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NCTRC September Webinar-(Zoom)
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>> Nicki: Good afternoon, I'd like to say hello and welcome to the latest presentation in the National Consortium of Telehealth Webinars series. Telehealth Implementation: A Guide and Case Study for Critical Access Hospitals. These webinars are designed to provide you timely information and demonstrations to support and guide the development of your telehealth programs.

These webinars are presented on the third Wednesday of every month.

We, the NCTRC is HRSA-funded. We are part of 12 regional telehealth resource centers and two national, as I mentioned, we're the northwest regional. We serve that blue, upper left-hand corner of the United States.

There are eleven other regional TRCs that are represented by color and geographic region.

We also have two national centers that serve on policy and technology. They each serve as focal points for advancing the effective use of telehealth and supporting access to telehealth services in rural and underserved communities.

A few housekeeping tips before we get started. Your phone and/or computer microphone and video has been muted. If, for some reason, we don't answer your question today, please contact your regional Telehealth Resource Center.

Please fill out the post webinar survey, that helps us identify the needs and topics you want further discussion on. Closed captioning is available today. Please submit your questions during the session, using the Q&A function.

We do have staff to be answering those as we go. This webinar is being recorded. And the recordings will be posted to our YouTube channel at the site here.

So, today's webinar is Telehealth Implementation: A review of a guide and case study for Critical Access Hospitals. We have three speakers today. Victoria Leach oversees 45 cooperative state agreements to partners, supporting 1350 Critical Access Hospitals nationwide in quality improvement, quality reporting, performance improvement and benchmarking to assist facilities seeking designation as Critical Access Hospitals.

And to create a program to establish or expand the provision of rural emergency medical services.

She also serves as program coordinator for the Technical Assistance and Service Center, TASC, cooperative agreement with the National Rural Health Resource Center.

She provides tools to individual state TASC programs. She's a Peace Corps volunteer. She graduated from Union College with a degree in biology and literacy studies. Thank you for joining us today, Tori.

We also have Trudy Bearden. She served as senior consultant since 2010. Leveraging her experience as a clinician in the primary care and in-patient settings to provide consulting and practice facilitation to Health Care organizations across the country and beyond.

Miss Bearden provides technical assistance on a broad range of topics, issues, working with teens to improve quality, safety and efficiency.

She has strong expertise in telehealth, quality improvements, care management, population health, EHR workflow optimization and change management.

Miss Bearden has led the Telehealth Response Team to pivot to support telehealth in virtual implementation. She's worked with primary care associations and health center-controlled networks across the country, as well as within the Northwest Regional Telehealth Resource Center. The University of Utah, Idaho Department of Health and Welfare and many others to support health.

Tressa Keller has worked at Logan Health in Shelby for ten years. She's born and raised in Shelby, Montana. She attended Montana Tech where she received her Bachelors and Masters in Health Care informatics.

I'll hand it to Tori to start us out today.

>> Hi, welcome everyone. My role today will be to provide a centered perspective on this great resource we've provided for you all. Next slide, please?

As a background to those who may be unfamiliar with the Flex Program, it's designated by section 1820 of the Social Security Act, which asks state designated entities, Offices of Rural Health to engage in implemented rural Health Care plans and networks, to designate Critical Access Hospitals and providing support for quality improvement, quality reporting, performance improvement, benchmarking and educating rural emergency EMS services.

As you can see on this slide, we have 45 state flex programs and those are within states that have Critical Access Hospitals as designation.

And you can see the major categories on the left-hand side, which we engage in activities, such as quality, major migrational population health, rural EMS and I hyperlinked our state flex profiles on the slide here. You can look up a state if you're interested and see what that program is engaged with.

Like I mentioned, this program is primarily to support Critical Access Hospitals and we noticed that a huge missing area was connection to telehealth. Especially during the public health emergency where telehealth has been a major source of care in rural areas.

We wanted to provide a guide that would help engage Critical Access Hospitals in how to implement telehealth programs within their facility.

We provide resources and tools to support Critical Access Hospitals and state flex programs.

On the next slide, you'll see my contact information and that's where you can reach me with any questions regarding state flex programs or the National Rural Health Resource Center.

I'll now turn it over to Trudy.

>> Nicki: Trudy, I believe you're muted --
>> Trudy: Yes, you'd think by now, right? So, today, we've gone through our introductions, we're going to take a quick walk through the CAH telehealth guide, we're going to open it up for questions or comments and then hear from a critical access hospital about their telehealth implementation.

We're going to talk a little bit about how this whole thing got started. How we developed the content. While we go through this, we want to open it up to any and all feedback. Cost, telehealth guide 1.0. We know there's going to be a 2.0.

So, we really solicit feedback, heartily. Please let us know if you come upon errors or missing things, just let us know and... in case you haven't had a chance to see it, I'm just going to pass a link to the guide, right there.

And so, we'll take -- we'll look at the table of contents. The guide has a hyperlink table of contents. It's rather difficult to demo an 88-page guide.

We're happy about a page we've put together. We'll show you the telehealth program assessment as well.

So, it was a partnership that got us started. The National Rural Health Resource Center, or the center, had this vision, based on a need that we really needed a critical access hospital guide around telehealth and virtual service delivery during the pandemic and beyond.

And they gave the NRHRC and Comagine health specifications that were really helpful. We have all these public health emergency waivers, et cetera, we know that there's -- we know how things are going to -- we kind of know how things will be after the public health emergency.

Some of those details are still murky. There's pending legislation, there's a proposed rule in the works, so, you know, we're going have to update it. Next slide.

So, we received very clear direction from TASC and The Center.

The guide was geared towards practicality and minimizing as much as possible, what I call truly useless information. Information that's broadly out there and really bulks up the content. It ends up being about 88 pages long and it reminds me of a team I was working with and we had a guide that was 30 pages long and my colleagues from Malaysia said, that's really great, if you're having trouble falling asleep.

We hope this isn't how you feel about an 88-page guide and you can pick and choose pieces that make sense to you.

It was informed by so many subject matter experts and individuals.

We want to be clear, this is a starting place. It's not an all-inclusive guide for telehealth. There's just so much verbiage in there.

And we have the calendar year '22 physician fee schedule proposed rule. There may be changes. Let's go to the next slide.

So, we want your feedback. This is the way that you build skill and expertise, is by feedback. So, we'd love to hear, either now or you know, when you're trying to fall asleep and reading all 88 pages, what's helpful? What's not? Is there missing or incorrect information? Are there other resources that really should be? Anything else.

We'll have a section with Q&A, you can chime in then, you can chat in your thoughts or go directly to info@NRTRC.org to let us know.

All right, so, look at that, we've already knocked out like, three out of seven of what we're going to do. So, I'm going to go through the slides that I have, Nicki, really quickly and then I'm going to shift to actually looking at the guide, itself.

So, let's go to the next slide. So, that hyperlink table of contents, that's what it looks like. There's a lot in there. It's chock-full. There are tons of topics. Each one is succinct, and condensed, as we can possibly get it.

Hold on a second, we're going to get to it. Let's go to the next slide.

Today, we're orienting you to some of the resources in the guide and the guide, itself, but your Regional Telehealth Resource Center has amazing resources.

So, I don't know, about nine months ago, I went to all of the websites, all of the Telehealth Resource Centers so I could get a sense for who has what. I was so impressed.

Nicki, if you stop sharing and let me take over control... let's take a peak at the guide.

And so, if you attended many telehealth webinars, you'll hear how important it is to actually look at your patient, like look at the light on the camera.

But, like any good clinician, I'm going to, if I were looking at a second screen, if you see my eyes in this direction, it's because this is, I'm looking at my second screen. Can you confirm for me, Nicki, that you're seeing the guide?
>> Trudy: Okay, I got a nod --
>> It's at the page break, but we're seeing it -- there we go.

>> Trudy: Okay, good. All right. Usually I have a little green frame around to let me know I'm screensharing, but for some reason, it's not showing that.

We're going to take a really quick look at telehealth basics. It's really important to know that when we talk about telehealth, telehealth is, when we're doing Health Care service delivery, it is defined by the discrete set of codes that Medicare allows us to use for telehealth, so to speak.

So, it's important to know the basics. And... there's telehealth as per Medicare with a set of telehealth codes and rules and regulations. There's telehealth according to your state Medicaid and that could be very different.

So, Medicare, for example, reimburses Critical Access Hospitals for an originating site.

I've had to look up, probably half of our states for a variety of reasons to see whether the state Medicaid reimbursed

Critical Access Hospital, or rural health clinic on that originating type piece.

It's important to keep straight that Medicare will have certain rules. Medicare may have a huge number of telehealth codes they reimburse for, your state Medicaid may have just a select set that they reimburse for.

For telehealth basics, we primarily focus on Medicare, but just know that, for example, we have originating site where the patient is and the distant site, or hospital, what those requirements are.

Who the providers are, who can deliver telehealth services. That might be very different with your state Medicaid, consent, consent is very straightforward for Medicare.

But each state has their own requirements for consent. I know that there's at least one state in the nation that, the state Medicaid doesn't say anything about consent.

Most of the states have requirements and they can be really, really simple or they can be really complex. Just know what the case is for your state.

That's a really quick cache through the telehealth basics and then, if you're just starting out, you may look at what those initial steps are.

So, you might want to conduct a telehealth readiness assessment, which is included in the, in the guide and actually takes up about 22 pages of the 88. So, it's a pretty comprehensive assessment. We tried to keep the fuzzy stuff out.

A lot of assessments will say "have you done a market analysis?" You're going to hear from Tressa and Tressa -- her hospital's approach to doing market analysis was to talk to people and find out what their needs were, their actual needs are.

Tressa's hospital started doing telehealth in 2012. I think, by now, most Critical Access Hospitals and clinics are doing telehealth. Reach out and hear what other people are doing.

Nicki and I have interviewed two Critical Access Hospitals and every time I learn really new and school stuff. Reach out and find out whether the people don't reinvent the wheel.

Form a dedicated team. Clarify, enumerate and describe possible telehealth and virtual service opportunities. I feel as though Critical Access Hospitals have like a tiny subset of what they could be doing. What are all those telehealth codes you could be using. That's one of the things that I think is missing from other telehealth guides and tool kits.

We'll show that to you in just a second. You need to know what your broadband is, where you're going to be. As an originating site.

So, if you are going to set up a telehealth hub, where patients can come to your Critical Access Hospital and see specialists, you have to have adequate broadband and whether, what the broadband is in your area, may not be what that broadband is in the exam room you'll be using for your site to see specialists.

Make sure you know it's okay and that it can handle audio and video.

A few additional pieces, we try not to make this too overwhelming. Your internal processes will be really important. I talk to a lot of safety net clinics, rural health clinics that are really worried about budget and they think it'll be a huge outlay of money. It's actually not.

We find that you know, you have to have broadband that might be a cost, but as long as you have a device with mic and Tamara and you have some way to engage in a telehealth visit, it's not always a huge outlay of money.

And staffing ends up not being such a huge, huge deal as well, because what we've heard, especially from hospitals that we've talked to is that they end up cross-training staff. You just kind of make room for telehealth. And trade people.

Tressa's hospital had respiratory therapists as part of the telehealth visits. We like this very practical advice that we put together, there's so much and it's an area where people are very unsure. They want to make sure they're not locked into something.

They want to make sure they do their due diligence. Some very practical guidance on how you select your vendor. We talked to one Critical Access Hospital that decided to go with

Zoom. They used Zoom for their staff. They're familiar with it. Why bring on something new.

Some EHRs have great embedded options. Some of the state health information exchanges are coming up with telehealth solutions as well.

So, you know, here are a few steps. I think we only have about five and you'll see that we reference other resources, one of the other things we wanted to not do what recreate the wheel.

So, the AMA telehealth implementation play book is really, really great. So, why would we redo what they've already done?

So, in some cases, like this, we address you to work that's already been done really well.

We care a lot about person-centered telehealth and I think that that really resonates with people. Somebody heard a webinar I did called person-centered telehealth and they reached out and wanted me to deliver a -- actually, wasn't anything to do with telehealth, but they were so impressed with the fact that we considered person-centeredness.

We have to be person-centered. It's not just patient-centered telehealth. It's staff as well.

If your clinicians are confused or don't have support with telehealth, they'll be really frustrated.

Health equity and barriers and solutions is a subset of person-centered telehealth, it's the hugest thing that we're going to deal with in our rural communities and I really feel as though we can have person-centered telehealth, I'd love to see community-centered telehealth, where we have solutions for patients that are embedded in the community.

So, libraries have telehealth hubs where patients have a private place, they have connectivity, they have that private space, computer, a mic and a camera where they can take their call work. Our local employers have a private room where employees can -- I think we can have a community-based solution and I think Critical Access Hospitals are so aware of their communities and what's going on with their communities.

Does everybody have connectivity? They don't. What are the solutions? You can have lack of an internet connection or data plant.

If you want to take your telehealth visit on your phone, you might be using data and you may not be able to support, that so you might be able to talk for a half hour and boom, your data plan is over and you get set off.

Broadband, at a patient's location -- lack of -- being able to talk on the phone. We're going to be moving toward more audio-only options.

Lack of reliable transportation, you may have a great set-up where a patient can take a visit at the Critical Access Hospital, but how does the patient get there? Patients do this at home to engage in visits. Low, digital proficiency. I like not calling it literacy. If you don't have it, then are you illiterate? I prefer the term proficiency and a few other things that you should really think about, homelessness, hearing impaired.

This section on hearing impaired was added by one of our contributors to this document and I was so glad to have that additional input and insight into what's important when we think about equity.

And I want to really quickly cover our appendices. This table here is something that we're very proud of.

Because we haven't seen anybody else do it for you.

And it is, there are four buckets of telehealth codes. There's category one and category two codes. Those are kind of like the permanent codes. They're interim codes that will disappear at the end of the public health emergency.

There's a new category called category three. They'll be around until December 31st, 2023. We took category one and what we call permanent ones and we grouped them, instead of telling you, you can look at all the services, go to the massive Excel spreadsheet that CMS has posted. We put them in this table and grouped them, so you could see where they are.

So, hospital critical care consults and nursing facility services, these are codes that critical care hospitals can use. Even though you're not billing for them, they're the national average reimbursement rate.

You may not be able to build this amount and receive this amount of reimbursement, if you're going to talk to specialists about services that they can provide or telehealth into your

Critical Access Hospitals, knowing what the reimbursement is to make the case, for getting those services into your Critical Access Hospital can be really helpful.

So, we hope you find this table helpful. I'm almost at the bottom of the table, if your eyes aren't glazed over by now. See if you can find opportunities in here to really up your telehealth game at your Critical Access Hospital.

We have a whole set of workflows. They're just sample workflows. When we hear from practices in Critical Access Hospitals and rural health clinics and rural organizations, you know how with real estate, you hear location, location, location.

With telehealth, it's workflow, workflow, workflow. Here's an example of very busy workflow. I put this together. I'm a clinician, it's half telehealth workflow and half clinic protocol. It's a little bit of overkill.

But we have some examples of workflows and I like to use Vizio, but you know what? Post it notes on a wall works for workflow. Just going to bounce this back up to the other one.

Here's the telehealth program assessment. It's also posted on the NRTRC website in case you want to have just it and not 88 pages, but 22 pages and... bear with me a second while I scroll through.

So, it's arranged so there's kind of a maturity model. So, are you in level one? Level two? Level three? And this is -- we expect the teams will do this assessment together and decide where you are.

Are you here? You know... maybe you're in the yellow on this one. At the end of the assessment, it calculates your score and reminds you of the maturity model and where you might fall. Let me take a guess at what page that is on.

There's a bonus section for virtual services, I work with a lot of rural health clinics and they just are missing several services that they can provide.

That leads me to, we covered appendices. We -- I want to, what comes after this section, in this assessment, these additional virtual services, are you doing virtual communication services? Especially at your RHC?

Are you doing remote physiologic monitoring, et cetera? Are you doing principle care management? And for each of these, we have resources posted on the NRTRC website.

This is a document that is, goes into the chronic and principal care management services.

We have a table in here, I won't -- there's eight pages. I won't scroll because it drives people nuts on Zoom.

But, it's a source of Health Care service delivery that's really important. So, it's for your high-risk patients.

And especially in primary care, we're going to see CMS and Medicaid requiring more that we identify our high-risk patients and provide care management services.

Let's just do it now and starting in 20 -- starting in January of this year, our rural health clinics could also do principle care management. This is an exciting option for standing access, optimizing care and capturing revenue.

I do entire workshops on this. And webinars and we have it all condenses into one resource for you.

Interprofessional consults is a patient-centered referral option.

RHCs and Critical Access Hospitals are not reimbursed for these services, but it expands access and helps patients not have to drive hours for a consult.

So, it's an option to ask your specialist and say "do you do interprofessional consults?" They'll probably say "huh? Do we do what?" Send this resource and ask if they can provide these services.

CMS hasn't created any -- you know how they have those really great MLN booklets or fact sheets? They haven't done this for interprofessional consults. Nobody knows about it, we're hoping to get the word out. Remote physiologic monitoring. Same thing. CMS hasn't created any guidance documents around remote physiologic monitoring.

And so, here, we give you the low down and unfortunately, CMS doesn't reimburse rural health clinics. You can do some of this work under chronic care management.

If the final rule gets passed the way we think, we'll have to go in here and update this. CMS is adding remote, therapeutic monitoring codes, so, we're pretty excited about that, because that opens up another option.

Okay, so, I think I talked about as fast as I possibly can and I think I've covered all the information that I said I would. Correct me if I'm mistaken, I think I'm ready to hand things off to Q&A. If people have questions, I see there are a bunch of things in chat and I haven't taken them.

There are questions there, maybe we should try to tackle it.

>> Nicki: We don't have questions in the Q&A box. We've gotten a lot of feedback and comments expressing appreciation and gratitude for the guide in the chat box, but no specific questions I've seen.

If anybody has questions, they can throw it in now.

In the interim, we'll hand it over to Tressa from Logan Health of Shelby, Montana. Critical Access Hospital to share their Critical Access Hospital telehealth story and spotlight them and the good work that they're doing.

And I do see a couple questions that came in and we will move into those in about ten minutes.

So, Tressa, I'll start sharing the slides and hand it over to you.

>> Tressa: Thanks, Nicki, appreciate being on here today. I'm fortunate enough to work at Logan Health Shelby. We're a Critical Access Hospital located in Shelby, Montana.

We're in north central Montana near the border. I'm going to share from a CAH perspective, our journey. Go ahead to the next slide.

We're able to deliver a wide variety of specialty care in Shelby, Montana, via telehealth. We work to continue to build this list, of specialty care that we can provide. I was at the golf course last night and was approached by someone saying "my husband and I need a call to see if you guys have this telehealth specialty care, where we can have our son come and have telehealth services with you guys, versus us traveling across the state."

Not only will the kid miss school, but we'll miss work as well. It's true, connecting with your community, the fact that you know them and they know you're here for them. I think that's a huge part that leads to success of the telehealth program.

Next slide.

So, keys to success. There are a lot of different components that go over, go into the overall success of the program. The big thing though is keeping that patient at the forefront of this delivery of Health Care.

That is ultimately the most-important factor. We want them to be even-more impressed with a telehealth visit than they would be in person. We want them to walk away feeling like they received the best care possible in our community.

So, today, I'd like to talk about workflows. How can we help make that visit the best visit possible?

So, they are critical for success. They make the program. Nine years ago, if you called the medical center and wanted to make a telehealth appointment, you'd be transferred to a few people and then get the appointment made. They'd probably tell you the doctor wasn't there and you'd walk away super confused. Our staff would be super confused as well.

Today, if you fast-forward and you show up for an at least visit or call us for at least visit, you're being routed to the people you need to talk with. You're walked up to the registration desk you need to be at.

You're being provided the exact packet you need. Workflows do make the program a success.

What are workflows were in 2012 are not what they are today. What are the providers experiencing? What is the patient experiencing?

What are our staff experiencing? It's from scheduling, registration, the actual appointment, follow-up with a patient. Those are the care components, but you also have operational ones.

Do we have contracts in place? Do we have the credentialing in place? Billing and coding? It takes all different parts to make the overall workflow work.

Plus, we want to make sure we're working with those individuals who are boots on the ground, like Trudy mentioned.

It's definitely important to have that involved. Overall, we make sure that we also document the changes. And so, did something change? What changed? Who is responsible for implementing that change as well as communicating that change out?

So, with that, the education and engagement of the facility, we've seen definitely grow. They know that there is a binder down at the nurse's station that has the different packets available for the different specialties and the different sites.

They know it's going to tell you exactly who to contact and what workflow means. It's wonderful to know that anyone could pick that up and run with it and be a telepresenter for the day. It's a wide variety to make that work. It's important to document those changes so you can look back to know what worked and what didn't work.

We want to make sure that while we're delivering these services, that it's consistent so the patient and providers know at all times, what to expect. That provides guidelines for our staff to make sure the workflow is appropriate. We want to make sure, like Trudy showed, there's a lot of guidelines we're following at all times.

So, for example, the importance of standardization and education engagement of facility, there was a potential [indiscernible] that arrived in the ER. The staff new to grab the pact, follow the workflow on the machine. So, that way, that patient in our ER in Shelby, Montana, could be connected with a neurologist and receive a treatment they needed and there wasn't a time delay. It didn't need to be flowed out to get that addressed.

It's amazing to see outcomes of our community members where our staff made an impact by knowing our workflows and we had telehealth in place.

It's wonderful to utilize telehealth for Health Care. Technology and resources change. This is a great resource that's been put together. Use those resources. Learn from others. Having conversations makes it fun too. You're like

"what are you doing there?" I can learn from you and share with you. Use it to your advantage.

Overall, the workflows are important. Share and communicate.

So, collaboration and communication, we need the providers in the community on board. It is definitely important that we have their engagement. Back in 2012, they'd have been like "I'll drive six hours to go see that provider." Now they're like "I'll come across town." It literally takes less than a minute to get across town.

They'd love to come to our facilitate. Not only does it reduce their time and expenses, but it helps with continuity of care. That means we have that record and they can do their follow-up care.

So, without their engagement of providers who would be possible, we are very excited that we have several great partners who are always willing and open to the different things we have.

So, it's wonderful that we have people asking for it too. Our staff also, they're wear to ask if they have a patient that they're interacting with that is receiving care?

Can we do this? How can we make this happen? Also, engage with your community. There's a lot of different entities in everyone's communities. Reach out, you don't know what they might have as a need for their business, but also for their staff members. They might know they're having someone travel. Or that is becoming a financial burden. There's a lot of different things.

We utilize telehealth, our different health fairs, virtual health fairs, we put it on our Facebook. We really want the community to know about it as well.

Also, different Health Care facilities, even law enforcement. There's a lot of different opportunities that come as well.

So, reach out to other entities. And also, keep an eye on regulations. You never know what opportunities might be coming with regulation changes.

They definitely are improving for telehealth and continuing to improve. I also feel as a Critical Access Hospital, it's part of our responsibility to reach out to Nicki and our different resources to say "this isn't working" or we're running up against this issue.

If we don't communicate with them, that we have a barrier, they can't help us. And they really are a great resource.

So, we do have barriers, we have overcome a lot of barriers, but we still have them that continue to work.

Telehealth has come a long way over the years. It's an exciting component to the delivery of Health Care.

There's a lot of opportunities, we are so fortunate, like I said, to have a great facility that supports the program. Partners and other entities, as well as a community that supports this program.

Our ultimate mission is to support the delivery of Health Care for patients and providers. We want to keep that patient at the forefront of it. They are our community members. They're our family members, our neighbors and that is how we thrive as a Critical Access Hospital.

So, it's a continual process to promote and engage, to make sure our programs are continuing to improve.

And I feel that once you get that moment and working on your workflows, it'll come naturally and it's really exciting. So, thank you for your time.

>> Nicki: Thank you, Tressa and I do want to share that there will be a written-up spotlight that'll go out with the slides. There's a request for slides from this presentation. Those will be going out, along with the spotlight on Logan Health, Shelby and their telehealth program.

That'll be on the NRTRC website as well.

So, at this time, I'd like to take a minute, I did see some questions come in through the Q&A. So, the first one is do the interprofessional consultations apply to behavioral health consultations? Trudy, if you want to share the resource again, I can stop sharing. If you want to take that one?

>> Trudy: Sure, yeah. I responded in chat, as well. They can apply to any type of consult, it's not, it's not limited to

behavioral health or medical conditions. But... it's, you know, it's, so, CMS says these consults are typically initiated by a primary care provider to a specialist for low-acuity condition-specific question that can be answered without an in-person visit.

That is a mental health, low acuity condition-specific question. That'd still work. This is -- the other thing that it specifies, so... the consultant can do this for new or established patients, new or existing, problem that is exacerbated and have some documentation requirements as well.

There's some frequency limits, of course? And it does say that -- just to be really clear here. This -- so, they can provide the report, either electronically or verbally.

If you have a question, say you have somebody with schizophrenia and you have an antipsychotic medication or medication change or you need to up it or add a medication, if you have a specialist who will engage with you in this way, this might be an appropriate way to do that for behavioral health questions. Note that if you are the person doing the referring, there's only one code you can use. 99452 and it is -- there's not a lot of reimbursement.

You spend 16 minutes or more putting things together to sent to the consultant. The reimbursement is only $36 for Medicare-allowed charge.

It's really the consultant who has these codes for billing and so, if they do like, a really short quickie and they respond. You can see in the codes above, 99446, $19, if they spend a half hour or more, it's $73 reimbursement.

If they have to do research and review records and so forth, they'll be headed into the $73 reimbursement range. Not all consultants are going to do this. Would they like to get $73 for a half hour of looking over reports? Or would they like to get the patient into the office and have a face-to-face and charge a higher code?

So, I think there's potential for these, but it has to be the right specialist for the right condition. I probably over-answered that question, but there you have it.

>> Nicki: Thank you, Trudy and while you have that pulled up, you can go to the reimbursement table. Can you clarify what

services are reimbursed for Critical Access Hospitals?

>> Trudy: Critical Access Hospitals and rule health clinics can act as originating sites.

So, you can have, so, that's where the patient is. For a Critical Access Hospital or rural health clinic, can be the originating site and you can have any number of people delivering telehealth services to you.

It's not limited. Any of the telehealth codes, whoever is delivering it, they're going to build those codes, the Critical Access Hospital, depending on the insurance, can build that originating site base.

I know this is a little removed from what the actual question is. Here, we're the CMS-designated quality improvement organization for six states.

Back in April of 2020, we ran a billing report and we saw that one rural health clinic, in one year-captured $20,000, billing originating site fees. They were really busy with their telehealth.

There are two situations, so, here, you'll see there are two situations in which an institutional facility may bill for distant site services.

That's, you know, the -- the originated site fee, you bill a Q3014. Reimbursement, over the years, CMS increases the amount a little bit little. We're still only at like $27 per originating site fee reimbursement.

For the distant site services, yes, a Critical Access Hospital can, if you, if you have one of those two situations, the entire suite of telehealth code are available to the Critical Access Hospital.

So, there are, I think, a little over 100 category 1 and 2 codes. The permanent codes. I think there are 135 interim codes and there's -- I don't even know how many of the category 3 codes are.

There are a lot of telehealth codes. If the facility is a Critical Access Hospital that elected the methods or payment options with the practitioner that is delivering the services, reassigning their benefits to the Critical Access Hospital or when the facilities provide medical nutrition therapy services

which, I can't remember how many codes there are for M&T, but the reimbursement is not huge.

So, I think iffo don't know what your case is, at your Critical Access Hospital, I would see whether you have this option and then you're looking at being able to deliver distance site services.

If you're a rural health clinic, during the waivers, until the public health emergency ends.

The rural health clinics have that whole suite of telehealth codes where they could be delivering that telehealth. Their reimbursement will be around $95.

But, they can be delivering any of those telehealth services and I lost count of how many pending legislative bills there are to make rural health clinics and SQACs permanent distant sites and list the geographic requirements.

So, probably a little bit of an overanswer on that one too. Forgive me for both of those. If, if, by chance, you still have questions left souping that, please let me know.

>> Nicki: Thank you, I don't see any other questions in the chat box. If you could stop sharing your screen, I'll pull up the closing slides here.

If anybody has any other questions, feel free to throw them in as I review the upcoming webinar from the National Consortium of Telehealth Resource Centers.

So, they occur the third Thursday of every month. The topic is to be determined. The date is slated for October 21st, 2021. Hard to believe October 21st is next month.

From 11:00 to noon Pacific Time. So please check the website for upcoming webinar topics. This spotlight will be coming to you via e-mail. I just want to ask everybody to please complete the survey, that we'll open after this webinar. It is important to get your feedback so we know where we can improve. I just wanted to check -- I see the Q&A pop-up -- post the link to the guide again. Yep, we'll put that in chat right now.

And to the Critical Access Hospital guide and I just want to thank you all and for the clinicians and Health Care

providers out there in the group, thank you for all the hard work you're doing and everybody, stay safe.

[Call concluded at 2:54 p.m. ET].

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