March 12, Telehealth Session Chat Comments

Participants were allowed to submit questions in advance and reply to speakers throughout the informational session.

Yael Miller wrote: Agree patient education is crucial to success of telehealth as a care modality.

Patti McLellan wrote: I thought consent was a requirement to bill telehealth? My providers are doing this - so we would be covered in all these scenarios.

Larry Garber wrote: Patient education should be more like the HIPAA Privacy Notice which is really a statement that this is how the world works if you are going to be under my care. We need to ensure that the patient is informed, but it should be part of the consent-for-treatment by a practice. Not just telehealth.

Janice Karin wrote: so if they evaluate the image and then discuss it with the patient is that two visits?

Hilary Jacobs wrote: I think it is very important to reinstate HIPAA compliant platforms and this is especially important for behavioral health appointments including those covered by 42CFR Part 2. There is no guarantee of privacy on non-HIPAA compliant platforms. Zoom, a platform that many people are familiar with and use regularly has a business platform that meet both 42CFR and HIPAA compliance standards and this is seamless to the patient.

Steven Locke commented: In an informed consent process, patients should have the right to waive aspects of their HIPAA privacy protections where conditions warrant that the ease of electronic communication override the privacy protections.

Lakshman Swamy wrote: and also how others are interpreting the REQUIREMENT to provide asynchronous services

Larry Garber: I agree with Hilary. We can't ignore patient privacy and security when there indeed are other platforms that are just as convenient as Facetime. Having said that, I think patients should be able to do informed consent to use FaceTime.

Jonathan Greenwood, PT, MS, DPT, PCS, FACHE wrote: I believe sending asynchronous information through a secure link to a provider is important to recognize (an OT could receive a video of a child post operatively to inspect a splint or confirm precautions without needing the child to come to the hospital)

Jen CR wrote: Strikes me that this transition to telehealth is a great opportunity to re-educate patients in what is and isn't covered, involved w their care. And to Dr. Kimball's point maybe the deductibles and copays should be approached a little differently too in this new era. Having patient input on all this might be helpful

Chris Scofield asked: are they any states with good policy that we could use as reference?

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Philip Ciampa, MD wrote: Really important point

Yael Miller: Agree Primary Care Physicians conduct considerable behavioral health services.

Philip Ciampa, MD - Atrius Health wrote: I agree with Dr. Lee. Preserving BH access is critical, and including general practitioners that care for the behavioral health of their patients should be included under this definition

Chris Garofalo wrote: MMS agrees with the speakers. The definition of those who provide behavioral health services, as defined, is much more expansive and family medicine, internal medicine, pediatric medicine and other specialists should be included. If they are not, there will be a discordance with payment in 2 years between certain specialties.

Jonathan Greenwood, PT, MS, DPT, PCS, FACHE added: Great consideration about Early Intervention Services

Boston Children's-Dr. Michael Lee wrote: We think many autism services can move virtual and create access so really the goal here again should be to say we cover these clinical services and should not focus on what types of providers provide them -so developmental specialists, neurologists etc.. maybe in this as well especially in pediatrics

Donald Bae, MD wrote: comment about "chronic disease management": one of five people in Massachusetts are children, and there may be differences in what constitutes a "chronic condition" in pediatric patients. while there are some chronic conditions that change over time and require continual care (e.g. cancer), there are also some diagnoses/conditions that remain constant but the effect on a growing, developing child may change, requiring continual or “chronic” care (e.g. cerebral palsy, congenital differences, metabolic disorders affecting bone health, etc)

Heather Meyers: Agree with the providers. For example, Boston Children's has an Autism Spectrum Center and these children can be seen by a provider in any three specialty areas for diagnosis and ongoing care: developmental pediatrics, child neurology, or psychology. All are equally trained and follow the same clinical guidelines.

Philip Ciampa, MD - Atrius Health noted: CMS definition of chronic diseases are very narrow, and I feel are also exclusive of illness that affect children. Would advocate for CDC definition as an alternative: “Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both”

Brendan Abel wrote: It will also be important to have an expansive definition of the types of providers who can provide this care for the "substance use disorder" portion of the definition of behavioral health services. For SUD, there are many non-psychiatric physicians, such as

addiction specialists and PCPs, who are critical to treatment of persons with substance use disorder.

Ellen Brennan Boston Children's Hospital PT/OT: Agree with the providers as well. I would include Occupational Therapy on that list of appropriate providers as well.

karen granoff wrote: We would encourage the definition utilized by the Centers for Disease Control and Prevention that states that chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. The ACE kids acts, which was passed by the federal government and is being implemented by the CMS defines chronic conditions as: Section 1945A(i)(2) of the Act defines a chronic condition as a serious, long-term physical, mental, or developmental disability or disease. Qualifying chronic conditions listed in the statute include cerebral palsy, cystic fibrosis, HIV/AIDS, blood diseases (such as anemia or sickle cell disease), muscular dystrophy, spina bifida, epilepsy, severe autism spectrum disorder, and serious emotional disturbance or serious mental health illness. The American Academy of Pediatrics defines chronic conditions as a health condition that lasts anywhere from 3 months to a lifetime. Blue Cross Blue Shield defines a chronic condition as a condition that affects your health and can be controlled but not cured. In summary, the list must be much more expansive than what is defined via CMS.

Janice Karin wrote: I'm not entirely sure if this is the right place for this question, but the developmental discussion we just had made me wonder. Are there any clauses to related to telehealth as an accommodation for disability that makes onsite more difficult (be it developmental or physical or whatever)

Boston Children's-Dr. Michael Lee: Agree with above from Karen Granoff and Janice Karin

Steven Locke wrote: The patient's physician is in the best position to determine if a condition is a chronic disease. Definitions and lists will never accurately identify all the individual variations

Lee H Schwamm, Mass General Brigham wrote: some have proposed "principal Care" rather than primary care to encompass examples such as the neurologist who cares for MS patients. We really need to think about how to preserve the enhanced access to primary, specialty and behavioral health care that became possible thru COVID

Yael Miller: In addition to the BCBS definition, MMS also agrees with the CDC definition, the ACE language, and being as broad as possible.

Chris Garofalo wrote: primary care physician has its roots in HMO model. The traditional "primary care physician" of FM, IM, pediatrics, OB/GYN are specialists and provide "specialty care" in their specialty. Neurologists are really sub-specialists.

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Jonathan Greenwood, PT, MS, DPT, PCS, FACHE wrote: Thank you Dr. Bae. I agree with your sentiments and chat information presented.

Heather Meyers : Agree with Dr. Donald Bae's comment about "chronic disease management" and the consideration for pediatrics

Jonathan Greenwood, PT, MS, DPT, PCS, FACHE wrote: Dr. Lee. Great considerations. Patients with complex conditions do often require multiple appointments throughout their life

Boston Children's-Dr. Michael Lee wrote: One thing to consider here is that truthfully clinicians only have limited time during the day. SO allowing them to bill at parity for a tele-visit is not going to explode the utilization-and our data show that in 2020 we are still below baseline 2019 productivity despite huge tele-expansion. And we would again agree that the specialty of provider should not be relevant for payment-we have an ICU physician who is the "primary physician" for our patients on home ventilators.

Menno Verhave, MD (Boston Children's): Agree with the comments RE pediatrics and chronic care. Would not want a time limited definition, and 1 year is definitely too long- kids change quickly. Also need to include Nutritionists as providers who are critical in our work with children.