IPRC & Pediatric Director's Forum Discussion Call Summary

Thursday, April 16, 2020

12:00-1:00 pm EDT

DISCUSSION TOPIC: Telehealth & Virtual Visits: Strategies for Success in Pediatric Rehabilitation

I. Identified Organizations- 24 Organizations identified themselves as present on the call. Call was facilitated by Cindi Hobbes, IPRC Director, and open to all members of the Pediatric Rehabilitation Community.

II. Group Discussion: Topics to Guide Discussion:

A. What resources have proven most valuable during virtual sessions? What platforms are you using?
   1. Zoom - users recommend using a Pro, Business, or Enterprise account as these are more secure platforms and not prone to hacking like the free accounts
   2. Zoom Interface through EPIC
   3. Video Connect / MyChart
   4. Doxy.me
   5. Jabber, Microsoft Teams (for sessions requiring interpreters)
   6. LifeSize
   7. AmWell - EPIC interface with CareConnect
   8. PEXIT
   9. Microsoft Teams & Cerner for documentation support

B. How are you using/tracking outcome measures to evaluate efficacy?
   1. ORG A – Speech using Pearson Online tests, PT using TUG (Times Up & Go), 2 minute walk, 30 second sit to stand, others. Reliability depends on the session and family/caregiver ability and attention. Document attempt in each note and any concerns regarding reliability or standardization. ORG A

clinicians also using patient goals as outcome measures – working on very functional household skills.

2. ORG B – Finding parent assessments most valid versus clinician administered standardized assessments (example: The MacArthur Communicative Development Inventories)
3. ORG C – Using WeeFIM to measure outcomes for OP population using parent report

C. Have you provided any additional staff training and support for virtual sessions?
    1. ORG A – Daily huddle with all staff at noon each day. Created a virtual visit booklet that flows through the clinical process of virtual sessions. Booklet is a "Living" Document and is updated near daily at this point. It includes:
        a. How to prepare for a session
        b. Which patients are appropriate (the types of diagnoses seen via telehealth keeps expanding)
        c. How to prepare self for session
        d. How to document – including samples
        e. Operational Issues
        f. FAQ
        g. Regulatory items that need to be included
        h. Flowsheets
    2. ORG B – Increased frequency of staff meetings to once weekly (was prior EOW or monthly) via Zoom. Staff share experiences with virtual visits, group problem-solving, discuss ethical dilemmas that arise, coach one another on nuances of communication. Created an online Resource Guide and QuickTips for Telehealth
    3. ORG C – Created training videos for Telehealth, Developed a Therapist Supported Help Desk (staffed by tech savvy therapists)
    4. PRG D – Developed a structure for formal mentoring for clinical skills and technology skills

D. Are you experiencing any challenges with funding / Insurance push back for telehealth services?
    1. ORG A – using EPIC smartphrases to ensure compliance with telehealth regulations
    2. Question raised group regarding experiences billing for telehealth services. Are organizations billing under the hospital (Common Organizational NPI#) vs. Community Providers (Each therapist has own NPI #)?
        a. ORG B – Bill under common facility NPI # - experiencing difficulty obtaining individual NPI #s for therapists

b. ORG C – Bill under common facility NPI # - insurance payors being flexible and working with hospital to approve ways for billing
c. ORG D – Billing through hospital – Common facility NPI #s - having a challenge with billing
d. 7 additional organizations all reported billing for telehealth

E. How are you determining which clients can/should be seen via telehealth? Are you still seeing any patients face-face?
    1. ORG A – seeing post-operative patients one morning/week
    2. ORG B – All evaluations done in person, but non-emergent evaluations being postponed. Clinicians determine if virtual treatment can be effective to carryout POC. In person therapy visits offered judiciously.
    3. ORG C (Speech) - All Speech visits via telehealth with the exception of critical dysphagia (those deemed to be at risk for hospitalization). Virtual evaluations also being completed.
    4. ORG D (PT) – Post-rehab or post-trauma clients still being seen in person, but volumes are very, very, low. Referrals are triaged – very few in person evaluations being completed.
    5. ORG E – New evaluations are attempted via TeleMed. If not successful, then will schedule an in person evaluation.
    6. ORG F – not doing telehealth evaluations regarding concerns for validity and reliability. Group discussed that a separate discussion call regarding guidance for virtual evaluations would be helpful. Cindi to organize and schedule.

F. Whom/which clinicians are you allowing to work from home (WFH)? What requirements do you have to ensure patient privacy and staff accountability?
    1. ORG A – Not permitting WFH. Virtual visits happening at the clinic.
    2. ORG B – permitting WFH, created expectation guidelines (Wi-fi speed, etc)
    3. ORG C - therapists are permitted to WFH. Many combinations of virtual visits happening - therapists on site, off site, inpatients, outpatients.
    4. ORG D – WFH guidelines already established and Caseload guidelines also created. 5 step process/checklist must be in place to ensure productivity, privacy, supervision, etc.
    5. ORG E - Permitting WFH for both IP and OP clinicians. Prior WFH criteria were established (pre-COVID-19) with established projects, timelines, reporting, etc.
    6. ORG F – REDCAP survey created. Clinicians must complete at end of each workday. This survey captures billable hours, project time, etc. for tracking.

G. What is the average visits/day and length of visit for telehealth providers?
    1. ORG A – variable. Anywhere from 15 min check ins to 1 hr.

2. ORG B – average session is 30 minutes, 6-9 visits scheduled per clinician

H. Which disciplines at your organization are participating in telehealth?
    1. ORG A – PT, OT, ST, Psych (Inpatient & Outpatient)
    2. ORG B - Psychology and Speech (Inpatient)
    3. ORG C – PT, OT, ST, Nutrition
    4. ORG D – PT, OT, ST, PM&R (Outpatient), Neuropsychology & Social Work (Inpatient)
    5. ORG E – PT, OT, ST, All Medical Visits
    6. ORG F – PT, OT, ST, Sports therapy, Neuropsychology

I. Thoughts this experience as a segue to continues distance treatment?
    1. ORG A – Some therapists have found it to be useful. Will largely depend on payor willingness
    2. ORG B – Will be payor specific long term
    3. Discussion regarding opportunity for robust data collection to determine efficacy, patient satisfaction, clinician satisfaction, treatment consistency, cancel rates, etc.
        a. ORG C – Creating documentation about what is happening – clinician attitudes, patient satisfaction, creating focus groups. Interested in collaboration with other organizations for streamlined/standardized approach to collecting this data.

J. Have organizations looked at malpractice insurance for WFH and telehealth?
    1. ORG A – experienced organizational push back to WFH due to no telehealth clause in policy
    2. ORG B – has a virtual visit team – will reach out with this question
    3. ORG C – had established teletherapy practice prior to COVID-19 with specific coverage for virtual therapies

K. How have you accommodated translation for non-English speakers? What resources are available?
    1. ORG A – Using STRATUS for translation services – therapist calls into system and creates as 3 way call with client, interpreter, and therapist. Muted computer audio for video platform and used phone for session audio.
    2. ORG B – Zoom video, uses Cyracom for interpretation services through Zoom. Uses phone only sessions as last resort (only when video capability drops out). Try to avoid all non-secure applications, but if must use one, has family verbally consent and document in note.
    3. ORG C – Access to live interpreters – sometimes requires having only a telephone conversation, not video session.

L. How are you negotiating therapy across state lines? Therapists or clients in different states?

1. ORG A – for Known patients, considering them “ORG A state” residents regardless of where they physically are. Reciprocity granted for some nearby states. Practice guidance provided by Governor and hospital.
2. ORG B – for PT, licensure precludes any telehealth services outside of the state. ORG B is participating in “Compact” and the hospital is absorbing the cost for license fee for any clinician that requires that.

Summary compiled by: Cindi Hobbes, IPRC Director

Note: This document was de-identified for public sharing on the IPRC website. Organization lettering was re-started for each question such that “ORG A, ORG B, etc” does not refer to the same organization throughout the entire document.