Telehealth Toddler to Teen….Now What?

Virginia Rural Health Association Summit 2023
Wytheville, Virginia
Cynthia Scheideman-Miller has over 27 years’ experience in telehealth in multiple roles including project director of federal grants, state director of a federally funded telehealth resource center, and administrative director of telehealth at a large multifacility health system. She currently serves as a consultant and volunteer to promote telehealth.
Agenda

• Terminology and Trends
• Telehealth Benefits
• Post PHE
  • Compliance
  • Reimbursement
• Technology
• Visit Preparation
Terms and Trends
## Telehealth Care Delivery Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
<th>Clinical Application Examples</th>
<th>Common Technical Examples</th>
</tr>
</thead>
</table>
| **Telehealth**  | Telehealth is a collection of means or methods for enhancing health care, public health and health education delivery and support using telecommunications technologies. | • Episodic Primary Care  
• Urgent Care  
• Chronic Disease Management  
• Specialty Care  
• Behavioral Health | • Direct-to-Consumer Platform  
• Live two-way audio/video technology |
| **Synchronous** | Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology. (TeleVisit, TeleConsult: Virtual Visits, Video Visits) | • Dermatology  
• Radiology  
• Non-Urgent Primary Care  
• Wellness Coaching  
• Medication Management  
• Routine patient follow up | • Store and Forward  
• Secure Messaging  
• Remote Patient Monitoring  
• Smart Wearables  
• mHealth |
| **Asynchronous**| Transmission of recorded health history through a secure electronic communications system to a practitioner who uses the information to evaluate the case or render a service outside of a real-time or live interaction. Provides access to data after it has been collected and involves electronic communication tools. (eVisit, eConsult) | | |
US Population Outgrowing Current Healthcare Capabilities

- **68M**: Number of baby boomers in the US in 2022\(^2\)
- **73M**: Baby boomers becoming Medicare enrollees by 2030\(^2\)
- **6 in 10**: Adults in the US have a chronic disease\(^4\)
- **46M**: Baby boomers in the US in 2022
- **1 in 5**: Individuals took prescription medication for mental health in 2021\(^5\)
- **16.8%**: Of the US population was 65+ in 2022\(^3\)
- **90%**: Of healthcare expenditures are spent on Americans with a chronic disease\(^1\)

2. Statista (2023) Resident population in the United States in 2022, by Generation
4. CDC (2022) Chronic Disease in America
5. CDC (2022). Household Pulse Survey
Access to Care

Average Total Time for Typical In-Person Visits

- **24 days**
  - Wait Time for Appointment
  - In-Person: 24 days
  - Virtual: Same day

- **121 Minutes**
  - Traveling to and from appointment, filling out paperwork, etc.
  - 20 Minutes spent seeing the doctor

- **16 minutes**
  - Average Length of Virtual Visit

- **$79**
  - Average Total Cost

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**Virginia (2021)**

- 34.2% Adults who are obese
- 34.4% Adults with high blood pressure
- 19.6% Depression
- 16.9% High alcohol use

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3. Telehealth (2022) Best Online Doctors
6. American Journal of Managed Care (2019)
Rural Barriers to Health Care

46 million Americans - 15% of the US population - live in rural areas.

**Distance and Transportation**
Impact individuals by delaying treatment and affecting health care decision-making through cost and distance to care.

**Privacy and Stigma**
Rural residents may be apprehensive about seeking care because of privacy concerns or social stigma.

**Health Insurance Access**
Rural communities are less likely to have access to health insurance compared to urban counterparts. In 2017, 12.3% of people in rural counties were uninsured, compared to 10.1% of people in urban counties.

**Health Literacy**
Low levels have been linked to higher risk of hospitalization, reduced utilization of preventative services, and lower overall health.

**Health Care Workforce Shortages**
In 2021, 61% of 'Primary Care Health Professional Shortage Areas' were located in rural areas. Only 12% of physicians practice in rural communities.
Changes in Competition

• Mergers/Acquisitions
• Resource compression with more remote work
• Virtual Market Place
• Consolidation of services
Telehealth Market – The Growth

Industry is expanding at an exponential rate:

• U.S telehealth market to reach revenues of over $25 B\(^1\)
• Approximately 30% growth per year over next 5 years \(^1\)
• North America accounted for the largest share of the telehealth market in 2020\(^2\)
• 156 M telehealth services across six federal agencies in 2020 of those 114.4 M Telehealth visits for Medicare \(^3\)
• US telehealth market expected to value nearly $43 billion by 2026\(^4\)

1. PRN Newswire (2020) Telehealth Market in U.S.
3. Insights on Telehealth Use and Program Integrity Risks across Selected Health Care Programs During the Pandemic (2022)
Telehealth represents 22% of U.S. patient visits across all specialties and 36% for behavioral health.

ASPE Office of the Assistant Secretary for Planning and Evaluation Updated National Survey Trends in Telehealth (April 2023)
KFF and Epic Research Share of Outpatient Visits Delivered by Telehealth 2019-2021 (March 2022)
Virginia Telehealth Utilization Growth

76% of respondents use telehealth

56.6% plan to increase their telehealth usage

Source: Virginia Telehealth Network Annual Report 2022
Telehealth Benefits
Why Telehealth Now the PHE is Over?

Increase in management of Chronic Disease

- Increase Access
- Cost Effective
- Quality Improvement
- Decreased rehospitalizations
- Point of care moving to home-based monitoring
- Patient expectation
- Time and transportation

Decreased rehospitalizations
Why Telehealth in Rural America?

Only 11% of physicians practice in rural areas, despite 20% of the U.S. population living in such areas.²

- Improves monitoring, timeliness and communication with providers.¹
- Fewer patients need to be transferred from rural hospitals when utilizing telehealth.⁴
- Allows smaller hospitals to provide high quality care while keeping costs low.¹
- Minimizes the need for patients to travel for specialty and subspecialty care.¹

“Americans who live in rural areas are more likely to die prematurely from all of the five leading causes of death”³

2. AAAMC (2020). Attracting the next generation of physicians to rural medicine.
3. CDC (2020). Telehealth in Rural Communities.
Expanding Telehealth Patient Base

Pre-COVID

• Age 25-44 working moms
• Urgent Care
• Cash pay

Post PHE

• Shift to equal use of ages 25-44 (primary and chronic) and ages 45-65 (chronic care)
• OP telehealth services stabilizing at about 20% primary, 36% Behavioral Health
• Insurance and cash
CMS: Medicaid Unwinding Resources

<table>
<thead>
<tr>
<th>Telehealth is <strong>likely appropriate</strong> for:</th>
<th>Telehealth is <strong>less appropriate</strong> for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>General wellness visits</td>
<td>Health concerns that require a procedure</td>
</tr>
<tr>
<td>Management of chronic conditions</td>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Discussion of test results</td>
<td>Eye complaints</td>
</tr>
<tr>
<td>Counseling about diagnostic and therapeutic options</td>
<td>Gynecologic complaints</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Dental complaints</td>
</tr>
<tr>
<td>Prescriptions for medicine</td>
<td>Highly nuanced or multiple complex health concerns</td>
</tr>
<tr>
<td>Nutrition counseling</td>
<td>Any situation in which a physical exam would change your recommendation</td>
</tr>
<tr>
<td>Mental health counseling</td>
<td></td>
</tr>
</tbody>
</table>

Telehealth and Quality – Part of Growing UP

1. Humana.com
2. Hopkinsmedicine.org
3. Improving Quality and Safety of Telehealth (2021)
Telehealth and Quality

“We’ve always said that telemedicine is medicine. It’s just a different modality and the quality should be comparable.”

Krista Drobac, Exec. Dir. of the Alliance for Connected Care

- 526,874 patients
- 200 outpatient care sites
- March 1, 2020 to Nov. 30, 2021
Telehealth Program Recommendations: Performance Metrics

Look for metrics you are already tracking, e.g.:

- CMS Inpatient Quality Reporting Programs (IQR) and Pay for Performance; e.g. VBP, HRRP, HAC
- CMS Outpatient Quality Reporting Programs (OQR): Imaging measures (OP-8, OP-9, OP-10, OP-11, OP-13, and OP-14)
- CMS Physician Quality Reporting System (PQRS) → Medicare Access and CHIP Reauthorization Act (MACRA)
- Healthcare Effectiveness Data and Information Set (HEDIS)
- AHRQ Quality Indicators

- https://www.anthem.com/ca/shared/f0/s0/t0/pw_e209563.pdf?refer=agent
Fairhealth Telehealth Claims Data Notes

- Increase from Less than 0.2 all medical claims in 2019 to almost 5% in 2022.
- Uptick in pregnant individuals through the end of 2022
- January 2022 – social worker was the leading telehealth specialty, Primary care second.

Source: The Evolution of Telehealth during the COVID-19 Pandemic-A FAIR Health Brief.pdf (March 2023)
Why Providers Are Using Telehealth in Virginia

Source: Virginia Telehealth Network Annual Report 2022
Post PHE: Legislation and Reimbursement
Barriers to Telehealth Adoption

1. NIHCM.org Rural Health During the Pandemic (2022)
Waivers During the Declaration of Emergency

- Geographic Site Restrictions
- Expanded list of Practitioners
- Establishing patient relationship
- No modifiers
- Non-HIPAA compliant technology
- OIG relaxation – cost sharing /no copays
- DEA – Controlled Substance
- Broadband service speeds increased
- Parity of Payment
- RHC allowed to be distant sites
Post Public Health Emergency May 11, 2023: Adult Responsibilities

• HHS Office of Civil Rights (OCR) resumes HIPAA rules for technology including audio-only (90-day extension)
• Co-pays resume (OIG Policy Statement)
• Telehealth Consent required
• Distant provider required to put in address they are at during a Medicare/Medicaid telehealth visit
• Some limitations such as established patients only for virtual check-ins and e-visits

Licensure

Reimbursement Challenges

State Telehealth Laws

- **50** States (including D.C.) reimburse for some form of live video through Medicaid.
- **37** States (including D.C.) reimburse for services to the home (including VA).
- **28** States reimburse for store and forward (including VA).
- **36** States reimburse for audio-only (including VA).
- **34** States (including D.C.) reimburse for Remote Patient Monitoring (including VA).
- **43** States have laws regarding private payer reimbursement (including VA).

2. Journal of Nursing Practice (2021)
Telehealth Coding/Billing Post PHE

Permanent Medicare Changes

• Behavioral/mental health services
  • No geographic restrictions
  • Home acceptable originating site behavioral health
  • Audio Only Platforms acceptable for behavioral/mental telehealth services
  • Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can serve as originating or distant site providers for behavioral/mental telehealth services (with one in person visit within 6 months of telehealth service and annually thereafter
  • Virtual Communications will include virtual check-ins and remote evaluation of images under the HCPCS Code G0071

Medicare Extended Flexibilities to 12/31/2024

• No geographic restrictions for all approved telehealth services.
• Home acceptable originating site for all approved telehealth services
• An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required.
• Audio only platforms acceptable for some services when patient not able or prefers not to use video
• Telehealth services can be provided by a physical therapist, occupational therapist, speech language pathologist, or audiologist
• Continue to bill for “digital online services” under the Virtual Communications HCPCS Code G0071

Telehealth policy changes after the COVID-19 public health emergency | Telehealth.HHS.gov
Billing Medicare as a safety-net provider | Telehealth.HHS.gov
### Medicare Telehealth Post PHE – At a Glance

<table>
<thead>
<tr>
<th>COVID POLICY</th>
<th>PERMANENT</th>
<th>ENDS WITH PHE</th>
<th>ACTIVE THROUGH 2023</th>
<th>EXPIRES 12/31/24</th>
<th>FACT SHEET PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowing all eligible Medicare providers to provide services via telehealth.</td>
<td>X</td>
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<td>5</td>
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<tr>
<td>Temporarily continue to allow the use of audio-only to provide certain services.</td>
<td>X</td>
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<td></td>
<td>X</td>
<td>5, 8</td>
</tr>
<tr>
<td>Temporarily waive site requirements such as patient needing to be in a rural area or in a specified health care site when receiving services via telehealth.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Temporarily suspend in-person visit requirement for delivery of mental health services via telehealth when patient is not located in a geographically and/or site eligible location.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

**FACT SHEET:** PHYSICIAN & OTHER CLINICIANS

1. Source of change: Physician Fee Schedule
2. Source of change: Physician Fee Schedule

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<table>
<thead>
<tr>
<th>COVID POLICY</th>
<th>PERMANENT</th>
<th>ENDS WITH PHE</th>
<th>ACTIVE THROUGH 2023</th>
<th>EXPIRES 12/31/24</th>
<th>FACT SHEET PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary list of eligible services that may be provided via telehealth.</td>
<td></td>
<td>X</td>
<td></td>
<td>5-7</td>
<td></td>
</tr>
<tr>
<td>Allow remote evaluations, virtual check-ins and e-visits to be provided to new &amp; established patients.</td>
<td></td>
<td></td>
<td>X&lt;sup&gt;4&lt;/sup&gt; (established patients only)</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Allow other providers such as PTs, OTs, etc. to provide e-visits.</td>
<td></td>
<td>X</td>
<td></td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Allow remote physiological monitoring services to be furnished to new and established patients.</td>
<td></td>
<td></td>
<td>X (established patients only)</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Waive requirement that 99453 and 99454 maybe reported with fewer than 16 days of data.</td>
<td></td>
<td>X</td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>A subsequent inpatient visit could be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233).</td>
<td></td>
<td>X</td>
<td></td>
<td>9</td>
<td></td>
</tr>
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<td>A subsequent skilled nursing facility visit could be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 14 days (CPT codes 99307-99310).</td>
<td></td>
<td>X</td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Critical care consult codes could be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (HCPCS codes G0508-G0509).</td>
<td></td>
<td>X</td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Allowing certain face-to-face visits for ESRD to take place via telehealth.</td>
<td></td>
<td>X</td>
<td></td>
<td>9-10</td>
<td></td>
</tr>
<tr>
<td>In-person/face-to-face visit requirement for National Coverage Determination (NCD) or Local Coverage Determination (LCD) may take place via telehealth.</td>
<td></td>
<td>X</td>
<td></td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Allowing obtaining annual beneficiary consent for virtual check-ins to be obtained at the same time as when the services are furnished.&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
<td>X</td>
<td></td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

<sup>4</sup> Further changes will be made through the Physician Fee Schedule process.
<sup>5</sup> NOTE: Original waiver allowed it for new and established patients. Post PHE it is only for established patients.

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<table>
<thead>
<tr>
<th>COVID POLICY</th>
<th>PERMANENT&lt;sup&gt;1&lt;/sup&gt;</th>
<th>ENDS WITH PHE</th>
<th>ACTIVE THROUGH 2023&lt;sup&gt;2&lt;/sup&gt;</th>
<th>EXPIRES 12/31/24&lt;sup&gt;3&lt;/sup&gt;</th>
<th>FACT SHEET PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally required in-person visit for nursing home residents may take place virtually. <em>(Ended in 2022)</em></td>
<td>X&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td>10-11</td>
</tr>
<tr>
<td>Opioid Treatment Programs (OTPs) may use audio-only to provide counseling and therapy services when live video not available and certain other requirements met.</td>
<td>X&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Virtual presence maybe be used to meet direct supervision requirements</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Allowed teaching physicians utilizing a virtual presence to bill for services furnished by a resident in training if the setting was outside of an MSA and teaching physician was present during the key portion of service. For all teaching settings during the PHE, teaching physicians may direct care and review services each resident provides during or at once after each visit virtually.</td>
<td>X&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Flexibilities to Stark Laws</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>17-18</td>
</tr>
</tbody>
</table>

**FACT SHEET:** **FQHC/RHC**

| Allow FQHCs/RHCs to continue to act as telehealth providers                | X                     | 3-4            |
| Delay requirement of a prior in-person visit for the provision of a mental health visit via real-time telecommunication technology. | X                     | 4              |
| Allowing the use of virtual communication services (GO071)                | X (Not completely)    | 4              |

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<sup>1</sup> Ended in 2022.

<sup>2</sup> Temporarily extended to end of 2023 flexibility for OTPs to furnish periodic assessments via audio-only interactions under certain circumstances.

<sup>3</sup> After the PHE, teaching physicians only in residency training sites located outside of a metropolitan statistical area may direct, manage, and review care furnished by residents through audio/video real-time communications technology. This policy does not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services.

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Medicare Update 5/12/2023

- **Facility fee payment for hospital outpatient telehealth visits** – extended to 12/2023
  - Through the end of CY 2023, PT, OT, SLP, DSMT, MNT providers should continue to bill for these services when furnished remotely in the same way they have been during the PHE.

- **Virtual supervision for residents** – extended to 12/2023
  - CMS is exercising enforcement discretion to allow teaching physicians in all teaching settings to be present virtually, through audio/video real-time communications technology, for purposes of billing under the PFS for services they furnish involving resident physicians.
    - Added 3 new telehealth codes
    - Require 95 modifier for Telephone Calls
Virginia Medicaid / Telehealth

<table>
<thead>
<tr>
<th>Service(s)</th>
<th>Telemedicine-specific Service Limitations</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Echocardiography</td>
<td></td>
<td>93307, 93306, 93320, 93321, 93325</td>
</tr>
<tr>
<td>Genetic Counseling</td>
<td></td>
<td>96540</td>
</tr>
<tr>
<td>Maternal Mental Health Screening</td>
<td></td>
<td>98127, 98160, 98181</td>
</tr>
<tr>
<td>Physical therapy / Occupational therapy</td>
<td></td>
<td>• 97110, 97121, 97150</td>
</tr>
<tr>
<td>• 97530, 99129</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Nutrition Therapy</td>
<td></td>
<td>97804</td>
</tr>
<tr>
<td>Evaluation &amp; Management (Office/Outpatient)</td>
<td></td>
<td>99202-99205, 99211-99215, GQ modifier if teledermatology and store and forward</td>
</tr>
<tr>
<td>Evaluation &amp; Management (Hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation &amp; Management (Nursing facility)</td>
<td></td>
<td>• 99304-99306</td>
</tr>
<tr>
<td>• 99307-99310</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory therapy</td>
<td>Must have respiratory equipment set up in home and initial in-person visit by a respiratory therapist or member of the clinical team.</td>
<td>98503, 94664</td>
</tr>
<tr>
<td>Education for Diabetes, Smoking, Diet</td>
<td></td>
<td>00106, 97802, 97803</td>
</tr>
</tbody>
</table>
Telehealth Use During the Pandemic Across 6 Federal Agencies. *PRAC November 2022 Report*

Safeguards that could strengthen program integrity for telehealth services

- Additional monitoring of telehealth services
- Develop additional billing controls
- Educate providers and individuals
- Collect additional data
- Monitor the impact on quality of care

HHS, DoD, OPM, VA, DOL, and DOJ.
7 measures that may indicate fraud, waste, or abuse in telehealth services:

1. Billing both a telehealth service and a facility fee for most visits
2. Billing telehealth services at the highest, most expensive level every time
3. Billing telehealth services for a high number of days in a year
4. Billing both Medicare fee-for-service and a Medicare Advantage plan for the same service for a high proportion of services
5. Billing a high average number of hours of telehealth services per visit
6. Billing telehealth services for a high number of beneficiaries
7. Billing for a telehealth service and ordering medical equipment for a high proportion of beneficiaries
DEA Temporarily Extends Telemedicine Flexibilities for Prescribing of Controlled Medications

• 38,369 public comments
• Temporary extension to Nov. 11, 2023
• In addition, practitioner-patient relationships created during the waiver period, the waivers will continue through November 11, 2024.
• The delay will allow the DEA, jointly with SAMHSA, to conduct a thorough evaluation of regulatory alternatives.
• DEA plans to issue “one or more final rules...based on the two proposed rules published March 1, 2023”

Building Capacity

• Use Telehealth as a bridge for clinical needs you don’t yet have

• Telehealth builds capacity in your existing schedule:
  • Average visits are between 7-10 minutes
  • Use telehealth for bundled payments
  • Recover no-shows
  • Reduce overhead costs for real estate – smaller footprint

• Access or provide specialty services via telehealth
  • Facility Fee
  • Lab work at the clinic
Keys to Return on Investment

<table>
<thead>
<tr>
<th>Hard ROI – Reimbursement</th>
<th>Soft ROI – Quality Improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Reduction</td>
<td>Labor Capacity and Efficiency</td>
</tr>
<tr>
<td>Cost Avoidance</td>
<td>Patient and Provider Satisfaction</td>
</tr>
</tbody>
</table>
Telehealth Technology
Make a List of Needs

• Easy to use for provider
• Easy to use for patient
• HIPAA compliant
• Maintain audio if video fails
• Low bandwidth functionality
• Ability to join by a link (no app)
• Technical support 24/7/365
• Integration with EMR
• Scheduling feature for patient
Review the Vendors

- Contract Terms
- Require Service Level Agreements
- Understand Payment terms
  - Initial fees vs on-going
- Review Multiple Vendors
- Require References – at least 3 that you can talk to
- Do demos based on the key features you want – NOT what they want to show you.
- Unbiased evaluation
- Don’t rush
Contract Terms to Consider

• Commitment to Interoperability
• Service Level Agreement
  • Support call return
  • Text or Phone
• Up time % of at least 96%
• Payment terms – by visit/monthly/by provider
• Competitor – do they compete with you?
• Data Storage
  • Is data stored and where
• Access to Data – can you report and audit
• Recording of Visits
<table>
<thead>
<tr>
<th>Vendor Name</th>
<th>Product Name</th>
<th>Video Conferencing</th>
<th>Patient cost: Pay per visit cost</th>
<th>White Label</th>
<th>Vendor offers providers permitted to use software</th>
<th>Integration with EMR</th>
<th>Supports on demand visits</th>
<th>Supports scheduled visits</th>
<th>Data reporting capabilities</th>
<th>Multi-party video</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMD Global Telemedicine</td>
<td>Connect n Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>eprescribe</td>
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<td>Amwell</td>
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Technology Options

- Exam Med
- OhMD
- VSee
- Zoom for Healthcare
- Skype for Business
- Updox
- Doxy.me
- Google G Suite Hangouts Meet

- Asynchronous tool
- BrightMD
- Conversa
- Ro
- Babylon Health
- Zipnosis
- Microsoft Azure

New companies and options keep coming.
A Decision is Made

• Right Sized for your organization
• Flexible – willing to change based on your needs
• Contract terms that are equitable
• Payment terms without gotchas
• Prioritizes you.
• Easy to Use
• Partnership
Technology Deployment

• Is additional hardware needed?
• Do existing devices need to be reconfigured?
• Does a new telehealth visit type need to be created in your EMR?
• Are you setting up a dedicated telehealth space or are you allowing it to be done where and when available?
Telehealth Visit Preparation
Presentation Considerations

• At Home – area private and free from interruptions
• Present as if in the office – lab coat etc.
• At Home – bandwidth at home
• Background – make sure nothing in the background can offend
• No food or drink in camera shot
• AVOID the NOSTRIL SHOT! - consider putting your phone or device on a few books to raise the video to eye level
Training, Training, Training

• Have you created a short training video so that you can reach everyone in a short period of time?
• Do you have resources for one-on-one training if someone requires it?
• Have you created tip sheets and FAQs for your providers and staff to refer to after you are live?
• Is there a dedicated line of communication for support?
Communication

• Have you created communication for all staff to make them aware of the implementation of telehealth?
• Have you created scripting for your schedulers to reach out to patients making them aware of your telehealth offering?
• Have you emailed or messaged your patients about your telehealth offering?
• Have you posted updates on social media about your telehealth offering?
PHE is Over but Telehealth Is Here to Stay

Pandemic Response Accountability Committee (PRAC)

Psychology Today

American Psychological Association

American Medical Association (AMA)

American Medical Association

Nature medicine
Thank you for listening!

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Telehealth Toolkit Available on VRHA.org

@BCirrus