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Building Best Practices for Telehealth Record Documentation in the COVID-19 Pandemic

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Abstract

Telehealth services for patient visits have substantially surged during the COVID-19 pandemic. Thus, there is increased importance and demand for high-quality telehealth clinical documentation. However, little is known about how clinical data documentation is collected and the quality of data items included. This study aimed to identify the current state of and gaps in documentation and develop a best practice strategy for telehealth record documentation. Data were collected from January to February 2021 via a self-designed questionnaire for administrators and managers from physicians' offices and mental health facilities, resulting in 76 valid responses. Survey items included health organization demographic information, use of telehealth policies and procedures, and clinical documentation for telehealth patient visits. Findings from this study can be used to assist government, policymakers, and healthcare organizations in developing best practices in telehealth usage and clinical documentation improvement strategies.

Keywords: clinic data documentation, telehealth, quality improvement, best practice

Introduction

Healthcare documentation is the basis for communication between clinical practitioners and for reimbursement for care received. In-person care with well-established documentation practices has been the main focus for most physician practices rather than telehealth services. However, this changed as the demand for telehealth services use surged due to the COVID-19 pandemic. This increase in telehealth services has become a major driver of the US healthcare delivery system's work to expand telehealth rules and regulations.[1] As a result, there is an urgent need to build best practices for telehealth documentation.

The consensus among healthcare leaders is for the recognition of telehealth as a viable service for the health and welfare of patients everywhere. In addition, remote and telehealth services should be regulated, reimbursed, and treated with parity to that of services provided to patients in person.[2-4] Many healthcare leaders advocate for the same standards of documentation, maintenance, and transmission of patient information as traditional face-to-face patient encounters.[5-7] There continues to be backing for consistent telehealth coverage and payment across the board for all health care payers,[8-10] and further support of telehealth specific consents regarding the use of telehealth technologies, delivery models, and treatment methods or limitations.[11-13]

The American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) collaborated to reduce the burden of documentation for providers and eliminated the documentation requirement of medical necessity related to furnishing a visit in the home as opposed to in the office. Physicians can now choose whether their documentation is based on the total time spent or medical decision-making to support their evaluation and management (E/M) code selection.[14,15] This has not changed the documentation for telehealth services, which requires additional information to be captured, including 1) consent from the patient or patient representative (verbal or written) for visit; 2) the category for an office visit—real-time audio with video or audio/telephone only; 3) the date the patient was last seen or was billed for correspondence to avoid date overlap with other billable services; 4) the location of the patient for a visit; 5) provider location for a visit; 6) the names and roles of all participants; and 7) the start time and end time for telehealth encounter (length of time billing provider spent on the day of the visit and how time was spent if billing by time or a time-based code).[16,17] Documentation of the locations of both the patient and the physician is vital for payment purposes. Payment for telehealth services depends on the distant site or location of the provider as well as the originating site of the patient receiving care. Under the Social Security Act Section 1834(m), the use of a home as an office for a provider is not allowed as well as that for a patient unless the patient is receiving end-stage renal disease (ESRD) treatments.[18] However, CMS expanded telehealth coverage included the use of a home for all Medicare and Medicaid patients during the COVID-19 pandemic.[19,20]

As CMS continues to explore the possibilities for the expansion of telehealth services beyond the COVID-19 pandemic, the Office of Inspector General (OIG) will begin the process of auditing Medicare Part B telehealth services.[21] The OIG will focus on the assessment of whether telehealth services meet Medicare requirements. These audits will include documentation of distant and originating site locations, use of telehealth technology, and virtual check-in services.[22] Medical practices must now develop policies, procedures, and best practices for telehealth documentation in order to be prepared for such audits.

Currently, best practice recommendations for telehealth documentation includes supporting telehealth billing requirements and implementing documentation guidelines for telehealth services in the curriculum for medical students.[23,24] Reviewing consent forms to confirm they are relevant to virtual care visits, recording whether visits are audio-only or audio with video, and calculating visit time correctly for the provider (not including staff time) are all areas that should be especially considered.[25,26] To accommodate telehealth documentation requirements, note templates in the electronic health record should be modified along with clinician training and the development of procedures and forms to make documentation as streamlined as possible.[27,28]

Continuous monitoring of the guidelines on telehealth documentation from national and discipline-specific organizations such as the US Department of Health and Human Services (HHS), the Association of American Medical Colleges (AAMC), the American Academy of Family Physicians (AAFP), and the American Hospital Association (AHA) should be a priority for every practice.[29-32] Furthermore, policies and procedures must be updated to include telehealth chart audits as part of the practice compliance plan.[33]

It is also necessary to ensure documentation procedures address the need to adequately describe the physical findings that may and may not be acquired through distant care, detail the patient's surroundings, and integrate this into the clinical assessment, and use patient-generated data within the overall scope of the treatment plan.[34] This can be a challenge since the recent pandemic has accelerated the need for more virtual care delivery and many states and third-party payers including CMS have changed their rules and/or requirements.[35,36] The authors of this paper have attempted to provide insights for healthcare managers to understand how physician offices and other healthcare facilities are adapting processes to meet these new expectations as well as to offer best practices for successful navigation and documentation of telehealth visits.

The objective of this study is threefold: to assess the clinical data documentation status by types of healthcare facilities and by telehealth start dates; to explore policy and procedures used for telehealth data documentation; and to develop a strategy for the best practice in telehealth data documentation during and post the COVID-19 pandemic era.

Methods

Research Tool

A self-designed survey was developed and served as a data collection tool. This survey was designed based on the purpose of the study and from information gathered in the literature review. The survey questions used for this study included three main categories: demographic characteristics (such as healthcare facility types); data documentation collected (included 15 documentation items (**Table 1** and **Table 2**)), and telehealth usage (such as telehealth start date, policies and procedures used). All questions were tested and validated for logic flow, accuracy, and clarity.

Sample Selection

Two network email distribution lists were identified as the survey deliverables: one is Mid-Atlantic Telehealth Resources Center (MATRC), and another is Missouri Medical Group Management Association (Missouri MGMA). These two distribution lists covered states such as Pennsylvania, West Virginia, Kentucky, Virginia, North Carolina, New Jersey, Delaware, Maryland, Washington DC, and Missouri. The online survey links were sent to the contact persons from each network, and they were asked to distribute the survey link to their network mailing list. The total potential respondents are unknown due to the self-selection network survey distribution nature. The target participants included office managers and administrators from healthcare facilities who have used or are currently using telehealth services for patient care. Individuals who received the survey link could consent to and complete the survey or could forward the survey link to other eligible people in the same healthcare facility. Only one respondent per healthcare facility was inquired to complete the survey.

Survey Administration

Before the final survey was distributed, a pilot test was conducted on the survey logistics, validity and clarity of the questions. We selected 11 managers from physicians' offices to perform the pilot testing of the survey. The survey was revised and modified based on the responses and comments received from the pilot testing. The estimated time to complete the survey was 10 minutes.

The survey was distributed and administered through the Qualtrics online survey platform. In addition, two follow-up reminders were sent to each network after the initial survey distribution.

Analysis

For this study, we included survey items related to demographic information, such as healthcare facility types; date of initial telehealth use; types of telehealth services provided; data documentation status, such as data item collection; and policies and procedures used for data documentation. Other survey data collected from the study were reported elsewhere.

The question related to data documentation was a five-point Likert scale question, which included Never, Rarely, Sometimes, Often, and Always for the collection of listed data items. In this analysis, we combined scales of Sometimes, Often, and Always as a “Yes” group, while Never and Rarely as a “No” group to the responses of data collection items.

Qualtrics software was used for quantitative data analysis and included descriptive frequency distributions. For the free-text items, such as responses under the “others,” we coded and grouped them based on thematic and qualitative analysis approach.

Results

Demographic Information

There were 76 total responses to the survey. Manager and administrator made up the largest group of respondents (75 percent) when asked for their job title. The remainder of respondents self-described their role as coordinator (11 percent), healthcare provider (10 percent), or other (4 percent). Half (50 percent) of respondents worked in a physician practice, followed by behavioral/mental health (22 percent) and hospital (1 percent). The remaining 27 percent of “other” respondents worked at a variety of healthcare facilities in addition to the ones listed above. Other categories of healthcare facilities include PACE Center, Free Clinic, Nurse Practitioner Clinic, Rehabilitation Outpatient, and Inpatient/Outpatient multi-facilities. The majority of the respondents were located in North Carolina (54 percent), Missouri (20 percent), and West Virginia (12 percent), with responses received from 11 different states in total.

Data Documentation

Respondents were asked if their organizations collected the 15 documentation elements detailed in Tables 1 and 2. For this study, “always,” “often,” and “sometimes” were grouped as “yes” responses; while “rarely” or “never” were grouped as “no” responses to the documentation collection items. A total of 54 respondents answered this question. The responses were analyzed by the type of healthcare facility (**Table 1**), and how long they had been offering telehealth services (**Table 2**).

Respondents were asked to identify their type of healthcare facility. The type of healthcare facility was classified as physician office, hospital, mental health, and others. The other category included free clinics, community health centers, nurse practice clinics, inpatient/outpatient facilities, academic centers, or unspecified facilities. Respondents also were asked how long their organization had been offering telehealth services. The groups were less than one year, one to four years, and five years or more.

Totals for the documentation elements collected by type of facility/setting are displayed in Table 1. The totals are also displayed by the length of time offering telehealth in Table 2. There was only one respondent from a hospital setting, and all documentation elements were reported as collected (100 percent). The most frequently collected documentation items for physician offices and mental health were the communication method, date of service, diagnosis and impression, and recommendations (100 percent for all). The other settings category had similar findings, with the top three most collected documentation items being the date of service (94 percent), patient informed consent (94 percent), and diagnosis and impression (94 percent). Again, for all settings, the date of service, and diagnosis and impression were in the top three documentation elements collected.

The least collected documentation elements for physician offices were consulting physician (56 percent), referring physician (63 percent), and criteria used to evaluate whether the case was

appropriate for telehealth (69 percent). The three least collected items in the mental health settings were consulting physician (67 percent), referring physician (67 percent), and patient identification number (67 percent). In the other setting category, the items reported to be least frequently collected were referring physician (63 percent), start and stop time (67 percent), consulting physician (75 percent), and patient location (75 percent). For all settings the consulting physician and referring physician were among the least reported documentation elements collected.

Respondents were asked how long their organization had been offering telehealth services. The results are displayed in Table 2, grouped into less than one year, one to four years, and five years or more. Of those offering telehealth less than one year, communication method (97 percent), date of service (97 percent), and diagnosis and impression (91 percent) had the most responses as being collected. The lowest reported numbers in this group were for criteria used to evaluate if telehealth was appropriate for the case (42 percent, compared to 100 percent and 91 percent in the other groups), consulting physician (56 percent), and the reason for using telehealth (57 percent).

In the one-to-four years group, eight of the 15 documentation elements were reported as collected by 100 percent of respondents. Start and stop time (70 percent), consulting physician (80 percent), and referring physician (80 percent) had the lowest number of responses. Those offering telehealth for five years or more had five documentation elements reported as collected by 100 percent of respondents. This group had the lowest percentage of documentation collection in referring physician (56 percent), start and stop time (67 percent), and documenting other care providers involved or individuals present (67 percent).

Policies and Procedures Used

Respondents were asked what type of policies they used in guiding their delivery of telehealth services. Options included in-house written guidelines, federal/state governmental guidelines, third-party payer guidelines, professional association guidelines, or no guidelines. Forty-nine respondents answered the question and could have selected as many options as applied to their organization.

Only one hospital outpatient setting was reported utilizing federal/state government, third-party payer, and professional association guidelines. Additional care settings reported and displayed in **Table 3** included physician office, mental/behavioral health, and other settings. Most respondents used in-house designed guidelines and federal/state designed guidelines in physician's offices and other settings; for mental/behavioral health, in-house designed and professional association guidelines were the most reported.

The length of time a facility had been offering telehealth services by the types of policies used was also collected. **Table 4** displays the categories of less than one year, one to four years, and five or more years offering telehealth. For all three groups, the top three options for telehealth policies reported were 1) in-house designed guidelines, 2) federal/state government designed, and 3) professional association guidelines.

Discussion/Conclusion

This study provides a closer look at specific data items that should be collected for telehealth patient visits. Policies and procedures used in telehealth by healthcare facilities that guided decision-making and data collection were also examined. The results from this study add to the body of knowledge regarding telehealth documentation and also point to areas in which improvements could be made.

The results from this study found that current practices in telehealth documentation are progressing toward but not yet completely meeting best practice goals. The rapid adaptation of telehealth within the last 18 months and the uncertainties in related documentation standards have left many without clear guidelines. Between 85 percent and 100 percent of respondents are collecting consent forms, type of visit, and length of visit information. Respondents were noted to have high rates of complete documentation in these areas.

The majority of respondents were collecting most of the documentation items. However, the elements that were lacking in the collection were consulting physician, referring physician, and criteria for determining whether the case was appropriate for telehealth. These findings point to the need for training of physician office staff to include the referring and consulting physicians in telehealth documentation. In addition, there should be criteria developed to document the appropriateness of the telehealth visit.

Documentation standards were reduced to facilitate timely care during the pandemic. This reduction in documentation requirements will be discontinued at some point following the acute phase of the pandemic. Facilities will need to tighten their policies and procedures as we move forward out of the pandemic.

Telehealth guidelines and related literature identified additional clinical documentation items needed for best practices in telehealth documentation. It is important to capture all required documentation for telehealth visits, as this is essential for the reimbursement of such services. These include but are not limited to:

- Appropriate consent forms
- Documentation of types of visit (audio/audio and video)
- Length of telehealth visits (time)
- Location of the patients and physicians (home vs. office)
- Identification of all participants in telehealth visits

In addition, the use of note templates specific to telehealth visits is recommended to ensure appropriate documentation is captured. Telehealth training should be provided to both practitioners and office staff. Office administrators should develop practice specific policies, procedures, and forms to address telehealth services, including documentation requirements and reimbursement guidelines. Checklists, including all essential information, are recommended for the clinical staff to use as a data collection tool.

Finally, telehealth documentation should address any limitations, such as low-quality images or an inability to see patient characteristics via video clearly. Templates should meet payer requirements, and practitioners should document with audits in mind. Facilities should be constantly monitoring the updated guidelines on telehealth documentation. Policies and procedures must be updated accordingly.

The study findings are somewhat limited by the geographic and specialty areas of the respondents to the study. While the respondents represented 11 states, both urban and rural settings, large and small practices, and a variety of types of providers, the respondents were all members of the Mid-Atlantic Telehealth Resources Center and the Missouri MGMA. The majority of the respondents were from physicians' offices. A larger, nationwide study would provide additional information about the use of telehealth throughout the country and in a wider variety of specialty settings. As the use of telehealth grows, further study will also be needed to fine-tune the challenges and barriers. There are a variety of telehealth-related issues that will require further study and insight, including

implementation of new telehealth guidelines, privacy and security issues, and patient access issues. Further study in these areas could aid in the development of best practices in telehealth provision.

The COVID-19 pandemic spurred the quick adaptation to the use of telehealth services and, in turn, required additional telehealth data documentation. During their quick pivot to provide healthcare services in this alternative format to as many patients as possible, providers were less concerned with documentation. As telehealth services become more common, it is important that providers and organizations review and re-evaluate their policies and procedures related to telehealth documentation standards. All healthcare facilities require complete, timely, and high-quality data documentation to achieve the goals for best practices in the current high-demand data-driven environment.

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