



USING TELEHEALTH TO ADDRESS CHALLENGES, BARRIERS, AND WORKFORCE SHORTAGES

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KEY TAKEAWAYS

- Areas where telehealth shows strong ROI, including increasing access, maximizing resources, increasing efficiency, and improving provider and patient experience and outcomes
- Examples of how telehealth can be used in rural and urban hospital settings
- Best practices and key considerations when doing telehealth, including how to conduct a needs assessment, payment models, and basic ingredients to get started



WHY IS TELEBEHAVIORAL HEALTH IMPORTANT?



WHY IS THIS IMPORTANT?

- 68% of adults with a mental health condition have one or more chronic physical conditions¹
- People with mental health conditions have higher rates of heart disease, diabetes, high blood pressure, asthma, smoking, and obesity
- As of 2015, 10% of ED visits were behavioral health related— expected to increase to 23% in next decade²
- 40% of patients go to the ED knowing they are not having an emergency³

1. COLORADO HEALTH INSTITUTE, COLORADO STRUGGLES TO ADDRESS MENTAL HEALTH AND SUBSTANCE USE: A COLORADO HEALTH ACCESS SURVEY ISSUE BRIEF, 2018

2. 2015 EMERGENCY DEPARTMENT SUMMARY TABLES, NATIONAL HOSPITAL MEDICAL CARE SURVEY

3. COLORADO HEALTH INSTITUTE, 2015 COLORADO HEALTH ACCESS SURVEY

4. SAMHSA, ROBERT WOOD JOHNSON FOUNDATION, RESEARCH SYNTHESIS REPORT 21, MENTAL DISORDERS AND MEDICAL COMORBIDITY

WHY IS THIS IMPORTANT?

- There are significant behavioral health provider shortages
 - In 2016, there were **12 counties that did not have a single licensed psychologist or clinical social worker**²
 - In rural areas, on average, there is only **1 behavioral health provider per 6,008 residents**²
 - In Colorado, there are only approximately 600 actively practicing psychiatrists. That's **1 psychiatrist for around 7,692 patients.**

1. COLORADO HEALTH INSTITUTE, COLORADO'S BEHAVIORAL HEALTH LANDSCAPE, 2018

2. COLORADO RURAL HEALTH CENTER, THE STATE OF HEALTH IN RURAL COLORADO, 2016

PATIENTS LIKE IT

- 1 in 5 patients say they would switch to a provider that offers video visits¹
- 2/3 of patients would like their provider to offer telehealth¹
- **94% of patients reported being very satisfied with all telehealth attributes** in one study of 1,734 patient survey responses – studies consistently show high patient satisfaction and effectiveness²
- Care becomes more accessible, especially for patients in rural areas, or those that have mobility, transportation, work, or childcare barriers
- Wait times decrease - in a South Carolina study, average wait times to see a psychiatrist went from **4 days to 10 hours**³
- Increased privacy and reduced stigma

1. AMERICAN WELL, TELEHEALTH INDEX: 2017 CONSUMER SURVEY

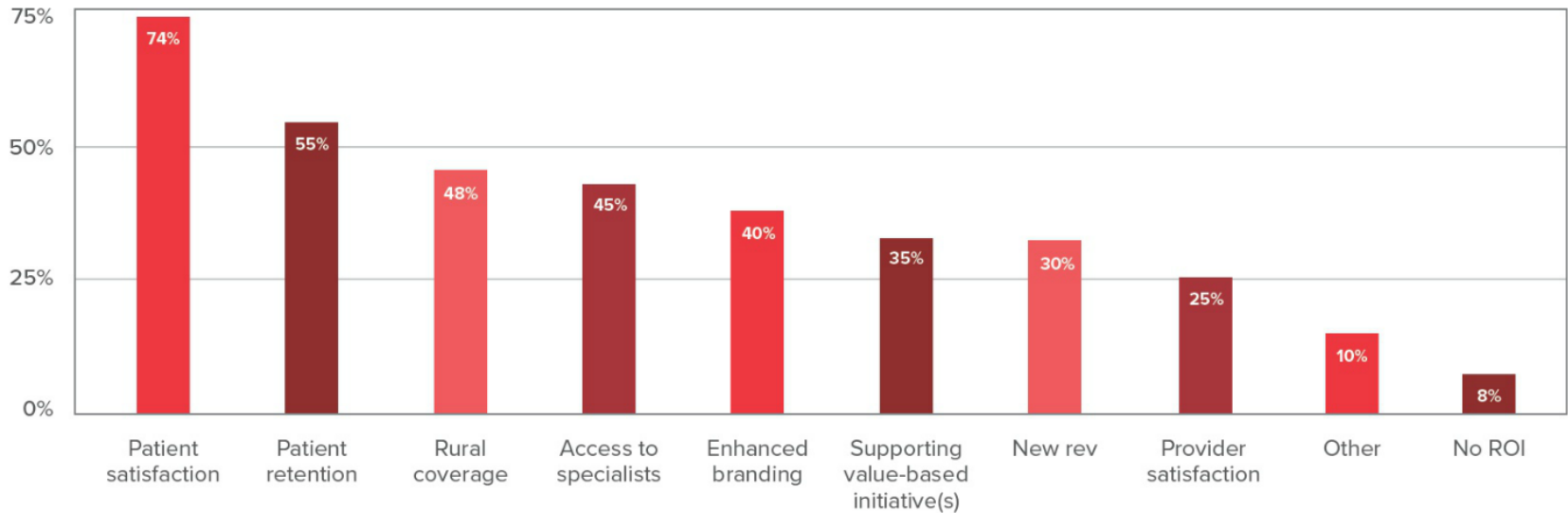
2. JOURNAL OF GENERAL INTERNAL MEDICINE, PATIENTS' SATISFACTION WITH AND PREFERENCE FOR TELEHEALTH VISITS

3. MEDCITY NEWS, MEDCITYNEWS.COM/2014/06/TELEPSYCHIATRY-REDUCES-WAIT-TIMES-PSYCHIATRIC-EXAMS-4-DAYS-10-HOURS-SC-HOSPITAL/

TELEHEALTH BENEFITS PROVIDERS

MGMA 2017 Telehealth Survey data

ROI with telehealth services:





HOSPITAL-SPECIFIC BENEFITS & USE CASES



TELEHEALTH SOLUTIONS CAN



- Provide/increase access to care, especially in rural areas
- Increase throughput
- Improve health outcomes
- Ease care coordination and discharge planning
- Reduce costs for patient and provider
- Support measures related to payment incentives
- Multiply a workforce and address provider recruitment challenges
- Overcome geographic limitations
- Improve patient adherence and engagement

MAIN OPTIONS

Maximize existing resources

- Direct to patient
- Clinic to clinic
- Workforce multiplier

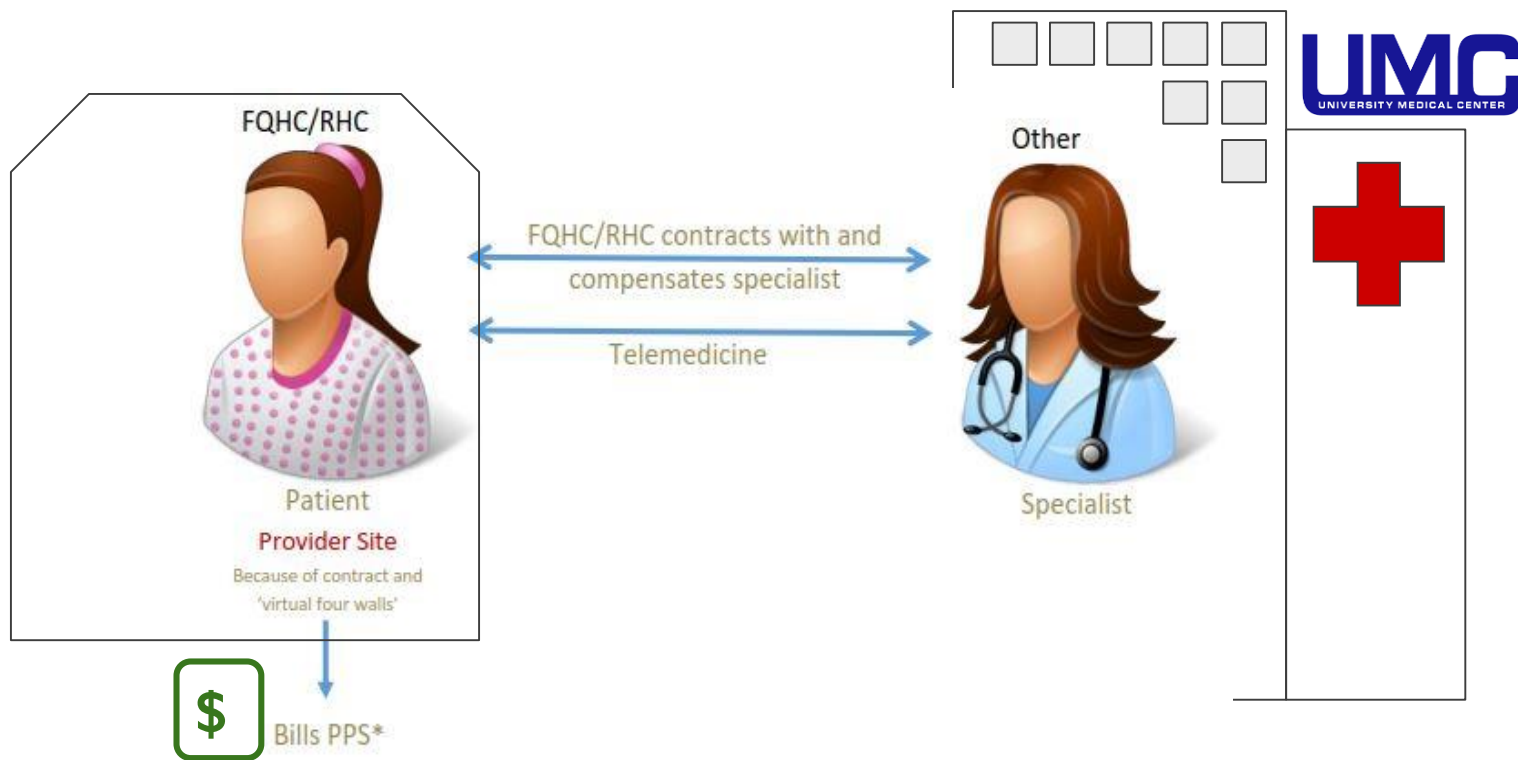
Partner with another organization

- Contract for services with a larger organization, e.g. university, specialty group, or large system
- Contract to sell surplus services and offset unused hours supporting smaller or rural organizations

Partner with telemedicine company

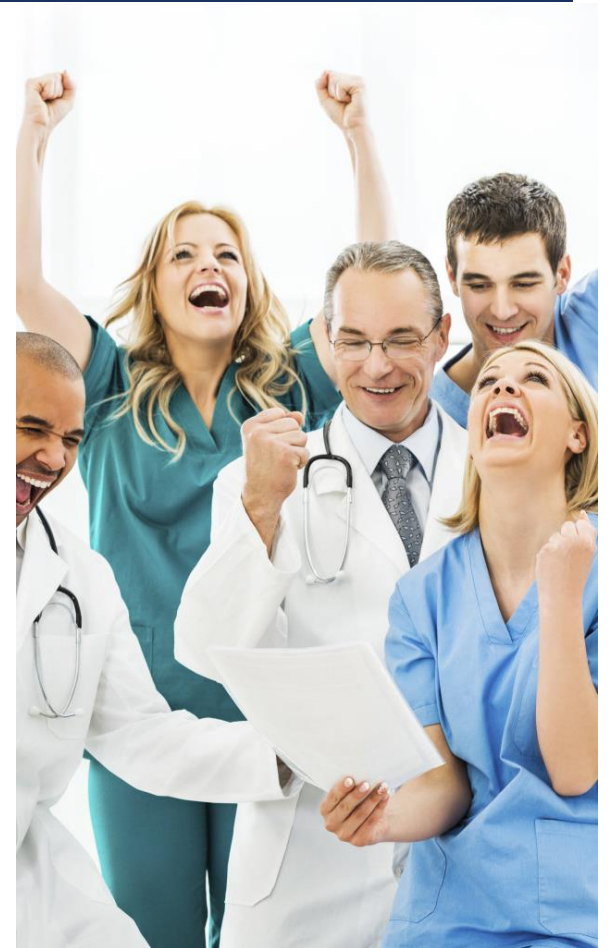
- "Out of the box" custom programs
- Subscription models for specialty consults
- Access to virtual provider teams

CONTRACTED SERVICES (HOSPITAL)



BENEFITS TO HOSPITALS: EFFICIENCY & EFFICACY

- Crisis intervention in the ER
- Reduce avoidable readmissions
- Shorten length of stay
- Increase throughput
- Convenient follow up
- Reduce no-show rates
 - Children's Omaha showed 50% reduction in no-shows for psych follow-up
- Reduce medication errors
 - 3.4% error rate vs 10.8% and 12.5%

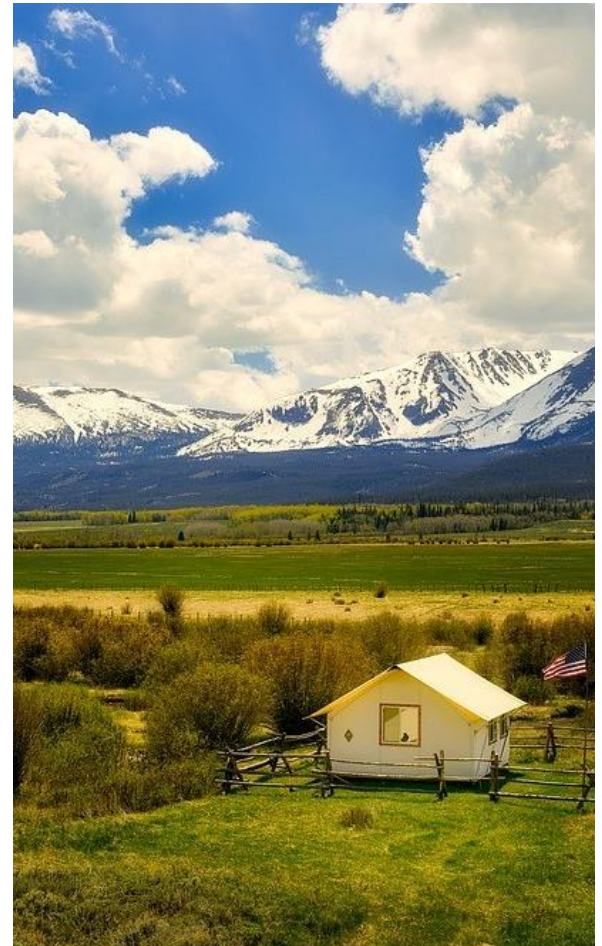


CASE STUDY: SOUTH CAROLINA

- Statewide program with 20+ hospitals participating
- Reduced costs by \$1,400 on average per visit
- Average wait times by ~8-10 hours
- Increased number of psychiatric consultations per day from 8.7 to 14.7

BENEFITS TO HOSPITALS – OVERCOMING GEOGRAPHY

- Staffing/recruiting
- Locum tenens
- Specialty access
- After-hours coverage
- Force multiplier
- Reduced transport costs

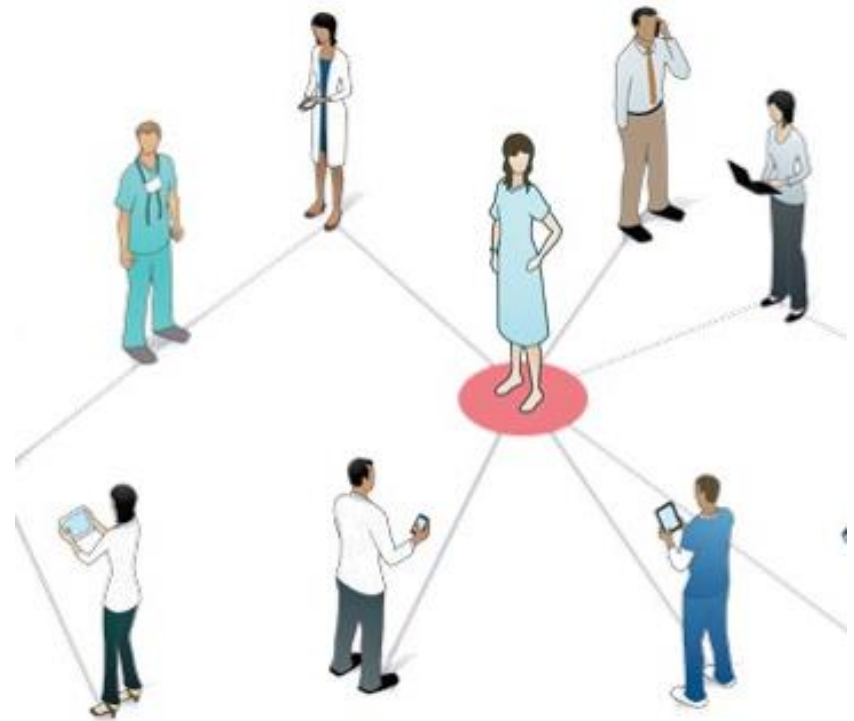


CASE STUDY: MISSISSIPPI

- University of Mississippi Medical Center + Rural Hospitals Partnership
 - Partnership between UMMC and 15 rural state hospitals
 - Study found average of 25% reduction in staffing costs
 - 20% increase in admissions to rural hospitals
 - One hospital saw an extra 101 patient admissions in one quarter

BENEFITS TO HOSPITALS – PATIENT SUPPORT

- Universal screening
- Care management/care coordination
- Discharge planning (Project RED + Telehealth)
- MAT/opioid partnerships
- Remote patient monitoring
- Patient adherence, engagement, education, navigation



PATIENT ENGAGEMENT

- Reduce the number of adverse safety events
- Make patients and families a partner in health and safety
- Improve adherence in pre- and post-operative guidelines
- Meaningful patient-provider communication
- Improve patient experience and satisfaction

CASE STUDY: DIABETES

- University of Mississippi Medical Center telehealth program for diabetes showed:
 - 1.7 point drop in HbA1c levels
 - ~\$400,000 cost savings
 - No ED visits or hospitalizations
 - within first six months of pilot



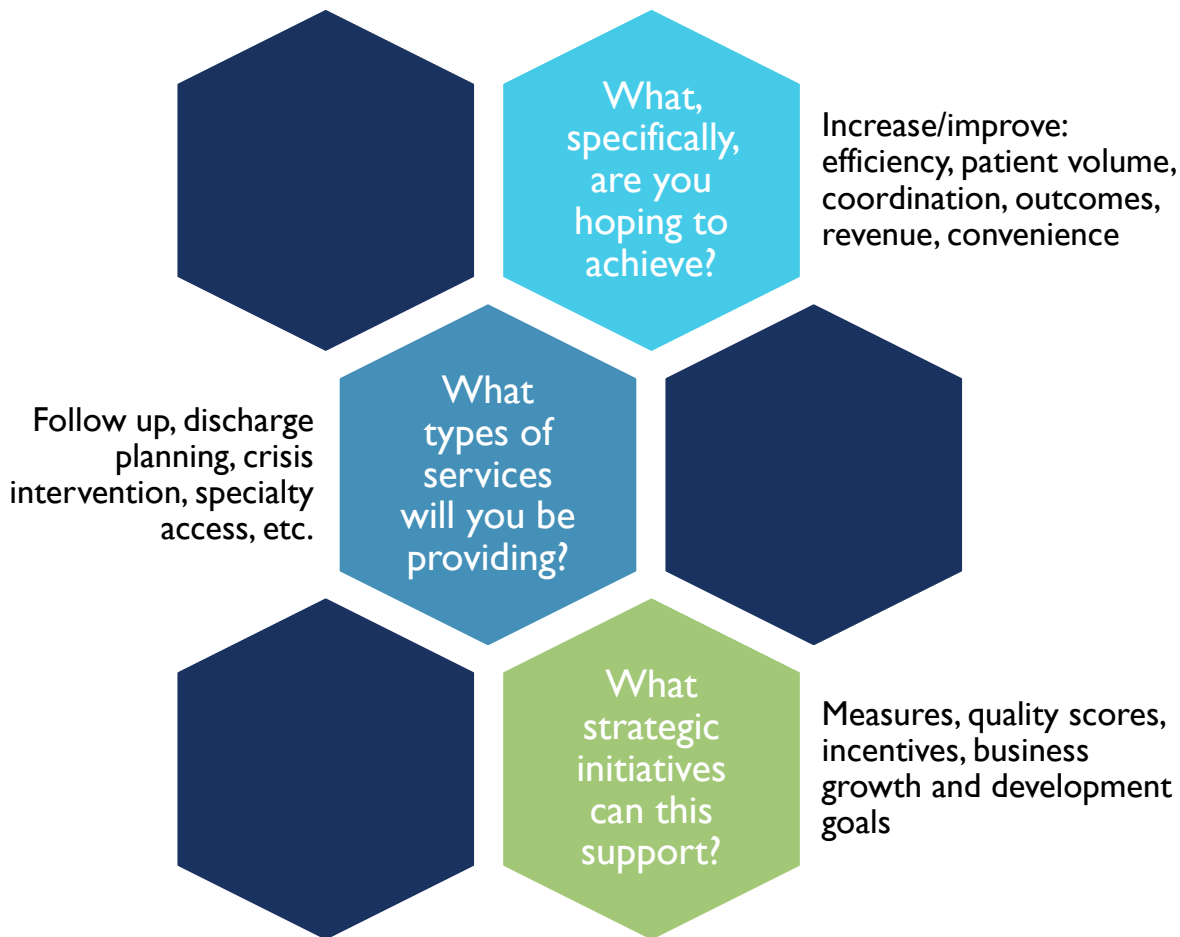
DESIGNING YOUR PROGRAM



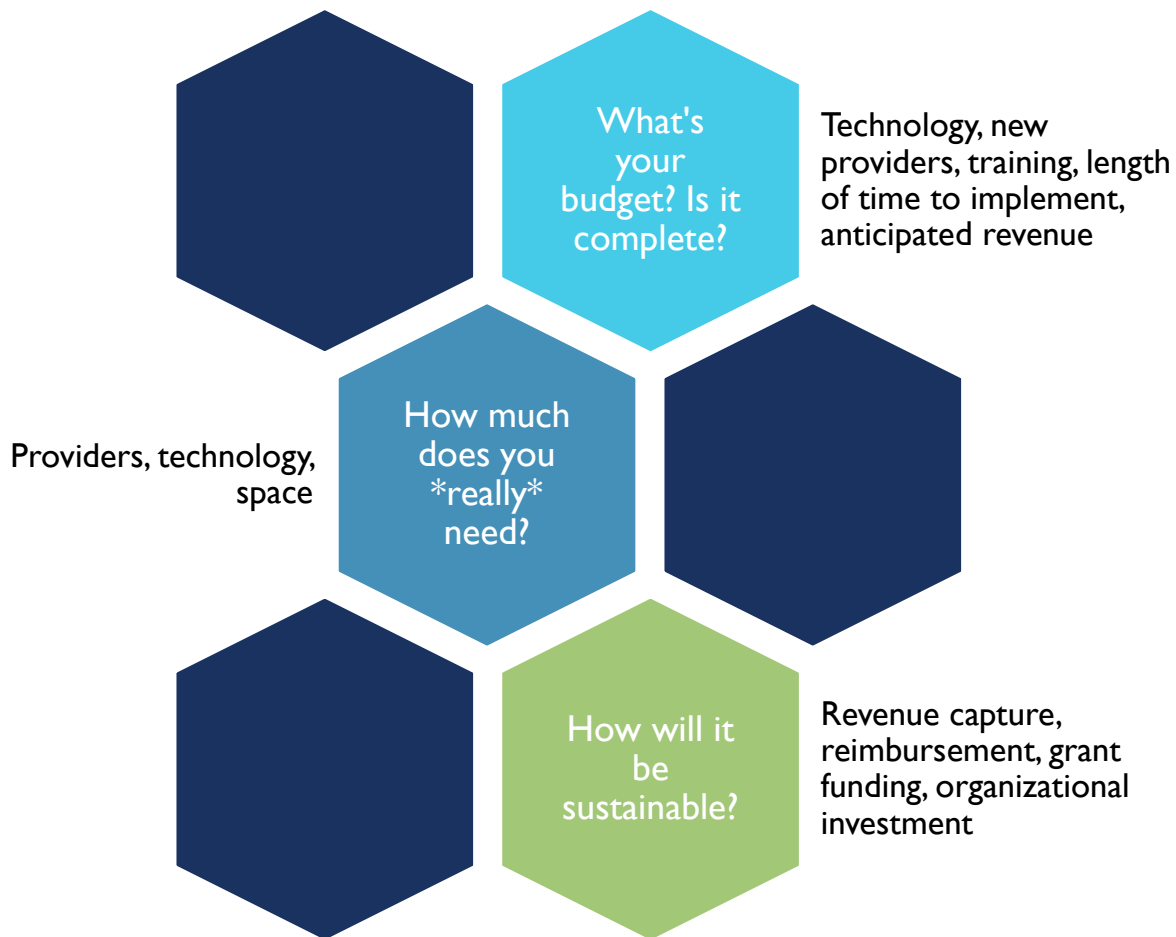


STARTING OFF
→ *on the* ←
RIGHT FOOT

THE MOST
IMPORTANT STEP
IS THE **FIRST** STEP



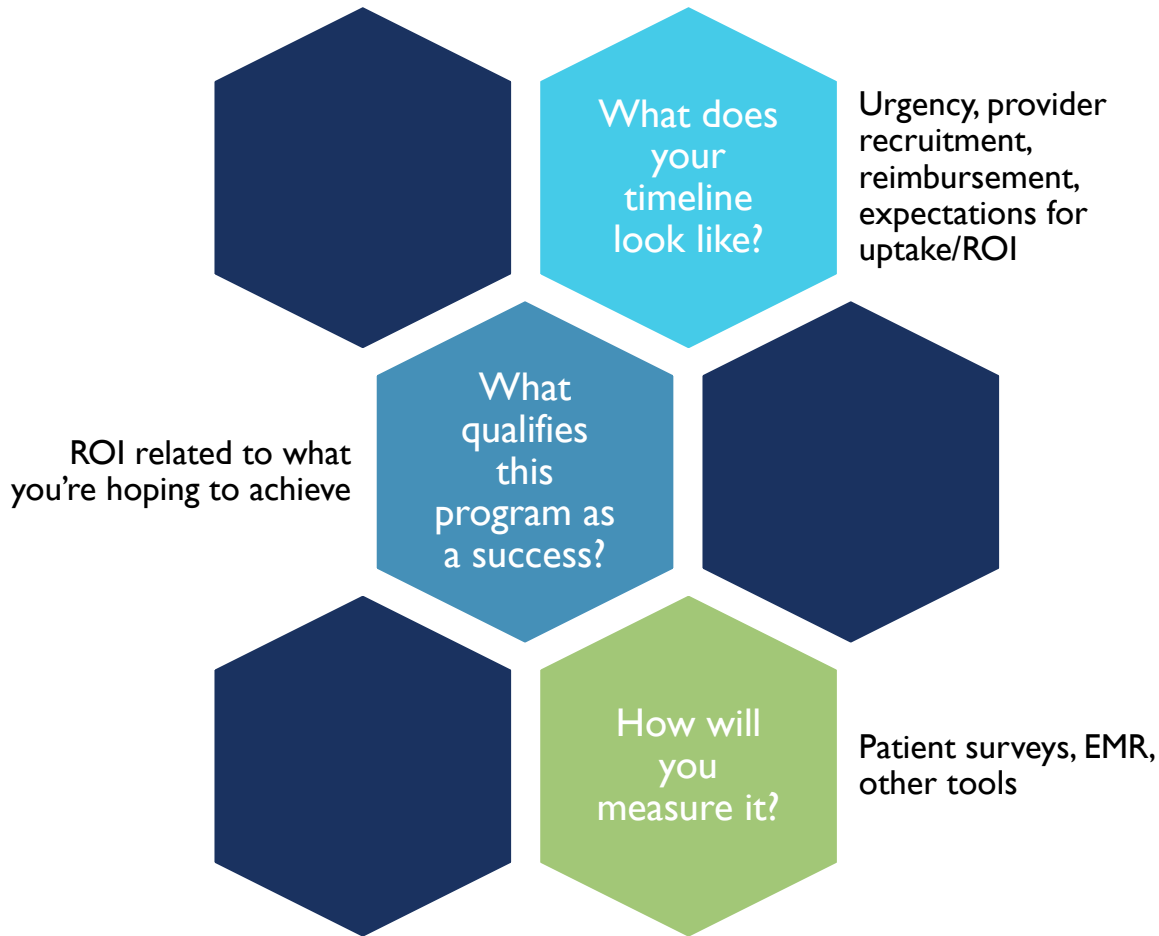
STRATEGY



RIGHT SIZING



IMPLEMENTATION



EXPECTATIONS

WHAT MAKES A PROGRAM SUCCESSFUL

Do

- Executive support, engagement at all levels, an accountable champion
- “Ready, Fire, Aim”
- Be a cheerleader
- Set expectations at the outset
- Remember in some cases programs are shifting ingrained clinical culture, years of training, and how people have “always done things” – change takes time
- Read, research, and seek out resources and best practices, including from other disruptive industries

Don't

- Buy more than what you need (space, tech, time)
- Don't over-solve the problem
- Take a one-size-fits-all approach
- Neglect clinic support staff, front desk, IT, or billers
- Make assumptions
- One and done – instead practice continuous improvement, iteration, check-ins and feedback



TECHNOLOGY, BILLING, & PRESCRIBING



TECHNOLOGY



- Most EMRs now have video and patient engagement capabilities embedded – this may or may not be your best option
- Most tools will and should integrate with your EMR
- Plan for growth
- Key Questions:
 - Is it HIPAA compliant?
 - Can it be used on tablets and mobile phones?
 - Does it have any browser restrictions?
 - How does it perform in low/fluctuating bandwidth scenarios?
 - How does the image quality look on various cameras and internet connections?

MEDICAID

- Eligible services are reimbursable at the same rate over telehealth as in-person
- No qualifying site requirements (can include in-home services)

BILLING FOR A TELEHEALTH ENCOUNTER

- CPT code is same as in-person
- GT modifier can be added to indicate “Via live 2-way video”
 - Check with your payer to see if required
- Place of Service = 02

COLORADO PARITY

- On or after January 1, 2017, a health benefit plan that is issued, amended, or renewed in this state shall not require in-person contact between a provider and a covered person for services appropriately provided through telehealth, subject to all terms and conditions of the health benefit plan. Nothing in this section requires the use of telehealth when a provider determines that delivery of care through telehealth is not appropriate or when a covered person chooses not to receive care through telehealth. A provider is not obligated to document or demonstrate that a barrier to in-person care exists to trigger coverage under a health benefit plan for services provided through telehealth.
- Subject to all terms and conditions of the health benefit plan, a carrier shall reimburse the treating participating provider or the consulting participating provider for the diagnosis, consultation, or treatment of the covered person delivered through telehealth on the same basis that the carrier is responsible for reimbursing that provider for the provision of the same service through in-person consultation or contact by that provider.

MEDICARE REQUIREMENTS

- The beneficiary is located in a qualifying rural area
- The beneficiary is located at one of eight qualifying originating sites
- The services are provided by one of ten distant site practitioners eligible to furnish and receive Medicare payment for telehealth services
- The beneficiary and distant site practitioner communicate via an interactive audio and video telecommunications system that permits real-time communication between them
- The CPT/HCPCs code for the service itself is a covered Medicare service

MEDICARE

Qualifying Sites

- Hospitals
- Critical Access Hospitals (CAH)
- Hospital-based or CAH-based Renal Dialysis Centers
- Skilled Nursing Facilities (SNF)
- Community Mental Health Centers (CMHC)
- Physician or practitioner offices
- Rural Health Clinics
- Federally Qualified Health Centers (FQHC)

Qualifying Provider Types


- Physicians
- Nurse practitioners
- Physician assistants
- Nurse midwives
- Clinical nurse specialists
- Clinical psychologists and clinical social workers
- Registered dietitians or nutrition professionals

KEEP IN MIND

- Controlled substances cannot be prescribed over telemedicine without an in-person visit once every 24 months per the Ryan Haight Act

This could change - *soon!*

- Currently in Congress:
 - Opioid Crisis Response Act of 2018 (S.2680)
 - Access to Telehealth Services for Substance Use Disorders Act. (H.R. 5603)



“HHS is committed to improving access to MAT for OUD and is working on a variety of strategies to improve access to this life saving treatment through increased funding to states and communities, payment policy changes, and education, training and technical assistance. One such area is to help providers understand how telemedicine can be used, in certain circumstances, to expand access to buprenorphine-based MAT.”

- Assistant Health Secretary Adm. Brett P. Giroir, MD

RESOURCES TO GET STARTED

- Colorado's **fantastic** digital health community
- HCPF Telemedicine Manual - www.colorado.gov/pacific/sites/default/files/CMS1500_Telemedicine_6.pdf
- Center for Connected Health Policy - www.cchpca.org/state-laws-and-reimbursement-policies
- American Telemedicine Association - www.americantelemed.org
- Healthcare Law Today by Foley & Lardner LLP - www.healthcarelawtoday.com/category/telemedicine/
- Setting up a telehealth room (video) - youtu.be/s6MIyc3FTAM

THANK YOU!

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