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Establishing a Telemental Health Practice

Because of their excitement over new technologies and their enthusiasm for extending services, providers are often eager to jump right to providing services. However, experience has shown that the most successful telepractices have taken the time to carefully identify and define program needs before beginning. A structured development process allows the provider to consider decisions and impact before making costly decisions (additional resources at http://www.hrsa.gov/publichealth/guidelines/behavioralhealth/behavioralhealthcareaccess.pdf). This chapter provides an overview of business planning and suggests additional resources for completing this in-depth process. The topics presented next are relevant for providers who either are interested in solely offering telemental health (TMH) services or who wish to augment their existing in-office services. This chapter informs providers working within a health care system as well as those who work alone or in group practices.

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NEEDS ASSESSMENT

Needs assessment supports the telepractitioner in identifying and assessing unmet clinical need in areas where he or she is considering practice and assessing individual and organizational readiness to meet these needs with telehealth. It includes data gathering about the prevalence of the behavioral condition within the target population as well as the service availability, often identified from federal (e.g., Health Resources Service Administration, Substance Abuse and Mental Health Services Administration, Centers for Disease Control's National Center for Health Statistics, Medicaid and Medicare reports) and regional (e.g., state and local health departments, community health assessments, community members, Telehealth Resource Centers) and other sources. If the provider is expanding services from an existing on-site practice, long wait times and patients/families driving miles for the particular behavioral treatment inform TMH focus. With existing practices, it is helpful to look at on-site referral patterns in identifying TMH partners.

The needs assessment also supports important relationship building with the local community. Ideally, it includes on-site conversations or focus groups with various stakeholders, including consumers and advocacy groups, local mental health professionals across settings and disciplines, primary care providers, and other formal and informal leaders (e.g., hospital administration or other community leaders). When feasible, it is a good idea to speak with payers about their interest in the new telepractice services. Other groups are relevant depending on the populations (e.g., schools, nursing facilities, substance abuse treatment). When on-site interactions are not feasible, telephone and video interactions are a good start. This process helps the provider identify where the demand for the service regularly exceeds local resources.

Remember that the goal of these early interactions is to listen and learn, reflecting genuine interest in how the provider can collaborate with the community to address a high need to use technology. As the provider builds relationships with the stakeholders, there is more detailed discussion of the proposed TMH service. These early conversations lay the foundation for the community engagement often needed to support the

telepractitioner at a distance and gain buy-in from formal and informal community leaders. As the telepractice clinic "goes live," these supporters are invaluable in "getting the word out" to the community and helping develop a sustainable clinic.

Needs assessments include many stakeholder questions, focused on gathering data to answer "who, what, where, when, why, how" questions. The core components of needs assessment can form the beginning of a TMH business plan and are summarized as follows:

- *Why* are you providing the telepractice services?
  - What are the service gaps in a geographic area?
  - Who is the current and potential competition?
  - Which types of services will be most advantageous now? How does that differ from the types of services to be delivered 5 or 10 years from now?
  - Does the proposed service align with the organization's current vision, mission, and strategic plan?
  - Does the proposed service have a champion? Do stakeholders support the program? Can the leaders of key organizations be recruited to support the plan prior to its initiation?
- *Which* telepractice services best fit the need?
  - Which assessment services will be offered over videoconferencing?
  - Which treatment services will be provided?
  - Which consultation services will be provided?
  - Which telesupervision services will be provided?
- *Whom* will you serve?
  - Which populations, including age groups, will be served?
  - What specific behavioral presentations will be included and excluded?
- *Where* will the telepractice services be delivered?
  - How will TMH services be integrated with other care services (e.g., primary care, hospital, federally qualified health centers, certified community mental health clinics, and other settings)?
  - What equipment, infrastructure, and space are required and available for TMH services, both at the provider site(s) and the client/patient site(s)?

- *When* will the clinic be established and telepractice services initiated?
  - How much time will it take to find and set up the equipment and connectivity?
  - How much time is needed to develop TMH clinical skills?
  - How much time will be allocated for service delivery once initiated?
  - What are the plans for "scaling" the service? How will the often-logarithmic increase in service demand be met over time? How will services be documented?
  - How will the new service be promoted initially and over time?
  - How many clients can be expected in the first year, 2 years, 3 years?
- *How* will the new telepractice service be delivered?
  - How will new referral sources be cultivated now and in the future, as well as maintained over time?
  - How can potential opposition to the telepractice services be minimized?
  - How can competitors be minimized?

The needs assessment includes gathering information about existing resources and how they may support telepractice, as well as considerations of new resources. Readers are referred to other chapters as they have additional questions based on their unique situation. This encompasses; technical needs (Chapter 2); administrative and professional needs (Chapter 3), including licensing, credentialing, and malpractice insurance; and emergency management needs (Chapter 5). There are also many resources to help telepractitioners learn about and complete telehealth needs assessment, such as the U.S. Department of Health and Human Services (http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Telehealth/howdoyoubegin.html), the Department of Defense (http://t2health.dcoe.mil/sites/default/files/TMH-Guidebook-Dec2013.pdf), and the federally funded Telehealth Resource Centers (http://www.telehealthresourcecenter.org/sites/main/files/file-attachments/complete-program-developer-kit-2014-web1.pdf), among others. For providers reaching out to underserved communities, the Community Toolbox provides additional insight (http://ctb.ku.edu/en).

BUSINESS PLANNING

Business planning goes hand-in-hand with needs assessment. It is essential for developing a plan for short- and long-term telepractice success. The needs assessment informs the resources that are needed across technologies, space, personnel, training, and marketing. A clear understanding of the proposed telepractice's financial impact is crucial, along with consideration of the risks associated with the implementation and decisions of the business model (Maheu, Whitten, & Allen, 2001; California Telehealth Resource Center, 2014). Careful attention should be given to whether one's organization is willing to implement telepractice if there is not a revenue positive or neutral program design, such as in the case of mission-driven services. The business plan includes estimates for service delivery, costs to develop and operate the behavioral service, and the sources of revenue. Costs for telehealth can be viewed from the perspective of the patients, the providers, and the client/patient site. Both start-up and operating costs should be taken into consideration, including who will pay for each component over time.

The following are important economic aspects to consider when establishing a practice (see Luxton, 2013):

- potential cost reductions (e.g., providers no longer traveling to remote clinics);
- costs for equipment, software, upgrades, office space, and network infrastructure;
- use of personally owned devices (patient's computer/webcams, etc.) versus need to purchase equipment;
- personnel costs across technical support, scheduling, billing, and general administrative supports;
- costs for specialized clinical training and documentation to meet legal and ethical requirements; general costs associated with the clinic including promotional/marketing materials, paperwork, behavioral questionnaires and scoring, clinic-specific materials (e.g., a scale may be of interest in a health psychology clinic), electronic health records;
- attorney and accounting fees;

- costs associated with distant site support of the patient, including a telemedicine coordinator when applicable;
- expected client/patient volume and payer mix, including planning for often-seen patterns of logarithmic growth as the telepractice is established;
- consideration of funding sources across insurers, contractual arrangements with sites, grants, philanthropy, institutional investment, and other potential sources;
- costs associated with internal quality improvement or other evaluation; and
- external economic factors such as inflation, interest rates, depreciation, and changes in technology costs.

A plan to track data to determine costs over time is recommended. Some large institutions and health care systems may already have a process for cost capture in place; however, the independent practitioner or group practices will need to establish a process for cost capture. More formal economic evaluation techniques can be used to determine the number of sessions to offset technology and staffing costs (see Luxton, 2013; see also Chapter 6, this volume).

REIMBURSEMENT

Before delivering service, the telepractitioner may benefit from knowing the details of reimbursement. In the United States and at the time of this writing, federal government insurance reimbursement for Medicare is available for many disabled retired Americans.[1] The Medicare program is under the purview of the Centers for Medicare and Medicaid Services (CMS). These programs will reimburse only for telehealth services delivered under strict guidelines. The patients must be presented from an originating site situated in a rural Health Professional Shortage Area (HPSA), located either outside of a Metropolitan Statistical Area (MSA)

[1] The authors have gone into some detail about the CMS programs because in the United Sates, many other insurance programs follow precedents set by CMS. Other countries have different payment systems so the delineation may be irrelevant.

or in a rural census tract, or in a county outside of an MSA. A federal website tool (https://www.cms.gov/telehealth/) assists in determining eligibility as a potential originating sites. In addition, the Telehealth Resource Centers (http://www.telehealthresourcecenter.org/reimbursement) are available for technical assistance. Several other conditions must be met for Medicare payments to be made for telehealth services. Specifically, the service must be on the list of covered Medicare telehealth services and meet all of the following requirements for coverage: The service must be delivered via an interactive telecommunications system to someone eligible for Medicare services; the practitioner furnishing the service must meet the telehealth requirements, as well as the usual Medicare requirements; and the individual receiving the services must be located at an eligible originating site. When all of these conditions are met, Medicare reimburses an "originating site" fee to the originating site and provides separate payment to the distant-site practitioner delivering the service. State Medicaid policies often follow Medicare guidance, but there is variability in specific requirements from state to state. Private insurers also tend to follow CMS regarding coverage but may have additional requirements for telehealth coverage.

For TMH assessment-related reimbursement through CMS, the telehealth service must generally be delivered via an interactive telecommunications system. Under the definition of *telehealth services* given by CMS (§410.78(a)(3), 2011), an *interactive telecommunications system* is defined as multimedia communications equipment that includes, . . . *at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner* (MS-1612-FC 187) (Telehealth Services, 2011). VC communication equipment must also meet all legal requirements for privacy and security.

Initial intake and associated assessment over VC is often reimbursed, within the reimbursement constraints addressed in other chapters. Nonetheless, many types of clinical assessments are conducted as part of typical TMH clinical care services in varied settings and situations. For example, the measurement of clinical symptoms for the assessment of treatment progress is quite common during TMH clinical treatment services (Luxton, Pruitt, & Osenbach, 2014).

PROTOCOLS

The needs assessment and business plan provide the road map for developing detailed protocols and procedures for the telepractice clinic. Protocols are practical documents describing the processes and each individual's role before, during, and after a telepractice consultation—in particular, how the telepractice clinic can ensure that proper procedures for documentation, staffing credentials and competencies, and patient privacy are followed. Protocols also include a plan for coordinating with staff at the remote site, troubleshooting technical problems, and managing clinical/medical emergencies (see Chapter 5 for more information). Alternate contact methods, such as by telephone, are necessary to maintain a connection between the patient and originating site and to contact technical support. In addition, protocols outline how electronic data and information remain accessible in the event of technical difficulties.

Protocols detail the telepractice workflow, including similarities and differences from the on-site setting. They help make sure best practices are implemented in the telehealth setting, and telepractices may consider protocol checklists to assist in understanding what is working as well as areas of improvement within the new clinic. In general, telepractice policies and procedures should approximate the in-office setting. Consideration should be given to the additional administrative demands required in some TMH practice models, including the scheduling demands when coordinating across numerous TMH providers and many sites, as well as billing staff well-versed in telehealth requirements. A process for ongoing provider, presenter, technical and administrative staff, and patient feedback should be established to continuously improve the protocol and match to evolving needs.

TELEPRACTICE CHAMPIONS AND DISTANT SITE COORDINATORS/PRESENTERS

For telepractices that are delivering services in supervised settings (e.g., hospitals, clinics, schools, prisons), it is important to identify a telepractice "champion" at the distant site. Ideally, the champion is a trusted leader

within the organization and someone with telehealth experiences. This "point person's" enthusiastic support lends credibility at the local level and can often be persuasive in convincing other local providers and agencies of the value of a new TMH clinic. The champion helps to gain buy-in both from the organization's leadership and administration and from clinic personnel who may be asked to expand their duties in support of the telepractice clinic.

In addition, a TMH site coordinator/TMH presenter/telefacilitator (American Telemedicine Association Telepresenting Standards and Guidelines Working Group, 2011; http://www.americantelemed.org/resources/nomenclature) is another crucial team member at the distant site. The role is often important in completing reimbursement requirements, such as verifying patient identity, confirming insurance coverage, collecting payment, and so forth. Sometimes the site champion and site coordinator are the same person. The site coordinator completes training to become proficient in both technology and behavioral health supports to meet the clinic needs. Qualifications for a telemedicine presenter include training as a health care professional (not necessarily behavioral health), technical proficiency and good communication skills, and a manner to make the patient and family comfortable throughout the telepractice session.

Site coordinators and other staff at the distant site (when available) may be responsible for a variety of helpful administrative, technical, and clinical tasks. The telepractitioner is encouraged to build strong relationships with these facilitators to jointly support the patient/family and to work together to resolve difficulties. As members of the client/patient's community, they can inform the provider of community-wide events that may impact the client/patient. The site coordinators assist as the extended "eyes and ears" of the telepractitioner and support all elements of the protocol before the session (with scheduling, paperwork, and socialization to the behavioral health system), during the session (with technical and clinical support, including assistance in emergency situations), and after the session (with understanding and implementing recommendations, including referrals). They orient patients/families to the telepractice and behavioral health processes, help complete the informed consent process,

allay worries about the technology, and answer questions that the patient may have. With the patient's knowledge and consent, the telepractitioner guides the site coordinator in terms of when he or she is needed in the room.

Again, with consent, the site coordinator may also provide information on the patient's functioning across systems/situations. For example, when the site coordinator is a school nurse, he or she may be able to comment on the progress of strategies within the school setting. The coordinator may also administer screening measures and assess for signs that suggest TMH may not be appropriate for the client/patient and communicate those concerns to the provider (see Chapter 7). They may coordinate electronic retrieval and transfer of necessary records or documentation to the provider delivering the service prior to the visit. They may also be able to prepare the VC equipment and test it to make sure that it is working properly, as well as check that the room is prepared for clinical encounters. Another advantage of these staff is that they may remain on call during the clinical sessions to assist in case any clinical or medical emergency protocols are initiated (see Chapter 5). Further, they can handle other necessary end-of-visit documentation that may include arranging follow-up scheduling, completing satisfaction surveys, answering questions about referrals or other recommendations, or serving any other immediate needs the patient may have at the completion of the encounter to help ensure coordination and continuation of care.

PILOT TMH PROGRAMS

As a standard recommended when initiating new clinics, we encourage a continuous quality improvement approach (see Institute for Healthcare Improvement, http://www.ihi.org) when starting a telepractice. A pilot of the telepractice service can test the waters before full adoption (Shore & Manson, 2005). A pilot may involve a limited number of TMH visits for a specified period of time to evaluate what worked and what did not to inform decisions regarding expansion of TMH services. A pilot can be useful for testing technical procedures and troubleshooting as well as refining the scheduling and referral processes. Protocols and processes can be refined based on feedback.