# TELEMEDICINE BEST PRACTICES SUMMARY

Telemedicine is an expanding and efficacious treatment modality through which members can have cost-effective increased access to care. Telemedicine is not a distinct service but is a modality through which providers deliver health care to patients as an alternative to face-to-face care. There are standards of care and expectations that should be considered to promote quality and safe behavioral health treatment.

This document is offered to support providers in best practices and standards of care but does not constitute medical advice. To the extent that any provision of these guidelines conflict with federal or state law, federal or state law will govern.

## Best Practices for Providers who are Utilizing Telemedicine to Treat Members:

**Benefit Coverage**

- Providers should follow traditional protocols to verify that a member has benefit coverage for Telemedicine services. Sessions should be administered in accordance with a member's service plan description.
- Providers should inform members of their cost-share prior to the provision of service.

**Technical Service Requirements**

- Providers should use a HIPAA-compliant platform for virtual services. Providers should ensure that technology platforms they are utilizing sufficiently safeguard their patients' rights for confidentiality and privacy and are compliant with HIPAA and other applicable federal and state laws.
- Consents and documentation: Providers should use a HIPAA-compliant and legally binding method of sharing consent forms and obtaining signatures from members and collateral contacts.
- Prior to each session, Providers should prepare by taking the following into consideration:
    - Checking connections
    - Checking speaker, microphone and camera
    - Preparing provider's room so patient has optimal view within a confidential setting
    - Beginning session with check of systems
    - Ensuring that service delivery occurs within a confidential setting
    - Ensuring availability of IT support as needed
    - For facility-based care, consider staff training for troubleshooting technical difficulties
- Providers should set clear expectations with patients regarding appropriate behaviors in virtual visits. Providers should set clear limits with patients surrounding topics such as where members are attending sessions (e.g., in a car, in their beds).
- Members should be notified that virtual platforms carry different privacy risks over in-person services. Providers should leverage all available encryption and privacy tools when using virtual platforms.

**Documentation**

- Providers should follow all documentation standards they would follow for in-person sessions.
- Session notes should clearly document the following: the session was conducted via telemedicine, which platform was utilized, physical location of patient and provider, applicable crisis plan, any technical issues that impacted the session and actions taken to resolve them.

**Safety planning**

- Prior to the first session and for each subsequent session, providers should identify how to contact social support and 911 services in the member's location.

- Providers should work with each member to ensure they have a crisis or emergency management plan in place by the end of the first session.
- At the beginning of each telemedicine session, the provider should verify the member's physical location, phone number and who else is present at the location.
- Providers should follow best practice standards for risk assessment (e.g., suicidal ideation, homicidal ideation, domestic violence) based on the member's unique clinical presentation.

**Coordination of care**

- In the absence of face-to-face interaction, it is important to coordinate care with other providers who have face-to-face contact with the member.
- For telemedicine that requires lab work, prescribers should follow all standards of care for the medications being prescribed. This includes but may not be limited to collecting and recording vital signs, metabolic monitoring, lab work and therapeutic levels. This may require coordination with other providers engaging the member in in-person care.

**Scope of Telemedicine Services**

- Providers should have clear criteria for determining which clients can be safely and effectively treated via telemedicine as well as criteria for when telemedicine can no longer meet their needs.
    - Providers should take steps to ensure they have access to relevant medical history, including presenting symptoms/problems and a thorough safety assessment.
    - Providers should fully assess the appropriateness of telemedicine services consistent with standards of care, professional judgment and ethical principles to include the patient's status, circumstances, and resources.
    - Providers should have clear written policies surrounding telemedicine services (e.g., prescribing policies, emergency plans, informed consent).
- Providers should assess whether a member has the electronic capabilities and access to participate fully in a telemedicine service.
    - Telemedicine services that encompass both audio and video services are preferable. Telephonic sessions are not an equivalent substitute for in person or telemedicine services with both audio and visual capabilities. Exceptions should be considered (as the benefit allows) if an individual is unable to attend a face to face visit and does not have appropriate tools or resources to participate in video-based telemedicine services.
- Evaluating progress: Provider should use objective, standardized measures of treatment progress. Many, though not all, measures have electronic versions and can be administered via Telemedicine.

## Specialty Care Considerations

**Applied Behavior Analysis (ABA)**

- Providers should use their clinical judgment about the appropriateness and effectiveness of using Telemedicine to deliver ABA services based on knowledge of each member's specific clinical needs.
- ABA clinicians should familiarize themselves with telemedicine practice standards created by CASP, APBA and other professional groups.

**Psychological Testing**

- Providers should put controls in place to ensure that additional variables or an individual's environment do not impact the testing environment (e.g., outside influence, access to information via cell phones or the internet).
- Providers should offer clear instruction to Members, or in the case of a minor, to parents or caregivers, regarding how to prepare their environment to minimize distractions as well as how to respond to any interruptions that may occur.

- Providers should adequately research the administration of their selected telemedicine instruments and follow recommended protocols, as available. Special attention should be given to diverse populations that may already have deficiencies in reliability and validity.
- Given inability of most tests for multiple administration, a secondary plan should be considered if front line platforms fail during the administration of the procedure or test.
- Modality of administration should be considered when providing feedback and recommendations to the member. Members should be informed of any potential differences in scoring due to telemedicine administration. A crisis and safety plan should be in place for all members prior to test administration in the event a member struggles with upsetting feedback.
- Documentation should include notation that the service was completed via telemedicine, as well as any available research to support scoring differences due to modality of administration. Limitations surrounding administration modality as well as any accommodations made should be clearly identified.

**Partial Hospitalization and Intensive Outpatient**

- The program should be able to provide telemedicine services (both audio and visual) for individual, group and family sessions.
- Members should be evaluated on each service date by a licensed clinician.
- Providers should have clearly defined and communicated policies which address mental health and medical service availability 24 hours per day, seven days per week for members in their home areas.
- Programs should have protocols and clearly outlined policies for addressing risk behaviors and decompensation. A crisis plan should be completed for each member prior to the conclusion of the intake appointment.
- Every effort should be made to coordinate all aspects of the members care including medical issues, general psychiatric concerns, group and individual therapies. Recent treating providers should be contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan.

**Group Therapy Considerations**

- Best practice supports having a minimum of two clinicians running the group – both to assist with IT challenges and to address ongoing assessment and evolution of member needs.
- Groups should have technical functionality to pull a member virtually into an individual session to address any pressing issues which may arise in a group format and provide crisis intervention or de-escalation as clinically indicated.
- Group therapy should maintain the same standards as in-person care, to include encouragement of group participation and maintaining reasonable group sizes.
- Informed consent and privacy controls are required when patients are participating in group Telemedicine (audio+ video) sessions.
    - In group settings, confidentiality should be discussed as part of informed consent to include the potential that a family member or alternate individual in another group participant's setting could potentially breach confidentiality.
    - Providers should consider requiring that members utilize headphones to support privacy in group settings.
- At the beginning of each treatment day and/or individual sessions, provider will review the Confidentiality guidelines and then survey patients to ensure that they are complying with the confidentiality/privacy guidelines.

**Eating Disorder Treatment**

- The program should be able to provide virtual individual, group and family sessions, as well as support member meal preparation as required for each level of care.
    - Family therapy is an important component of treatment and should be conducted, as clinically appropriate, using the same HIPAA-compliant platform and guidelines.

- Patients should participate in virtually supported meals for IOP/PHP. Nutritional planning with targeted weight range and planned interventions with a registered dietitian should be undertaken.
- For virtual traditional outpatient, updates should be provided weekly by provider to a member's treating dietician.
- Every effort should be made to coordinate all aspects of the members care including medical issues, general psychiatric concerns, meal plan as well as group and individual therapies. Recent treating providers should be contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan.
- Patients should be monitored for medical stability. Providers should have clearly defined policies which address how medical stability is monitored, including leveraging OP physicians for issues such as vitals, lab work and weighing.
    - Frequency of monitoring should be determined by the provider based on the individual's presentation.
    - Whenever possible, an identified medical provider who can monitor medical stability through in person care should be considered as best practice. When not available, exceptions should be carefully considered based on clinical judgment and presenting risk factors, and the provider is required to have a detailed, individualized plan addressing how medical stability will be monitored.

**Substance Use Disorders and Medication Assisted Treatment**

- For care traditionally offered outpatient in an office setting, prescribers should obtain a urine drug screen (UDS) as soon as feasible after an initial Telemedicine visit; the absences of a UDS should not delay initiation of treatment.
- Prescribing ancillary medication to alleviate opioid withdrawal symptoms should be considered during induction.
- Recommended best practices to address diversion control include obtaining laboratory testing to assess recent substance use, Hepatitis C, HIV and liver functioning, as well as conducting a pregnancy test, when applicable.
- It may not be possible for an in-office UDS to be obtained to confirm medication adherence or monitor for other substance use; prescribers should weigh the potential risks/benefits of obtaining UDS.
    - If obtaining a UDS not feasible, patients should be educated about the increased risk of overdose and should be co-prescribed naloxone.
    - If there is a concern a patient will over-use buprenorphine, the prescriber can prescribe smaller quantities.
- Resources: Consult with the state's Department of Health for any local regulatory changes.
    - Substance Abuse and Mental Health Services Administration (SAMHSA): https://www.samhsa.gov/coronavirus
    - Drug Enforcement Agency: https://www.deadiversion.usdoj.gov/coronavirus.html
    - Centers for Medicare and Medicaid Services: https://www.cms.gov/medicare/quality-safety-oversight-general-information/coronavirus
    - Centers for Disease Control and Prevention: https://www.cdc.gov/coronavirus/2019-ncov/index.html
    - National Consortium of Telemedicine Resource Centers: https://www.Telemedicineresourcecenter.org/