

**AHRQ National Web Conference on the Role of Telehealth
to Increase Access to Care and Improve Healthcare Quality
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**“Comparison of Asynchronous Telepsychiatry vs. Synchronous Telepsychiatry in Skilled
Nursing Facilities (CATEleST): A Preview”
Presented by Glen Xiong, MD
University of California at Davis**

QUESTION: Is the data about satisfaction in telepsychiatry seen in studies with adults, pediatrics, or both?

ANSWER: It is with both - satisfaction for pediatric patients are from their parents.

QUESTION: How would a hybrid ATP/STP model compare?

ANSWER: This is a great question. This needs to be studied, but it is likely the future. A flexible system where in-person, STP, and ATP that is adapted based on patient preference and clinical indication is the ideal. The current reimbursement structure favors in-person care, which unfortunately creates an unintended barrier to care.

QUESTION: What types of administrative barriers can be attributed to the underutilization of STP?

ANSWER: Scheduling appointments between the patient/receiving and treatment end. ATP removes the layer to coordinate the schedules. The patient can get care irrespective of when the psychiatrist is available. The psychiatrist can deliver care irrespective of patient's availability. The ATP interview flexes schedule based on patient preference. This is more patient centered!

QUESTION: How do you conduct the interviews in an asynchronous visit?

ANSWER: This interview can be done in-person (as presented) or via video (during the pandemic).

QUESTION: Did your interview(s) include a screening instrument?

ANSWER: Yes. We use a MINI interview as a guide but also other questions that is specific to nursing homes with more focus on function.

QUESTION: Are ATP services covered by insurances? My understanding is telehealth has to be real time to be covered.

ANSWER: This is being worked on, but ATP is mostly not covered. Legislation is favoring asynchronous care.

QUESTION: Are there any specific clinical conditions or patient populations that are more suitable to telepsychiatry visit (if cost is not a consideration)?

ANSWER: Most conditions can be treated. Imminent danger to self and others would be the main contraindication. But assessment of such are not necessarily contraindicated.

QUESTION: Are there any studies looking at the effectiveness of the Adverse Childhood Experiences screening tool used in the telehealth setting?

ANSWER: Not that I'm aware of.

QUESTION: How was the scheduling of appointments handled? Were you using a scheduling solution that integrates with your EHR?

ANSWER: For the study, we do it manually because the volume is not overwhelming, as participants need to be consented into the study. In practice, automated app-based scheduling would be ideal.

QUESTION: Was your ATP evaluation or therapy? If it was treatment, was it mostly pharmacological or psychological?

ANSWER: The ATP evaluation is primarily focused on diagnoses and pharmacological therapy. In many cases, the ATP therapists have social work backgrounds and are trained to provide supportive therapy.

QUESTION: Was the amount of time for patient visits the same for synchronous/asynchronous visits?

ANSWER: It is generally shorter for asynchronous on the psychiatrist side. We will need to compare the actual ATP video time.

QUESTION: Are there any examples of asynchronous telemed in non-psychiatric practices?

ANSWER: Any use of stored clinical data would be an equivalent to “async video” review. Examples may include x-ray for radiologists, photo for dermatologists, or echocardiogram for cardiologists.

QUESTION: Much telehealth research has focused on feasibility, satisfaction, and patient outcomes. Could the panelists please comment on what is known about how telehealth affects collaboration among members of interdisciplinary care teams?

ANSWER: There’s not enough research on how telehealth improves collaboration. Our primary care found that primary care doctors used ATP consult reports to make medication changes, as well as using STP reports. This is specific to collaboration using the traditional medical records communication format.

QUESTION: Please address integration of interpreter services in telemedicine.

ANSWER: ATP is ideal for this since the ATP interviewer may conduct the interview in the preferred language. The video can be translated using voice or caption as the video is replayed. This is another advantage of ATP and we are actively studying this.

QUESTION: What is the pitfall of telehealth moving forward?

ANSWER: Uncovering clinical conditions where telehealth is not clearly indicated. Thus far, technology barriers, such as bandwidth and access to smartphones, are the main barriers. In order to provide equitable access to care, access to the telehealth platform then becomes another priority for health.

QUESTION: Any data, thoughts, or opinions about the impacts in these various care spectrums on ePrescribing?

ANSWER: ATP and STP consults will still require a prescriber to provide eRx.

“Impact of Telemedicine on a Chronic Disease: Rheumatoid Arthritis”

Presented by Elizabeth D. Ferucci, MD, MPH

Alaska Native Tribal Health Consortium

QUESTION: Any tips for documenting the physical findings with telemedicine?

ANSWER: Think about everything that you observe and what it can tell you about the patient’s overall status. For example, the “General” section of the physical exam often doesn’t have much detail, but you can observe respiratory status, ability to get up and move around, comfort level, and facial expressions, all of which can give important clues about someone’s health and functional status. For the musculoskeletal exam, we document what we are and aren’t able to observe in as much detail as possible (for example, swelling was clearly present in the 2nd and 3rd MCP joints of the right hand, but I was unable to determine whether swelling was present or not in the MTP joints of the feet). I also recommend documenting how what you observe corresponds with what the patient is telling you (for example, subjective vs. objective findings in specific joints).

QUESTION: How limited in the physical exam have you felt using the untrained presenter?

ANSWER: It is definitely not as good as in-person or using a trained presenter. Having said that, an important concept is

that physical exam in the traditional sense is not always the only important component of a clinic visit. I always recommend focusing on what you can do well, such as spending more time listening to the patient and providing education, and not focusing too much on what you can't. I don't see telehealth as a complete replacement for in-person visits due to the limitations of physical exam, but there is a lot that we can do to improve health.

QUESTION: Are there studies looking at telemedicine vs. in-person for evaluation and initial visits?

ANSWER: As I mentioned in my description of tele-rheumatology literature, there are very few published studies in rheumatology and most of them addressed the followup phase of care. A few studies have assessed tele-rheumatology for initial visits. The systematic review citation is as follows:

McDougall JA, Ferucci ED, Glover J, Fraenkel L. Telerheumatology: a systematic review. *Arthritis Care Res.* 2017; 69:1546-57. doi: 10.1002/acr.23153. [Epub ahead of print] PMID: 27863164

QUESTION: How many questions were included in the telephone survey? How many minutes did it take to complete?

ANSWER: We had two different surveys completed by telephone for this study. The disease activity measure (RAPID3) includes 15 questions, and the telemedicine perception survey includes 12 questions for patients never seen by telemedicine and 15 questions for those who have used telemedicine. Each survey took approximately 5 minutes to complete, though this varied by participant.

QUESTION: Can you provide a citation for the telehealth perception tool administered in your study?

ANSWER: We created the survey based on several different resources. The survey questions are presented in Figure 1 in our publication in *Arthritis Care and Research*. The citation is as follows:

Ferucci ED, Holck P, Day GM, Choromanski TL, Freeman SL. Factors associated with use of telemedicine for follow-up of rheumatoid arthritis. *Arthritis Care Res.* 2019 Aug 17; doi: 10.1002/acr.24049. [Epub ahead of print] PubMed PMID: 31421020.

QUESTION: The presenter mentions that "any" disease could involve telemedicine, though most prevalent was RA. Is there any disease where telemed is not advisable? Projecting forward, is the future of medicine for visits to be largely telemedicine or only in areas with shortage of practitioners or rural areas?

ANSWER: As a general rule, any disease is eligible unless in-person physical exam is critical for decision-making at this visit, or tests or treatments are needed that cannot be delivered in the home or home community. So, the decision is based less on a specific disease and more on what is needed at the time of this visit.

Projecting forward, telemedicine has expanded dramatically due to the COVID-19 pandemic and it is unlikely to go away. We have started using it for patients in more urban areas and we have had positive feedback, as they also appreciate not having to come into the clinic for every visit.

QUESTION: What is the scheduling barrier you experienced?

ANSWER: Scheduling live video visits clinic-to-clinic requires more coordination than scheduling an in-person visit. It requires coordination between the patient, the remote clinic, and the specialty clinic, so it adds another element to the complexity of scheduling. This is not an issue for direct-to-patient telehealth visits or for the use of asynchronous telehealth.

QUESTION: In the COVID19 shift you mentioned, did you detect changes in patient acceptance of telehealth?

ANSWER: We have not done a formal assessment yet from a research perspective, but anecdotally we found much higher levels of patient acceptance in the clinic setting.

QUESTION: Could physical exams be performed without a trained presenter in the majority of patients? Would you please provide an example of a scenario that would undoubtedly require this service?

ANSWER: As above, the physical exam is somewhat limited without a trained presenter, but we are able to get useful information in most cases. An example where we prefer an in-person exam is in a patient with multiple reasons for joint pain, such as rheumatoid arthritis and fibromyalgia. In that case, in-person exam or the use of a highly trained presenter

is needed to distinguish inflammatory arthritis (RA flare) vs. non-inflammatory pain (fibromyalgia).

QUESTION: Can you discuss the challenges of sexually transmitted infections and pregnancy ascertainment via telehealth as well as any ways to overcome challenges?

ANSWER: Some of the challenges in this setting may be related to privacy concerns, as well as the need for specialized tests that need to be performed. For STI testing, there is a home testing program in Alaska called "I Want the Kit," which can help with obtaining the tests in a remote location. I am less familiar with management of pregnancy by telehealth, but certainly home testing can be valuable in ascertainment and telehealth can be incorporated in the management of pregnancy.

QUESTION: Could you please explain what you meant by more active disease?

ANSWER: Disease activity is a concept that relates to the amount of ongoing inflammation of the joints in RA. There are a variety of different disease activity scoring systems endorsed by the American College of Rheumatology. For this project, we used the RAPID3, which is fully patient reported.

QUESTION: When you list "pros" of less travel and less expense, is this patient travel/expense or provider?

ANSWER: This depends on your local context and who is paying for travel. In our setting, some travel is paid for by Medicaid and some is by the patient, so avoiding travel could lead to savings for the payer or the patient.

QUESTION: Please address integration of interpreter services in telemedicine.

ANSWER: I do not have experience using interpreters in telemedicine, but this could be done by having the interpreter join the "room" remotely, as most platforms allow for more than two participants in the virtual room.

QUESTION: Much telehealth research has focused on feasibility, satisfaction, and patient outcomes. Could the panelists please comment on what is known about how telehealth affects collaboration among members of interdisciplinary care teams?

ANSWER: I am not aware of research in this area, but in the clinical setting, it has been used in several ways to facilitate interdisciplinary care. Some examples I am aware of are in palliative care (including different providers and family members in different locations in one virtual room), specialist visits with primary care provider and patient together in the room, and tele-ICU.

QUESTION: How was the availability of the telemedicine option communicated/socialized with the RA patients, and did you see any difference in the acceptance rate in men vs. women?

ANSWER: This option was communicated to patients by clinic staff scheduling followup appointments, as part of usual care. Since this component was not part of research but rather clinical care, we did not assess acceptance by gender. However, we found no statistically significant difference in the proportion of male vs. female patients when we compared those enrolled in our study who were seen by telemedicine vs. in-person only.

QUESTION: Do you find that Alaskans are more accustomed to being open to alternative methods of health care because of the geographic challenges to seeking care, or do the cultural barriers make it more difficult?

ANSWER: The geographic challenges are more extreme and in general, people are more open to other solutions to avoid travel than they might be in other settings. We have asked about cultural considerations in telemedicine, and most people have said it can be culturally appropriate as much as in-person care, as long as the providers are culturally competent.

QUESTION: What is the pitfall of telehealth moving forward?

ANSWER: One of my concerns is that there may be a call to replace in-person care with telehealth. I don't think that is realistic and feel that despite all of its benefits, there are some limitations inherent to telehealth. In rheumatology, our biggest limitation is in the initial consultation and diagnosis phase of care.

QUESTION: Any data, thoughts, or opinions about the impacts in these various care spectrums on ePrescribing?

ANSWER: There have been some concerns about over-prescribing medications in the setting of urgent care telehealth

visits. In chronic disease care, this is less of a concern. In general, ePrescribing would be the preferred method of prescribing medications when patients are seen by telehealth, though this is the method most commonly used in in-person care as well.

Telemedicine to Reduce Disparities in Primary Care
Presented by Kenneth M. McConnochie, MD, MPH
University of Rochester Medical Center

QUESTION: Is there data on the total cost of delivery of telemedicine vs in-person, since this would involve provider time, other non-clinician time, cost of equipment, and rent of space at clinical (remote or in-person) locations?

ANSWER: There are multiple stakeholders involved in the delivery and receipt of healthcare. Stakeholder groups include patients, providers, provider organizations, payers, and society as a whole. Responses to this important question vary with the stakeholder group. It is important to consider time, and intangibles (such as anxiety reduction) as well as dollars in an economic assessment when comparing telemedicine visits vs. in-person visits. Assume that reimbursement for a telemedicine visit is equal to that of an office visit. Assume also that the telemedicine model used is the one I described in my presentation (“information rich”). I should emphasize that this model not only includes history and physical exam, but also real-time video interaction with the patient and caretakers (e.g., parent, child-care or school staff).
Provider organization: Loses much money when an ED visit (~ \$800) is replaced with a telemed visit (~\$80).

Patient and caretaker/parent: Much less wait time, actual visit takes about the same amount of time. Less time lost from school, childcare, work.

Provider: Visit takes less time because physical exam observations (e.g., ear images, throat image, lung sounds, skin images) have all been collected.

Society: Gains from greater parent/caretaker productivity, greater provider productivity, less school absence.

QUESTION: Are you concerned with the loosened regulations for telemedicine in response to the COVID-19 pandemic as this may relate to possible HIPPA concerns, as well as fraud?

ANSWER: I am very concerned about quality (especially diagnostic accuracy) delivered by a telemedicine model that does not enable the physician to gather the clinical information required for high-quality care. Accurate diagnosis is essential for effective intervention.

QUESTION: Any data, thoughts, or opinions about the impacts in these various care spectrums on ePrescribing?

ANSWER: Accuracy of diagnoses depends on ability to acquire information that supports diagnostic decisions and treatment plans. ePrescribing can only be as useful/appropriate as the diagnosis is accurate. Our published research comparing both an in-person diagnosis and a telemed diagnosis with the diagnosis of a second exam done in person (using the second exam as the “gold standard”) indicates that reliability of telemed exams is at least as good as in-person exams. Based on my personal experience, I strongly believe that telemed ear exams are MORE reliable than in-person ear exams.

QUESTION: What type of care provider was used on the patient end of the telemedicine visits?

ANSWER: We trained onsite childcare staff and school staff to be telemedicine assistants (TAs). We also trained individuals to be “roaming TAs.” These people traveled from one child site to another as requests for telemed visits arose. Some TAs had prior experience as home health aides, LPNs, or RNs. We developed a training program (6-8 hr.) and training manual to ensure quality of care provided by these individuals.

QUESTION: Have there been any efforts to re-educate patients, so they understand the benefits of telemedicine versus in-person visits?

ANSWER: Some of the childcare programs held parent meetings to introduce telemedicine to parents. Our staff participated in these meetings.

QUESTION: Were nurse practitioners and physician assistants conducting telemedicine visits in your practice?

ANSWER: Nurse practitioners conducted over 80% of telemed visits. A physician was always available for backup.

QUESTION: Do you know now after implementing telemedicine - what was the asthma admission rate for suburban vs inner-city pediatric patients?

ANSWER: The asthma admission rate for inner-city children was reduced to the same rate as for suburban children.

QUESTION: Is the telemedicine equipment at the "child site" purchased specifically for telemedicine visits? Or is that a computer monitor that can be used as a regular computer?

ANSWER: A regular computer monitor was used for telemed visits. The computer can be either a desktop or laptop.

QUESTION: Do you think image studies will become better than in-person observation? For example, the ear exploration showed in the slides extended to physical exploration in general.

ANSWER: My opinion is that ear images, as obtained with the Welch-Allyn electronic otoscope, generally are more useful than the usual in-person exam with a hand-held otoscope. Of course, one could use the electronic otoscope during in-person exams.

QUESTION: Can you expand on the attitudes toward telehealth being an inefficient care delivery model for primary care?

ANSWER: Regarding *illness* visits in primary care, telehealth can be very EFFICIENT if one employs a care model, such as ours, that is "information rich," i.e., that includes all the equipment we used. Equipment we used included: video conferencing camera; high resolution camera for ear, throat, eye, and skin exam; electronic stethoscope for lung and heart exam; rapid Streptococcal antigen test; capacity to send skin cultures (e.g., fungal) to microbiology lab.

QUESTION: Much telehealth research has focused on feasibility, satisfaction, and patient outcomes. Could the panelists please comment on what is known about how telehealth affects collaboration among members of interdisciplinary care teams?

ANSWER: Telemedicine could facilitate interdisciplinary collaboration. For example, if I am not confident of diagnosis or management of a skin condition, I can send skin images to dermatologist. I am not aware of any studies relating to interdisciplinary collaboration, however.

QUESTION: Please address integration of interpreter services in telemedicine.

ANSWER: Multi-way videoconferencing (readily accomplished with Zoom) would enable interpreter services, including sign language for hearing-impaired patients.

QUESTION: What is the pitfall of telehealth moving forward?

ANSWER: Two key obstacles: (1) failure to understand the strengths and limitations of different telemed models and (2) failure to use an "information rich" telemed model, such as the one we evaluated.