ACADEMIC HEALTH CENTER
Best Practices

Case Study

TRANSFORMING THE CLINICAL ENTERPRISE

Regionalized Telehealth Care and Academic Health Centers

MEDICAL UNIVERSITY OF SOUTH CAROLINA

KEY POINTS

As trends in telehealth point toward rapid growth, large investments in the telehealth industry require academic health centers to strategically plan for models that include virtual delivery of healthcare:

- ✓ **Consider changes in healthcare staffing, most notably by outsourcing to national provider groups often white-labeled under the local healthcare entity or insurer.**
- ✓ **Apply adjustments to workforce distribution.**
- ✓ **Develop opportunities in the telehealth market to not only serve your own telehealth needs, but to also serve as high-quality sources of clinical manpower for your regions.**
- ✓ **Pursue opportunities to learn from experienced telehealth centers and look to obtain external accreditation. The Medical University of South Carolina (MUSC) is an example of an academic center succeeding in telehealth with a recent designation as a National Telehealth Center of Excellence.**

ISSUES AND CHALLENGES

Building a Strategic Plan for Telehealth Services in a Competitive Market

As reimbursement and awareness of telehealth services improve, academic health centers should seize this market opportunity to keep up with the changing delivery of healthcare and continue to influence a high level of quality of care.

THE MUSC APPROACH

Developing a Community-Focused Design with a Telehealth Alliance

In order to meet the intent of the state legislature in South Carolina, MUSC designed telehealth service arms to serve its own mission as well as meet needs of external health systems. Using state appropriations, MUSC and other partners in the South Carolina Telehealth Alliance developed these services together.

TRENDING MODALITIES OF TELEHEALTH

There are many reasons that academic health centers should consider undertaking these service arms, not the least among them is the goal of maintaining high-quality standards of healthcare. The primary initial barrier is the business model and the ability to take on the risk of increasing staffing with growth. Academic health centers may need to increase their how-to knowledge, but that is doable with leadership commitment.

There are three major modalities in telehealth design that are trending toward an outsourced staffing model, and which could serve as opportunities for academic health centers. While these cases are diverse, the theme and barriers to overcome are very similar, albeit at varying scales.

Hospital-Based Consultation/Management Services

The first example in telehealth design is that of hospital-based consultation and management services (telestroke, tele ICU, etc.). These services are increasingly in demand as community hospitals struggle to maintain the physician specialties they would like to have. Alternatively, perhaps they only need a specialist at a level not justifying the hire of a full physician. Telehealth companies targeting this market are quickly growing (e.g., Specialist on Call).

This is a natural niche for an academic health center because of the wealth of specialties available at these institutions, and many community hospitals are willing to pay for telehealth coverage. The primary barriers to academic centers serving as an alternative to a national telehealth company is the business planning, telehealth expertise, and growth in specialists needed to develop this service arm. The business aspect and telehealth expertise may be too daunting to develop robust services without clear leadership buy-in and support.

Direct-to-Patient Services

The second use case is that of direct-to-patient urgent care services delivered via the patient's home computer or device. Many hospitals already provide this service, but it may not be widely known that the manpower to staff this service is heavily outsourced to national telehealth companies focusing on this niche (TeleDoc, American Well, etc.).

The utilization rates of the service has not matured to the level that it warrants the staffing of a stand-alone service line, so most health systems are using this modality to maintain their market share while outsourcing the staffing. Academic health centers could become the outsourced workforce for their regionally partnered health systems by extending their technologies, forming common contracts, and justifying the increase in staffing on their own campus so that the national call-pools of physicians are not needed.

Remote Patient Monitoring

Lastly, remote patient monitoring of chronic diseases is an exciting modality commonly used as a mechanism to reduce readmissions. Reimbursement opportunities for this modality are becoming more available, but doing the monitoring on a large scale requires, once again, increased manpower. In this case, the increased staffing is likely to be nurses who review the data coming in and act on standing orders from the care team.

This structure lends itself well to an academic health center increasing its nurse expertise in the field of remote monitoring, and contracting to surrounding health systems and clinics to be part of an extended multidisciplinary team.

RESULTS/OUTCOMES

MUSC's move in the direction of regionalized care has been largely successful, but not universally so, with much opportunity ahead.

- For the MUSC telestroke program, we now staff more than 4000 consults a year, handling more strokes in our 29-hospital network than we do on our own campus. Decreased transfers to MUSC and increases in quality metrics have been robustly demonstrated for these hospitals.
- At least three other services lines have been launched out of requests from our partner hospitals, and many more are in development as demand increases.
- Our Tele-ICU program is demonstrating impressive reductions in mortality for partner hospitals, but the intensive staffing requires a partnership with a national telehealth vendor. We continue to work toward increasing our own staffing, but also foresee a long-term partnership with the vendor.
- Direct-to-patient urgent care and remote patient monitoring services have been established for MUSC and are designed to be extended to independent outpatient clinics from the beginning. For remote patient monitoring, we are already serving some rural areas through just such a partnership with demonstrated reductions in HA1C for the patients served.

FOR MORE INFORMATION AND RELATED MATERIALS ABOUT THE PROGRAM

South Carolina Telehealth Alliance: Annual Report

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