WELCOME TO THE UAHQ WEBINAR SERIES

The session will begin at 12:00 PM

If you are having any technical issues please send a chat to Emily Carlson or email emily.carlson@hsc.utah.edu

ABOUT UAHQ

- The Utah Association of Healthcare Quality (UAHQ) is a non-profit organization for healthcare quality professionals in all settings.
- UAHQ provides
  - Education
  - Leadership development
  - Networking opportunities
- Sign up to become a member and continue to receive newsletters and access to educational events. Membership information can be found on our website uahq.org.

HOUSEKEEPING ITEMS

- Today's presentation is being recorded be published to the UAHQ website. Please remember to mute your audio for the duration of the presentation.
- If you would like to make a comment or have a questions please use the chat feature to help us cut down on ambient noises.
- If you run into any technical difficulties during the presentation, please send a chat to Emily Carlson.

Register by October 31 to secure your spot!

The Utah Association for Healthcare Quality is pleased to present

The Quality Journey

Presenter

Nancy Claflin, DNP, MS RN, NEA-BC, CENP, CCRN-K, CPHQ, FNAHQ

November 17 & 19 2020

12:00-4:00 PM MDT

Where are you on your quality journey?
Have you thought about seeking certification in quality?

The field of healthcare quality and the healthcare quality professional's role are expanding exponentially in today's ever-changing healthcare climate. This course will present key milestones in the quality journey including structure and integration; change, regulatory, accreditation, and external recognition; education, training, and communication; health data analytics, design and data management; measurement and analysis.

Register at **http://uahq.org**

Cost is $50

UAHQ

CEU CREDITS

- An email link will be sent to you for CEU credits by the end of the day today
- Please complete the survey in its entirety and we will email you a certificate of attendance within 1 week.
- If you do not receive the email with the survey link, please email Emily.Carlson@hsc.utah.edu

10/15/2020

12:00-1:30 PM MT

Jan Orton, *MS BSN RN CPHQ*
Intermountain Healthcare System
Director Clinical Data Management

Building the Database for COVID-19 Pandemic

Participants will understand HHS, CDC/NHSN and State history and changes in the requirements for COVID-19 data submission.

Participants will review and understand State of Utah and HHS reporting locations, with an understanding of variation in data sources.

Chutuoc C. Trandinh, *M.D*
Molina Healthcare
Medical Director for Utah and Idaho

How COVID-19 is Changing the Delivery of Care

Reviewing before, during and after COVID delivery of care, with a focus on hospital beds, ER visits and telehealth usage.

Participants will learn lessons from care after COVID and how to improve the delivery of care and cut cost.

Deepak Rajpoot, *M.D*
Molina Healthcare
Behavioral Health Medical Director for Utah and Idaho

The Advantages and Limitations of Telepsychiatry

Participants will identify and describe the Ryan Haight Act, the uses and limitations of Telepsychiatry at the outpatient and inpatient levels of care.

Participants will identify some best practices in HIPAA compliant software.

For Registration:

https://www.surveymonkey.com/r/P9BSTYT

UAHQ

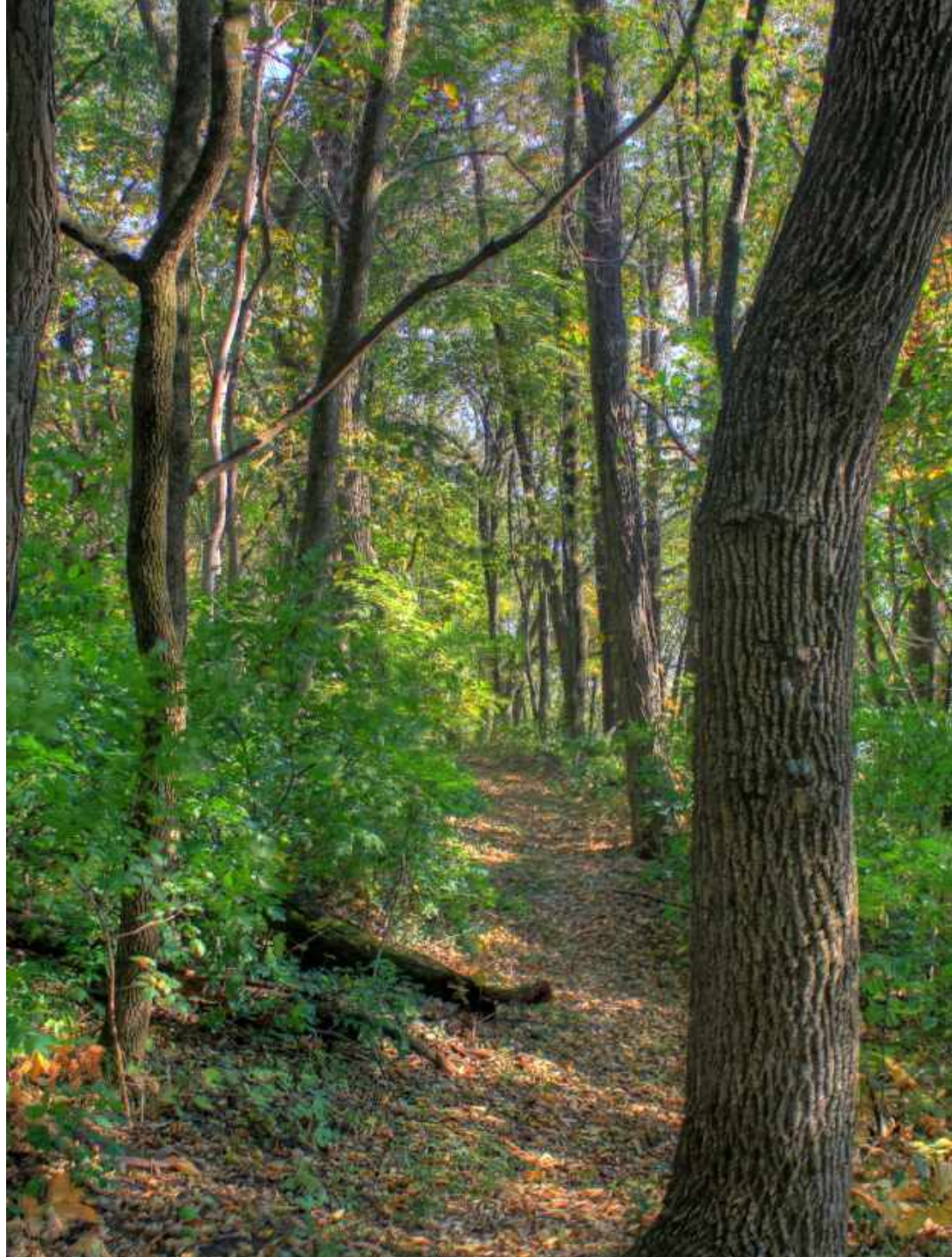
The data trail of a pandemic

Jan A Orton, RN, MS, CPHQ

System Director Clinical Data Management

Intermountain Healthcare

Office of Patient Experience



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Remember these days?

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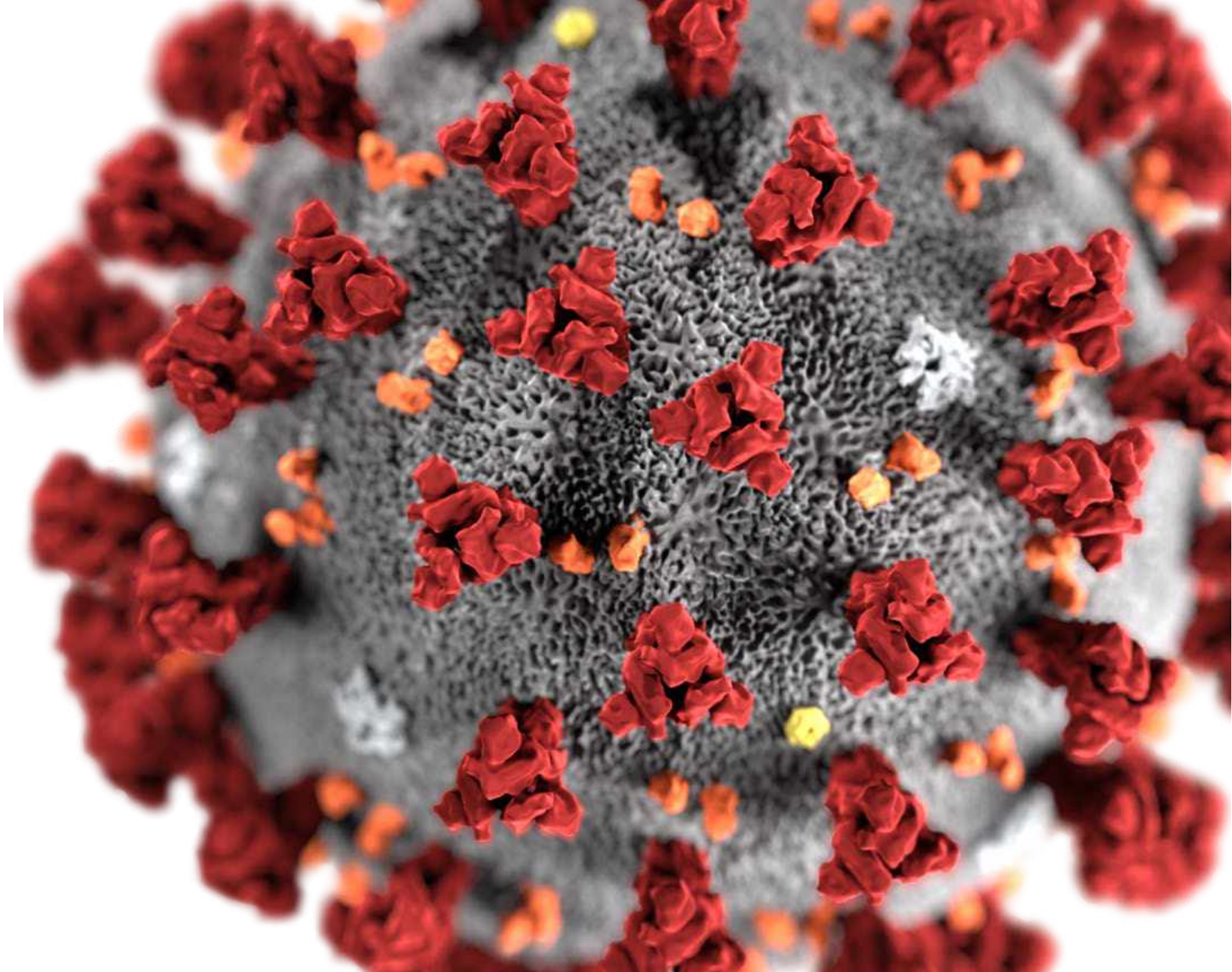

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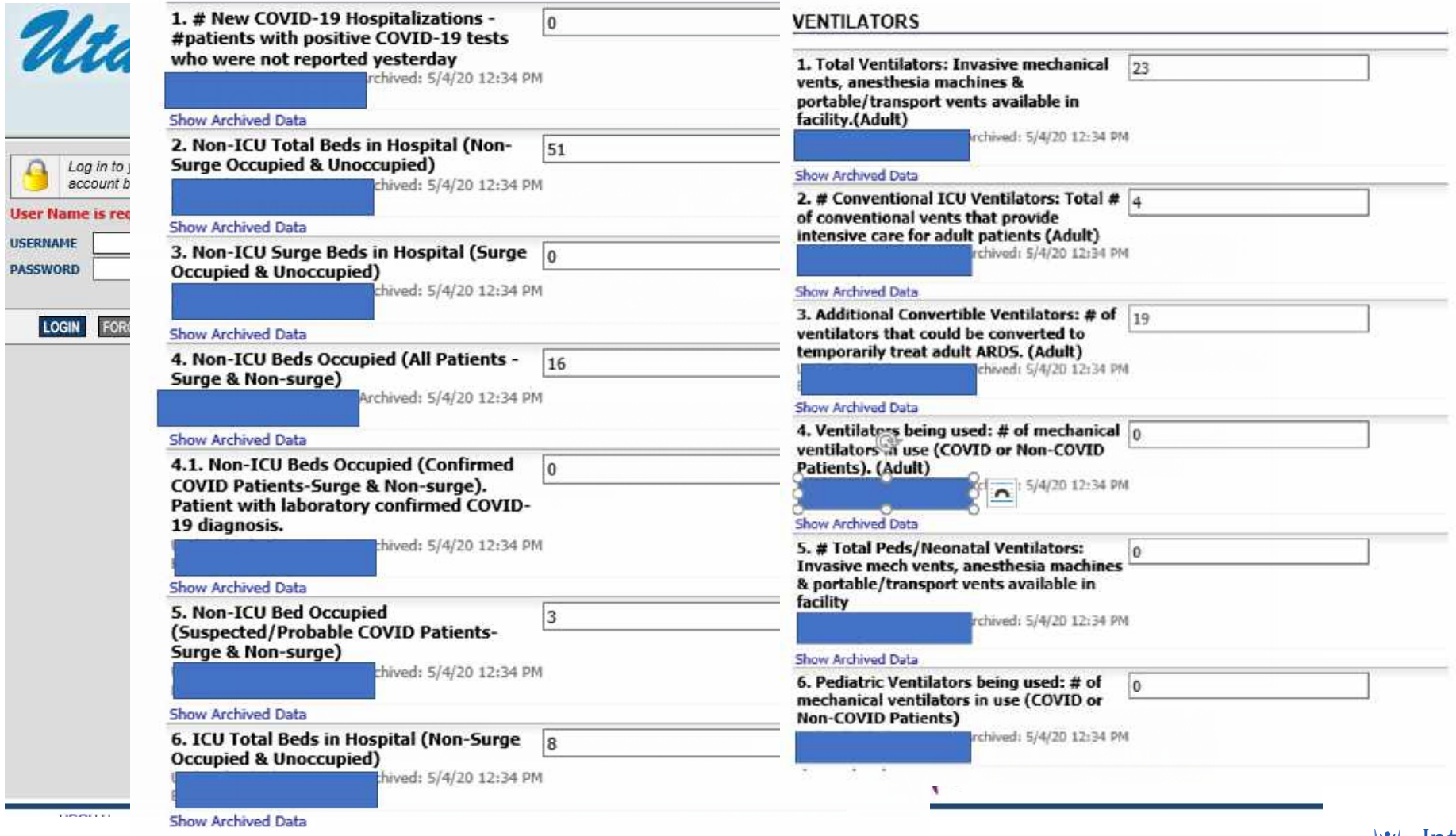
The trail begins….

Feb 2020
Admin → State for Data & Resource evaluation



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Everyone wants the data….

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The Journey ….

Feb 2020
Admin → State for Data & Resource evaluation

Mar 2020
VP Pence
Lab & NHSN

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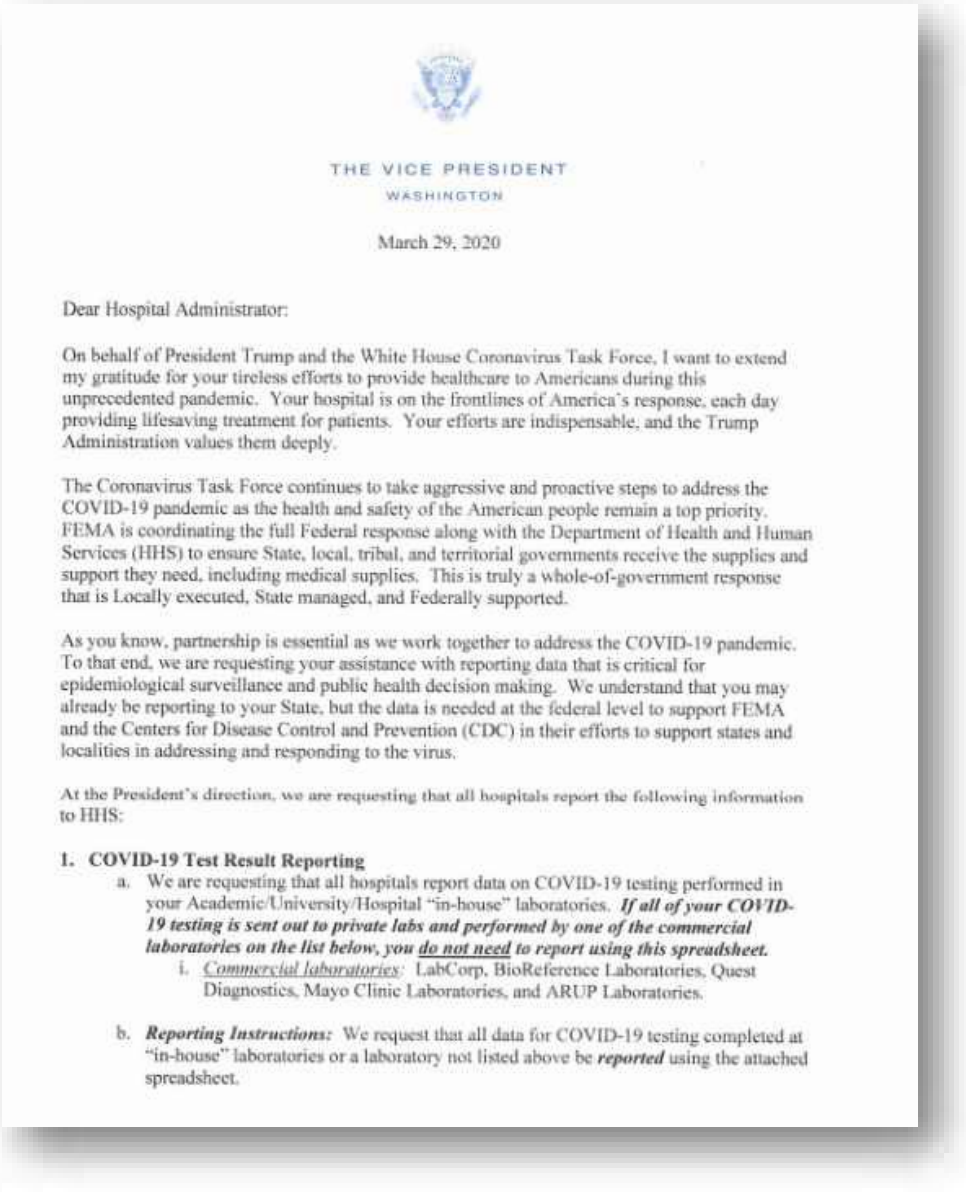
First Major Changes

State: UHRMS continues

Federal: Required NHSN Capacity, Death & Ventilator

Daily process for Laboratory reporting counts

- Any in-house laboratories reported separately
- LabCorp, AURP etc. submit test they run



THE VICE PRESIDENT
WASHINGTON

March 29, 2020

Dear Hospital Administrator:

On behalf of President Trump and the White House Coronavirus Task Force, I want to extend my gratitude for your tireless efforts to provide healthcare to Americans during this unprecedented pandemic. Your hospital is on the frontlines of America's response, each day providing lifesaving treatment for patients. Your efforts are indispensable, and the Trump Administration values them deeply.

The Coronavirus Task Force continues to take aggressive and proactive steps to address the COVID-19 pandemic as the health and safety of the American people remain a top priority. FEMA is coordinating the full Federal response along with the Department of Health and Human Services (HHS) to ensure State, local, tribal, and territorial governments receive the supplies and support they need, including medical supplies. This is truly a whole-of-government response that is Locally executed, State managed, and Federally supported.

As you know, partnership is essential as we work together to address the COVID-19 pandemic. To that end, we are requesting your assistance with reporting data that is critical for epidemiological surveillance and public health decision making. We understand that you may already be reporting to your State, but the data is needed at the federal level to support FEMA and the Centers for Disease Control and Prevention (CDC) in their efforts to support states and localities in addressing and responding to the virus.

At the President's direction, we are requesting that all hospitals report the following information to HHS:

1. **COVID-19 Test Result Reporting**
   a. We are requesting that all hospitals report data on COVID-19 testing performed in your Academic/University/Hospital "in-house" laboratories. ***If all of your COVID-19 testing is sent out to private labs and performed by one of the commercial laboratories on the list below, you do not need to report using this spreadsheet.***
      i. *Commercial laboratories:* LabCorp, BioReference Laboratories, Quest Diagnostics, Mayo Clinic Laboratories, and ARUP Laboratories.

   b. ***Reporting Instructions:*** We request that all data for COVID-19 testing completed at "in-house" laboratories or a laboratory not listed above be ***reported*** using the attached spreadsheet.

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Beginning of the definition game

State of Utah	NHSN
# New COVID-19 Hospitalizations # patients with positive COVID-19 test who were not reported yesterday	# of New OR SUSPECTED patient hospitalizations
Organization may have a feed to state taskforce that has deaths State of Utah works from death certificates	Deaths: Patients with suspected or confirmed COVID-19 who died in the hospital, ED or any overflow location on the date for which you are reporting.

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The Journey begins….

Feb 2020
Admin → State for Data & Resource evaluation

Mar 2020
VP Pence
Lab & NHSN

April – June
5 Special Teletracking requests

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5 Special Data Collection (April, May, June)

COVID-19 related volumes for Remdesivir

Only in Teletracking (so if you are using NHSN, extra work)

The Journey begins….

Feb 2020
Admin → State for Data & Resource evaluation

Mar 2020
VP Pence
Lab & NHSN

April – June
5 Special Teletracking requests

June 2020
LTC NHSN

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Long Term Care

Within NHSN

- Adds staff testing information (# tested, suspected and confirmed, deaths)
- Resources include non-nursing, and physician/APP
- Supplies are different

The Journey begins….

Feb 2020
Admin → State for Data & Resource evaluation

Mar 2020
VP Pence
Lab & NHSN

April – June
5 Special Teletracking requests

June 2020
LTC NHSN

June 2020
No NHSN New Elements

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July 13, 2020

Abrupt cessation of data collection in NHSN – Teletracking only

LTC data collection continues in NHSN

Added additional categories

- Previous admission by age groups (forgot 18 & 19-year old's)
- Remdesivir Use
- Staffing information
- PPE (Ventilator, N95, PAPRs, Masks, Eye protection, Gowns, Gloves)
  - Count #, duration in days, Obtain items, Maintain a 3-day supply)

More definition game

HHS Secretary Letter			HHS Implementation
9.	a) Total hospitalized adult suspected or confirmed positive COVID patients	Patients currently hospitalized in an adult inpatient bed who have laboratory-confirmed or suspected COVID-19.	Implementation breaks out confirmed vs suspected
	Subset: b) Hospitalized adult confirmed-positive COVID patients	Patients currently hospitalized in an adult inpatient bed who have laboratory-confirmed COVID-19.	

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NPR Article

https://www.npr.org/sections/health-shots/2020/09/24/916310786/trump-administration-plans-crackdown-on-hospitals-failing-to-report-covid-19-dat accessed 10/9/2020

Trump Administration Plans Crackdown On Hospitals Failing To Report COVID-19 Data

September 24, 2020 · 5:00 AM ET
Heard on Morning Edition


PIEN HUANG


SELENA SIMMONS-DUFFIN

3-Minute Listen + PLAYLIST

Hospitals may soon be at risk of losing a critical funding stream — Medicare funding — if they don't comply with new COVID-19 data reporting requirements.

John Lamparski/NurPhoto via Getty Images

Updated Friday 2:15 p.m. ET to include a comment from the Centers for Medicare & Medicaid Services.

The federal government is preparing to crack down aggressively on hospitals for not reporting complete COVID-19 data daily into a federal data system, according to internal documents obtained by NPR.

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Down the path….

Feb 2020
Admin → State for Data & Resource evaluation

Mar 2020
VP Pence
Lab & NHSN

April – June
5 Special Teletracking requests

June 2020
LTC NHSN

June 2020
No NHSN
New
Elements

Oct 2020
Required data or loss of Medicare

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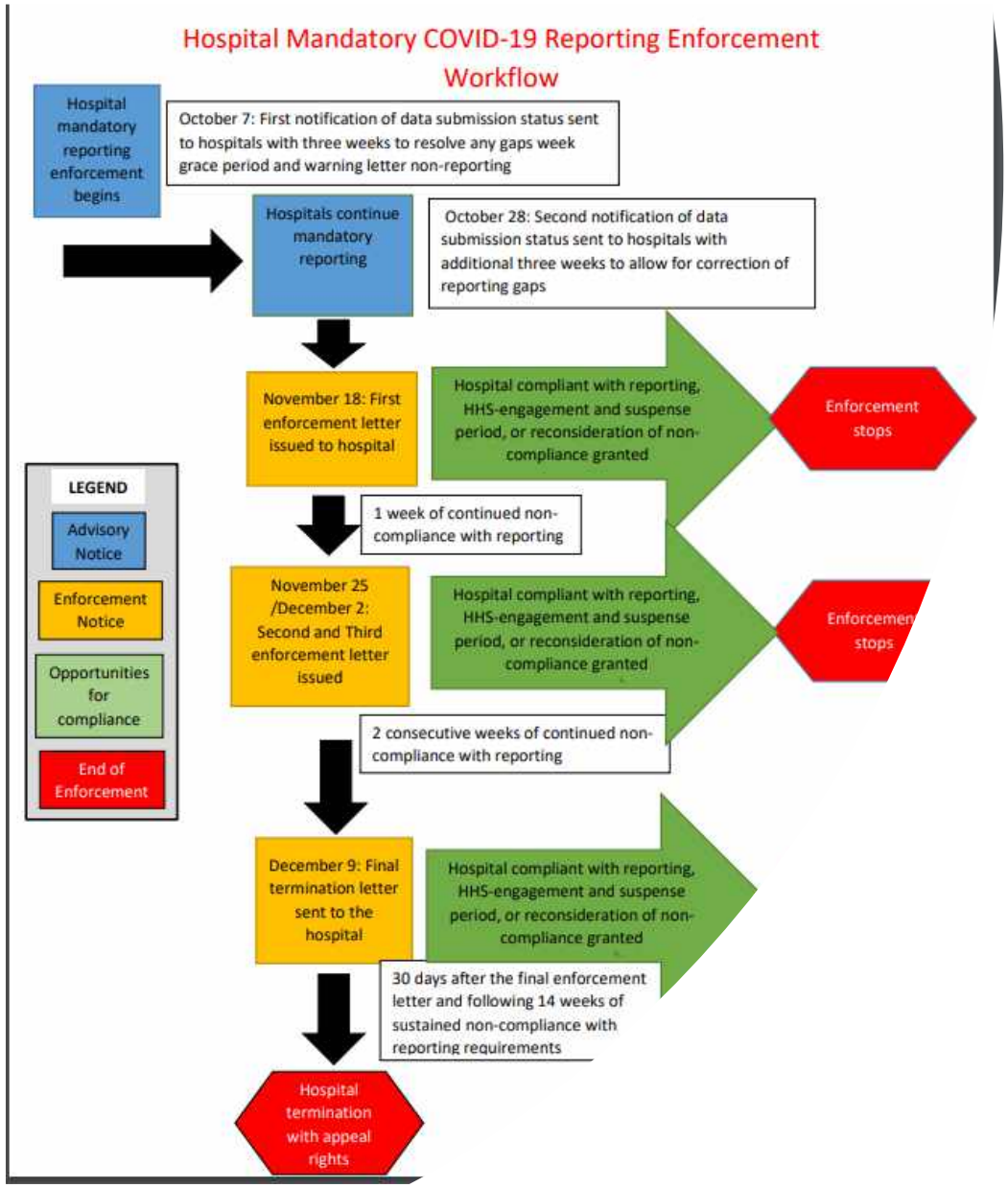

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The Letter…

Dear Administrator:

SUBJECT: COVID-19 Reporting

2019 NOVEL CORONAVIRUS (COVID-19) REPORTING REQUIREMENTS
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of COVID-19. On September 2, 2020, CMS released an Interim Final Rule Comment (IFC), announcing that in accordance with 42 CFR § 482.42(e) and 485.640(d), hospitals and Critical Access Hospitals (CAHs) are required to report information on COVID-19 in accordance with a frequency and in a standardized format as specified by the Secretary during the Public Health Emergency (PHE) for COVID-19 (https://www.hhs.gov/sites/default/files/covid-19-faqs-hospitals-hospital-laboratory-acute-care-facility-data-reporting.pdf) through one of the approved reporting methods to ensure appropriate tracking, response, and mitigation of COVID-19 in hospitals.

For providers to demonstrate compliance with the new requirement, facilities must submit the data to one of the approved methods at least once daily. For additional information on COVID-19 reporting requirements please visit:
https://www.hhs.gov/sites/default/files/covid-19-faqs-hospitals-hospital-laboratory-acute-care-facility-data-reporting.pdf.

This letter provides you with your reporting status based upon the information provided to CMS, through HHS, in order for you to correct your data submission or identify submission problems prior to beginning enforcement. Non-compliance is assessed based upon a one-week reporting period. As of October 6, 2020, a preliminary analysis showed that this facility did not meet the requirements for the

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ID	Information Needed	Definition
Items 1 – 25 are to be reported daily (except psychiatric and rehabilitation hospitals who are to report these weekly)		
1.	Hospital information (in separate fields) a) Hospital name b) CCN c) OrgID (Optional) d) State e) County f) ZIP g) TeleTracking ID (Optional)	
2.	a) All hospital beds Subset: b) All adult hospital bed	
3.	a) All hospital inpatient Subset: b) Adult hospital inpatie beds	
4.	a) All hospital inpatient occupancy Subset: b) Adult hospital inpatie occupancy	
5.	a) ICU beds Subset: b) Adult ICU beds	
6.	a) ICU bed occupancy Subset: b) Adult ICU bed occupancy	Total number of staffed inpatient ICU beds that are occupied. This is a subset of #4
7.	Total mechanical ventilators	
8.	Mechanical ventilators in use	
9.	a) Total hospitalized adult suspected or confirmed positive COVID patients Subset: b) Hospitalized adult confirmed-positive COVID patients	
10.	a) Total hospitalized pediatric suspected or confirmed positive COVID patients Subset: b) Hospitalized pediatric confirmed-positive COVID patients	
11.	Hospitalized and ventilated COVID patients	
12.	a) Total ICU adult suspected or confirmed positive COVID patients Subset: b) Hospitalized ICU adult confirmed-positive COVI patients	Patients currently hospitalized in a designated adult ICU bed who have suspected or laboratory-
13.	Hospital onset	
14.	ED/overflow	
15.	ED/overflow and ventilated	
16.	Previous day's COVID-19 Deaths	
17.	Previous day's adult admissions: a) Previous day's adult admissions with confirme COVID-19 and breakdow by age bracket: b) Previous day's adult admissions with suspected	
	COVID-19 and breakdown by age bracket:	Enter the number of patients who were admitted to an adult inpatient bed on the previous calendar day who had suspected COVID-19 at the time of
18.	Previous day's pediatric COVID-19 admissions: a) Previous day's pediatri admissions with confir COVID-19 b) Previous day's pediatri admissions with suspec COVID-19	
19.	Previous day's total ED vi	
20.	Previous day's total COVI 19-related ED visits	
21.	Previous day's remdesivir (Required until November and then Optional)	
22.	Current inventory of Remdesivir (Required until November 4th and then Optional)	
23.	Critical staffing shortage today (Y/N) (Required until November 4th and then Optional)	Enter Y if you have a critical staffing shortage today. Enter N if you do not have a staffing shortage today.
24.	Critical staffing shortage anticipated within a week (Y/N) (Required until November 4th and then Optional)	
25.	Staffing shortage details (Optional)	
	For items 26 – 32, repo	
26.	Are your PPE supply items managed (purchased, allocated, and/or stored) at the facility level or, if you are part of a	health system, at the health system level (or other multiple facility group)? (SYSTEM or FACILITY)
27.	On hand supply (DURATION IN DAYS) a) Ventilator supplies b) N95 respirators c) Surgical and procedu masks d) Eye protection including face shields and goggles e) Single-use gowns f) Exam gloves (sterile and non-sterile)	• Health system level or multiple-hospital group (e.g., PPE purchased at the health system level,
28.	On hand supply (INDIVIDUAL UNITS/"EACHES") (Optional) a) N95 respirators b) Other respirators such as PAPRs or elastomerics c) Surgical and procedu masks d) Eye protection including face shields and goggles e) Single-use gowns	f) Launderable gowns g) Exam gloves (single)
29.	Are you able to obtain these items? (Y/N/NA) a) Ventilator supplies (any supplies excluding medications) b) Ventilator medications c) N95 respirators d) Other respirators such as PAPRs or elastomerics e) Surgical and procedure masks f) Eye protection including face shields and goggles g) Single-use gowns h) Exam gloves i) Are you maintai launder	• Reusable/launderable gowns • Exam gloves (single) Information can be obtained from materials management, infection prevention leader, operational leadership, or the COVID-19 incident command leadership in your facility. Select YES for each of the supply types that your facility is able to order and obtain. If you have placed an order but are not able to have that order filled, please answer NO. Enter N/A if item is not applicable at the facility. • Ventilator supplies (any supplies, including flow sensors, tubing, connectors, valves, filters, etc.) • Ventilator medications • N95 respirators • Other respirators such as PAPRs or elastomerics • Surgical masks • Eye protection including face shields and goggles • Single-use gowns
30.	Are you able to lease a 3-day su items? (Y/N/N a) Ventilat supplies medicat b) Ventilat c) N95 res d) Other r as PAPI elastom e) Surgical masks f) Eye pro includin and gog g) Single- h) Exam Gloves	• Exam Gloves • Laboratory – nasal pharyngeal swabs? • Laboratory – nasal swabs
	i) Laboratory – nasal pharyngeal swabs j) Laboratory – nasal swabs k) Laboratory – viral transport media	• Laboratory – viral transport media
31.	Does your facility re-use or extend the use of PPE? a) Reusable/launderable isolation gowns b) PAPRs or elastomerics c) N95 respirators	Enter YES for each supply type your facility re-uses or extends use of. Enter NO for those supply types your facility does not re-use or extend use of. Enter N/A if the item is not applicable for your facility.
32.	Indicate any specific or critical medical supplies or medication shortages you are currently experiencing or anticipate experiencing in the next three days. (Optional)	Free text entry

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And after Influenza…

3.	a) All hospital inpatient beds	Total number of staffed inpatient beds in your hosp including all overflow, observation, and active surge/expansion beds used for inpatients (includes ICU beds). This is a subset of #2.
	Subset: b) Adult hospital inpatient beds	Total number of staffed inpatie [redacted], observation, [redacted] hospital including all overflow and active surge/expansion beds used for inpatients (includes designated ICU beds). This is also a subset of #2.
4.	a) All hospital inpatient bed occupancy	Total number of staffed inpatient beds that are occupied.

Influenza fields 33 - 38 to be reported every day except for psychiatric and rehabilitation hospitals who report weekly – Optional starting 10/19/20 with the intention to have these be mandatory fields within the coming weeks.

Existing upload templates will continue to work during transition.

Laboratory confirmation includes detection of influenza virus through molecular tests (e.g., polymerase chain reaction, nucleic acid amplification), antigen detection tests, immunofluorescence tests, and virus culture.

33.	Total hospitalized patients with laboratory-confirmed influenza	Patients (all ages) currently hospitalized in an inpatient bed who have laboratory-confirmed influenza. Include those in observation beds.
34.	Previous day's influenza admissions	Enter the number of patients (all ages) who were admitted to an inpatient bed on the previous calendar day who had laboratory-confirmed influenza at the time of admission. This is a subset of #33.
35.	Total ICU patients with laboratory-confirmed influenza	Patients (all ages) currently hospitalized in a designated ICU bed with laboratory-confirmed influenza. This is a subset of #33.
36.	Total hospitalized patients with both laboratory-confirmed COVID-19 and influenza	Patients (all ages) currently hospitalized in an inpatient bed who have laboratory-confirmed COVID-19 and laboratory-confirmed influenza. This is a subset of #9b/10b and #33.
37.	Previous day's influenza deaths	Number of patients with laboratory-confirmed influenza who died on the previous calendar day in the hospital, ED, or any overflow location.
38.	Previous day's deaths with both COVID-19 and influenza	Number of patients with laboratory-confirmed influenza AND laboratory-confirmed COVID-19 who died on the previous calendar day in the hospital, ED, or any overflow location. This is a subset of #16.

Intermountain® Healthcare

Intermountain Experience

23 hospitals and 2 LTC

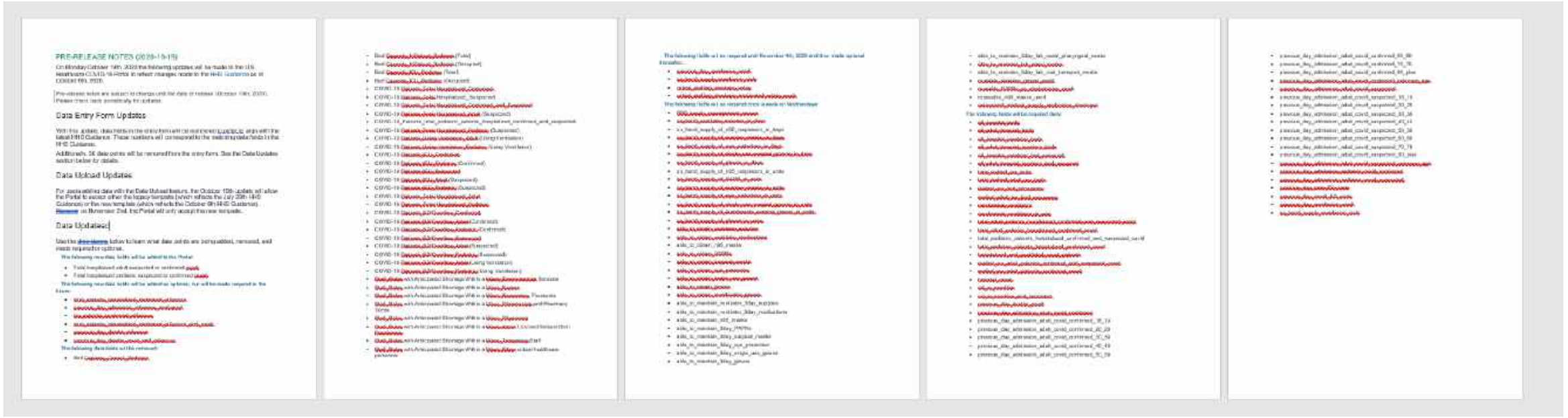
Utah, Idaho, NHSN & HHS

Total hours

- ***6 rewrites of files***
- ***3365*** hours (excluding Waivers but including internal dashboard support… ***134*** hours / week)
  - Analytics is bulk… about 14 hours a week is manual entry or uploading 7 days a week

Intermountain® Healthcare

New HHS file structure



Total daily elements (latest version)

87 elements for HHS

- 38 required weekly (supplies)
- 49 required daily (COVID / Capacity)
- 36 being removed, 9 added, 4 optional (staffing and remdesiver)

8 – 32 daily elements for HHS laboratory

47 daily elements for LTC NHSN

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When & Where will the trail end….

Keystone to success

- Change is inevitable
- Someone watching briefs / AHA etc.
- Tight communication w/ vendor or analytics
- Develop data source granular element level
- Close attention to the details
- Breathe!

Intermountain® Healthcare

COVID-19 The future of healthcare delivery

10/2020 | Presented by: Chu Trandinh, M.D.

MOLINA HEALTHCARE

Who Am I?

BEFORE, DURING, AFTER COVID

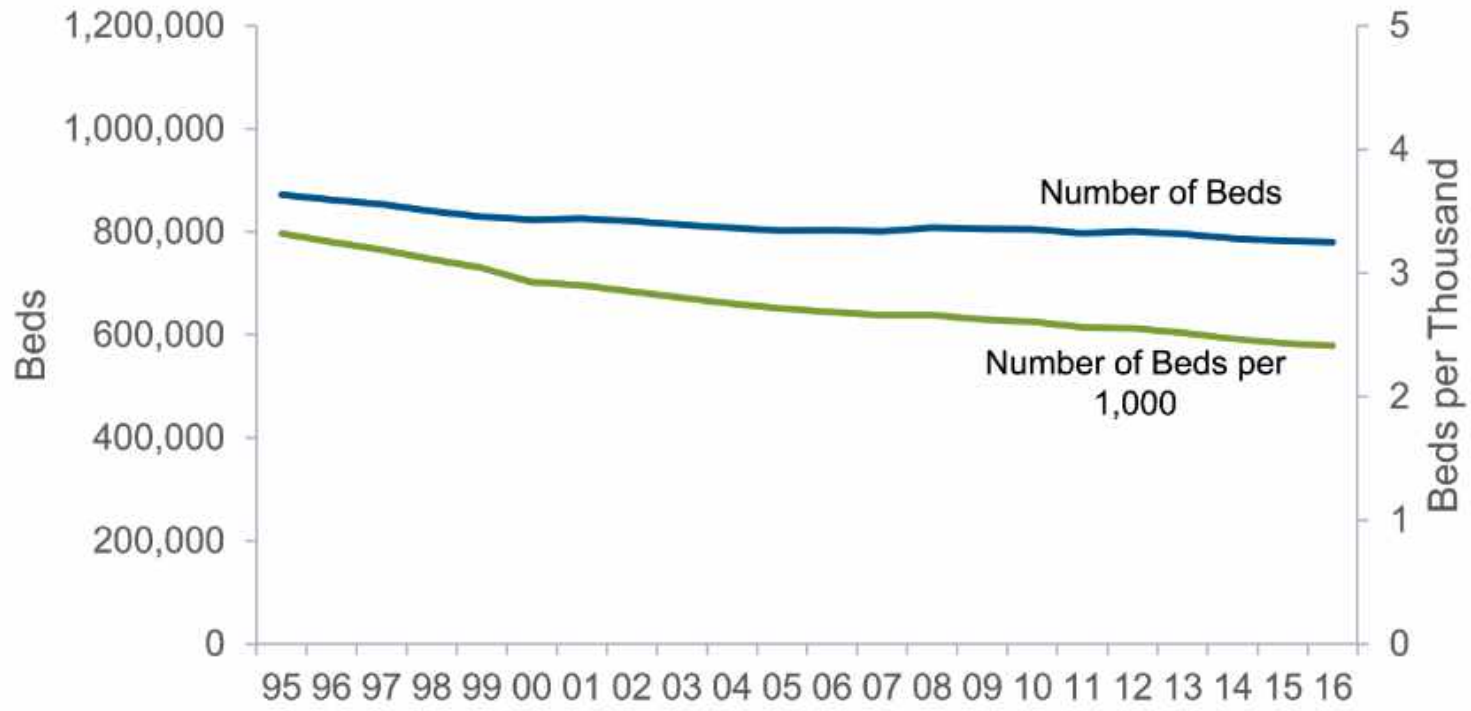
- Hospital Beds

HOSPITAL BEDS Before COVID

LESS IS MORE

MOLINA HEALTHCARE

Number of Beds and Number of Beds per 1,000 persons 1995-2016

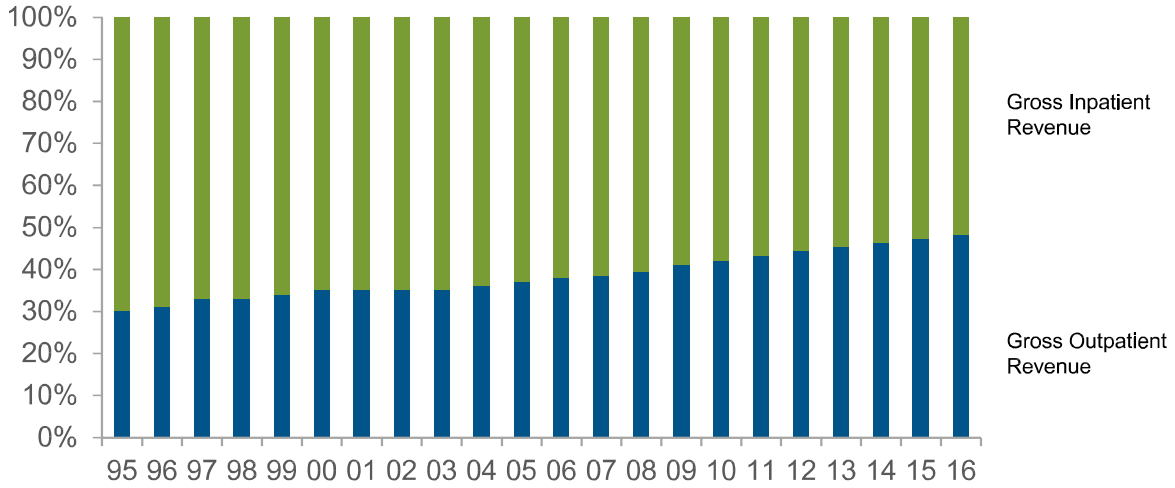


Source: Analysis of American Hospital Association Annual Survey data, 2016, for community hospitals.

OUTPATIENT VS. INPATIENT REVENUES

TRENDWATCH CHARTBOOK 2018
Trends in Hospital Financing

Chart 4.3: Distribution of Outpatient vs. Inpatient Revenues, 1995 – 2016



Source: Analysis of American Hospital Association Annual Survey data, 2016, for community hospitals.

MOLINA HEALTHCARE

DURING COVID

OMG

Not enough Beds

Not enough ICU Beds

Strategy to increase ICU beds

MOLINA HEALTHCARE

How Italy created 500 ICU beds in 18 days

1. Admit COVID-19 patients to 15 first-responder hospitals
2. Identified hospitals were asked to take several actions to increase surge capacity, including creating "cohort ICUs,' units that are separate from other ICU beds
3. The hospitals were asked to cancel nonurgent procedures

Becker Hospital Review Italian 500 beds in 18 days Digested

JAMA source data for Becker Review

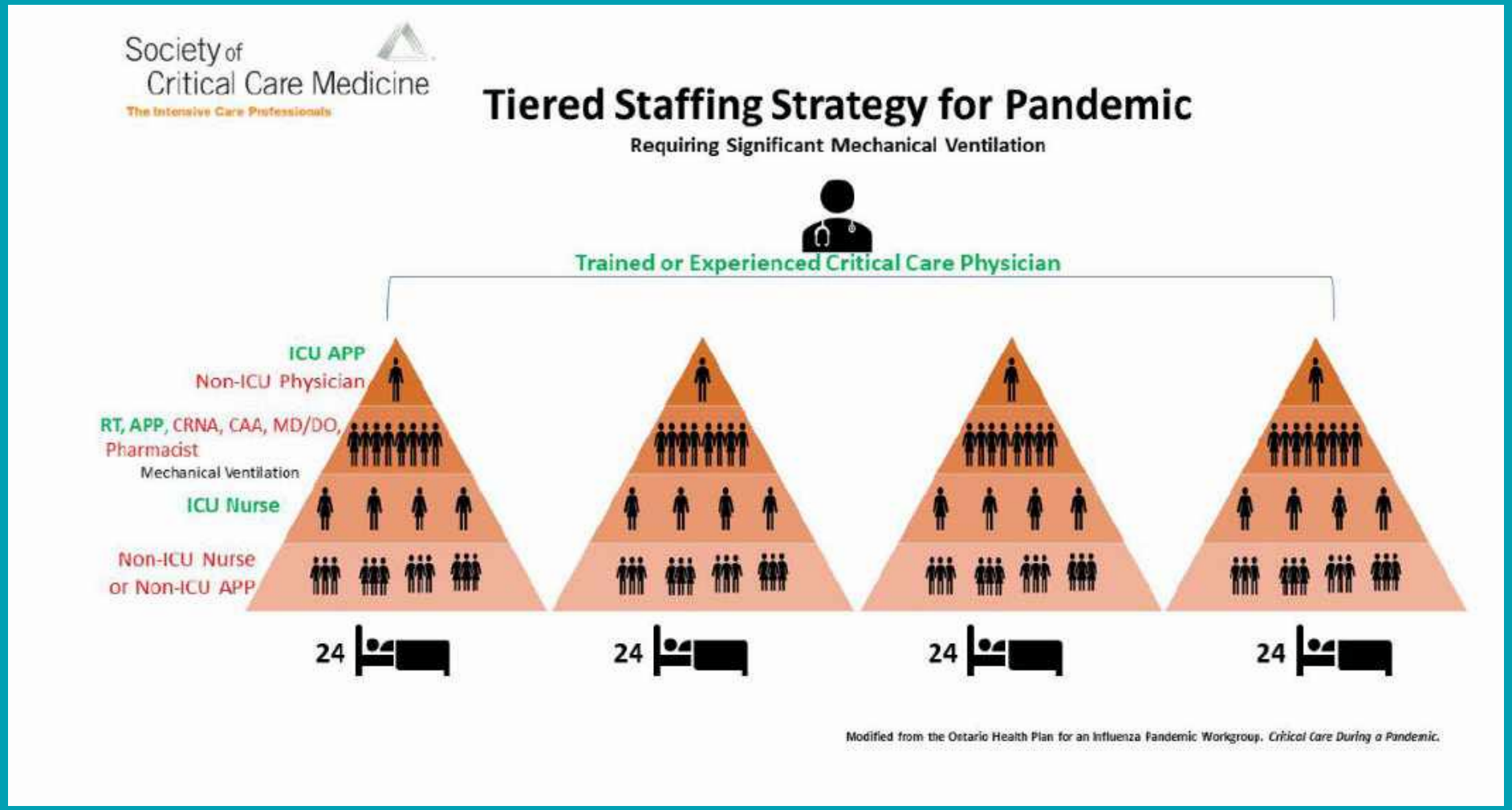
STRATEGY for the US

Society of Critical Care Medicine

- ICU, step-down, and burn beds
- PACU
- USNS Mercy (T-AH-19) and USNS Comfort (T-AH-20)
  - USNS Mercy was deployed in LA
  - USNS Comfort was deployed in NY
    - 182 patients were treated

MOLINA HEALTHCARE

STRATEGY FOR STAFFING



CARES Act Provider Relief Fund

- HHS is distributing $175 billion to hospitals and healthcare providers on the front lines of the coronavirus response
- LTAC (Long Term Acute Care)
- AIR (Acute Inpatient Rehab)

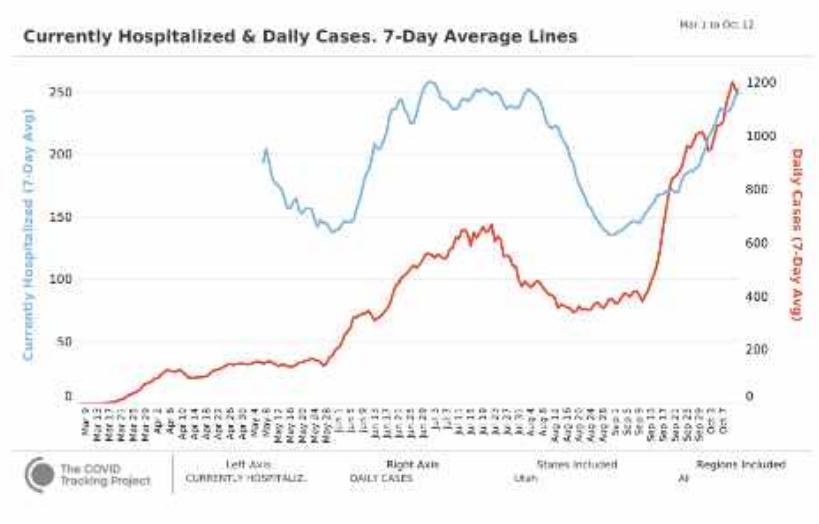
MOLINA HEALTHCARE

Discharge Destinations

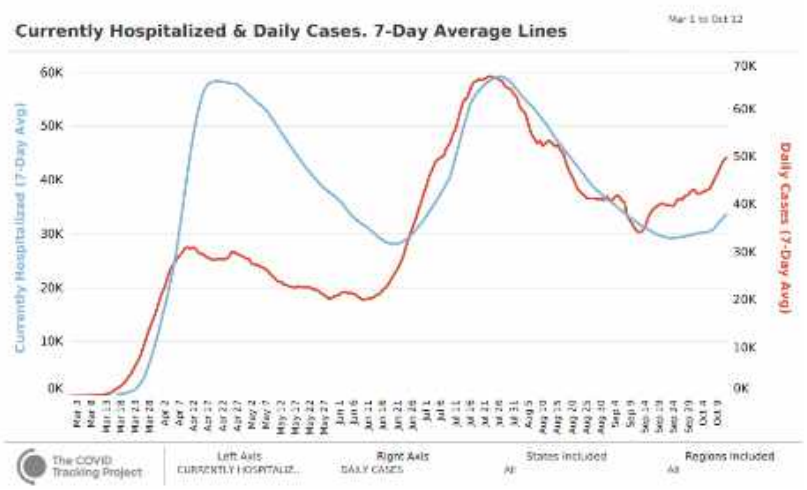
- COVID designated Nursing Facilities
- Discharge to Motels/Hotels
  - Greater NY Hospital Process for Discharging Homeless Requiring Isolation
  - Home health, services like oxygen
  - Meals delivered
  - Calls to the patients twice a day

UTAH COMPARED TO US HOSPITALIZATIONS

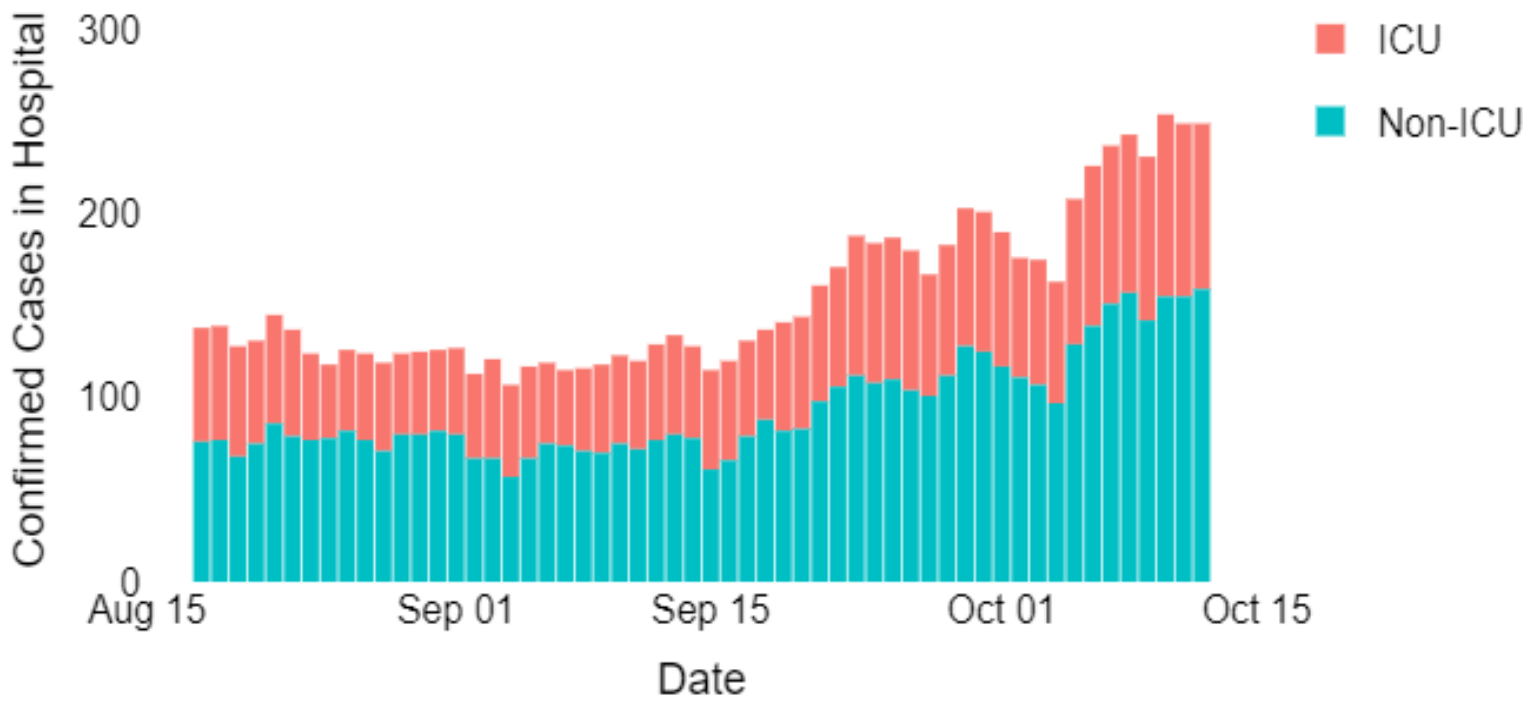
UTAH



UNITED STATES



UTAH ICU VS. NON-ICU HOSPITALIZATIONS



Utah Covid Dashboard

University of Utah report

Return to School on Sept 8

New peak in infection – as of October 6

- 176% increase since 8/31 (15-24 years)
- 222% increase since 9/10 (45-64 years)
- 240% increase since 9/11 (65-84 years)

Peak number of hospitalizations in early October

- More ICU admissions than Ward admissions
- “Having to actually defer and delay some episodes of care”

MOLINA® HEALTHCARE

Future of Hospital Beds

What we should learn from COVID

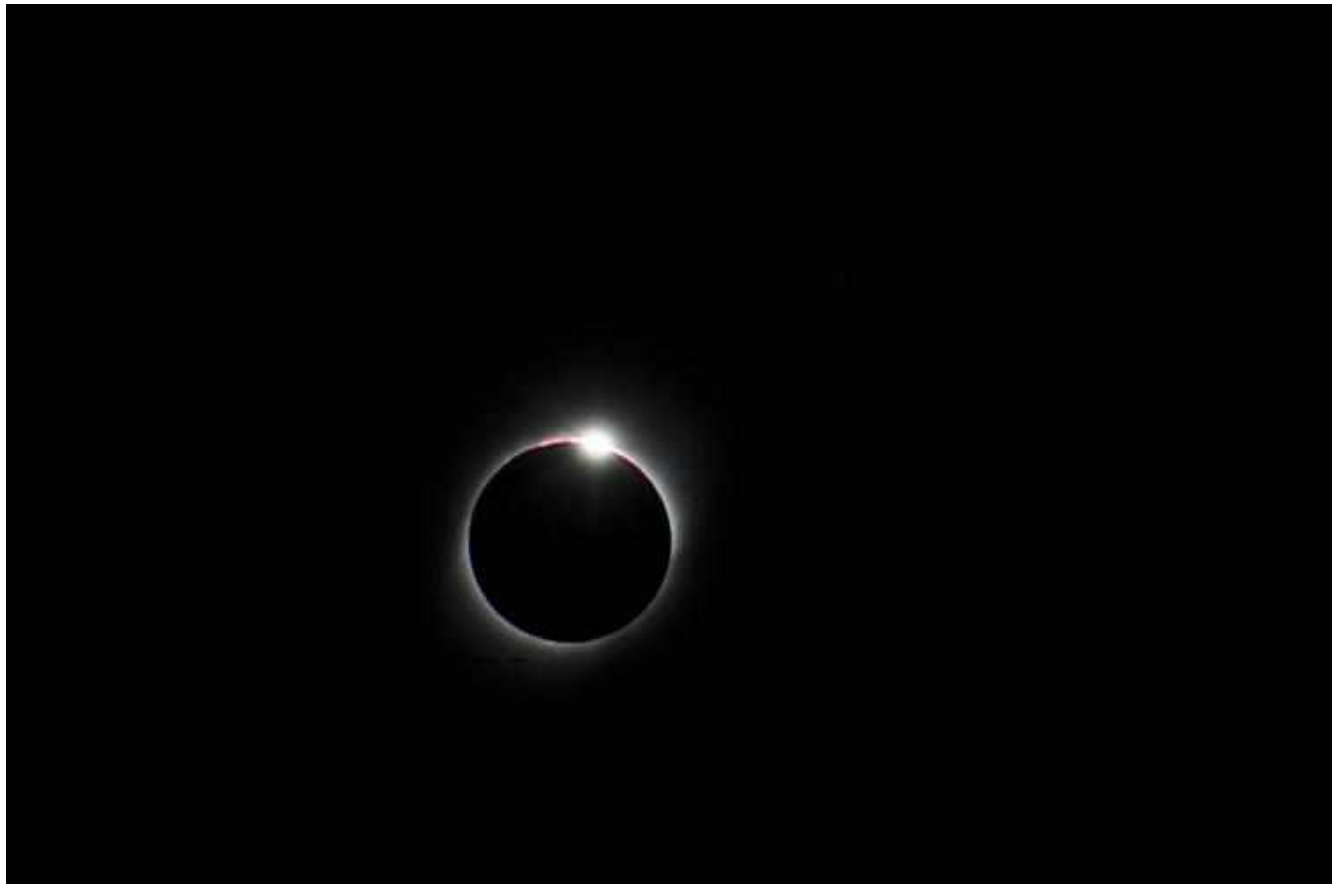
Fewer beds

Rapid deployment for emergencies

Creative discharge planning

Questions

2019 Diamond Ring



Telepsychiatry

What it is and how we can grow with it?

Deepak Rajpoot, M.D.
Behavioral Health Medical Director
Molina Healthcare of Utah and Idaho

MOLINA HEALTHCARE

Poll Question # 1:

Are you or your organization using telehealth at this time?

A. Yes

B. No

C. Unsure

Psychiatry

- Psychiatry is the medical specialty devoted to the diagnosis, prevention, and treatment of mental disorders. These include various maladaptations related to mood, behavior, cognition, and perceptions.

- Initial psychiatric assessment of a person typically begins with a case history and mental status examination. Physical examinations and psychological tests may be conducted. On occasion, neuroimaging or other neurophysiological techniques are used.

Psychiatry

- Mental disorders are often diagnosed in accordance with clinical concepts listed in diagnostic manuals such as the *International Classification of Diseases* (ICD), edited and used by the World Health Organization (WHO) and the widely used *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (APA). The fifth edition of the DSM (DSM-5) was published in 2013 which re-organized the larger categories of various diseases and expanded upon the previous edition to include information/insights that are consistent with current research.

- The combined treatment of psychiatric medication and psychotherapy has become the most common mode of psychiatric treatment in current practice, but contemporary practice also includes a wide variety of other modalities, e.g., assertive community treatment, community reinforcement, and supported employment. Treatment may be delivered on an inpatient or outpatient basis, depending on the severity of functional impairment or on other aspects of the disorder in question.

Poll Question # 2:

Are you or your organization using telepsychiatry at this time?

A. Yes

B. No

C. Unsure

Telepsychiatry

- Telepsychiatry is the application of telemedicine to the specialty field of psychiatry. The term typically describes the delivery of psychiatric assessment and care through telecommunications technology, usually videoconferencing.

- Telepsychiatry services can be offered through intermediary companies that partner with facilities to increase care capacities, or by individual providers or provider groups. Most commonly, telepsychiatry encounters take place at medical facilities under the supervision of onsite staff, though at-home models are becoming accepted as long as they are in compliance with HIPAA standards.

Telepsychiatry

One of the drivers behind telepsychiatry's growth in the United States has been a national shortage of psychiatrists, particularly in specialty areas such as child and adolescent psychiatry; telepsychiatry can allow fewer doctors to serve more patients by improving utilization of the psychiatrist's time.

Telepsychiatry can also make it easier for psychiatrists to treat patients in rural or under-served areas by eliminating the need for either party to travel.

Types of Telepsychiatry

Home-based telepsychiatry:

- Psychiatric treatment of patients who are at home or in another private setting is called home-based telepsychiatry or direct-to-consumer telepsychiatry, and it can require only a webcam and high-speed internet service. However, in order to avoid the risk of violating the patient-provider relationship, issues of security and possible HIPAA violations, providers who wish to practice home-based telepsychiatry are best served doing so from within a secure, HIPAA compliant online platform.

- Led by psychiatrist Jill Afrin, South Carolina Department of Health Deaf Services Program has used home-based telepsychiatry as a part of its services since the mid-1990s.

- Individual psychiatrists are adopting this method more and more with willing, interested patients, and it is an especially useful tool for consumers with limited mobility included the elderly and the disabled. Unfortunately, home-based telepsychiatry is not typically reimbursed by private payors or Medicaid, though many states are adopting measures into their legislation in the form of parity laws that would allow for it to be reimbursed in the future.

Types of Telepsychiatry

Forensic telepsychiatry:

- Forensic telepsychiatry is the use of a remote psychiatrist or nurse practitioner for psychiatry in a prison or correctional facility, including psychiatric assessment, medication consultation, suicide watch, pre-parole evaluations and more.

- Telepsychiatry can deliver significant cost savings to correctional facilities by eliminating the need for prisoners to be escorted to off-site appointments and psychiatric interventions.

Types of Telepsychiatry

On-demand telepsychiatry:

- As of 2008, guidelines are being developed for the provision of telepsychiatric consultation for emergency psychiatric patients, such as the evaluation of suicidal, homicidal, violent, psychotic, depressed, manic, and acutely anxious patients. However, emergency telepsychiatry services are already being provided to hospital emergency departments, jails, community mental health centers, substance abuse treatment facilities, and schools. Emergency telepsychiatry can ease staff shortages in overworked hospital emergency departments and increase patient throughput and ED disposition. Rather than employ expensive, short-term locum tenens doctors or have emergency department physicians evaluate the psychiatric stability of their patients, hospitals can use telepsychiatry to decrease costs and increase patient access to behavioral health evaluations by psychiatric specialists.

- Crisis telepsychiatry is also an efficient means of reducing the need for psychiatric boarding. Psychiatric boarding is when a mentally ill resident is detained, often in a hospital emergency department, while waiting for proper psychiatric treatment. With the increased throughput offered by telepsychiatry, psychiatric consumers enjoy reduced wait times and faster access to care.

Types of Telepsychiatry

Scheduled telepsychiatry:

- Many facilities that offer behavioral health care are turning to telepsychiatry providers to allow for an increased care capacity. With routine telepsychiatry, a consistent provider or small group of providers serve a regular caseload of consumers in previously scheduled blocks of time. Remote providers can be consulted for medication management, treatment team meetings, supervision, or to offer traditional psychiatric assessment and consultations.

- Having access to remote providers allows facilities, especially those in rural areas that struggle to recruit and maintain providers, access to a greater variety of specialty care to offer their consumers.

- Facilities that use routine telepsychiatry include:
  - Community Mental Health Centers (CMHCs) Outpatient Clinics
  - Federally Qualified Health Centers (FQHCs)
  - Universities and Schools Residential Programs
  - Nursing Homes
  - Accountable Care Organizations (ACOs)
  - Substance Use Treatment Centers Military Bases

Software Available for Telepsychiatry Use

The following vendors offer telepsychiatry platforms:

- Zoom (special purchase/BAA required)
- Skype (special purchase/BAA required)

Clinical platforms available with telepsychiatry functionality:

- American Wells
- Teladoc
- Talk Space

Poll Question # 3:

Do you feel comfortable that you or your organization are in compliance with regulations around telepsychiatry?

A. Yes

B. No

Ryan Haight Act and Federal DEA Regulations

- The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 was designed to combat the rogue internet pharmacies that proliferated in the late 90s, selling controlled substances online.

- The Act took effect April 13, 2009, and the Drug Enforcement Agency issued regulations effective that same date. The Act essentially imposed a federal prohibition on form-only online prescribing for controlled substances. Although the Act was intended to target "rogue" internet pharmacies, legitimate telemedicine providers who prescribe controlled substances must carefully review the regulations to ensure compliance.

- Among other things, the Act requires a practitioner to have conducted at least one in-person medical evaluation of the patient, in the physical presence of the practitioner, before issuing a prescription for a controlled substance.

Ryan Haight Act and Federal DEA Regulations

- Under the Ryan Haight Act, no controlled substance may be delivered, distributed, or dispensed by means of the internet (including telemedicine technologies) without a valid prescription.

- A valid prescription means a prescription that is issued for a legitimate medical purpose in the usual course of professional practice by:
  1. a practitioner who has conducted at least one in-person medical evaluation of the patient
  2. a covering practitioner

Ryan Haight Act and Federal DEA Regulations

- "In-person medical evaluation" means a medical evaluation that is conducted with the patient in the physical presence of the practitioner, without regard to whether portions of the evaluation are conducted by other health professionals.

- Once the prescribing practitioner has conducted an in-person medical evaluation, the Act does not set an expiration period or a mandatory requirement of subsequent annual examinations (although specific drugs may have their own rules for subsequent exams).

- This should not be construed to imply that one in-person medical evaluation demonstrates that a prescription has been issued for a legitimate medical purpose within the usual course of professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is on the prescribing practitioner.

Ryan Haight Act and Federal DEA Regulations

- There are some exceptions to the in-person exam requirement, but none readily apply to a telemedicine service where the patient is at his or her home.
- The DEA is currently drafting a proposed rule that will create a special registration process allowing physicians to prescribe controlled substances via telemedicine without an in-person exam, regardless of the patient's location.
- Notwithstanding the DEA federal rules, physicians still must comply with state laws on controlled substance prescribing. If a state law is more restrictive than the federal rules, the more restrictive provisions apply.
- Physicians must also comply with other state and federal regulations, such as licensure, state DEA registration, etc.
- The Ryan Haight Act does not apply to all prescription drugs; only controlled substances.

Ryan Haight Act and Federal DEA Regulations

Telemedicine Exceptions to the In-Person Exam Requirement

The Act offers seven telemedicine exceptions to the in-person exam requirement, but they are very narrow and do not reflect contemporary accepted clinical telemedicine remote prescribing practices. They are summarized as follows:

1. The patient is being treated in a DEA-registered hospital or clinic.
2. The patient is being treated in the physical presence of a DEA-registered practitioner.
3. The telemedicine consult is conducted by a DEA registered practitioner for the Indian Health Service, who is designated as an Internet Eligible Controlled Substances Provider by the DEA.
4. The telemedicine consult is conducted during a public health emergency declared by the Secretary of the U.S. Department of Health and Human Services.
5. The telemedicine consult is conducted by a practitioner who has obtained a DEA special registration for telemedicine.
6. The telemedicine consult is conducted by a Veterans Health Administration practitioner during a medical emergency recognized by the VHA.
7. The telemedicine consult is conducted under other circumstances specified by future DEA regulations.

Poll Question # 4:

Knowing what you know now, would you start/expand current telepsychiatry services?

A. Yes

B. No

QUESTIONS?

THANK YOU FOR JOINING US!
WE HOPE TO SEE YOU AGAIN NEXT WEEK

UAHQ