Telehealth: programs, pitfalls and payment

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Conflict of Interest

- Nothing to declare
- Thanks to Chris Green, Jeff Grossman, and to Ken Wood, for mentoring and leading the way

1750s Tobacco Resuscitator Kit

The Dutch Method of Resuscitation

The "Fumigator"
Maatschappij tot Redding van Drenklingen, 1767, (the Society for the Rescue of Drowned Persons)

The past has caught up

Not “the future” anymore

Article from February 1925
Cover of Science & Invention

The Jetsons, ABC, 1962
The expanding universe

Telemedicine & Telehealth

- The convergence of (1) high tech, (2) medical care and (3) access for patients to the system
- Disruptive
- Innovative
- Immediate
- “www.” = “Wild Wild West”
  - Few laws, little regulation, lots of money & cowboys and a few land barons

Telemedicine: ideal world

- On the horizon for ACOs
  - Expands revenue via increased # covered lives
  - Engages patients: convenience, satisfaction
  - Saves costs: avoidable penalties, overutilization
- Revenue generation, extended reach
  - Off-hour urgent care services
  - Capacity management: lower wait times, balance loads, improved triage
  - Billing synergy with community clinics

Telemedicine: ideal world

- Engages patients
  - “Convenience care:” wait times, travel, lost work, child care
  - Engaged patient = better outcomes
  - Technology supports adherence to rx
  - May help identify and fill gaps in care
- Saves money---maybe
  - Avert some readmissions, better d/c care
  - Re-direct inappropriate acute care utilization

The forces on us internally

The global crisis of harm and waste must be addressed. Our goal must be to move from harm to healing and from waste to value as hospitals move from a provider-centered, volume-driven care to a person-centered, value-driven care.
The forces on us externally

The patient always comes first

“The best interest of the patient is the only interest to be considered, and in order that the sick may have the benefit of advanced knowledge, union of forces is necessary. It has become necessary to develop Medicine as a cooperative science.”

William J. Mayo, MD, 1910

“It is not at all certain that whether hospitals as they are now managed exist for the patients or the doctors... It has been an aim of our hospital to cut away from all of these practices and to put the interest of the patient first.”

Henry Ford, My Life and Work, 1922

Squeeze to Juice Ratio Continuum

Telehealth Vision & Mission

Vision: The UW Health Telehealth program will be the comprehensive resource for all initiatives incorporating the use of telehealth to achieve UW Health’s strategic goals.

Mission: Through collaborative program design, development, and implementation:

• Improve outcomes, access to care, and enhance the patient and family experience.
• Provide innovative tools and care delivery models to serve Wisconsin and beyond.
• Utilize scarce resources efficiently to provide the highest quality of care.

Organizational Strategic Charge

• Move rapidly down the pathway of robust Telehealth services deployment
• Embrace crisply-defined approach to retail healthcare
• Define an Approach to “Retail” healthcare, including Best Deployment of Telehealth
  - Retail healthcare extends well beyond the concept of a “nurse in a box” or “doc in a box” to a much broader view of how healthcare – preventative, primary, sub-specialty, chronic and acute – can be provided to meet the needs of those in our care in ways that are most attractive to them. This implies adding to our traditional methods of interaction the spectrum of modern communication modalities that we so depend upon in the rest of our lives.

UW Health’s Telehealth Program

• History: 2011-ish, started in an outreach arm of UWHealth
• Mission: unify programs, create efficiencies, save $$$ on MD outreach, “look for small wins”
• 2014: 4 staff, medical director, no representation on the 8th floor (C suite), steering committee lacked both rudder and sail/engine
• No mandate from IT to help, only “hope”
UW Health’s Telehealth Program

- Moved into hospital organization under Ambulatory Ops
- New Ambulatory dyad leadership
- New CEO’s dream realized?
- Hired CMIO with extensive EHR/IT hx
- Renewed attention to IT infrastructure, gaps
- Timing (2015): AboutHealth member health systems came together officially

UW Telehealth External Services

- Dept. of Corrections & Mental Health Institute
  - Allergy, Cardiology, Endo, GI, ID, Nephrology, Pulm, Rehab, Rheum, Transplant, Urology
  - Ophthalmology
- Genetics
- ICU
- Interpreters
- MyChart e-Visits
- NICU Virtual Visitors
- NICU/PICU Transport
- Pathology
- Psychiatry
- Stroke
- Virtual rounds

UW Telehealth & ImageShare

UW Telehealth Internal Services

- Virtual Consults (Inpt.):
  - Infectious Dis
  - Pulmonary
  - Diabetes Mgmt
  - Wound & Skin
  - Psychiatry
  - Team rounds
  - ICU
  - Stroke
  - Nutrition
- Virtual Consults (ED):
  - Psychiatry
  - Trauma Surgery
  - Stroke
  - NICU/PICU
  - Interpreters
  - Pathology
  - Ebola/Special Pathogens Unit

Strategies for Robust Telehealth Deployment

- Outside UW Health IS Network
  - Direct to consumer (Retail)
  - Employer Groups
  - Health Plans
  - Ambulatory Clinic Visits
  - Specialty Clinics
  - Primary Care
  - Urgent Care
  - Transitional Care
  - Chronic Care
  - Complex Case Management
  - Other Clinical Services
    - Nutrition
    - Wound
    - Etc.

- Within UW Health IS Network
  - Inpatient Video Consults
  - Ambulatory Clinic Visits
    - Specialty Clinics
    - Primary Care
    - Urgent Care
  - eVisits

- Operationalizing Digital Health Partners Strategy

- Outside UW Health IS Network
  - Direct to consumer (Retail)
  - Employer Groups
  - Health Plans
  - Ambulatory Clinic Visits
    - Specialty Clinics
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    - Nutrition
    - Wound
    - Etc.

- Operational Strategy 1
  - Digital Health Partner
  - Select and begin partnership with a third party vendor
  - Telehealth and IS Stakeholders have narrowed the vendor candidates to MDLive and American Well
  - Considerations of a Partnership Strategy:
    - Capital investment
    - Ongoing cost
    - Internal resource demand (project scope, build, implementation)
    - Long term strategy
Operationalizing Digital Health

Partners Strategy

Outside UW Health IS Network
- Direct-to-consumer (Retail)
- Employer Groups
- Health Plans
- Ambulatory Clinic Visits
  - Specialty Clinics
  - Primary Care
  - Urgent Care
- Transitional Care
- Chronic Care
- Complex Case Management
- Other Clinical Services
  - Nutrition
  - Wound
  - Etc.

Operational Strategy 2
MyChart/EPIC Functionality
- Develop internal system for implementing Digital Health Strategies
- Considerations of Internal System Strategy:
  - Capital investment
  - Ongoing costs
  - Internal resource capacity
  - Technical infrastructure
  - Scalability
  - Ongoing support

UW Health Telehealth Project Requests

Real Time

Non-Real Time

Partners Strategy

Considerations of Internal System Strategy:
- Develop internal system for implementing Digital Health Strategies
- Considerations of Internal System Strategy:
  - Capital investment
  - Ongoing costs
  - Internal resource capacity
  - Technical infrastructure
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Pitfalls

- Information Technology
  - “The only group in the hospital that can say no and get away with it”
  - Need for strong clinical IT leadership
    - CMIO, MD informaticists, Dept. of Nursing Informatics
    - Alignment of major IT infrastructure (EHR) with telemedicine technologies
- Legal: 3 lawyers = 4 opinions
- Build it or buy it? A recurring dilemma...
**Telehealth Reimbursement**

- **Payment:** how we are doing it
  - Bill all inpatient and ED videoconsults
  - Write off claims with denial of non-covered service
  - Assume 60% denial
  - Supplement departments at 100% billing and give 1 FVU credit, same as a F2F visit

**Telehealth Reimbursement: Evaluating Your Current State Reimbursement**

1. Does your state have a Telehealth Parity Law?
2. Does your payer mix have favorable Telehealth reimbursement policies?
3. What is your organization's Risk profile?
4. Will Medicare reimburse in your service area(s)?
5. Different risk require different approaches to financial modeling

**Evaluating Risk Profile:** Capitated

- Capitated, non-reimbursed (CNON)
- Capitated, reimbursed (CREIMB)
- Non-capitated, non-reimbursed (NCNON)
- Non-capitated, reimbursed (NCREIMB)

**UWMF Department Revenue Proposal**

<table>
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<tr>
<th>Code</th>
<th>Description</th>
<th>Covered</th>
<th>Payment*</th>
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<tr>
<td>99251-GT</td>
<td>3rd Party</td>
<td>Yes</td>
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<tr>
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<td>Reimburse</td>
<td>Yes</td>
<td>$130</td>
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</table>

**Total Dept Revenue**

- Average Consultment: $91.23
- Health UW: $54.74
- Total Dept Revenue: $67.74

**Financial Models: Revenue**

- Classic Fee for Service - Revenue/Cost Model
- Contracted Services/Assigned Billing
- Non-billable services (e.g., virtual visits)
- Indirect benefits (e.g., improved patient experience)
- Non-reimbursement: onus on you to fund lost reimbursement
- Some programs may be loss leaders (downstream generators, leads to admission/surgery)

**Financial Models: Cost**

- Indirect costs (Audit, Due Diligence, Cost Avoidance, Claim Denials)
- Direct costs (Staff, Supplies, Telehealth Coordinators, Equipment)
- Outpatient: Cost Avoidance:
  - Labor, travel
  - Pre-service/Pre-op: Cost avoidance
  - Post-service/Post-op:
  - Cost savings
  - Costs are spread/absorbed through:
    - High Provider Risk Strategies (Far Left)
    - High Payor Risk Strategies (Far Right)

**UW Health**

- High Payor Risk Strategies (Far Left)
- High Provider Risk Strategies (Far Right)

- Prevenion of negative margin FFS business (e.g., low-level urgent care operational costs > operational efficiencies)
- Appropriate use of resources, especially scarce or specialized
- Costs savings models are specific and cannot ignore revenue model
- Total cost savings for system and program planning
- Incremental cost savings to evaluate projects

**Telehealth Reimbursement: Revenue**

- Contracted Services/Assigned Billing
- Non-billable services (e.g., virtual visits)
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**Financial Models: Revenue**

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Cost avoidance: how we’re doing it

• eConsults: UCSF’s experience -> CMMI grant with AAMC
• Use of a Digital Health Partner
  – Retail urgent care replacing ED visits -- if we could do most level 2s vs eVisits/DHP, then we could see more level 3s and faster -- would result in more revenue from various payers (in our mix)

Our Model: Cost Savings

• Virtual Health/Digital Health
  – Offer Video visits to patients on their smartphone/tablet/computer 24/7
  – Save incremental cost for each capitated patient visit avoided

<table>
<thead>
<tr>
<th>Level</th>
<th>Revenue/ED Visit</th>
<th>Total Variable Cost/ED Visit</th>
<th>Difference</th>
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<tbody>
<tr>
<td>1</td>
<td>$63.01</td>
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<td>($7.67)</td>
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Our Model: Cost Savings

• Virtual Health/Digital Health
  – Reduce unnecessary visits to ED for low level acuity to reduce cost
  – Replace with higher acuity, higher margin business

Telehealth Reimbursement

Keys to Success

• Understand your payer environment
• Understand your financial risk
• Define financial success
• Communicate with leadership

Development

• Patient portal & mHealth
• Retail “on demand”
• Regional specialty clinics
• Episodic consults
• Physician collaboration
• The Virtual Hospital

Questions
References

- http://www.americantelemed.org
- http://ctel.org/
- http://cchpca.org/
- http://www.telehealthresourcecenter.org/