



The integration of telehealth

How legislation and licensing boards are dealing with the new technology

This article is based on a presentation given by Mike Billings, PT, MS, CEEAA and Mei Wa Kwong, JD at the 2013 FSBPT Annual Meeting.

The APTA definition of telehealth: Telehealth is the use of electronic communications to provide and deliver a host of health-related information and healthcare services, including, but not limited to physical therapy-related information and services, over large and small distances. Telehealth encompasses a variety of healthcare and health promotion activities including, but not limited to, education, advice, reminders, interventions and monitoring of interventions.

The APTA position statement: It is the position of the American Physical Therapy Association that telehealth is an appropriate model of service delivery for the profession of physical therapy when provided in a manner consistent with Association positions, standards, guidelines, policies, procedures, Standards of Practice for Physical Therapy, ethical principles and standards and the Guide to Physical Therapist Practice.

Telehealth may be used to overcome barriers of access to services caused by distance, unavailability of specialists and/or sub-specialists and impaired mobility. Telehealth offers the potential to extend physical therapy services to remote, rural, underserved and culturally and linguistically diverse populations.

Among the states using telehealth for physical therapy are Alaska, Arizona, California, Georgia, Oklahoma and Washington. It's also used in Australia, Canada and the European Union,. A Canadian study concluded that telehealth is at least as effective as usual care with the potential to increase access to PT.

The Washington story

In the state of Washington, there was a significant problem of patient access to physical therapy while trying to meet Washington supervisory requirements. The practice was located in a challenging setting in an urban area in Tacoma. There was high turnover and it was difficult to find therapists.

The regulations in Washington mandate supervision every fifth visit or if the treatment is performed more than five times per week, evaluation must be performed at least once a week

and when there is any change in the patient's condition not consistent with planned progress or treatment goals.

The first step to incorporating telehealth was to clarify the intent of the regulation with the board of physical therapy. The board's response was, "When the Board of Physical Therapy wrote this rule, it was their intent that re-evaluation means that the licensed physical therapist must at a minimum lay eyes on the patient."

At that point, the group went to the board meeting with a proposal, asking for use of approved telehealth equipment to interact with the patient and assistant. Everyone agreed that if telehealth did not meet patient needs, then an onsite PT visit was required. A recorded session was later presented to the board (by board request) and the board required that the telehealth sessions be identified in electronic medical records as such.

The pilot project required a financial investment of \$2,000 for initial hardware (not including computers, Internet, etc.) and the monthly software cost was \$150. The goal was to improve clinical outcomes and access; therapist continuity, treatment plan progression, functional outcomes, patient satisfaction and therapist satisfaction.

Obtaining the sophisticated technology was the easy part; actual implementation was slower:

Here's the timeline:

- Nov. 2008 – Letter to the board.
- Nov. 2008 – Presentation to the board.
- March 2009 – Pilot project approved by the board.
- June 2009 - Recorded telehealth session was presented to the board.
- October 2009 – Draft language proposed.
- October 2010 – Public hearing was held.
- February 7, 2011 – Final approval by the state. It became a permanent regulation.

The revised language in the regulation states, "Licensed physical therapists and physical therapist assistants may provide physical therapy via telehealth following all requirements for standard of care. The physical therapist or physical therapist assistant must identify in the clinical record that the physical therapy occurred via telehealth."

It defined telehealth as providing physical therapy via electronic communication where the physical therapist or physical therapist assistant and the patient are not at the same physical location. It added that electronic communication means the use of interactive, secure multimedia equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the physical therapist or the physical therapist assistant and the patient.

Typical episode of care

The typical episode of care begins with an onsite visit with an examination, evaluation and treatment plan; the PTA will then do the daily onsite encounters with the patient and the PT will do re-evaluation by teleconference, observing the patient and PTA, record the encounter in

EMR, give feedback to the PTA and patient and modify the plans and goals. A PT is onsite for every tenth visit, and arrangements can be made for an onsite PT visit sooner than scheduled. Patient safety and outcome are priorities.

Among the telehealth successful outcomes:

- There was rapid adoption by patients and therapists.
- It resulted in superior clinical outcomes, with consistency of care, progression of treatment plan.
- It's in compliance with APTA and with the state.
- The turnover ended. The same PT and PTA have been at the site for five years.

Consider these issues when implementing telehealth sessions:

- Patient confidentiality (a designated area that is suitably private and enclosed)
- Informed patient consent (look at potential risks and benefits)
- Liability insurance
- Technical loss of connectivity, equipment failures
- Protect the public and avoid abuse

Opportunities

It provides better access, better quality and lower-cost healthcare and it speaks to license portability. Evidence supports the efficacy of telehealth. Telehealth also lends itself to collaborations with FSBPT, APTA, AOTA, ASHA, ATA, congressional leaders and the National Association for Support of Long-Term Care, the National Association of Rehabilitation Providers and Agencies. Telehealth still has to be approved by Medicare.

Is PT being left behind?

To ensure there is telehealth in the physical therapy future, state boards should put PT telehealth adoption on current (and beyond) strategic plans. Boards should also identify licensure portability barriers for telehealth, push for reimbursement for telehealth, promote continued research and education on safety and efficacy of telehealth and seek collaboration opportunities.

Center for Connected Health Policy (CCHP)

CCHP is a non-partisan, non-profit policy organization focused on issues related to telehealth and the role it plays in the California and national health systems. It was established in 2009 by the California Health Care Foundation and provides technical advice on policy, regulatory and legal issues related to telehealth on a state and national level. CCHP publishes reports, policy briefs, studies and papers and looks at things from a state and national level. CCHP, which has been designated as the National Telehealth Resource Center on Policy by HRSA, provides technical assistance to 12 resource centers around the country.

Telehealth is important to physical therapy because it addresses a different delivery system. Physical therapy should stay ahead of the curve and regulators should push hard to be included in all telehealth legislation. Telehealth is for everybody involved in health and physical therapy

needs to be part of that equation. Currently, it's mostly about doctors and nurses.

Establishing telehealth legislation involves research and background (think long-term and flexible), finding the right partners and educating policy makers. Once it's legislated, the regulation work begins. Everything relies on the language. How the language is crafted for law will impact where telehealth goes.

Telehealth history

On the federal level, it's all about Medicare and reimbursement for specific items. In 1997, Medicare beneficiaries in health professional shortage areas were permitted to receive care via telehealth, but the practitioner was required to be with patient during the consult. The consulting and referring physicians shared the fee (75/25 respectively).

In 2000, the law was changed to include non-MSA sites. Fee sharing was eliminated and reimbursable services were expanded.

Medicare improvements for patients and providers were the focus of minor changes in the act of 2008, which expanded the types of facilities that may act as an originating site. Medicare policy did not keep pace with changing technology and serves to restrict the use of telehealth rather than encourage it. There are geographic and facility restrictions and only live video is reimbursed. The reimbursable services are not a very big list, and it is difficult to get a service added to the list.

The provider definition is limited to physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists and clinical social workers.

State policies

State policy is different throughout the country. Some have followed Medicare, while the federal government has told the states they can do what they want with Medicaid telehealth reimbursement as long as the service satisfies federal requirements of efficiency, economy and quality of care.

Most states do some form of reimbursement by Medicaid for telehealth-delivered services. This is what CCHP found:

- 41 states have a definition for telemedicine.
- 17 states have a definition for telehealth.
- 2 states have no definition for either.
- 44 states reimburse for live videos.
- 10 states reimburse of remote patient monitoring.
- 7 states reimburse for store and forward.
- The most common reimbursements are for consultations, mental health and radiology.
- The most common providers reimbursed are doctors and nurses.
- Arizona, Minnesota and New Mexico specifically reimburse physical therapists in their Medicaid program for telehealth.
- The state Medicaid policy places limitations on the type of provider reimbursed as well

as the type of services that are reimbursed. The actual definition contains restrictions as well.

- 21 states passed private payer laws (4 recently passed legislation that is not yet in effect).
- Most simply say “healthcare professional” and don’t define what that is.
- How they define telehealth/telemedicine may still be limiting.

California’s telehealth policy

The telemedicine advancement act of 1996 was limited to certain physicians. Telemedicine was defined as a practice and not as mode of delivery. The act did not allow for flexibility for advancements in technology or treatment, and there were additional requirements that acted as safeguards.

CCHP looked at the model in 2010. It was an 18-month process that included thorough research, a workgroup of national experts that met four times and development of recommendations. A report was then presented at a briefing at the state capitol in California. As the bill went through the process, a coalition of diverse statewide organizations such as clinics, hospitals, providers and advocates started to sign on, and the proposal received bipartisan support.

The resulting legislation expanded the definition of telehealth as the mode of delivering healthcare services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient’s healthcare while the patient is at the originating site and the healthcare provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

It now includes physical therapists, occupational therapists, nurses, physician assistants, speech and language professionals, pathologists and dental hygienists, among others.

It became law in 2012 and private payers began to make adjustments to their policies. Medicare did not fully implement changes until September 2013, and regulatory board began weighing what they will do.

The board of occupational therapists proposed regulations in early 2013, with a second draft of regulations done in the summer of 2013. The board of physical therapy indicated it will be introducing draft regulations in September 2013.

More movement on telehealth

The current federal and state legislation environment is active. Seventeen telehealth-related bills have been introduced, and potential bills are on the horizon to address Medicare reimbursement, licensing, location and provider definitions. On the state landscape, 41 of 50 states and the District of Columbia introduced telehealth-related legislation in 2013.



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Mike has been in the rehab industry since 1991 and currently oversees all operations for Infinity Rehab. Mike received a Master of Science degree in Physical Therapy from Duke University. His clinical experiences include outpatient, acute care, home health, long-term care and wellness.

Mike has been a member of the American Physical Therapy Association (APTA) since 1992 and a member of the American Telemedicine Association (ATA) since 2013. He has lectured nationally on wheelchair seating and positioning, Medicare regulations, fitness for the older adult, and telerehabilitation. He has served as an adjunct professor at Pacific University in Forest Grove, OR and earned his Certification as Exercise Expert for Aging Adults (CEEAA) from the APTA.



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Mei Wa Kwong, has over a decade of experience in state and federal policy work. She is currently the Senior Policy Associate for the Center for Connected Health Policy (CCHP) and acts as Project Director for the National Telehealth Policy Resource Center. She has written numerous policy briefs, crafted state legislation and led several coalition efforts on a variety of issues.

More recently, Ms. Kwong co-authored CCHP's 50 State Medicaid Telehealth Reimbursement Survey. She is recognized by organizations and policy makers as an expert on telehealth policy and has been consulted by state and federal lawmakers on potential telehealth policy.