Telepsychiatry Resources

In the interest of being of service and support during this critical time, we would like to share the following materials with you:

- Preparing for What's Next
- Telepsychiatry Checklist
- Telepsychiatry: A Primer

Please remember that we are all operating in uncharted territory and there are very few clear answers. This is a very fluid situation, and recommendations change based upon events and new guidance and actions from federal and state governments.

Preparing for What's Next - To Do List

JUNE 2020

NOTE: We are operating in uncharted territory and there are very few clear answers currently. This is a very fluid situation and the risk management recommendations below may change. This document will be updated on our FAQ page (www.PRMS.com/FAQ), and should be checked regularly. Nothing presented here is legal advice.

While we do not know exactly what will happen next in terms of the country re-emerging from the COVID-19 Public Health Emergency (PHE), psychiatrists should be prepared to address at least the following issues:

1. RE-OPENING YOUR PSYCHIATRIC OFFICE

In addition to your local community guidelines, review guidelines and best practices from the AMA, MGMA (Medical Group Management Association), CMS, and others.

***Tip**: Links to these resources are in our FAQs.*

2. FOR PATIENTS THAT REMAINED LOCAL, DETERMINE WHETHER THEY NEED TO BE SEEN IN-PERSON, REMOTELY, OR A COMBINATION OF BOTH

This determination should be based on your assessment of the patients' clinical needs, not on the patients' preference for telepsychiatry.

3. FOR PATIENTS CURRENTLY OUT-OF-STATE, DETERMINE IF THEY HAVE IMMINENT PLANS TO RETURN TO YOUR AREA

Manage patient expectations – let them know that the rules may be changing soon and you may not be allowed by law to continue to treat remotely.

4. TRACK STATE LICENSURE WAIVERS IN YOUR PATIENTS' STATES

They may expire on specific dates, or be extended, or withdrawn at any point.

***Tip**: PRMS will continue to track these licensure waivers in our FAQs.*

5. ONCE LICENSURE WAIVERS HAVE EXPIRED IN STATES WHERE YOUR PATIENTS ARE LOCATED, DETERMINE WHAT IS NEEDED TO CONTINUE TO TREAT YOUR PATIENT VIA TELEMEDICINE

States may require full licensure, a telemedicine registration, or there may be no requirements other than licensure in your own state to treat existing patents.

PRMS will help our insureds find this information.

6. IF AFTER THE WAIVER ENDS, YOU ARE ALLOWED TO CONTINUE TO SEE THE OUT-OF-STATE PATIENT, DETERMINE AND FOLLOW THAT STATE'S STANDARD TELEMEDICINE RULES THAT WILL LIKELY BE BACK IN EFFECT

States can have laws addressing requirements for in-person visits, informed consent, documentation, etc. If your patient's state does not have such laws, follow the telemedicine guidelines developed by the Federation of State Medical Boards.

PRMS will help our insureds find this state information.

7. IF AFTER THE WAIVER ENDS, YOU ARE NOT ABLE TO CONTINUE TREATING THE OUT-OF-STATE PATIENT (I.E. FULL LICENSURE IS REQUIRED), TERMINATE TREATMENT

Although this should be done quickly, do not abandon your patient– consider giving 30 days' notice.

8. IF AFTER THE WAIVER ENDS YOU WANT TO CONTINUE TREATING YOUR PATIENT REMOTELY AND HAVE DETERMINED THAT YOU ARE IN COMPLIANCE WITH LICENSING REQUIREMENTS, ENSURE YOU ARE ALSO IN COMPLIANCE WITH THE PATIENT'S STATE'S PRESCRIBING LAWS

There may be specific state laws, particularly for controlled substances.

You should also register with and use, to the extent possible, the state prescribing drug monitoring program.

9. IF YOU ARE PRESCRIBING CONTROLLED SUBSTANCES FOR OUT-OF-STATE PATIENTS, BE ALERT TO WHEN HHS DECLARES THE END TO THE PHE

The current PHE declaration is set to expire near the end of July. It can be revoked earlier, or extended.

***Tip:** PRMS will be tracking this in our FAQs.*

When the PHE ends, two currently suspended federal requirements for prescribing controlled substances will likely go back into effect.

First, the requirement that there be an in-person visit prior to prescribing controlled substances will likely go back into effect. It is unclear whether the DEA will require those who began treating patients during the PHE to have an in-person visit after the PHE expires in order to continue prescribing controlled substances to these patients.

Second, the requirement to have a federal DEA registration in the patient's state (as well as in your state) will likely go back into effect.

10. WHEN THE PHE ENDS, EXPECT HHS TO REINSTATE THE REQUIREMENT THAT TELEMEDICINE MUST BE CONDUCTED VIA A HIPAA-COMPLIANT PLATFORM

This generally means that you will need a Business Associate Agreement (BAA) from the vendor.

For additional information, see our Telepsychiatry Checklist at PRMS.com/FAQ

TELEPSYCHIATRY CHECKLIST – MODIFIED PER CORONAVIRUS UPDATES (9/2/20)

□ I have reviewed my state's law on telemedicine, including, but not limited to:

- □ In-person examination requirements
- □ Prescribing requirements

3/19/20: States may be relaxing some of these requirements given the need for individuals to stay home.

□ If I'm located in a state where I'm not licensed, and I'm not seeing any patients located in that state:

- □ I have confirmed with that state's licensing board that no license is necessary to treat out-of-state patients.

□ If a patient will be treated in a different state:

- □ Licensure
  - □ I am licensed in the patient's state, all state requirements are met (CME requirements, PMP requirements, etc...)

  OR

  - □ A license in that state is not required (3/9/20)

3/19/20: States MAY be relaxing licensure requirements, but it may be only in limited circumstances, such as only to treat patients in a hospital, or only if actually treating the coronavirus.

- □ Law
  - □ I have reviewed the law on telemedicine in the patient's state, including, but not limited to:
    - □ In-person examination requirements
    - □ Prescribing requirements

3/19/20: States have been slow to offer licensure waivers and even slower to address state treatment laws. The risk management advice is to do what you can. For example, a state may require written informed consent for the use of telemedicine. That may or may not be possible; if not possible, providers can obtain verbal consent and document that verbal consent to telemedicine.

□ I am using HIPAA-compliant equipment

- □ If the equipment vendor stores any patient information, I have a Business Associate Agreement from the vendor

3/19/20: The federal government has exercised "its enforcement discretion and will waive potential penalties against health care providers that serve patients through everyday communication technologies during the COVID-19 nationwide public health emergency. This exercise of discretion applies to widely available communication apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19."

https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html

□ I understand that services are considered rendered at the patient's location, not my location

□ I understand that the standard of care for telepsychiatry services is the same as for in-person visits

3/19/20: This is still true. So, for example, just as you need to get a patient in crisis to the hospital from your office, you would need to be able to call emergency services if a remotely treated patient is in crisis. Be sure to know the patient's exact location at the beginning of each session.

□ I understand that this treatment modality is not appropriate for all patients and I engage in careful patient selection

- □ I re-evaluate periodically the appropriateness of treatment

□ I require patient identification at the first session

□ I confirm patient location at the start of every session

□ I obtain informed consent to the use of telepsychiatry, in addition to informed consent to treatment

3/19/20: if written informed consent is not possible, at least document consent obtained verbally.

□ If I am prescribing, I am complying with:

- □ State law in my state and, if different, state law in the patient's state
- □ Check the Prescription Monitory Program, as applicable
- □ Federal law, if prescribing controlled substances, by:
  - □ Having a DEA registration in my state as well as each patient's state (if different from my state)

    3/31/20: The DEA has temporarily waived the requirement to have a DEA registration in the patient's state.

- □ Seeing patient one time in person prior to prescribing controlled substances

  OR

  - □ Qualifying for one of the DEA's very limited exceptions to the one in-person visit rule

  3/19/20: The DEA has reminded providers of the public health emergency exception to the one in-person visit prior to prescribing controlled substances.
  www.deadiversion.usdoj.gov/coronavirus/html

- □ I provide appropriate patient monitoring, including follow-up on testing ordered

- □ I provide appropriate follow-up care

- □ I maintain appropriate documentation of all sessions

- □ I have contingency plans for:
  - □ Clinical emergencies – including contact information for local authorities in the event of a crisis
  - □ Technical failures

    3/19/20: An example would be continuing the interrupted video session by telephone.

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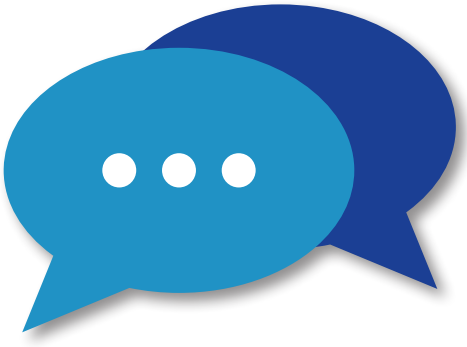
TELEPSYCHIATRY: A PRIMER

CONDENSED VERSION

INTRODUCTION



Telemedicine, and specifically telepsychiatry, has been practiced in this country since at least the mid-1960s. As technology has advanced it has not just been large institutions who have engaged in the use of telemedicine, but also individual practitioners many of whom are psychiatrists. This trend is expected to continue as recent developments and events have brought increased focus to the need for greater access to mental healthcare.

THIS PRIMER IS INTENDED as an overview of the risks associated with the practice of telepsychiatry and suggestions for minimizing those risks. A more comprehensive version of this guide is available to PRMS clients by emailing TheProgram@prms.com.

TELEPSYCHIATRY: GETTING STARTED

Psychiatrists who contact our Risk Management department with questions on the use of telepsychiatry fall into two major categories: those who have a particular patient (or patients) whom they wish to treat remotely, and those who are contemplating the use of telepsychiatry as a way to expand their practices either by affiliating with a company that provides telepsychiatry or by setting up as a service within their own offices. Regardless of whether your intent is to use telepsychiatry once or to make it a routine part of your practice, your initial considerations are the same.

Step One: Determine what exactly you want to do

When contemplating the use of telepsychiatry, the first questions to ask yourself are, what activities do I wish to engage in and what services do I want to perform? Do I want to offer consultation to other healthcare providers? Treat patients directly? Perform emergency evaluations? Provide service to a specific population such as inmates at a correctional facility? Will I be prescribing medication?

Once you have answered the question of what it is you want to do, you must then think about how you want to do it. Do you want to provide services directly on your own or do you want to collaborate with others such as an internal medicine group or through an established telemedicine program at a facility? Perhaps you want to contract as a provider with a company that offers telemedicine services. What technology will be used?

Step Two: Overcoming legal hurdles

Depending upon the type of activity you have chosen to perform and the technology you want to utilize, there may be legal requirements that must be met. Among these are licensure, credentialing, standard of care, and other state-specific requirements.

Licensure

After you have defined the scope of your telepsychiatry practice, the next step is ensuring that you can meet all of the legal requirements; the first of which is licensure. A physician is deemed to be practicing medicine in the state in which the *patient* is physically located at the time of treatment and thus he or she must meet the licensure requirements of that state. Currently each state has its own rules and whether a license is required may vary depending on several factors including: type and frequency of the encounter, duration of treatment, whether another local psychiatrist is also involved in care, etc.

If you are contemplating treating a patient who will be located in a state in which you do not hold a current medical license, the following steps should be taken:

- Contact the remote state's licensing board and explain your intended activities
- Ask whether a state license is required
- Contact your own licensing board to ensure its requirements have been met
- Contact should ideally be in writing or via email to allow for a written record of the board's answer
- Alternatively, note the number called, the date, time, with whom you spoke, the question posed, and the answer given

Understand also that although what you plan on doing (e.g., telephone consultation) may not fit your state's (or that of the patient) definition of "telemedicine," that does not mean that the issue of licensure is moot. If you are tempted to proceed without requisite licensure consider this. In many states the practice of medicine without a license is considered a criminal act. Should you be involved in a claim or a lawsuit, coverage may be denied as criminal acts are an exclusion under malpractice insurance policies. In a worst case scenario, you might find yourself subjected to criminal prosecution, licensing board actions, and a malpractice lawsuit all without defense coverage.

Credentialing

If you intend to provide telepsychiatry services through a hospital, you will need to consider the issue of credentialing which may be a lengthy process. The Centers for Medicare and Medicaid and The Joint Commission do allow credentialing by proxy where the governing body of the hospital whose patients are receiving telemedicine services may choose to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site telemedicine entity when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services.[1]

The Standard of Care

The standard of care is a legal concept but is based upon clinical standards determined by the medical profession. What care meets the standard of care ultimately depends upon the particular patient and his or her unique needs. It is important to remember that the standard of care for treatment via telemedicine is *exactly* the same as it would be were the patient seen in a face-to-face encounter.

When practicing telemedicine, one must consider not only meeting the standard of care from a *clinical* perspective but also meeting the standards required for the practice of *telemedicine*. Many states have very specific regulations for telemedicine practices that must be complied with. In addition to licensure requirements, be aware of other rules and regulations your state (and that of the patient) may have regarding telemedicine practice as you will be required to comply with both sets of rules. These may include requirements for such things as:

- Documentation
- Obtaining informed consent for the use of telemedicine
- Establishing a treatment relationship
- The need for a face-to-face visit prior to prescribing
- Type of equipment used
- Etc.

Failure to follow these requirements could subject you to a licensing board action. In addition, there are various professional organizations and associations (such as the Federation of State Medical Boards and American Telemedicine Association) that have issued guidelines for the practice of telemedicine that may also inform the standard of care. Evidence of failure to comply with various rules and guidelines could potentially be used to establish that the standard of care was not met in the event of a lawsuit. (For more information regarding the standard of care, see Clinical Hurdles on page 6.)

OTHER CONSIDERATIONS

HIPAA Compliance

HIPAA privacy and security protections represent the *minimum* of what is required in terms of confidentiality standards. This is true regardless of whether you are a covered entity under HIPAA as several courts have recently allowed HIPAA rules to be used as evidence of the standard of care.[2]

If you utilize a system wherein patient-identifying information is created, received, maintained, or transmitted, you must have in place a Business Associate Agreement with the system vendor. If the information is not stored and the system merely acts as a conduit then the vendor is not a Business Associate under HIPAA.[3] Take note, however, that the conduit exception applies to *very few* situations and thus, if your system vendor is unwilling to provide a Business Associate Agreement, you must closely scrutinize

their privacy policy to confirm that they are not Business Associates. Remember, it is *your* responsibility to ensure HIPAA compliance in addition to payer rules regarding technology.

Prescribing

If part of your treatment plan includes prescribing medication, you should be aware of relevant federal and state laws regarding the internet prescribing of controlled and non-controlled medications. Prior to prescribing any medications, most states require that a physician-patient relationship exist between the patient and prescribing physician. Other requirements many include the need for a physical examination before a prescription may be written. What constitutes a valid physical examination varies greatly from state to state.

Prescribers must also bear in mind federal law, specifically the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 which amends the Controlled Substances Act. Following to the Act, no controlled substance may be delivered, distributed or dispensed by means of the Internet without a valid prescription. Whether a prescription is valid is based upon whether the patient was examined in-person by the physician writing the prescription. The Act does, however, provide exceptions for certain telemedicine activities such as when the patient is located in a hospital or other facility registered with the DEA and the remote physician/prescriber possesses a DEA license in the patient's state.

While the intent of the Ryan Haight Act was well-reasoned, the wording of the law has proved to be troublesome for the advancement of telemedicine – particularly telepsychiatry. In an effort to remedy this, on October 15, 2015, the American Telemedicine Association (ATA) sent a letter to the DEA advocating a "structured yet flexible framework for appropriate online prescribing that recognizes long-standing practices by legitimate, licensed providers who offer needed medical services to a highly targeted group of patients" that would recognize a distinction between telepsychiatry and other forms of telemedicine.[4] Stay tuned.

CLINICAL HURDLES

When providing care via telepsychiatry, you must be cognizant of the problems of lost abilities; in other words, the inability to use (or fully use) certain senses to examine the patient. For example, if you are treating a patient with an alcohol abuse problem, being able to smell the patient's breath or to determine whether he or she had a hand tremor or unsteady gait might be important. Less easy to articulate is the sixth sense that most psychiatrists have with regard to their patients that lets them know immediately if a patient is not doing well. This ability is often lost in telemedicine. All of this becomes

very important because, as previously stated, the standard of care does not change when you are treating a patient remotely. You are expected to be able to render the exact same level of care you would provide were the patient in your office. Consider whether the processes you currently have in place will work when seeing the patient via telemedicine.

- How will you monitor your patient remotely?
- Will you be able to spot patient non-adherence?
- How will interim care be provided?
- How will prescriptions be handled?

None of these issues are insurmountable; however, it is important to determine how they will be handled *before* you begin seeing patients via telemedicine.

In addition to possibly modifying your procedures to fit with remote providing care at a distance, you must also consider the additional care issues that are related to telepsychiatry.

ADDITIONAL CARE ISSUES

Patient Selection

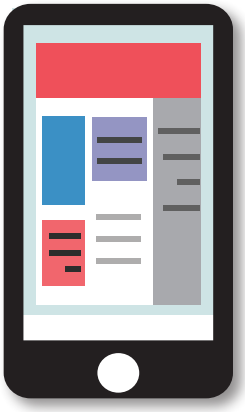
Psychiatrists routinely engage in patient selection by using initial and ongoing evaluations to identify patients who are and who are not a good fit for the psychiatrist's particular practice. In the context of telepsychiatry, it may be helpful to first define a general patient population for whom telepsychiatry would be an appropriate method of delivering care.

Begin by thinking about what conditions you routinely treat and which of these might reasonably be managed remotely, taking into consideration the problem of lost abilities. Whether a condition may be managed remotely will be affected by the model of telepsychiatry you have chosen. For example, if you are treating a patient who will be in the presence of another healthcare provider, that person may be able to compensate for your lost abilities, but if the patient is not in the presence of another, the problem of lost abilities may make optimal care difficult.

There are other considerations:

- Is your patient stable?
- Is your patient tech-savvy enough to handle the equipment and possible tech glitches?
- Do you trust your patient?
- Will your patient be truthful about his or her location during the session?
- Where will your patient be located at the time of treatment?
- Has this patient been a reliable reporter in the past?
- How will the use of telemedicine impact this particular patient?

Even if your patient appears to be a good candidate for the use of telepsychiatry initially, these questions must continually be re-asked during the course of treatment to ascertain whether your patient continues to be a good candidate and is truly benefitting from its use.



Consent to Telepsychiatry

In some states, consent to the use of telepsychiatry is mandated. Even where this is not the case, psychiatrists should obtain their patients' consent to the use of telepsychiatry *in addition* to obtaining consent to treatment. Part of this conversation should include discussing the limitations of telepsychiatry. Patients should be made aware of the issue of lost abilities and the potential that conditions that could be diagnosed with an in-person visit may go undetected in a remote encounter.

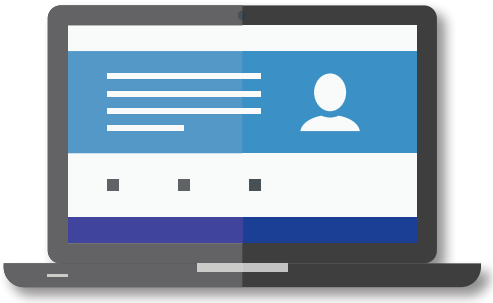
The chosen telepsychiatry method may present privacy considerations not present in traditional office-based practice. If so, these should be incorporated into the informed consent discussions as well. Psychiatrists should also be aware of any laws, regulations, or rules in their states related to specific requirements for informed consent in telemedicine.

In its *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*, Federation of State Medical Boards (FSMB) recommends the following:

"Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials

- Types of transmissions permitted using telemedicine technologies (e.g., prescription refills, appointment scheduling, patient education, etc.)
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures
- Hold harmless clause for information lost due to technical failures
- Requirement for express patient consent to forward patient-identifiable information to a third party."[5]



Contingency Planning

Even though your patient may be very stable you must still have a plan for handling emergencies just as you would were the emergency to occur in your own office. As you are expected to provide the same level of care to a patient being seen via telepsychiatry, you should be as familiar with the resources available at the patient's location as you would be with the resources available to patients seen in-office. Consider the following:

- What would you do if a patient were to become actively suicidal or suffer a seizure or a heart attack during a session?
- You know generally that a patient is located in a specific city during your sessions but do you know the precise address of his location?
- Do you know the telephone number for the local police?
- Do you know how to have your patient involuntarily hospitalized?
- Do you have an alternative plan?
- How would you handle a technology failure?
- Technology allows patients to communicate with physicians from anywhere they can find a signal, whether using cable, closed-circuit television, phone lines, cellular phone towers, wireless internet, or satellite. Uncertainty about patient location can pose challenges for reacting to emergencies.
- It is also important to be familiar with the non-emergency medical resources available to the patient.

Optimizing the Encounter

If you've never communicated with anyone via video-teleconferencing, you might be surprised at how different the interaction is. It might actually be a good idea to practice with someone before you "see" patients. How to you appear on screen? Think about things like background lighting, whether you are wearing a pattern that "vibrates." Are you sitting close enough to the camera but not too close? Are you making certain that you enunciate clearly and take into consideration the delays in transmission? You may find that you need to accentuate your speech as you may come across as flat on camera. Is there any background noise that might be heard by the other party? Remember also that if you are looking at the screen when you speak, you may not be looking into the camera and it will appear that you are looking down rather than at the patient. These same suggestions will be beneficial to your patient for the best presentation from his end.

Documentation

In addition to your usual documentation for a patient appointment, if treating the patient via telemedicine, you should also add the following to your documentation:

- Your location and that of the patient at the time of the encounter
- Technology used
- Name and role of anyone else present for the encounter, e.g., a presenter at a remote site
- The patient's continued agreement and satisfaction with the use of the chosen technology
- Any technical problems that occurred during the encounter

TELEPSYCHIATRY: PUTTING IT ALL INTO PRACTICE

Summary

- Determine your telepsychiatry endeavor.
- Determine all relevant laws and other standard of care factors.
- Evaluate your ability to comply with legal requirements.
- Understand the importance of the location of the patient, both for legal and clinical purposes.

- Understand the standard of care does not change with technology.
- Evaluate the impact of your proposed telepsychiatry endeavor on your ability to meet the normal standard of care.
- Consider what will be lost when treating individual patients remotely.
- Ensure the ability to treat individual patients within the standard of care.
- Ensure patients have a basic understanding of the technology being used and appreciate its limitations.
- Prepare for possible emergencies by having patient addresses and local emergency services numbers available.
- Utilize a consent form.
- Documentation should reflect session occurred via telepsychiatry.
- Continually re-evaluate physician and patient level of satisfaction.

As you have by now realized, treating patients via telepsychiatry carries with it two sets of risks: those related to the usual practice of psychiatry and those related to the use of the technology. Fortunately, the standard risk management strategies you have been taught to use in regular practice may also be used in telepsychiatry: collecting information, communication, and careful documentation.

CONCLUSION

Telemedicine is a rapidly-expanding field and, given the greater focus being placed on access to mental healthcare and the continued shortage of mental health providers, psychiatrists can expect to be a part of that expansion. Because the field is still developing, it is incumbent upon physicians to carefully analyze the implications of any telemedicine activities they wish to undertake. However, with proper preparation and thoughtful risk management, telemedicine can be an invaluable tool for allowing greater access to patients who would otherwise not be able to access their services.

1 42 CFR 482.22

2 Vanderpool, D. (2015). Legal aspects of teleanalysis in the United States In J. S. Scharff (Ed.), Psychoanalysis online 2 (pp. 93-104). London: Karnac

3 Vanderpool, D. (2015). An overview of practicing high quality telepsychiatry In N. A. Dewan, J. S. Luo & N. M. Lorenzi (Eds.), Mental health practice in a digital world (pp. 159-182). New York: Springer.

4 http://www.americantelemed.org/news-landing/2015/10/08/ata-letter-to-the-dea-on-ryan-haight-act#.VsSjBrQrJD8

5 http://www.fsmb.org

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