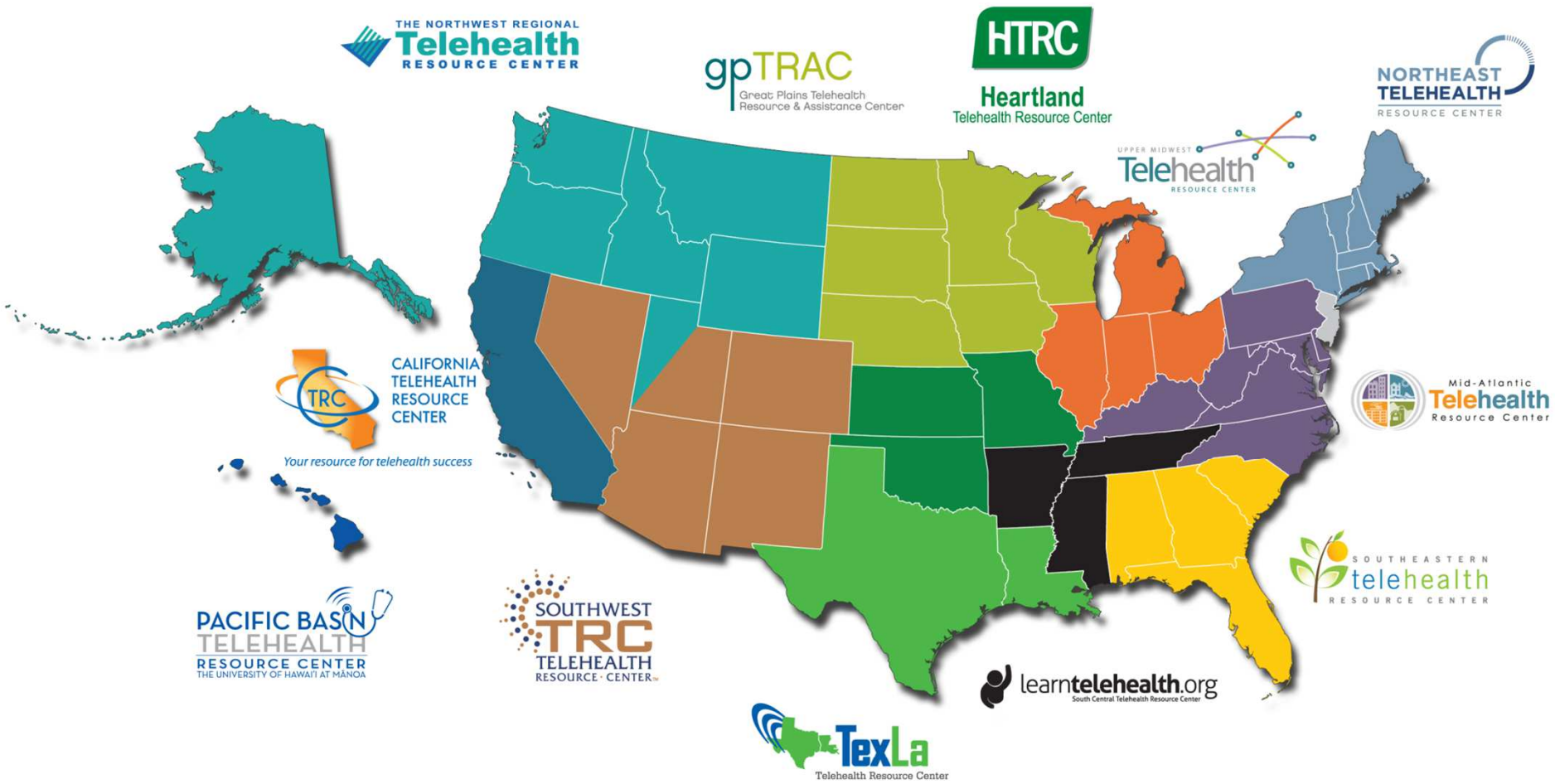
Telemedicine and Telehealth in Context

Jonathan Neufeld, PhD

Clinical Director

Upper Midwest Telehealth Resource Center

TelehealthResourceCenters.org



TTAC
TelehealthTechnology.org
National Telehealth Technology Assessment Resource Center

Center for Connected Health Policy

2 National Resource Centers

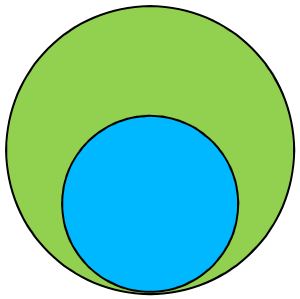
NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

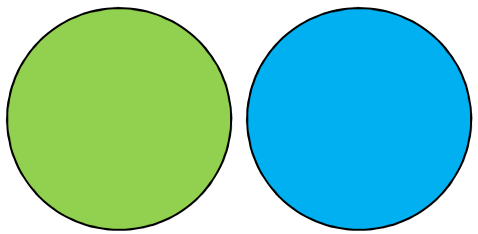
12 Regional Resource Centers

Definitions and Concepts

<u>Telehealth</u> and <u>Telemedicine</u>

- Sometimes used interchangeably
- Two types of distinctions -
  - Telemedicine = billable interactive clinical services
  - Telehealth =
    - Broader field of distance health activities (CME, etc.)
    - Clinical remote monitoring (usually at home)

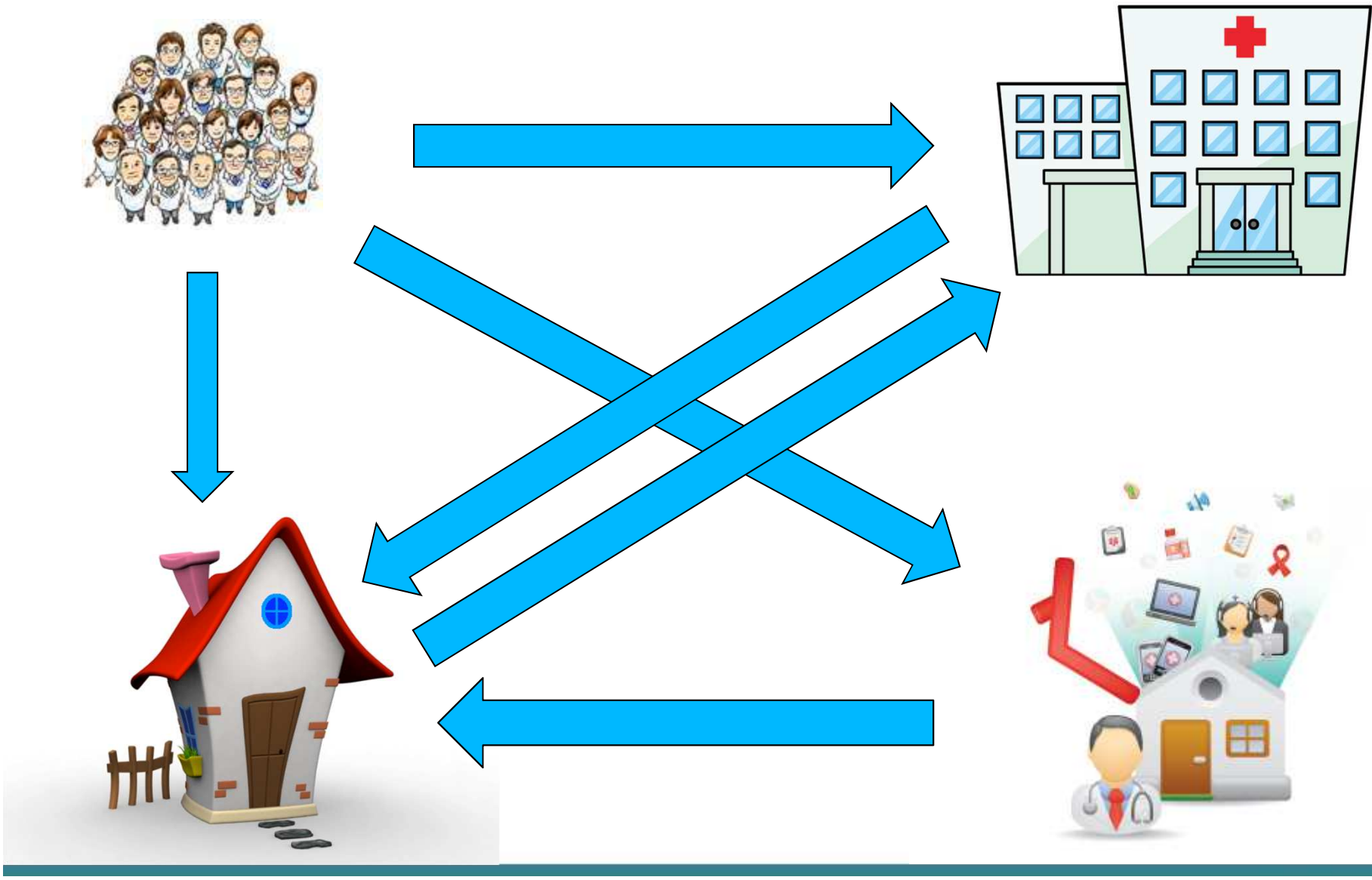




Historical Context – “Is it new?”

- Used at Nebraska Psychiatric Institute in 1955
- Developed extensively by NASA in 1960’s
- VA started in 1990’s – CCHT Program
  - Pilot in VISN 8 in 2003 – 63% reduction in ER visits, 88% reduction in SNF days
  - 2012 Utilization: 0.5 M patients; 1.5 M episodes
- Added by Medicare in 1996 (multiple updates)
- Regulations requiring Medicaid and commercial coverage in states began about the same time
  - Wave of equipment and program grants, projects

Clinical Context – “How does it work?”



Three Basic "Types" or Models

Hospital & Specialties

- Specialists see and manage patients remotely

Integrated Care

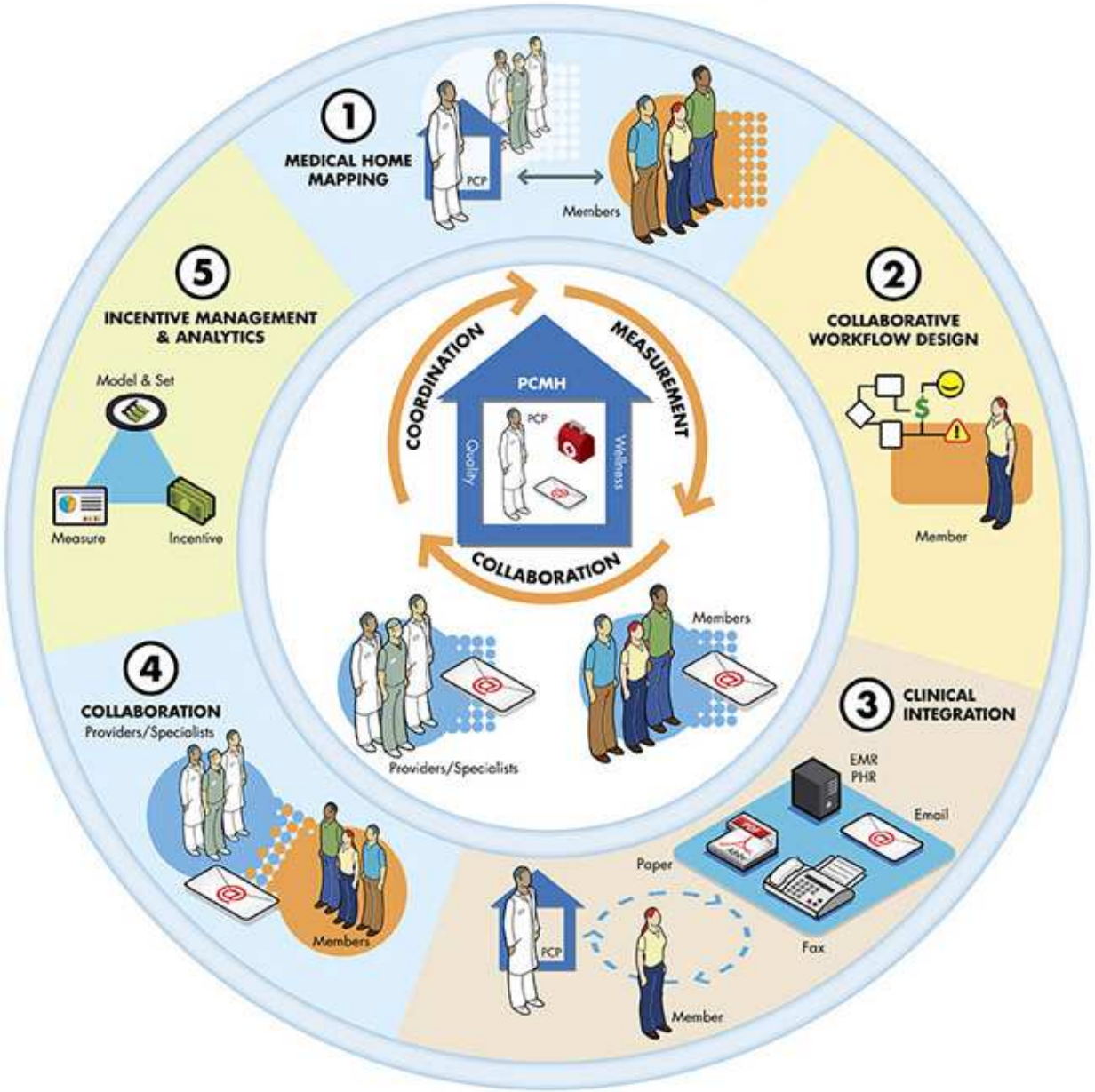
- Mental health and other specialists work in primary care settings (e.g., PCMH's, ACO's)

Transitions & Monitoring

- Patients access care (or care accesses patients) where and when needed to avoid complications and higher levels of care


4. Provide self-care and community support
3. Plan and manage care
5. Track and coordinate care
2. Identify and manage patient populations
6. Measure and improve performance
1. Enhance Access and Continuity of Care
7. Template of the future

Patient-Centered Medical Home Management



UMTRC.org

Research Context – Good medicine

- 20+ years of rigorous research
- 11 current standards/guidelines documents

<u>Summary of Findings</u>:

When used appropriately, medical care delivered via telemedicine is

- as effective
- as satisfactory (to patients and providers)
- as efficient

as the same services delivered via traditional in-person medical care.

Research Context – Good medicine

<u>Caveats</u>:

1. Every program is different
2. Some telemedicine services are novel (most are not)
3. Some services offset other services
4. Not all medical treatments are effective (but we still provide them)

Economic Context – Cost-effective

- Medicare: ~ $6 M in costs in 2012
- Medicaid (44 states cover at least some):
  - Indiana – 2012: $160,000 ($0.14 per enrollee)
  - Virginia – 2012: $257,800 ($0.31 per enrollee)
  - Texas – 2009: $506,137 ($0.13 per enrollee)
- VHA saved $1,999 per enrolled pt/yr
- Partners: 20-45% fewer readmissions
- HealthPartners: $88 saved per episode

Federal Telemedicine Law & Policy

Professionals are regulated at the state level (doctors, nurses, counselors, etc.)

Medicare: Pays for certain outpatient professional services (CPT codes) for patients accessing care in rural counties and HPSAs in rural census tracts.

*No regs; only conditions of payment.

Medicaid: Telemedicine is "a cost-effective alternative to the more traditional face-to-face way of providing medical care…that states can choose to cover."

Ohio Telemedicine Law & Policy

- Providers may prescribe non-controlled substances remotely if they obtain a history and examine the patient in real-time.
  - Controlled substances require in-person exam
- Remote counseling, social work, and marriage/family services require separate informed consent
- Medicaid only pays for telemedicine services at Community Mental Health Centers and Alcohol & Drug Addiction Service Providers

Telemedicine in Ohio

Hospital and Specialty Care

- Tele-stroke, tele-burn, e-ICU, neonate care
- Pediatric specialty programs

Primary Care and Integrated Care

- Telepsychiatry, therapy, and outreach services at CMHCs and ADAS providers

Transitions

- Home monitoring
- Rapid access programs (WellPoint, others)

Ohio Legislative Initiatives

HB 123 – Wachtmann/Gonzales

Would require Medicaid to adopt rules for covering telehealth services.

Appears likely to pass when session resumes.

SB 118 – Tavares

Would prohibit any payer from excluding telemedicine services solely because they are not provided face-to-face.

No action taken.

Critical Needs for Going Forward

- Recognition of multiple sources of value
- Practical methods for measuring effectiveness and efficiency rather than volume
- Principles to minimize fraud and abuse
- Shared vision for greater integration and advancing the Triple Aim:

Better Care - Better Health - Lower Cost

Work Group Charge

1. **Interact** – seek active engagement
2. **Learn** – hear from other stakeholders
3. **Clarify** – account for all perspectives, hold all perspectives accountable
4. **Advise** – seek and articulate workable solutions