

# Establishing clinical pharmacist telehealth services during the COVID-19 pandemic

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**Purpose.** After community transmission of the novel virus that causes coronavirus disease 2019 (COVID-19) was detected in the State of Washington in February 2020, innovative measures, such as telehealth appointments, were needed to safely continue to provide optimal pharmaceutical care for patients with chronic conditions and cancer.

**Summary.** Prior to the COVID-19 pandemic, federal regulations limited the scope of telehealth pharmacist services. However, enactment of the Coronavirus Preparedness and Response Supplemental Appropriations Act, followed by guidance by the Centers for Medicare and Medicaid Services and the Department of Health and Human Services, allowed currently credentialed providers (including pharmacists) to continue to provide patient care services via telehealth with fewer restrictions. Our health system has numerous credentialed pharmacists across multiple ambulatory care clinics. In this article, we highlight our process of expediting the implementation of telehealth services. This process included obtaining authorization for the credentialed pharmacists to provide telehealth services, completion of training modules, implementation of new technology platforms, development of new workflows, and utilization of resources for providers and patients to facilitate successful completion of telehealth visits. We also highlight the consent and documentation components crucially important to the telehealth visit and share some of our successes, as well as identified limitations, in providing pharmacist services via telehealth.

**Conclusion.** In the setting of the COVID-19 pandemic, our institution was able to swiftly implement clinical pharmacist telehealth services for many patients, offering a safe and effective way to continue providing a high level of care. This article discusses our experience with and potential limitations of telehealth to assist other pharmacists seeking to implement and/or expand their telehealth services.

**Keywords:** ambulatory care, care access, COVID-19, pharmacy services, telehealth, telemedicine

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Community transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the causative pathogen in the coronavirus disease 2019 (COVID-19) pandemic, was detected in the State of Washington in February 2020.<sup>1</sup> It quickly became apparent that innovative measures to protect the health and safety of patients and healthcare workers were needed. Due to measures implemented to decrease the potential for SARS-CoV-2 exposure, the delivery of care for patients with chronic conditions and cancer changed

dramatically. From the time the first patient with COVID-19 was identified in the state until the time of this writing, the number of cases continued to rise. Three months after the first case of COVID-19 was detected, 14,327 cases and 814 deaths from COVID-19 had been reported in Washington.<sup>2</sup>

University of Washington (UW) Medicine is an integrated healthcare system that provides comprehensive patient care throughout the greater Seattle area. The system has over 300 clinics, 4 acute care facilities, and

partnerships with the Seattle Cancer Care Alliance (SCCA) and Seattle Children's Hospital. Credentialed clinical pharmacists working in primary care and specialty clinics at SCCA, Harborview Medical Center (HMC), and the University of Washington Medical Center (UWMC) have altered their delivery of clinical services to ensure that patients continue to receive high-quality and safe care. One of the tools employed to accomplish this is telehealth services. The US Health Resources and Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration."<sup>3</sup> In this article, we review an expedited process used to obtain telehealth privileges for pharmacists and highlight our experience providing clinical services to patients with COVID-19.

### Federal regulation changes

In the early 2000s, during a critical pharmacist shortage, pharmacists in the United States began offering telehealth services. There were strict criteria regarding who could receive a telehealth visit. For example, patients eligible to engage in telehealth encounters primarily included those who were located in rural areas or had limited access to healthcare.<sup>3-6</sup> These earlier telehealth services focused on remote verification of medication orders or remote dispensing services. Telehealth visits that focused on therapy management performed by pharmacists were less common. In a study by Nieves et al,<sup>7</sup> psychiatry pharmacists used videophones for pharmacy consultations to expand patient access to care and to improve treatment adherence. Another study, by Nye and colleagues,<sup>8</sup> described an interdisciplinary diabetes management program in which pharmacists used telemedicine to complete medication histories, conduct medication teaching, and provide medication therapy change recommendations to

### KEY POINTS

- Recent changes to federal regulations have allowed more patients to receive care and more providers to deliver care through telehealth during the COVID-19 pandemic.
- Telehealth visits with a clinical pharmacist offer several advantages, including flexibility in scheduling chemotherapy education, pain management, anticoagulation visits, primary care, and specialty care disease management; however, limitations involving patient factors and technological issues may be encountered.
- Telehealth visits are preferred over phone visits to ensure patient understanding and to help establish the pharmacist and/or care team establish and build rapport with the patient.

a primary care provider. Results from this interdisciplinary program demonstrated equivalent outcomes for telemedicine patients and those who completed in-person visits.

In response to calls for flexibility and broadening of access to care during the COVID-19 pandemic, the Coronavirus Preparedness and Response Supplemental Appropriations Act was enacted and became law on March 6, 2020.<sup>9</sup> This law provided funds for healthcare organizations to address the pandemic and loosened restrictions on telehealth services. Shortly thereafter, on March 17, 2020, the Centers for Medicare and Medicaid Services (CMS) announced that its telehealth waiver had been expanded to allow for new patients to receive diagnosis and treatment of COVID-19 via telehealth.<sup>10</sup> It also outlined payments and reimbursements for office, hospital, and other types of visits conducted via telehealth. This

provision allowed management of conditions unrelated to COVID-19 via telehealth.

In addition to these relaxed regulations, the Health and Human Services (HHS) secretary was granted the authority to waive restrictions on telehealth during a public health emergency. CMS continues to modify its regulations to expand pharmacists' ability to provide telehealth services.<sup>11</sup> At the time of this writing, changes to restrictions included the following<sup>9</sup>:

- Who can offer telehealth services: Under the waiver, telehealth services can be delivered by nonphysician qualified health professionals such as social workers, physical therapists, occupational therapists, speech therapists, and clinical psychologists. Pharmacists are considered "auxiliary personnel"; however, they can provide and bill for telehealth services rendered "incident to" services provided by a Medicare-eligible provider.
- Originating site: Previously the CMS telehealth requirements stated that a patient must visit the originating site of service provision, such as a physician's office, skilled nursing facility, or hospital, each time telehealth services were provided (ie, telehealth services had to be provided on-site) in order for providers to bill for telehealth services. However, in addition to waiving the geographical site restrictions, the HHS secretary also allowed patients to receive services wherever they are located, including patient homes.
- Technology used in telehealth: The HHS secretary loosened the restrictions on the types of devices and applications that could be used for telehealth services. Therefore, personal phones and computers, including tablet computers, are now acceptable provided that the patient and provider have interactive audio and visual capabilities that permit real-time communication between a remote

site and the patient at home. Providers are also able to use additional popular applications for telehealth visits such as Microsoft's Skype, Apple's FaceTime, Google Hangouts, and Zoom (Zoom Video Communications, Inc., San Jose, CA), among others, during the COVID-19 emergency without violating Health Insurance Portability and Accountability Act (HIPAA) requirements.

- Patient eligibility: Previously, only existing Medicare beneficiaries who were seen in the past 3 years could access telehealth services, which were narrowly defined. These patients had to be in a designated rural area and could only receive services pertaining to "common office visits," mental health counseling, and preventative health screenings. Now, both

new and existing patients can access telehealth for a wide range of services. Telehealth services still require informed consent from the patient at the start of the appointment.

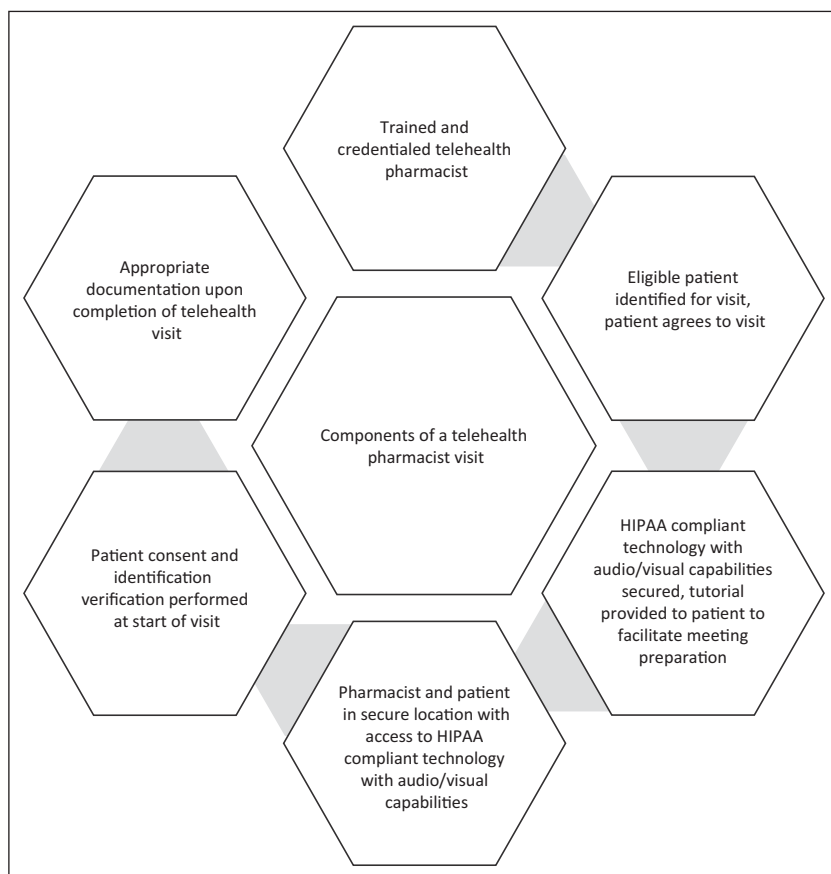
**Process implementation: credentialing for telehealth**

In response to the federal regulation changes and the rapidly developing pandemic, the leadership at UW Medicine recognized that the care of our patients had to be adapted as well. Per the Joint Commission, practitioners who are credentialed and privileged by a healthcare organization can provide to patients via telehealth the same services that were previously provided without needing to obtain additional privileges or credentialing.<sup>12</sup> At UW Medicine, 69 pharmacists are credentialed (under collaborative drug therapy

agreements) to offer comprehensive medication management via telehealth to patients in primary care and specialty clinics, and 32 pharmacists have completed telehealth visits to date.

In our organization, in order to be credentialed to provide telehealth services, individuals (including pharmacists) completed 2 comprehensive learning modules developed internally by the UW Medicine telehealth department, which are appropriate for all provider types. These modules reviewed a variety of topics, including obtaining informed consent, videoconferencing etiquette, documentation, billing requirements, adverse event reporting, and risk management. The modules also reviewed requirements for using the telehealth platform, such as how to enable technical requirements, obtaining HIPAA-compliant access to the platform, and audio and video setup.

**Figure 1.** Clinical pharmacist telehealth visit model. HIPAA indicates Health Insurance Portability and Accountability Act.



**Components of a telehealth visit**

**Technology.** The UW Medicine telehealth department chose Zoom as its system-wide, preferred HIPAA-compliant telehealth platform. The addition of telehealth visits required supplemental technology resources for pharmacist telehealth appointments. This process included obtaining additional computers with audio and video capabilities, access to communications applications that included phone routing technology, and setup of a personal HIPAA-compliant telehealth account. At HMC and UWMC, this HIPAA-compliant platform was integrated into the Epic electronic medical record (EMR) system (Epic Systems Corporation, Verona, WI) for the convenience of both the telehealth provider and the patient. There are many components that need to be considered for a successful telehealth visit. These components are described in Figure 1.

**Workflow.** For telehealth to be successful, new workflows and resources had to be created. Historically, the pharmacist-managed and inter-professional oncology clinics at SCCA, HMC, and UWMC managed patients

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with phone and in-person visits. There are key differences between these platforms and telehealth. Whereas phone visits are more flexible and could take place at any point during the business day, the telehealth visit mimics a scheduled in-person appointment format. For telehealth to be successful, both parties must stick to their scheduled appointment time. Therefore, new support staff workflows for scheduling patients had to be developed. Practice changes were also implemented. For example, a phone visit allows the pharmacist to review records during the visit; however, in a telehealth appointment more advanced preparation is required to ensure that a provider minimizes distractions or lack of eye contact with the patient when reviewing notes. Lastly, telehealth visits may be longer than phone or in-person visits. It takes time to orient the patient to the technology, troubleshoot any technology issues, and obtain consent at the beginning of each telehealth visit. To help minimize these potential challenges, resources were developed for providers and patients. Key resources for providers included how to set up a recurring meeting link for a patient and how to use interpreter services. Integration of the EMR has increased the ease of the provider's and the patient's ability to interface and enhances security while also reducing technical challenges. In addition, patient resources on how to set up the telehealth platform in preparation for an appointment were developed.

**Patient eligibility.** Substantial changes were also made in the area of patient eligibility. A patient is now eligible to receive a telehealth appointment if he/she does not require a physical examination, narcotic medication changes, or other in-person services the same day. The pharmacy department further identified key patient factors for telehealth appointments. For example, in the anticoagulation clinics, telehealth was the preferred visit format for new and return patients. The telehealth platform allows the pharmacist to conduct necessary protocols, ensure patient

understanding, and visually establish rapport and trust with the patient. Telehealth was also an option for credentialed pharmacists to complete medication education requiring visualization across all clinic types. The telehealth visit type was preferred because it allows pharmacists to visually assess understanding and adherence while simultaneously walking a patient through complex regimens.

**Scheduling.** If patients meet the eligibility criteria, they can be scheduled for a telehealth visit. To schedule these telehealth visits, a new visit type (ie, telehealth) was created in the EMR. The patient is supplied with resources to set up and prepare for the visit. The patient is also provided by support staff with a unique, HIPAA-compliant hyperlink to enter the scheduled appointment. However, the patient may refuse this type of visit. A telehealth refusal could be due to patient preference, time limitations, or limitations related to computer access. In these scenarios, a patient must be offered either a phone or face-to-face visit with the clinical pharmacist.

### Performing a telehealth visit

**Consent.** Consent is required for a successful telehealth visit. During each telehealth visit, the patient is "consented" at the beginning of the appointment. The pharmacist asks the patient to respond to several scripted questions to obtain consent. Once verbal consent is received, per regulations the pharmacist must verify the patient's identity, location, and whether additional individuals are accompanying the patient during the visit. In return, pharmacists conducting telehealth visits introduce themselves (and any accompanying students or residents) and state their clinical role and location.

**Documentation.** All patient responses and provider information are recorded (either with video or written documentation) and uploaded as a clinical note into the EMR after the visit.

### Experience

During the period of March 31 through April 28, 2020, clinical

pharmacist telehealth services were offered to 139 patients. Of these patients, 83% ( $n = 116$ ) completed telehealth visits. Fourteen patients cancelled appointments, 11 patients declined telehealth visits, and 6 patients did not show up to their telehealth appointment. Reasons for declined telehealth services included patient preference for phone or in-person education and technological difficulty.

Telehealth is a versatile method of education that can span a variety of specialties which is described in Table 1. In our experience, telehealth visits have offered some significant advantages during the pandemic, including flexibility in scheduling chemotherapy education, pain management, anticoagulation visits, primary care, or specialty care disease management. Flexible scheduling is particularly important for patients who travel long distances for on-site appointments and for patients with several provider visits scheduled in a single day, for whom the amount of critical information provided can quickly become overwhelming. Other benefits of telehealth visits include personalized communication, the ability to visually review the patient's medications or injection technique remotely, and avoidance of office space limitations for in-clinic visits, particularly with social distancing requirements. In addition, both the pharmacist and the patient can use verbal and nonverbal cues to determine whether the patient has a good understanding of his or her medications, which can be more challenging to assess in a phone encounter. Compared to phone visits, telehealth visits may promote effective and personalized care, as patients must use both verbal and nonverbal communication. Additionally, pharmacists are able to reinforce information by sharing their computer screen with the patient and visually referencing the patient education handouts to be provided after the session (via email or mail, as indicated by patient preference). Logistically, telehealth visits allow for an on-time appointment with patients

**Table 1.** Examples of Clinical Pharmacy Telehealth Services by Practice Specialty Area

	Anticoagulation	Pain Management	Primary Care (IBD, RA, Dermatology, Diabetes)	Oncology	Specialty Pharmacy
Population served	New and return patients	Return patients	New and return patients	New and return patients	New and return patients
Clinical services provided via telehealth	Injection technique Laboratory test results review Adherence assessment Adverse effect assessment	Pain management assessment Adherence assessment Laboratory test results review	Injection technique Medication box reviews	Oral and i.v. chemotherapy education Adverse effect monitoring Adherence assessment	Medication education Injection technique Adherence assessment Adverse effect monitoring Medication box reviews Laboratory test results review

Abbreviations: IBD, irritable bowel disease; RA, rheumatoid arthritis.

and their caregivers without relying on the availability of a limited number of conference rooms that would typically be used for education appointments in a clinic. Without space constraints, patients are also able to invite any number of caregivers to their telehealth visit, which may increase the chances of the patient retaining information.

During the COVID-19 pandemic, telehealth visits have maintained the collaborative and academic practice model of in-person service provision. Telehealth visit documentation can be shared with an attending physician or advanced practice provider. Patients can be placed into a virtual waiting room while treatment discussions happen, and then patients can be invited back into the virtual visit to make treatment decisions. This practice has also worked with pharmacy residents, who are able to attend telehealth visits with their pharmacist preceptors.

There are, however, a few limitations to telehealth that we have encountered to date, mainly involving patient-specific factors and technological issues. Some patients may not seem comfortable with the telehealth platform and have difficulty navigating through the necessary elements required to perform a telehealth visit. Especially during the first telehealth visit, it is important that the pharmacist is ready to use an alternative communication method, such as a phone call, in order to help assist the patient in setting up telehealth equipment. Alternatively, some clinics have had medical assistants or clinic support staff to help set up and room the patient in the virtual waiting room prior to the telehealth visit. The telehealth visits also rely on a stable Internet connection on the part of both the patient and the provider, and any interruption in Internet service may result in ineffective education. This has not been a problem for on-site pharmacists connected directly to their institution's Internet network; however, for pharmacists working off-site, wireless Internet seems less stable, and a direct connection to a local Internet source is recommended.

In addition, some patients with lack of access to computers or the Internet or more complicated social or living situations (such as homelessness) may not be able to engage in telehealth services due to lack of resources. In these cases, patients can be seen for an in-person visit or via telephone according to their needs.

**Conclusion**

With the rapid progression of the COVID-19 pandemic, particularly early on in Washington state, it was clear that innovative ways to provide clinical pharmacist services to patients would be needed. After changes to federal regulations were made and based on guidance from the Joint Commission, we were able to expedite authorization for telehealth services for pharmacists who were already credentialed at our institution. We were also able to implement a streamlined process for authorization of telehealth privileges as well as resources and workflow changes needed for pharmacists as well as patients. This model is a beneficial visit type that will prove useful should regulation changes become permanent after the COVID-19 pandemic resolves. We hope that our experience will help others provide these telehealth services as COVID-19 continues to be a significant issue in many areas around the country.

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**Disclosures**

The authors have declared no potential conflicts of interest.

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