



Transcript:

Telehealth in a Public Emergency – A Quick Start Guide

Presenter: Jonathan Neufeld, Lisa Lizak, and Thomas McCarthy.
Recorded on April 24th, 2020

ANN SCHENSKY: Hello everyone, and welcome to our webinar Telehealth in a Public Health Emergency-- A Quick Start Guide. My name is Ann Schensky. And I am the project coordinator for the Great Lakes MHTTC and the Great Lakes PTTC. And I will be your moderator for today's webinar. Our speakers today are Jonathan Neufeld, Lisa Lizak, and Thomas McCarthy.

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These are the cooperative agreements that all three of the TTCs are funded under. And just some quick housekeeping notes -- because today's webinar is recorded, it will be available on the Great Lakes MHTTC web page and the Great Lakes current YouTube channel. There are no CEUs or attendance certificates available for this webinar.

And please send any general questions regarding online resources and recorded webinars to the Great Lakes MHTTC. And again, please follow us on social media so you can find out about new webinars and other exciting information that we put on our websites.

A little bit about our presenters today-- Dr. Jonathan Neufeld is the director of the Great Plains Telehealth Resource and Assistance Center, a federally-funded technical assistance program housed at the University of Minnesota. GPTRAC provides telehealth training to health care providers and programs interested in implementing, evaluating, and enhancing telehealth programs. The program serves organizations in a six-state region that includes Minnesota, Wisconsin, North and South Dakota, Iowa, and Nebraska. Thank you for joining us, Dr. Neufeld.

Our other speakers today are Lisa Lizak and Thomas McCarthy from Journey Mental Health. Lisa has worked in the field of social services for 30 years and has provided clinical, case management, and administrative services. For the past 13 years, she has worked as a policy writer and organization resource



manager at Journey Mental Health center in Madison. Lisa created the telehealth program six years ago at Journey.

Thomas has worked at Journey Mental Health center for over three years with experience as community-based clinician, outpatient therapist, and clinical EHR system analyst. In his current role, he provides training and support to clinical staff using the electronic health record. Thomas recently assisted the agency in developing workflows to rapidly expand use of telehealth technology. Thank you all for joining us today.

SPEAKER: Thank you, Ann. And doctors, just feel free to start whenever you're comfortable and ready.

JONATHAN NEUFELD: Well, thank you for having me, folks. I am going to talk about telehealth specifically with regard to the public health emergency and also behavioral health generally. I'm going to first give you just a little bit of an introduction to who I am and what the telehealth resource centers are.

We are a federally-funded program that is very similar to the ATTC program, the other technology transfer centers that are funded by SAMHSA. But the telehealth resource centers are funded out of HRSA. And so our primary target are safety net providers of all kinds, especially RHCs, FQHCs, rural health care providers, critical access hospitals, and other small and safety net providers who serve rural and underserved areas.

I wanted to start off my presentation today by just giving a list of resources right up at the top so that if and when you pull down these slides and you want to access some of these resources, you have access to them. We keep a version of these quick start slides on our telehealth quick start dot org website there at the bottom.

And then also the Center for Connected Health Policy is an outstanding telehealth resource. It is one of the telehealth resource centers specifically focused on policy. I linked to the ATTC network here, as well as the telehealth learning site and then our national telehealth resource center site where you can get to all of our telehealth resource centers and a new telehealth resource site that HRSA just set up. And it has a lot of excellent information as well.

Let's talk about telehealth. I want to make a couple of quick comments first about telehealth in general. And the first is to recognize that although we've all been thrown kind of pell-mell into telehealth really quickly, telehealth is larger than just direct to consumer health care at a distance. It started out as being site to site consultation, specialty consultations from site to site. And there's still an awful lot of that going on across the country.

More recently, primary care sites have started to integrate services into their sites. And in many ways, this was a development made possible by advancements in technology, as well as a focus-- a new focus on integrated



primary care services that came along with the ACA and a lot of the advancements that were made in the domain of primary care.

Remote monitoring uses another whole type of technology but is also within that domain of telehealth. And then the way a lot of people are finding out about telehealth is through direct to consumer services, which for years were contracted directly with-- directly by insurers, payers. But now, everybody is in the business of direct to consumer health provision. And so that has become a mode that many, many people are aware of as well.

Telemedicine is not a service, but it is a delivery mechanism. So when you think about the regulatory framework, or you think about trying to reason out what policies and what reimbursement mechanisms are in place, you have to realize that telehealth is not paid for as a service. But the services that are delivered via telehealth are what are being paid for. So a primary care visit, a behavioral health visit-- those are the services. Telehealth is just the modality or the channel by which it's being provided.

The regulatory framework around telehealth at the federal level is really fairly slight until just recently. There really was no-- there really were no federal rules about what you could or could not do using telehealth other than some restrictions around prescribing controlled substances.

Rather, when we talk about federal regulations of telehealth, we're really talking about Medicare's conditions of payment, so what you could or couldn't get paid for. And that was certainly a very loud voice, a very influential voice at the federal level.

What you can or can't do is actually regulated primarily at the state level through licensing boards. Now, this varies just a little bit from certain substance use providers and mental health treatment providers. But it is largely along the same lines in that the licensing board that regulates physicians or psychologists, social workers, whoever is providing services, that board is what determines what you can or can't do as a clinician using telehealth.

Then again at the state level, there are plenty of layers about reimbursement that have to do with Medicaid or what commercial payers can or can't pay for, and then, of course, commercial payers are going to have their own policies as well.

So when you think about telehealth, you have to think about that regulatory framework between federal and state levels and how they interact to realize that there are certain things that you can or can't do. But then there are also certain things you can or can't get paid for.

So let's talk a little bit about prerequisites, including technology platforms and network connections and certain things that you need to know to get started in



telehealth. For one thing, first of all, you need to know that services, any health care services, legally occur at the patient's physical location.

So whether that's in a clinic or at a home or an emergency room or in Illinois or Tennessee, that physical location of the patient is what drives regulation, not the provider. So it's important to recognize that. If you're seeing a patient in another state, you have to be licensed in that state, not just your own state. And in fact, the provider's physical location is relatively-- is a relatively moot point in most telehealth encounters.

Specific consent is generally required. Right now, it can be verbal for just about any situation outside of 42 CFR Part 2 certain situations or prescribing methadone. But other than that, verbal consent is generally possible.

And we often recommend that procedures mirror the usual procedures as much as possible, telehealth procedures mirror usual procedures, and that we don't rely on telehealth for clinical emergencies, in particular, mental health emergencies, unless we're talking about a program that's designed to be an emergency response program.

There is, of course, a technological layer, an equipment layer that goes along with providing telehealth services. And that technology should be viewed as a spectrum all the way from separate videos platforms like Zoom or BC or others that just provide a video conferencing solution, and then all of the practice management or EHR functions are separate or managed in a separate device or a separate system, all the way to fully integrated EHRs where my EHR also includes all of my telehealth functionality and my live video and my e-visits and all of that.

And then there are a number of platforms in the middle there, what I call for short e-visit platforms. They're often patient portals, parts of any EHR or standalone portals that provide what we call asynchronous communication, in other words, not at the same time.

It's not live video. It's basically chat or message transmission back and forth through a secure channel. Patients can upload images. And providers and patients can basically interact in an enhanced chat environment then. And those services can be paid for. And for short, I will call those e-visits.

Kind of encompassing all of this or digging down a little deeper, a patient portal becomes a very critical piece of the whole infrastructure because it's the way you're going to communicate with your patients when they can't come into the office. Now, of course, you can still talk to them on the phone. And doing administrative stuff over the phone is kind of our default position. But it does take a lot more time.

It's way more efficient to communicate with patients en masse or even one at a time using a portal. So we really recommend that organizations look hard at



their portal strategy, and how their portal is being deployed, and think about investing resources into portal deployment because that's going to be critical going forward in this sort of new normal that we've had to establish now.

Video platform-- various video platforms are out there. I just have a couple of comments here about Zoom and the various others. There's a health care account. There's a pro account. There's also a free account that gives you unlimited one to one. All of these are encrypted by default. It's just that the health care account is the only one that provides you with an explicit BAA. But they are highly similar all the way through at the technological level.

So I just make that point specifically about Zoom. But I also want to make some general points about encryption and recording and other optional settings.

Make sure that whatever platform you use, you spent some time on configuration and settings because it's those settings that have caused-- almost all of the problems that we've seen in the Zoom platform have been as a result of default settings not being changed or settings that were just kind of left open, rather than configured in such a way that they would provide greater security, which is certainly possible on the platform. It's just that it needs to be configured.

I want to say too about e-visit platforms, the sort of middle of the road platforms, there are literally dozens out there. And I don't know of a really good comparison of all of them. I'll list some, but they provide basically enhanced portal capability, allow you to upload images and for patients to report symptoms, and like I say, this sort of asynchronous communication between patients and providers, which are billable to Medicare and other payers.

There are a few comparison sites out there. The first one, the Telehealth Technology Assessment Center, provides a sort of a framework for looking at platforms. Jay Ostrowski, an independent clinician, has set up some comparisons, as well as the American Association of Family Practice making some recommendations.

And then the platform, the video platform VSee also has a comparison site which, of course, you take with a grain of salt because they're reviewing their competitors. But at least they list out a number of live video platforms as well.

Unfortunately, there is no comprehensive Consumer Reports comparison for these platforms. And we're kind of left testing them out and digging for information. With the help of the folks at the TTAC, at the Telehealth Technology Assessment Center, they would be happy to help with that.

I list a few endpoint peripherals here that are popular just for reference. And recognize too that your patients when they connect are going to be using their



own data resources, whether that's their home Wi-Fi or their cellular data if they have data. The quality of that network connection is going to determine the quality of the call.

Also, for that matter, if your providers are seeing patients from home, then their home network quality is going to also influence the quality of the call. So it's important to recognize that and make sure patients are aware of that when they connect.

The pain points that tend to arise in these sort of settings as we're all getting started in telehealth are primarily in three categories. One is keeping-- making sure that those virtual visits are private, that only-- that room numbers and whatnot are assigned in such a way that patients don't end up in the same room together or that you don't have unauthorized entry into patient rooms.

Most portals manage that fairly well. Some of the live video platforms leave it to the user to configure. This is, again, the situation with Zoom that I mentioned that there are ways to configure it such that it's very easy to get into rooms. There are other ways that make it harder like by locking rooms or providing passwords or using virtual waiting rooms. And those services need to be encrypted through or enabled through the settings configuration page.

The other things that come up are basically patient issues. One is providing technical support to clients or patients who have difficulty connecting. Sometimes, they have difficulty. And you don't want your doctor being the one saying, well, try that button on the bottom left, or try calling this number instead. That's a lot of technical support that sometimes needs to happen. And providers really aren't the best people to be doing that.

Sort of related, there are always going to be patients that don't have cell phones or don't have minutes or don't have computers or Wi-Fi or whatever, or they find some other creative way to make the connection. And we need to be ready and have thought through a bit how we're going to provide alternatives for those patients.

Let's talk a little about policies and basically informed consent and then various policies to have in place to manage situations that come up that are not planned. You have to document patient consent for telehealth. It can be verbal under the public health emergency or PHE, other than a few certain situations, as I said.

Patients often are curious about security on calls. They want to know if a call is being recorded, or they even assume a call is being recorded if it's a video call. Not so much with telephone, but with video, patients definitely tend to think that they're being recorded. So you need to let them know if it's a video call or phone call that we don't record sessions just like we don't record sessions when you come into the clinic.



They need to be told what to do if the call drops, just some basic sort of steps to take. They need to be informed that there are some confidentiality risks, and that they can take some steps to minimize those, and to be assured that the provider is taking those steps to minimize confidentiality risks.

They need to be taught and coached to connect from a quiet, private, safe place with minimal distractions. And there will be times when they don't have access to that.

And you need to have procedures in place to deal with that-- I'll say a bit about that in a minute-- and that they should only use approved software and links and/or hardware if they're being provided hardware, and they should know how to what to do in case of an emergency and not necessarily assume that you're available through your portal, or through texting, or through Zoom, or your video platform, whatever it is, as an emergency contact.

It's important to recognize that-- for patients to recognize what your preferred emergency contacts are and what doesn't work for that. And of course, documenting all of that is important.

It is incumbent upon providers to make some sort of reasonable assessment of whether video or other sorts of technologies, telephone, any kind of technology being used with a patient encounter, is appropriate for that patient or for that condition or for that encounter. And so sometimes, there's difficulty using the equipment.

Sometimes, people have lack of access or inability to-- the provider can't collect the information they need to make a valid diagnosis. Or for whatever reason, the platform provider or the encounter is inadequate in some ways, deficient.

And we need to recognize that the provider is responsible for making sure either that they use the encounter appropriately, or making other arrangements if the encounter is not working, or making a decision about whether the clinical needs in the situation or the urgency outweigh other concerns.

And so it's just something to be aware of and maybe have conversations with medical staff, clinical staff, so that they have thought that through ahead of time and get caught off guard as few times as possible. We know that unforeseen situations are going to arise. We need to be aware of that ahead of time as much as possible.

Patients will be-- will tend to be very creative and resourceful when connecting to calls. So it's important that they're seen in a safe and secure manner. We want to confirm the patient's identity and their location at the outset of every encounter just like we do in the hospital or in the clinic.



We know where they are, of course. But we confirm their identity in various ways that usually happen at the front desk out of sight of the clinicians. But it is part of a clinical encounter. And we need to instantiate that online as well.

We need to be sure that we have local non-emergency numbers in case we need them and other information we might need in an emergency and if the patient's insecure or in an inappropriate setting, then we need to take appropriate steps like agree to wait until they've parked the car and pulled over or whatever until they've-- try and reschedule at another time or coach them on getting to a place with fewer distractions or whatever.

And of course, if there is an emergency then we engage emergency procedures as necessary. So a little bit more about those emergency procedures. As part of the consent or initial session, you definitely need to discuss emergency procedures and any foreseeable risks. As clinicians, it's not that we need to avoid all risks.

But rather, we need to have thought about them ahead of time and have some steps in place so to show that we haven't just been caught off guard. And so collecting numbers for emergency contacts, local fire, police, because your 9-1-1 is not going to be they're 9-1-1 necessarily. So you need to have thought about that.

And then if and when an emergency situation arises, you maintain contact and work to transfer care to an appropriate on-site responder. You are not the-- you want to avoid being the primary responsibility in an emergency. But if you are, if you're the only one who knows that the patient is choking, or that the house has caught fire, or they're having a panic attack or whatever, document the event and work toward-- back up a bit.

Work toward engaging appropriate on-site authorities, whether that's a parent, a neighbor, an emergency contact, local EMS, local police, whatever that is, you work toward engaging them and then transferring care to that on-site authority and documenting that transfer of care. That's how your encounter ends when you can safely turn over care to somebody locally.

Just a couple of things in the policy section about 42 CFR. And there are a great wealth of resources available through the Technology Transfer Centers in some of the links that I provided or that were provided at the top of the account-- of the webinar.

But the CARES Act changed 42 CFR in a couple of significant ways. One is that consent is now a little bit easier to-- well, it's similar to obtain. We can't obtain it verbally. And it can be used in a way similar to HIPAA in that disclosures can be redisclosed for appropriate reasons.

So this relaxation is meant specifically for the current public health emergency. But it also looks like they're going to be-- this is going to be the



situation moving forward with regard to confidentiality and 42 CFR. So recognize that and adjust accordingly. And inform your patients accordingly.

There are also in the CARES Act some specific anti-discrimination provisions that have been added to 42 CFR and then a number of other ways in which the guidelines or the rules in 42 CFR Part 2 have been made to align with HIPAA specifically with regard to breach notifications, civil and criminal penalties, notice of privacy practices that have to be provided to patients, and accounting of disclosures.

So recognize those changes. And you have resources that you can follow up with those. Certainly, you can follow up with the TRCs or the TTCs, ATTCs about those specifics.

A few comments about procedures. Like I say, we try and follow normal procedures so that telehealth is not an unusual situation. Now, that may be a little bit unusual now to say. The horse is kind of out of the barn here. And we're all scrambling to figure out how to make telehealth a usual procedure.

But a number of things contribute to that. If you can get a routine down, if you can show up as a provider dressed professionally in a professional situation, have an opening script, whether it's by telephone or video where you identify yourself, recognize-- or work on a clear video or audio to make sure that the patient can hear, and then introduce yourself, confirm the patient's identity, working through basically a structured sort of invocation of the session.

This is a professional encounter. This is not two friends catching up over the phone or chatting with your college students who are traveling in Europe. This is a professional encounter. And so using a routinized script at the beginning helps make that case in a very low key kind of way. Making sure that the provider or the patient confirm their location so you know where they are and that they're in a private and secure place, whether anyone else can hear them-- these are just ideas to consider.

You can, of course, make up your own script. But when you have-- asking if they have any questions and reaffirming consent for this encounter, always a good idea so that you can document that. Answer any questions, of course, that they have, and then what to do if you get disconnected or if something-- some unforeseen situation arises, just confirming that information, making sure the patient has that information or that you have correct information to follow up with them.

Of course, you're going to use whatever capacity your platform has, whether you're on a telephone or using live video or you're doing some sort of asynchronous e-visit. You use whatever facilities you have to collect the information you need to provide the treatment or provide the diagnosis.



Health providers are learning all over again about how to use functional questions and noncontact techniques to assess conditions and manage conditions remotely or over the phone. And of course, you're always going to be making decisions about when a patient needs to be brought in, when you have to see them on site, and then, of course, procedures on site to minimize interactions, minimize the chance of spreading an infectious disease.

I list one link down here to a very nice article on just helping physicians think about the clinical history and how to use that in lieu of an instrument-based exam.

Disposition and follow-up is very much the same as an in-person encounter. You, of course, document all of your-- document your encounter. You make referrals. You do treatment planning. You recognize also that many payers are allowing for waived or reduced coinsurance and copays.

But make sure you recognize that for public payers at least, that means that copay is coming out of the provider's pocket, not the payer. There are some commercial payers I've seen who are reducing patient responsibility on their end so that they are covering that amount, that coinsurance amount. But be sure that you understand what those financial implications are.

Documentation of a telehealth encounter is generally the same, or it follows the guidance for that CPT code that you bill. Every encounter is going to be billed using the CPT code. And there will be regulations associated with that code about how it gets billed or how it gets documented.

If you're billing an in-person CPT code like an E&M encounter, then there are some-- you would, of course, bill according to the needs of that encounter.

But then also, you will add if it's a telehealth visit the patient's location, provider's location, that the encounter was conducted by telehealth, exact start and stop times because the patient doesn't leave the clinic as a physical indicator that the encounter's over. They are still at home. So you need to know exact start and stop times. That the patient consented, and then any other information that's pertinent around-- about the encounter.

So let's say a little bit about billing before I wrap up. The realities of telehealth billing is that telehealth reimbursement varies by payer. And billing policies vary by payer. There is no one right way to bill for telehealth. There are many right ways, one for each payer. So although it doesn't quite mean there are a hundred different ways, but there are quite a few different ways.

We had hoped that many would mimic Medicare. And many do, but many don't. So recognize that each payer may want you to bill in a certain way for telehealth visits. They may define telehealth visits in various ways. And they may reimburse them in various ways.



So there are state organizations, professional organizations that can help you with those details. Course, the telehealth resource centers have information about those details for all those different payers, as well as other sources of information that you have.

To briefly talk in general terms about billing, this is a nice slide from the AMA that summarizes the five points of relaxation that have occurred with regard to the COVID-19 epidemic. And I'll leave those for you there as reference.

The next two slides are tables that specifically apply to what Medicare calls telehealth. And recognize that for Medicare, the term telehealth, or telemedicine for that matter, is reserved for live video encounters.

So if you're reading CMS's regulations about telehealth, they are talking about live video encounters. And they're talking about paying for Medicare only. There are other regulations and other reimbursement principles for every Medicaid payer, for the Medicaid in your state and then every commercial payer. So don't confuse what CMS says with what every other payer might say.

But as far as CMS goes, because it is a standard that many payers use, this table lists all the codes that can be billed by a qualified health professional-- by a physician or another qualified health professional for live video encounters. And there's a set of codes based on E&M video. Or if they are telephone only, then you're looking at that bottom right quadrant there of telephone evaluations-- the 99441, 2, and 3 codes down there.

Now, for a non-E&M encounter, non-live video, these are encounters that can be done with a online portal, what is called an e-visit, what I've been calling e-visit and Medicare sometimes calls e-visit, or virtual check-ins, which is generally done with a phone call, audio only.

And there are two columns here about physicians or other qualified health providers and then qualified nonphysicians who aren't E&M providers, so behavioral health folks. That's the right-hand column there. So those are the codes that you can use to bill those various check-ins.

Recognize that if you're in a CCBHC or a CMHC environment, your billing for mental health codes may be different than these Medicare fee for service codes. If you're billing Medicare fee for service, these will apply. But if you have a different reimbursement mechanism in your state, then be aware of that.

This table basically breaks down those previous two pages a little more succinctly and provides for a recognition of that first row, Medicare telehealth visits. Remember, that's live video, virtual check-ins, which are basically using a portal of some kind, and then e-visits, which-- I'm sorry-- virtual check-ins,



which is using a telephone, and then e-visits, which is usually using a portal or some other kind of e-visit platform.

Recognize also that during the public health emergency, many of the restrictions regarding new patients versus established patients have been waived. So you can use almost any of these encounter types with new patients. You don't necessarily have to only reserve them for established patients.

Final point I want to make is we're all being pushed into this quickly. If it is at all possible to get some time, put some extra time in your schedule to practice ahead of time. Practice afterwards. Debrief. We're all doing these micro PDSA cycles to try and figure out how to do this stuff. Give yourself a little time and recognize that it's much easier to pick up skills and develop procedures with practice, with a little bit of time for practice.

So I strongly encourage all organizations to think about setting aside some time to practice these telehealth techniques to make them the most effective they can be. This is my contact information. You, of course, can reach me through Midwest TTC, or you can reach me directly. And I'm happy to engage with you on any of these telehealth-related questions. And with that, I will end my part of the presentation.

ANN SCHENSKY: Thank you, Dr. Neufeld. That was some really great information as everyone tries to get telehealth services in their agencies. This was some really great practical information. Our next two speakers today will be Lisa Lizak and Thomas McCarthy from Journey Mental Health in Madison, Wisconsin explaining how they implemented rapidly expanding telehealth services. And I will turn it over to you.

LISA LIZAK: OK, thank you. This is Lisa. And Tom and I will be switching off presenting slides today and at the end also switching off about discussing what we've learned and some top lessons to take away.

So I think I'd like to do is start out with our first slide about an agency overview just to give context to our organization for everyone. So Journey Mental Health Center is a private nonprofit organization providing community mental health and substance use services for over 70 years.

We serve consumers with a variety of funding resources-- Medicaid, Medicare, and commercial insurance, in addition to uninsured. And we have a continuum of care throughout the lifespan that Tom will talk about. We have six locations in Dane County and one location in Columbia County. We are based in Madison, Wisconsin. And we currently have a staff of 327. And last year, we provided services to 12,000 consumers.

THOMAS MCCARTHY: We do a variety of services across several divisions of our agency. First, our emergency services-- we have a crisis intervention



unit, which does a variety of things, a 24/7 crisis hotline, a mobile response to mental health emergencies, collaborating with law enforcement and our county with emergency detentions.

That unit also offers crisis stabilization services for individuals who have recently been in a mental health crisis and offers hospital diversion residential programs to support consumers before and/or after a hospital placement.

We have community-based services, several community support programs which provide assertive community treatment to consumers in our community. We have a first episode psychosis program. We have a program called Yahara House, which is an international clubhouse model kind of a day treatment program, and then we have a targeted case management program as well.

In our clinic-based services, we have outpatient mental health for children, family, and adults. We have substance use and medication-assisted treatment. We have a family preservation program focused on keeping families together who are involved with child protective services.

We offer psychiatric evaluation and medication management on an outpatient basis. We offer OWI assessments and drug and alcohol treatment programs for court diversion. Lastly, we have, in our outpatient services, a couple of culturally-specific programs for Spanish-speaking consumers and consumers of African descent.

Our comprehensive community services offer a blend of community and clinic-based services that's an array of psychosocial rehabilitation. This program also links our consumers with a network of providers from across the county.

LISA LIZAK: So to give a background of history of telehealth at Journey, we initiated telehealth services in 2014. And at that time, we had started a program up in Columbia County, which is 40 miles away from Madison. And we were serving consumers in Columbia County who had very little access to psychiatric services. There was only one psychiatrist in Columbia County that would accept Medicaid consumers.

So we started a community-based program. And we were providing telehealth services where the provider was in Madison at our outpatient services facility and then providing that telehealth prescriber service to consumers who were in Columbia County with case management assistance. And we were using our telehealth platform that way.

So we had a very limited amount of prescribers doing this at that time. And I guess from initiation from 2014 to March 23rd of this year, we had three prescribers doing this. And part of the reason too was that Wisconsin Medicaid paid for telehealth, but commercial insurance did not.



So as Dr. Neufeld had talked about, the state had a certification that we had to go through each year in order to provide telehealth services. So there was policy and procedure written, informed consent for telehealth.

And the state was fine with having a number of different providers providing that service. But the only providers who were allowed for us to bill for would be psychiatrists, EPNPs, so it was limited. It wasn't a larger group involving our other professional behavioral health and SUD clinicians.

THOMAS MCCARTHY: OK, so Lisa just gave an overview of the history of Journey with regard to telehealth services. And I'm going to talk a little bit about our recent and rapid expansion of telehealth services. So in light of the public health crisis, we've, as has been covered already, there has been expanded insurance coverage through other payers and some of the recently modified administrative rules by Wisconsin's Department of Human Services.

So that has enabled us to expand our offering of services. And at this point, we are offering outpatient individual and case management services, individual therapy and case management. Nearly all of our psychiatric evaluations at this point are being done either by telephone or video telehealth services.

We have enabled our crisis unit to do crisis assessments via telehealth where appropriate or desired, although that has not been utilized a lot at this point. Our CCS array of psychosocial rehabilitation services have also been approved to start doing services via telehealth.

And of course, we are conducting many of our staff meetings, care team meetings, clinical consultations between providers who are all working from home and using the same telehealth videoconferencing platform.

Additionally, we do have one location available at one of our sites for any consumers across our agency who do not currently have the necessary technology at home so they can come in for a scheduled appointment and use a kiosk that we have set up to get on a computer, log right into a Zoom session with their provider. So that enables the consumers who do not have the technology at home.

So next, we're going to talk a little bit about the steps that have been involved in the expansion of telehealth. First, as far as the telehealth platform, we are requiring staff to use a HIPAA-compliant telehealth platform.

And the accounts and settings for that are managed by Journey, by Journey's IT department, to ensure, as Dr. Neufeld talked about, that we have as many of the settings drilled down and defined as possible to ensure privacy and security for our consumers.



We've offered technical training guides and also some live support sessions for clinical staff to join us to talk about their experiences initially, what they've encountered, what's gone well, what has been a challenge, and to offer support and advice on using the platform.

We've had a variety of telehealth-specific trainings that we have vetted and reviewed to determine what we're going to offer and require for our staff to take in order to become proficient and competent with telehealth.

And lastly, we've spent quite a bit of time, across all of our various programs, developing the workflows that are going to be needed to obtain consumer's contact information. We're not using a patient portal to invite our consumers to these sessions. So developing the workflows, scheduling the appointments-- that has all been quite an effort on our part. Lisa?

LISA LIZAK: Yeah, so some additional steps involved in our expansion are revising our informed consent for telehealth to include-- when we first did the document, we were only using the word computer as a way to connect. And by using this platform, we have people connecting through smartphones in addition to computers, so kind of revising some of the wording within the document.

Also, adding in a section within that document to document verbal consent that we're getting from the consumer at that time that we start, since we can't get that signed immediately by the consumer. Information sheets and tip sheets for consumers that are being sent via email to those consumers who are going to participate in our telehealth platform.

Program-based technical support for consumers-- and what that means is that we initially were going to have a couple of people from our main communications team available to help consumers kind of walk them through that process of either getting an app loaded on their phone or any initial technical issues with connecting.

And what our individual program managers came back telling us was we would rather have our own staff doing that with our consumers because our consumers have that relationship with them. So it helps to bridge that step with any frustration or building some confidence in using the telehealth platform.

We have a consumer telehealth satisfaction survey that we have in Survey Monkey that's anonymous. We have an English and Spanish version and have been collecting information for about 1 and 1/2 weeks so far. And it's been very encouraging, even though we have a small amount of surveys coming back. It looks very positive so far.



We're also closely monitoring security, confidentiality, and safety while we're doing this, both on the staff side of using the platform and the best we can do on the consumer side.

So some things that we've learned-- and we talked a little bit about the first bullet, feedback from staff and consumers. So through our technical support groups with staff, maybe, Tom, you can talk a little bit about what you've learned from the staff feedback.

THOMAS MCCARTHY: Sure, yeah. So everything ranging from just basic troubleshooting ideas that we've shared with them of sometimes just restarting your computer, restarting the application, some of those. Although they may seem basic and obvious, it's helpful to remind people to do some of those really basic troubleshooting steps.

We've had feedback about consumers who are in an area where they do not have the greatest connectivity, so talking through how they can support their consumers in maybe finding a different location for participating in telehealth services, all sorts of things as far as the audio-video settings, so environment and the ambient lighting and things like that, just giving staff ideas, letting them share ideas.

So that's been some of the feedback that we've received from staff. And again, also, just as I think Dr. Neufeld mentioned, practice, practice, practice-- getting staff and encouraging staff to work with each other before their first real session with a consumer. That's been some of the feedback from those groups.

LISA LIZAK: And I've been able to go in on a daily basis into the Survey Monkey app to glean information from comments consumers have made about what's worked well, what hasn't worked well. And we've been able to then take that information on a daily basis, if something comes in and we identify an issue, to be able to put it through what we're calling rapid cycling also.

So daily review of an evaluation of feedback from staff and from consumers, and working as a group comprising our organization resources staff, EHR, IT, billing, and clinical leadership-- we meet on a daily basis. And so we're doing rapid cycling PDSA continuously right now to improve the telehealth experience for the consumer.

THOMAS MCCARTHY: Some of the things that we've learned, some lessons and advice from our consumer telehealth satisfaction survey, we assessed how consumers are accessing telehealth, whether by computer or by a smartphone. And we were actually surprised that we have a relatively equal number utilizing smartphones as using computer. And so that level of smartphone use was not initially expected by us.



And so that has kind of prompted us to start thinking more about specifically the concerns of privacy, sound and audio, and internet connectivity that come with being on a mobile device. So we're working on increasing testing and troubleshooting for smartphone-specific use of the telehealth platform.

LISA LIZAK: Another lesson we've learned is that there is the potential of using a HIPAA-compliant telehealth platform in non-HIPAA-compliant ways. And Dr. Neufeld had talked about that. Many, many settings within different platforms. So an important thing is needed testing within an organization of the telehealth platform prior to making it available for consumer use and testing throughout the use of that platform. And in addition, as new telehealth platform updates become available to staff, assisting staff to adapt to those changes.

THOMAS MCCARTHY: We also learned that as much upfront and continued education as we can provide to consumers about the telehealth experience is beneficial. So first, that starts with in the informed consent what they can expect, how we're addressing security, things like that, the confidentiality, but providing that in an ongoing way, providing tip sheets for the consumers to understand and visualize what we expect them to experience during the telehealth session.

And as Lisa mentioned earlier, that provider-based education on how they can support their consumers because the providers themselves are the ones that have the relationship with the consumers. So while on one hand, maybe the providers are not always the best folks to be providing the technical support, they're the ones that have the relationship with the consumers.

LISA LIZAK: And it might also be we have program support staff within each of our many programs where consumers might know that person just from interaction and coming into the office. And that might be another person who might be providing some of that training also.

Some other continued evaluation areas that we identified. One is to a need to evaluate and implement workflows and how to best engage new consumers coming through Journey's intake program and OWI program where there's not a relationship that exists with the program and the consumer versus people who we've been serving for quite some time. And this was a switch in how the service was-- the modality and how it was provided.

Another point is continued evaluation of decreasing consumer's apprehension of using the telehealth platform regarding security concerns or level of competence or comfort in using the telehealth platform, such as assisting some consumers to switch from telephone interaction to telehealth interaction with video. So we identified a few consumers who just-- we heard back from staff that consumers didn't like seeing their face.



And part of that was in a training issue to help staff-- help consumers understand well, how do you change your picture or reduce that or hide your picture. And we didn't want them to hide it but just reducing it so they don't see it. And they're not distracted. Because we get a lot of information from that video part of the telehealth that we're doing.

There's a need to evaluate what telehealth might look like after the Wisconsin Safer at Home emergency order and the transition into the Wisconsin Bounce Back emergency order. And there's also a need to plan for the transition of consumers back to an in-person appointment model or have an in-person slash telehealth hybrid model of care. And that's all dependent on what the different payer sources deem as to what they're going to do.

And we've already talked as a group at Journey about this could be a hard transition for some consumers who like this form of sessions or interaction being provided. And they don't have to travel. They don't have to find childcare. And so it will be-- it'd have to be very planful as to how we will encourage people to come back to the office to provide one on one care in person.

THOMAS MCCARTHY: I think that covers the items that we received as far as feedback and some of the lessons that we've learned that we wanted to pass on. You are more than welcome to contact Lisa or I if you have follow-up questions. We've provided our contact information there, as well as the link to the Journey website. And I think with that, we'll say thank you for your time today.

LISA LIZAK: Thank you.

ANN SCHENSKY: Fantastic. Thank you both, Lisa and Tom, for that. Again, a lot of really practical information and feedback from clients on what they do and don't like or feel comfortable with. These are all really good tips for people moving forward. I would like to thank everyone for their time today. And we appreciate all of your good, solid, practical information. Thank you.