

Specialty Care Safety Net Initiative Integrating Telehealth in the Primary Care Setting

EXECUTIVE SUMMARY MAY 2013



In 2009, the Center for Connected Health Policy (CCHP) received a three year grant from the California HealthCare Foundation to conduct a Specialty Care Safety Net Initiative (SCSNI). This Initiative was envisioned as an opportunity to engage all five of the University of California Health Systems in expanding their roles as providers of specialty telehealth consultation to the low income and underserved population traditionally served by California's safety net providers. The project was initiated in June 2009 and concluded in April 2012.



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This Initiative also sought to assess the potential of California's Federally Qualified Health Centers, (FQHCs) and other non-profit rural health clinics to incorporate telehealth services into their operations. Specifically it sought to increase the capacity and ability of the state's safety-net clinic providers to integrate telehealth specialty care consultation into their practices, and be able to continue to access these services appropriately in the future.

This paper provides a description of the experiences of safety-net providers who applied for support under this initiative to launch or expand their telehealth services. Additionally, it provides a series of recommendations for the safety-net providers who may be considering the addition of telehealth as part of their services.

In conducting SCSNI, CCHP partially subsidized the specialty clinic time for the five participating UC Medical Centers. SCSNI consultants closely tracked costs of each of the University of California specialty care services to determine to what extent Medi-Cal (Medicaid in California) reimbursements (when available) were able to cover their actual costs.

Using a competitive Request for Proposal (RFP) process, CCHP selected 43 safety-net providers to participate in the demonstration. Each health center was provided \$10,000 for staffing and operational support. Each selected health

center conducted a thorough needs assessment to determine their technology and equipment needs, the specialties most needed by their clients, and the level of buy-in of their clinical staff and leadership. Based on this assessment telehealth equipment was provided to each at no cost. CCHP supported the needs of the safety net providers through the provision of on-site technical assistance and support as needed.

All specialty care services were provided at no cost to primary care clinics and their clients. Clinical telehealth services were provided by all five University of California Academic Medical Centers. These specialties included dermatology, hepatology, psychiatry, orthopedics, endocrinology, and neurology. By February 2010, SCSNI "went live" with the first cohort of 12 clinics. A second cohort of 26 clinics was added between May and September 2010; a third and final cohort of five clinics was added between September 2010 and December 2011. Among the 43 participating SCSNI clinic sites, 20 sites entered the project with some amount of prior telehealth experience and/or equipment, while 23 sites were completely new to telehealth. Among the 20 sites with some telehealth experience, five had dormant programs that required updates and reinvigoration while the remaining 15 would expand their telehealth services through new specialty access.





SCSNI Results

After three years of intensive statewide efforts and 24 months of clinical services, SCSNI clinics successfully referred over 3,000 patients for specialty care. A total of 43 clinics participated – both urban and rural – providing 2,301 consults and connecting clients and medical professionals in offices as far as 600 miles apart. In this way, SCSNI served as a laboratory to identify the means of establishing lasting relationships between UC Medical Centers and California’s safety-net providers.

As a result of conducting SCSNI, CCHP observed that the incorporation of telehealth specialty consultations proved to be somewhat disruptive to both the safety-net clinic and the UC systems, and as a result, it took some time and effort to get the project off the ground. Through this process, CCHP has identified these ten keys to success that collectively offer a road map to effectively establishing, integrating and utilizing telehealth to meet the increased demand for primary and specialty care services over the next decade:

- 1. Secure support of executive leadership.**
- 2. Perform a comprehensive needs and site readiness assessment.**
- 3. Designate a dedicated “Telehealth Services Coordinator”.**
- 4. Standardize processes associated with telehealth.**
- 5. Build understanding and appreciation of telehealth technology.**
- 6. Secure active involvement of participating providers.**
- 7. Be selective in contracting for specialty care services.**
- 8. Anticipate and respond constructively to disruption.**
- 9. Increase role of mid-level practitioners.**
- 10. De-mystify telehealth.**





Conclusion

While SCSNI demonstrated that primary care clinics have much to gain in partnering with academic medical centers, the project revealed that even when the services and equipment are made available at no cost, much planning and coordination needs to take place at all levels of the clinic system to be successful. One significant challenge for the health centers is SCSNI did not go far enough to provide participants with sufficient opportunities to explore a variety of reimbursement structures and strategies to continue the program at its conclusion. In order to sustain access to specialist services through telehealth, there will need to be a source of adequate reimbursement for each consultation. Establishing adequate reimbursement will require a change from current reimbursement policies, practices and strategies.

With the arrival of ACA and the expansion of Medicaid managed care throughout much of the country, the role and means of reimbursement for FQHCs will likely be evolving. Clinics must begin to look beyond the current horizon of healthcare and imagine where possibilities for funding allocation, reimbursement or cost savings might be possible. As safety-net providers continue to seek avenues to ensure access to specialty care for their clients, we anticipate a future in which providers must be nimble, creative and knowledgeable in order to finance much-needed services. Examples of potential options for the future include: a) purchasing services from specialty providers, b) primary care (FQHC) clinics collaborating to hire their own specialists and, c) utilizing potential changes in the “cost-based” reimbursement system to a prospective payment system. Through the use of bundled payments, health centers may be able to effectively capture their telehealth costs thereby improving the efficiency and quality of their services.



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Funding for this effort was provided through the generous support of
The California HealthCare Foundation
www.chcf.org

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