gpTRAC
Great Plains Telehealth Resource & Assistance Center

May 2021

Toolkit Series

Telerehabilitation Services

This toolkit addresses the use of telehealth across the professions of Occupational Therapy (OT), Physical Therapy (PT) and Speech Language Pathology (SLP). Included are aspects of practice as it relates to Occupational Therapists, Certified Occupational Therapy Assistants, Physical Therapists, Physical Therapy Assistants, and Speech Language Pathologists.

Each profession uses their professional organizations to establish telehealth guidelines and all are heavily involved in advocating for clinical integration and reimbursement of rehab services. The three professional organizations that cover these professions are: **American Physical Therapy Association (APTA)**, **American Occupational Therapy Association (AOTA)**, and **American Speech-Language-Hearing Association (ASHA)**. All three organizations also participate in and guide the work of the **American Telemedicine Association** (ATA). The terms telehealth, telerehabilitation, telepractice, virtual, and digital are used throughout this document to represent services delivered remotely using technology. The term "telerehab/telerehabilitation" will be used going forward.

While OT, PT and SLP each offer distinct rehabilitation expertise, they are typically addressed together as "rehabilitation services" in the areas of policy and reimbursement. This toolkit will address telehealth as it applies to common themes of practice for these professions while calling out specific uses for each profession and client group served. For in-depth guidance, we direct the reader to resources from each professional organization, state and local licensing entity, and reimbursement sources, as payers' reimbursement policy impacts each practice area differently.

More terms and definitions found in Appendix A.

Five Foundational Concepts in Telerehabilitation

These five concepts give each therapist a good foundation to begin building services delivered through telehealth.

1. **Telehealth is a service delivery model.** Telehealth, and therefore telerehabilitation, is not a medium or practice unto itself. It is a method of delivering care to clients/patients, families, and communities using technology from a distance.

2. All rules, regulations, clinical expectations and professional obligations toward a patient, family or group of clients are expected to be delivered at the **same level of service and quality during a telerehabilitation encounter as an in-person encounter.**

3. **The encounter or service is considered to have occurred where the patient is located.** The provider or clinician must meet the licensing requirements of the patient's location at the time of the encounter. For example, if the therapist is in Wyoming and the patient is in South Dakota, the encounter is considered to have been provided in South Dakota. The therapist must meet the rules of South Dakota licensure and enrollment for payer reimbursement. While multi-state licensing compacts have eased the paperwork for some states, therapists are advised to fully research professional licensing and regulations at the international, national, state and organizational level.

4. **Telerehab brings unique opportunities to the therapy service.** A video connection into the home of a patient and their family can uncover the functioning reality of the patient's life. These connections can allow therapists to develop a broader picture of the client's home, space, resources/tools available to dedicate to home programming, and whether the therapy is having the

expected functional impact. Relationships and communication patterns are unique to each family unit, and trauma or disability can disrupt or change those relationships and communication abilities. Understanding our patients' everyday life dynamics is important when developing effective and personalized therapy plans of care.

5. **Caregiver involvement** in telerehab sessions will enhance that caregiver's understanding of the therapeutic interventions and the expected outcomes of interventions. This involvement and support by a caregiver during the telehealth encounter can include physically assisting the patient during exercises, managing the computer equipment and connections as well as the therapy space during the on-line sessions.

Benefits & Challenges

Documented Benefits

Using technology for therapy services connects therapist and patient at a new level, expanding therapy care. Telerehab…

- Increases access to both therapy and therapy specialty care if the patient does not live close to the therapist
- Gives therapists insight into the patient's home environment
- Reduces anxiety by delivering care in a familiar environment, thereby enhancing outcomes
- Reduces burden and cost of travel for families. This may be a benefit both in rural areas and urban areas
- Reduces the travel required of therapists who travel to several locations to deliver care
- Increases access to therapy treatment at critical milestones in therapy care plans
- Reduces the need for patients and families to take time off from work and/or find childcare
- Reduces risk of contracting COVID and other shared illnesses
- Reduces patient cancellations
- Improves compliance with home programs
- Improves caregiver involvement in therapy by including family and care team members and incorporating health care advocates

Challenges to Delivering Therapy Through Telehealth

There are also documented difficulties that compromise the delivery of care through telehealth. Experience with telehealth alleviates some struggles, but the overwhelming issue of limited WiFi availability and poor technology literacy among our patients is a huge deterrent to success.

Challenges to utilization include:

- Therapists lack the hands-on aspects of therapy care with telerehab. Explicit instructions of patient positioning, hand placement, equipment use, and physical movements during the therapy sessions becomes a chore. To direct the flow of the encounter, the provider must completely, accurately, and slowly state instructions to the patient in an acceptable tone of voice. This may be a new skill that some therapists will have to learn.
- There is a sound delay with technology. Providers must be patient to allow for the patient's transmission of speech, as two people talking over each other cancels out the communications.
- Lack of WiFi and low bandwidth hampers delivery. Sound and video are both affected. Maximize the available bandwidth by closing apps, programs and moving to find the optimal spot in the house away from structures will help.
- Each session requires preparation and communication with the patient or caregiver before the session begins. This may include sending supplies, written pages, or instructions to gather items for therapy use. A test connection the day of the session or day prior will give first-time users time to problem solve and ease the stress of technological glitches.
- Successful telerehab therapists are technology problem solvers at times. Being well-versed in the possible issues of connections, software, WiFi, and sound problems becomes vital. Teaching the patients how to deal with technology is an important practice skill and should not be overlooked.
- Setting up appointments and communicating via phone calls. Many people with mobile phones and number recognition do not answer their phones if they don't recognize the phone number. Share the phone number with which you will be contacting the patient so they know to respond.

There is an abundance of research in telerehabilitation, including The International Journal of Telerehabilitation. Research shows that there is no significant difference between in-person service and telehealth services for a variety of therapy services (Tenforde, et al, 2020) . Some outcomes are reportedly better with treatments through telerehab . The Department of Veterans Affairs uses telehealth extensively to provide the wide variety of healthcare needed by our veterans. There is also abundant research on VA services that is rich with innovation and guidance (Darkins et al., 2008, Gately et al., 2020, Hale-Gallardo et al., 2020)

HIGH Patient Satisfaction with Virtual Visits During COVID

A study published November 2020 by Tenforde et.al. outlined high patient satisfaction in 6 areas during the telerehab visit. The majority (86.8%) of patients surveyed agreed on the value of having a future telerehab visit. Of the 211 patient surveys, there was no association between age and patient satisfaction with 75% of patients 65 yrs. or older operating the telehealth platform without the assistance of a patient care advocate.

Telerehab requires many modifications for musculoskeletal work on the part of the therapists and their patients. Creativity will be required to address myofascial deficits traditionally managed manually. Teaching hands-on facilitation techniques to caregivers and patients can also prove more difficult through telerehab, but learning self-management techniques is a valuable patient skill. SLPs experience barriers to pragmatic practice in the absence of natural, face-to-face social situations and due to the limitations of an assessment of safe oral motor and swallow function during virtual feeding therapy. Nevertheless, to be able to sit in on the patient's dining experience via telehealth will give important clues in designing a better care plan.

The delivery of virtual pediatric therapy for patients with significant behavioral or attention difficulties is challenging and ineffective for some children, yet very successful for others. Some clinicians attest to improved attention to the screen and other psychiatrists feel that adolescents and teens are more open to sharing their feelings and problems through an online connection.

In 2019, 53% of seniors owned a smartphone.

The ageist generalization that all patients over 55 are averse to the use of technology is difficult to accept with the vast use of Facetime and Zoom to connect grandparents with distant grandchildren and families. Opportunities to learn new software applications for therapy connections takes patience, but reaps vast rewards.

Authorized telemedicine locations under Medicare rules for reimbursement are set by legislative action and may only be changed by law. Due to COVID, temporary policies relaxed those limiting requirements and expanded beyond rural healthcare settings. These temporary policies also allow therapists to reach the patient who sits in his truck over lunch and connects with his therapist for service. Here's a list of possible service locations and practice areas that serves as a starting point for consideration. After all, NASA uses telehealth to reach our astronauts in space!

- Private homes
- Hospitals (ER, ICU, Covid units, etc)
- Clinics, RHC, FQHCs
- Skilled nursing facilities
- Assisted living situations
- Residential care facilities
- Psychiatric and addiction settings
- Schools and childcare centers
- Community Mental Health Centers
- Community-based worksite
- Correctional centers
- Homeless shelters

Here are examples of current telerehab practice areas. The options are, however, as robust as the therapy applications you provide in the clinic:

- Pediatric and School based therapy
- Sports injuries
- Pediatric neurology
- Lower limb injuries
- Lower Back Pain
- Articulation disorders
- Aphasia
- Autism
- Functional movement screen (FMS)
- Post-discharge checkups and safety screens
- Wellness and preventative services to avoid hospitalizations
- Dysarthria
- Dysphagia
- Fluency disorders
- Language and cognitive disorders
- Voice disorders
- Prevention of readmission through home safety evals and mobility screens

Where do I begin?

The Great Plains Telehealth Resource and Assistance Center (gpTRAC) has several resources available at www.gptrac.org. Check out the *Checklist for Initiating Telehealth Services* (and other resources) as a starting point for establishing a solid foundation around the aspects that will need consideration when developing this service.

Prepare Your Team for Success

Therapy service delivery takes a team, as does telerehab. To begin telerehab service delivery, include the whole rehab staff in communications, development, and idea generation. Each step of the workflow—from marketing, scheduling, technology support, patient outcomes and surveys—could contribute to the development and successful implementation of telerehabilitation services.

Present the plan to implement telerehab and elicit the support from the leadership and middle management of your organization. Ask for each team's commitment to the work required for high-quality implementation. Together, determine what is needed to begin, when to begin and what a successful outcome will look like. Find a small, manageable starting point rather than trying to begin with the most complicated or difficult situation. Preferably, you should start with some aspect of telerehab that can be used in a variety of therapy situations. Accept that not all therapy situations or patients will be appropriate for this type of care.

From the beginning of the project, acknowledge the work and involvement of all the teams that are involved in patient services. Gather the leaders from Legal, Billing, Marketing, IT, Contracting, Quality Improvement, and Patient Registration/Scheduling services to share the goal and get input on the work ahead. Continue with regular meetings to check on progress and work activities with quality improvement targets clearly outlined. Keep open dialogue and encourage them to report on progress and barriers from their perspectives. Continue to ask for their support and expertise as the program develops.



Find an advocate or champion. Choose a respected medical team leader that understands the importance of modeling good examples. Arm him/her with accurate information on the project and keep them updated on progress and barriers. Within the rehab team, support therapists who are leading by expanding their practice options to include telerehab. Share out their examples of teletherapy care and their 'lessons learned'.

Not all therapists will embrace this new model of care, and existing providers and clinicians with well-established work patterns will be uncomfortable or possibly threatened by changes to include telehealth in their practice patterns. Give them time to adjust and integrate telehealth, and offer strategies for using the new technology. Listen and value the feedback that speaks to frustration or feelings of disruption. Providers may be more likely to accept a telerehab workflow structure that closely replicates their in-person workflow. Additionally, therapists may need extra resources such as a second monitor, or document camera, a tripod for their camera, specialized therapy software, and further education.

Marketing telehealth services takes a dedicated strategy. Simply making telehealth available does not guarantee its use. There are two parts to a successful campaign: 1) informing patients, and 2) signing them up to use the service. Be bold. Be repetitive. If you are accepting direct payment, offer an incentive for first appointment. Use multiple communication streams to share the invitation to use the new service including: In-office brochures, posters, website messaging, social media campaign, and direct mail. You could even host a "demo day" to allow your patients to get acquainted with the new service and invite them to bring in their device for setup.

Share the success. Be generous with communications regarding growth and success of the whole team. Let your patients and their families know that new virtual care options have been successful. Share the joys as well as the barriers encountered. Therapists care about their patients, and specific examples tell how telerehab worked, why it worked, and how much it was appreciated.

Helpful Hint: A wise therapy leader will show gratitude for providers' efforts to change their work habits and techniques to adopt telrehab.

Structuring a Successful Teletherapy Session

Telehealth visits should be integrated into the existing departmental workflow for a smooth delivery of telerehab. Patients and clients should have a good understanding of what is offered and how to get and use telerehab services at each therapy site.

1) Have a practice video visit with each patient new to telehealth. Find your team member to take the lead on educating the patients in the technology needed to use telerehab applications. Consider a support staff person with good tech background and communication skills and who understands the limitations of rehab conditions treated via telerehab. Connect during a low stress time, outside of the therapy session to test the connection, download software, and change settings. Use this time to discuss the flow of the appointment, who to call if there are troubles and the expectations of the therapy.

2) When scheduling, consider the patients and families daily routine with meals, rest times and medications. If a caregiver is needed as a helper, schedule the session when the caregiver does not have to care for additional family members' needs.

3) Therapists' preparation for online therapy sessions is vital. Consider an online filing system organizing each patient's resources, such as using an electronic folder of therapy medium or home programming for each patient.

4) Prior to the encounter, communicate to the patient what items, equipment, or homework to have ready and available in the space where the visit will occur. Therapists may send packets of instructions, exercises, therapy plans, therapy items to the home or email and instruct the patient and family to find items to use in upcoming therapy sessions.

5) It is easy to forget about therapy appointments when no travel is involved. Send reminder messages days ahead of the scheduled encounter and minutes ahead, these may be automated in some therapy platforms. "Time till connection" is a message to patient and family to ready themselves, much like sitting in the waiting room. Many software packages have virtual waiting rooms, making this convenient for patients and therapists.

6) Remind family or caregivers with small children or other distractions that therapy time is dedicated to the patient and their therapy goals. Turn off TV and other distractions and give therapy priority.

ACCESS TO CARE = LIMITATION TO THERAPY SERVICES

Therapist workforce measures generally show an undersupply of PT, OT and SLP. This is acutely felt by a recent stroke patient who lives 100 miles away from the closest therapy treatment option. However, a patient located in an urban high rise can be just as 'remote' or homebound as the Montana rancher and will also benefit from telehealth services.

Spinal Cord Injury Rehab centers in England propose to build capacity by enhancing expertise and remote consultations through Digital Health Technologies. Specialists available via a web portal will give timely input to care and improve outcomes.

A consultative or mentoring approach to telehealth therapy services is especially supportive for new practitioners, rural or urban. Videoconferencing that includes a therapy specialist in the patient encounter gives insight and learning opportunities into patient care techniques and accepted protocols. The support for rural therapists can also be a valued networking opportunity. For example, a hand therapist (CHT) located in the urban surgical center could devise the post-surgical plan of care and follow up periodically via telehealth to include the patient and rural therapist. This shared care model gives optimal patient care, supports the rural therapist through on-going professional collaboration, works to maintain the "standard of care protocol" is being delivered by both therapists, and keeps the rural patient connected to the services without significant loss of work time.

Lights! Camera!: Preparation is Everything

Practice and preparation are important when learning how to deliver therapy over video. Personal experience on social video calls does not give therapists the skills needed for telerehab. Online care delivery takes practice; comfort levels will grow with experience in telerehab care.

Pre-visit

Ensure Privacy: Choose a room with a door that closes and hang a sign for privacy. Anticipate any possible interruptions or background noises: silence your phone, let the dog out, and have someone manage your children.

Connections: Hard wired is always more dependable. However, if using WiFi, position yourself near the WiFi router. If using cellular connection, find the most dependable spot, possibly near the window and away from building infrastructure. Ask for a WiFi booster to be installed in your office, if needed. Turn off other web applications and notifications to conserve bandwidth.

Dress: Dress like you would for an in-person encounter. Avoid stripes and busy clothing patterns or all white. Big clunky jewelry may be noisy through a microphone. Wear your name badge or make your credentials posted and visible to address states' requirements.

Room Setup: Keep an uncluttered area and limited design in the background. Use a space that meets your demands for physical movement, demonstration, and manipulation of therapy tools. *NOTE: Virtual backgrounds do not work well with large muscle movement and demonstrations. Set device or camera at eye level and use settings to include a wide angle for large muscle activity and demonstration. A USB webcam will offer better pictures and more options than embedded cameras. Do not hold your mobile device, place it on a stable surface. Elevate the camera to your eye level, even simply using books or a box. Frame yourself so that your eyes are in the upper third of the frame. If patients are on camera with the therapist, back the camera away from subject 2 feet for every additional person. Give additional space to patients who are uncomfortable with cameras, such as autistic or oppositional and depressed.*

Set up extra monitors or document cameras to show your patient handouts, worksheets etc. or set up a video program for the share screen. Document cameras are additional camera pointed at the table to see paper allow the activity to be interactive

Lighting: Have good lighting with the main light source in front of you and preferably above eye level. Try an inexpensive ring light or lume cube used with a tripod to position above your eye level, especially if you wear glasses. If working on a desktop, try reducing the monitor lighting level to reduce eyeglass glare. Avoid one overhead light or light source shining directly behind, like a window with sunshine. The camera adjusts for the brightest light source (window), making your face very dark (almost a silhouette) and in shadows.

Sound: Be sure sound will pick up across the room, if using a large space. Headphones or headsets with a boom mic will improve sound quality and save therapists' voices. A separate mic/speaker unit strategically placed to pick up sound in a larger room is effective and worth the cost.

During Visit

Patient Safety and Location: Be sure your patient is in a safe environment and situation. Know how to manage emergency situations and how to summon emergency support for the distant patient if needed.

Begin you visit: In a telehealth visit, there are two additional steps to start off an encounter. First, be sure the patient can see you and hear you adequately. Adjust sound or instruct the patient on how to adjust sound settings on their end. Use a phone call if the audio portion of the video call fails. Second, follow the patient consent guidelines for telehealth visits, which vary by state and organization. Apply the same workflow requirements as in person client contact, such as patient identity verification.

Communications: Introduce yourself, your facility, and the purpose of your visit. After verifying patient identity, ask who is in the room and possibly off camera. Document these names in the chart, as required. Narrate your actions with the patient. For instance, let them know that you are looking at the medical record or at a care plan when your eyes are not on the screen. Speak clearly toward the microphone, and use non-verbal cues to signal that you are listening. Pause after speaking to allow for transmission delay so that you and the patient do not talk over each other. Talk your patient through the activity with detailed instructions using a kind, patient voice. As you draw the encounter to a close, ask if the patient has questions and let the patient end the session. Finally, have a backup communication plan (such as the patient's phone number) in case of technology failures.

Post Visit

Accepted therapy post-visit process is a home program revision or reminder. Discuss with the patient and/or family which communication method they would prefer: email, texts, or patient portal. Some electronic medical records (EMRs) may send a generated visit summary after each encounter.

Consider using short surveys or questionnaires (phone, on-line) to elicit patient and/or family feedback regarding their comfort with the virtual encounters. Some areas to inquire about include: ease of connectivity, treatment effectiveness, needs for technology support, and other relevant questions.

Plan and Communicate Prior to Each Encounter

Each patient will have unique setting requirements for their telehealth visit, just like they would in the clinic setting. Anticipate the treatment needs and communicate the requirements to meet each session's goals with the patient and family, or the school/facility prior to the visit. If the therapy activity is large muscle coordination, a large space and equipment should be set up and ready for the teletherapy visit.

Here are two different patient treatment sessions to consider regarding a teletherapy encounter:

- Nancy is a patient who is 6 months post-stroke with aphasia. She can be easily frustrated and distracted. Her telehealth appointment will be most successful in a quiet room, with a table, good lighting. Her tools for therapy may include electronic whiteboard or interactive workbook, paper and pen. For optimal sound quality, a headset may provide the best voice and sound qualities for both her and the therapist. This will help her focus and the therapist will hear the different speech sounds.
- Sammy is a lively 6 year old with gross motor impairment. For his telehealth appointment, he needs a large space with his mat on the floor and therapy devices at the ready for coordination activity. He needs his mom or caregiver's attention and hands-on guidance during therapy. The camera view should be set to include the wider space, with sound settings or an additional speaker to accommodate the larger space and distance. If Sammy was being seen at a school, recommendations may include purchasing a conference or room size camera with a hand-held remote for the caregiver to zoom in and out, while the therapist has camera control via software to follow the child in the room. Conference cameras are increasingly available and easy to use.

Therapists should also prepare their own 'stage' or environment for each patient therapy session according to the activity of the day. The therapist treating Nancy will need a quiet space with camera focus on the therapist's face, while Sammy's therapist may need a wider camera angle or placement to include the therapist's whole body for visual instruction and a headset for better sound while demonstrating actions. Visual and audio quality is important as it sets the stage for therapist/patient interaction and relationship building.

Best Practice Advice

Set up your physical environment, virtual tools and connect with a professional mentor or colleague to practice treatment. Accept feedback to perfect your image and presentation.

Your online presence will embody the 'therapeutic self' that all rehab therapists know is an important part of patient treatment. Check out a short etiquette list available from the National Telehealth Resource Centers.

Additional Training Information

Many online training videos are available about video conferencing methods, lighting, and audio techniques, as well as blogs, user groups, and therapy networking sites with implementation strategies and tools specific to different therapy areas. Seek out the resource page at the end of this toolkit for more references.

A few immediate examples are:

- TelehealthShare is a well-respected pediatric site with free resources and CME for purchase.
- Go2Care is a site addressing occupational wellness, hand therapy, orthopedic telerehab with training resources for purchase.
- For telepractice resource sites addressing speech-language therapy, ASHA suggests: Readworks.org, Quig, Everyday Speech, TeacherspayTeachers, BoomCards, PBS Kids, Starfall.

Novice providers often request to see how it is done. Stanford Health has produced two well-developed videos demonstrating a medical assessment and the virtual patient encounter. They are short, concise, and include great information:

"COVID-19: Tele PRESENCE 5 by Stanford Medicine" highlights how to overcome the digital challenges with practices to relate and connect with patients over telehealth and virtual visits.

"Stanford Medicine Videovisits: Problem-Based Approach to the Provider-Directed Patient Self-Exam" includes physical exam for shoulder pain and low back pain with demonstration of the Hawkins, Neer, Jobe and Low back pain with components of palpation, sensory for L4, L5, S1 and functional strength testing.

Platforms and Software

Video software is typically a standalone software with different capabilities, whereas a platform is a larger operating system with a variety of applications available. A platform may include video software as well as scheduling, billing, and documentation software, encrypted email, and messaging, asynchronous or e-visits, automated delivery of documents, and encrypted photos. While a fully integrated platform has many handy options and functionality, utilizing an application separate from the electronic medical record software or large platform may better support therapists' needs for specific therapy applications. It is important to consider the various functions which might be available from either option, such as:

When choosing video software applications, be sure that the options being considered have the elements needed for the therapy service(s) being provided. Features such as screen-sharing, freezing the screen, drawing applications, and tools to quickly switch between dual cameras will support most therapy applications. Furthermore, software that has virtual elements with objective scoring of key therapeutic elements, such as range of motion, is becoming mainstream. These components gather information from sensors placed on key body points that are then monitored by a therapist to improve objective measurements.

- Mobile phone functionality
- Home Exercise program
- Screen sharing
- Annotation
- Whiteboards
- Jamboard
- Touchscreen
- Interactive virtual games
- Virtual goniometer
- Live stream of exercise programs
- Text chat
- Recording (with or without editing capability)
- Interactivity features (e.g., animations, widgets, games, stamps, and paintbrush)

Factors and options to consider during your selection include the following:

- Camera capabilities differ between a **built-in laptop camera**, **webcam**, and a **conference camera**. A conference camera will have pan–tilt–zoom (PTZ), or a wider angle for the video. This works well for large muscle movement and demonstration. Conference camera set-ups are reasonably priced, and therapists who will be demonstrating full body movements should consider this equipment. Therapists could also invest in a handheld remote to move the camera from across the room, which would be efficient and professional. Webcams outperform built-in cameras of laptops by increasing field of vision, color modification, and resolution. These cameras often have a microphone built in that will outperform built-in microphones of computer devices and come with software to manage the virtual image of the speaker and virtual backgrounds.
- **Virtual backgrounds** can be distracting and an additional factor to manage. They do not work well with demonstrations. Use an uncluttered background or plain wall for best results.
- The **color of the room or walls** can be important, especially when skin assessment is a priority, such as in wound care. Blue is the preferred wall color. Avoid yellows and green as this will affect skin tone on camera.
- A **document camera** is a second camera typically focused downward on a desktop item or second image. Quickly switching from the main camera image (presenter) to the 'doc' cam is like looking at a work surface together.
- **Whiteboard** capacity in the software will give the therapist and client a shared working surface.
- **Peripheral devices**, such as recording devices or auxiliary video input equipment for computer interfacing, pharyngeal cameras, or virtual goniometers may be essential for some treatments.
- **Virtual waiting rooms** are handy to help keep the telerehab visits private and keep clinicians on time for each appointment. Virtual rooms can be monitored by reception staff.

- The **chat function** is extremely helpful during a session when having difficulty or give additional direction.
- The **testing function** allows the patient to test their equipment for sound and video automatically prior to the visit.
- A small **tripod** for your smartphone or camera may assist in positioning the device at the appropriate position.
- A **ring light** or a **lume cube** (on a tripod) better illuminates the therapist and their demonstrations of positioning and techniques.
- Therapists who wear **glasses** may want to adjust the monitor lighting to a lower setting and have lamps above your eye height to reduce glare.

Client Selection for Telerehab

Telehealth and remote patient connections will not solve all barriers to accessing care. Therapists must assess the appropriateness of using telehealth with each patient, taking into account the patient's physical and cognitive abilities, technology literacy, and family support. Initial and ongoing patient mentoring regarding telehealth technology will increase successful interactions and treatment outcomes in telerehab. Consider these factors when selecting patients for telerehab:

- Hearing ability
- Auditory comprehension
- Interpreter needs
- Visual Ability
- Computer literacy
- Attention to task
- Cognitive processing
- Frustration tolerance
- Manual dexterity for keyboard/mouse
- Availability of computer or device
- Dependable Wi-Fi signal or data plan
- Sitting endurance
- Independent mobility skills or a facilitator for support

Administrative Guidelines for Telerehabilitation

These resources will give guidance on general telehealth information and will provide an informational foundation to build on.

* National Consortium of Telehealth Resource Centers
* American Medical Association Telehealth Playbook
* American Telemedicine Association - Principles for Delivering Telerehabilitation Services
* General Telemedicine Toolkit – CMS
* Rural Telehealth Toolkit – RHIhub
* State Medicaid Telehealth Toolkit
* The Federation of State Medical Boards provides telemedicine policies by state.
* The Center for Connected Health Policy has various state-based resources including telehealth policy and reimbursement by state, and state-by-state information on regulations, cross-state licensing, and reimbursement.

Licensing: Therapists must be licensed in the state in which the client is located as well as the state from which they are providing remote services. Be aware of federal, state, and regional requirements for licensure, credentialing, and licensing compact agreements. Though many state practice acts do not address telehealth service delivery, the consensus is that if the practice act does not limit the practice, it is allowed. Additionally, civilian employees of the Department of Defense and the Department of Veterans Affairs may not be bound by the same licensing requirements.

Seek clarity and counsel from your legal resources to verify what would be applicable in your service area. A resource which could be helpful, The Center for Connected Health Policy has a listing of state laws and regulations around the use of telehealth and virtual technologies. This resource is updated regularly.

Therapy services delivered in school settings may have additional requirements from state departments of education (DoE), possibly including a teaching credential in addition to your professional license. Contact the DoE in the therapist's state and in the patient's state for additional information on telehealth service delivery. The requirements to provide tele-therapy services in a school setting will likely be the same as those needed to provide those services in-person.

Clinical supervision: Supervision of SLP Clinical Fellows (CF), SLP students, or SLP/audiology assistants is currently supported by ABESPA. Individual state practice acts generally provide guidelines for supervision of students on clinical rotations and of therapy assistants. Refer to your state's professional standards as this continues to evolve.

Informed Consent: Be aware of and follow state laws, professional regulations, organizational policies regarding informed consent. When writing policy, weave telehealth and telerehab into existing policy surrounding organizational consents, supporting telehealth as a mode of the same level of patient service delivery.

Risk Management: Check with your risk or malpractice insurance for specific language regarding telepractice, telemedicine, telehealth, telerehabilitation, or service from a distance.

NOTE: Supervision During COVID

CMS is allowing direct supervision of therapy personnel to be provided using real-time interactive audio and video technology. The change clearly applies to "incident to" situations in which PTs are working under the direct supervision of physicians; APTA is seeking clarification as to whether it also applies to PTAs working under the supervision of PTs in private practice. Check your state practice act for other supervision regulations.

Patient Privacy and Security: Therapists must be aware and follow all requirements from HIPAA, HITECH, FERPA, and organizational policies for appropriate use of devices and materials. For instance, HIPAA requires that your software vendor has medical grade video conferencing that includes a Business Associates Agreement (BAA).

Patient safety: Therapists are responsible for the safety of their patients during the session. Therapists must know the exact location of the patient at the time of the encounter, and have a phone number to reach the patient or a family member *or a phone number for the nearest emergency response group.*

Documentation: Documentation guidelines for telerehab are the same as those for regular clinical documentation with some additions, including documentation of the location of the patient, additional family members present during the visit, and documentation that the visit was virtual. Check payer policy, specifics of time treated, attestation to the appropriateness of telehealth treatment etc.

> *For example, a clinical therapy documentation may state: "Patient Maggie Smith is connecting via Telemed today from her home in Hollywood. Her caretaker, Susie J., is helping with the session."*

Continuity of Care: A practitioner utilizing telehealth must provide the patient a reasonable mechanism by which to contact the practitioner (or a covering practitioner) for follow-up care related to the patient's telehealth encounter. If the patient is located outside of reasonable travel distance and requires therapy intervention, the treating therapist should have a relationship with local therapy options for referral and patient care.

Contracting Arrangements: Therapists may enter arrangements for service provision at distant facilities. These arrangements enhance services for patients and facilities alike. Each partner in this agreement has responsibilities to provide successful therapy experiences, which can be laid out in a Professional Services Agreement (PSA) or Memorandum of Understanding (MU). The PSA/ MU should include: scope of services, clinical expectations, physical space and environment, documentation, scheduling, support personnel or telepresenters, billing, technical and support issues, and privacy requirements. Patient endpoints or sites must be willing to schedule patients, dedicate space and staff time, human resources to educate staff as well as patients and their families, and provide a trained telepresenter.

Ethics: In summary, the accepted standard is that remote services must address all ethical parameters that are required for in-person care. While technology and privacy issues come to the forefront in telerehab, other areas to address include patient care and patient privacy, therapist competency, integrity, law/regulation compliance, and workplace values. It is the responsibility of the therapist to inform the patient about the potential loss of client privacy (especially when a telepresenter is part of the session), potential for equipment malfunction, any additional costs (such as data for connections), and the potential for modification of treatments. Existing policies addressing rehab service could be amended to include telerehab as an additional mode of service and should embody the same ethical expectations as those for in-person services. In addition, telerehab policy should include a statement regarding the patient's right to refuse or discontinue telerehab services and the right to end the telerehab session if the patient wishes.

Telepresenters: A telepresenter is someone (could be a family member, caregiver, or trained helper) who assists during the visit to manage the technology and position the patient for muscle activity, mobility exercises or to appropriately place therapeutic equipment to be effective. It is the responsibility of the therapist to direct the session and ensure that the telepresenter is adequately trained to assist. The telepresenter may report patient information, such as vitals and handle the peripherals, such as an electronic stethoscope or hand camera. For a medical provider, the telepresenter is often a nurse or nursing assistant. In a facility setting, such as a residential rehab or skilled nursing facility, their role may include managing the schedule, preparing the room and patient, transporting the patient to the telemed room, setting up equipment, conducting patient follow-up, and transporting the patient back to their room. Insurers do not reimburse for the time of the telepresenter, so clear discussion surrounding this resource and requisite expenses will be key to telemedicine success. The telepresenter's responsibilities will vary based on the requirements of the encounter, however, in every situation it is the therapist that assesses the patient and interprets the presentation on the screen.

ASHA defines the facilitator as an individual who is present at the patient site to assist the client during telepractice. This person may be a teacher's aide, nursing assistant, student clinician, audiology assistant or speech-language pathology assistant, teleradiology clinical technician, or paraprofessional. Be aware of professional and licensing restrictions as well as institutional or state policies regarding the telepresenter.

Additional Regulatory Concerns

The **Health Information Technology for Economic and Clinical Health** (HITECH) Act HITECH issues minimum requirements for technology use in telehealth. They have recommended that both the patient and provider should have a minimum of 10 Mbps (megabits per second) for both upload and download speeds to ensure a successful connection throughout the patient visit.

Device vs. Software: Organizational-wide informational systems have policies and security settings regarding patient information, such as image retention, while smaller therapy groups should develop internal policies and guidelines for use. Work closely within these policies or be very knowledgeable about the vendor security used. Although telemedicine video encounters are not typically recorded and saved, telerehab encounters may be recorded for documentation of milestones. These recorded materials will become medical record materials and must be stored on secure servers. Digital images or still photos should never be saved on a personal device, as even a photo of a body part could potentially be identifiable. Photos and images can be saved within the electronic medical record for documentation purposes.

For HIPAA RESOURCES during COVID

Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student education records (20 U.S.C. § 1232g; 34 C.F.R. Part 99). The law applies to all educational agencies and institutions that receive funds under any program administered by the Secretary of Education. Therapists working in an educational setting should follow all requirements of state, district, and organizational level, in addition to FERPA requirements.

Billing and Coding

Medicare has parameters around the delivery of reimbursable telehealth services that are set by law. The first limitation is that Section 1834 of the Social Security Act statutorily excludes Occupational therapy, Physical Therapy and Speech-Language Pathology from billable telehealth codes. Therefore, patients who have traditional Medicare cannot receive therapy via telehealth. Patients who have Medicare coverage through an Accountable Care Organization may have expanded telehealth services, including therapy services. Coverage under each plan should be researched and verified prior to providing services. The second limitation for telehealth services is the location of the patient: Under traditional Medicare, patients must reside in a rural location (defined by a Metropolitan Statistical Area (MSA) Medicare Telehealth Payment Eligibility Analyzer (hrsa.gov) and specific facilities (most notably, home) are not included.

For a complete and up to date Medicare code payment listing, go to: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

For patients with health insurance through Medicaid or private payers, each payment source can be verified for telehealth/virtual care services. Research and understand the policies for services and payment.

During the COVID-19 Public Health Emergency, there have been several policy changes that broadened Medicare coverage for telehealth and impact therapy services. These policy changes have influenced Medicaid and private insurers to adopt similar policies or address the opportunities for virtual care for their clients' benefit. Although it is unknown at this time whether these regulatory changes will be made permanent after COVID-19, it is generally accepted that reimbursement guidelines for telehealth and virtual care will not return to pre-COVID status. The efficiencies gained and efficacy of therapy treatment from a distance has been proven and accepted. Monitor the changes with each payer source and advocate for coverage to best serve patients with their therapy needs. As the US healthcare system is experiencing frequent changes to policy and payments for telehealth, contact the National Telehealth Policy Resource Center for the most up to date information. https://www.telehealthresourcecenter.org/cchp/

2021 Telehealth Codes (PHE-Related)

Therapy codes for telehealth payment were included in the Medicare 2021 Physicians Fee Schedules under Category III, which states that the codes will be paid through the calendar year of the Public Health Emergency. Those codes are listed on page 13.

MEDICAID TELEHEALTH

Telehealth reimbursement policies under Medicaid vary from state to state and among managed care plans. During COVID-19, a federal directive was issued to encourage states to use broad authority to allow telehealth in the state Medicaid plan. Check with each state's Medicaid office for telehealth coverage.

The American Physical Therapy Association (APTA), the American Occupational Therapy Association (AOTA), and the American Speech-Language-Hearing Association (ASHA) jointly developed a document as a resource for public and private insurers, employers, and consumers to evaluate the appropriateness of rehabilitation and habilitation benefit design. Telehealth is addressed briefly in this 2019 document. See: Joint Habilitation/Rehabilitation Benefit Coverage Statement: Guide to Assessing Adequacy of Benefits

The Center for Connected Health Encounters offers "Billing for Telehealth Encounters: An Introductory Guide on Fee-for-Service" Billing Guide for Telehealth Encounters_FINAL.pdf (cchpca.org). Also, billing guides specific to states in the gpTRAC region are found at https://www.gptrac.org/states/.

Therapy in Times of COVID-19

Under Presidential Waiver 1135, Medicare expanded access to telehealth with payment options to include more providers and more locations. Waiver 1135 took effect March 6, 2020 and is in effect for the duration of the emergency. With the waiver, OT, PT and SLP/ Audiology services are now paid for in a variety of locations that include the patient's home, whether urban or rural.

Medicaid and private insurance coverage followed suit, in most cases. Ongoing and diligent communication with the patients' insurance provider is important as the COVID-19 emergency continues to impact care delivery and payment.

Waiver 1135 is extensive and impacts therapy services in several services: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf (See summary on page 14)

Is this Telehealth, Telemedicine or Virtual Care?

Telehealth is an exciting and expanding world of service and connectivity for patient care. As options change with technology and platforms, the telehealth industry defines and redefines services. Sometimes the services are defined by connection platforms, such as 'telephonic' or specific to the electronic record application used. Other times the payor source defines the service, such as 'digital' vs 'on-line'. Regardless, it is confusing and will have different guidelines and payments associated with the service.

Communication technology-based services: In FY 2019, Medicare generated a new type of telehealth when it devised the codes for services delivered through virtual communications called communication technology based services (CTBS). CTBS do not have the stringent requirements of patient location and provider limitation included in the traditional telehealth rules and, as such, therapists can bill for services delivered to the patient at home or in an urban area. CTBS includes e-visits, virtual check-ins, and telephone assessments for Medicare Part B beneficiaries. These virtual services are intended to increase communication between patient and provider and thus decrease the number of more expensive in-office visits or services. Therapists can connect to patients by

2021 Telehealth Codes (through PHE)

Telehealth Assessment & Management services (video and audio) for rehabilitation	
97161 – 97164	Physical therapy evaluations
97165 – 97168	Occupational therapy evaluations
Telehealth treatment codes for physical therapy, occupational therapy,	
97110	Therapeutic exercises to develop strength, endurance, range of motion, flexibility
97112	Neuromuscular re-education
97116	Gait training, including stair climbing
97535	Self-care/home management training (activities of daily living, etc.)
97750	Functional capacity evaluation
97755	Assistive technology assessment
97760	Orthotic management and training
97760	Prosthetic training, upper and/or lower extremity(s)
Speech-Language Pathology Telehealth Codes	
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive, and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
Modifiers: In addition to modifiers for therapy services, there are modifiers for telehealth	
GQ	Telehealth service rendered via asynchronous telecommunications system
GT	Telehealth service rendered via interactive audio and video telecommunications system
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system **Note:** Modifier 95 was created through the CPT system and can be appended to CPT codes to reflect services that were provided via real-time telecommunication systems. This code does not replace the existing GQ and GT modifiers that were created through the HCPCS by the Centers for Medicare & Medicaid Services (CMS). Clinicians should check with individual payers regarding use of telerehab-related modifiers on the claim form.
Place of Service Code for Telehealth	
02	**Telehealth** - The location where health services and health-related services are provided or received through a telecommunication system. For more information on place of service codes (POS) go to the CMS website.

Summary of Waivers Granted During the Public Health Emergency (PHE):	
Inpatient Rehabilitation Unit 60% rule	Inpatient Rehab Units may exclude patients in the Rehab Unit when calculating the thresholds requirements for payment
Inpatient Rehabilitation Unit 3-hour rule	Requirement for minimum of 15 hours of therapy per week for inpatient Rehab Units is waived
HHA Initial and Comprehensive Assessment	Allows OTs, PTs, and SLPs to perform initial and comprehensive assessment when only therapy services are ordered as part of the plan of care, regardless of whether or not the service establishes eligibility for the patient to be receiving home care.
Hospice Non-Core Services	Waives requirement to provide PT, OT, and SLP
Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens)	Modifies timetable for substitute billing arrangements when a physical therapist is unavailable to provide the services.
Incorporating newly allowed technology due to HIPAA flexibility	Empowers therapists to use widely available applications that are "non-public facing applications", such as Facebook Live and Twitch, without risk of penalties under HIPAA. Examples of non-public facing video chat applications: FaceTime, Facebook Messenger, Facebook Messenger video chat, Zoom, Skype, Jabber, WhatsApp, iMessage. For further information: https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/
Providing telehealth services for Medicare patients	Authorized providers may treat patients located in their home and outside of designated rural areas. Both new and established patients are allowed under Medicare, however, professional guidelines and best practices for therapy treatment should supersede this payment guideline. Telehealth is not limited to video only and telephone visit are allowed. See list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
Licensing requirements and interstate compacts	Medicare will allow treatment across state lines; however, each state may have more restrictive requirements and the most restrictive will supersede in most cases. See: Providerbridge.org http://ptcompact.org/ https://aslpcompact.com/ OT compact https://otcompact.org/ SLP compact https://aslpcompact.com/
Prescribing controlled substances	A practitioner can prescribe a controlled substance to a patient using telemedicine, even if the patient is not at a hospital or clinic registered with the DEA. Qualifying practitioners can prescribe buprenorphine to new and existing patients with opioid use disorder based on a telephone evaluation.
Reducing or waiving cost-sharing obligations	Health care providers will not face administrative sanctions for reducing or waiving any cost-sharing obligations for telehealth services paid for by federal or state health care programs, such as Medicare and Medicaid. See: https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf

telephone, audio/video conferencing, secure text messaging, secure messaging (email), or through a patient portal. An example of use would be the 're-check appointment': If a patient is doing well in their rehab programming, a quick secure message to the therapist about the status of the home program may be substituted for the in-person encounter. The therapist would review and respond and may progress the home program to the next level. Using this medium instead of an in-person session allows the therapist to work more efficiently and creates more time for them to see other patients.

Virtual services must be patient-initiated and involve clinical decision-making. Although the patient must initiate the service, staff may notify the patient of the service's availability and guide them to the service. The patient must give annual verbal consent to receive these services, and coinsurance and deductible generally apply. During COVID-19, virtual services may be used by either a new or established patient. An established patient is defined as one who has received services within the past three years from you or another clinician from the same specialty who works in the same group practice. Check with local and state practice acts as they may be more restrictive on these services.

Payment for these codes/services, are less than a video encounter. However, these services are not typically scheduled and can be completed during unscheduled professional time as it is available within the schedule. Establish policies within your group that include expectations on response time and content. It remains the responsibility of the therapist to determine if this service is appropriate for the care required in each instance and for each patient. Utilizing virtual care codes will benefit therapy practices as a means to meet the growing patient demand for online services and communication with their therapist while also increasing the access to therapy care.

Virtual Check-ins (G2251): Virtual check-ins are brief encounters initiated by the patient to help determine whether they need to be seen for a full treatment or evaluation service. The G2251 code is used for a 5-10 minute visit for an established patient that is not related to service provided within the previous 7 days nor leads to a service or procedure within the next 24 hours. Services should be synchronous by phone, video, secure text messaging, or a patient portal. The exchange must document the medical necessity and be stored.

> *An example: A patient is continuing with his home program for speech treatment of aphasia. The patient is having difficulty with certain sounds. While on a work break, he records his speech and sends the sound file over the online portal to his therapist. His therapist responds via secure messaging or a phone call with instructions. Therapist records a billable unit with average payment of $10-$15.*

eVisits (98970-98972): eVisits allow an established patient to connect asynchronously (not in real time) through an online portal (sometimes referred to as digital assessment). These encounters are supplemental to in-person therapy. Therapists are not covered under the Evaluation and Management eVisit codes that are defined for medical providers, therefore rehab/therapy eVisits have their own specific codes (98970-98972). These codes cover a 7-day period (billing cumulative time) of communications initiated by the patient using the online portals. Do not bill the codes if the eVisit leads to an evaluation or treatment service within the next 24 hours at the next available appointment.

> *An example: A patient of Sunshine Therapy Center is at high risk for COVID-19 and does not wish to leave home for care. The reception desk suggests that he connect with his therapist via telehealth, which he does via a secure message to the therapist with questions about his treatment program. The therapist answers later in the day with adaptations to the program and attaches several photos to guide the patient. The patient reaches out to the therapist three days later with more questions, and the therapist responds with further instructions. The therapist adds the time it took to respond to both requests and bills 98971 for the 18 total minutes of service. The average national payment for 98971 in 2020 was $21.65.*

Although reimbursement for eVisits is lower than that for in-office encounters, clinicians complete these services at times convenient for them, creating efficiency and productivity. It is important to be clear with your patients about when to expect responses and to provide directions to call a therapist or other medical provider in case of situations that require immediate response.

Remote Evaluation of Patient Videos/Images (G2250): This code is billable for the asynchronous review of patient-submitted recorded video and/or images interpreted by therapist with follow up within 24 hours. This code should not be reported for real-time review and discussion of images or video over an audiovisual platform. The patient must be an established patient, and the service must be through a HIPAA-compliant platform.

Telephone encounters (98966-98968): Valid professional guidance and therapy care can be issued over the telephone and historically has been an important part of giving guidance to patients and their families. Telephone encounters are defined as assessment and management services by a qualified non-physician healthcare professional for an established patient, parent, or guardian, when not related to assessment and management services within the previous 7 days. Codes 98966-98968.

Examples for care: A patient's family phones their OT and asks about cleaning and strapping on the newly issued orthotic. The therapist spends 15 minutes with the patient's family and the patient on the phone and bills 98967 for the service with average national reimbursement at $30.

Telehealth Parity Laws

Parity laws require private payers to provide coverage and/or payment for telehealth services at the same level as that for in-person care. Payment parity requires commercial health carriers to reimburse for telehealth services at rates that are similar or equal to the rates for the same services provided in person, while coverage parity laws require payment for a telehealth service if it is equivalent to the in-person service, though it does not necessarily need to be reimbursed at the same rate. Some laws have clauses that stipulate parity is "subject to conditions and requirements." There is great variety across the nation on the statutory language, which is confusing to consumers who opt to use these services under their plans. Therapists should check out their state's parity law or the Center for Connected Health Policy at https://cchpca.org

Conclusion

Telerehab service means providing care from a distance and includes assessment, monitoring, prevention, intervention, supervision, education, mentoring, pre-service, continuing education, consultation, and counseling. The opportunity to expand access to care through telerehabilitation is an important factor for the health and wellbeing of rural and urban consumers alike. It is well accepted that telerehabilitation has the capacity to provide service across the lifespan and across a continuum of care. Clients' age-specific needs and limitations regarding telehealth are important considerations for all therapists and remain the responsibility of the treating therapist. The authority for telerehab services rests within the licensing rules of the state where the patient is located at the time of the patient service and may impact the professional license in each state where the therapist is licensed.

> ***"The pessimist complains about the wind; the optimist expects it to change; the realist adjusts the sails."***
> *— William Arthur Ward —*

FINAL TAKEAWAYS:

- **Learn your technology platform** and be prepared to **teach your clients** to connect using low-tech language.
- Telerehab will not be a good fit for all your clients. Have a **plan for collaboration with a local therapist** for in-person or hands-on care if needed.
- The **age of your client is not the predominant factor determining success**. Do not assume who will connect comfortably using technology.
- **Practice the skills** needed to use technology to connect with your patient and grow in your confidence on camera. Telerehab may require a redesign of therapy tools and treatment techniques. Invest in your skills and learn to use telerehab.
- Be prepared to **address your patient's discomfort** in dealing with technology and seeing their image on camera.
- When you teach your clients to use technology for therapy, **you are teaching them a valuable life skill** that will help them relate to today's world.
- Be sure to **include all the department staff** in the implementation and growth of telerehab services, and share the wins with that same staff. Success in telerehab service delivery is a team effort.

Appendix A: Terminology

Terminology for providing care through telehealth and virtual connections is broadly applied and confusing. The following list of terms should not be considered all-inclusive since telehealth, in general, continues to shift and grow. The goal is to provide a uniform vocabulary for application in this toolkit.

Telerehabilitation refers to habilitative and rehabilitative services provided from a distance via information and communication technologies. This term is used by the American Occupational Therapy Association in its Position Paper on Telerehabilitation (2005) and American Telemedicine Association in its "A Blueprint for Telerehabilitation Guidelines" (2010).

Telepractice is the application of telecommunications technology to provide speech language pathology and audiology professional services at a distance by linking clinician to client or clinician to clinician for assessment, intervention, and/or consultation. This term is used by the American Speech-Language-Hearing Association (ASHA). Also used: teleaudiology, telespeech*, and speech teletherapy*.

Telehealth is defined by American Telemedicine Association (ATA) as any form of health care delivery using telecommunications technologies. It includes but not limited to, asynchronous connection, synchronous connection, and remote patient monitoring used by a healthcare practitioner to connect with a patient or a practitioner at a different physical location than the original health care practitioner. Telephone communications may also be included in the broad sense of telehealth.

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. This term is often use interchangeably with telehealth. A narrower definition used is the real-time, two-way interactive communication between a recipient and a provider

Virtual encounters by Medicare definition include telehealth visits, virtual check-ins, and e-visits. To some medical providers and electronic record vendors, virtual encounters refers to professional visits through the electronic medical record software.

Telepresence refers to a set of technologies which allow a person to feel as if they were present, to give the appearance of being present, or to have an effect —via tele robotics—of being in a place other than their true location.

The originating site is the location of the patient. This term is often used in traditional telemedicine settings such as a facility, clinic, or hospital. ASHA conversely uses the term "remote site" as the patient site.

The distant site is the location of the clinician or provider often used in traditional telemedicine settings. It may refer to a facility, clinic, or office.

Peripherals are pieces of equipment that enable technology to interact during a telehealth encounter, such as electronic stethoscope, otoscope, dermatology or retinal camera. They are used at the patient or originating site to assess physical traits or conditions affecting the heart, lungs, ears, eyes, skin.

Encryption is a system of encoding electronic data so that information can be retrieved and decoded only by the individual or computer system authorized to access it. Aa an important note, standard software does not typically have a level of encryption acceptable by HIPAA.

HIPAA is the Health Insurance Portability and Accountability Act.

A patient portal is a secure online website that gives patients convenient, 24-hour access to their personal health information from anywhere with an internet connection.

Digital physical therapy is defined by APTA as health care services, support, and information provided remotely via digital communication and devices with the purpose of improving access to care and information and helping to manage health care resources. APTA's definition is broad, including communication-based services such as e-visits and virtual check-ins, but excludes live video connections.

A telepresenter is defined by the Centers for Medicare and Medicaid Service (CMS) as a medical professional at the originating (patient) site who 'presents' a patient to the physician or practitioner at the distant site. In a broader sense, this is any person assisting with technology and connections, patient assessment, and patient reporting. Check state professional laws and guidelines. It is generally accepted that a telepresenter is not required to be medically trained, however, it is widely accepted that it is advantageous to the patient and the provider if the telepresenter is trained in the telemedicine services provided.

In-person care is when the provider and client are in the same location at the same time. Medicare recently reiterated in the 2021 Final Rule that telehealth rules do not apply when the beneficiary and the practitioner are in the same location even if audio/video technology assists in furnishing a service. If a therapist is on site in a hospital and treats a patient in a COVID ward in that same hospital or location, it is not considered telehealth, but rather in-person care.

Synchronous telehealth refers to real-time live audio-video interaction between a patient or group of patients and a clinician/provider using telecommunications technology replicating an in-person encounter. Video may be carried over video conferencing units, computers, tablets, smartphones. This is also referred to as telemedicine, virtual or video visits.

Asynchronous telehealth, also termed "store-and-forward telehealth," refers to patient information (in form of a text, photo, image, or data) sent to a provider via a secure web server, encrypted email, specially designed store-and-forward software, or electronic health record for review and interpretation with response of diagnosis, treatment, and planning recommendations at a later time. An e-Visit is a form of asynchronous care.

Remote Patient Monitoring (RPM) uses digital technologies to collect medical data—such as blood pressure, oxygen saturation, weight, heart rate, electrocardiogram, or blood sugar—from an individual in one location and electronically transmit that information securely to a health care provider in a different location for assessment and recommendations. RPM is typically used for chronic condition management such as chronic heart failure, diabetes, COPD, and COVID-19.

Virtual check-ins are brief communication technology-based services with the provider using secure text message, secure email, audio/phone call, use of a patient portal, or digital images. This service may include video, but typically does not. According to Medicare requirements, the provider must obtain the patient's verbal consent (each year), and the visit cannot be related to an encounter within the previous seven days or lead to an encounter in the next 24 hours.

An eVisit is a patient-provider encounter using an online patient portal. It is non–face-to-face, patient-initiated digital communications requiring a clinical decision that otherwise typically would have been provided in the office.

Virtual Services

Traditional Medicare telehealth services require a statutory change when adding services, adding patient locations, or changing providers paid.In 2019, virtual services were added for coverage under Medicare.

Under the 2021 Federal Medicare Physician Fee Schedule final rules, OT, PT, and SLP will permanently be allowed to report CTBS codes for virtual check-ins, e-visits, and remote assessment of recorded images or videos. Although these codes were recognized as a positive step toward virtual care, they are poorly reimbursed and reflect the general perception that virtual services are less expensive to administer and use for treatment.

The professional organizations APTA, AOTA, and ASHA specially address the options for use and payment of these codes and issue guidance for specific situations.

Commercial insurers and Medicaid have individual interpretations on the definition of the services and the professionals authorized to use the codes.

gpTRAC
Great Plains Telehealth Resource & Assistance Center

Thank you to Marsha Waind, MOTR/L,CHT,CLT for being willing to share her vast experience around telerehabilitation programs and services, and for leading the development and composition of this toolkit.

***Disclaimer**: The information and links contained in this toolkit are current as of publication. The evolution of data, especially in health and technology related topics, continues to be rapid.*

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number GA5RH37464. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Appendix B: Therapy Assessments and Evaluations through Telehealth

An accurate patient assessment is vital when treating a patient in person or over telehealth. Remote patient assessment requires these additional considerations:

Patient Safety: A patient receiving therapy services at home needs to have the necessary equipment and adequate space that is free of obstacles. Ensure that you understand the patient's awareness of their own personal safety risks and physical capabilities. The therapist should also consider the level of supervision necessary for the patient to be safe during treatment and the training of the family or telepresenter in the physical and mental needs of the patient: If a patient requires physical assist for safety, will the home helper be available and able to provide that level of assistance? Could they brace the client from a fall? During a dysphagia/feeding assessment and treatment, could the telepresenter or involved family member quickly clear the mouth of a choking patient?

Testing materials: Does the assessment testing company use a HIPAA-compliant platform? Are therapists using HIPAA-compliant methods to exchange information and store results? Check out copyright laws and use of tests that are available for electronic use. Companies to consider: PAR, Pearson Clinical, WPS Publish, Academic Therapy Publications.

Competency: Therapists must have the proper licensure and training for electronic administration of certain therapy assessments. Review the assessment guidance for specific instructions on remote use. Practice remote administration with clear verbal instructions, and have a contingency plan for technical issues.

Assessments: Therapists and other telehealth providers have trepidation around assessments and physical exams through tele-health. Here is a list of of assessments that are administered remotely by therapists, some in electronic interactive format:

- BEERY-VMI – Neuro https://www.pearsonassessments.com/content/school/global/clinical/us/en/professional-assessments/digital-solutions/telepractice/telepractice-and-the-beery-vmi.html

  https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2788.2010.01282.x
- Berg Balance Test W. K. Durfee, L. Savard and S. Weinstein, "Technical Feasibility of Teleassessments for Rehabilitation," in *IEEE Transactions on Neural Systems and Rehabilitation Engineering, vol. 15, no. 1, pp. 23-29, March 2007. doi: 10.1109/TNSRE.2007.891400*
- Canadian Occupational Performance Measure (COPM)
- Telehealth Functional Fine Motor Assessment (FFMA)
- Katz Index of Independence in Activities - *ADLs and IADLs.*
- Lawton Instrumental Activities of Daily Living scale - *Cognition.*
- Manual Ability Measure-16 (MAM) - *Parkinson's Disease (PD)*
- McMaster Handwriting Assessment Protocol (MHAP) - *Pediatrics.*
- Mini-Cog© - *Cognition*
- Montreal Cognitive Assessment (MoCA) – *Cognition Instruction for remote use: DeYoung N, Shenal BV. The reliability of the Montreal Cognitive Assessment using telehealth in a rural setting with veterans. J Telemed Telecare. 2019 May;25(4):197-203. doi: 10.1177/1357633X17752030. Epub 2018 Jan 10. PMID: 29320916.*
- Modified Barthel Index (MBI) - *ADLs and Functional Mobility.*
- Pediatric Evaluation of Disability Inventory - Computer Adaptive Test (PEDI-CAT) - *Pediatrics.*
- Sensory Profile Measure and Sensory Profile 2 - *Pediatrics.*
- Short Form Everyday Technology Use Questionnaire (S-ETUQ) - *Cognition. Herr M, Ankri J. A critical review of the use of telephone tests to identify cognitive impairment in epidemiology and clinical research. J Telemed Telecare. 2013 Jan;19(1):45-54. doi: 10.1177/1357633X12474962. Epub 2013 Feb 6. PMID: 23390209.*
- Timed Up and Go (TUG) Test - *Functional mobility.*
- Orthotoolkit is an online fillable pdf forms. Use may ease quick completion and transmittable to the therapist. The DASH, LEFS, HOOS and more are available.

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