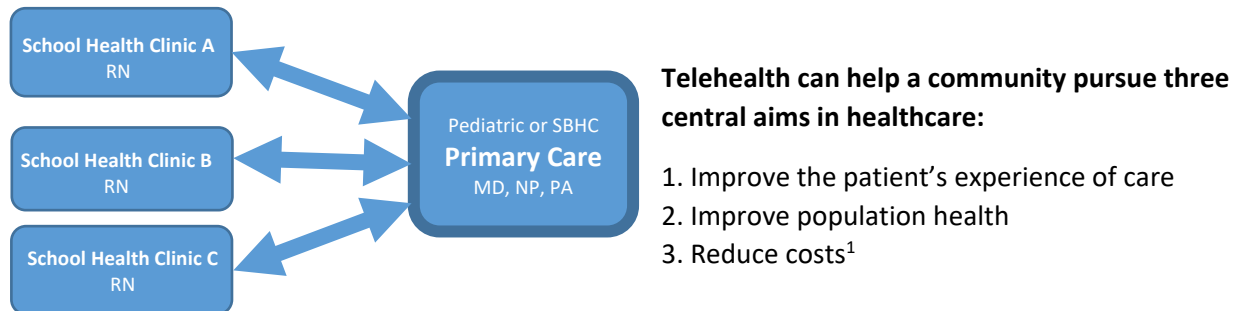
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Implementing Telehealth in Michigan Schools

School telehealth programs use pediatric registered nurses (RNs) and technology to reduce barriers to healthcare by providing health and wellness services to youth where they are every day – at school. RNs working under standing orders provide high quality, comprehensive healthcare at school. When care is needed beyond what a RN can provide, video and audio connections can link the school nurse's office to primary care providers at a pediatric or school-based health center (SBHC). Multiple RNs in different schools may link to the same primary care provider or office.



There are many documented benefits to using the school telehealth model of care. The benefits identified in a 2015 literature review² include:

- Improving care for children with chronic conditions
- Providing health education and health promotion
- Reducing student absenteeism and improving convenience
- Collaborating with parents, school nurses, and clinical providers
- Savings at many levels – hours of work time, emergency department costs, physician costs

Initiating and maintaining a successful school telehealth program takes careful planning in a number of areas, including²:

- Assessing community needs, support, and resources
- Gaining and maintaining the buy-in of school nurses and providers
- Finding appropriate funding for the short and long term
- Choosing, purchasing, and maintaining equipment
- Securing initial and ongoing technical support
- Training staff
- Informing parents
- Designing appropriate space and workflow
- Internet speed and bandwidth capabilities
- Protecting health information
- Reimbursement

More about the school telehealth landscape can be found here: <http://www.cahctelehealth.com/school-telehealth-landscape/>

What follows is a guide to planning steps and resources that will equip you to develop a thriving school telehealth program.

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Table of Contents: School Telehealth Planning Steps

Step One: Environmental Analysis and Organizational Readiness

- Assess your population's needs
- Assess and confirm organizational and school readiness for school telehealth
- Identify partners and resources in the community
- Grow your champions
- Assess your ability to incorporate health information technology

Step Two: Detailed Implementation Plan

- Components of school telehealth and prioritization
- Plan for development of protocols, policies, and procedures
- Initial and ongoing training
- Workflow
- Room design

Step Three: Performance Monitoring Plan

- Establish both short- and long-term goals
- Develop a continuous quality improvement process

Step Four: Showcase Your Model – Marketing & Communication Plan

- Know your story
- Market to your administrators and others within your organization
- Market to your community
- Invite others to be part of your success

Step Five: Sustainability

- View grants as short-term 'pilot funding'
- Develop multiple revenue streams
- Partner with larger organizations and communities

Appendix

Sources and Acknowledgments

This manual was developed by adapting multiple resources from sources including the California Telemedicine and eHealth Center, the California Telehealth Resource Center, AMD Global Telemedicine's "10 Critical Steps for a Successful Telemedicine Program," and many others.

Step One: Environmental Analysis and Organizational Readiness

A. Best Practice: Assess your population's needs

- Review population data from your organization, community, county, state, and the nation. Look for data that showcases specific needs within your population, to help make the case for implementing a school telehealth program.
- Go visit! Interview professionals and potential clients. There is simply no substitute for taking the time to visit your sites, meeting your colleagues and community members, and learning firsthand about their lives, clients, local opportunities, challenges, and concerns.

Lessons from the field...

1. Consider these useful data sources:
 - Your local Community Health Agency is an optimal resource for community data and statistics.
 - In addition, the [Michigan Profile for Healthy Youth](#) (MiPHY) Survey is a useful tool.
 - School district surveys and parent surveys can provide data to help narrow down your focus on the specific needs of your targeted population.

B. Best Practice: Assess and confirm your organizational and school readiness for school telehealth

- Ensure the school telehealth model matches the mission/vision of your organization and the school climate.
- Prioritize the components of the model of care into three categories: “Essential,” “Would be helpful,” and “Nice to have.”
- Bring administration and staff from both organizations into the process early to ease implementation and acceptance.

Lessons from the field...

1. It often takes a few months or longer to fully implement a school telehealth program. It is best to start the planning process *well in advance of the school year end*, or else “live” visits may need to be delayed until after summer break.
2. Performing a formal readiness assessment prior to implementation can help you determine the impact of other projects, readiness to change, capacity, and available resources within your organization.

Here are examples from a program SWOT analysis:

- “Strengths of the program include strong administrative leader support. The program is connected to a successful, established pediatric and adolescent practice. Our nurses are pediatric RNs that have established relationships

with the pediatric physicians. The program has access to all hospital resources including, electronic health record, laboratory, diagnostic imaging, and billing services.”

- “Weaknesses of the program include an ongoing concern of having a lack of funding and creating a sustainable program. Telemedicine is also a relative unknown or new concept in a rural community. As a team we strive to provide ongoing community education about telehealth and the benefits it has in a school health setting.”
- “Our program is unique in that we were able to create a new model of school based health care, in a population that has not previously had even nursing services in the schools. We have also been able to show our community as well as others in the state that telemedicine is a viable, quality solution to rural areas to increase access to care. The program is assisting students with improved health outcomes through easy access to age-appropriate health care.”
- “The potentials threats to our program are lack of funding and discontinuation of financial community support.”

C. Best Practice: Identify partners and resources in the community

- Identify organizations in your target communities that do similar work to what you are proposing, and reach out to them.
- Identify the activities and interests of local leaders, organizations, and other stakeholders that match with your model of care. Would they support and collaborate with you? How would they do this?

Lessons from the field...

1. “The community hospital, community health agency, and school systems formed a partnership that allowed for the process of bringing school telehealth to the district. After the clinics were established, the hospital’s foundation was key in identifying funding opportunities, both present and future.”
2. Create partnerships with established medical practices in the community to increase “buy-in.” Have one-on-one conversations at all levels of the practice (secretaries, medical assistants, nurse practitioners, office managers, and physicians) to help them understand what your program has to offer, and ask for suggestions on ways to work together. Provide structured opportunities for them to ask questions on an ongoing basis.
3. Local service groups such as Rotary, the United Way, and community foundations can all be supporters of your program. Use a wide range of media outlets to help draw interest and propel new donors.

D. Best Practice: Grow your champions

- Identify champions at both the administrative and program staff levels to play a key role in creating momentum and excitement for the project – and be sure to nurture their involvement.
- As much as possible, involve these individuals at the very beginning of program planning to help you design and drive development.
- Look for inspirational figures who play a key role in creating a professional and nurturing environment in which additional champions will be encouraged and develop.

Lessons from the field...

1. Champions of the program can be found at all levels of your organization. Communicate to each person involved in the school telehealth program about what they individually bring to the process; identifying individual strengths will increase buy-in.
2. While administration may be the catalyst for a school telehealth program, individual conversations about the program and discussions of possible processes at the staff level are vital in creating a successful model. Good communication is essential for staff engagement, and allowing staff to have input into the workflow will increase employee satisfaction, ownership, and motivation. In addition, regular contact with distant providers via meetings and program updates has been proven to increase engagement.
3. Champions of the program can be both internal and external. Testimonials, from students or parents who have used the health clinic's services, are a way to identify champions. School administrators, school staff, and parents can be helpful in supporting your clinic by word of mouth and referrals. Fundraising through your hospital's foundation can be useful in increasing awareness of your program.
4. Hiring practices need to be aligned with getting "the right person for the right position." School nurses need to be passionate about adolescent health and work well autonomously.

E. Best Practice: Assess your ability to incorporate health information technology (HIT)

- A high speed (T1 and above) network, to support high quality images, is necessary infrastructure at each site.
- A VPN tunnel with a secure connection between the distant and originating site.
- High Bandwidth that can support high quality images
- Dedicated bandwidth for HIPPA (amount unknown)

- A hardwire (vs. wireless) connection is recommended where applicable. (It may make things less portable, but will decrease variability.)
- School and healthcare systems must support health information exchange.
- Technology leadership must be involved to develop effective network security and privacy systems.
- To ensure health information is protected, use HIPPA compliant software and provide space in the clinic for private check-in and exam. In addition, paper medical records should be kept in a private/locked area.
- Equipment should be purchased from a telehealth/telemedicine company to ensure it meets all current standards and may include:
 - Utility cart
 - Web-cam
 - Telehealth Stethoscope
 - Examination Camera
 - Telehealth Otoscope
 - Telehealth Monitor and Headphones (An additional monitor and headphones at the pediatric clinic)
 - Video conferencing software at both locations

Lessons from the field...

1. Have a conversation with leadership about policies regarding equipment vendor selection *early in the planning process*. One site initially decided to use outsourced equipment, but after purchase, setup, and initial testing, they were informed of a requirement to use the same equipment as other telehealth projects within the health system. They were able to work on policies and protocols as they waited for new equipment, but they had to deal with the logistics of removing the outsourced equipment and returning it to the vendor. The new equipment took longer than expected to arrive, and the implementation timeline had to be pushed out.
2. In a school telehealth project, a participating site may experience network connection and server issues. For example, firewalls may affect telehealth links. Work closely with the IT team. The Information Technology (IT) Director/contact needs to have a clear understanding of how school telehealth works. They need to understand that any technical difficulty with the hardware/software and peripheral devices leaves the clinic unable to provide patient care. Fixing the issues should be considered highest priority.
3. Ideally a dedicated IT staff member who has been involved with the project will be available during office hours. Consider scheduling a weekly meeting to resolve non-urgent issues on a regular/routine basis. When new IT staff are hired they should be provided with a tour of the clinic and an orientation to the hardware/software to

assist in providing troubleshooting during “down-times.” Document lessons learned from previous helpdesk resolutions to assist in future “down-time” occurrences.

4. Develop a relationship with your telehealth distributor (e.g. AMD Global Telemedicine). Know what they offer as far as technical assistance and equipment training sessions. If a site is experiencing connectivity issues, the problem may be related to faulty equipment. It is important to work with the equipment vendor for support and resolution; faulty equipment will need to be returned for a replacement. Familiarize yourself with their policy regarding shipment of replacement parts, peripheral devices, and technical support. Budgeting to have additional peripheral devices to use when others are in for repair is important.
5. Staff should consider attending training sessions with the equipment vendor to learn techniques for effective use of the equipment and how to troubleshoot audio and visual issues.
6. Portable unit audio issues are often resolved by configuring changes to the playback settings. Work with the equipment vendor for instructions on how to make the necessary changes. It may be as simple as moving a button to the down position! Poor stethoscope audio quality (e.g., picking up surrounding sounds, intermittent sound, etc.) can often be resolved by turning down the receiving volume or replacing the cart’s transmitter box attachment to the stethoscope.
7. If picture resolution quality is distorted (e.g., poor quality images from the exam camera, otoscope image distortion, etc.), it may be necessary to troubleshoot not only with the IT team and equipment vendor, but also with outside network teams. In one case, a school site’s pictures were distorted because of a mismatch between the site’s old legacy routers and their internet service provider’s specifications. It is important to note that visits can still be successful in spite of picture issues, but better to find a solution.
8. It is best to check with the equipment vendor before attempting to make any modifications to the units. There was a case report of a well-meaning IT group that dismantled its school’s telehealth equipment to build additional safeguards into it, and upon reassembly the equipment did not function properly, including a lack of stethoscope audio and overall audio. The IT team had to spend additional time working with the vendor to regain functionality.
9. It is very important for RNs at the originating site to perform on-site testing prior to linking real visits. Schedule weekly tests with each cart at originating sites and distant sites well before going “live.”
10. Trial-runs will be most beneficial if a standardized process is put into place prior to testing the system, including formalized procedures holding the equipment, taking pictures, and saving images to upload into the EHR. It is highly recommended to visit a site that is already “live” to learn their process and “tips and tricks” for equipment usage. If possible, include key players from all of your participating facilities at this site meeting.

11. Remind schools that clinics work year round, so during summer as an example, when they decide to shut down services for upgrades etc., the clinic can plan around it. Technology needs to be consistent for success.

F. Sample Documents in Appendix for Step 1

- Organizational readiness check list – SWOT analysis
- School readiness checklist
- Telehealth equipment vendors can be found here, Michigan has experience working with AMD Global
Telemedicine: <http://thetelemedicinedirectory.com/lc/telemedicine-equipment-devices/>

Step Two: Detailed Implementation Plan

A. Best Practice: Components of the school telehealth program and prioritization

Essential Components:

- Quality telemedicine equipment
- High definition connection for audio/video
- Strong IT support with frequent updates as required
- See implementation plan in appendix for essential equipment and staffing
- Written parental consent is an essential component to patient care. Patients that do not have a consent will not receive telemedicine visits, immunizations, or over-the-counter medications. Example consent documents can be found here: <http://www.cahctelehealth.com/sample-documents/>
- A registered nurse staffed clinic to facilitate telemedicine visits and implement standing orders
- A distant site with healthcare providers committed to telehealth services.

Lessons from the field...

1. In addition to the providers, we have needed a Program Coordinator to pull all the pieces together. This role includes setting up and testing the equipment, becoming a 'super-user' of both the equipment and the EHR in order to be the first person to call for tech support. The role also includes training the school nurses and other presenters and being the primary contact for anyone in the schools about the program – teachers, principals, parents. It includes presenting the program to parent, faculty & community groups, in the school and out, such as County Commissioners or Rotary. The Program Coordinator also provides/restocks supplies, collects enrollment forms from each school, and tests the equipment and connections regularly. He or she is the "Office Manager" from a traditional practice, also processing claims and sending out bills for co-pays. In our first year, all of this was done by one person. Going into our third year, this is divided between three people, all who spend just part of their time on it.
2. We also have to have a Medical Director, who is the supervising physician of record for the Nurse Practitioners, and who is responsible for clinical oversight of the program. This role is no more than a few weeks per month.
3. Consent, coverage, and eligibility are important issues to navigate when working with distant site primary care facilities. Some facilities are unable to accept a one-time phone consent. Others cannot provide care for uninsured students or students that are not already established at their facility. It is beneficial to create a plan for connecting uninsured or otherwise ineligible students to an alternative distant site, such as a school based health center (SBHC).

4. It is not recommended to allow a one-time verbal consent for a visit or medication at the clinic. Enrollment packets sent home after this one-time verbal have proven to not be returned.
5. Telemedicine equipment can be easily operated by most people after a short demonstration. We strongly recommend the exam be led by a registered nurse (RN) who has a larger scope of practice and can provide a higher quality of exam. An RN can also work independently under standing orders.

B. Best Practice: Development of protocols, policies and procedures

- These documents should be clearly written in plain language.
- Make these documents relevant to your implementation.

Suggested plan categories

- Policies for implementation of telehealth and services provided. Example policies can be found in the appendix and here: <http://www.cahctelehealth.com/sample-documents/>
- Workflow – at the school site and at the distant medical clinic site. See details in the Workflow section below.
- Staffing – outline a schedule of availability and participation of RNs, program coordinators, distant-site physicians, Medical Directors, and IT staff. Identify IT and clinic staff responsible for technical issues and interacting with equip company (AMD or other). These will be invested/champions of the model.
- Services to be provided – e.g., acute illnesses and injuries, such as upper respiratory issues, rashes, and UTIs; well care and forms filled out for school, sports, and camps; screenings and vaccine review. RN should provide enhanced care using standing orders developed and signed by a supervising physician (may be at distant site or another). Standing orders examples can be found here: <http://www.cahctelehealth.com/billing/>
- Tools and consumables – kits for the school sites that might include items like: specula for the otoscope; BP cuffs; thermometer with covers; biohazard bags; alcohol wipes; BZK wipes; specimen cups; CLIA-waived tests for strep, glucose, urinalysis, and hCG; timer for the tests and batteries for the thermometer; a scale; and a stadiometer.
- Equipment & connectivity – steps for turning the unit on in the AM and off in the PM; instructions for using accessories like the stethoscope, otoscope, and Web Cam; and instructions for face-to-face teleconferencing.

Important tips:

- Be sure to test equipment and walk through a mock visit before going live.
- Turn on and run your equipment each morning, this will allow timely updates and less interruption for updates as you are trying to use the equipment.

- Have an extra otoscope and light bulbs on hand (light bulbs are necessary for the equipment to function as intended).
- Update Java on an ongoing basis.
- Hardwire your equipment (do not use wireless).
- Turn the cart on/off every few days for a full reboot.
- For IT issue resolution, have your on-site IT staff work with the external IT tech (from distant site or equipment company) on the phone
- If school nurse is not an employee of distant site – get RN access to EHR of distant site in order to integrate and support care.
- Room design – Is there a dedicated space in the school that is already used by the school nurse, or will a multi-purpose room be used? Plan the room setup and the flow of patient intake, care, and discharge. See details in the Room Design section below.
- Parental / School / Student engagement – plan to be present (with your equipment, handouts, and smiling faces) at every school event, meeting, and sporting activity. Work with the school principal to spread the word about the program, and consider spearheading student health advocacy groups. Here are samples of letters to parents and fliers on the CAHC website: <http://www.cahctelehealth.com/sample-documents/>
- HIPAA / FERPA – privacy laws and regulations must be understood in the context of telehealth. The **HIPAA** Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Family Educational Rights and Privacy Act (**FERPA**) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.
- Billing – Take time to understand Michigan's Medicaid telehealth billing guidelines, originating site and distance requirements, and authorized provider information found here: <http://www.cahctelehealth.com/billing/>

Lessons from the field...

- Create a detailed implementation plan to establish RN and NP roles. Include protocols, policies, and procedures related to: gathering patient history, documentation, billing, standards of care, RN standing orders, EHR changes to accommodate shared visits, visual diagrams for telehealth visits and spirometry, discharge summary, patient education, and follow-up. For example, if an originating site wants RNs to have larger role in spirometry administration and reporting, they will need to create a protocol for telehealth-based spirometry and asthma visits – and test the protocol with RNs before finalizing.

- Working with surrounding school based health centers to share policy and procedure information is preferred. In developing a process for standing orders and RN services at the originating school site, it can be helpful to seek guidance from a local primary care facility, using their standing orders protocol documentation for reference. A web search identifying sustainable models similar to yours will provide an opportunity to network with them.
- Using the education offered by the telemedicine distributor will provide a thorough orientation to the equipment. Working with the IT department on clinic-specific processes, such as the electronic health record and billing, will provide a site-specific orientation.
- Attending educational sessions surrounding adolescent health or current telehealth updates will allow for professional growth. Having the nursing staff shadow individual clinicians for assessment techniques will gain buy-in from the providers as to the telehealth process. Providers need to fully trust the assessment skills of the nursing staff acting as their “hands” during an assessment via tele-health.

C. Best Practice: Initial and on-going training

- Create high quality, structured, and layered training for everyone involved that includes telehealth, equipment, and clinic procedures and practices. Many times telehealth equipment companies have training opportunities.
- Plan to provide it on an ongoing basis to all involved in the new program.

D. Best Practice: Workflow

- When the originating school site uses a *different EMR/billing system* than the distant site, there are added considerations for workflow and documentation. It will take additional time to register new patients from the originating school site into the EMR of the distant site. A registration workflow process can help medical assistants (MAs) or other support staff register patients at the distant site. Another helpful method is *to appoint a telehealth technician* to manage telehealth registrations. The workflow might look something like this: RNs from originating sites across the county scan consent documents into a web-based portal (such as AGNES Interactive); and then a centrally located telehealth technician with access to the portal uses the scanned consent documents to register patients into the distant site EMR system. Note: Many sites have reported that AGNES Interactive works best through Google Chrome.
- The following is a case example of a workflow within a successful school telehealth program:
 Our patients are a combination of “walk-in” and scheduled in advance. When a student presents in the school nurse office, they are assessed by the nurse according to her protocols. If the school nurse thinks that the student needs to be

referred for care beyond her scope then she has the opportunity to offer telemedicine.

First, the school nurse will try to contact the parent and also determine if the student is enrolled for telemedicine services (by checking in the EHR). If the parent consents AND the student is already enrolled, then the school nurse will check the schedule for the available distant-site providers (also in the EHR). The school nurse can schedule an appointment in the EHR at that time. Ideally, there are a few minutes between the time that the appointment is scheduled and when it occurs.

During that time, the distant-site provider will review the chart & health history as well as attempt to contact the parent for HPI. At the same time, the school nurse will take vitals, record them either in the EHR or in the encounter program, and may take some images to save and share, if appropriate. She will also explain the encounter to the patient and coach them on how it works.

Appointments are also scheduled in advance for follow-ups and non-acute issues. These are arranged by our Clinic Coordinator to be convenient for the school nurse as well as to minimize the student missing core classes.

E. Best Practice: Room Design

- Give special consideration to the room design and set up at both the school site and the clinical site. Be sure to include this in your budget.

Lessons from the field...

- Room location – quiet area away from sources of noise, no windows or with shades that reduce in coming light and glare.
- Room size: *Patient exam room* – needs to be service dependent.
 - Large enough to move around and work with patients comfortably.
 - Patient should be able to both sit in a chair and use the exam table and be in the camera's view.
 - Camera should be 6 – 8 feet from the patient. It should be able to pan out for a full view of the room with the patient and presenter, and zoom in for close-up views of the patient.
- Room size: *Remote clinician consultation room* – may be smaller than patient exam room, however consider camera viewing area and angle.
- Placement of equipment and furniture:
 - Exam table should be positioned so the presenter can see both the patient and the monitor when using scopes that transmit images to the distant provider site.
 - Place for a chair for patient and a second chair for family members.

- Avoid backlighting! Do not place the patient or the distant provider in front of a window. ***NOTE*** Shades/blinds generally cannot reduce this kind of lighting enough.
- Avoid clutter in the background for optimal camera images.
- Cameras must be placed so that both participants are looking directly at each other during the video call. Beware of 1) mounting cameras on top of computer monitors and 2) placing participants too close to the camera.
- Electrical and telecommunications connections – choose the best place for the exam table and telemedicine unit and then install/expand the telecom and electrical outlets to be near the units. Avoid long runs of cables on the floor. A 120v outlet with surge protector is generally appropriate but be sure to tailor to your needs.
- Lighting – true color reproduction is essential!
 - Use diffused soft light source positioned in front of the patient shining on them diagonally.
 - Avoid having light sources behind the patient/clinician such as from windows and overhead lights.
 - Avoid harsh lighting sources and shadows on faces.
 - Full spectrum lighting is recommended.
 - Use supplemental lighting when necessary.
 - Color accuracy is also affected by the white balance of cameras and peripheral scopes.
 - A blue towel behind skin can be helpful to view skin tone and rashes.
- Acoustics – don't use a room near the cafeteria, band room, or other area of the school that may cause a lot of background noise. If possible have a door closing the exam room off to the rest of the originating site office space to reduce noise from others in the office.
- Include photos of distant-site providers in the exam room.
- Wall color:
 - Use flat paint to avoid reflection off the walls.
 - Video test the selected color before painting the entire wall – how does it look at both sites on camera? Note that different lighting conditions will affect color appearance.
 - Avoid white or very light walls, avoid dark walls, and avoid any extreme colors and contrasts.
 - Examples of ideal colors – light blues and light grays work well with all skin tones.



Sample Documents in Appendix for Step 2

- Telehealth model of care policy
- Staffing and training
- Implementation of telehealth
- Telehealth-telemed equipment requirements and cart use
- Telehealth-script and workflow
- CH Telehealth Process (school telehealth clinic example)
- Use and limitations of telemed for visits

Step Three: Performance Monitoring Plan

A. Best Practice: Establish both short- and long-term goals

- Determine what your organization and stakeholders are interested in improving related to school telehealth (adolescent health improvements, access to care, etc.)
- Plan to collect vital program data from the very beginning of your program and on a regular and on-going basis.
- Establish measurable objectives and outcomes for all key elements of the program.
- Establish timelines related to these goals.

Lessons from the field...

1. Successful implementation of a program is demonstrated by a school telehealth model that provides high-quality healthcare to students in a clinic setting while at school. It is carried out via credible assessment practices of a registered nurse and high-definition telehealth equipment to an NP, PA, or physician.
2. Goals are understood and embraced by staff by involving them in the process of developing the goals. Tying the “why we provide care the way we do,” with the “how” increases engagement.

Use data that is captured in electronic format, such as the electronic health record to make collecting and reporting data more thorough and accurate. When doing surveys, use electronic tools such as Survey Monkey that have tabulation and reporting features.

3. Having a structured evaluation created an opportunity to use the feedback as a tool for improvement. In addition, it highlighted areas of strength that can be useful in marketing your program. Also, the evaluation process provided an objective outlook and ideas to enhance workflow of the program as well as services offered:

“The goal of the School Telehealth Program was to increase access to healthcare for students utilizing technology, while positively impacting the nurse: student ratio in Branch County. An additional goal was creating a model that was sustainable. The goal of increasing access to healthcare never wavered throughout the project, but our focus on sustainability has become a priority with the grant coming to a close. Through the Transformational Grant, CHC was able to achieve a replicable model of school based health care using RNs and telehealth equipment in the schools with a hub and spokes model to the Pediatric and Adolescent Center. This program was the first of its kind for the State of Michigan.”

B. Best Practice: Develop a continuous quality improvement process (CQIP)

- Choose an area of telehealth to monitor for quality – could be satisfaction, standard of care for a particular illness, etc. Develop a plan to monitor, assess the measure, plan for improvements, reassess measure.

Lessons from the field...

1. The telehealth patient satisfaction survey, which provides valuable program data, can only be filled out by students in 7th grade or above. Keep this in mind when planning where to locate telehealth services. If located in an elementary school, survey data will be lacking.
2. “Because we were taking part in a pilot model, many issues arose and were dealt with on an as-needed basis. Workflow improvements were designed with the medical director and staff input and then placed into policy format for consistency.”
3. “When an additional clinic was brought on in year 2, identified issues from previous launches were avoided by revisiting lessons learned. All new employees are required to complete a thorough orientation and policy review.”
4. “One area identified in CQIP was incorporating the online risk assessment or post visit satisfaction survey into the initial workflow. In replicating this model, a recommendation would be to take the time to bring in these required surveys early in your process to make it part of the routine of care. These pieces can help gain revenue through enhanced billing and process improvement.”

C. Sample Documents in Appendix for Step 3

- School telehealth outcomes and evaluation measures
- CQIP

Step Four: Showcase Your Model – Marketing & Communication Plan

A. Best Practice: Know your story

- Know your story – and share it with others! Provide internal communication within your organization, such as informational flyers or open houses to see the clinic. Local radio interviews can raise awareness within the community. Clinic staff should be present at school open houses, parent/teacher conferences, and back-to-school staff in-services. Offer clinic tours for community partners and presentations for their staff to explain the scope of the clinic. Community Advisory Committees have a multi-disciplinary representation of members that can disseminate accurate information regarding the clinics and services at a community level.
- Written testimonials used in annual reports are an effective way of reinforcing the value of school telehealth. Video testimonials and social media outlets also are a cost-effective way to share your message.

Lessons from the field...

Case studies are powerful. Here is an excellent example: A high school student was assessed at the clinic and identified as needing a linked medical visit. Upon further assessment, we learned the student lived with his single mother, did not have insurance, and had not seen a physician in six years. The telehealth clinic was able to work in partnership with the Community Health Agency Certified Health Navigator to assist this student and his mother with health care coverage. In turn, the student was able to receive the healthcare he needed and get his vaccination status up to date. The student was also referred to a local eye doctor after he was enrolled into his insurance. The student was in need of mental health services, and through collaboration between the school and clinic, he was set up with counseling. Certified interpreter services were used in his care and when communicating with his mother to enhance communication between all partners. This student is healthy and is doing well in school now.

B. Best Practice: Market to your administrators and others within your organization

- Let them know when you meet goals and add value to the organization.

Lessons from the field....

Garner support! A presentation at the board level is important to gain feedback at the administrative level. Annual reporting to the board of trustees on the clinic is recommended.

C. Best Practice: Market to your community

- Build your message based on wants, needs, measurements and outcomes.

- New partnerships can be formed based on program successes.

Lessons from the field....

The program can sell itself. Be open to community members that approach your clinic with partnership opportunities.

D. Best Practice: Invite others to be part of your success

- Tell the world what good things you've done and what's coming next.
- Be generous with giving credit.

Lessons from the field....

It takes a village! The success of your program will be a culmination of many efforts. Don't be afraid to ask for help. It won't be long before you are the expert in your area and can pay it forward.

E. Sample Documents in Appendix for Step 4

- Annual report example
- Communication plan
- Infographic example

Step Five: Sustainability

A. Best Practice: View grants as short-term 'pilot funding'

- Actively seek long-term funding strategies from the outset.

Lessons from the field....

1. Work with philanthropic resources for long-term funding and endowment opportunities. Organizations and foundations that support innovative approaches to healthcare or unique ways to increase access to healthcare are desirable.
2. Seek support from local community foundations and other giving organizations in your community.
3. Be able to demonstrate to potential funders an ability to assist in sustainability, such as billing for services, in-kind support from collaborative partners, and top-of-mind awareness within your organization's fund development department. The innovative nature of this model peaks interest within alternative funding sources outside of healthcare.

B. Best Practice: Develop multiple revenue streams

- Identify and develop your revenue and reimbursement opportunities.
- A sustainable program requires multiple revenue streams.

Lessons from the field....

1. Frequently used billing procedure codes have been provided in the Appendix.
2. Billing for services when performing telemedicine visits, RN visits, and immunizations have created a stream of reimbursement for the program. Clarification is often needed regarding billing for telehealth, 99211 guidelines, and RN visits under standing orders.
3. Keep in mind that the originating site (where the patient presents) receives the telehealth facilitation fee, and the distant site (where the provider is located) receives the revenue for the billed visit. The originating site should use the same dx code as the distant site: labs and spirometry should be billed from the originating site, and patient education should be billed using the proper evaluation and management (E/M) codes. Detailed billing-related resources can be found on the CAHC website: <http://www.cahctelehealth.com/billing/>
4. Sites that noticed discrepancies between billed visits and tracked telehealth visits using GT modifiers found it helpful to run a report for Q3014 (HCPCS code for "telehealth originating site facility fee") on a monthly basis to find and resolve errors more quickly.
5. It is recommended that each year you familiarize yourself with new billing requirements for each vendor to ensure proper billing and reimbursement.

C. Best Practice: Partner with larger organizations and communities

- Learn from others in the field about their sustainability strategies and challenges.
- Look for feasible ways to integrate your model into intervention settings and existing infrastructure and workflows to increase the likelihood of your model becoming widely adopted and sustained.

Lessons from the field....

“Choosing a fiduciary with ample resources that can assist in making your clinic successful would be recommended. Support from IT, billing, electronic health record, and existing clinic experience were useful in our pilot and were provided by the hospital. The expertise of the staff at the state-level allowed for success from a school-based health perspective.”

D. Sample Documents in Appendix for Step 5

- Strategic plan example

Appendix Items

Step One: Environmental Analysis and Organizational Readiness

Documents

- Organizational readiness check list – SWOT analysis
- School readiness checklist

Step Two: Detailed Implementation Plan

Documents

- Telehealth model of care policy
- Staffing and training
- Implementation of telehealth
- Telehealth-telemed equipment requirements and cart use
- Telehealth-script and workflow
- Telehealth Process SBHC and PCP
- Use and limitations of telemed for visits

Step Three: Performance Monitoring Plan

Documents

- School telehealth outcomes and evaluation measures
- CQIP

Step Four: Showcase Your Model – Marketing & Communication Plan

Documents

- Annual report example
- Communication plan
- Infographic example

Step Five: Sustainability

Documents

- Strategic plan example

Appendix

Step One: Environmental Analysis and Organizational Readiness

SWOT Analysis

As you work through each category, don't be too concerned about elaborating at first. Just capture the factors you believe are relevant in each of the four areas. Once you are finished, reorder the items in each category from highest priority to lowest.

Strengths (internal, positive factors) Strengths describe the positive attributes, tangible and intangible, of your organization. These are within your control.	Weaknesses (internal, negative factors) Weaknesses are aspects of your business that detract from the value you offer or place you at a competitive disadvantage.
Opportunities (external, positive factors) Opportunities are external attractive factors that represent reasons for your business to exist and prosper.	Threats (external, negative factors) Threats are external factors beyond your control that could put your business at risk. You may benefit from having contingency plans for them.

School Readiness Checklist

Core Readiness	<ul style="list-style-type: none">• Recognition of unaddressed physical and mental health needs• Dissatisfaction with the status quo• Legal and reimbursement rules governing telehealth practices locally and regionally
Engagement	<ul style="list-style-type: none">• Champions• Reduction of nay-sayers/resisters• Education and awareness for community, school, parents and students• Ability and willingness of senior administration to consider benefits• Alignment with school's mission or strategic plan.• Willingness to consider long timelines for implementation• Cost-benefit analysis
Structural Readiness	<ul style="list-style-type: none">• Identification of clinic space and equipment• Well conducted needs assessment• Community consultation process; ownership• Determine the range of technologies available to provide telehealth• Accessible, comprehensive technical support, locally available and on-call• Major organizational or technology barriers in the school or sponsoring organization that should be addressed• Effective scheduling; integration into the school routine• Provision of a telehealth coordinator• Written policy on reimbursement, liability, cross-jurisdiction use, privacy• Sufficient ongoing funding (local, provincial, federal)

Appendix

Step Two: Detailed Implementation Plan

Telehealth and Telemedicine Policy

PURPOSE:

- a. To improve access to health care services by enabling the provision of health care with the utilization of telehealth equipment in order to meet the needs of the patient, while complying with all applicable federal and state statutes and regulations.
- b. To outline the minimum requirements related to the performance of telehealth services.

SCOPE

- a. This policy applies to all organization's employees, management, contractors, student interns, and volunteers.
- b. This policy describes the organization's objectives and policies regarding the use of telehealth services in Michigan child and adolescent health centers/network.

DEFINITIONS

- (1) **Telehealth Services** are those services that are provided using communication technologies for clinical care (telemedicine), patient teaching and home health, provider and health care professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.
- (2) **Telemedicine services** are the practice of health care delivery, diagnosis, consultation and treatment, as well as the transfer of medical data through interactive audio, video and data communications that occur over a secure connection in the real-time or near real-time, and in which the provider and the patient are not at the same site. For purposes of the delivery of mental health care via telemedicine, the use of telemedicine shall be considered a face-to-face, in-person encounter between the provider and the patient, including the initial visit.

The following shall not be considered telemedicine:

- a. Telephone conversation (including text messaging)
 - b. Electronic mail message
 - c. Facsimile (fax)
 - d. Store and forward
 - e. Unsecured networks such as Skype, FaceTime, etc.
- (3) **Distant site** means the site where the medical provider providing the service is located at the time the service is provided via audio/video telecommunications.
 - (4) **Provider** means an NP, PA, MD or DO, LMSW, LLMSW or CFT with an unrestricted license that provides health or mental health services at the distant site.

- (5) **Health Care Professional** means a licensed nurse or medical assistant trained in the provision of telehealth services.
- (6) **Presenter** means a health care professional that is at the originating site with the patient and at the start of the telemedicine visit, presents the patient to the provider at the distant site.
- (7) **Originating site** means the location of the client receiving health care services at the time the service is being performed by a provider via audio/video telecommunications.
- (8) **Video conferencing** means conferences and/or consultations between the client, the presenter and the provider are held live over distances via a range of telecom services.

RESPONSIBILITIES

A. Executives/Management

- 1) Provides and oversees training in telemedicine equipment for appropriate providers and health care professionals.
- 2) Approves privacy policy for the use of all medical and mental health care services including those provided by telemedicine services.
- 3) Ensures appropriate maintenance of telemedicine equipment occurs according to agency policy.
- 4) Designates a telemedicine expert at the agency.
- 5) Ensures retention of telemedicine policies and procedures, training documents, quality improvement documents to meet compliance requirements.
- 6) Ensures telemedicine sites shall meet all technical and confidentiality standards as required by state and federal law in order to ensure the highest quality of care.

B. Originating Site Health Care Professional

- 1) Appropriately completes necessary training to utilize telehealth equipment and, when necessary, perform parts of the physical exam as directed by the provider.
- 2) Ensures telehealth equipment is functioning properly prior to use with a client.
- 3) Appropriately triages the client for appropriateness of telemedicine services.
- 4) Ensures the client has a consent on file for services at the health center.
- 5) Assesses the client's willingness to participate in a telemedicine visit.
- 6) Provides informed consent for the client regarding telemedicine procedures.
- 7) Receives pertinent medical history from the client and parent or guardian and communicates the information to the provider, as necessary.
 - a. Client history of medical allergies
 - b. Client vital signs
 - c. History of Present Illness
 - d. Pertinent Past Medical History
 - e. Results of appropriate POC testing performed through standing orders
 - f. Client preferred pharmacy
 - g. Contact information of the parent/guardian
- 8) Ensures client confidentiality throughout the telemedicine visit.

- 9) Ensures the health center environment is conducive to providing a telemedicine visit (quiet, comfortable, etc.).
- 10) Assesses client and family satisfaction with telemedicine visit after completion of the visit.
- 11) Follows the standards of care of his/her profession when administering client care through telemedicine equipment.
- 12) Is aware of limitations to telemedicine visits, and his/her own professional skills.
- 13) Appropriately codes the visit using telemedicine modifiers.

C. Distant Site Provider

- 1) Appropriately completes necessary training to utilize telehealth equipment.
- 2) Ensures telehealth equipment is functioning properly prior to use with a client.
- 3) Ensures client confidentiality throughout the telemedicine visit.
- 4) Provides verbal and/or written summary to the client's parent/guardian after the visit.
- 5) Provides verbal and/or written summary of the visit to the client's primary care provider.
- 6) Ensures the health center environment is conducive to providing a telemedicine visit (quiet, comfortable, etc.).
- 7) Assesses client and family satisfaction with telemedicine visit after completion of the visit.
- 8) Follows the standards of care of his/her profession in the assessment, diagnosis, treatment and evaluation of a client using telemedicine equipment.
- 9) Understands the limitations of telemedicine visits, and refers the client for in-person care, where appropriate.
- 10) Codes the visit using appropriate telemedicine modifiers.

TELEHEALTH RECORD REVIEW

The agency and employees of the health center will include telemedicine visits in the Continuous Quality Improvement (CQI) procedures according to agency CQI policies.

CLIENT CONFIDENTIALITY

The agency and employees of the health center will ensure client confidentiality throughout telemedicine visits according to the agency's confidentiality policies.

CLIENT EDUCATION

The following client informed consent/assent procedure will occur with regard to telehealth visits:

- 1) The parent/guardian will be given a consent for services that contains general information on telehealth, the limitations of telehealth, and be informed that they may opt out of telehealth visits prior to

performing a telehealth visit. The consent will remain valid until written retraction is provided to the clinic by the parent/guardian.

- 2) The client will provide verbal assent to participate in a telehealth visit, as well as be informed that they may opt out of telehealth visits. Child/teen assent will be documented in the patient's medical record.

DOCUMENTATION

Documentation of telehealth visits will be recorded in the electronic health record according to agency policies and procedures.

STAFF TRAINING

- a. Describe your agencies training policies for the utilization of telehealth equipment: (See References for Telehealth Training Checklist)
 - 1) New staff member training:
 - 1) Recurrent training:
 - 2) Special function training:
 - 3) [Identify privacy training program content.]

BILLING DEPARTMENT

- 4) Assists in development and execution of appropriate billing procedures for telemedicine visits.
- 5) Provides feedback to providers and health care professionals on the appropriateness of visit coding for telemedicine visits.
- 6) Submits billing for telemedicine visits according to agency policies and procedures.

MAINTENANCE OF TELEHEALTH EQUIPMENT

Pre-Installation

- a. Log manufacturer, model and serial number of all equipment.
- b. Assure equipment is working accurately and that the inspection is current.

During Installation

- a. Access health center utility system for compatibility and safe use in relation to electrical outlets, extension cords, grounding and cord connection.
- b. Unpack, assemble and test equipment function.
- c. Make connection with the provider station to validate assessment findings.
- d. Medical peripherals should be checked for accuracy based on manufacturer's instructions.
- e. Perform troubleshooting procedures, if necessary.
- f. Correctly store medical equipment in the health center.
- g. Agency determines if telehealth equipment requires immediate emergency maintenance, replacement or backup.

Equipment Storage

- a. Clearly identify and separate areas for:
 - 1) Clean and dirty equipment.

- 2) Cleaning and disinfecting equipment.
- 3) Equipment requiring maintenance or repair.
- 4) Maintain storage area cleanliness.

Maintenance of Equipment

- a. Perform yearly safety, operational and function checks and as problems arise.
- b. Perform routine and preventative maintenance at defined intervals.
- c. Track the location of each piece of equipment (include serial number).
- d. Document maintenance, testing and inspections on equipment log.
- e. Monitor and act on equipment hazard notices and recalls.
- f. Monitor and report incidents in which a medical device is connected with the death, serious illness of any individual as required by the Sage Medical Devices Act of 1990.
- g. Notify patients, staff and prescribing physician of medical equipment hazards, defects, recalls.
- h. Follow defined process for written reports to the manufacturer and the appropriate regulatory agency when a known equipment malfunction or serious injury or death associated with equipment occurs.

REFERENCES

ATA Practice Guidelines for Live, On Demand Primary and Urgent Care December 2014 accessed at :
<http://www.americantelemed.org/docs/default-source/standards/primary-urgent-care-guidelines.pdf?sfvrsn=4>

UHC Telemedicine Policy accessed at:

[http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/reimbursementpolicies/Telemedicine-Policy-\(R0046\)-1-1-11.pdf](http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/reimbursementpolicies/Telemedicine-Policy-(R0046)-1-1-11.pdf)

Medicaid Telemedicine Page accessed at:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

The State of Oklahoma Medical Board Telemedicine Policy accessed at:

http://www.okmedicalboard.org/download/497/Adopted_Telemedicine_Policy_9_18_08.pdf

The Great Plains Telehealth Resource and Assistance Center

Telepresenter Training Checklist accessed at: <http://www.gptrac.org/wp-content/uploads/2012/01/RN-Telepresenter-Competency-Check-List.pdf>

Post-visit Client Evaluation Form accessed at:

http://www.gptrac.org/wp-content/uploads/2011/10/TM_Patient_Evaluation_Form-UofMn1.pdf

Telehealth Start-Up and Resource Guide accessed at:

<http://www.gptrac.org/wp-content/uploads/2015/01/TelligenTelehealthGuide-Final-2014.pdf>

gpTRAC Toolkit accessed at:

<http://www.gptrac.org/resource-center/proven-practices-and-models/>

School Telehealth Programs use registered nurses (RNs) working under physician standing orders to provide high quality, comprehensive health care to students while they are at school. For care that is needed beyond what a RN can provide, they use specialized video and audio connections to link youth at the school clinic to primary care providers located in a pediatric or school-based health center in their community.

Staffing: Required Roles and Responsibilities

While a single person may cover one or more of these roles, the following functions should be considered:

At the Distant Telehealth Site:

- **Clinicians/Healthcare Providers** at the distant site who are committed to telehealth services.
- A **Nurse Practitioner** at the distant site who is dedicated to receive linked telehealth visits from the school clinic during designated hours is ideal.
(The “prime time” for student visits is also a busy time for most physician offices. Having an NP who can cover these high volume times alleviates stress on the practice overall, while ensuring availability/coverage for the telehealth clinic.)
- **Medical Director**, who is the supervising physician of record for the Registered Nurses at the originating school clinic site.

At the Originating School Clinic:

- **Program Coordinator**, responsible for:
 - Training of nurses and other staff.
 - Ensuring policies and procedures are updated and adhered to.
 - Primary contact for anyone in the schools about the telehealth program – teachers, principals, parents.
 - Lead on presenting the program to parent, faculty & community groups (in the school and out, such as County Commissioners or Rotary)
- **Office Staff**, responsible for:
 - Phones and scheduling.
 - Ordering and restocking supplies.
 - Collecting enrollment and consent forms.
 - Processing claims and sending out bills for co-pays.
 - EHR “Owner” – primary contact.
- **Registered Nurses (RN)** to staff school clinic, facilitate telemedicine visits and implement standing orders.
(While telemedicine equipment can be operated easily by most people after a short demonstration, ideally an RN – who has a larger scope of practice and clinical experience – should provide the telemedicine exam. Additional training may be required-see TipSheet #6- Training RN’s.)
- **IT Staff** to help with equipment, software and connectivity issues. This can be a shared resource with the school or distant site – but ideally would be on-call during clinic hours.

Hiring Considerations at the Telehealth Clinic:

- Candidates should be screened by human resources and the medical director for qualifications, and by coworkers for culture fit.
- Screening should include assessment:
 - Of comfort level with sensitive issues (sexual health, LGBTQ) to ensure the candidate is free of bias and that personal beliefs will not conflict with services to be provided.
 - Ideal candidates should be flexible, able to “go with the flow” and willing to switch between tasks/roles.
 - Of any potential conflict of interest with the school community or community, in general.

Training and Role Recommendations:

- Having the telehealth school clinic RN staff shadow individual distant site clinicians for assessment techniques will gain buy-in from the clinicians. The clinicians at the distant site need to fully trust the assessment skills of the RN staff to act as their proxy during an assessment via telehealth. Each clinician has a unique style of practice and physical assessment, this in-person “hands-on” training provides an understanding of each clinician’s unique preferences, language, and expectations.
- RNs will need to be fully trained in all aspects of the equipment (how to use and hold it properly) and in how to improve or maximize performance of the equipment (e.g. removing cerumen from the ear canals for better image quality). Ideally, both the distant site provider and the RN will be trained together (in the same space) and have the opportunity to practice with the equipment. See RN Training tip sheet.
- Identify IT *and* clinic staff responsible for technical issues and interfacing with telehealth equipment company. These will be invested/champions of the model. Duties will include:
 - Setting up and testing new equipment.
 - Becoming a ‘super-user’ of both the equipment and the EHR in order to be the first person to call for tech support.
 - Testing the equipment and connections regularly.

Workflow Sample:

See example workflows for SBHC and PCP distant site providers.

Workflow Tips and Recommendations:

- When the originating school site uses a *different EHR/billing system* than the distant site, there are added considerations for workflow and documentation. It will take additional time to register new students from the originating school site into the EHR of the distant telehealth site. A registration workflow process can help medical assistants (MAs) register patients at the distant site. Another helpful method is *to appoint a telehealth technician* to manage telehealth registrations. The workflow might look something like this: RNs from originating school clinic sites across the county scan consent documents into a web-based portal (such as AGNES Interactive); and then a centrally located telehealth technician with access to the portal uses the scanned consent documents to register students into the distant telehealth site’s EHR system. Note: Many sites have reported that AGNES Interactive works best through Google Chrome.
- Bring in required surveys (screenings, risk assessment, satisfaction) early in your process to incorporate them as part of routine care. In addition to providing valuable clinical and program insight, the resulting information can provide data for grants and PR efforts, as well as facilitate billing and process improvement.
- It can be helpful to have a half hour or so gap between when the RN begins working with the student and when they are scheduled to be seen by the provider at the distant telehealth site. With strong standing orders in place, this gap provides time for the RN to begin the assessment – and to run any necessary tests in advance (e.g. rapid strep, urine analysis)
- Be rigorous about documenting change in processes and why they occurred (the lessons learned) – and include these findings in new hire training materials.

Implementation Process for creating the Telehealth Clinics

The Community Health Center of Branch County (CHC) applied for a Michigan Department of Health and Human Services (formerly Michigan Department of Community Health) MDHHS grant in collaboration with the local health agency, community schools and Intermediate school district.

Upon award the following implementation steps were completed. These steps although in sequence also happened concurrently at times.

Hired School Telehealth Program Manager/RN for Coldwater Schools

- Immediately began looking for RN for Bronson Schools
- Candidates interviewed with program staff after clearance from human resources.
- Desirable candidates then would be interviewed by medical director.
- If cleared by physician, candidates had a second interview to see if they are open to discussing sensitive issues with students. (sexual health, LGBTQ)
- Are the candidates free of bias? Would religious beliefs affect their reaction to student diversity?

Began reading and modeling the "Minimum Program Requirements for Child and Adolescent Health Centers"

- Primary Care- Who will be the provider?
- What services will you provide with Telehealth? Acute Care visits
 - Sore Throats
 - Cough Fever
 - Sinus Congestion
 - Allergies
 - Simple Urinary Issues
 - Sports Physicals
 - Immunizations
 - Health Education
 - Mental Health Assessment
 - Referrals
- What services will your clinic NOT provide?
 - Abortion Counseling Services
 - Referrals for abortion services
 - Provide, dispense, or distribute family planning drugs on school property

Provide Insurance to the Uninsured

- Approach local health department to find a certified navigator.
- If budget allows, contract navigator to assist students in clinic.

Apply for CLIA waived testing certificate

- Which tests will your clinic provide? (ex. Strep, mono, influenza, glucose, urinalysis, pregnancy)
- Where will your cultures be sent? (all strep negative results, and urinalysis studies are sent for culture)

STI/HIV Testing

- Minor Confidential vs. Medicaid vs. private insurance
- Are you collecting urine or using vaginal swab or both?
- Parent Permission? If yes, send to hospital. If no, send to the state.

Clinic Set-up

- Visit existing outpatient health centers to give ideas on how to model your clinic.
- Make clinic appealing to the age of patients being served. (we have found that teens enjoyed being a part of the decision making process. ex. murals education pamphlets, giveaways)

Exam Space Items

- Telemedicine Cart
- Exam table
- Vitals Signs Machine
- Sink (must be American Disabilities Act compliant)
- Scale with height bar
- Snellen eye chart
- O2 tank
- Pain scale chart
- HIPPA Privacy Notification Forms
- Sharps box

Vaccines

- State approved refrigerator/freezer with separate compressors for Vaccines for Children (VFC)
- Alarm Monitoring System (ex. Sensaphone)
- Min/Max Thermometers
- Data Loggers
- All staff must be trained at local health department to receive VFC Vaccines.

Lab Space

- Clinical Laboratory Improvement Amendments (CLIA) waived tests
- CLIA waived test training
- CLIA waived testing certificate from the state must be hanging in the lab space.
- Designated and marked "clean" and "dirty" spaces in testing areas
- Biohazard Pick-up
- Ice Machine
- Vaccines- Private and VFC
- Vaccine Information Statements (VIS)
- Specimen refrigerator
- Min/Max temp thermometer for specimen refrigerator
- Dressings
- Over the counter medications
- Medication log
- Emergency Bag- Benedryl, epinephrine, decadron, albuterol nebulizer, albuterol inhaler, syringes, alcohol wipes, oxygen tubing.
- Urine specimen cups
- Biohazard bags Biohazard Pick-up

- State STI testing supplies and shipping containers
- Dressings
- Oxygen tubing
- Non-rebreather mask
- Ambu-bag
- Peak flow meter
- Coban wrap for sports injuries
- Linen
- Syringes
- Needles

Waiting Room Space

- Private desk area for scheduling
- Vinyl covered chairs for easy cleaning
- Decor that is cheerful and age appropriate for ages served
- TV/DVD player- for informational videos on health topics and also helps with background noise to help with privacy.
- Age appropriate reading materials and health education cards (we have found that students will not take large pamphlets, but will take small wallet sized cards)
- Laminated "Cover you Cough" poster
- Education Board that is changed frequently to keep students interested

Scheduling Patients

- Be flexible-allow for mainly walk-in appointments
- Don't scold patients for not making appointments. Students have many factors that may interfere with them being able to make appointment on time.
- Many schools have a period of time in their day that students are able to study or get help from teachers on classes that they may be struggling with. This is a great time to schedule patients for less emergent problems and keeps you from disrupting students in their core classes.
- Make sure the scheduling area allows for privacy.

Where will the clinic be located within the school?

- Meet with Superintendent/ Principal/ Board of Education
- Does the space allow for patient privacy?
- Is it easy for patients to enter and exit easily?
- Do you enough designated space for exams, lab collection, and waiting area space?
- Is there a bathroom nearby so patients can self-collect specimens?

Telehealth-Telemed Equipment Requirements and Cart Use

Equipment:

Tele-health school cart which includes:

- Utility cart
- Tele-health Monitor
- Web-cam
- Headphones
- Tele-health Stethoscope
- Examination Camera
- Tele-health Otoscope

Additional monitor/headphones/video conferencing software at distant site

Connectivity:

- Agnes Software (AMD)
- Cisco Jabber- Video component
- Fiber optic line using Ethernet
- Internet Protocol Telephony
- Sensophone for immunization refrigeration monitoring
- Fax

Steps for turning on the telehealth unit in A.M.:

- Every morning turn on unit and pull up Agnes Software to check to make sure that stethoscope, otoscope and web cam are in working order.
- Pull up Cisco Jabber and scroll over to the phone and make sure that there isn't an "X" over the top of it. If there is an "X" over it. Turn entire computer off and restart the computer. If the "X" continues to cover the phone, call x5080 and ask IT to assist you if correcting this.
- Password for the computer is ###

Steps for turning off telehealth unit in P.M.

- Turn off main screen on top of the tower
- Remove the bottom on the otoscope and place in the outlet for the night
- Please check to see that web cam light and camera are off.

Steps for Using Accessories on telehealth unit:

- To use the **stethoscope**, simply press **Start**, and place headphones over your ears. By doing this, both practitioners will be able to hear the heart tones and lungs sounds simultaneously.
- To use the **Otoscope**, go to the drop box where it is labeled Video. The box will say "No Video". Click on the arrow to the right of this and choose "**otoscope high**". There will be a dew second delay and then there will be a black box that shows up. This is how you will be able to visualize

the inner ear on the screen. Place otoscope specula on the end of the otoscope (located in the top drawer of the cart) and spin the green button around to turn on the light. Place otoscope into the ear or nose and the images will display on the computer screen. When exam is completed, change the drop down box back to **“no video”**, turn the light off before putting it back down.

- To use the **Web Cam**, go to the drop box where it is labeled Video. The box will say “No Video”. Click on the arrow to the right of this and choose **“Webcam High”**. There will be a few second delay where the screen will turn blue. Then you will pick up the exam cam, and turn on camera and light. The image will then appear on the computer screen.

Cisco Jabber:

Cisco Jabber is the teleconferencing piece for face to face interaction between nurse/patient and the Nurse Practitioner/Physician.

- To call the PEDS office simply take the mouse over the bar where it says ***Peds Telehealth***.
- Scroll to the right if this box and a small picture of a phone receiver will appear.
- Click on this and the call will begin to the Peds office. When the call is answered, the image of the practitioner will appear.
- When the exam is completed, go to the bottom of the screen and ***click on the red phone***. This will end the call.

Telehealth Visit – Script and Workflow

Example Script to Explain to Students:

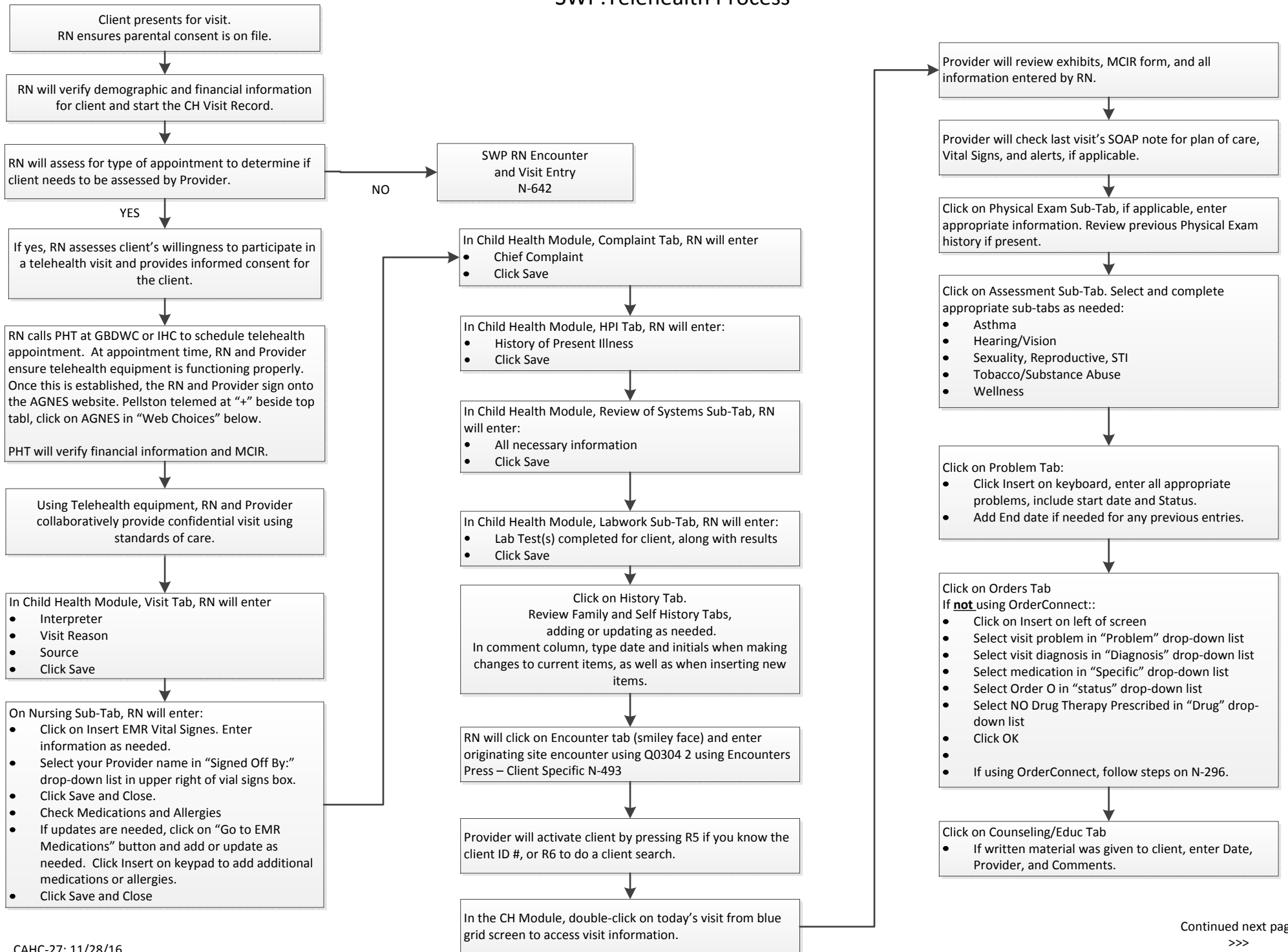
Due to (reason they came into the SBHC or symptoms we find) we would like you to see our (nurse practitioner/doctor). We are going to use *telehealth* technology for this visit. Telehealth is a sophisticated type of medical Skype or FaceTime that will connect us to the (NP/Dr) in the (peds office/SBHC) across town. The (NP/Dr) will see and talk to you through our equipment and monitor. (He/She) will see and hear the exam exactly the way you and I do. I will show you everything before we actually use it during the exam. Are you OK with this type of visit with the (NP/Dr)?

Workflow:

- Parental consent given for clinic to treat student
- Student visits clinic, risk assessment completed
- Student examined by a registered nurse and standing orders initiated based on student's symptoms
- After RN assessment, student linked to licensed healthcare provider using telehealth equipment with nurse facilitating the examination
- Licensed healthcare provider makes diagnosis and treatment recommendations
- RN provides treatment as directed by healthcare provider and/or follow-up with healthcare provider when needed OR student referred to emergency room as needed
- If parent is not present during visit, parent contacted to provide visit summary and follow up instructions

Intake

SWP.Telehealth Process



In CH Module, with client's visit open,
Click on "Billing Encounter" in gray bar at
top of visit. Click Insert New.
Enter encounter date, select Clinic from
dropdown list, and click OK.
Click on Billing Tab.

Billing General Tab

Complete Required Fields:

- CoSite
- Visit Type
- Visit Status
- **Billing Supervisor (Always Dr. Meyerson)**

Click on **Procedure Details Tab** -

Complete

- Sub-Program: Child & Adolescent Health
- Provider – of Service
- Procedure – RN selects Telehealth
Originating Site Facility Fee or Rapid Strep
test.
- Procedure – Provider selects visit code
from drop-down list.
- Payor Class – Choose and check to ensure
correct.
- Insurance: Choose correct Insurance
- Units – Defaults to 1
- Hours/Minutes – Enter
- The provider must add the modifier, "Via
Interactive Audio and Video
telecommunications systems."

Click on **Diagnosis** tab and select
appropriate diagnosis code from
dropdown box or click on World button
and in the "Term" box, type in DX code or
description, click search. Double click on
selected Diagnosis code and it will
populate the Diagnosis tab. If additional
diagnosis are needed, repeat the process.

Click on Save

**Press
Add Another Detail**
(lower left of "Procedure
Details") to enter additional
services for the SAME client

Yes

Need to enter
additional services for
the SAME client?

No

Click on Billing Encounter

- Highlight encounter, click Select
- Click Save
- Click Load Tx which opens Quick Add Procedures
screen
- Select diagnosis from Diagnosis drop-down
- Select Payor Class from drop-down
- select Insurance in drop-down
- Click Load from Lab, if applicable
- Verify appropriate procedure code(s) are checked
under the selected column
- Click Apply

Distant site PHT will verify originating site and distant site's
encounters are complete

SOAP NOTE

Click on EMR tab

Click on EMR Notes

Click on Insert

At Note Type –
Select SOAP Note EMR note type
from dropdown list

Select your name as provider from drop down list.

Select Sub Program
Child and Adolescent Health

Select Cosite

Click on "Note" Tab

Click in field beside SOAP Note line

Click on Pre-Defined Text

Double click on name of
Pre-Defined Text. This will insert text into soap note memo
field.

Make any necessary changes, additions, or deletions to the
memo

Click on follow-up needed, WOW program, or referrals if
appropriate for client.

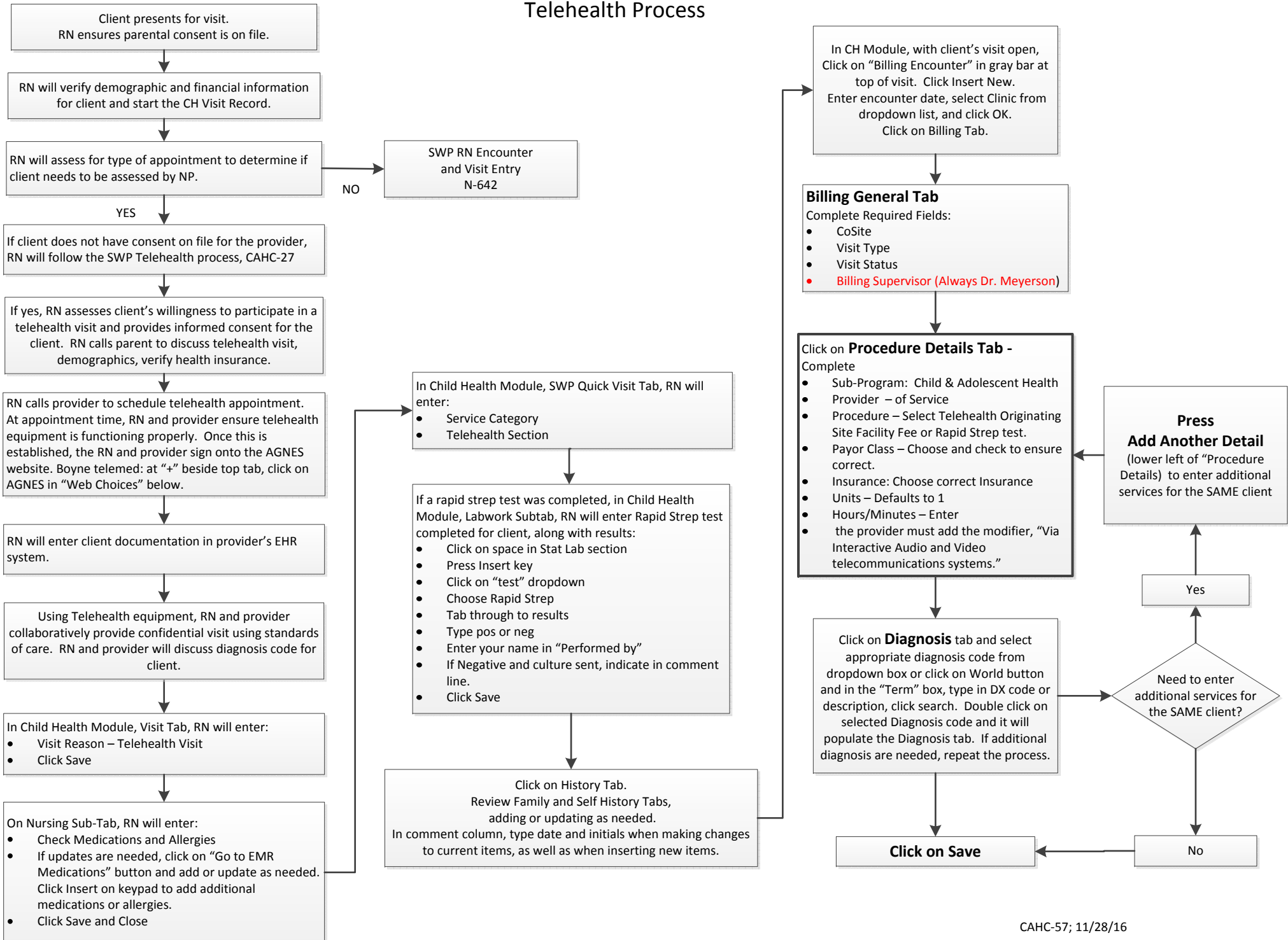
Click "Save", then click "Close"

If plan of care is established, Provicer/RN will complete visit
documentation as described and provide verbal and/or
written summary to client and/or parent/guardian

If assessment, diagnosis, treatment and evaluation are
beyond the limitations of a telehealth visit, the Provicer will
refer client for an in-person care, where appropriate.

SWP Boyne City Rambler Wellness Telehealth Process

Intake



School Telehealth

Telehealth can be used to assess, treat, and monitor a wide range of acute and chronic pediatric illnesses, thereby expanding the schools capacity to meet student healthcare needs (NASN, 2015)

When to use School Telehealth:

In general when a student's presenting condition:

- ✓ requires a diagnosis and treatment,
- ✓ is non-life threatening,
- ✓ does not require tactile exam/assessment,
- ✓ falls out of the scope and practice of a licensed registered nurse.

Some Examples of What Can Be Treated With Telehealth

Allergies	Dermatitis
Asthma	Gastrointestinal Symptoms*
Bronchitis	Respiratory
Cold & Flu	Conjunctivitis
Communicable Disease	Limited Physical Examination
Diabetes	STI/STD
Otitis Infection	UTI

*abdominal examination can't be completed using telehealth equipment

Appendix

Step Three: Performance Monitoring Plan

Telehealth Model of Collaborative Healthcare Delivery in Schools

Vision: Telehealth technology and collaborative partnerships are used to positively impact the health and well-being of students across Michigan.

Outcomes:

1. Increased access to healthcare for students.
2. Increased reimbursement for health services provided in school clinics using RNs and telehealth technology.
3. Youth satisfaction with using telehealth technology for healthcare visits.

Evaluation Measures:

1. # of unduplicated students and visits annually.
 - a. Telehealth visits equal 20% of number of RN visits
2. # of RN visits
 - a. "mom care"
 - b. Nursing care under standing orders
3. # of healthcare claims submitted and reimbursed for telemedicine originating fees, visit fees and services provided by RNs working under medically supervised standing orders.
 - a. Submitted quarterly for each site using telehealth equipment
4. Satisfaction levels of students receiving healthcare visits using telehealth technology.
 - a. Completed with every patient (grades 7-12) after each telehealth visit with a minimum of 50 surveys completed at each school

Site Expectations:

Submit quarterly telehealth reports

Visits

Billing

Participate in monthly check in calls

PDSA Directions and Examples

The Plan-Do-Study-Act method is a way to test a change that is implemented. By going through the prescribed four steps, it guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again. Most of us go through some or all of these steps when we implement change in our lives, and we don't even think about it. Having them written down often helps people focus and learn more.

For more information on the Plan-Do-Study-Act, go to the [IHI \(Institute for Healthcare Improvement\) Web site](#) or this PowerPoint presentation on [Model for Improvement](#).

Keep the following in mind when using the PDSA cycles to implement the health literacy tools:

- **Single Step** - Each PDSA often contains only a segment or single step of the entire tool implementation.
- **Short Duration** - Each PDSA cycle should be as brief as possible for you to gain knowledge that it is working or not (some can be as short as 1 hour).
- **Small Sample Size** - A PDSA will likely involve only a portion of the practice (maybe 1 or 2 doctors). Once that feedback is obtained and the process refined, the implementation can be broadened to include the whole practice.

Filling out the worksheet

Tool: Fill in the tool name you are implementing.

Step: Fill in the smaller step within that tool you are trying to implement.

Cycle: Fill in the cycle number of this PDSA. As you work through a strategy for implementation, you will often go back and adjust something and want to test if the change you made is better or not. Each time you make an adjustment and test it again, you will do another cycle.

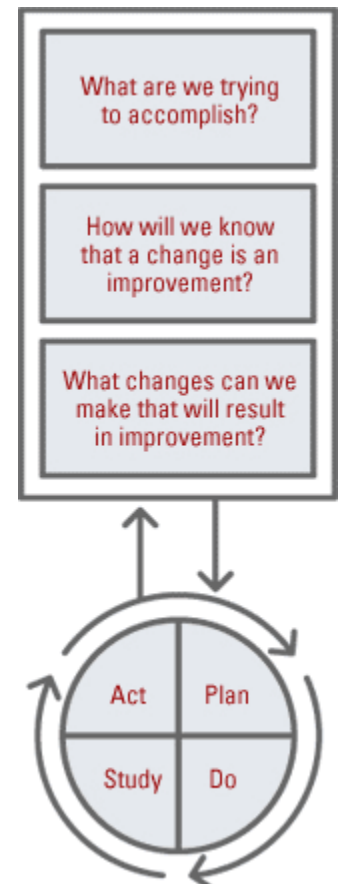
PLAN

I plan to: Here you will write a concise statement of what you plan to do in this testing. This will be much more focused and smaller than the implementation of the tool. It will be a small portion of the implementation of the tool.

I hope this produces: Here you can put a measurement or an outcome that you hope to achieve. You may have quantitative data like a certain number of doctors performed teach-back, or qualitative data such as nurses noticed less congestion in the lobby.

Steps to execute: Here is where you will write the steps that you are going to take in this cycle. You will want to include the following:

- The population you are working with – are you going to study the doctors' behavior or the patients' or the nurses'?



- The time limit that you are going to do this study – remember, it does not have to be long, just long enough to get your results. And, you may set a time limit of 1 week but find out after 4 hours that it doesn't work. You can terminate the cycle at that point because you got your results.

DO

After you have your plan, you will execute it or set it in motion. During this implementation, you will be keen to watch what happens once you do this.

What did you observe? Here you will write down observations you have during your implementation. This may include how the patients react, how the doctors react, how the nurses react, how it fit in with your system or flow of the patient visit. You will ask, "Did everything go as planned?" "Did I have to modify the plan?"

STUDY

After implementation you will study the results.

What did you learn? Did you meet your measurement goal? Here you will record how well it worked, if you meet your goal.

ACT

What did you conclude from this cycle? Here you will write what you came away with for this implementation, if it worked or not. And if it did not work, what can you do differently in your next cycle to address that. If it did work, are you ready to spread it across your entire practice?

<h3><u>Examples</u></h3>

Below are 2 examples of how to fill out the PDSA worksheet for 2 different tools, Tool 17: Get Patient Feedback and Tool 5: The Teach-Back Method. Each contain 3 PDSA cycles. Each one has short cycles and works through a different option on how to disseminate the survey to patient (Tool 17: Patient Feedback) and how to introduce teach-back and have providers try it. (Tool 5: The Teach-Back Method).

PDSA (plan-do-study-act) worksheet

TOOL: Patient Feedback

STEP: Dissemination of surveys

CYCLE: 1st Try

PLAN

I plan to: We are going to test a process of giving out satisfaction surveys and getting them filled out and back to us.

I hope this produces: We hope to get at least 25 completed surveys per week during this campaign.

Steps to execute:

1. We will display the surveys at the checkout desk.
2. The checkout attendant will encourage the patient to fill out a survey and put it in the box next to the surveys.
3. We will try this for 1 week.

DO

What did you observe?

- We noticed that patients often had other things to attend to at this time, like making an appointment or paying for services and did not feel they could take on another task at this time.
- The checkout area can get busy and backed up at times.
- The checkout attendant often remembered to ask the patient if they would like to fill out a survey.

STUDY

What did you learn? Did you meet your measurement goal?

We only had 8 surveys returned at the end of the week. This process did not work well.

ACT

What did you conclude from this cycle?

Patients did not want to stay to fill out the survey once their visit was over. We need to give patients a way to fill out the survey when they have time.
We will encourage them to fill it out when they get home and offer a stamped envelope to mail the survey back to us.

PDSA (plan-do-study-act) worksheet

TOOL: Patient Feedback

STEP: Dissemination of surveys

CYCLE: 2nd Try

PLAN

I plan to: We are going to test a process of giving out satisfaction surveys and getting them filled out and back to us.

I hope this produces: We hope to get at least 25 completed surveys per week during this campaign.

Steps to execute:

1. We will display the surveys at the checkout desk.
2. The checkout attendant will encourage the patient to take a survey and an envelope. They will be asked to fill the survey out at home and mail it back to us.
3. We will try this for 2 weeks.

DO

What did you observe?

- The checkout attendant successfully worked the request of the survey into the checkout procedure.
- We noticed that the patient had other papers to manage at this time as well.
- Per Checkout attendant only about 30% actually took a survey and envelope.

STUDY

What did you learn? Did you meet your measurement goal?

We only had 3 surveys returned at the end of 2 weeks. This process did not work well.

ACT

What did you conclude from this cycle?

Some patients did not want to be bothered at this point in the visit – they were more interested in getting checked out and on their way.

Once the patient steps out of the building they will likely not remember to do the survey.

We need to approach them at a different point in their visit when they are still with us – maybe at a point where they are waiting for the doctor and have nothing to do.

PDSA (plan-do-study-act) worksheet

TOOL: Patient Feedback

STEP: Dissemination of surveys

CYCLE: 3rd Try

PLAN

I plan to: We are going to test a process of giving out satisfaction surveys and getting them filled out and back to us.

I hope this produces: We hope to get at least 25 completed surveys per week during this campaign.

Steps to execute:

1. We will leave the surveys in the exam room next to a survey box with pens/pencils.
2. We will ask the nurse to point the surveys out/hand them out after vitals and suggest that while they are waiting they could fill out our survey and put it in box.
3. We will see after 1 week how many surveys we collected.

DO

What did you observe?

- Upon self report, most nurses reported they were good with pointing out or handing the patient the survey.
- Some patients may need help reading survey but nurses are too busy to help.
- On a few occasions the doctor came in while patient filling out survey so survey was not complete.

STUDY

What did you learn? Did you meet your measurement goal?

We had 24 surveys in the boxes at the end of 1 week. This process worked better.

ACT

What did you conclude from this cycle?

Approaching patients while they are still in the clinic was more successful.
Most patients had time while waiting for the doctor to fill out the survey.
We need to figure out how to help people who may need help reading the survey.

PDSA (plan-do-study-act) worksheet

TOOL: Teach-back **STEP:** MDS initially performing Teach-back **CYCLE:** 1st Try

Appendix

Step Four: Showcase Your Model – Marketing & Communication Plan

Donor List

Mr. and Mrs. Lane Knauss
Mr. and Mrs. Nick Krzeminski
Lakeside Point Blank
The Lamp Lighter
Ms. Linda Lance
Mr. and Mrs. Walt Lane
Lawton Ridge Winery
Mr. and Mrs. Thomas Lennard
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Martha Gomez
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Pastrami Joe's
Dr. and Mrs. Regio Penna
The Pickle Factory
Pizza Hut
PNC Bank
Mr. and Mrs. John Pollack
Post Employees Balloon Club
Dr. Kamal and
Dr. Sabeena Pradhan
Mr. and Mrs. Curtis Proctor
Pure Eden Salon
Rainbow Motor Sales
Renner Law Office
Ms. Georgann Reppert
Mr. and Mrs. Remus Rigg
Mr. and Mrs. William Robinson
Mr. and Mrs. John Rohloff
Mr. and Mrs. Richard Rose
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Mr. and Mrs. Ronald Sampsel
Ms. Darene Sargent
Mr. and Mrs. Jason Schabloski
Mr. and Mrs. Eric Scheske
Schley Architects
Schuler's Restaurant and Pub
Second Story Marketing
Mr. and Mrs. Randy Sell
Seybert's Billiards and Supplies
Seybert's Implements
The Shoppers' Guide
Ted and Amy Short
Mr. and Mrs. Bryan Smith
Ms. Mary Smith
Mr. David Smoker and
Ms. Lucinda Wakeman



Mr. and Mrs. Jim Sobeske
Stables
Stafford's Hospitality – Petoskey
Crooked River Lodge
Mr. and Mrs. Jack Stansell
Star Line Mackinac Island Ferry
Mr. Norbert Strobel
Studio 17 – Amanda
Studio 17 – Bekah Hampton
Studio 17 – Crystal Preston
Studio 17 – Sheena Spielbusch
Studio 17 – Terah Reichart
Studio 17 – Wendi Williams
Super Liquor II
Sussex Vision Center
Mr. and Mrs. John Swanson
Swick Broadcasting
Tasty Twist
Taylor's Stationers
Through His Eyes Photography –
Betty Geer
Tibbits
Tilted Tulip
Timeless Treasures by Jenny –
Jennifer A. Doty
Mr. and Mrs. Keith Tracy
Union City Rotary Club
United Educational Credit Union
Velo Law – Scott Renner and
Bill Renner
Dr. Baron V. Whateley
Ms. Laurel Walkup
Wendy's
Windy City Bags
Wingate by Wyndham Sylvania
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Women's Health Fest
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Paxton - Yarnologist
Dr. and Mrs. Bruce Young
Younique Beauty Consultant –
Abby Austin

2014/2015

Community Health Center School Tele-health

Annual Report



The Power
of Partnership

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MISSION STATEMENT

We are committed to providing access to high quality, integrated health services to the students of our community utilizing advanced technology.

VISION STATEMENT

To be the leading school tele-health program in the State of Michigan and to positively impact the health of students in our community and across the state.

VALUE STATEMENTS

**Respect each individual.
Commit to excellence in all areas of service.
Maintain integrity in all that we do.
Take responsibility for our actions and attitudes.
Show compassion for all.**



Donor List

- | | | |
|---|---|--|
| Adventure Zone | Coldwater High School Athletic Department | Mr. and Mrs. Dylan Foster |
| Affordable Lawn Care | Coldwater Lake Marina | Mr. and Mrs. Robert W. Fox |
| Mr. Erik Agar | Coldwater McDonald's | Dr. and Mrs. Gene Fry |
| A Grand Occasion | Mr. and Mrs. James Cole | Dr. and Mrs. David Fuchs |
| Albright Swine Farms | Cole Lincoln Ford | Ms. Grace Gaglio |
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| -Cynthia Woolner-Hemker | | |
| Mr. and Mrs. Douglas Clyne | | |
| Coldwater Gun and Pawn | | |

Strategic Plan

It is hard to believe another year has passed so quickly. As the Community Health Center of Branch County (CHC) School Tele-health program staff prepares to provide healthcare to students for the third school year, we are also nearing the end of the program's transformational grant from the Michigan Department of Health and Human Services. To ensure we are here to care for students for many years to come, CHC and collaborative partners recently defined three areas of focus for the CHC Tele-health Program.

1. Maintain financial stability and continue to positively impact the health of students
2. Develop and implement a multifocal marketing plan
3. Expand the current model/services

Each area of focus is essential for the continued success of the school based tele-health clinics. CHC is dedicated to continuing to seek funding to help secure the future of the clinics through fundraising, grant opportunities, and support from the collaborative partners. Key to ensuring sustainability and growth will be raising community and statewide awareness of our program while reminding students and parents of our services. Finally, we are committed to expanding the behavioral health services available to our students and their families. A recent survey of school staff identified mental health as the priority service that is needed for students. In Branch County, 30% of deaths in people ages 15 to 24 are caused by suicides compared to 27% in the State of Michigan.

Thank you for taking the time to review our annual report. Please continue to support the work of the CHC School Tele-health Program. Your contributions, whether through time, talent or financials resources, are helping us build a healthier Branch County.

Sincerely,

Kristin Smith
Grant Administrator



Kristin Smith



Letter from the CEO and President

As you probably know, annual reports are a tool to provide an overview of a program's activities and accomplishments throughout the year. Usually an introductory letter is used to set the tone for the report contents and I'm pleased to have the chance to do just that. As you will see on the following pages, since its inception, the Community Health Center of Branch County (CHC) School Tele-health Program has offered opportunities and rewards never imagined.

We've learned from parents, educators, and students about the needs of the community and how CHC can play a role in meeting them. We've learned about new ways to improve access to care and to start reducing barriers to providing services. We have learned that tele-medicine is embraced throughout health-care and have been surprised at the number of other facilities looking to replicate our model.

We also learned never to underestimate the power of collaboration and community. Our collaboration partners have stayed at the table – providing more than \$64,000 of support for the program and helping to build valuable relationships with students and parents. Our generous community members exceeded the required 30% match, providing more than \$69,000 to support equipment and salaries.

Thank you for being a part of this extraordinary journey. We are committed to continuing the program and look forward to your continued support.

Randy DeGroot



TEAM PROFILES



Arivoli Veerappan, MD. is a Board Certified Pediatrician at the CHC Pediatric and Adolescent Center. Dr. Arivoli graduated from Stanley Medical College, Chennai India and completed his internship and residency at Michigan State University, Sparrow Hospital in Lansing Michigan.



Edelwina Dy, MD. is a Board Certified Pediatrician at the CHC Pediatric and Adolescent Center and is the Medical Director of the CHC School Tele-health Program. Dr. Dy is a graduate of the University of Illinois at Chicago/College of Medicine.



Mehalai Arivoli, MD. became Board Certified in Pediatrics in 2004. Dr. Arivoli is a graduate of Madras Medical College, Tamil Nadu Dr Mgr Medical University. She completed her internship and residency at Michigan State University, Sparrow Hospital in Lansing, Michigan.



Kamal Pradhan, MD. is a Board Certified Pediatrician at the CHC Pediatric and Adolescent Center. Dr. Pradhan completed medical school at All-India Institute of Medical Sciences in 1993 and completed his residency in 2000 at Metro Health Medical Center in Cleveland, Ohio.



Sarah Collins, MS, FNP-BC is the family nurse practitioner at the CHC Pediatric and Adolescent Center. Sarah works side by side with the pediatricians. She is a 2012 graduate of the University of Michigan Family Nurse Practitioner Program. She has been with CHC since 2013. She and her husband have raised five children.



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- Tasty Twist • Taylor's Stationers • Through His Eyes Photography – Betty Geer • Tibbits
- Tilted Tulip • Timeless Treasures by Jenny – Jennifer A. Doty • Union City Rotary Club
- Velo Law – Scott Renner and Bill Renner • Dr. Baron V. Whateley • Laurel Walkup • Wendy's
- Windy City Bags • Wingate by Wyndham Sylvania • Susan White
- The Yarn Doctor – Dr. Chantal Paxton - Yarnologist • Younique Beauty Consultant – Abby Austin

2015 CHC Foundation Gala

Continuing the Legacy

Thanks to your support more than \$69,000 was raised to support the CHC School Tele-health Program.



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Bruce and Ruth Young

Special Thanks

The CHC Foundation Board of Directors would like to offer a heartfelt thank you to the committee members who worked tirelessly to make this event a success and to Marty Mayer for donation of the beautiful gladiolas.

TEAM PROFILES



Theresa Gillette RN is the manager of the CHC School Tele-health Program and nurse for CHC Cardinal Connect. She attended Ferris State University and has been a registered nurse for 17 years. Most of her career has been spent at CHC working in pediatrics. Theresa enjoys going to Pittsburgh Steeler games with her family and watching her twin sons compete in sports.



Jessica McKinley RN is the nurse at CHC Viking Connect. Jessica is a graduate of Bronson Junior/Senior High School and continued her education at Kellogg Community College. She has been a registered nurse specializing in pediatrics for seven years. Jessica enjoys spending time with her husband, Jon, and her two children.



Lori Loveberry, RN has been an employee of CHC for 29 years on the obstetrics floor and currently serves as the CHC Oriole Connect health clinic nurse. Lori enjoys biking and March Madness. Lori is married to Bob and both graduated from Quincy High School. Lori had two daughters, Jordan and Megan, who also graduated from Quincy.



Rochelle Bassage is the clinical health educator for the CHC School Tele-health Program. She graduated from Central Michigan University and is working on this project on behalf of the Branch-Hillsdale-St. Joseph Community Health Agency, a project partner. Rochelle serves as a resource for parents and students to help them learn to take better care of themselves and their families.



Jenny McDaniel was born and raised in Branch County and graduated from Coldwater High School. Jenny is a Medical Assistant for the Community Health Center of Branch County and is currently in school to receive her nursing degree. Jenny and her husband Ben live in Coldwater with their daughter Addison who is 7 years old.

National 2015 Kick Butts Day

Each school tele-health clinic has a youth advisory council made up of a diverse group of students. The councils assist clinic staff in creating programs that are adolescent friendly. Council members help to identify the most important health education topics and then assist in presenting topics in a way that captures student interest. The councils are an opportunity for students interested in the medical field to gain exposure to healthcare.

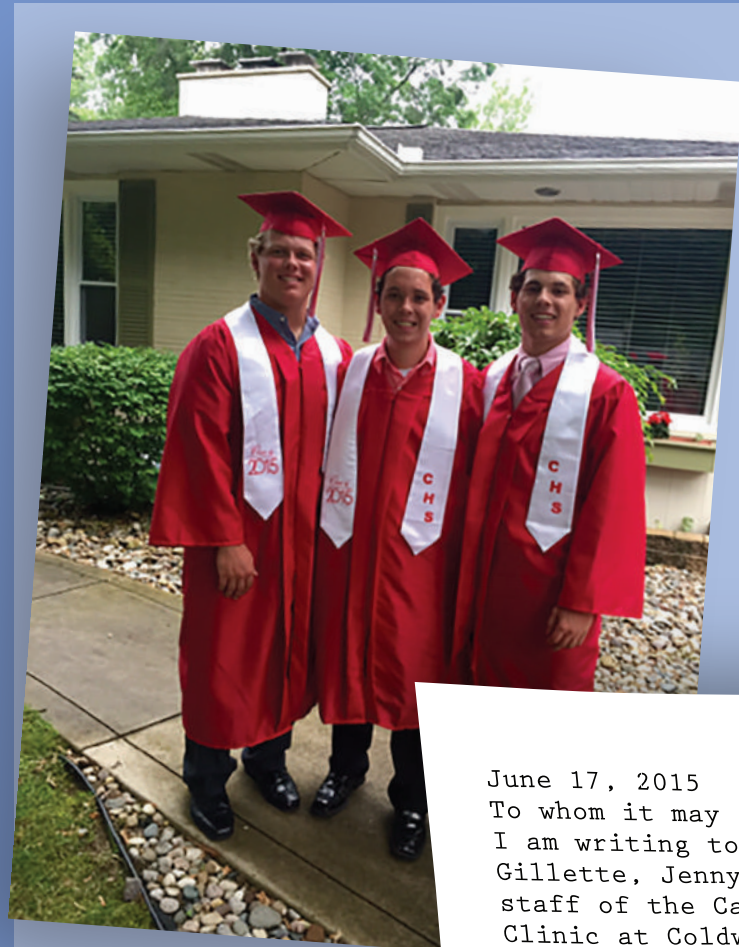
One of the major projects of the youth advisory council this year was participating in the National 2015 Kick Butts Day. Council members approached students in the cafeteria and encouraged them to stand up to tobacco companies who think their generation will be the sectors' "replacement smokers." Students took photos and posted them online to make the statement "I am not a replacement!" The campaign had the most widespread engagement of any health education topic in the 2014/2015 school year.



Financial Results

CHC School Tele-health Program

	2014/2015 Actual	2015/2016 Budget
<u>Income</u>		
Patient Revenue	\$101,676	\$102,000
Transformational Grant	\$200,000	\$200,000
Donations and Grants	\$118,750	\$100,000
In-Kind Contributions	\$12,250	\$12,250
Total	\$432,676	\$414,250
<u>Expenses</u>		
Salaries and Wages	\$219,667	\$281,164
Fringe Benefits	\$53,181	\$84,349
Contract Services	\$26,946	\$27,000
Supplies and Food	\$10,247	\$10,250
Immunizations and Drugs	\$27,610	\$28,000
Equipment	\$697	\$700
Travel and Training	\$2,328	\$5,000
Rent and Utilities	\$7,000	\$7,000
Billing Services	\$5,250	\$5,250
Promotion and Engagements	\$20	\$5,000
Total	\$352,947	\$453,714
Net Income/(Loss)	\$79,729	(\$39,464)



From the Eyes of a Parent

June 17, 2015

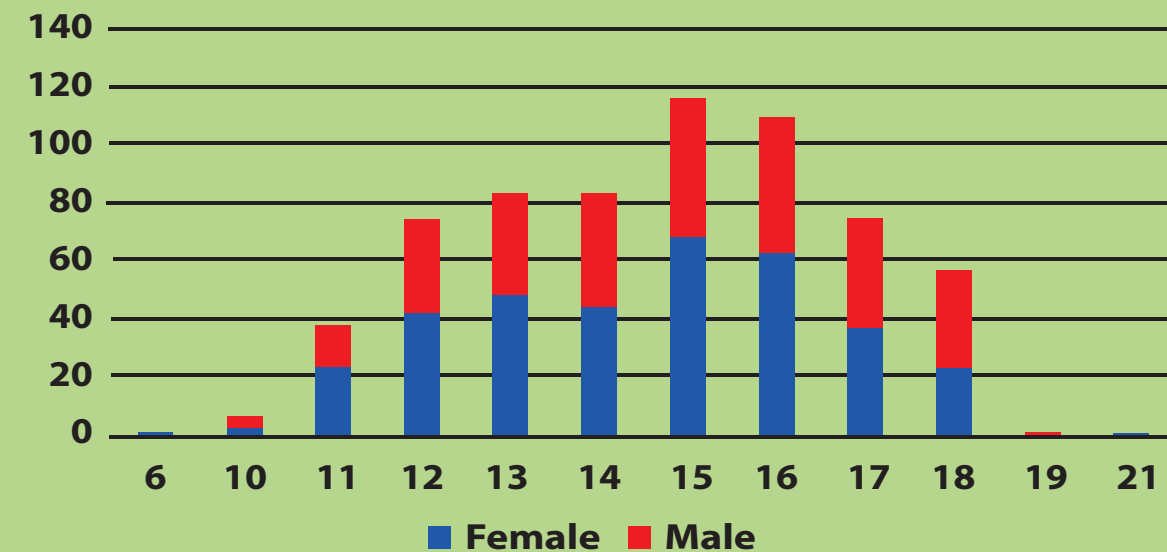
To whom it may concern:

I am writing to commend and thank Theresa Gillette, Jenny McDaniel, and the entire staff of the Cardinal Connect Tele-health Clinic at Coldwater High School. They have provided compassionate, professional, and thorough care of my sons for the past two years. I must be honest, I was very skeptical of the clinic when I first learned of it in the fall of 2013. I thought it was going to be very impersonal, and care from a distance. I was entirely wrong! They have treated, counseled, and educated the kids about many issues that face our teens today. Their medical care has been extraordinary, and they have provided accurate diagnosis and treatment of various health concerns and issues. They have also provided a safe place to go for help, not only medical help, but practical help as well. They would offer a snack if they forgot to eat breakfast, or many times welcomed them in to simply talk, and get some support and encouragement. I am confident that I speak for many parents in our community, CHC Cardinal Connect Tele-health Clinic is an asset to our school and community! Keep up the great job! Thank you again for all your care, and the positive impact you have made in the life of my sons.

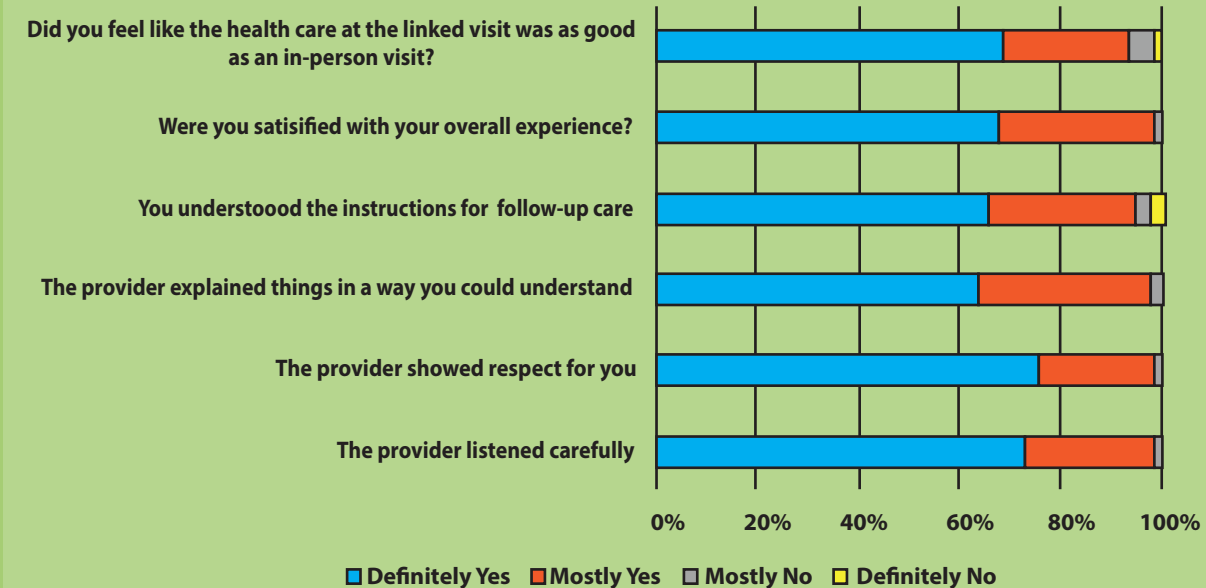
Sincerely,
Joanne Johnston

Demographics/Impact

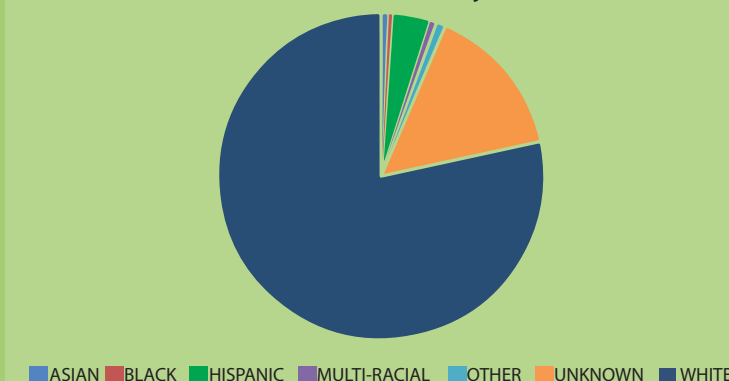
Students Served by Age and Gender



Students Survey Results Post Linked Visit



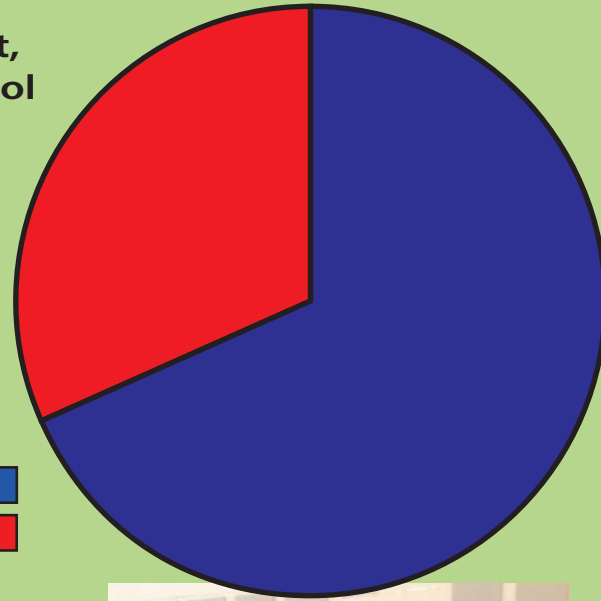
Students Served by Race



SURVEY RESULTS

After the linked visit,
did you stay at school
and go to class?

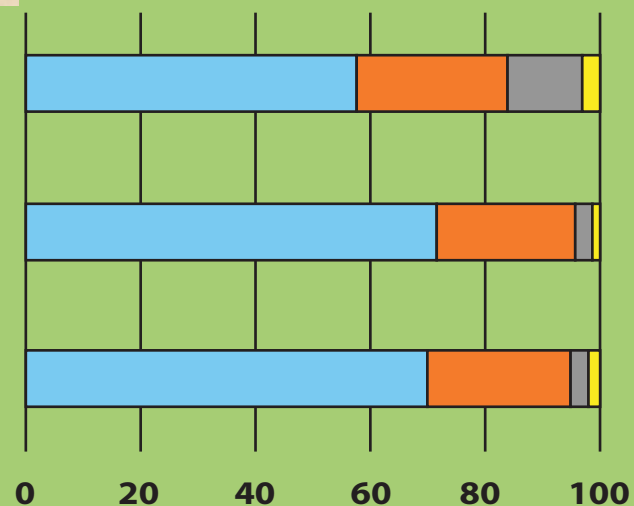
YES 
NO 



The school tele-health clinic keeps me from
missing school when I'm sick or injured

I recommend the clinic to others in my
school

I am completely honest when talking to
them about my health, personal life, and
activities



 Definitely Yes  Mostly Yes  Mostly No  Definitely No

State-wide Recognition and Replication

On June 25, 2015, the Community Health Center of Branch County's School Tele-health Program received the Michigan Hospital Association (MHA) Ludwig Community Benefit Award. The MHA award recognizes health care organizations that demonstrate community benefit by collaborating with other local organizations to improve the overall health and well-being of their communities. The award included a \$3,000 cash gift from the Michigan Hospital Association (MHA) to assist in the ongoing efforts of the program. "We are very proud of our program but even more grateful to have the opportunity to serve kids in our community," School Tele-health Program Manager, Theresa Gillette.

The program continues to impress state health officials. This year the program has hosted more than six site visits from other hospital systems looking to replicate the model to improve access to healthcare for children in their community.





Communication Plan for School Tele-health Clinics

Staff:

- *Communicator* article – January issue
- Fast Fact – January

Physicians:

- Physician newsletter article - January
- Resource Alerts - January

Volunteers:

- Update at March Volunteer luncheon
- Articles/pictures in monthly newsletter

Public:

- Community Advisory Group January meeting
- Facebook postings
- Website page
- *HealthLine* article – December, April
- Presentations
 - Service clubs
 - ♦ Noon Rotary
 - ♦ Sunrise Rotary
 - ♦ Altrusa
 - ♦ Noon Exchange
 - ♦ Early Bird Exchange
 - ♦ Coldwater Kiwanis 1/23/14
 - ♦ Bronson Rotary
 - ♦ Bronson Kiwanis
 - ♦ Quincy Rotary 12/2/13
- Media releases
- Radio/Q1 interviews
- Display ads
 - Daily Reporter
 - Shoppers Guide
 - Nuevas Opinion

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miss class



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leaving school.

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More questions? Want to
enroll? Talk to the school
nurse or go to:
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Appendix
Step Five: Sustainability

2015 – 2018 CHC School Tele-Health Program Strategic Plan

Goal	Objectives	Strategies	Responsibility	Target Completion Date	Measurement
1. Maintain financial stability and continue to positively impact the health of students	1. Define a successful clinic	<ol style="list-style-type: none"> 1. Review costs 2. Review outcomes 3. Set performance goals 4. Define staffing levels 5. Define value of hospital community benefit 6. Define value of community health benefit 	Randy D Amy C Theresa G Diane G Kristin S MDHHS Team		
	2. Identify funding goals and opportunities	<ol style="list-style-type: none"> 1. Determine annual operating and capital costs 2. Identify and solicit funding prospects and cycles 3. Prioritize expansion 	Terra D Kristin S Randy D		
	3. Showcase outcomes and impact of program	<ol style="list-style-type: none"> 1. Annual Report 	Terra D Kristin S Theresa G		
	4. Create referral patterns		Dr. Dy Theresa G		
2. Develop and implement a multifocal marketing plan	1. Develop and implement local marketing plan to include providers, CHC employees, school employees, the public, parents, students, and funders	<ol style="list-style-type: none"> 1. Identify target markets 2. Develop budget 3. Develop strategies 4. Prioritize target markets 6. Prioritize strategies 7. Develop tactics 8. Develop measurements 	School Nurses Kristin S Diane G		

2015 – 2018 CHC School Tele-Health Program Strategic Plan

3. Expand the current model/services	2. Advocate for program at state and federal levels		Theresa C R Bassage MDHHS Team		
	3. Improve relationships with insurance providers		MDHHS Team		
	1. Analyze behavioral health services	1. Analyze current behavioral health status of students 2. Develop understanding of reimbursement for services 3. Investigate models for delivery of services 4. Determine costs and space needs 5. Determine funding opportunities	Terra D Theresa G Kristin S School Nurses		
	2. Identify expansion into other buildings		Theresa G		
	3. Investigate student special health services		Theresa C Kristin S		

Telehealth Implementation Guide

for

West Virginia School-Based and Community Sites



Prepared by the
School-Health Technical Assistance Center
Department of Family & Community Health
Marshall University School of Medicine

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Introduction

The Marshall University School-Health Technical Assistance Center (MUTAC) provides telehealth project support including connecting organizations to specialists, providing insight on equipment and software, support for developing telehealth policy and procedures, and program planning and implementation.

Implementing a telehealth program is an organizational change. It is about people and the ability to manage the change that is occurring. A sound foundation for planning must be established and a solid team assembled with necessary skills encompassing technological capabilities, clinical background, operations, and project management. We hope that this Implementation Guide will provide you with the tools and guidance necessary to establish a successful telehealth program within your organization.

This guide was developed with financial support from the Claude Worthington Benedum Foundation and the West Virginia Bureau for Behavioral Health.

WV School Health Technical Assistance Center

For Information About:

Contact:

Professor and Project Director

Program oversight, design and evaluation,
quality improvement

Richard Crespo, PhD

Email: crespo@marshall.edu

School Health Coordinator

Implementing telehealth, quality
improvement and continuing education

Judy Koehler, BS

Phone: 304-661-1040

Email: jkoehler@marshall.edu

School Mental-Health Coordinator

Implementing telemental health
quality improvement and continuing
education

Tiffany Pittman, MA, LPC, AADC

Phone: 304-617-6395

Email: pittman6@marshall.edu

Data Manager

Data management and evaluation
for telehealth programs, satisfaction
surveys

Stephanie Montgomery

Phone: 304.634.1008

Email: smontgom@marshall.edu

IT Specialist /Web Developer

Telehealth technology requirements

Kevin Simpson

Phone: 304.691.1185

Email: simpson13@marshall.edu

Glossary of Telehealth Terms

A list of commonly used words or phrases to describe telehealth activities, equipment and requirements.

Telehealth / Telemedicine / Telemental health: There are many definitions for telehealth. The Health Resources and Services Administration (HRSA) defines telehealth as “The use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration (<http://www.hrsa.gov/ruralhealth/about/telehealth/glossary.html>). When telehealth relies on synchronous (interactive) technologies, such as videoconferencing or telephone to deliver medical care to patients, the term “telemedicine” is used, and when that care specifically involves mental health or psychiatric services, the terms “telemental health” (TMH) and “telepsychiatry,” respectively, are generally used (American Telemedicine Association; www.americantelemed.org).

Hub / Distant Site: The Centers for Medicare and Medicaid Services (CMS) define the distant site as the telehealth site where the provider/specialist is seeing the patient at a distance or consulting with a patient’s provider. Others common names for this term include – the hub, specialty site, provider/physician site and referral site.

Spoke / Originating Site: CMS defines originating site as the site where the patient and/or the patient’s physician is located during the telehealth encounter or consult. Other common names for this term include – spoke site, patient site, remote site, and rural site.

Interactive video / Live / Face to Face: This is videoconferencing technologies that allow for two-way live, interactive video and audio signals for the purpose of delivering telehealth, telemedicine or distant education services. It is often referred to by the acronyms – ITV, IATV or VTC (video teleconference).

Store and Forward: Captured audio clips, video clips, still images, or data that are transmitted or received at a later time (sometimes no more than a minute).

Codec - Codec stands for Coding and Decoding. The Codec is software used to compress the outgoing video and audio data, transmit this information to the far end and decompress the incoming information. The codec also provides embedded security encryption. The software is HIPAA compliant and abides by a federal code pertaining to telehealth.

Telehealth Coordinator: Responsible for the overall management of the telehealth program, facilitates all aspects to include scheduling, marketing, patient data collection, and financial aspects to include billing. The coordinator is also responsible for ensuring equipment and connectivity are working prior to the visit.

Telehealth Presenter: Assists with the clinical examination of the patient. This individual, ideally, has a clinical background (LPN, RN, PA, BSW, etc.), trained in the use of telehealth equipment and will “present” the patient to the consulting telehealth provider.

Steps to Developing a Successful Telehealth Program

The most important step is to bring all key players to the planning table early, ensuring that everyone understands telehealth. Program goals should be clear and match the mission and vision of all key players.

Step 1: Complete a Needs Assessment

- Identify current service needs
- Identify potential telehealth opportunities
- Assess organizational readiness

Step 2: Define Program Model

- Consider the type of program that will meet needs

Step 3: Develop Business Case

- Determine the impact of the proposed telehealth program

Step 4: Develop and Plan Program & Technology

- Create a detailed project plan

Step 5: Develop Performance Monitoring Plan

- Define monitoring and evaluation mechanisms and program improvement process

Step 6: Implement Telemedicine Program

- Perform all work required to implement the program

Step 7: Monitor and Improve Program

- Ongoing

The tool [Telehealth Readiness Assessment](#) asks a series of questions to determine the level of readiness to offer telehealth services. The tool was designed for providers and practices in the state of Idaho who were in the early stages in building their telehealth program.

Approved Telehealth Sites

Authorized Spoke (originating) sites

- Offices of physicians or practitioners;
- Private Psychological Practices;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics (RHCs);
- Federally Qualified Health Centers (FQHCs) and any sponsored School-Based Health Centers;
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNF); and
- Community Mental Health Centers (CMHC).

Source: WV Dept. of Health and Human Services. *Medicaid Provider Manual, Chapter–519.17 Practitioner Services: Telehealth Services*. Revised Jan. 15, 2016 (Accessed Apr. 2018).

Approved Providers at the Hub (Distant) Site

Authorized distant site providers include:

- Physicians;
- Physician Assistants (PA);
- Advanced Practice Registered Nurses (APRN)/Nurse Practitioners (NP)
- APRN/Certified Nurse Midwife (CNM);
- APRN/Clinical Nurse Specialists (CNS);
- Licensed Psychologists (LP); and
- Licensed Independent Clinical Social Worker (LICSW)

IMPORTANT: RHCs and FQHCs are not authorized to serve as distant sites for telehealth consultations, which is the location of the practitioner, and may not bill or include the cost of a visit on the cost report.

Source: WV Dept. of Health and Human Svcs. *Medicaid Provider Manual, Chapter–519.17 Practitioner Services: Telehealth Services*. Revised Jan. 15, 2016 (Accessed Aug. 2018).

Source: WV Dept. of Health and Human Svcs. *Medicaid Provider Manual, Chapter–519.17 Practitioner Services: Telehealth Services*. Revised Jan. 15, 2016 (Accessed Aug. 2018).

Implementation

Connect Hub and Spoke Site

Once the organization has determined the service level and program that works best, as well as the providers, the two sites can be connected. Remember, the *hub* site is where the provider is located and the *spoke* site is where the patient is located. Connecting these sites is all about communication.

This step is not about the technology connection, but ensuring the two sites are aware of the process and are now involved in the planning and implementing piece.

If they were not already involved in the beginning, bring key people from each site together, most importantly the Telehealth Coordinators at each site.

Select a Program Start Date

This step is often overlooked because it is easy. However, it is crucial to the successful commencement of any telehealth program. By identifying the start date, there is now a measurable goal for the program that will keep the process moving in the right direction.

Once a start date is selected, the organization confirms to all involved stakeholders that they are committed to a successful program launch.

If an unrealistic goal is chosen (i.e. two weeks or two years), then the base that has been built could be threatened. By selecting a date that is too soon, the program could suffer. Key pieces may be forgotten and staff may not feel adequately trained and prepared to begin. Alternately, a date that is too far ahead could cause the program to become deprioritized.

Also, consider the type of implementation approach; phased, pilot, limited number of sites initially, one type of telehealth service to start, etc. Many organizations find that small steps are useful, some find larger implementations to be successful. Decisions are generally based on the time and resources available.

Establish a work plan, or even a chart to record and track progress on tasks. Execute the plan to complete all tasks required to implement the program and *keep stakeholders updated!*

Always remember to choose a date that will be feasible for the organization to start without rushing and risking too much of a delay. Depending on where an organization is, a start date can range from four months to one year.

Technology and Equipment

How does an organization pick the right technology? Marshall University IT can help with this process. Start by answering certain questions pertaining to the mode of service delivery:

- What type of provider will be using this system?
- Where will the technology be placed? Does the organization have an established room? What is the signal strength in that room or area?
- How many people will be using the technology? Do additional staff need to be hired?
- What are the technological requirements?
- Who will manage the technology and troubleshooting efforts?
- How will the clinical staff be trained? What clinical guidelines should be established? This will depend on the mode of service delivery and type of service being offered.
- What ongoing training and education will be needed or required?

Equipment: The telecommunication equipment must be of a quality to complete adequately all necessary components to document the level of service for the CPT OR HCPCS Codes that are available to be billed.

There are different types of equipment used for telehealth services. Self-contained or mobile units are often used for patient consultations such as one requiring physical examinations or assessments. These units are easily moved. Another type of unit is a desktop system.

Each of these systems has common components. The main components of telemedicine equipment are:

- the main camera
- the viewing screen or screens
- the microphone
- the codec (computer program for encoding or decoding a digital data stream or signal)
- various peripheral equipment such as specialized cameras and diagnostic scopes

Network: Recommended minimum speeds for telemedicine applications range between 512 KB and 1Mbps over ISDN (Integrated Services Digital Network) or proprietary network connections including VPNs (Virtual Private Networks), fractional T1, or T1 comparable cable bandwidths. At lower speeds, such as 384 KB, the video quality begins to disintegrate. At 256 KB, you will lose the synchronization of video and sound.

Codec stands for Coding and Decoding. The Codec is the software used to compress the outgoing video and audio data, transmit this information to the far end and decompress the incoming information. The codec also provides embedded security encryption. Though products cannot ensure compliance, some products may contain elements or features that allow them to be operated in a HIPAA-compliant way. Some commonly used products include Zoom or WebEx. Marshall University IT Department may be able to provide direction on selecting a product.

Necessary Paperwork

- 1) *Licensing and Credentialing* – ensure that the providers who will be performing telehealth are licensed to do so. This is especially important if they are crossing state lines – providers **must be credentialed in both states** for most payers to reimburse. It may be that "temporary" privileges can be granted so that consultations are not delayed. Your organization is at risk if you do not keep current with the status of your provider's credentials and privileges.
- 2) *Policies and Procedures* – telehealth policies and procedures should be as close as possible to non-telehealth policies and procedures to ensure all staff will not feel they're engaging in a process that is strange or unusual. Policies and procedures should also include job descriptions of key roles if someone leaves. These documents should be kept both electronically and on paper and be reviewed at least once per year. Examples are included in the Appendix – [Policies and Procedures](#).
- 3) *Business Associates Agreement* - In the most basic sense, a *Business Associate Agreement* or BAA is a legal document between a healthcare provider and a contractor. A provider enters into a BAA with a contractor or other vendor when that vendor might receive access to *Protected Health Information* (PHI). Covered entities must ensure that they have a current HIPAA **business associate agreement** in place with each of their partners to maintain PHI security and overall HIPAA compliance. An example of a BAA is located in the Appendix on page 38. [Sample Business Associate Agreement](#).
- 4) *Special Consent Forms for Telehealth* – It is important that the patient understand and consent to how a telehealth visit will work as well as any situations that may occur that are different from their standard office visits. An example of a Telehealth Consent Form is located in the Appendix on pages 21 - 24. [Sample Telehealth Consent Forms](#). In addition, the patient will need to have signed a release of information for the exchange between the Spoke and Hub providers.
- 5) *Marketing/Communication Strategy* - newsletter, website post, news releases, social media, patient brochures in a hospital or health center.

Reimbursement

It is crucial to understand the existing reimbursement methods and current payer mix. Reimbursement for telehealth is complicated and the policy environment is in constant flux. In addition to self-pay, Medicare, Medicaid and many private payers offer some form of reimbursement for telehealth delivered services. However, policies vary by both state and payer. For more information, click on the icons to open the document, or use the accompanying web link.



The Center for Medicare and Medicaid Services Telehealth Learning Guide – Includes HCPCS/CPT Codes and GQ modifiers. This document was released January 2019.

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf>



The **Telehealth Reimbursement Fact Sheet** produced by the Center for Connected Health Policy summarizes some of the current telehealth reimbursement issues.

<https://www.cchpca.org/sites/default/files/2019-03/TELEHEALTH%20REIMBURSEMENT%202019%20FINAL.pdf>



State Telehealth Laws and Medicaid Program produced by the Center for Connected Health Policy, including information for West Virginia as of 2018.

<https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies?jurisdiction=78&category=All&topic=All>



The **West Virginia Bureau for Medical Services** encourages providers that have the capability to render services via Telehealth to allow easier access to services for WV Medicaid Members. Some service codes give additional instruction and/or restriction for Telehealth. Please review individual policies such as 502, 503, 504, 519, 521 and 538 to see what services are individually identified as being a covered telehealth service.

<https://dhhr.wv.gov/bms/Pages/Manuals.aspx>

The School-Health Technical Assistance Center at Marshall University has attempted to provide the most recent information about billing for telehealth services in West Virginia. However, this is provided for informational purposes only and is not legal advice. Each agency is solely responsible to ensure proper billing. Marshall University is not liable for any claims or losses of any nature arising directly or indirectly from use of the information, data, documentation or other material in this document.

Staffing

Telehealth requires many staff applying their specialized knowledge to make a telehealth program operate smoothly.

The Telehealth Coordinator is at the center of everything, playing a key role in ensuring that the patient encounter is successful and that a high quality of service is received. Both the originating/patient site and the distant/consulting site will have a Telehealth Coordinator.

The Telehealth Coordinator Responsibilities include:

- Coordinate all clinic operations related to telehealth
- Supervise the scheduling of patients for telehealth consultations
- Coordinate the use of equipment for educational and administrative uses
- Assure telehealth space is appropriate and maintained
- Assure telehealth equipment is operational
- Assure clinical protocols, policies and procedures are in place
- Work with billing office on telehealth visit reimbursement
- Assure that clinicians are properly credentialed and privileged
- Collect data on telehealth use
- Oversee financial aspects of the telehealth service
- Prepare reports on utilization, costs, cost/benefit and other program information
- Advocate for telehealth with other clinic departments and staff
- Represent telehealth program in local community
- Have working knowledge of the functions of the patient presenter
- Coordinate with technical support staff

Clinical/Telehealth Medical Director

The Clinical Telehealth Medical Director is the clinical "champion" of the Telehealth program and provides credibility for the services.

Telemedicine Clinical Presenter

The Telemedicine Clinical Presenter at the patient or presenting site is required to assist with the clinical examination of the patient. This individual with a clinical background (LPN, RN, PA, BSW, etc.), is trained in the use of telehealth equipment, will "present" the patient to the consulting telehealth provider.

IT Personnel and Network Support Staff

Please note: Telehealth Coordinators and Clinical Presenters should be responsible for turning on the equipment and should be able to perform basic troubleshooting before calling on the technical support staff.

Having ready access to trained and knowledgeable IT personnel and network support staff is critical to the effective running of your program. It is vital that an IT champion is identified and that the IT department is involved. During consults or any clinical interaction taking place via the telehealth system, trained and efficient technical staff must be on hand to troubleshoot and make technical adjustments as necessary.

- Identify an IT champion.
- Introduce IT personnel at all sites to each other. The better they know one another, the smoother your technical troubleshooting will be.

Quality Assurance & Program Evaluation

In addition to payment and stakeholder buy-in, the key to sustaining a telehealth program is measuring the outcome and “telling the story” of the program. It is important to collect meaningful data on all key elements of the program from the very beginning and on a regular basis to monitor progress toward the goals established during the planning phase. Gathering data and reporting on performance will assist your program in obtaining organizational support, funding and further expansion of services.

Include a wide range of data points in the plan: utilization by site, by school, grade & age, date of initial referral and date of visit, visit type and payer type. Data should be reported on a monthly basis.

Include patient, family and provider satisfaction surveys.

Include cost savings reports as possible.

A system to capture this information has been developed by MUTAC. **The Telehealth Process and Utilization Data** recording form is included in the [Appendix on page 48](#). The data should be entered **monthly** into survey using the link below. MUTAC will export the information on a quarterly basis (or more frequent by request) and provide an aggregate report for your organization. To access the online data entry form, click on the survey link below.

<http://survey.constantcontact.com/survey/a07egd6auyojw9d7tyg/start>

Examples of various **Satisfaction Surveys** are included in the Appendix. These should be offered after each visit when possible. Click on the survey name to be directed to the Appendix. The information can be reported by using the associated Survey Monkey link. MUTAC will export the information on a quarterly basis (or more frequent by request) and provide an aggregate report for your organization.

Telehealth [Referring Provider](#) (Spoke Site) Satisfaction Survey

<http://survey.constantcontact.com/survey/a07egd70ew3jw9kw85v/start>

Telehealth [Consulting Provider](#) (Hub Site) Satisfaction Survey

<http://survey.constantcontact.com/survey/a07egd76kjejw9moge/z/start>

Telehealth [Parent](#) Satisfaction Survey

<http://survey.constantcontact.com/survey/a07egd7a39wjw9ns1ij/start>

Telehealth [Client](#)/Student Satisfaction Survey

<http://survey.constantcontact.com/survey/a07egd78ikcjw9n7h1i/start>

Test the Process

Depending on whether an organization is the hub or spoke site, site preparation is necessary to be ready for the first telehealth encounter. There are several items to consider prior to testing the first encounter:

1. *Workflow* - Determining how the program will run on a day-to-day basis, known as the workflow, is a key step in designing a telehealth program. This involves careful planning about where to place equipment, who will present a child during a telehealth visit, and the provision of training and technical assistance.
2. *Staff Training on Equipment* – test, test, and test again! Ensure that all staff members who will be involved in telehealth encounters have been thoroughly trained on the equipment, know how to use all peripherals, know who to contact if technical issues arise, etc. and feel confident.
3. *Room Design* – Clarity and accuracy during video encounters is of the utmost importance. Consider the following when selecting a telehealth exam room:
 - a. Room Location – should be quiet and minimize exposure to office noise or busy corridors.
 - b. Room Size – dependent on the service being provided and if you are the hub or spoke site.
 - c. Equipment Placement – need to optimize the camera’s view of the patient and allow staff to enter and exit without disrupting the visit.
 - d. Lighting – the most critical factor in designing a telehealth examine room. Ideally use a diffused light source that does not create shadows and depicts color accurately.
 - e. Wall Color – white or light walls can darken faces; a light gray or robin’s egg blue background works well on all skin tones.
4. *Video-conferencing Etiquette* – Avoid distractions, close any shutters or blinds in the exam room, and ensure there are no distracting elements in the background. Limit excessive hand gestures and movements, talk slightly slower than normal, and always pause for comments. No eating or drinking during any visit.
5. *Test Run* - Once the equipment and technology have been thoroughly tested, find a patient who is willing to be a “test patient” for the program. Walk them through the process in its entirety and work out any “kinks” that staff may come across.

Telehealth Visit Protocol

This information provides a basic format for a telehealth session. The framework can be adapted to any telehealth practice. It is recommended that any clinic practice is adapted for telehealth visits, including: confirming clinic appointment, documenting patient arrival time, integrating within the clinic workflow, and obtaining patient consent (if applicable). Further, if telehealth visits occur between two providers, it is recommended that the providers determine which side will take the lead during the visit.

Step 1

- Test the equipment prior to the first clinic appointment (preferably 20-30 minutes prior to the visit). This should be tested by the Information Technology staff at both sites.
- Connect and test the peripheral equipment.
- Troubleshoot any technology glitches.
- Collect a roster of key staff contacts at each site (including; cell phone numbers, email, and a landline phone number in the event of technical difficulties).
- Ensure that the camera and equipment is ready for use.

Step 2

- Document the patient arrival and place patient in the clinic room.
- Obtain a signed consent and release of information, if applicable.
- Review the protocol of the telehealth visit and explain what the patient can expect.

Step 3

- Alert the provider that the patient is ready and send the provider into the room.
- Request that introductions begin at patient site. Include everyone in the room.
- Begin the visit, per protocol.
- Obtain a history and physical exam, as applicable.
- Review medication, if applicable.
- Develop a plan of care with the team.
- Identify a follow-up plan.
- Document the visit (both sites)
- Evaluate the visit with Satisfaction Survey
- Conclude visit.
- Process payment.
- Clean and store equipment and peripherals.

Helpful Links

Mid-Atlantic Telehealth Resource Center – Our region’s technical assistance and resource center, including webinars and links to other telehealth programs.

<https://www.matrc.org/>

The tool **Telehealth Readiness Assessment** asks a series of questions to determine the level of readiness to offer telehealth services. The tool was designed for providers and practices in the state of Idaho who were in the early stages in building their telehealth program.

http://ship.idaho.gov/Portals/93/Documents/ITC/Telehealth_ReadinessAssessment_Tool_PRINT.pdf?ver=2016-10-11-163504-617

Training Videos on how to establish a successful telehealth program, staffing roles and responsibilities, technology options and a live visit demonstration. The videos were developed by the California Telehealth Resource Center and are available to the public on YouTube:

<http://www.caltrc.org/knowledge-center/videos/>

Telehealth Resource Center, **Telehealth Technologies** and Preparing to Select a Vendor

<https://nosorh.org/wp-content/uploads/2016/11/NOSORH-Telehealth-Vendor-Fact-Sheet-FINAL.pdf>

Telehealth and HIPAA – Telehealth Resource Center Fact Sheet

<http://www.telehealthtechnology.org/sites/default/files/documents/HIPAA%20for%20TRCs%202014.pdf>

Medicaid Regulation and Reimbursement:

<https://www.medicaid.gov/medicaid/benefits/telemed/index.html>

Medicare Regulation and Reimbursement:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf>

SAMHSA-HRSA Center for Integrated Health Solutions **Telebehavioral Health** Training and Technical Assistance Series

<https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>

Star Telehealth at New College Institute: **Training and Credentialing** for those interested in using telehealth.

<http://www.startelehealth.org/>

Appendix

Sample Telehealth Policies and Procedures

The following sample Policy and Procedures are included with permission from the existing
Telehealth Implementation Guide of New York

www.telehealthny.org

Department:	Policy Description: Telehealth Patient Selection
Page: 1 of 1	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH001
Approved by:	

Purpose: Telehealth provides patients located in rural areas with timely access to specialist care via real- time television/video communication.

Policy: Patients in need of specialty care, as determined by their primary care provider, will be referred to telehealth services provided at the affiliated hub/specialist site.

Procedure: Providers at the spoke/patient site will use their clinical judgment in selecting patients for the telehealth service. Patients who would otherwise be referred to an outpatient appointment with a traditional specialist are welcome to utilize the telehealth service. If a patient is in a crisis situation and in need of emergency services, the same emergency procedure should be followed as was in place prior to the launch of the telehealth program.

Patients who do not have insurance coverage for telehealth services can be referred to the service if they agree to pay for the service out-of-pocket.

If the provider at the spoke/patient site determines that one of his or her patients could benefit from telehealth services, the provider will:

- 1) Discuss the service with the patient or legal guardian and obtain their consent.
- 2) Put the patient in contact with the front desk staff who will issue the patient the *Telehealth New Patient Packet*.
- 3) Complete a telehealth referral authorizing the appointment. Refer to telehealth referral process policies and procedures for more information.

Department:	Policy Description: Telehealth Referral Process
Page: 1 of 1	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH002
Approved by:	

Purpose: To describe the process that must be completed for patients to access the Telehealth services provided at the hub/specialist site.

Policy: All paperwork in the *Telehealth New Patient Packet* must be completed by both the provider and the patient to refer a patient to telehealth services.

Procedure: Patients will only be referred to specialists at hub/specialist sites that have completed a *Business Associate Agreement*, *Telehealth Services Agreement*, and a *Provider Declaration* form. These forms minimally include:

- 1) Statement of work outlining the responsibilities of each party;
- 2) Number of hours provided each month for telehealth services and that such services will be provided remotely;
- 3) How the specialists or hub/specialist site will be reimbursed for services rendered;
- 4) Who has the right to bill the patient's insurance, noting the professional fee and facility fee;
- 5) Who is providing the necessary telehealth equipment;
- 6) Declaration that providers are qualified to provide services, e.g. state licensed and credentialed at hospital, if applicable.
- 7) Details of communication between the provider at the spoke/patient site and the specialist at the hub/specialist site including timeframe of completion of medical reports to be provided;
- 8) Declaration of which site maintains and "owns" patient records; and
- 9) Agreement of both parties to follow HIPAA guidelines.

The *Telehealth New Patient Packet* must be completed prior to a telehealth appointment being scheduled. The *Telehealth New Patient Packet* includes:

- 1) A telehealth referral which is completed by the provider and office staff at the spoke/patient site and includes patient's name, date of birth, medical record # (if applicable), current insurance information, contact information, preferred pharmacy name, and medical history/summary (includes medical diagnosis and current medication and dosage); referring physician name and signature; and any other pertinent information as deemed necessary.
- 2) *Telehealth Consent* form ([see Appendix pages 21 – 24](#))
- 3) Any other forms/consents the spoke/patient or hub/specialist site or legal team require, including the Notice of Privacy Practices, Patient Rights and Responsibilities Form and the HIE Consent to View form.
- 4) The spoke/patient site will fax, e-fax, or secure electronic message a copy of the *Telehealth New Patient Packet* to the hub/specialist site prior to the patient's first scheduled appointment.
- 5) All materials contained in the *Telehealth New Patient Packet* must be documented in the patient's medical record at both the spoke/patient and hub/specialist site.
- 6) Referrals for telehealth may be accepted as orders, written or verbal, from physicians, nurse practitioners, and/or physician assistants.
- 7) Referrals are logged in a *Telehealth Referral Log* ([see Appendix page 25](#)) at both the spoke/patient and hub/specialist sites. The log provides a place for staff to identify the date of a referral, patient's name and DOB or medical record number (if applicable), date of the scheduled appointment, comment field to track messages, or other pertinent information.

Department:	Policy Description: Telehealth Consent
Page: 1 of 1	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH003
Approved by:	

Purpose: To describe requirements of healthcare providers to ensure a telehealth patient's understanding of the risk and benefits of the service, and to document a patient's agreement to the delivery of a telehealth service and obtain a patient's, or if applicable, a person's guardian, custodian, or agent's signature to verify consent.

Policy: A signed *Telehealth Consent* form must be obtained prior to the first patient telehealth examination/consultation.

Procedure: Any person aged 18 years and older or the person's legal guardian, or in the case of persons under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency, must give voluntary consent to treatment, demonstrated by the person's or legal guardian's signature, if aged 18 years and older, or in the case of persons under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a *Telehealth Consent* form ([see Appendix pages 21 – 24](#)); prior to the delivery of the telehealth service.

Any person aged 18 years and older or the person's legal guardian, or in the case of persons under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits, and risks of treatment, has the right to decline receiving telehealth services.

Patients acknowledge the telehealth program's no-show policy in the *Telehealth Consent* form.

The spoke/patient site will fax, e-fax, or secure electronic message a copy of the signed *Telehealth Consent* form to the hub/specialist site prior to the delivery of the telehealth service.

The *Telehealth Consent* form must be documented in the patient's medical record at both the spoke/patient and hub/specialist sites.

All patients aged 18 years and older or the person's legal guardian, or in the case of persons under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency will receive a *Telehealth: What to Expect* form with their *Telehealth Consent* form. The *Telehealth: What to Expect* form provides a patient-friendly description of the telehealth program.

Telehealth: What to Expect

Your doctor at (spoke) site is working in partnership with specialists at (hub site in city) to offer you telehealth services.

What is Telehealth?

Telehealth is the exchange of medical information from one site to another via electronic communications. The telehealth service offered to you will allow you to have a medical appointment with a specialist via secure and interactive video equipment. You will be able to speak in real-time with the specialist during your telehealth appointment.

Is Telehealth Safe?

Yes, all telehealth sessions are safe, secure, encrypted, and follow the same privacy (i.e., HIPAA) guidelines as traditional, in-person medical appointments. Your telehealth appointments will always be kept confidential. In addition, telehealth appointments are NEVER audio or video recorded without the patient's consent.

Can I Choose Not to Participate?

Of course, with this program you have been offered the option of seeing a specialist via secure and interactive video equipment within your primary care office. It is your choice to follow this referral.

Things to Remember about Your Telehealth Appointment:

1. You will schedule your telehealth appointments the same way you currently schedule an appointment with your doctor by calling XXX-XXX-XXXX.
2. As with your traditional, in-person medical appointments it is your responsibility to call healthcare organization at XXX-XXX-XXXX to cancel an appointment if you are unable to attend your telehealth appointment. Cancellations should be made at least 24 hours prior to the appointment time.
3. The telehealth program has a no-show policy. You will be discharged from the telehealth program if you no-show for **two consecutive** telehealth appointments, without prior contact to the scheduling staff at healthcare organization. To prevent this from happening, always call XXX-XXX-XXXX if you cannot make your appointment.
4. On the day of your appointment you will check-in at healthcare organization as you would for a traditional, in-person medical appointment.
5. At the time of your appointment, a nurse or medical assistant will escort you into the telehealth patient room.
6. If you have any questions before or after the session, you may ask the office staff at healthcare organization.
7. The *Telehealth New Patient Packet* must be completed prior to scheduling your first telehealth appointment. You must complete these forms to schedule your first appointment:
 - *Telehealth Consent* form
 - Any other forms/consents the spoke/patient or hub/specialist site or legal team require, including the *Notice of Privacy Practices, Patient Rights and Responsibilities* form and the *HIE Consent to View* form.
8. If you are prescribed medication(s) by the specialist you will be able to pick it up directly at your pharmacy of choice as the specialist will either phone in or electronically prescribe your medication(s).
9. If you miss a telehealth appointment and need a prescription refill or you have any questions about your medication, you must contact healthcare organization directly at XXX-XXX-XXXX. The healthcare organization will get in touch with the specialist on your behalf. Please be sure to call at least 72 hours prior to running out of medication.

If you have any questions or concerns after reading this form, please contact Spoke Site: xxx-xxx-xxxx

Telehealth Consent Form

1. I authorize spoke site to allow me/the patient to participate in a telehealth (videoconferencing) service with hub site.
2. The type of service to be provided by via telehealth is: specialty.
3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I/the patient will not be in the same room as the healthcare provider performing the service. I understand that parts of my/the patient's care and treatment which require physical tests or examinations may be conducted by providers and their staff at my/the patient's location under the direction of the telehealth healthcare provider.
4. My/the patient's physician/therapist has fully explained to me the nature and purpose of the videoconferencing technology and has also informed me of expected risks, benefits and complications (from known and unknown causes), possible discomforts and risks that may arise during the telehealth session, as well as possible alternatives to the proposed sessions, including visits with a physician in-person. The possible risks of not using telehealth sessions have also been discussed. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the patient's healthcare provider or I can discontinue the telehealth service if we believe that the video conferencing connections are not adequate for the situation.
6. I understand that the telehealth session will not be audio or video recorded at any time.
7. I agree to permit my/the patient's healthcare information to be shared with other individuals for scheduling and billing. I agree to permit individuals other than my/the patient's healthcare provider and the remote healthcare provider to be present during my/the patient's telehealth service to operate the video equipment, if necessary. I further understand that I will be informed of their presence during the telehealth services. I acknowledge that if safety concerns mandate additional persons to be present, then my or guardian permission may not be needed.
8. I acknowledge that I have the right to request the following:
 - a. Omission of specific details of my/the patient's medical history/physical examination that are personally sensitive, or
 - b. Asking non-medical personnel to leave the telehealth room at any time if not mandated for safety concerns, or
 - c. Termination of the service at any time.
9. When the telehealth service is being used during an emergency, I understand that it is the responsibility of the telehealth provider to advise my/the patient's local healthcare provider regarding necessary care and treatment.
10. It is the responsibility of the telehealth provider to conclude the service upon termination of the videoconference connection.
11. I/the patient understand(s) that my/the patient's insurance will be billed by both the local healthcare provider **and** the telehealth healthcare provider for telehealth services. I/the patient understand(s) that if my insurance does not cover telehealth services I/the patient will be billed directly by both the local healthcare provider **and** the telehealth healthcare provider for the provision of telehealth services.

12. My/the patient's consent to participate in this telehealth service shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.
13. I/the patient agree that there have been no guarantees or assurances made about the results of this service.
14. I/the patient acknowledge the telehealth program's no-show policy which states that I/the patient will be discharged from the telehealth program if I/the patient no-show for two, consecutive telehealth appointments, without prior contact to the scheduling staff at spoke site.
15. I confirm that I have read and fully understand both the above and the *Telehealth: What to Expect* form provided. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

Patient/Relative/Guardian Signature*

Print Name

Relationship to Patient (if required)

Date

Witness

Date

Interpreter (if required)

Date

* The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Provider's Signature

Date

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD

Telehealth Referral Log Form

WVTH004

Date of Referral	Patients Name	DOB or MR#	Visit Date	Comments

Department:	Policy Description: Telehealth Appointment Scheduling, Cancellations, and No-Shows
Page: 1 of 1	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH005
Approved by:	

<p>Purpose: To describe the requirements of both the spoke/patient and the hub/specialist sites as it relates to appointment scheduling and handling cancellations and no-shows.</p>
<p>Policy: Telehealth appointment scheduling will be conducted at the spoke/patient site and will be communicated to the hub/specialist site.</p>
<p>Procedure: <u>Scheduling</u></p> <p>The specialist at the hub/specialist site will provide their date and time availability for telehealth visits to the spoke/patient site. The scheduling staff at the spoke/patient site will schedule telehealth visits based on the availability provided by the specialist. Due to the block time system being used for scheduling, new appointments will be allotted 60 minutes and follow-up appointments will be allotted 30 minutes for adults and 45 minutes for children/adolescents. Once appointments are scheduled, contact will be made with the specialist at the hub/specialist site to confirm.</p> <p>The scheduling staff at the spoke/patient site will call the patient or legal guardian one business day before the telehealth appointment to remind the patient of their upcoming visit.</p> <p>Patients will be required to complete all necessary telehealth forms provided in the <i>Telehealth New Patient Packet</i> prior to their first telehealth appointment being scheduled.</p> <p><u>Cancellations</u></p> <p>Patients are to call the spoke/patient site at least 24 hours prior to their appointment time to cancel a telehealth appointment.</p> <p>The scheduling staff at the spoke/patient site will keep a telehealth cancellation list on file in the event of cancelled telehealth appointments. The list will be utilized to try to fill the open appointment slots. If filling a slot for a new patient appointment, patient information for substitute patients, who take the place of a cancellation, must be sent to the specialist at the hub/specialist site at least 24 hours prior to the scheduled session.</p> <p><u>No-Shows</u></p> <p>No-show appointments will be communicated to the specialist at the hub/specialist site via his/her direct line by the staff at the spoke/patient site. Documentation of the missed appointment will be entered into the patient's medical record at both the spoke/patient and hub/specialist site. Scheduling staff at the spoke/patient site will call the patient to reschedule their appointment after the first no-show and will remind them of the no-show policy. Additionally, after the first no-show, scheduling staff at the spoke/patient will send a letter to the patient/guardian informing them that they will be discharged from the telehealth program if they no-show for their next appointment. If a patient needs to be discharged from the telehealth program after two consecutive no-shows, the specialist at the hub/specialist site will be the party to communicate this decision to the patient, as they are the direct provider of care and to prevent against patient abandonment. Alternative care options will be presented by the specialist to the patient, which will be documented in the patient's medical record.</p>

Department:	Policy Description: Physical Surroundings and Staffing
Page: 1 of 2	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH006
Approved by:	

Purpose: Services provided via telehealth will be safe, confidential, and efficient and will meet or exceed the quality of care provided at an in-person setting.

Policy: A patient exam conducted via telehealth will replicate as closely as possible an in-person exam.

Procedure: The patient will be seen in a designated telehealth room at the spoke/patient site.

The telehealth room will be inspected by staff prior to the launch of telehealth clinic to ensure it is free from sharp objects, pens, pencils, paper clips, and any other objects that could be used to harm the patient or others. If the room is used for other purposes in the interim, the spoke/patient site clinic staff will inspect it prior to each day of the telehealth clinic to ensure it is still free from harmful objects.

A nurse or medical assistant will escort the patient into the designated telehealth room at the beginning of each session. If this is the patient's first telehealth appointment, the nurse or medical assistant at the spoke/patient site will explain to the patient how the system works, emphasizing that the system is confidential; that no audio or video taping of the exam is done, and that no one except the consulting provider and patient will be in the exam room at either the spoke/patient or hub/specialist site, without the patient's knowledge and approval. If safety concerns mandate additional persons to be present, then patient or guardian permission may not be needed. Time should be allowed for patients to ask questions, if applicable.

The nurse or medical assistant will ensure the telehealth equipment is working properly and the volume is acceptable to both the specialist and patient. If the telehealth specialist needs any vital signs taken, he or she will ask the nurse or medical assistant while they are still in the room. Additional seating will be provided if the patient would like family to accompany them during the session.

The specialist at the hub/specialist site will introduce himself or herself to the patient before the exam begins. The specialist will ask the patient's permission to have any other person in the room to observe the exam. If the patient declines, the observer must leave the telehealth room.

The telehealth patient exam will replicate as closely as possible the way the specialist currently examines patients in a traditional, in-person setting. The room is positioned so that the specialist can view and adequately observe the patient during the telehealth visit.

The telehealth specialist will make every effort to ensure he or she remains competent on the technology used for this telehealth program. Prior to seeing the first patient in this program, each telehealth specialist agrees to participate in a mock appointment with staff at the spoke/patient site to help ensure competency.

Department:	Policy Description: Physical Surroundings and Staffing
Page: 2 of 2	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH: 006
Approved by:	
<p>The telehealth visit will be set-up to achieve a positive patient-provider relationship. Surveys may be developed and distributed to patients and/or providers at any time, to ensure quality and gauge satisfaction with the program.</p> <p>Protection of the patient's privacy should be maintained always. Once all parties are in the exam room, an occupied sign is placed on the exam room door so others will know not to enter the room. Avoidance of inadvertent interruptions should be of primary importance.</p> <p>As required by law, the consulting specialist will be licensed to practice medicine in West Virginia. If applicable, specialists will be credentialed and privileged at the distant site hospital. Specialist providers will practice telehealth within the boundaries of their licenses, credentials, and privileges, keeping in mind that the technology is only a tool assisting in the provision of care at a distance and not substitute for appropriate, responsible decision making.</p>	

Department:	Policy Description: Telehealth Security and Emergency Protocol
Page: 1 of 1	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH007
Approved by:	

Purpose: To provide guidelines to establish an environment as free from the threat of violence or harm to patients, employees, physicians, volunteers, contractors, and visitors as possible.

Policy: Patients at the spoke/patient site will be able to receive safe psychiatric care through the provision of telehealth.

Procedure: If the specialist at the hub/specialist site perceives a threat to the patient or any person at the spoke/patient site during the telehealth visit, he or she shall immediately report it to the spoke/patient site. The spoke/patient site shall designate a phone line which the specialist at the hub/specialist site shall use in case of an emergency during a telehealth visit. The police or appropriate law enforcement agency may also be contacted.

The specialist at the hub/specialist site will have posted on an ongoing basis the following phone numbers in the event of an emergency or security concern:

- 1) The spoke/patient site's direct physician line to be used for emergencies or if the specialist would like the staff at the spoke/patient site to intervene mid-session: XXX-XXX-XXXX.
- 2) Local police or appropriate law enforcement agency phone number(s): XXX-XXX-XXXX (Local Police) or XXX-XXX-XXXX (State Police).

If the specialist at the hub/specialist site determines that a patient needs to be hospitalized the specialist will:

- 1) Inform the patient.
 - 2) Contact the triage nurse or the crisis worker at the nearest inpatient facility to discuss the case.
 - 3) Inform the primary care provider at the spoke/patient site. The spoke/patient site will assist with logistics in getting the patient to the ED and providing copies of medical records which can be given to the patient prior to leaving the office, if applicable.
 - 4) The patient is sent to the ED.
 - 5) The ED psychiatrist determines whether the patient should be admitted (voluntary or in-voluntary) and whether there is an available bed.
- The specialist will be accessible by phone to the inpatient facility's ED staff, if necessary.

Department:	Policy Description: Telehealth Check-in and Check-out for Patients
Page: 1 of 1	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH008
Approved by:	

Purpose: To ensure patients who are seen for telehealth appointments have an experience that mimics, as closely as possible, an in-person medical appointment.

Policy: Check-in and check-out for telehealth appointments will replicate as closely as possible an in-person medical appointment.

Procedure:

Check-In

The patient presents at the spoke/patient site as they would during a traditional, in-person visit with the provider at the spoke/patient site.

The patient registers at the front desk. Patient demographics and insurance information are verified at that time by spoke/patient site front desk staff. After checking in with front desk staff the patient is asked to wait in the spoke/patient site waiting room.

At the scheduled visit time, the patient is brought to the telehealth room by the spoke/patient site nurse or medical assistant. The nurse or medical assistant will ensure the telehealth technology works and the volume is acceptable to both parties before leaving the room. If this is a new patient, the nurse or medical assistant will also introduce the physician to the patient before leaving the session.

Check-Out

The specialist at the hub/specialist site will inform the patient that the telehealth visit has concluded. The patient will be asked to check-out with the scheduling staff at the spoke/patient site.

When the patient presents to the check-out area at the spoke/patient site, the staff member responsible for check-out will call the specialist at the hub/specialist site on their direct line to determine appropriate follow-up. The check-out staff will schedule the patient for their next telehealth appointment accordingly.

Department:	Policy Description: Telehealth Administration and Billing
Page: 1 of 1	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH009
Approved by:	

Purpose: To ensure providing services via telehealth will be financially sustainable for the providers involved.

Policy: Providers participating in telehealth services will bill patient's insurance for services rendered, if applicable.

Procedure: The spoke/patient site should bill the patient's insurance for the telehealth facility fee for each telehealth session. If the spoke/patient site is not providing any medical services or care other than offering the telehealth link to the hub/specialist site, the spoke/patient site should bill the appropriate CPT code to recoup administrative expenses associated with the telehealth patient encounter.

The hub/specialist site should bill the patient's insurance using the appropriate CPT code for the visit with the GT modifier (representing the use of interactive audio and video telecommunications systems).

In the event of a telephone consult given technical difficulty with the telehealth unit, all parties understand that the session may not be reimbursed by insurance.

If a patient does not have insurance coverage for telehealth services, the spoke/patient and hub/specialist sites may bill the patient directly for services rendered.

Department:	Policy Description: Telehealth Provider Communication
Page: 1 of 2	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH010
Approved by:	

Purpose: To ensure relevant patient information is communicated in a timely manner between the provider at the spoke/patient site and specialist at the hub/specialist site.

Policy: The spoke/patient site will share pertinent patient information with the hub/specialist site prior to the first telemedicine appointment being scheduled and the hub/specialist site will share limited visit information with the spoke/patient site after the first telemedicine appointment.

Procedure: The provider at the spoke/patient site will have the opportunity to meet face-to-face with the telemedicine specialists at the hub/specialist site to whom they will be referring patients.

The provider at the spoke/patient site and his or her staff will have access to the specialist's, at the hub/specialist site, direct telephone line if they have questions about medication or any other issues about the patient. The telemedicine physician's direct/personal number is not to be given out to patients. If the patient has questions about their medication, they are to contact the specialist on their main line during normal business hours.

Patient information to be shared with the specialist at hub/specialist site prior to every new patient appointment via fax, e-fax, or secure electronic message:

New patients:

1. A completed telemedicine referral which includes date of referral, patient's name, DOB, medical record #, current insurance information, contact information, medical history/summary (includes medical diagnosis and current medication and dosage), preferred pharmacy name, referring physician name and signature, and any other pertinent information.
2. A copy of the patient's insurance card.
3. Signed *Telemedicine Consent* form (see telemedicine form #1).
4. Any other forms/consents the spoke/patient or hub/specialist site, or legal team requires including the signed Notice of Privacy Practices, Patient Rights and Responsibilities form and the HIE Consent to View form.

Department:	Policy Description: Telehealth Provider Communication
Page: 2 of 2	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH010
Approved by:	

Returning patients:

1. Any significant changes in clinical status, if applicable.

Visit information to be shared with the primary care provider at spoke/patient site after the first patient appointment via fax, e-fax, or secure electronic message:

Consultation:

1. Completed specialist consultation evaluation notes.

Ongoing Care:

1. Completed specialist summary note to include diagnosis and medication(s) prescribed. Any changes in medication(s) prescribed would be communicated to the primary care provider, if applicable.
2. If a patient gets admitted to an inpatient psychiatric or substance abuse facility and the spoke/patient site is informed of the admission, a staff member at the spoke/patient site will let the specialist at the hub/specialist site know of the admission within 48 hours. The admitting physician will coordinate care of the patient (vs. the specialist) until he or she is released from the unit. The specialist at the hub/specialty site will coordinate discharge planning with the inpatient facility (if requested). In addition, the specialist will arrange for the patient to be seen, via a telehealth appointment, within 5 days of discharge.

Department:	Policy Description: Telehealth Prescribing and Medication Management
Page: 1 of 1	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH011
Approved by:	

Purpose: To ensure telehealth patients are prescribed medication in a timely manner and are appropriately managed while on medication(s).

Policy: The specialist at the hub/specialist site will prescribe and manage telehealth patients' medications.

Procedure: The specialist at the hub/specialist site will confirm with the patient their pharmacy of choice.

For prescriptions of non-controlled substances, the specialist will phone in the order to the patient's pharmacy of choice until electronic prescribing becomes standardized practice. For prescriptions of controlled substances, the specialist will call the patient's pharmacy of choice and place a 5-day order over the phone. In addition, a hardcopy of the prescription will be mailed directly to the patient's pharmacy of choice.

Any medication prescribed will be documented in the patient's medical record held at the hub/specialist site. For patients receiving ongoing, telehealth care, a completed specialist summary note which includes diagnosis and medication(s) prescribed will be shared with primary care provider at spoke/patient site after the first patient appointment via fax, e-fax, or secure electronic message.

The specialist at the hub/specialist site will manage telehealth patients' medication(s) throughout the course of treatment.

If a patient misses a telehealth appointment and needs a prescription refill or has any questions about his/her medication, the patient is directed to call the spoke site at: XXX-XXX-XXXX. Staff at the spoke/patient site will contact the specialist at the hub/specialist site directly to discuss the prescription refill or question. Patients are asked to call spoke site at least 72 hours prior to running out of medication.

Department:	Policy Description: Telehealth Technology Troubleshooting
Page: 1 of 1	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH012
Approved by:	

Purpose: To ensure telehealth technical difficulties are handled in a timely manner.

Policy: The spoke/patient and hub/specialist site will each be responsible for troubleshooting technical problems that are related to the systems located on their own end.

Procedure: At least one staff person at the spoke/patient and hub/specialist site will be assigned to managing telehealth technical difficulties related to the equipment at each end. The contact information for the responsible party/parties should be posted with the telehealth equipment at each site.

Marshall University School-Health Technical Assistance Center will ensure any data transmitted to/from each site involved is encrypted prior to the launch of the program.

If technology problems emerge mid-session, the specialist at the hub/specialist site should call the physician line at the spoke/patient site at XXX-XXX-XXXX. The staff at the spoke/patient site will move the patient to a location with a direct phone line so the telehealth appointment can be continued.

The specialist at the hub/specialist site will have posted on an ongoing basis the following phone numbers in the event of technical problem:

- 1) The spoke/patient site's direct physician line: XXX-XXX-XXXX 2) The hub/specialist IT TA line: XXX-XXX-XXXX
- 2) Other IT TA: XXX=XXX-XXXX

Department:	Policy Description: Telehealth Technology Standard Operating Procedure
Page: 1 of 1	Replaces Policy Dated:
Effective Date:	Reference Number: WVTH013
Approved by:	

Purpose: To ensure telehealth technology is fully functional and secure.
Policy: The spoke/patient and hub/specialist site will each be responsible for viewing the Telehealth Equipment as a part of their facility's IT inventory. Updates will be executed according to each sites update policy.
Procedure: At least one staff person at the spoke/patient and hub/specialist site will be assigned to managing telehealth equipment updates. The contact information for the responsible party/parties should be posted with the telehealth equipment at each site.

Sample Business Associates Agreement And MOU

The information provided within the following Business Associate Agreement and Memorandum of Understanding examples, does not constitute, and is no substitute for, legal or other professional advice. Users should consult their own legal or other professional advisors for individualized guidance regarding the application of the law to their particular situations, and in connection with other compliance-related concerns.

THIS BUSINESS ASSOCIATE AGREEMENT (this “Agreement”) is entered into effective _____ by and between _____ (the “Covered Entity”) with an address at _____, (the “Business Associate”), with an address at _____ (each a “Party” and collectively the “Parties”).

WITNESSETH

WHEREAS, _____ is considered a “Covered Entity” and _____ is considered a “Business Associate” as such terms are defined under the Health Insurance Portability and Accountability Act of 1996 (as amended, modified or superseded from time to time, “HIPAA”) and the final Privacy Rule issued pursuant thereto (codified at 45 CFR Parts 160 and 164 as amended, modified, or superseded from time to time, the “Privacy Rule”) (collectively, HIPAA, the Privacy Rule and any other state or federal legislation relating to the protection of health information is referred to herein as “Applicable Privacy Law”); and

WHEREAS, amendments to the HIPAA Regulations contained in the HIPAA Omnibus Final Rule became effective on March 26, 2013, and amended HIPAA’s Privacy, Security, Breach Notification and Enforcement Rules; and

WHEREAS, the requirements of the HIPAA Administrative Simplification Regulations (including the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules) implement sections 1171-1180 of the Social Security Act (the Act), sections 262 and 264 of Public Law 104-191, section 105 of 492 Public Law 110- 233, sections 13400-13424 of Public Law 111-5, and section 1104 of Public Law 111-148.

WHEREAS, Covered Entity will make available and/or transfer to Business Associate certain Protected Health Information, in conjunction with goods or services that are being provided by Business Associate to Covered Entity, that is confidential and must be afforded special treatment and protection;

WHEREAS, Covered Entity and Business Associate desire to enter this Agreement to comply with the Applicable Privacy Law;

THEREFORE, in consideration of the Parties’ continuing obligations under the HIPAA Privacy Rule and Security Rule, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree to the provisions of this Agreement to address the requirements of the HIPAA Privacy Rule and Security Rule and to protect the interests of both Parties. In consideration of the mutual promises below and the exchange of information pursuant to this Agreement, Covered Entity and Business Associate agree as follows:

Defined Terms. Except as otherwise defined below or elsewhere in this Agreement, all capitalized terms shall have the meanings provided in 45 CFR 160.103 and 164.501. (For convenience, a few of the definitions are highlighted below.)

- a. **Breach** shall have the same meaning as the term “breach” in 45 CFR 164.402.
- b. **Business Associate** shall have the meaning given to such term in 45 C.F.R. § 160.103.
- c. **CFR** shall mean Code of Federal Regulations.
- d. **Agreement** shall refer to this entire document.
- e. **Covered Entity** the term “Covered Entity” (abbreviated as “CE”) shall mean 1) a health plan; 2) a healthcare clearinghouse; 3) a healthcare provider who transmits anyhealth information in electronic form in connection with a transaction covered by this subchapter.
- f. **Electronic Protected Health Information** shall have the same meaning as the term “electronic protected health information” in 45 CFR 160.103.

- g. **HHS Privacy Regulations** shall mean the Code of Federal Regulations (CFR) at Title 45, Sections 160 and 164, Subparts A and E.
- h. **HIPAA Data Breach Notification Rule** means 45 CFR Part 164, Subpart D and any amendments thereto.
- i. **Individual** shall mean the person who is the subject of the Protected Health Information, and has the same meaning as the term “Individual” as defined by 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502.
- j. **Parties** the term shall mean Business Associate and Covered Entity.
- k. **Protected Health Information** the term “Protected Health Information” (abbreviated as “PHI”) shall mean any individually identifiable “health information” provided and/or made available by Covered Entity to Business Associate, and has the same meaning as the term “Health Information” as defined by 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. Protected Health Information includes health information in electronic form.
- l. **Required by Law** shall have the same meaning as the term “required by law” in 45 CFR 164.103.
- m. **Secretary** shall mean the Secretary of the Department of Health and Human Services (“HHS”) and any other officer or employee of HHS to whom the authority involved has been delegated.
- n. **Security Incident** shall have the same meaning as the term “security incident” in 45 CFR 164.304. **Security Rule** means the Security Standards and Implementation Specifications at 45 CFR 164.306, 164.308, 164.310, 164.312, and 164.316.

- 2. **Use and Disclosure of PHI.** Business Associate shall not use or further disclose PHI other than as permitted or required by this Agreement and by the HITECH Act, or as Required by Law. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of Covered Entity, provided that such use or disclosure of PHI would not violate Applicable Privacy Law if done by Covered Entity. The Business Associate is authorized to use Protected Health Information to de-identify the information in accordance with 45 CFR 164.514(a)-(c). Except as otherwise limited in this Agreement or any other agreement between Covered Entity and Business Associate, Business Associate may also:
 - a. Use PHI for the proper management and administration of Business Associate contracted services or to carry out the legal responsibilities of Business Associate; and
 - b. Disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and that the person will notify Business Associate of any instances of which it is aware in which the confidentiality of the information may have been breached in which a Security Incident occurred.
- 3. **Permitted Uses and Disclosures by Business Associate.** In case Business Associate obtains or creates Protected Health Information, Business Associate may use or disclose Protected Health Information only if such use to disclosure, respectively, is in compliance with each applicable requirement of § 164.504(e) Title 45, Code of Federal Regulations. It means that:
 - a. **Refer to Underlying Services Agreement.** Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the signed agreement between the parties, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.
 - b. **Use of Protected Health Information for Management, Administration and Legal Responsibilities.** Business Associate is permitted to use Protected Health Information if necessary for the proper management and administration of Business Associate or to carry out legal responsibilities of Business Associate.

c. Disclosure of Protected Health Information for Management, Administration and Legal Responsibilities. Business Associate is permitted to disclose Protected Health Information received from Covered Entity for the proper management and administration of Business Associate or to carry out legal responsibilities of Business Associate, provided:

- i. The disclosure is Required by Law; or
- ii. The Business Associate obtains reasonable assurances from the person to whom the Protected Health Information, including Electronic Health Information and/or Electronic Protected Health Information, is disclosed that it will be held confidentially and used or further disclosed only as Required By Law or for the purposes for which it was disclosed to the person, the person will use appropriate safeguards to prevent use or disclosure of the Protected Health Information, and the person immediately notifies the Business Associate of any instance of which it is aware in which the confidentiality of the Protected Health Information has been breached.
- iii. Business Associate may use or disclose Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j)(1).

d. Data Aggregation Services. Business Associate is also permitted to use or disclose Protected Health Information to provide data aggregation services, as that term is defined by 45 CFR 164.501, relating to the health care operations of Covered Entity.

4. **Safeguards.** Business Associate agrees to implement, maintain and use administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Protected Health Information and Electronic Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Privacy Rule, Security Rule, and HITECH Act 45 CFR 164.304.
5. **Mitigation.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Business Associate Agreement.
6. **Security Rule.** Business Associate, shall comply with applicable provisions of the Security Rule (45 CFR 164.308, 310, 312, 316 and any amendments thereto) as required by the HITECH Act, including developing and implementing written information security policies and procedures and otherwise meeting the Security Rule documentation requirements.
7. **Downstream Contracts.** In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of the Business Associate agrees in writing to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.
8. **Access to PHI.** Business Associate, including its agents and subcontractors, shall provide access, at the request of Covered Entity, as soon as administratively practical and in no event later than 30 days following the Covered Entity's request, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an individual in order to meet Covered Entity's requirements under 45 CFR 164.524. To the extent it maintains a Designated Record Set, Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR 164.526 at the request of Covered Entity or an individual, as soon as administratively practicable. Business associate agrees to make Protected Health Information available for purposes of accounting of disclosure, as necessary to satisfy the Covered Entity's obligations under 45 CFR 164.528.
9. **Amendments to PHI.** If any individual requests an amendment of PHI directly from Business Associate or its agents or subcontractors, Business Associate must notify Covered Entity in writing.

Any denial of amendment of PHI maintained by Business Associate or its agents or subcontractors shall be the responsibility of Covered Entity.

10. **Access to Books and Records.** Business Associate agrees to make internal practices, books and records relating to the use and disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to Covered Entity, or at the request of Covered Entity to the Secretary, in a time and manner designated by Covered Entity or the Secretary, for purposes of determining Covered Entity's compliance with the Privacy Rule.
11. **Documentation of Disclosures of PHI.** Within 10 days following notice by Covered Entity of subcontractors shall make available to Covered Entity the information required to provide an accounting of disclosures to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR 164.528. As set forth in, and as limited by, 45 CFR 164.528, Business Associate shall not provide an accounting to Covered Entity of disclosures: (a) to carry out treatment, payment or health care operations, as set forth in 45 CFR 164.502; (b) to individuals of PHI about them as set forth in 45 CFR 164.502; (c) to persons involved in the individual's care or other notification purposes as set forth in 45 CFR 164.510; (d) for national security or intelligence purposes as set forth in 45 CFR 164.512(k)(2); or (e) to correctional institutions or law enforcement officials as set forth in 45 CFR 164.512(k)(5). Business Associate agrees to implement a process that allows for an accounting of disclosures to be collected and maintained by Business Associate and its agents or subcontractors for at least six years prior to the request, but not before the compliance date of the Privacy Rule. At a minimum, such information shall include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's written authorization, or a copy of the written request for disclosure. Such requirement shall not extend to disclosures occurring prior to April 14, 2003.
12. **Confidential Communications.** Business Associate shall, if directed by Covered Entity, use alternative means or alternative locations when communicating PHI to an individual based on the individual's request for confidential communications in accordance with 45 CFR 164.522.
13. **Responsibilities of the Covered Entity with Respect to Protected Health Information.**
The Covered Entity hereby agrees:
 - a. to advise the Business Associate, in writing, of any arrangements of the Covered Entity under the Privacy Regulations that may impact the use and/or disclosure of PHI by the Business Associate under this Agreement;
 - b. to provide the Business Associate with a copy of the Covered Entity's current Notice of Privacy Practices ("Notice") required by Section 164.520 of the Privacy Regulations and to provide revised copies of the Notice, should the Notice be amended in any way;
 - c. to advise the Business Associate, in writing, of any revocation of any consent or authorization of any individual and of any other change in any arrangement affecting the use and disclosure of PHI to which the Covered Entity has agreed, including, but not limited to, restrictions on use and/or disclosure of PHI pursuant to Section 164.522 of the Privacy Regulations;
 - d. use only if services involve marketing or fundraising to inform the Business Associate of any individual who elects to opt-out of any marketing and/or fundraising activities of the Covered Entity;
 - e. that Business Associate may make any use and/or disclosure of Protected Health Information as permitted in Section 164.512 with the prior written consent of the Covered Entity.
14. **Remuneration.** As of the effective date specified by HHS in final regulations to be issued on this topic, Business Associate shall not directly receive remuneration in exchange for any Protected

Health Information of an individual unless the Covered Entity or Business Associate obtains from the individual, in accordance with 45 CFR 164.508, a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving Protected Health Information of that individual, except as otherwise allowed under HIPAA.

15. **Warranty for Transactions and Code Sets Rule.** If Business Associate conducts all or part of any transaction covered by 45 CFR Part 162 with or on behalf of Covered Entity (including but not limited to, claims payment and referral certification and authorizations), then Business Associate covenants and warrants that it shall comply with all applicable requirements of 45 CFR 162, and require its agents or subcontractors to comply with all applicable requirements of 45 CFR 162.
16. **Security Rule Compliance.** Business Associate shall comply with applicable provisions of the Security Rule (45 CFR 164.306, 308, 310, 312, 316 and any amendments thereto) as required by the HITECH Act, including developing and implementing written information security policies and procedures and otherwise meeting the Security Rule documentation requirements. Business Associate acknowledges that it is subject to civil and criminal enforcement for failure to comply with the Privacy Rule and Security Rule.
17. **Breaches and Security Incidents.**
 - a. Privacy or Security Breach. Business Associate will immediately report to Covered Entity any use or disclosure of Protected Health Information not permitted for by this Agreement of which it becomes aware of; and any Security Incident of which it becomes aware of. Business Associate will treat the breach as being discovered in accordance with 45 CFR 164.410. A breach is considered discovered on the first day the Business Associate knows or should have known about it by exercising reasonable diligence. Business Associate agrees to notify the Covered Entity of any individual whose Protected Health Information has been breached. Business Associate agrees that such notification will meet the requirements of 45 CFR 164.410. If a delay is requested by a law-enforcement official in accordance with 45 CFR 164.412, Business Associate may delay notifying Covered Entity for the applicable time period. Business Associate's report will at least:
 - i. Identify the nature of the breach or other non-permitted use or disclosure, which will include a brief description of what happened, including the date of any breach and the date of the discovery of any breach, no later than 24 hours after a breach is discovered;
 - ii. y the Protected Health Information that was subject to the non-permitted use or disclosure or breach (such as whether full name, social security number, date of birth, home address, account number of other information were involved) on an individual basis;
 - iii. Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;
 - iv. Identify what corrective or investigational action Business Associate took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further breaches;
 - v. Identify what steps the individuals who were subject to a breach should take to protect themselves;
 - vi. Provide such other information, including a written report, as Covered Entity may reasonably request.
 - b. Security Incidents. Business Associate will report to Covered Entity any attempted or successful (A) unauthorized access use, disclosure, modification, or destruction of Covered Entity's Electronic Protected Health Information or (B) interference with Business Associate's system operations in Business Associate's information systems, of which Business Associate becomes aware. Business Associate will make this report monthly, except that if any such Security Incident resulted in a disclosure not permitted by this Agreement or Breach of Covered Entity's Unsecured Protected Health Information, Business Associate will make the report in accordance with the provisions set

forth in the paragraph above.

18. Representations and Warranties of Both Parties.

Each party represents and warrants to the other Party that:

- a. it is duly organized, validly existing, and in good standing under the laws of the state in which it is organized or licensed;
- b. it has the power to enter this Agreement and to perform its duties and obligations hereunder;
- c. all necessary corporate or other actions have been taken to authorize the execution of the Agreement and the performance of its duties and obligations;
- d. neither the execution of this Agreement nor the performance of its duties and obligations hereunder will violate any provision of any other agreement, license, corporate charter or bylaws of the Party;
- e. it will not enter nor perform pursuant to any agreement that would violate or interfere with this Agreement;
- f. it is not currently the subject of a voluntary or involuntary petition in bankruptcy, does not currently contemplate filing any such voluntary petition, and is not aware of any claim for the filing of an involuntary petition;
- g. neither the Party, nor any of its shareholders, members, directors, officers, agents, employees or contractors have been excluded or served a notice of exclusion or have been served with a notice of proposed exclusion, or have committed any acts which are cause for exclusion, from participation in, or had any sanctions, or civil or criminal penalties imposed under, any Federal or state healthcare program, including but not limited to Medicare or Medicaid or have been convicted, under Federal or state law of a criminal offense;
- h. all its employees, agents, representatives and contractors whose services may use or disclose PHI on behalf of that Party have been or shall be informed of the terms of this Agreement;
- i. all its employees, agents, representatives and contractors who may use or disclose PHI on behalf of that Party are under a sufficient legal duty to the respective Party, either by contract or otherwise, to enable the Party to fully comply with all provisions of this Agreement. Each Party further agrees to notify the other Party immediately after the Party becomes aware that any of the foregoing representation and warranties may be inaccurate or may become incorrect.

19. Term and Termination.

- a. Term. The Term of this BA Contract shall be effective as of Effective Date, and shall terminate on whichever date comes first (i) the date of termination pursuant to paragraph 21b, or (ii) when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in the following paragraphs.
- b. Termination of Agreement by Covered Entity. Upon the Covered Entity's knowledge of a material breach of this Agreement by Business Associate, the Covered Entity shall either:
 - i. Provide an opportunity for the Business Associate to cure the breach and then terminate this Agreement if Business Associate does not cure the breach within the time specified by Covered Entity;
 - ii. Immediately terminate the Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
 - iii. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.
- c. Termination of Agreement by Business Associate. Upon the Business Associate's knowledge of a material breach of this Agreement by Covered Entity, the Business Associate shall either:
 - i. Provide an opportunity for the Covered Entity to cure the breach and then terminate this

Agreement if Covered Entity does not cure the breach within the time specified by Business Associate;

ii. Immediately terminate the Agreement if Covered Entity has breached a material term of this Agreement and cure is not possible; or

iii. If neither termination nor cure is feasible, Business Associate shall report the violation to the Secretary.

d. Effect of Termination of Agreement for Any Reason.

i. Except as provided in paragraph ii of this Section 20(d), upon termination of this BA Contract, for any reason, Business Associate shall promptly return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to all Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

ii. If the Business Associate determines that returning or destroying Protected Health Information is infeasible, Business Associate shall promptly provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon notifying Covered Entity that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this BA Contract to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

20. **HITECH Act.** This Agreement incorporates herein by reference the applicable provisions of Title XIII of the American Recovery and Reinvestment Act of 2009 known as the Health Information Technology for Economic and Clinical Health ("HITECH") Act, including but not limited to, the regulatory provisions described in 74 Federal Register 56123-56131 (October 30, 2009).

21. **Miscellaneous.**

a. **Regulatory References.** A reference in this Agreement to a section in the Privacy Rule means the section then in effect or as amended.

b. **Amendment.** The Parties agree that if Applicable Privacy Law changes, this Agreement shall be deemed to incorporate such changes as necessary for Covered Entity to operate in compliance with the amended or modified requirements of Applicable Privacy Law.

c. **Survival.** The respective rights and obligations of Business Associate under paragraphs 9, 19(c) and 19(d) shall survive the termination of this Agreement.

d. **Interpretation.** Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with Applicable Privacy Law.

e. **No Third-Party Beneficiaries.** Nothing expressed or implied in this Agreement is intended to confer upon any person other than Covered Entity, Business Associate and their respective successors and assigns, any rights) remedies, obligations or liabilities.

f. **Disclaimer.** Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement, HIPAA or the HIPAA Regulations will be adequate or satisfactory for Business Associate's own purposes.

g. **Agreement Provisions.** If any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of the Agreement will remain in full force and effect. In addition, in the event a Party believes in good faith that any provision of this Agreement fails to comply with the then-current requirements of the HIPAA Privacy Rule or Security Rule, such Party shall notify the other Party in writing. For a period of up to 30 days, the Parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such 30-day period, the Agreement fails to comply with the requirements of the HIPAA Privacy Rule and Security Rule, then either Party has the right to

terminate upon written notice to the other Party. This Agreement shall be construed per the laws of the State of West Virginia applicable to contracts formed and wholly performed within that State. The Parties further agree that should a cause of action arise under any Federal law; the suit shall be brought in the Federal District Court where the Covered Entity is located.

21. **Entire Agreement.** This Agreement consists of this document, and constitutes the entire agreement between the Parties. There are no understandings or agreements relating to this Agreement which are not fully expressed in this Agreement and no change, waiver or discharge of obligations arising under this Agreement shall be valid unless in writing and executed by the Party against whom such change, waiver or discharge is sought to be enforced.

INTENDING TO BE LEGALLY BOUND, the parties hereto have duly executed this Amendment as of the Effective Date.

Business Associate

Covered Entity

Signed: _____

Signed: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

(Hub Site) AND THE (Spoke Site) REGARDING TELEMEDICINE CONSULTATIONS

1. PARTIES. The parties to this Agreement are (insert legal description and full address), and (insert legal description and full address).
2. AUTHORITY. This agreement is authorized under the provisions of (insert any necessary authority).
3. PURPOSE. To outline the administrative and clinical procedures for generating and reviewing telemedicine consultations. This (is/is not) a chargeable agreement. Reimbursement for services provided by (insert consultant name here) to (insert referring site name here) is through the (insert payer name here, or reference section outlining reimbursement process).
4. BACKGROUND. Telemedicine enables a provider to generate an electronic record that can be transmitted and stored for a designated provider to review, or consult on. Using telemedicine can eliminate the need for a patient to travel to the consultant site and improve access to limited services. Both parties understand the need to treat all information generated from, or in conjunction with, a telemedicine consult as a traditional face-to-face consultation and comply with current HIPAA privacy & security rules. Additional services and requirements are described in the following paragraphs.
5. RESPONSIBILITIES:

Referring/Spoke Site

- a. Designate a staff member in writing as the facility telehealth coordinator.
- b. Provide (consultant) a current contact list for key office personnel to include Provider/s, Office/Practice Manager and telehealth coordinator. The contact list will include phone numbers, fax number and email addresses for key personnel.
- c. Insure Private Health Information is protected (HIPAA Privacy & Security Rules).
- d. Complete necessary health care forms as required by current regulations and directives.
- e. Insure patient information is complete and transmitted with each case.
- f. All required insurance information is completed and sent with the consult request.
- g. Insure staff generating and/or handling telemedicine consults receive initial user training and annual refresher training on the proper use of cart peripherals.
- h. Notify consulting provider by telephone of any urgent cases.

Consultant/Hub Site

a. Provide consultation report to the referring provider within (select agreed time frame 24/48/72) hours of request.

b. Notify the Office Manager of any discrepancy with patient or billing information.

c. Insure required forms are completed at the time of care to include: Work/Duty Limitations.

Profile Status. If warranted, Providers may contact the referring site directly (phone, fax, or email).

d. Insure Private Health Information is protected (HIPAA Privacy & Security Rules. HIPAA.

e. Provide timely billing of services to: (name/Address of organization-if appropriate)

f. Provide (referring site name) with necessary credentialing documentation as required.

g. The (site name) agrees to pay (consultant name) for services on a (monthly, 10 day, etc.) for services provided.

6. POINTS OF CONTACT:

Point of Contact for (referring site) (name/address/phone) e-mail:

Point of contact for (consulting site) (name/address/phone) e-mail:

Point of contact for (additional POCs) (name/address/phone) e-mail:

7. OTHER PROVISIONS. Nothing in this agreement is intended to conflict with current law or regulation. If a term of this agreement is inconsistent with such authority, then that term shall be invalid, but the remaining terms and conditions of this agreement shall remain in full force and effect.

8. EFFECTIVE DATE. The terms of this agreement will become effective on the date of the last signature below.

9. MODIFICATION. This agreement may be modified upon the mutual written consent of the parties.

10. TERMINATION. The terms of this agreement, as modified with the consent of both parties, will remain in effect for a period of (# of years) years from the effective date. The agreement may be extended by mutual agreement of the parties. Either party upon 90 day written notice to the other party may terminate this agreement.

APPROVED BY:

Signed: _ (name) (Title) Referring Site

Date

Signed: _ (name) (Title) Consulting Site

Date

Telehealth Process and Utilization Data

<http://survey.constantcontact.com/survey/a07egd6auyojw9d7tyg/start>

1. Enter the **site location** for this report. (Please note that if your project provides services at more than one site, you will need to complete a report for each site and then enter that information into Survey Monkey)

Site Location for this Report: _____

2. Please enter the month for which you are reporting. _____
3. Number of requests/referrals for telehealth services. _____
4. Number of requests for telehealth services that were successfully scheduled. _____
5. Number of requests for telehealth services that were successfully completed. _____
6. Number of telehealth visits that included a parent/guardian in addition child/adolescent. _____
7. Number of requests for telehealth services that were scheduled but NOT completed. _____
8. Indicate the number of times *within this reporting period* WHY telehealth services were NOT completed.

Distant provider was not available _____

Presenter/originating provider was not available _____

Necessary consents/records were not available. _____

Technical problems _____

Patient failed to appear _____

Patient refused the telehealth visit _____

Other (please specify) _____

9. Number of COMPLETED visits that were impacted by technical difficulties. _____
10. Indicate the number of times *this reporting period*, technical issues impacted the telehealth visits.

Dropped connection _____

Poor video quality _____

Poor audio quality _____

Other (please specify) _____

11. Number of Satisfaction Surveys (all types) completed & entered into Survey Monkey _____
12. Average number of minutes per telehealth encounter (including prep & charting) _____
13. Average number of video minutes per telehealth encounter. _____

14. Indicate the number of times *this reporting period*, that the telehealth encounter resulted in any of the following:

Corroborated initial diagnosis/treatment plan. _____

Resulted in a definite diagnosis/treatment plan. _____

Confirmed need for face-to-face visit with distant provider. _____

Confirmed need for urgent/emergent transport. _____

Avoided need for face-to-face visit with distant provider. _____

No change in diagnosis or treatment plan. _____

Change in diagnosis or treatment plan. _____

Other (please specify) _____

15. Indicate the total number of telehealth encounters by insurance type *for this reporting period*.

Medicaid _____

WV CHIP _____

Private/Employer Insurance _____

None _____

Self-Pay _____

16. Indicate the total number of telehealth encounter by gender *for this reporting period*.

Female _____

Male _____

17. Indicate the total number of telehealth encounters by age group *for this reporting period*.

Less than 12 ____ 12–17 ____ 18–24 ____ 25–34 ____ 35–44 ____

45–54 ____ 55–64 ____ 65 or older ____

Telehealth Referring / Spoke Provider Satisfaction Survey

<http://survey.constantcontact.com/survey/a07egd70ew3jw9kw85v/start>

Please tell us about your experience using telehealth. The information that you provide will help us to make improvements in this method of bringing important healthcare to those who otherwise may not receive this care.

Your individual answers and comments will not be shared with anyone except in an aggregate report. We appreciate your input.

1. Site Location: _____

2. What is your role as the referring provider?

☐ Medical Provider ☐ LPC ☐ LGSW ☐ LICSW ☐ LCSW ☐ Other _____

3. Thinking about your experience using telehealth services, how would you rate the following:

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
I could clearly see the consulting provider during the visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could clearly hear the consulting provider during the visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The telehealth visit was as good as a face-to-face visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Technical difficulties distracted me from the consultation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using telehealth takes longer than a face-to-face consult.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Telehealth improves clinical efficiency.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My communication with the consulting provider was unimpaired by the use of telehealth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The "doctor-patient" rapport was unimpaired by the use of telehealth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The patient was comfortable with the telehealth consult.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, I am satisfied with the use of telehealth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Please provide any additional comments or suggestions about your experience using telehealth.

Telehealth Consulting / Hub Provider Satisfaction Survey

<http://survey.constantcontact.com/survey/a07egd76kjeiw9mogeiz/start>

Please tell us about your experience using telehealth. The information that you provide will help us to make improvements in this method of bringing important healthcare to those who otherwise may not receive this care.

Your individual answers and comments will not be shared with anyone except in an aggregate report. We appreciate your input.

1. Site Location: _____

2. What is your role as the consulting provider?

☐ Psychiatrist ☐ Licensed Psychologist ☐ Psychiatric Nurse Practitioner ☐ LPC ☐ LGSW
☐ LICSW ☐ LCSW ☐ Other _____

3. Thinking about your experience using telehealth services, how would you rate the following:

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
I could clearly see the referring provider during the visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could clearly hear the referring provider during the visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The telehealth visit was as good as a face-to-face visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Technical difficulties distracted me from the consultation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using telehealth takes longer than a face-to-face consult.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Telehealth improves clinical efficiency.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My communication with the referring provider was unimpaired by the use of telehealth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The "doctor-patient" rapport was unimpaired by the use of telehealth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The patient was comfortable with the telehealth consult.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, I am satisfied with the use of telehealth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Please provide any additional comments or suggestions about your experience using telehealth.

Parent Telehealth Satisfaction Survey

<http://survey.constantcontact.com/survey/a07egd7a39w9ns1ij/start>

Please tell us about your experience using telehealth. The information that you provide will help us to make improvements in this method of bringing important healthcare to children and adolescents who may not otherwise receive this care.

You are not required to answer any question that makes you feel uncomfortable. Your individual answers and comments will not be shared with anyone. If you choose not to answer any questions, your child will still receive services. We appreciate your input.

1. Site Location: _____

2. What grade is your child currently in?

☐ PK ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ Grad

3. What insurance does your child have?

☐ Medicaid ☐ WV CHIP ☐ Employer/Private ☐ None ☐ Self-Pay

4. Thinking about the school-based telehealth services your child received, how would you rate the following:

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
The staff provided me with enough information to know how telehealth would work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was given the option to be present during my child's visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The staff contacted me after my child's visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I did not have to take time away from work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My child is comfortable using telehealth for visits with the therapist.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, I am satisfied with the use of telehealth for my child.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Please provide any additional comments about your experience with telehealth for your child.

Client Telehealth Satisfaction Survey

<http://survey.constantcontact.com/survey/a07egd78ikcjlw9n7h1i/start>

Please tell us about your experience using telehealth. The information that you provide will help us to make improvements in this method of bringing important healthcare to those who may not otherwise receive this care.

You are not required to answer any question that makes you feel uncomfortable. Your individual answers and comments will not be shared with anyone. If you choose not to answer any questions, you can still receive services. We appreciate your input.

1. Please tell us where you had your telehealth visit? _____

2. Please place a check by your age group.

Less than 12 ____ 12 –17 ____ 18–24 ____ 25–34 ____ 35–44 ____ 45–54 ____ 55–64 ____ 65 or older ____

3. Gender: ☐ Female ☐ Male

4. Thinking about the telehealth service you received today, how would you rate the following:

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
I could clearly see the therapist during the visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could clearly hear the therapist during the visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The telehealth visit was as good as a face-to-face visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The camera and other equipment embarrassed me or made me feel uncomfortable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would have had to miss school/work to see this therapist, if it were not for telehealth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My parents like it that I use school-based telehealth. (Students only)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, I am satisfied with using telehealth.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Please provide any additional comments or suggestions about your experience with telehealth.
