Frequently Asked Questions
EB TNP
D-TEC Tool

Patient Data Form

1. If a patient receives more than one EB TNP service (such as behavioral health AND primary care), can/should both services be indicated on the enrollment form?

No, only one EB TNP service can be indicated on the patient data form.

Per the Data Element Dictionary, page 5:
(In variable 11 - EB TNP primary service provided to patient) "Patients may receive multiple services if more than one is available through the EB TNP, however only one service should be chosen as the principal service that the patient will receive. This choice will be made at the time of enrollment."

2. If a patient receives more than one EB TNP service (such as behavioral health AND primary care), what process should the grantee take to make a standard decision on how to categorize the patient?

Decisions on the patient's principal type of service are entirely up to the grantee, keeping in mind that the NOFO specified that each grantee must offer at least one of the primary services listed in the NOFO (i.e., primary care, urgent care, behavioral health) so make sure that some patients are assigned to at least one of those services. Although patients may receive multiple services, only one service can be specified as the principal service and that decision should be made at the time of patient study enrollment. For grantees offering multiple services that a patient qualifies for, at enrollment grantees could identify the service that the patient is likely to receive the most often during the next year or the service that is most important for the patient's care at the time of enrollment. Once assigned, the patient's specified principal service should not be changed.

Per the study protocol, page 12:
"The EB TNP NOFO identified six services as the focus of treatment activities, and the grantees indicated which services they plan to deliver. At the time of enrollment, a single, primary service must be identified for each patient. If grantees are offering multiple services, it is possible the patients will receive more than one service through the EB TNP, however only one service must be chosen as the principal service for data collection purposes."

3. If a patient receives one service (e.g., primary care) and then after the 12-month data collection period begins to receive a different service (e.g. maternal care), can/should data be collected on that new service?

No. Patients may only be used once.

Patient Encounter Form

4. If a patient is assigned to one service (e.g., behavioral care) and then has some encounters in a different service (e.g., chronic care management), should those be entered in the encounter form?

Yes, all encounters during the 12-month data collection period should be entered in the encounter form, with the following caveats.

- First, if the patient receives remote patient monitoring, then special rules apply to limit data collection for remote patient monitoring to once per month.
- Second, if the patient receives an encounter that is completely unrelated to the primary service, then it does not need to be entered. An example might be a patient receiving behavioral health through EB TNP who has a visit with a dermatologist. The easiest way to operationalize this decision is to look at the diagnosis codes that are listed for each encounter. If the ICD-10 codes listed for the primary service show up, then include that encounter in the encounter form. Over-inclusion is preferable to under-inclusion.
- Third, grantees are not expected to include encounters that occur outside of their healthcare organization where they do not have access to the patient's medical record. For example, if a patient has an encounter for the assigned service (e.g., acute care), or any other service, at an unaligned healthcare facility while on vacation, then grantees are not expected to enter that in the encounter form.

5. What if a patient's first encounter is in person, but the remaining are in telehealth? The patient should be assigned to a telehealth or in-person treatment group at enrollment in the patient data form. It is not uncommon for a patient to be seen first in person but be assigned to a telehealth group for most of treatment. Overall, we expect there may be some crossover from assigned treatment group to the other. Every encounter will need to indicate the type regardless of assignment.

Per the Data Element Dictionary, page 2:
"The patient is assigned to the Telehealth Treatment Group if telehealth is intended to be the primary treatment modality. The patient is assigned to the In-person Treatment Group if the patient's intended primary treatment modality is in-person. Note that patients may occasionally "crossover" (i.e., receive treatment via the opposite modality) during the course of the study. Regardless, the treatment group would remain as originally assigned."

Per the study protocol, page 12:
"For each patient, grantees identify whether the patient will be assigned to the Telehealth treatment group or the In-person treatment group at the beginning of data collection. This means that the patients in the Telehealth group will primarily receive services via telehealth and the patients in the In-person group will primarily receive in-person services. This assignment is based on intent for the primary mode of treatment. It does not mean that the patients in each group will exclusively receive services that way. There will be crossovers where patients assigned to one group will occasionally receive services akin to the other group."

6. RTRC want data from before January 3, 2024?
While all data from January 3, 2024, forward is required, if a grantee can and is willing to voluntarily provide previous patient/encounter data that was part of EB TNP, that is welcome.

7. What if grantees enter data on encounters that occur after the 12-month data collection period?
Encounters through 365 days will be accepted in REDCap®. It will let you know that it can't take the data if you try to enter an encounter past 365 days.

Volume of data

8. In order to reduce the data burden, is there a minimum number of patients that can be used rather than trying to manage every patient?
The NOFO specified that data was to be collected on all EB TNP patients – in both telehealth and in-person groups. We tried to reduce burden by asking for only one EB TNP service type per patient. We further reduce burden by limiting data collection to one year per patient. The one-year data collection timeframe was determined by OAT.

Per the NOFO: HRSA-21-082, page 41:
"COMPARISON GROUP: Data are to be collected on all patients where telehealth services are used as part of the award (Telehealth group) and on a 1-to-1 comparison sample of patients who receive comparable services in-person (non-telehealth comparison group). Collecting data on non-telehealth comparison groups is an important component of the research design and will enable important research questions to be answered using a more rigorous research approach. Ideally, award recipients will be able to identify treatment sites that provide in-person services that are comparable to those delivered through telehealth, and to patients who are similar to those receiving telehealth services."

What we mean by a 1-to-1 comparison sample is that data are to be collected on all patients where telehealth services are used as part of the award (Telehealth group) and on a similar number of patients who receive comparable services in-person (non-telehealth comparison group). If a grantee has data available on a large number of patients who receive comparable services in-person, they do not need to enter data on all those patients and can select a subset of those patients to enter data on, selecting those that match best in terms of comparable services, conditions, and demographics. In this case, it is permissible to adjust selection of the in-person treatment group patients as the characteristics of the telehealth group become known. For example, after a group of chronic care management telehealth patients are entered, a tally of their primary diagnosis will inform which conditions to focus on when selecting the in-person treatment patients.

9. Is there an alternate way to enter large quantities of data into RedCap®?
Direct import options are possible but will not be viable or useful for all grantees; it is an option for those with highly skilled IT resources and a large volume of patients/encounters.

Documentation describing the process is available and RTRC is happy to discuss with those interested.

Remote Patient Monitoring (RPM) Data

10. For grantees with RPM projects, is there a clear description on how to count those encounters?

RPM services are typically billed monthly and so we only expect one monthly "encounter" to be reported.

Per the Data Element Dictionary, page 6:
"Once the patient is enrolled, ***all encounters that are scheduled to be delivered during the 12- month follow-up period should be entered, with the exception of remote patient monitoring data transmissions/monitoring/interpretation, which will only be entered once per month.*** *See protocol for clarification."*

Per the study protocol, page 8:
"*Remote patient monitoring presents a special situation for data collection. In remote patient monitoring, multiple services and CPT codes may be billed to Centers for Medicare & Medicaid Services (CMS) monthly. These include patient data that are being monitored (CPT 99457 and 99458) and interpreted (CPT 99091) by clinicians and billed each 30 days. In addition, there are other activities that involve initial set-up and patient education (CPT 99453) and supply of device (CPT 99454) that occur once or periodically. Each of these activities, matching one of these cited CPT codes, should be treated like an encounter for data collection purposes."*

REDCap® access

11. What if one of our staff leaves during data collection?

If a REDCap® user no longer needs access or is no longer involved in D-TEC data collection, it is up to the grantee to inform RTRC (Kim at kimberly-merchant@uiowa.edu) about that person so access can be removed.

IRB

12. How do grantees explain to their IRBs that this is NOT a research project?

Every IRB has their own understanding and implementation of human subject research rules and guidelines. We actually believe that this IS a research project, but it is possible that some grantees may implement safeguards and protocols that would qualify this with their IRB as quality improvement. Grantees are strongly encouraged to consult with their local IRB for guidance in meeting requirements.

Use of data

13. How will D-TEC data be used?

RTRC is collecting and pooling data across all grantees to expand the evidence base of telehealth. As in previous OAT evidence-based telehealth programs, RTRC develops measures, collects and analyzes data, and publishes journal articles to answer research questions.

Per the study protocol, page 13:
"The purpose of this data collection effort is not to evaluate any individual grantee's efforts, but rather to pool data across grantees to provide sufficient data for statistical analysis aimed at addressing important research questions. Analyses will only be presented in aggregate form. Individual grantee, treatment site, and patient data will be kept confidential and will not be identified in manuscripts. The goal will be to contribute to the evidence base by publishing multiple peer-reviewed journal articles."

Here are examples of journal publications associated with past OAT telehealth network projects:

Tele-Emergency

- Mohr NM, Young T, Harland KK, Skow B, Wittrock A, Bell A, Ward MM. Telemedicine is associated with faster diagnostic imaging in stroke patients: A cohort study. Telemedicine and e-Health. 25(2):93-100, 2019
- Heppner S, Mohr NM, Carter KD, Ullrich F, Merchant KAS, Ward MM. HRSA's Evidence Based Tele-Emergency Network Grant Program: Multi-site prospective cohort analysis across six rural emergency department telemedicine networks. PLoS One. 2021 Jan 12;16(1):e0243211. doi: 10.1371/journal.pone.0243211. eCollection 2021. PMID: 33434197

School-based telehealth

- Ward MM, Ullrich F, Merchant KAS, Carter KD, Bhagianadh D, Lacks M, Taylor E, Gordon J. Describing changes in telebehavioral health utilization and services delivery in rural school settings in pre- and early stages of the COVID-19 public health emergency. Journal of School Health. 92(5), 452-460, May 2022
- Ward MM, Bhagianadh D, Ullrich F, Merchant KA, Mena C. Overview of School-Based Telehealth Network Grant Program services delivered to students in rural schools. The Journal of School Nursing. 2022 Dec 4:10598405221142498

Telebehavioral health

- Ward MM, Carter KD, Bhagianadh D, Ullrich F, Merchant KA, Marcin JP, Law KB, McCord C, Neufeld J, Nelson EL, Shane DM. Comparison of telehealth and in-person behavioral health services and payment in a large rural multisite usual care study. Telemedicine and e-Health. April 10, 2023
- McCord C, Ullrich F, Merchant KAS, Bhagianadh D, Carter KD, Nelson E, Marcin JP, Law KB, Neufeld J, Giovanetti A, Ward MM. Comparison of in-person vs. telebehavioral health outcomes from rural populations across America. BMC Psychiatry 22, 778 (2022)