Telemedicine, Transplant, and COVID-19

One Transplant Center's Experience

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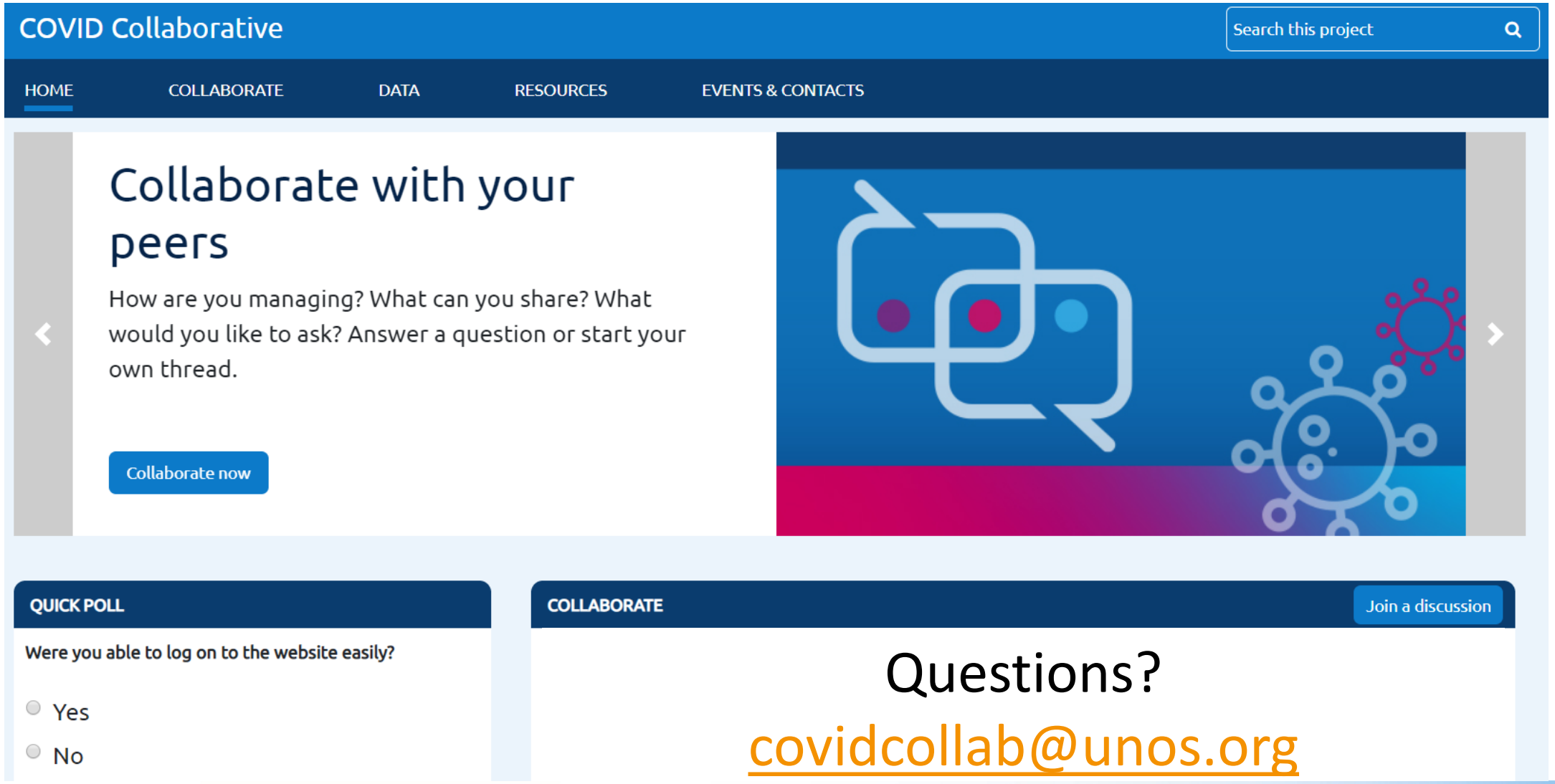


Questions?

covidcollab@unos.org

Speaker
Pooja Singh, MD,
Jefferson Transplant Institute
Thomas Jefferson University, Philadelphia, PA

Dr. Singh is the Medical Director for Kidney Transplantation and the Living Donor Program. She is the Region 2 Representative on the UNOS Live Donor Committee and will be starting her one year term on the AST Audit Committee in June 2020. Her special interests include removing barriers to live donation, waitlist maintenance, management of failing renal allograft, and telemedicine. She is currently pursuing an MBA (expected graduation in May 2021).

Moderator
Kristen Sisaithong, MA, CMQ/OE
United Network for Organ Sharing, Richmond, VA

Kristen joined UNOS in 2016 with a focus on internal and member performance improvement. She lead UNOS team efforts for the Collaborative Innovation and Improvement Network (COIIN) which focused on increasing the utilization of moderate-to-high KDPI kidneys. She is passionate about quality improvement and supporting the donation and transplant community to save lives.

Poll

Who drove telehealth transformation at your institution?

1. CEO
2. CIO
3. COVID 19

Jefferson Health

Telehealth Visits for Transplant Programs

Pooja Singh MD
Medical Director, Kidney Transplantation
Medical Director, Live Donor Kidney Transplant Program
Jefferson Transplant Institute
Thomas Jefferson University
Philadelphia, PA

Telemedicine or Telehealth ?

Telemedicine → individual patient care or remote clinical services

- Distant site → location of practitioner
- Originating site → location of patient
- Under normal circumstances, telemedicine providers typically needed to be licensed in the state where the distant site AND originating site were located (temporary waiver during COVID 19)

Telehealth → **remote non-clinical services**, such as provider training, administrative meetings, and continuing medical education, in addition to **clinical services**. Focuses on technology aspect…..telemedicine incorporated into telemedicine

Telemedicine & Level Setting

- Telehealth is not just technology, its about the **workflows and operations**
- Telemedicine is a care delivery model
- Is telehealth better than an in-person visit?
- Is telehealth better than no visit?
- You *are* doing a physical exam
- You might actually get more information than in an office visit
  - It is about actionable information.
  - MyChart signup is required to access the visit

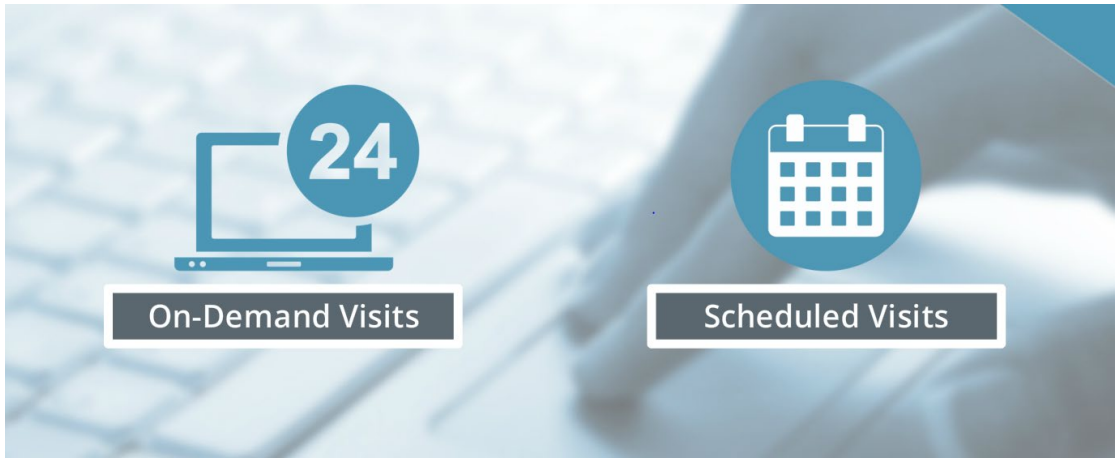
TELADOC

Jefferson

NEWS RELEASE

11/12/2018

Jefferson and Teladoc Introduce First Telehealth Fellowship

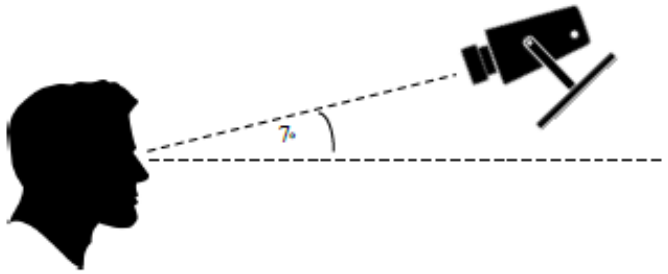


HIPAA-compliant telehealth solutions for ambulatory care: TytoCare, AmericanWell, Teladoc, Zoom, Vidyo .

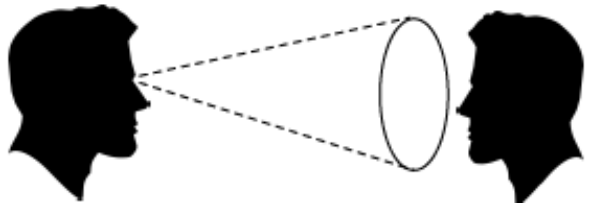
You Can Examine the Patient…

- **Webside** manner
  - Eye contact
  - Webcam positioning/tablet/ I phone(tripod)
  - Patients don’t want UTN view!
  - EHR positioning
  - Lighting tips
  - Illuminate your face
  - Background

Camera Position



Cone of Gaze



- Patient interface : via My chart app for scheduled visits
- Physician interface is via Epic : Haiku/Canto on mobile phone/tablet.

‘Web side’ Physical Exam: On Camera Appearance

- **Vitals signs:** Self-reported or observed on camera via a BP monitor, weight, temperature.
- **General:** Distressed, sick, healthy appearing, flushed, observe gait.
- **HENT :** Camera lit nasopharyngeal exam, assess for oral ulcers, plaques, thrush.
- **Lung :** Respiratory rate, effort of breathing, intercostal retractions, use of accessory muscles, nasal flaring, wheezing with breathing, coughing.
- **Cardiac**: BP monitor pulse check or if available “smart watch” for pulse, rhythm
- **Abdominal**: Distension, assess surgical incision for bruising, drainage, and integrity. Assess peritoneal catheter site. Look for umbilical or ventral hernia. Patient or family assisted palpation for tender points.

‘Web side’ Physical Exam: On Camera Appearance

- **Extremities:** Color, ulcers, patients assisted exam of arteriovenous access (observed pulsations and self-reported thrill), evaluation of pedal edema with patient or family’s help. Ask to remove shoes and socks to check feet and nail hygiene.
- **Musculoskeletal:** Assess for range of motion or joint swelling.
- **Skin exam:** pallor, icterus, rash characteristics: macular, papular, vesicular, or nodular. Pictures can be sent on HIPPA compliant portal.
- **Neurological:** Alert, awake, orientation. Assess for tremors
- **Psychological exam:** Mood, behavior, attention span, agitation, demeanor.

Common Misconceptions

- My patients don't want it
  - Many do & many like it better than in-person visits
- It is not as good as an in-person visit
  - But it's better than no visit or a phone call!
- You can't examine the patient
  - Does much better than no visit or a phone call
- It is not reimbursed YET (pre-COVID)
  - Neither is no visit or a phone call
  - Reimbursement is changing
- It is too hard
  - You do it with your family all the time….

Expanding Health Care Access: COVID

- Removal of traditional boundaries to health care delivery during COVID-19 crisis
- **1135 Waivers**
  - Issued pursuant to Section 1135 of Social Security Act
  - Increase access to medical services during national emergency by allowing waiver of administrative requirements under federal law
  - Requires Presidential declaration of emergency
  - Requires declaration of public health emergency by HHS Secretary

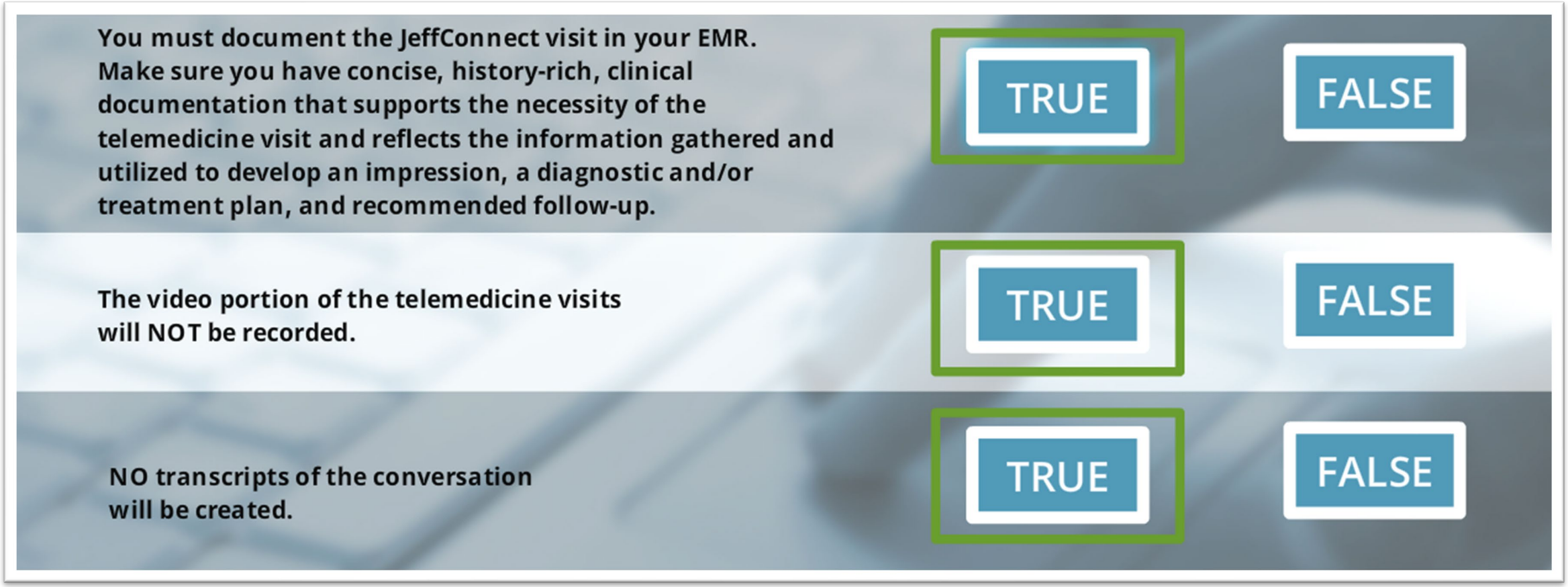
CARES ACT

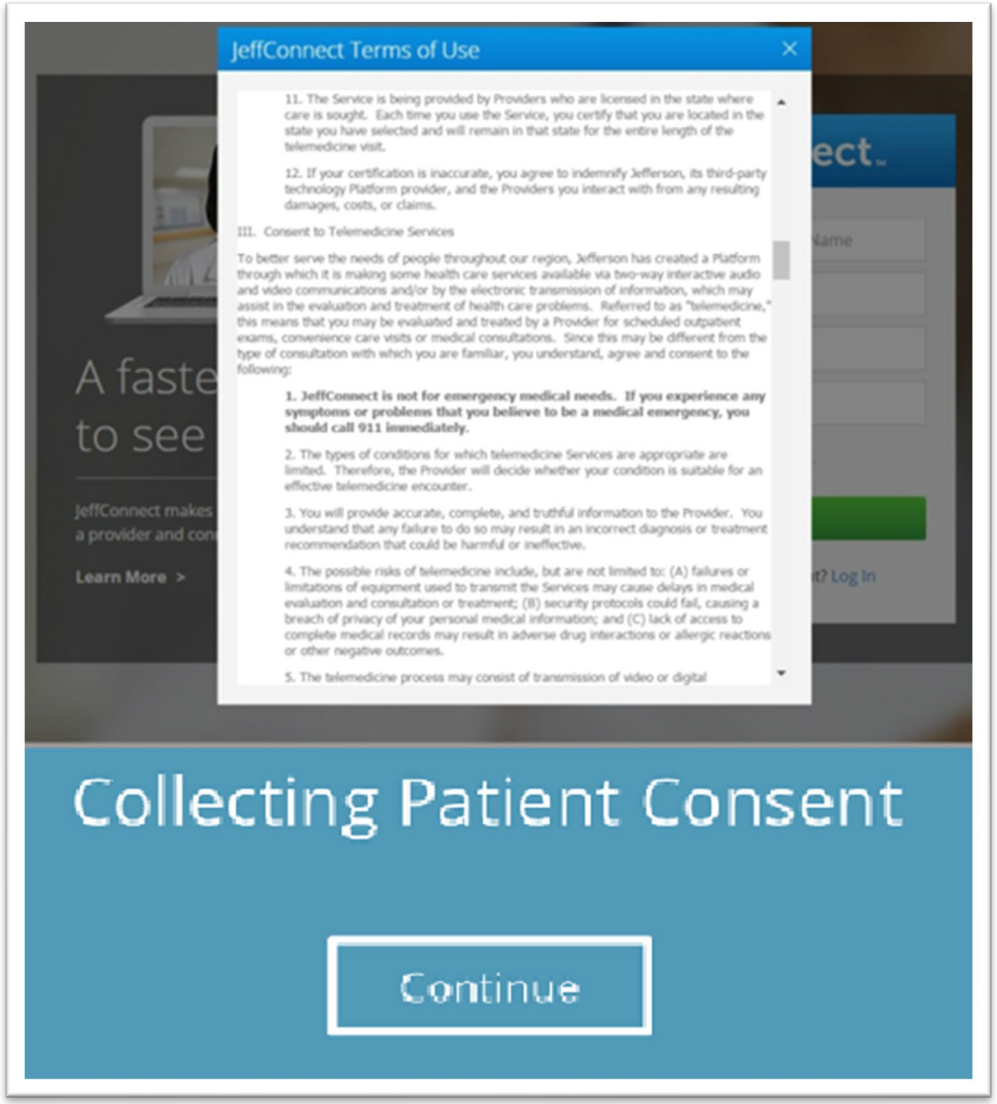
- Under Coronavirus Aid, Relief, and Economic Security (CARES) Act**, licensures, telemedicine reimbursements and supervision roles** were given some leniency.

- Wall Street Journal reported that Medicare telemedicine visits increased from 100,000/week to 300,000/week as of March 28, 2020 and the CMS Administrator called telemedicine a “clear example of untapped innovation”

- The COVID-19 pandemic was an unfortunate yet effective catalyst to address two major roadblocks to telemedicine adoption**: consumer willingness** to try new care deliver models and **insurance coverage** for providers and institutions for these visits.

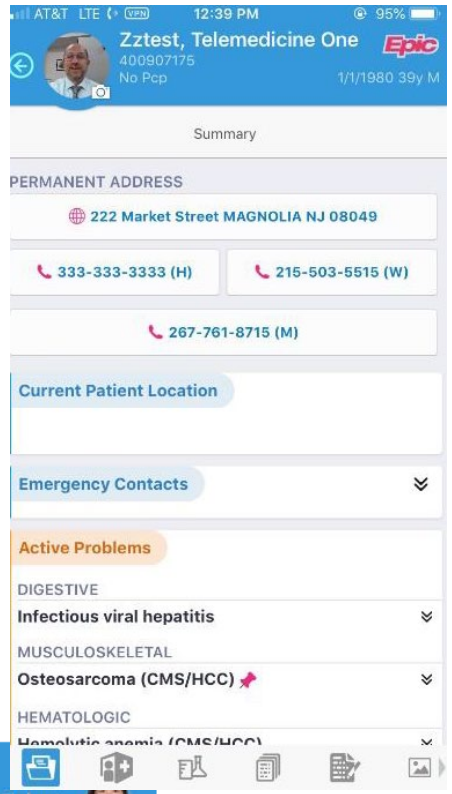
Fact or Myth?

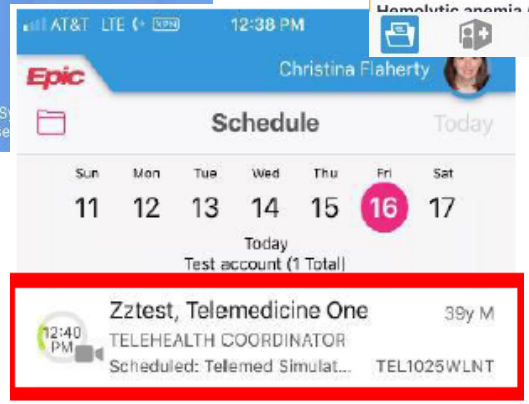

You must document the JeffConnect visit in your EMR. Make sure you have concise, history-rich, clinical documentation that supports the necessity of the telemedicine visit and reflects the information gathered and utilized to develop an impression, a diagnostic and/or treatment plan, and recommended follow-up.
TRUE
FALSE
The video portion of the telemedicine visits will NOT be recorded.
TRUE
FALSE
NO transcripts of the conversation will be created.
TRUE
FALSE

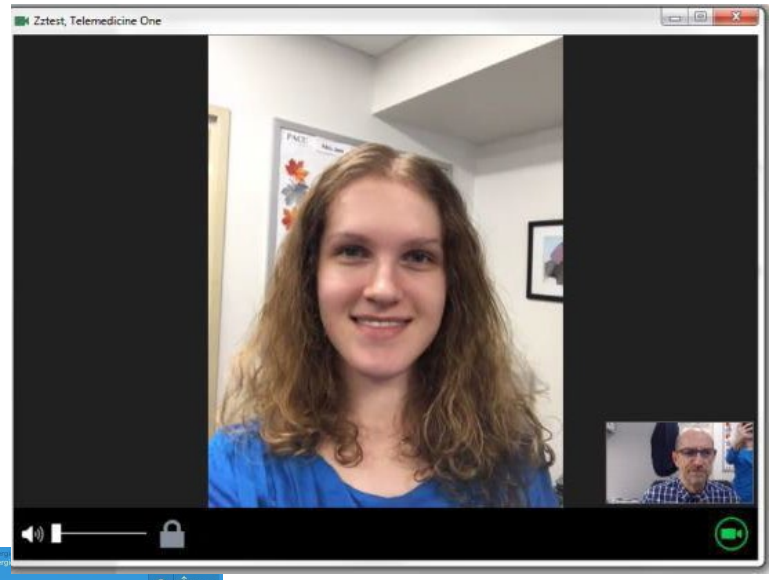


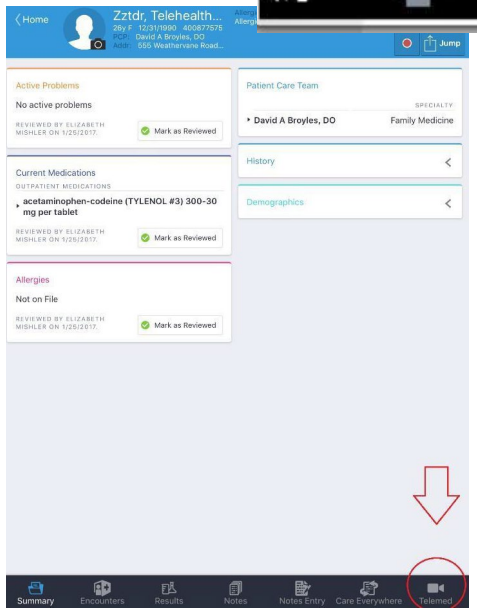
Do
Have access to your EMR during the visit, so you can document it.
Be in a room/area that looks professional.
Use a room/area that ensures patient privacy, i.e. has a door.
Don't
Be in a public area where others can overhear the conversation.

Provider Workflow

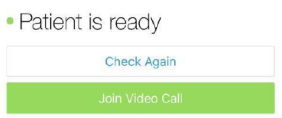








Step 5: When button turns green and says "Patient is ready" Tap "Join Video Call". Do not join before patient is ready



Polling question 2

- _____% of US adults own a smart phone.

1. 35%
2. 81%
3. 69%

https://www.pewresearch.org/internet/fact-sheet/mobile/

Workflow for Donor Evaluations: Pre COVID-19

- Remote donors, after health assessment document review and basic labs
- Local PCP check off done
- Transplant nephrologist Telehealth, SW phone call, dietician, ILDA phone call
- If acceptable full studies locally followed by donor surgeon telehealth visit
- Discuss in donor meeting, recipient readiness evaluated, provisional surgery date
- Donor flies into Philadelphia 7-14 days before for PAT, in person evaluation.
- In COVID era: look for any previous data in Care everywhere, look for letters from PCP, telehealth with DONORS, hold off on studies for now. Very promising donors can still have coordinator/ILDA/dietician etc. do videoconferencing. Decide on next steps based on weekly secure ZOOM multidisciplinary team meetings
- **Work is cumulative**, with live donor cases put on hold, best for the transplant staff and physicians to try and engage patients via telehealth to minimize work buildup.
- Use this as a **Business continuity plan during CRISIS management**.

Telehealth Medicine: A Novel Tool to Make Living Donation Simple & Financially Neutral

Anju Yadav MD, Maria P Cantarin Martinez MD, Pooja Singh MD
Thomas Jefferson University Philadelphia, PA
Accepted at ATC 2020 Poster

- Live donors may have to spend up to $5000 for various direct and indirect costs.
- Telehealth Live donor evaluations between Jan 2016- Nov 2019:
  - **Telehealth evaluations for remote potential donors 19**
  - **Kidney donations 12**
  - Median time to donor surgery was **68 days** (IQR 29-234 days).
  - Donors reported high satisfaction rates, lessened financial burden and travel needs.
  - Seven potential donors: ineligible or aborted plans to donate based on education.
- Utilize telehealth for remote live donors, to lessen financial disincentives and more importantly to avoid delays in donor work-up.

Workflow for Post-Transplant Visit: Pre COVID-19

- Pre COVID: labs prior, target patients who live away from transplant center, at patient request, for the frequent ‘no show’ patients.

- Coordinator typically will call patient before appointment and document :

1. *Update Medication list*
2. *Refills*
3. *Weight/BP reading*
4. *Confirm labs in Epic and any issues and document a note*

Workflow for Post-Transplant Patients: Post COVID-19

- Telehealth visit /telephone/in person for brand new patients with clinic performed labs
- Do COVID screen, avoid screen + patient to clinic. Direct to Jefferson drive through Testing areas. Call ER for prep if patient being sent.
- Labs will be done 3-4 days prior at LabCorp or Quest : go at non-peak time, avoid public transport (mobile blood draw option).
- As per institutional guidance, the transplant department identified super users that were trained in ensuring patients were “telemedicine ready”, provided technical assistance to patients and then conducted a trial session with each patient.
- Clinic will be covered by a designated In ‘Person Attending’ and ‘Telehealth Attending’.
- Chart prep by post coordinator or MA (previous slide).

Workflow for Post-Transplant Patients: Post COVID-19

- If telehealth system is not operational @ visit, convert to phone call and document a note.
- Whenever possible, labs will be drawn at Nicoletti Kidney Transplant Center, where in person follow up is being done (new)
- *DGF patients will need a same day lab and an in-person visit*
- Patients called by our front desk staff to book next appointment (simulate in person experience). MD explicitly specifies next visit interval.

<u>Patients educated regarding telehealth visit or prep</u> :

- The phone call for prep may come from an unknown phone number(many coordinators working from home and using *67)
- Log in on time and wait for the physician to log on, physicians may be backed up or having technical issues; ensure to have mobile handy.

Workflow for Transplant Evaluations: Post COVID-19

- Do partial evaluations via telehealth: 'AGILE LISTING MODEL'
- Pre coordinators are calling patients in advance and offer telehealth conversation
- Coordinator does consent and education via phone and now via password protected ZOOM. Links to educational video sent. We are actively seeking an **E consenting** option.
- Coordinator reviews medical/surgical/family/social history, allergies, medications, height/weight and record as self reported.
- If pre-emptive, patients are encouraged to complete minimal labs for potential inactive listing until they are able to complete testing. List of studies plus blood work to be done provided.
- Review available data in care everywhere to see prior work-up.
- Expedite those with live donors.
- Book future appointments as telehealth.

Billing for Telehealth: Pointers

- The CPT codes are the usual codes for outpatient visits; 99201-99205 and 99212-99215 (**no consult codes**).
- Providers should document and select New or Established CPT codes as they would for an in-person visit. CPT **99211** is **not billable**(only 5 min & physician not needed)
- The TELEMEDICNE visit type NEW or ESTABLISHED **MUST** be selected in order for logic to work behind the scenes in Epic.
- Providers telehealth visits use regular LOS/E&M codes.
- **COVID related billing details are constantly changing and evolving.**
- **Payors will adjust claims accordingly, Medicare is covering.**
- **Federal guidelines on use of non-compliant video platforms for COVID response need clarification.**

Telephone Encounters

- Telephone visit should be documented in the medical chart.
- Minimal required documentation elements include:
  - Patient consent to a telephone visit (note that the encounter was held via telephone).
  - Chief complaint or reason for telephone visit
  - Relevant history, background, and/or results
  - Plan and Assessment (medical decision-making)
  - Appropriate diagnoses
  - **Total time spent** on medical discussion and evaluation of the patient
  - Total time spent providing **counseling** to the patient
  - Any additional items related to the telephone visit (e.g., prescriptions, laboratory or diagnostic test orders, referrals, follow).

Billing for Telemedicine/Telephone Calls in Epic

- Code 99441 (5-10 min), 99442 (11-20 min) and 99443 (21-30 min): compliance check.
- Fact that visit performed by telephone and the time should be stated in NOTE.
- If the video works – you bill using the usual E&M codes.

Visit Type	Connection Technology	Connection Description	Encounter Conversion Workflow	Billing
Telemedicine New/Established/ Post-Op	Video	Successful video visit	Automatically checked-in when patient connects	Typical E/M level 1-5 (with modifier added)
Telemedicine New/Established/ Post-Op	Telephone	Interrupted/failed video visit resulting in audio visit	Manual check-in & documentation	99441/99442/ 99443/99024
Telemedicine New/Established/ Post-Op	None	Unsuccessful	N/A	No Charge
Telephone Call New*/Established	Telephone	Successful audio visit	Manual check-in & documentation	99441/99442/ 99443/99024
Telephone Call New*/Established	None	Unsuccessful	N/A	No Charge

Telehealth Across State Lines

- Jefferson Executive Leadership approved physicians and APPs prioritizing patient care and utilizing telehealth across state lines for their **established patients only** during the COVID-19 national emergency.
- Election to treat cross-border patients in a state where you do not hold a license is voluntary. In the event you provide such care, please note in the patient's record that the visit is being conducted via telehealth for continuity of care during the COVID-19 national emergency.
- Therefore, there remains some level of risk from a state licensing board and malpractice coverage perspective.

Technical Support Challenges for Telehealth

- Visit volume has grown from 50 visits/day to 3000+ visits daily
- System capacity – concurrent connections limited to 15, NOT ANYMORE!
- Telehealth Coordinators don’t have capacity to support the increased volume.
- Long phone delays.
- Rapid expansion and switch to Teledoc sync with Epic, aim for unlimited **concurrent sessions.**
- Dedicated staff to instruct individual practices on self-sufficiency.
- MyChart Instant Activation options being explored.

Telemedicine as a Growth Strategy

- Does it solve a strategic problem (unmet need)
- This is major growth strategy
- Bring care to patient not patient to care
- If you want first mover advantage
  - Build it and they will come
  - Impossible to dot every i and cross every t, but we try!!
  - Don’t wait for payment reform.

Second Health Crisis ?

- Care that was not delivered or was avoided because of cancelled surgical cases, closed preventative health clinics, and strong avoidance of healthcare institutions
- Moving forward, as healthcare institutions navigate this “new normal,” we cannot expect that patients will be ready and willing to visit healthcare providers in person as the threat of COVID-19 is still present.
- A **hybrid model** of **telemedicine and ambulatory visits** will enable organizations to provide the best health care not only to transplant patients, but all consumers of the healthcare delivery system during these unprecedented times

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Virtually Perfect? Telemedicine for Covid-19

Judd E. Hollander, M.D., and Brendan G. Carr, M.D.

Perspective

"Commercial reimbursement, Medicaid reimbursement, and credentialing are the states' domain.

Only 20% of states require payment parity between telemedicine and in-person services.

Both CMS/ Medicaid Services and some local commercial payers have modified payment policy in response to Covid-19. "

Discussion

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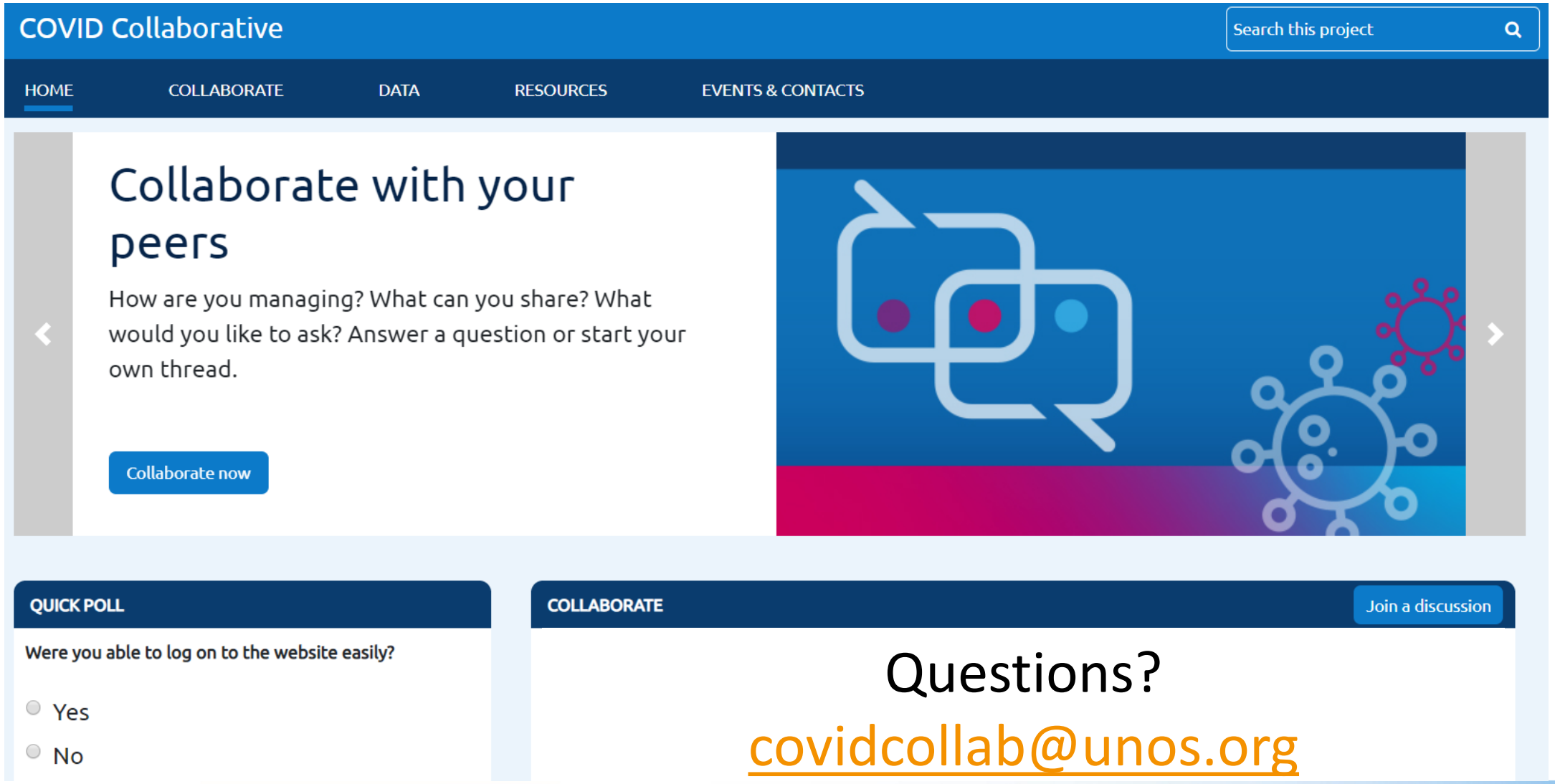

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