2014 NRTRC Telemedicine Conference

Telehealth Finances and Business Models for the Present and Future

Jonathan Neufeld, PhD
Upper Midwest Telehealth Resource Center
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Disclosures

• **Practice Gap:** Lack of awareness on how to provide specialty care services to under-served populations in the region.

• **Desired Outcome:**
  – Providers will be able to apply knowledge acquired from the conference to better provide care using telemedicine to patients across the region.
  – Providers will be able to solve problems within their practice using telemedicine.
  – Providers will be able to identify the services available for their patients via telemedicine within their region.
  – Providers will be able to recognize the changes in telemedicine and how best to continue improving their practices during change.

• **Disclosure of relevant financial relationships in the past 12 months:** I have no relevant financial relationships with commercial interests that may have a direct bearing on the subject matter of this CME activity.
Outline

I. Introduction to UMTRC
II. What is Driving Telehealth Adoption?
III. Who is Winning? How?
IV. Embracing the Future
telehealthresourcecenters.org

- Links to all TRCs
- National Webinar Series
- Reimbursement, Marketing, and Training Tools
UMTRC Services

- Presentations & Trainings
- Individual and Group Consultation
- Training and Technical Assistance
- Connections with other programs
- Program Design and Evaluation
- Information on current legislative and policy developments
Behold the Headlines

- Top Health Trend For 2014: Telehealth To Grow Over 50% (Forbes, 12/28/13)
What’s Driving Adoption?
NOT Reimbursement

- Medicare
  - Incremental expansion of 1996 law
  - About $10-15 Million payout annually
- Medicaid
  - 40+ states cover some type of telehealth
- Commercial
  - 20 states mandate commercial coverage
NOT Technology

- More reliable
- Cheaper (+/-)
- Great new cloud-based tools for small-to-medium organizations
NOT Broadband Penetration
What IS Driving Adoption?

• The Threat of Payment Reform
• Ascendancy of the Spoke Site
• The Shifting Role of the Physician
Legacy Model of Telemedicine

Historically, Telemedicine usually involved:

• A Specialty (sub-(sub-)specialty) Physician
• An Academic (or Urban) Medical Center
• “Sending Services to Needy Areas”

“The Missionary Model”
Legacy Model of Telemedicine

• Payment
  – Professional Fee to physician
    • Often from a relatively poorer payer mix
  – Facility fee ($20-25) to originating site
    • Barely covers cost of doing the billing

• Supplemented with:
  – Grant Support (hub)
  – Academic & Outreach Missions (hub)
  – IT Support (hub)
Legacy Model of Telemedicine

• Hub site could usually squeeze into the model
  – “It’s part of the mission.”

• Spoke site business was often less robust
Change Is Coming

Healthcare
1. Payment Reform

- Healthcare entities are business and respond to business pressures
  - “You get what you pay for.”
- Outcomes more important than Procedures
  - Payment based on results (or quality targets)
Why This Drives Telemedicine

• “Un-billable codes” don’t matter as much
  – Freedom to “experiment” with telehealth

• Innovator’s Dilemma:
  “What programs can you finance for 4% of your Medicare billing?”
Example: Home Monitoring

- It used to be that home monitoring wasn’t covered; now it doesn’t matter anymore
- Well designed home health programs work
  - Simpler, less expensive systems work better
  - Facilitating personal connections with caregivers (and hospital) works best
- “Using (right) tech to deliver (right) touch”
- Every hospital can benefit from this
2. Ascendancy of the Spoke Site

Sites that used to rely on a “hub” for services can now find and develop their own.

• Sustained need for services/clinicians
• Technology becoming more approachable
• Willingness/imperative to innovate
• Exploration of new/alternative reimbursement models where both partners benefit
Peer-to-Peer Telemedicine Project

Inputs:

• Simple equipment
• Basic training
• Ongoing access to mentoring

Result:

A collection of home grown, self-run “networks” extending practitioners into new areas and bringing them from outside areas
P2P Network(s)

- 3 CMHC
- 1 RHC
- 2 FQHC
- 1 LTC (plus MD/NP site)
- 2 CAH
- 1 Admin (Grantee)
Example – Bowen Center

- 5 sites spread across 5 counties
- 70+ miles between furthest sites
- History of specialists driving to sites
- Project began 2009
  - 2 APNs (psychiatric NPs)
  - 2 remote clinics
  - Medication evals/re-evals by TM
Bowen Center Results
Bowen Center Results
Example – Union Hospital Clinton

CAH Tele-cardiology Service

- Patient presents in rural ED
- Evaluated by tele-cardiologist in Terre Haute
  - High risk: triage and transport
  - Low risk: imaging/labs, treat, observe, re-evaluate
Example – Union Hospital Clinton

124 Cases Evaluated for “Chest Pain r/o MI”

Union Clinton CAH

5 Transported to Terre Haute for treatment

119 Cases Retained, Tested, Re-evaluated

Terre Haute Cardio

Union Hospital Terre Haute (Main Campus)
Example – Union Hospital Clinton

- **Tele-cardiology Service (2012)**
  - 124 cases evaluated (119 kept in CAH)
  - $69,000+ in additional revenue at Clinton
    - Reduced overall treatment costs to payers
  - High satisfaction for patients, families, and providers
  - Direct outreach AND rural benefit

Stephanie Laws:
slaws@uhhg.org  812-238-7479
3. Changing Role of the Physician

- Increasingly employed (vs. private practice)
- Individual interests folded into goals of a larger (and growing) organization
- Greater flexibility in locations and settings
- Growing importance of work-life balance
- Greater comfort with technology
- Greater ability to form professional relationships at a distance
National Telehealth Bill 2013

Doris Matsui (D-Calif.) and Bill Johnson (R-Ohio) introduced the Telehealth Modernization Act of 2013 last December

**Intent:** to provide principles that states could use for guidance when developing new telehealth policies.

**Key Points the Bill Addresses:**

- **Establishing relationships:** The fundamental patient-provider relationship can be preserved, established and augmented through the use of telehealth;

- **Informing care:** A healthcare professional should have access to and review the medical history of the individual he or she is treating via telehealth;
National Telehealth Bill 2013

• **Providing documentation:** A healthcare professional should document the evaluation and any treatment furnished to the patient, as well as generate a medical record of the telehealth encounter;

• **Improving continuity of care:** Telehealth technology platforms should allow each patient the ability to forward documentation to selected care providers to uphold the patient's continuity of care;

• **Providing prescription requirements:** Prescriptions provided by telehealth providers should be issued for a legitimate medical purpose only and be filled by a valid dispensing entity.
National Telehealth Bill 2013

• Telehealth is adequate (when properly used) to establish and maintain a valid doctor-patient relationship

• The best healthcare is integrated healthcare; telehealth should be used to further the integration of care
Result: Innovators Are Emboldened

“First mover advantage”

• Healthcare Organizations that can respond to business pressures like good businesses can maximize their advantage
Recruitment & Retention

Recruiting from anywhere, to anywhere

• New hires from other markets/locales
• Spouses in-tow
• Part-timers
• Part-year, “snow birds”
• Contracting for “dirty work” (on call, etc.)
• Innovative arrangements
  – Corporate time-share, anyone?
Paying Wholesale, Not Retail

Anthem/WellPoint LiveHealth Program

• Services provided by American Well
• Beneficiaries call directly 24/7
  – Nurse triage
  – Direct video telemedicine with doctor if appropriate
  – Co-pay (or self-pay) collected online

“End run” around brick-and-mortar docs
Convenience & Concierge

• Primary Care Diversion
  – Example: WellPoint (LiveHealth)
    • Paying “wholesale” rather than “retail” for docs

• Work Site (Employer Owned/Contracted)
  – Urgent and Occupational
  – Routine chronic disease care

• School
  – Multiple-win scenario
Programs for Special Populations

- **Inpatients**
  - Tele-hospitalists
  - Tele-ICU/NICU

- **SNF/LTC**
  - Regular appointments
  - Urgent care

- **Forensic**
  - Hearings, prison/jail
De Facto Vertical Integration

- Each clinical entity can “specialize” in what it does most efficiently
- Access between levels must be easy/seamless
- “Best Practices” can develop for each niche
- Niche providers become interchangeable
Vertical Integration as Best Practice
Vertical Integration as Best Practice
Viral Vertical Integration
UC Davis Tele-NICU Research

- Tertiary Care NICU *always* full
- Rural ICU *always* transfers some patients
- UCD specialists consult via telemedicine
- Over time, more cases are kept in rural ICU, and both sites increase average complexity

*Both sites increase total revenue*

Population Health Management

- Deploying the most effective programs, each at the point of its greatest impact
- The most under-utilized “point of impact” is the patient in their natural environment
- Improving population health will require getting closer to the patient

Telemedicine == Medicine
Telehealth == Health
Financing Telehealth Nationally

Financing telehealth will happen to the extent that we quit financing telehealth and just finance health.

Measure (and buy) health, not procedures
Empower all partners to innovate
Connect, integrate, and focus the clinician
Jonathan Neufeld, PhD
Clinical Director
Upper Midwest Telehealth Resource Center
jneufeld@umtrc.org
(574) 606-5038