Telehealth to Healthcare as Jet Plane to Buggy

From “Telehealth Promises to Reshape Health Care” by Geri Aston in H&HN, 3/10/15:

“In the not so distant past, telehealth primarily involved a patient in one health care setting talking to a clinician in another. Today, it’s that and much more, and it has the potential to change in fundamental ways how patients interact with the health care system.”

“Hospitals are expanding the virtual services they offer, as well as their geographic reach. They’re embracing smartphone and tablet apps and other tools that give patients almost immediate access to providers.”

“The transformational forces in play throughout healthcare today are driving the trend—the push toward pay for value, the growth of accountable care and risk contracts, reimbursement pressure, Medicare readmission penalties, increased consumer price sensitivity, and a growing demand for care paired with a limited physician supply.”

“‘About a year ago, the delivery side realized that if they’re going to be gradually more accountable for the well-being of their patients, they need to find a way to envelop their patients better when they leave the hospital, the practice, the clinic, and go home,’ says Roy Schoenberg, M.D., president and CEO of the telehealth service company American Well. ‘The arrival of risk contracts has cemented the notion that if you believe that your future is only serving people through your brick-and-mortar buildings, you will be marginalized. What we’ve seen is that every delivery system out there is looking to equip itself with telehealth capabilities.’”

“Another motivator is hospitals’ desire to meet the Triple Aim of improved patient experience, population health and lower cost established by the Institute for Healthcare Improvement. Hospitals are using telehealth to prevent unnecessary visits and to give patients easier, quicker access to care.”

“Hospitals’ initiatives run the gamut of care, including e-ICUs, telestroke programs, e-visits for primary and specialty care, tele- rounding, video-connected post-surgical transfers and follow-up, and urgent care. Some hospital systems are working toward virtual EDs and home monitoring to prevent illness.”

The reimbursement conundrum—“Provider reimbursement has long been a barrier to telehealth adoption, although the payment picture is beginning to improve. Twenty-two states and the District of Columbia have laws that require private insurers to pay the same amount for telehealth as face-to-face care, although restrictions still apply in six of those states, ac-

“OIG views rural as simply a small version of urban. They don’t recognize that it is a different healthcare delivery system.” - Alan Morgan, CEO, National Rural Health Association, 3/10/15.

RWCH Eye On Health, 3/14/15
According to the American Telemedicine Association. Forty-seven states offer some type of telehealth coverage in Medicaid, though limitations often exist.”

“Traditional Medicare covers some services, but only in rural areas and not from the patient’s home. A bipartisan coalition in Congress is working on legislation to improve access to covered telehealth services in Medicare.”

“Even when telehealth is covered, its potential to drive down utilization by preventing hospital visits and promoting better care management carries the risk of financial losses for health systems that embrace it. ‘If hospitals remained purely interested in top-line revenue, [telehealth] could be very bad because we’re substituting telemedicine for services that hospitals used to offer,’ says Jeff Levin-Scherz, M.D., national leader, health management practice at Towers Watson.”

“Alternative reimbursement models, however, turn that dynamic on its head because they create the incentive to avoid unnecessary care and to keep people well. But alternative contracts, such as bundled payment, accountable care and risk contracts, remain the exception and fee-for-service payment the norm. In 2013, 18 percent of hospitals participated in an ACO and 9 percent in bundled payment, while slightly more than 92 percent of hospitals had no patient revenues based on capitation, according to the 2015 edition of AHA Hospital Statistics.”

“Early telehealth adopters are counting on that to change. ‘You have to decide to stay stationary or skate to where the puck is going to be,’ Hollander says. ‘Right now, telehealth is under-reimbursed, if reimbursed at all, so we are subsidizing our telehealth program for the time being. But, if one believes five years from now that patients aren’t going to want to drive to Center City Philadelphia to get their care and that payment models are going to catch up, then we’re ahead of the game.’”

“That viewpoint got a boost from Health & Human Services’ January announcement that it has set a goal to dramatically increase the percentage of Medicare payments through alternative payment models in the next few years.”

“Telehealth has business advantages in the here and now, notes Randall S. Moore, M.D., president of Mercy Virtual, part of a multistate health care system headquartered in Missouri. It makes the hospital system more attractive to payers and patients by offering convenience, quality and savings.”

“Telehealth gives health systems an opportunity to establish a brand using devices that most doctors and patients already use. ‘Everybody has a phone in his or her pocket, everybody has access to a browser,’ says Roy Schoenberg, M.D., president and CEO of the telehealth service company American Well.”

“Health care will be unable to continue to avoid consumer demand for online services that already have transformed other industries, predicts President and CEO Stephen K. Klasko, M.D. of Jefferson University Hospitals. ‘The younger generation is not going to tolerate it. They’re going to want to understand why they can’t do in health care what they can do in every other part of their lives.’”

“In a move hoped to ease the path toward telehealth, the Federation of State Medical Boards last September issued model legislation aimed at speeding interstate medical licensure in participating states. As of January, the model legislation had been introduced in nine states, and 25 medical and osteopathic boards had expressed support for it, according to the federation.”

“As more states approve the measure, Schoenberg predicts, nationally known health systems will begin to compete for patients across the country via telehealth. Meanwhile, local systems might prove to be more agile in telehealth offerings and carve out virtual markets of their own. ‘You are looking at the point in time where the play for patient traffic is going to truly change,’ he says.”

Big bumps, bigger benefits—“Despite the bullishness on telemedicine, change won’t come overnight. Getting a telehealth program up and running takes time.
Hospitals have to determine what types of services to offer, create new types of shifts for physicians, and come up with internal reimbursement models, Schoenberg says.”

“While telehealth poses some staffing challenges, it also brings opportunities. If virtual care meets its promise of avoiding unnecessary hospital visits and mitigating or eliminating the progression of chronic diseases, it would open up hospital capacity for patients who need hospital care, Moore says. The system then could shift some of its providers who were taking care of patients with heart failure, emphysema and diabetes in the hospital to virtual, person-centric care, he says.”

“In the case of a heart failure, use of telehealth to prevent a patient from deteriorating to the point of needing hospitalization not only cuts the cost of the condition, but also improves the patient’s quality of life and maybe prolongs life, Moore says. ‘We take part of that cost savings and shift it into care teams and other ways to optimize people’s health.’ ”

“Telehealth could help to recruit and retain physicians, Moore says. Small hospitals have difficulty attracting highly specialized physicians but, with virtual care, communities have access to a higher level of care.”

“In addition, a physician who’s been practicing for decades and wants to wind down practice could shift to taking more patients via telehealth at home. That doctor can be the perfect person to support partners who are busier in the office,” Moore says.”

“Telehealth can enable hospital systems to provide more care with their existing staff, regardless of location. For example, American Well is rolling out software that allows physicians to plug into the telehealth system when they’re available for e-visits on their smartphones.”

‘ ‘If there is a need somewhere for a neurologist, our system would prompt them on their phones. If the physician is busy, he or she can just ignore it, and the system will hunt for the next one,’ Schoenberg says.”

“That means hospitals could expand to new locations with fewer in-person providers, Schoenberg says. ‘The whole rationale about where you operate, how quickly you can increase your footprint, changes because you can project those services through the technology.’ ”

2015 Wipfli-RWHC Cost Champions Awards

The purpose of the Wipfli-RWHC Cost Champions Awards is to encourage and share implemented cost saving ideas suggested by a team or individual employed by a RWHC-member rural hospital. A first-place award of $1,500 and two honorable mention awards of $500 each are made possible by the generous support of Wipfli LLP. Wipfli is helping rural hospitals to more effectively understand and manage their resources. This year’s award winners are:

First Place: Dale Massey, Manager of Patient Registration, at Ministry Door County Medical Center for “Implementing Pre-Registration for Scheduled Hospital and Clinic Patients.” Whereas in the past patients had to wait to be registered, now over 75% of patients do not have to sit down at registration before proceeding to their site of service. On top of the increase in patient satisfaction, this new process also saved a tremendous amount of salary dollars for the organization.

Honorable Mention: Nicole Adrian, Pharmacy Purchasing Control Technician, at Southwest Health Cen-
ter for “Coordinate Purchases of Drugs Utilizing the 340B Purchasing Program and the Vaccines For Children.” Nicole attended 340B University and became competent concerning the regulations of the Vaccine for Children Program. Following this training, Nicole successfully led an expansion of qualifying purchases and conserving drug expenses at Southwest Health Center. In addition, Nicole has been instrumental in leading the preparatory work to meet Southwest Health Center’s goal of providing in-house Employee Drug Benefits.

**Honorable Mention:** Melinda Schoen, CQI Director, at St. Clare Hospital for “Waste Walk-Through.” Melinda educated hospital department leaders on the 8 most common wastes according to Lean methodology. This led to each department creating two action plans to eliminate waste from their departments. Through the Waste Walk efforts, St. Clare Hospital saved an estimated $220,669.

By January 31 of each year, RWHC member CEOs are invited to make one nomination of a hospital team or employee’s cost saving idea implemented in the prior calendar year. The awards will be made annually and sent directly by Wipfli to the nominating hospital for distribution to the nominated employee(s) as a cash award or in a manner consistent with hospital policy.

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**The 21st Century Rural Hospital**


“Hospitals have changed over recent decades. Hospital stays are shorter. Procedures once requiring hospitalization are now done in an outpatient setting. Hospitals have moved beyond providing mainly inpatient and emergency department care. They have become vertically integrated systems with ‘one-stop shopping’ for all of one’s health care needs.”

“The transformation of hospitals has also occurred in rural areas where the presence of a hospital with traditional inpatient and emergency department services may also ensure that other health care is available.”

“Even with a cursory scan of rural hospital websites, one can see that rural hospitals offer a variety of services that range from traditional inpatient medical, surgical and obstetric care to advanced imaging, laboratory, and rehabilitation services. Outpatient primary and specialty care are available, and hospitals provide important health promotion and wellness services for the community.”

“Hospitals vary, however, based on their resources and the needs of the populations they serve. As is often said about many things, ‘if you’ve seen one hospital, you’ve seen one hospital.’”

“This Chart Book uses available data to present a broad profile of the 21st century rural hospital and includes such descriptors as: Where are they located? Whom do they serve? What traditional hospital services do they provide? How do they ensure outpatient services for their community? What other community benefits do they provide or enable for citizens in their area? How are they doing financially?”

“Those who are unfamiliar with today’s rural hospital may be surprised by many data points shown here; others may use this document to research a particular data point.”
Is There a Typical Rural Hospital?

“The data presented in this Chart Book illustrate the variability in rural hospitals across the United States. Using the means, medians and percentages from the data as a guide, we describe what might be considered a typical rural hospital.”

The typical rural hospital:

▪ is located in a small or large rural area, not in an isolated area,
▪ has 25 beds,
▪ has 7 inpatients every day,
▪ employs 321 full-time equivalent workers, and
▪ has a physical plant that is 10 years old.

The typical rural hospital is located in a county:

▪ with a median population of 27,980,
▪ with 36 residents per square mile,
▪ with 16.8% of the population 65 years and older,
▪ with an average per capita income of $32,781, and
▪ with 17.5% of the population living below the federal poverty level.

The typical rural hospital offers inpatient care that includes:

▪ surgical services,
▪ obstetric services, and
▪ swing bed services;

but does not include:

▪ an intensive care unit,
▪ a skilled nursing facility,
▪ a psychiatric unit, or
▪ a rehabilitation unit.

The typical rural hospital offers outpatient care that includes:

▪ outpatient surgical services,
▪ cardiac rehabilitation services,
▪ breast cancer screening/mammography, and
▪ a health fair;

but does not include:

▪ a rural health clinic,
▪ hospice services,
▪ home health services,
▪ chemotherapy services,
▪ dental services, or
▪ outpatient alcohol/drug abuse care.

The typical rural hospital has a financial profile with:

▪ total margin of 2.7%,
▪ current ratio of 2.2,
▪ outpatient care representing 69.3% of total revenue,
▪ charges for Medicare patients representing 31.0% of all charges,
▪ 58 days cash on hand, and
▪ patient deductions/allowances making up 52.0% per revenue dollar.

Swing Beds: OIG Misses Forest for the Trees

The following is from the blog “OIG Swing Bed Report: seeing the forest for the trees” by Brock A. Slabach, Sr. Vice-President, Member Services, National Rural Health Association, 3/10/15:

“The Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) once again can’t see the forest for the trees in its recent report <http://ow.ly/KcOnb> the cost of swing bed services. OIG’s attention to a mass of detail prevents it from seeing the bigger picture, a picture that tells an important story regarding rural health.”

▪ “Rural health is a continuum of services that are dependent on each other to protect our nation’s rural patients. This mosaic of care in rural America saves Medicare 2.7% on a Medicare spend per beneficiary vs. care provided in urban areas.”

▪ “This number is significant, amounting to almost $7 billion annually that could be saved if urban communities spent at the same rate as rural. Even in Washington terms, that’s real money.”
• “Swing bed services in critical access hospitals (CAHs), as envisioned by Congress in 1997, ensure safety net access to skilled-nursing services in rural communities that can’t be guaranteed otherwise. High acuity skilled-nursing patients, often turned away from distinct-part nursing facilities can at least be assured they will have a place for care...close to home. This access and intensive service requires resources, an investment in the care continuum described above.”

• “Additionally, recovery time in a swing bed is a full day shorter than a PPS skilled nursing facility according to the Sheps Center at the University of North Carolina.”

• “NRHA member Tim Wolters from Missouri points out a gaping hole in the OIG report. If CAH swing bed services were reimbursed like PPS swing bed services, the cost reports would look far different, with a significant increase in CAH acute care costs. Therefore, Medicare reimbursement for CAH acute care services would increase significantly, eating into the $4.1 billion in savings OIG quotes in Appendix F of the report. It certainly wouldn’t wipe it out, but it wouldn’t be surprising if it erased at least $3 billion off OIG’s estimated savings. Stroudwater reported that 90% of incremental costs would be shifted to acute inpatient care, thus confirming this observation.”

• “In a pleasant surprise, CMS Administrator Marilyn Tavenner agreed that these savings are indeed inflated.”

• “The administrative burden on CAHs to operate a PPS swing bed would be high by adding additional cost of personnel needed to document and code the care provided. It’s reported that often a full-time registered nurse is needed just to keep up with the administrative paperwork. It seems the OIG would like to take highly trained RNs, already in short supply in rural areas, just to manage the paperwork. There are those pesky details again.”

• “OIG has peeled back just one layer of the onion and made a shocking conclusion that gives an impression that Medicare swing bed dollars are not spent well. Medicare can save money in many different ways; that isn’t the question. The question truly is what is the right thing for Medicare beneficiaries and ensuring safety net access to valuable skilled nursing services in rural communities?”

RWHC Financial Consulting Services

RWHC provides financial consultation to individual hospitals relating to managed care contracting and other financial issues—including Medicare cost report preparation. Our experts will meet with your CFO, administrator or other staff onsite or over the phone, whichever works best for you.

Moving Forward in the Face of Chaos
The RTT Collaborative Annual Meeting
Madison, Wisconsin - May 27 to 29, 2015

With all the uncertainty around payment reform, workforce needs, medical education finance and governance, it’s sometimes difficult to know how to move forward, even to take the first step. There are lessons to be learned from each other, from the past as well as the present. This is your opportunity to both teach and learn! All are invited to participate and contribute to this rural training collaborative!

Information and registration available at: http://ow.ly/KcWhu
RWHC Financial Consulting Services offer a wide range of customized options, including the following:

- Per diem CFO support
- Assistance with budget preparation
- Assistance with financial reporting issues
- Evaluation of debt financing alternatives
- Consultation on reimbursement issues
- Contract review and negotiation
- Strategic planning for financial performance
- Educational updates
- Medicare compliance guidance

RWHC also has expertise in coordinating retirement plans and external financial audits, including determining RFP parameters and negotiating fees with CPA firms.

For additional information about RWHC Financial Consulting Services please contact Rich Donkle at rdonkle@rwhc.com or (800) 225-2531.

Leadership Insights: “Conflict or Coaching”

The Leadership Insights series is by Jo Anne Preston, RWHC Organizational Development Manager. Back issues are available at www.RWHC.com.

“Sometimes leaders will ask me to help resolve a conflict with an employee when it is not actually a conflict. What really needs to happen is a coaching conversation. At its core, conflict involves emotions, competing needs and differing viewpoints. It makes sense that when coaching an employee about a performance problem—particularly around something that we are passionate about that isn’t going well—feelings might rise up and lead to confusing these two terms.”

“Coaching is a relationship that acts to support the growth and the development of others. Marcus Buckingham in The One Thing You Need to Know About Great Managing, Great Leading and Sustained Individual Success states that the coaching instinct is that drive to “Discover what is unique about each person and capitalize on it.” Reinforcing positive behavior can be rewarding, but not so comfortable is having to address tough issues like poor job performance, behavior problems or failing to meet expectations.”

“If the discomfort, that feels like conflict, comes from friendship with your employee: Try just acknowledging the discomfort. You both know it is uncomfortable, so just say so. ‘I need to talk with you about a job performance issue. This is uncomfortable because we are friends and it seems awkward to talk with you like this. But our friendship only makes me more committed to helping you be successful and doing what I can in my role as your manager to support that.’ ”

“If you are squirming because you didn’t always follow the rules before you were promoted: Admit it and share what you have learned. ‘You are right; I didn’t always follow this policy before either. I want to tell you what I have learned about how important this really is and why I am now committed to it, and why I am asking you to be as well.’ Sometimes the very reason people don’t follow policies is because they make no sense until the dots are connected, and that is something you can do in your leadership role.”

“If you are angry with them about not doing what they should be doing: Perform a self anger exam. An employee’s issues and performance are not personal towards you. You might want to re-read that last sentence for emphasis. What stories are you telling in your head about the employee? What kinds of judgments are you labeling onto them? How might you act if you were NOT angry? Step back from the stories and judgments to examine the facts of what has happened and the clear

2015 National Health Service Corp Scholarship Program Application Cycle Now Open

The 2015 National Health Service Corps (NHSC) Scholarship Program application cycle is now open. Applications will remain open through May 7, 2015. Applicants are encouraged to begin the application process early as it takes up to 3 weeks to complete the application.

Info at: http://ow.ly/Kgwfv
and objective expectations you have going forward without the drama. It’s not personal, it’s performance. Approach the coaching conversation after you have sorted this out for yourself.”

“Whether it is a conflict resolution or coaching conversation that is needed, ask yourself: ‘What part of this do I own?’ Have you tolerated subpar performance in the past? Have you addressed issues but neglected to follow through? Is it possible that your instructions were misunderstood? Take responsibility for what is within your control.”

“For a great resource to dive further into coaching, conflict resolution and many other leadership skills, download the Leadership Toolkit from the Wisconsin Center for Nursing at http://ow.ly/KcSZK.”

“The Leadership Toolkit is not just for nursing leaders, this toolkit was jointly created by a team of Wisconsin health care leaders as part of the “Taking the LEAD for Nursing in Wisconsin: Leadership, Educational Advancement & Diversity” grant from the Robert Wood Johnson Foundation® State Implementation Program (SIP) Grant.”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For Info re the RWHC Leadership Series go to www.RWHC.com/Services.aspx or contact Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

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