



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

July 2013





Introduction

Access to specialty health care services in California has historically been a challenge for many Californians, especially for those residing in rural communities. The Patient Protection and Affordable Care Act (ACA), due to take effect January 1, 2014, will expand comprehensive insurance coverage for millions of residents in the coming years. Additionally, access to primary care services will also be greatly expanded during this period as a result of increased funding for Federally Qualified Health Centers (FQHCs), expanded training opportunities for primary care physicians and increased reimbursements under Medicaid for primary care services.

Despite these positive advances to improve access to health care and coverage, there are no provisions in place to address the expected increase in demand for specialty care. This will create an even greater challenge for community health centers to respond to the needs of their patient population.

One possible answer to this dilemma will be the expanded use of technology-enabled health care to connect specialists with patients and primary care providers. Incorporating telehealth modalities of care into community health center practices can be the key to ensuring timely access to the increased demand for specialty care amongst the newly insured in California, and across the country.



In 2009, the Center for Connected Health Policy (CCHP) received a three-year grant from the California HealthCare Foundation (CHCF) to conduct the Specialty Care Safety Net Initiative (SCSNI). SCSNI engaged all five University of California Health Systems providing telehealth specialty consultations to low-income, underserved populations. It also assessed the potential of California's Federally Qualified Health Centers (FQHCs) and other nonprofit rural health clinics to incorporate telehealth services into their operations.

This report describes the experiences of the participating safety net providers who launched or expanded their telehealth services under this initiative. The findings from this demonstration have been distilled into a set of 10 recommendations for safety net providers considering adding telehealth to their services.

The initiative began in June 2009, nearly a year before President Obama signed the Affordable Care Act and it concluded in April 2012. The findings reinforced our belief that the well-coordinated use of telehealth will be crucial if California and the rest of the country are to meet the "Triple Aim" of the Centers for Medicaid and Medicare Services:

- Improving the health of the population
- Enhancing the patient experience of care
- Reducing the per capita cost of care

SCSNI shows why we need to expand the use of telehealth. More importantly, it shows *how* to successfully put telehealth to work in primary care.

CCHP, in partnership with the California Telehealth Resource Center, will keep building upon the knowledge gained from SCSNI by:

- Continuing to assess new financial models for safety net community clinics and health centers (CCHCs) to make sure that the true costs of telehealth are captured.
- Developing methods for CCHCs to evaluate, select and work with vendors to limit losses at first, and to eventually produce a return on investment in telehealth.
- Examining models for the provision of specialty services by UC Health Systems, other academic medical providers and the growing sector of private telehealth providers.

This demonstration project was based in California, but we firmly believe that the findings and recommendations are valuable for all safety net providers and academic medical centers in the country with an interest in providing telehealth.

We are deeply grateful for the support of CHCF for funding SCSNI. CHCF's vision, leadership and resources are essential to making all of our founding projects a reality.

With satisfaction and gratitude,

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Center for Connected Health Policy

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Telehealth and the Safety Net Challenge in California

The U.S. health care system is undergoing dramatic changes as coverage becomes available for millions of previously uninsured people. Waves of new patients, particularly those with lower incomes, will stress safety net programs across the country.

In California, an over-extended safety net is bracing to meet the increased demand for primary and specialty care over the next five years. It includes Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Tribally Operated Indian Health Services. The Affordable Care Act increases the funding available to community health centers nationwide. In California, 131 health centers operate 1,222 sites, providing preventive and primary health care services to 3,104,183 people. Health center grantees in California have received \$509,544,091 under the Affordable Care Act to support ongoing health center operations and to establish new health center sites, expand services, and/or support major capital improvement projects.

California's safety net is extensive and committed to improving the population's health. But they offer limited access to expensive specialty health care services. Many low-income, underserved people may never receive care for their chronic health issues.

Even if specialty care is available in their communities, these patients have to navigate an uncoordinated array of medical specialists. Most do not serve Medi-Cal or uninsured patients.

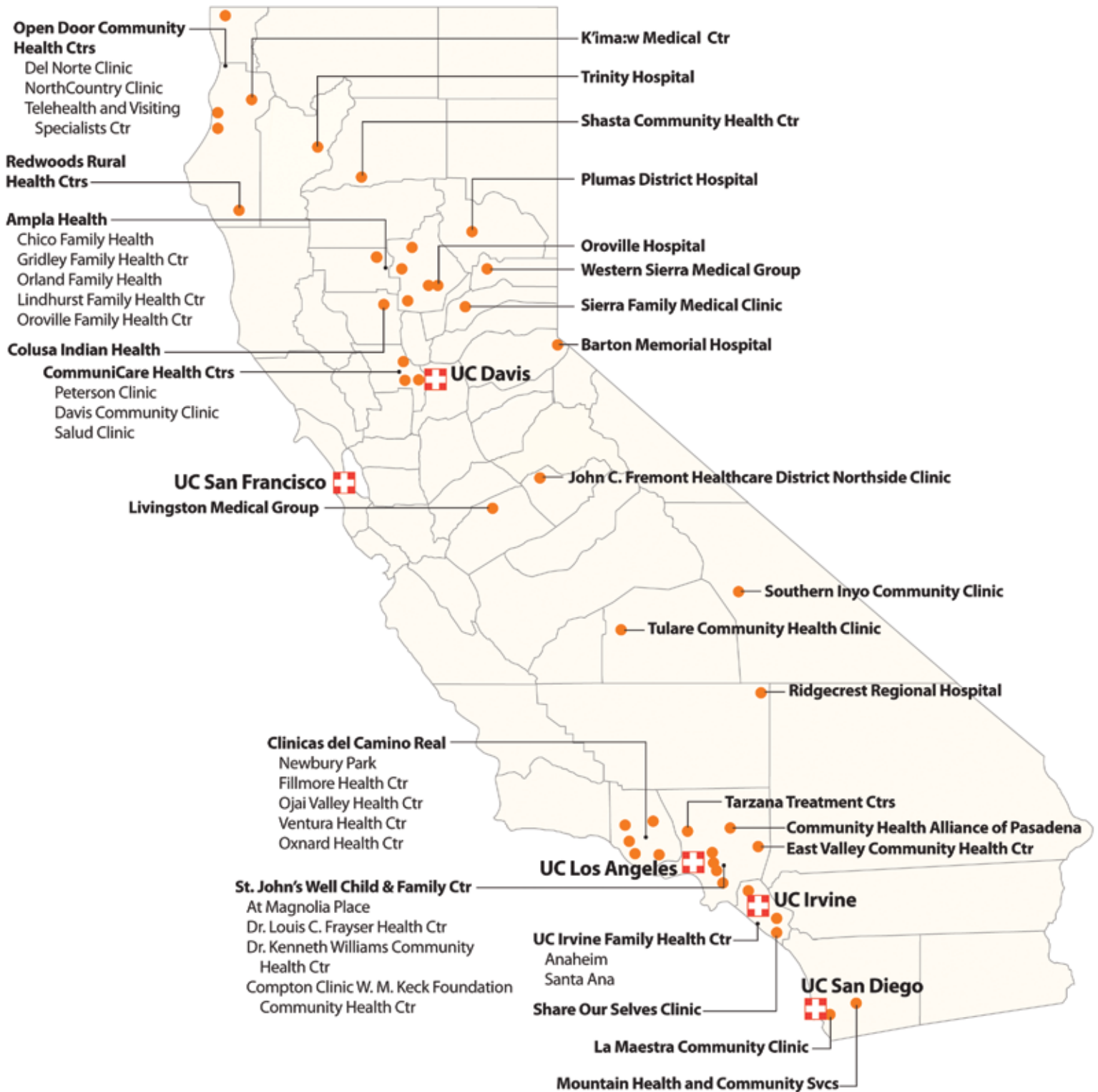
For example:

- Merced County, a predominately rural section of the San Joaquin Valley, is almost entirely dependent on out-of-town specialist referrals. For patients, this means time-consuming travel and missed appointments. A 2009 survey by University of California Merced, found that for about 80 percent of patients who received specialty referrals, less than 25 percent actually kept the appointments.
- South Los Angeles is a diverse, low-income and medically underserved community with 1.1 million residents. A 2009 survey of physician wait times by Merritt Hawkins & Associates found that in Los Angeles overall, wait times for appointments in cardiology, dermatology and orthopedics averaged 11, 13 and 12 days respectively.
- A 2008 survey of community health centers in San Diego County by the Council of Community Health Centers found patient wait times of up to 6 months for pain management and neurology; up to four months for rheumatology; and up to three months for orthopedics, dermatology and endocrinology.

Safety net patients who cannot get specialty care when they need it often go to the urgent care and emergency departments of hospitals, where services are costly. If these patients had been cared for earlier by the appropriate specialists, their conditions could have been treated, stabilized or even healed.



SCSNI Partners



Specialty Care Safety Net Initiative

Integrating Telehealth with Primary Care

This initiative sought to expand the UCs' role as providers of telehealth specialty consultations to safety net patients, mostly in rural areas. It also sought to encourage and enable the state's safety net providers to incorporate telehealth into their practices.

Finally, SCSNI sought to encourage the creation of new relationships between California's safety net providers and telehealth specialty care providers, including the UCs, so that more effective comprehensive care can be provided in the future.

Putting SCSNI Into Action

Forty-three safety net providers, both urban and rural, participated. Fifteen of these clinics already had some telehealth experience and/or equipment. Five had dormant programs that required reinvigoration and updates.

Each health center conducted an assessment to determine equipment and technology needs, and the level of buy-in by clinical staff and leadership. SCSNI encouraged the adoption of telehealth in these practices by providing:

- No-cost equipment and subsidies for high-speed broadband connections
- No-cost UC specialty consultations
- \$10,000 in grants for staffing and operational support
- On-call and technical support

All specialty care services were provided by all five UC centers at no cost to primary care centers and clients. Specialty care services included dermatology, hepatology, psychiatry, orthopedics, endocrinology and neurology.

SCSNI consultants tracked the costs of each UC for their specialty care services to determine to what extent reimbursements from Medi-Cal (Medicaid in California) covered the actual costs.

SCSNI "went live" with the first cohort of 12 clinics in February 2010. A second cohort of 26 clinics joined between May and September 2010. A third group joined between September 2010 and December 2011.

SCSNI Results and Recommendations

After three years of intensive effort, which included 24 months of clinical service, SCSNI clinics referred more than 3,000 patients for specialty care. The clinics provided 2,301 consultations, connecting clients with medical professionals in offices up to 600 miles away. This was an important first step in establishing more formalized referral and treatment relationships between UC Medical Centers and safety net providers.

CCHP observed that incorporating telehealth specialty consultations proved somewhat disruptive to both the clinics and the UC centers. For a number of reasons, it took time to get the project off the ground. In the process, CCHP discovered 10 keys to success that offer a roadmap to establishing, integrating and using telehealth to meet the increased demand for primary and specialty care services. Additionally, the road map more effectively positions community health centers as a critical component in the new models of care resulting from national health care reform:

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. Demystify telehealth



In the following description of the 10 findings, the originating site is the clinic where the patient is located and the distant site is the location connected to the originating site by telehealth technology.

1. Secure Support of Executive Leadership

SCSNI revealed great enthusiasm for adopting telehealth technology at clinics throughout the state. At some sites, the physicians were advocates. At other sites, administrative leaders and IT staff led telehealth efforts.

However, if the executive leaders did not understand and commit to integrating telehealth, the quality of care would suffer and telehealth was unlikely to thrive.

Originating Sites

The CEO, medical director and Board of Directors must buy in and commit to telehealth if it is to succeed. Leadership and staff must be ready to expect and tolerate a certain amount of disruption to traditional practice systems, create a professional learning environment and inspire support staff to take the initiative.

Distant Sites

Academic medical centers have more levels of authority than primary sites. Primary sites need support of senior leadership. Specialty centers require fully informed and enthusiastic support from department chairs and division heads for a successful telehealth initiative.

2. Perform a Comprehensive Needs and Site Readiness Assessment

Project leaders worked with staff at each SCSNI to assess needs and readiness. Some providers had overestimated their readiness to provide telehealth services. More importantly, these assessments brought to light needs that had not been considered before.

The factors reviewed during a telehealth needs and site readiness assessment are largely the same for originating and distant sites.

Operations

The full administrative, medical and technical staff needs to answer these questions:

- What are the needs that the provider intends to address?
- What are the responsibilities of each team member?
 - » Role of physician
 - » Role of mid-level practitioner
 - » Role of site coordinator
 - » Role of administrative assistant
- Do the telehealth coordinator and technical staff have expertise in using and troubleshooting the technology and presenting telehealth to patients?
- Are the coordinator and staff willing and able to learn and support the new software, technology and patient presentation techniques?
- What is the level of buy-in from both the clinic management and the referring providers?
- How will existing systems, structures and practices be adapted for:
 - » Billing
 - » Scheduling
 - » Knowing what to expect before, during and after a telemedicine consultation
 - » Adopting the best practices of other similar programs

Technical Considerations

Work with technical staff and outside vendors to determine:

- Current IT infrastructure
- What is needed for a secure, stable, high-speed, medical quality broadband connection
- Current usage and topology
- Future plans for expansion
- Ability to support telehealth technology



- Network integrity including:
 - » Utilization
 - » Wireless
 - » Segmenting
 - » Firewalls
 - » Hardware
 - » QoS
 - » Security

If the clinical site has existing telehealth equipment, determine:

- Make, model, software version and the status of videoconferencing, medical peripherals and supporting software.
- The equipment and software the site requires to provide the desired telehealth services.

If the clinic does not have telemedicine equipment, assess what specialty services the site plans to offer to determine what hardware and software is needed.

3. Designate a Dedicated Telehealth Services Coordinator

SCSNI project leaders found that the most important factor in the success of each site was the appointment of a well-trained telehealth services coordinator. This was true for both originating and distant sites. *This is not a position for a staff member who is already juggling other responsibilities.*

The telehealth services coordinator makes the system work and keeps it working. It is absolutely critical for program efficiency, as well as the satisfaction of patients and providers. This demanding role requires:

- The ability to grasp the whole system and the constituent parts, from installation to troubleshooting glitches.
- A full understanding the technology and broadband, including its capabilities and quirks.
- Knowledge of how the various providers will use the technology.

Finally, the coordinator needs a committed telehealth team. Each member should have a defined responsibility:

- Administrative leadership to guide development, funding, staffing, compliance and progress.
- A medical director who is a telehealth champion, working with the patient care staff to ensure quality and efficient care as they incorporate telehealth into daily practice.
- A technical team to support clinical staff and maintain equipment and assure telecommunication connections.

4. Standardize Telehealth Processes

Providing specialty care services with telehealth requires people, technology and systems to work in sync. When the pieces fit together, there is an easy flow. This requires careful mapping and tracking, with numerous corrections along the way.

No single staff member can be responsible for every piece of the system. But, a dedicated telehealth coordinator can ask the right questions to identify and solve problems and a coordinator can make sure team members understand their roles in the process.

Factors to consider include:

Originating Sites

- How staff determines which clients are eligible for telehealth services.
- How the process is tracked prior to submitting a referral to a specialty center. Some specialties require additional lab work, questionnaires, etcetera before accepting a referral.
- How referrals are tracked for initial and follow-up visits.

Originating and Distant Sites

- How telehealth equipment is scheduled for use at the same time that telehealth exams are scheduled.
- How specialists and primary care handle follow-up conversations and documents for the clinical record.
- How to handle special details for billing.



Distant Sites

- How to track the name and contact information for the referring clinical coordinator.
- How to establish referral guidelines on clinical conditions appropriate for referral, along with the materials (charts, lab test, X-rays, etc.) the specialist needs for referrals.

5. Build Understanding and Appreciation of Telehealth Technology

Providing telehealth requires continuous learning to improve patient care. Clinics need people who can master the current technology and be unafraid to learn more as innovations occur and policies change. This affects the way you train your current staff – and the kind of people you hire in the future.

Telehealth sites should offer professional development opportunities for team members to build knowledge and familiarity. A skilled telehealth services coordinator can identify where training is needed most.

Under the guidance of the coordinator and knowledgeable staff members, the team can develop the needed information and build a clear system for helping one another with challenges and questions.

Telehealth provides learning opportunities for physicians. For example, the SCSNI specialty providers prepared a series of Continuing Medical Education courses designed specifically for the health care providers in California's safety net. In underserved communities, particularly in remote areas, learning opportunities like this might be critical in recruiting and retaining physicians.

6. Get the Primary Care Providers Involved

Primary care providers need to do their homework to get ready for telehealth. Physicians and medical directors must know how their telehealth systems work and understand their role.

As with many facets of medicine, the best teacher is experience. Each consultation builds knowledge and confidence. Using telehealth, clinicians can work together and support each other in strengthening the primary care system by:

- Consulting with – and learning from – one another.
- Collaborating on continuity of care plans.

- Obtaining or providing continuing education.
- Referring patients for specialty services.

7. Be Selective in Contracting for Specialty Care Services

Originating Sites

Establishing relationships between primary care centers and specialty care providers should be undertaken carefully to ensure a good fit.

While this project used pre-selected providers from the UC Medical Centers, we did develop criteria for selecting telehealth specialists:

- Are the specialty providers qualified with the right licensure, training, board certification, etc.?
- Is the program financially stable?
- Does the program have experience with telemedicine?
- Can the program handle its anticipated referral volume?
- What geographic factors might affect continuity of care?
- How has the provider estimated the cost of services, and what is their billing policy?
- Is the provider billing for office space or administrative time that is no longer required as a result of telehealth?
- Can shortening the length of new and follow-up visits reduce specialty care costs?

Originating Sites and Distant Sites

Whenever possible, patient sites and specialist sites should formalize a contract or memo of understanding. Elements of a structured relationship include:

- Reserve X hours per month in X specialty community health centers for my patients only, or cover Monday – Friday 8-12.
- Specialists will be licensed and Board certified in the specialty requested.
- Dictated notes will arrive or be available within 72 hours of consult.
- Specialty clinics will be staffed at all time – no cancellations.
- Credentialing considerations.
- Malpractice insurance.



Distant Sites may require the following from Referring Sites:

- Referrals will adhere to established specialty guidelines
- Patients will be scheduled into allotted time only when chart is complete and required documentation is present
- Patients will be presented by a qualified clinician when specified as such in the provided referral guidelines
- Payment considerations
- Credentialing considerations
- Malpractice insurance

8. Anticipate and Respond Constructively to Disruption

Administrative and clinical staff will experience frustration with telehealth at first because it disrupts the existing system and requires reorganizing the patient care process. There will also be unanticipated ripple effects.

Originating Sites

Telehealth is a new way of delivering health care. But it has to work with traditional clinical practice. Weaving the two together will shake up the routine. But, it's also a dynamic, innovative way to improve efficiency and access.

Staff should redesign the system to take advantage of telehealth's many benefits, rather than try to eliminate complications and "get back to normal." Telehealth will not thrive in a broken system.

Distant Sites

Specialty providers should carefully consider how their actions might increase or lessen disruptions when partnering with primary care clinics. Both sides should be flexible and realistic about appointment scheduling. Primary care providers should be efficient in their use of specialty time. And specialists should not expect inordinate amounts of time from the primary care providers in consultations.

When a specialist cancels a pre-arranged appointment or block of clinical time, rescheduling patients is difficult. Give as much lead time as possible for absences. Specialty providers should be judicious in requests for lab work before a referral, keeping in the mind the time and cost.

9. Increase Role of Mid-Level Practitioners

Increasing the role of nurse practitioners, physician assistants and other mid-level practitioners is one way to increase efficiency without sacrificing quality. Academic providers of specialty care can also increase efficiency through a more expanded role for junior faculty and nurse specialists.

Originating Sites

With telehealth, primary care physicians can work at the highest level of their license through expanded supervision and real-time consultation with mid-level practitioners working at satellite clinics. This expands access to health care without compromising standards of quality.

This model is being used to provide dental care across Alaska. Specially-trained dental health assistants can work in remote towns and villages, using video conferencing or other technologies to obtain approval and guidance from supervising dentists.

Distant Sites

Among academic providers of specialty care, the senior faculty often takes the lead in telehealth services. They're accustomed to being the first to test innovations. But they also bill at a far higher hourly rate than junior faculty or nurse specialists. Junior faculty and nurse specialists also have more availability and scheduling flexibility.

Using the time and services of junior faculty and skilled mid-level practitioners is an effective way of lowering the cost of providing specialty care. Because a physician must supervise residents, they are often not effective in lowering the cost of specialty care.

10. Demystify Telehealth for Consumers

As primary and specialty care providers increase their use of telehealth, health consumers must become familiar and comfortable with it. Once patients experience the improvement in the quality and timeliness of their care through telehealth, they become enthusiastic. This includes people who don't tend to use computers or the Internet. It's therefore critically important that health centers develop a process for educating their patient population on telehealth and how it's used, and designate key staff to reinforce this at the time of care.



The Road Ahead

As SCSNI drew to a close, Quade & Associates conducted surveys and interviews with participating telehealth coordinators. The results show the challenges and opportunities of making the transition to a post-SCSNI service model.

Staff and leadership at every community health center interviewed expressed enthusiasm for the progress made during SCSNI. The centers reported great benefit to patients, smooth implementation and a deeper knowledge and acceptance of telemedicine.

The only serious barrier to continuing telehealth services was the gap between the cost of and reimbursement for the specialty care, which was provided at no cost during SCSNI. As a result, the health centers are uncertain about how to fund continuing services.

It is clear that community health centers and their patients have a lot to gain from partnering with academic medical centers. SCSNI did not explore new structures for reimbursement models, policies and practices. The arrival of ACA and the statewide expansion of Medi-Cal Managed Care are forcing reimbursement systems to evolve. Community health centers must explore new possibilities for funding allocation, reimbursement and cost savings.

SCSNI revealed a clear measurement of the true costs to the UC Health Systems for providing telehealth specialty services, including areas where savings can be achieved to make the costs more competitive.

However, the changes in the national and state health care systems under health care reform will likely be the drivers to make the financial models and systems investigated during SCSNI effective in the long run. Strategies for using telehealth to improve access and control costs will emerge as the health system confronts these changes.

We can conclude that safety net provider organizations interested in using telehealth to bring specialty care to its patients must make a total commitment to transforming their practices accordingly. The biggest mistake that can be made is believing that telehealth services can simply be added on top of existing services. They also have to be creative, nimble and knowledgeable to finance these much-needed services. Potential models include:

Purchasing Service from Specialty Providers

Academic specialty providers such as the UCs are interested in selling blocks or percentages of specialist time to referring clinics. A contract model using the RHC health center for FQHC rate may allow specialty health providers and safety net clinics to recover their costs. The growing number of private telehealth providers could also offer blocks of time or as-needed appointments.

Primary Community Centers Collaborating to Hire Specialists

In this model, community health centers become providers of specialty care. A center hires a specialist, then sells the services to other community health centers. Centers could form a telehealth specialist network serving a broad region. There are costs up front, but ultimately this model would likely reduce costs.

Advocating for Changes in the Present System to Incorporate Telehealth Costs.

The Prospective Payment System (PPS) rates pre-date telehealth. Reimbursements are already negligible compared to the costs of delivering care. The PPS rates should be increased to cover the costs of hiring a telehealth coordinator, buying and maintaining equipment and providing specialty services. Community health centers have to work with the federal government to create a stable and appropriate source of income as in the Accountable Care Organizations and Person Centered Health Home Model.



Funding for this effort was provided through the generous support of
The California HealthCare Foundation
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