The NCTRC is dedicated to building sustainable telehealth programs and improving health outcomes for rural and underserved communities.

Danielle Louder, Director
Northeast Telehealth Resource Center
Co-Director – MCD Public Health

Maine AAP: Trends in the Telehealth Landscape & Pediatric Practice

March 2, 2022
Disclosures and Acknowledgements:

- Any information provided by NETRC is for educational purposes only and should not be regarded as legal advice.
- I do not have any financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this session.
- Acknowledgements: Amazing partners and stakeholders throughout the region and beyond!

NETRC is made possible by grants 1 U1UTH42523-01-00 and GA5RH37459 from the Federal Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

About Us:

NETRC aims to increase access to quality health care services for rural and medically underserved populations through telehealth. We serve New England and New York, and are a proud member of the National Consortium of Telehealth Resource Centers.
We provide expert technical assistance to help build and enhance telehealth programs across the nation. Key focus areas include but are not limited to: telehealth policy, technology, workflow, workforce training, etc.

Our services

**Technical Assistance**

We develop educational materials and resources for health systems, providers and patients. Includes: designing/executing needs assessments, identifying funding sources, and assisting with telehealth technology selection is also among our specialties.

**Development**

We connect telehealth leaders at local, state, and federal levels to raise awareness and collaboratively produce specialized tools and templates for telehealth programs and providers.
Telehealth Utilization - Medicare

- The number of Medicare fee-for-service (FFS) beneficiary telehealth visits increased 63-fold in 2020, from approximately 840,000 in 2019 to nearly 52.7 million in 2020.
- Despite the increase in telehealth visits during the pandemic, total utilization of all Medicare FFS Part B clinician visits declined about 11% in 2020 compared to levels in 2019.
- Most beneficiaries (92%) received telehealth visits from their homes, which was not permissible in Medicare prior to the pandemic.
- Prior to the pandemic, telehealth made up less than 1% of visits across all visit specialties but increased substantially in 2020. Telehealth increased to 8% of primary care visits, while specialty care had smallest shift towards telehealth (3% of specialist visits).
- Visits to behavioral health specialists showed the largest increase in telehealth in 2020. Telehealth comprised a third of total visits to behavioral health specialists. While data limitations preclude clear identification of audio-only telehealth services, up to 70% of these telehealth visits during 2020 were potentially reimbursable for audio-only services.
- Black and rural beneficiaries had lower use of telehealth compared with White and urban beneficiaries, respectively. Telehealth use varied by state, with higher use in the Northeast and West, and lower in the Midwest and South.

Telehealth Utilization - MaineCare

Telehealth Utilization Trend
Using MaineCare Claims w/ Telehealth Modifiers

Behavioral Health Utilization Trend Examples
Using MaineCare Claims and Telehealth Modifiers

Source: Update to the Maine State Legislature – Committee on Appropriations and Financial Affairs – September 23, 2020. Presentation by Benjamin Mann and Michelle Probert
Telehealth Utilization – Private Payers

Source: FAIR Health
Monthly Telehealth Regional Tracker

Top Mental Health Diagnoses, Nov. 2021

Source: FH NPIC® database of more than 31 billion privately billed medical and dental claim records from more than 80 contributors nationwide. Copyright 2020, FAIR Health, Inc. All rights reserved. CPT © 2019 American Medical Association (AMA). All rights reserved.
# Key Policy Changes During COVID PHE

## Medicare

<table>
<thead>
<tr>
<th>Category</th>
<th>During PHE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic Limit</td>
<td>Waived</td>
</tr>
<tr>
<td>Site Limitation</td>
<td>Waived</td>
</tr>
<tr>
<td>Eligible Provider List</td>
<td>Expanded</td>
</tr>
<tr>
<td>Eligible Services</td>
<td>Expanded (80+ addlt. codes)</td>
</tr>
<tr>
<td>Visit Limits</td>
<td>Waived certain limits</td>
</tr>
<tr>
<td>Modality</td>
<td>Live video, Phone for some services</td>
</tr>
<tr>
<td>Supervision</td>
<td>Relaxed – allowing via video</td>
</tr>
<tr>
<td>Licensing</td>
<td>Relaxed requirements</td>
</tr>
<tr>
<td>Tech-enabled/Comm based</td>
<td>More codes eligible for phone &amp; addtl. providers allowed</td>
</tr>
</tbody>
</table>

## State Medicaid (Most Common Changes)

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modality</td>
<td>Phone allowed</td>
</tr>
<tr>
<td>Location</td>
<td>Home allowed</td>
</tr>
<tr>
<td>Consent requirements</td>
<td>Relaxing requirements</td>
</tr>
<tr>
<td>Eligible Services</td>
<td>Additional types of services eligible</td>
</tr>
<tr>
<td>Eligible Providers</td>
<td>Additional provider types allowed (OT, PT, SLP, etc)</td>
</tr>
<tr>
<td>Licensing</td>
<td>Some requirements waived</td>
</tr>
</tbody>
</table>

- DEA: Prescribing exception - allowing phone for suboxone for Opioid Use Disorder
- HIPAA: Office of Civil Rights will not fine during PHE

*Federal PHE extended to April 16, 2022*
The Highlight Reel for Telehealth

- **Final PFS** – officially published November 19, 2021
- Category 3 services will be extended to end of CY 2023
  - Added multiple cardiac rehab codes to Cat. 3
- Significant Changes to Mental Health Services Provided Via Telehealth
  - Consolidated Appropriations Act (CAA) passed in Dec 2020 implementation related to provision of mental health visits via telehealth. Certain conditions applied.
  - Allowing use of audio-only to provide mental health visits if certain conditions met.
  - FQHC/RHC redefinition of mental health visit, not considered telehealth
Audio-Only: In 2022 CMS redefining the definition of “telecommunications system” which is not defined in federal law. MENTAL HEALTH services can be provided for the evaluation, diagnosis and treatment of mental health disorder IF:

• Established patient
• Patient at home
• Provider has capability of doing live video
• Patient cannot or does not want to do via live video
• Has an in-person visit with the telehealth provider 6 months prior/12 months subsequent
FQHC/RHC CMS is redefining what a mental health visit is for an FQHC/RHC. The new definition would "also include encounters furnished through interactive-real-time telecommunications technology. Includes audio-only if patient cannot use video or if they consent to audio-only.

- New Remote Therapeutic Monitoring codes 98975-98981
- Permanent adoption of G2252 (virtual check-in 11-20 minutes)
- Principal Care Management (PCM) and Chronic Care Management (CCM) codes being finalized
Final PFS CY 2022 – Other Changes

• Allow Opioid Treatment Programs (OTPs) to use audio-only to furnish therapy and counseling when live video not available to beneficiary after PHE is over. Modifier 95 will need to be used to claims for the counseling and therapy add on code G2080, but not when included in the weekly bundle and for when using live video. After the PHE, OTPs will need to document audio-only was used in patient medical record and along with a modifier.

• During the PHE, CMS allowed for certain in-person supervision requirements or the availability of the supervisor in-person to be provided virtually through telehealth. After soliciting comments, CMS has decided that it will consider addressing concerns raised in future rules or guidance.

• Originating site facility fee will be $27.59

• CMS is allowing for inclusion of 99441, 99442 and 99443 in the definition of primary care services used for beneficiary assignment until no longer payable under the physician fee schedule fee for service payment policies under the Shared Savings program for ACOs

• CMS declines to add telephone codes 99441-99443 as permanent services that will be reimbursed

• Medical nutrition therapy (MNT) and diabetes self-management training (DSMT) services may be provided as telehealth services when registered dietitians or nutrition professionals act as distant site practitioners.

A Few Key Points:

• 6 month in-person requirement does not kick-in until the federal PHE is over

• PHE was renewed for another 90 days on January 16, 2022

• Changes to allow FQHCs/RHCs to provide mental health visits via live video and audio-only is not telehealth

• For FQHCs/RHCs, the 6 month in-person visit requirement only happens when the patient is receiving services in the home
Moving Forward: Federal Policy Activity

Well Over 100 Telehealth Related Bills – see CCHP’s Federal Policy Tracker for Details and Status of Pending Legislation and Regulation

CONNECT Act (re-introduced) – would remove long-standing barriers to telehealth and promotes program integrity. See CCHP CONNECT Fact Sheet.

KEEP Telehealth Options Act (re-introduced) - bill would require several federal entities to study all of the telehealth actions taken during the PHE.

TH Modernization Act – would remove originating/geographic site restrictions; give HHS secretary authority to expand provider types; allow TH to meet face-to-face requirements for hospice care and home dialysis, enable CMS to continue to use sub-regulatory authority to add telehealth services; extend FQHC and RHCs distant site ability

S. 3593: Telehealth Extension and Evaluation Act (new Feb ‘22) – would amends titles XI and XVIII of the Social Security Act to extend certain telehealth services covered by Medicare and to evaluate the impact of telehealth services on Medicare beneficiaries. Key areas include FQHCs/RHCS, CAHs and Prescribing.

In 2022, trend toward extension of policy flexibilities and allowing more time to study affects vs. permanent change
State Policy Trends

• **Expansion of telehealth definition** to be broader in scope to entail more than just live video, although often with some caveats

• **Training or Certification** – e.g. Mississippi telemental health CE requirement for mental health counselors

• **Registration and/or Reporting** – e.g. New Jersey added requirement for telehealth or telemedicine organizations to annually register with the Department of Health and submit an annual report

• Medicaid **expansions of eligible patient (originating) sites** and **clarifications on types and locations of eligible distant site providers** (e.g. FQHC/RHC; out of state providers)

• **Extensions of State waivers** and flexibilities (e.g. audio-only, payment parity)

• Enactment of **Licensure Compacts**

Check out CCHP’s [Policy Trends Maps](#)
Where are we Headed? Digital Health Predictions…

- Consumer needs and preferences will be increasingly important
- Continued evolution of care models with virtual care a focal point
- Continued transition of more care delivered at home
- More data driven care, including artificial intelligence
- Personalized, predictive and engagement driven models
- Digital first approaches
- Payment models driven by long-term patient outcomes

74% Agree
Implementing video-based telemedicine is critical for the long-term financial solvency of my practice.

Source: 2020 HHS Telemedicine HACK Baseline Survey
Pediatric Telehealth

03.02.2022

Michael Ross FAAP FACMI
Medical Director of TeleHealth, Northern Light Health
Medical Informatics Officer, EMMC
General Pediatrician
Outline:

• The NE TeleHealth Resource Center:

• TeleHealth in Practice, 2022:
  • Overview and History
  • Direct to Patient (Ambulatory practice)
  • AAP Support
  • Patient Engagement (Healthychildren.org)
  • E-Consults:
    • Role Within Pediatrics Subspecialties
    • Specific Underserved medical disciplines (Dermatology)
  • Hospital-to-Hospital:
    • TeleNICU/TelePICU
    • Challenges and Victories

• Future developments; Where are we going?
TeleHealth in History:

- Radio Times add, 1920s
- Telepsychiatry, 1950s
- MGH/Logan Airport telemed project, 1960s
- Papago Indian Reservation Telehealth Pilot, 1970s
Prior and Ongoing Pediatric Telehealth Barriers:

(AAP’s 2015 policy statement on telehealth)
Telehealth Benefits:

**For Practices**
- Reaching underserved populations/Improve access
- Increase depth of provider workforce
- Deliver more Preventative and Mental healthcare
- Decrease Costs(*)
- Strengthening patient-provider relationships
- Decreasing likelihood of no-shows for appointments
- Enhancing patient comfort and compliance

**For Patients**
- Reduce Healthcare costs
- Decreased needs for travel to an appointment
- Reduce waiting time for appointments
- Reduction in emergency room and walk-in clinic volume
- Improved access to specialists
- Increased patient comfort in home vs. office
- Enhanced access for those with specific conditions

Northern Light Health.
Key Changes to Coverage Restrictions for Medicare Fee-for-Service During the COVID-19 Emergency

- Allows beneficiaries living in any geographic area to receive telehealth services
- Allows beneficiaries to access telehealth visits from their home
- Allows telehealth videoconference visits to be delivered via smartphone
- Removes requirement for preexisting relationship between patient and provider
- Allows FQHCs and RHCs to provide telehealth services
- Allows some services to be delivered via audio-only phone

### Types of Telehealth:

**Real time or “synchronous”**
- Virtual visit: video visit between physician/provider and patient
- Virtual consult: video consult between two providers (or more)

**Store-and-forward or “asynchronous”**
- eVisit: online exchange of medical information between provider and patient
- eConsult: consult between providers

<table>
<thead>
<tr>
<th>Provider-to-Provider Platforms</th>
<th>Use Case</th>
<th>Description</th>
<th>Timing</th>
<th>Video</th>
<th>Information Transferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>eConsult</td>
<td>Templated communications, where primary care provider eConsults with specialist to share information and discuss patient care.</td>
<td>Asynchronous</td>
<td>No</td>
<td>Medical records and images</td>
</tr>
<tr>
<td>2</td>
<td>Virtual video consult</td>
<td>Distant specialist connects in real time to a provider/clinical setting to deliver a clinical service directly supporting the care of a patient (e.g. telestroke).</td>
<td>Synchronous</td>
<td>Yes</td>
<td>Medical records and images</td>
</tr>
<tr>
<td>3</td>
<td>eICU/TeleAcute</td>
<td>Remote covering clinicians use multiple modalities (video, monitor data) to follow a defined set of seriously ill patients.</td>
<td>Synchronous</td>
<td>Yes</td>
<td>Medical records, images and monitoring data</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Direct-to-Consumer Platforms</th>
<th>Use Case</th>
<th>Description</th>
<th>Timing</th>
<th>Video</th>
<th>Information Transferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Second opinion</td>
<td>Patient-initiated electronic request for provider to give an opinion on a clinical case.</td>
<td>Asynchronous</td>
<td>No</td>
<td>Medical records and images</td>
</tr>
<tr>
<td>5</td>
<td>Remote-patient monitoring</td>
<td>Providers remotely monitor patients via connected/mHealth devices or PROs.</td>
<td>Synchronous</td>
<td>Yes</td>
<td>Monitoring data and patient-reported data</td>
</tr>
<tr>
<td>6</td>
<td>Video visit</td>
<td>Provider connects directly with patient via video to conduct equivalent of a visit.</td>
<td>Synchronous</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td>7</td>
<td>eVisit</td>
<td>Provider connects with patient via email or secure messaging to provide clinical advice or support.</td>
<td>Asynchronous</td>
<td>No</td>
<td>Patient-reported data and images</td>
</tr>
</tbody>
</table>

Source: Manatt, 2019
Asynchronous:
- Provider-to-Provider:
- Patient-to-Provider
E-Consults:

- E-Consultations involve the formalized *asynchronous* transfer of health information from a PCP/referrer to a specialists via a secure environment (our shared electronic health record).
- E-Consultations utilizes a standardized electronic process where the Referring provider outlines the workup performed to date and poses patient/condition-specific question to the subspecialist. The specialist responds to the questions via a written consultation.
- Should there be insufficient information, or should the medical indications require in-person evaluation, the specialist can convert the E-consultation to a future face-to-face consultation.
E-Consults Literature Review:

**Pediatric dermatology eConsults: Reduced wait times and dermatology office visits**

Kira Seiger, Elena B Hawryluk


**Use of Electronic Consultation System to Improve Access to Care in Pediatric Hematology/Oncology**

Donna L Johnston, Kimmo Mi


**Impact of Pediatric Electronic Consultations in a Federally Qualified Health Center**

Anthony Porto, Karen Rubin, Kristina Wagner, Wei Chang, Giuseppe Macri, Daren Anderson

## Benefits of E-Consults:

<table>
<thead>
<tr>
<th>Patient Benefits:</th>
<th>Primary Care Benefits:</th>
<th>Specialist Benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improved access to specialist</td>
<td>• Avoid back-and-forth “telephone tag” with specialists.</td>
<td>• Avoid back-and-forth “telephone tag” with Primary Care.</td>
</tr>
<tr>
<td>• Improved convenience, 40% of patients avoid an in-person specialty consultation.</td>
<td>• Enhanced relationship with my patients and colleagues.</td>
<td>• Improved access to specialty clinic appointments</td>
</tr>
<tr>
<td>• Decreased Patient Cost through reduction in travel and life disruption.</td>
<td>• Improved responsiveness (documented reply within 3 days).</td>
<td>• Reduce liability concerns from advising on a patient without full access to the chart</td>
</tr>
<tr>
<td>• Decreased patient Travel</td>
<td>• Enhanced ability to manage patients who would normally require a subspecialist consult.</td>
<td>• Productivity for a task already done without compensation.</td>
</tr>
<tr>
<td>• Improved time to response</td>
<td>• Specialist decisions guided by entire clinical picture when accessing the chart.</td>
<td>• Able to incorporate E-consults into my schedule and not be interrupted by phone calls</td>
</tr>
<tr>
<td>• Increased relationship in the patient’s primary care delivery</td>
<td>• Productivity for a task you already do</td>
<td>• Able to enhance the base knowledge of the Primary Care Community in my area of expertise.</td>
</tr>
</tbody>
</table>

- Increased educational opportunities
PCP / Referrer Guiding Principles:

• An E-consult should be limited to a specific question, supporting ongoing PCP management. Requests for ongoing subspecialist management is better suited for a conventional, in-person referral.

• E-Consultation should be initiated through Referral management within Cerner, as opposed to direct PCP-to-Specialist messaging.

• E-Consultations require the patient to have had a visit with the referring PCP. Question must be answerable based on the information available within Cerner, to include:
  • Documented pertinent history (required)
  • Pertinent physical exam findings by the PCP
  • Imaging and lab (per specialty if appropriate)
  • Time spent preparing the eConsult (PCP) should be noted

• Patient should be aware and consented to the E-consult process:
  • Patient should be made aware of the benefits and increased access to specialty care.
  • Patient should verbally Consent to the referral being made, and verbal consent should be documented at time of PCP appointment.
  • The results of the specialist referral should be communicated back to the patient via the PCP (i.e. I spoke with the specialist, who found ___).
  • An e-Consult patient-facing brochure should be used to support patient understanding of an E-Consult
Specialist Guiding Principles:

- Expected turnaround of E-consult by specialist, upon receipt of the referral is **3 business days**.
- Communication from Specialist to PCP should be a formalized note within the EMR, with a specific plan for next steps:
  - If an E-consult is converted to a request for in-person specialty care consult, the specialist should send a communication back to PCP indicating an in-person referral is required.
  - If an E-consult is converted to a request for in-person care consult, the specialist office should “flip” the referral to a formal in-person consult.
- E-Consultations should be processed through Referral management within Cerner, not direct Specialist-to-PCP messaging.
- New imaging/labs/others might be considered as a response to the request for consultation, and a detailed description of the suggested workup should be made by the specialist supporting the ordering of the workup (i.e. Imaging/labs) by the PCP. Future collaboration of the results of such studies should be performed from the patient’s chart via message center.
- Time spent (Specialist) should be documented to support billing.
E-Visit Experience: Pediatric Portal Image visits

Impact of Asynchronous Electronic Communication-Based Visits on Clinical Outcomes and Health Care Delivery: Systematic Review

Oliver T Nguyen 1,2; Amir Alishahi Tahbiz 3,4; Jinhai Huo 1; Karim Hanna 5; Christopher M Shea 6; Kea Turner 3,4

Results:
Out of 1859 papers, 19 met the inclusion criteria. E-visit usage was associated with improved or comparable clinical outcomes, especially for chronic disease management (e.g., diabetes care, blood pressure management). The impact on quality of care varied across conditions. Quality of care was equivalent or better for chronic conditions, but variable quality was observed in infection management (e.g., appropriate antibiotic prescribing). Similarly, the impact on health care utilization varied across conditions (e.g., lower utilization for dermatology but mixed impact in primary care). Health care costs were lower for e-visits than those for in-person visits for a wide range of conditions (e.g., dermatology and acute visits). No studies examined the impact of e-visits on health care access. It is difficult to draw firm conclusions about effectiveness or impact on care delivery from the studies that were included because many used observational designs.

Conclusions:
Overall, the evidence suggests e-visits may provide clinical outcomes that are comparable to those provided by in-person care and reduce health care costs for certain health care conditions. At the same time, there is mixed evidence on health care quality, especially regarding infection management (e.g., sinusitis, urinary tract infections, conjunctivitis). Further studies are needed to test implementation strategies that might improve delivery (e.g., clinical decision support for antibiotic prescribing) and to assess which conditions can be managed via e-visits.

J Med Internet Res 2021;23(5):e27531
Patient-to-Provider:
Virtual care stabilized above pre-pandemic levels of use:

• Virtual care usage peaked in the second quarter of 2020, and then decreased in the second half of the year and throughout 2021

• While drop off has been significant, virtual volumes remain significantly higher than pre-pandemic levels

• At the same time, multiple stakeholders, including health plans and providers are investing in improving the quality and convenience of virtual visits, suggesting telehealth is here to stay

Telehealth continues to stabilize: Endorsed by National AAP

Telehealth: Improving Access to and Quality of Pediatric Health Care

Alison L. Cuffman MD, MBA, FAAP; Jesse M. Hackell MD, FAAP; Neil E. Hendersen MD, MS, FAAP; Joshua J. Alexander MD, FAAP; James P. Marcin MD, MPH, FAAP; William B. Moskowitz MD, FAAP; Chelsea E. F. Bodnar MD, MPhil, FAAP; Ilanord K. Simon MD, MBA, FAAP; S. David McSwain MD, FAAP.

Section on Telehealth Care, Committee on Practice and Ambulatory Medicine, Committee on Pediatric Workforce

All children and adolescents deserve access to quality health care regardless of their race/ethnicity, health conditions, financial resources, or geographic location. Despite improvements over the past decades, severe disparities in the availability and access to high-quality health care for children and adolescents continue to exist throughout the United States. Economic and racial factors, geographic maldistribution of primary care pediatricians, and limited availability of pediatric medical subspecialists and pediatric surgical specialists all contribute to inequitable access to pediatric care. Robust, comprehensive telehealth coverage is critical to improving pediatric access and quality of care and services, particularly for under-resourced populations.

MORE PEDIATRIC TELEHEALTH

Experts plead case for kids with developmental, behavioral issues

BY HOWARD MOLNISKY

A specialty group is asking federal and state governments to preserve and expand access to telehealth services for children with developmental and behavioral problems. Citing the success during the COVID-19 pandemic of telehealth for these patients, the Society for Developmental and Behavioral Pediatrics has issued a position statement in its official journal calling for continued use of video and telephone for home-based diagnostic assessments, medication management, follow-ups, and therapeutic interventions for children with autism spectrum disorder, attention deficit/hyperactivity disorder, and other neurodevelopmental conditions. "Telehealth offers plenty of opportunities for care beyond the pandemic, as research suggests telehealth for these conditions is as effective as in-person care. Our goal is to ensure telehealth is affordable, accessible, and available to all children who need it," said Dr. Robert B. Keddy, president of the Society for Developmental and Behavioral Pediatrics.
Digital inequity is a three-pronged issue

Access
Lack of patient access to technology (e.g., computer, smart phone) and broadband connection.

Knowledge
Lack of patient knowledge and comfort using technologies, especially during account creation and installation.

Interoperability
Lack of integration between EMR, telehealth, and peripheral technologies.

40% of Black and Latino Americans report not owning a desktop or laptop computer

61% of physicians see “low digital literacy” as a big challenge to providing telehealth

Related Advisory Board resource
Cheat sheet: Digital inequity
Telehealth 101: Get Plugged in to Your Child’s Health

Sometimes it’s hard to get to the doctor’s office. Maybe you can’t take off work or your child can’t take off school. Your pediatrician’s office might offer a visit through a video call or a phone call instead. This is called “telehealth.”

The American Academy of Pediatrics (AAP) supports telehealth for doctors’ visits, especially when you can’t meet face-to-face. It’s best to use telehealth within your child’s medical home. Think of this as the “home base” for your pediatric health care team. Telehealth won’t replace in-person visits, but could be an option for some visits or just to share information with your doctor. There are benefits like:

How Telehealth Can Enhance Mental Health Care

If you’ve noticed your child or teen is struggling in school, having difficulties with

Signs that your child may be struggling emotionally

- Difficulties with others
- Changes in eating
- Shift in sleep habits
- Mood swings

left many children, teens, and young adults feeling a sense of isolation, loss, and anxiety. They have lost loved ones, gone to virtual schools, and even lost people they know to COVID-19. Everyone is struggling in this time.

A pediatrician

A child’s emotional health, you might be able to schedule a telehealth visit. Telehealth can be a visit that takes place by video allowing this is a good way to talk with you and your child’s medical home. A telehealth visit can ease any feelings of isolation and teens may feel when talking about emotional health...
NLH Recent Experience:

Telehealth Utilization: System Service Lines

- Cardiology
- Gastroenterology
- Neurology
- Oncology
- Orthopedics
- Pediatrics
- Primary Care
- Rheumatology
- Surgery
- Women's Health

- 1/9 -1/15
- 1/16 – 1/22
- 1/23 – 1/29
- 1/30 – 2/5
- 2/6 – 2/12
- 2/13 – 2/19
Virtual Walk-in Care: Metrics and Horizon

- 170 Successful Visits to-date
- 16 different providers across AR Gould, EMMC, and Mercy have completed at least one visit.

Important Dates

- **October 2021:** Initial internal launch:
- **April 2022:** Statewide expansion of the vWIC to all patients currently in Maine.
vWIC Clinical Considerations:

**AGE RANGE OF PATIENTS IN SCOPE FOR CARE FOR VIA THE vWIC:**
- > 4 years of age onward.
- Between the ages of 4-18yrs, both the patient and parent or guardian need to be visible during the visit.

**WHAT CLINICAL CONDITIONS ARE OUT OF SCOPE OF THE vWIC:**
- Behavioral Health:
- Pediatric Care < 4 years of age:
- Preventative Care Services:
- Workers Comp.

**SUMMARIZING STATEMENT FROM THE ATA URGENT CARE PRACTICE GUIDELINES:**

*Telemedicine providers shall determine the appropriateness of telemedicine on a case-by-case basis, whether or not a telemedicine visit is indicated, and what portion of the examination must be performed and documented in conformance with appropriate standards in evaluating the patient. Wherever possible, diagnostic interventions should be supported by high-quality evidence. Where evidence is lacking, providers shall use their professional judgment, experience, and expertise in making such decisions.*

**CLINICAL CONDITIONS TO BE EVALUATED AT THE vWIC:**
- Seasonal allergies
- Upper respiratory congestion
- Cough
- Cold/flu
- Ear Pain
- Pink eye
- Sinus congestion
- Sore throat *
- Vomiting / diarrhea
- Rash/Skin infection or conditions
- Dysuria/UTI (Adult only)
- Conjunctivitis/other eye conditions
- GI upset
- Dental pain
- Sprains/minor/mild muscular skeletal pain
- Tick bites

**Go to the emergency room for:**
- Chest pain or pressure
- Uncontrolled bleeding
- Sudden or severe pain
- Coughing/vomiting blood
- Difficulty breathing or shortness of breath
- Sudden dizziness, weakness, change in vision, slurred speech, numbness, or other neurological changes
- Severe or persistent vomiting or diarrhea
- Changes in mental status, such as confusion
- Assault, physical or sexual abuse, or child abuse
- Obstetrical care
- Mental Health concerns
- Pediatrics < age 4
Questions:
Thank You!

www.NETRC.org
800-379-2021
Email: netrc@mcdph.org

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• Telehealth Policy Resources
• Telebehavioral Health and SUD Resources
• Patient/Consumer Resources
Policy and Reimbursement Resources

Center for Connected Health Policy
- CCHP Video Learning Series: Telehealth Policy 101, 201 & 301
- State Policy Finder Tool
- Billing For Telehealth Encounters – CCHP 2021 Updated Guide on Fee-for-Service

CMS/Medicare - COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers
- Medicare Telemedicine Health Care Provider Fact Sheet
- Medicare Learning Network (MLN) Booklet – Updated June, 2021
- Medicare - Covered Telehealth Services CY2022

Office of Civil Rights
- FAQs on Telehealth and HIPAA during COVID-19 public health emergency

DEA COVID-19 Information Page

SAMHSA COVID-19 Page

Federation of State Medical Boards – Board by Board Review
- U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19
Telebehavioral Health and SUD Resources

• HHS Best Practice Guide: Tele-treatment for substance use disorders

• Mid-Atlantic Telehealth Resource Center (MATRC) Telebehavioral Health Center of Excellence (TBHCOE): https://tbhcoe.matrc.org/


• Center of Excellence for Integrated Health Solutions (Funded by Substance Abuse and Mental Health Services Administration (SAMHSA) Operated by the National Council for Behavioral Health) https://www.thenationalcouncil.org/integrated-health-coe/resources/

• National Alliance on Mental Illness (NAMI)- Mental health Training for Providers https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-Provider
Telebehavioral Health Resources

- **US Center for Disease Control and Prevention (CDC)** - Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic


- **Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCH)** - MCH Navigator Online Training: https://mchb.hrsa.gov/training/mch-navigator-description.asp

- **Suicide Prevention Resource Center (SPRC)** - Treating Suicidal Patients During COVID-19: Best Practices and Telehealth

- Search the **NETRC Telehealth Resource Library** for additional resources!
HHS Telehealth Webpage for Patients/Consumers:  https://telehealth.hhs.gov/patients/

TRC and Other Consumer Resources: How Patients Can Engage Telehealth, Telebehavioral Health, Tips to Keep Your Telehealth Visit Private, Downloadable Tech Guides, Virtual Healthcare for Patients/Consumers, How to Prepare for a Video Visit with Your Mental Health Provider

Devices/Connectivity:
FCC LifeLine Program and FCC Affordable Connectivity Program - provides devices and subsidies on monthly voice and data fees for low income consumers and those impacted significantly by COVID-19. There are eligibility requirements (see webpages) and an application process.

National Digital Equity Center, has a device loaner program – any Maine resident over 70 years of age can borrow devices for 90 days at no charge, and pay $25/month after that 90 days if they wish to keep it longer. Older adults from other states can participate for small fee.