

# Telehealth's promise for the nation's long-term care residents.

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Innovation and change are two of the hardest things for people to accept and doctors are no exception.

Every day the medical industry is forced to change because of the technological advances that science continues to give us. It may come in the form of a new instrument, a new scanning device, a new diagnostic tool or even an entirely new infrastructure for how medicine is practiced.

Telecommunication is such an innovation: far beyond the computer, it will dramatically alter how we practice medicine. In fact, we're not even talking about adding a new tool to the workbench. The workbench itself will morph into bandwidth allowing the "Star Trek" imaginings of "Beam Me Up, Scottie" to become reality as an 85-year-old Mrs. Jones living in North Dakota is "seen" by one of the best geriatricians in the nation, specializing in adult onset diabetes in Philadelphia.

And therein lies the technological gift of telehealth. Mrs. Jones never leaves her bed yet she finds one of the best specialists in the nation at her bedside.

The demographic tidal wave of aging baby boomers and the current aging World War II generation populating rural long-term care facilities across the country call for a quick and steep learning curve among our physicians and long-term care providers.

The promise of better care and better quality of life to the hundreds of thousands of residents living in long-term care facilities from the application of telehealth shouldn't be viewed as some sort of slippery slope from which to steer clear. Rather, we must ready ourselves with the training, skills and standards of practice for the bunny slopes of telehealth lying directly in front of us--and soon enough we will be ready for the Olympic downhill.

Long-term care demand is high

The current environment of the nearly 17,000 long-term care facilities in the country cries out for innovative solutions: the demand for chronic, specialized long-term care services is rising rapidly while the supply of staffing to provide those services is shrinking.

More residents need heavy care (e.g. ventilator, dialysis, tracheotomy, IV antibiotics) that requires the expertise of specialists. Many nursing facilities report the high demand for psychiatric and mental health care, however, they lack access to professional psychiatric support.

The lack of access to specialty services is, of course, more severe in rural nursing homes. In excess of one-third (35 percent) of the nation's nursing homes are located in non-metropolitan counties accounting for 500,000 certified beds, or about 29 percent of the total supply of long-term care beds in the United States of which over half are certified for Medicare participation.

Many of them now qualify for reimbursement of telehealth medical provider services under the Benefits Improvement and Protection Act of 2000. Yet, despite the new availability of funds, only a few employ telehealth in their facilities.

Nursing homes that have taken advantage of Medicare payment for telehealth consults report a number of substantial benefits: (1)

\* On-site primary care is enhanced as a complement to existing primary physicians and nursing staff.

\* On-site specialty care is enhanced.

\* Ambulance transportation for off-site care is reduced, decreasing risk of

injuries and stress among dementia patients during transport.

- \* Transport costs are significantly reduced.
- \* Unnecessary emergency room visits and hospitalizations are reduced due to enhanced specialty and preventive primary care.
- \* Loss of revenue due to bed vacancies caused by hospitalizations is reduced.
- \* Opportunity to add new services such as psychiatric consults, oral health, dermatology and orthopedic care is increased.
- \* Social and counseling services for family and caregivers through video conferencing is a telehealth spin-off that creates a team approach to care.
- \* Family visits with residents through teleconferencing increases morale for both the resident and family member.
- \* Professional staff training that offers CME by the best practice experts in the field can readily be provided on site.

These benefits have been realized by--not only a few pilot studies--but by other providers who have long been in the forefront of using telecommunications to enhance health care in remote or difficult environments: the United States military, prisons, and hospitals that connect to rural clinics. They provide over 20 years of experience. The testing is done; we just need to apply the protocol.

### Debunking the myths of telehealth

Telehealth has been moving at a snail's pace into the mainstream of medical practice. Hopefully, we will be following the U. S. Army's lead in telehealth just like we did when they introduced the intranet that quickly evolved into the Internet.

Soon enough we'll find ourselves catapulted from "I don't need it" to "I can't live without it." But in the meantime, let's take a look at why we think "we don't need it."

[ILLUSTRATION OMITTED]

Christopher J. Caryl in his article, "Malpractice and other legal issues preventing the development of telemedicine" argues that there are four obstacles telehealth must overcome before we can't live without it. (2)

## 1. Cost and payment provisions

Some naysayers contend that telehealth is too expensive. They are taken in by the razzle dazzle of technology and assume it must be very expensive. But just as the sticker price of computers is on a constant, consumer-friendly descent, so too, are the telehealth costs of infrastructure and hardware.

One recent study by the University of Iowa found that a chronic care wound consultation at a rural nursing home connected to a telemedicine clinic costs \$136.16. However, had the patient been transported for a traditional face-to-face consultation, the costs would have been \$246.28. The study also found that they were able to increase the volume of patients served, thereby offsetting the costs of equipment depreciation and maintenance. (3) Most facilities that invest in the equipment realize their return in short order. This is especially true as reimbursement schedules increase under the Benefits Improvement and Protection Act of 2000.

Medicare has included 28 CPT codes that cover telehealth services such as office visits (codes 99201 through 99215), consultation (codes 99241 through 99275), individual psychotherapy (codes 90804 through 90809) and pharmacologic management (code 90862).

If a physician, clinical nurse specialist, nurse practitioner, physician assistant, nurse midwife, clinical psychologist, or clinical social worker is licensed under state law to provide one of these services, then these practitioners may bill for and receive payment for this service when delivered via a telecommunications system.

Not only is telehealth now compensated by Medicare, more private insurance carriers are also starting to allow reimbursement for telehealth services.

## 2. Privacy assurances: Too personal or not personal enough?

The telehealth provider must design a delivery system compliant with the Health

Insurance Portability and Accountability Act of 1996 to ensure privacy and protection of the patient's information as they would with any hard copy information and data.

Many users of telemedicine have found that consumers are often satisfied with the services they receive through their video relationship with a medical provider. They find that most patients are all too familiar with the medium of "reality" television and the comforting persona that emanates from talk show hosts like Oprah and Dr. Phil. Thus, transferring their familiarity with television to an onscreen physician is not that great a leap.

St. Luke's Hospital in Cedar Rapids, Iowa compared satisfaction levels of patients and providers between those who received care via video technology and those who received it in-person. The nurses were equally satisfied with both mediums and felt that they were able to provide better care to their patients with the video technology.

Surprisingly, 55 percent of the patients were satisfied with the telehealth consultation as compared to 40 percent with the in-person consultation. (4) The researchers did report that patients expressed hearing difficulty in both the telehealth and in-person consult. They further recommend that larger screens and lighting are critical components in offering video telehealth services.

Three Texas Tech pilot studies also reported similar findings of high consumer and provider satisfaction with telehealth physician consultations. (1)

### 3. Licensing issues

Intra-state licensure for telemedicine falls within the standards of practice and law for medicine within each state. So physicians within a state who are conducting telemedicine consultations with each other are governed by the licensure and medicine standards of their state.

However, once their virtual consultation crosses state lines, the service they render is considered the practice of medicine and is subject to that state's laws regarding medical practice. This usually means acquiring that state's license to practice medicine. (5)

However, some states realize that requiring out-of-state physicians to undergo

full licensure exams within their state in order to conduct telemedicine is an undue hardship and can impede the progress of medicine and deny patients expert care. They are devising more creative ways to assure that the public is receiving telemedicine by credentialed providers.

For instance, Ohio addressed this issue by passing a law [Ohio Sub. H.B. No. 585] allowing for an out-of-state physician to obtain a "telemedicine certificate" without taking a full exam for licensure.

Telemedicine providers and receivers need to carefully research licensure rules by state whenever an out-of-state physician provides consulting services.

#### 4. The virtual terrain of malpractice

Telehealth may actually be a way to break some of the malpractice deadlock gripping the national health care system. Digitally capturing what services were performed in real time during an exam may remove any question or doubt in numerous situations.

By adding the visual documentary to the medical record you enable enhanced communication and defense of any action and enable better understanding from the suffering parties. It is obvious that illegal, unethical, negligent, or immoral actions will be easier to prove or disprove with high quality audio, video and image capture.

But beyond that, malpractice is less likely to occur when front-line medical providers can rapidly access specialty physicians who can advise them on difficult or infrequent procedures or assist with making a tough, differential diagnoses.

The telehealth specialty physician with monitoring and diagnostic capabilities in hand can provide a more qualified second opinion to facilitate better care. The long-term care facility's on-site, primary physician, also receives expert validation for the medical options he or she chooses--all of which benefit the resident.

The bottom line: it's time to move past the "why not" of telehealth. We need both providers of long-term care and their doctors to push us to the other side of the "I don't need it" to "I can't live without" continuum.

Quite frankly, elderly residents do need it and, sometimes quite literally, they can't live without it.

#### IN THIS ARTICLE ...

Examine how telehealth could help lower health care costs and bring better care to long-term care patients, especially those living in rural areas.

To discuss this article and other issues about health care technology visit the Doctor-Patient Electronic Communication Network at [www.acpe.org](http://www.acpe.org)

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[ILLUSTRATION OMITTED]

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