ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Telehealth in Alaska Hospitals – Identified Issues, Needs & Opportunities
October 2014

The following is a brief summary of telehealth issues and needs identified as part of the telehealth collaborative project between the Alaska State Hospital and Nursing Home Association (ASHNHA) and the Alaska Department of Health and Social Services. [1] These were identified through interviews with hospital administrators, research, and hospital training opportunities including webinars and conferences. Also included are ideas and possible strategies for next steps.

Limited Collaboration

- There is no single organization that has a focus on statewide telehealth development. The AK Collaborative for Telehealth and Telemedicine is just getting started. The Telehealth Technology Assessment Resource Center (TTAC) is a national organization, although based in Alaska, and the Alaska Native Tribal Health Consortium (ANTHC) telemedicine program serves only the tribal organizations. This contrasts with other states, such as Arizona, that have focused resources on promoting the development of telemedicine across the state, and consequently have a well-developed network.
- There is interest in learning more about how systems in a competitive market manage to work cooperatively in telemedicine. Some systems are more evolved and sophisticated than Alaska's (e.g. Spokane, Arizona) and it would be good to learn from them how the systems developed and what organization (i.e. university, state or other organization) took the lead.
- There is a need for a "registry" of providers who are licensed and willing to provide telemedicince services to rural hospitals and patients. Creating a telemedicine provider registry would require collaboration and information sharing and an organization willing to take the lead in compiling the information, updating, and disseminating.

Payment/Financing Issues

- Reimbursement issues and questions are significant. There is a need for more information and discussion on how to finance telehealth services and what reimbursement options exist. Payers have been expanding the telehealth services they will cover (e.g. Medicare recently added new physician codes and Premera is working to expand payment for telehealth). Medicaid pays for many telehealth services. The reimbursement for the originating facility is often small making it difficult for rural facilities to develop services that are financially sustainable.
- Payers identified a number of issues: how to share risk and cost of providing case management, difficulty of determining the cost/benefits of various telemedicine options, and payment parity (mandated in many states).
- It's difficult and not optimal to continue the fee-for-service model in a telemedicine environment. Telemedicine may be an opportunity as part of payment reform to increase access to care and improve care coordination and home monitoring.
- Determining the return on investment and sustainability of telehealth services can be difficult, especially with uncertain reimbursement. The cost of telemedicine implementation may be substantial and requires careful analysis to determine feasibility.
- In-home monitoring to promote health among vulnerable populations has a lot of potential and will probably become more prevalent. Similarly, home-based case management using telecommunications may be very useful, especially with "super-users" to reduce hospitalizations.

However, at this point it is difficult for hospitals to make a business case to invest in these types of services without a partnership with payers.
- Although EMR adoption is outside the scope of this project, it is a significant requirement that is costly and time-consuming, and probably is/will be funded from the same resources that telemedicine would/could utilize.

Regulatory Issues
- Online prescribing and provider to patient tele-consultation are considered "unprofessional conduct" and are prohibited by Alaska regulations: 12 AAC 40.967(27) and (29). This is not the case in many other states. At least one payer is seeking to develop direct provider to patient services (using vendor like MD Live) and sees this regulation as a major obstacle.
- There is no "parity" legislation in Alaska, requiring the same payment for telemedicine services as for face-to-face. Many other states have adopted this concept.

Connectivity Issues
- There are numerous issues with connectivity in the state, and many creative solutions. Satellite is taking the place of broadband connection in many communities, but has delays and outages that must be endured.
- Hospitals have access to Universal Service funds (USAC) that significantly reduce the cost of connectivity in rural communities. These funds are essential in Alaska, but it is uncertain how long these funds will be available. The cost of connectivity is significant and without USAC funds, services would be unsustainable in rural facilities.

Technology Issues
- The rapid evolution of new technologies presents great opportunities and great confusion. It can be difficult to choose the appropriate technology to meet identified needs.
- "The devil is in the details." Some telemedicine applications, e.g. physical therapy, may be very labor, technology, and time intensive. The cost must be balanced against the alternative of not providing the service at all.
- Not all mobile apps are as helpful or useful as their marketing departments would have us believe. Currently, most mHealth interventions lack a foundation of basic evidence, let alone data that would permit evidence-based scale up.
- There are security and privacy issues that have been identified with the remote transmission of patient data. These issues are probably outside the scope of this group to address, but awareness of their existence is important as it may impact the adoption of telemedicine.
- Equipment and other technology applications can be costly.

Training/Human Resource Issues
- Provider engagement is an issue in some communities, as they may have a hard time adapting to technology and understanding the need for it.
- Many hospitals expressed the need and desire for specialty consults by videoconference. Would also like to do pre- and post-surgery consults by videoconference. The challenge is finding the specialty providers willing to deliver care.
- More telepsychiatry support across the state would be helpful.
- Patient acceptance of telehealth is an issue that hospitals will have to address.

Availability of Resources
- There are a number of "readiness assessment" and "need/demand assessment" tools available. These could be useful to hospitals as they emphasize the many facets of readiness; leadership, human resources, technology availability, environment, infrastructure, funding, provider buy-in, etc.

- National and regional resources provide helpful information and advocacy: e.g. ATA, CTEL, TTAC, Northwest Regional Telehealth Resource Center.
- The American Telemedicine Association has developed standards and guidelines for a number of telemedicine applications; many other professional organizations (e.g. CTEL) offer standards, guidelines, and cautions as well.

Next Steps

The following is a summary of some ideas for action for both the short term and the longer term to support continued learning and development of telehealth services by small/rural hospitals in Alaska.

Short Term (1-4 months)

1. Continue to sponsor webinars including: Providence telehealth services offered to Alaska hospitals such as e-ICU and telestroke; payers not able to participate in the telehealth workshop panel - Premera and Medicare; best practices in developing telehealth programs from Spokane and Arizona.
2. Contact Alaska Collaborative for Telehealth and Telemedicine to determine their mission and goals and to consider joining/supporting the group.
3. Assist hospitals with "readiness assessments" for telemedicine if desired.
4. Analyze HB281: "An Act relating to prescription of drugs by a physician without a physical examination." This was transmitted to the governor for signature in August.
5. Determine if there are advocacy issues to present to ASHNHA membership.
6. Begin planning a meeting or conference to explore telemedicine collaboration in a competitive environment. This could have application for the tribal/non-tribal areas of overlap in the state, and various other areas of competition (e.g Anchorage, Southeast Alaska).
7. Disseminate information on the UAS telehealth classes available.

Longer Term (4-12 months)

1. Create a telehealth registry that allows sharing of services, providers, specialists between hospitals.
2. Consider a mini-ATA (American Telemedicine Association) conference, with vendors, presenters, and networking possibilities. Arizona is sponsoring a similar state conference in October in Phoenix (www.ttspsworld.com).
3. Create a "payer work group" to work with stakeholders on regulatory and other barriers, and to promote collaboration and communication. Consider alternatives to fee-for-service and/or telehealth pilot projects in collaboration with payers.
4. Investigate QI data collection challenges to determine importance and legitimacy.
5. Continue to investigate cost/benefits of various telemedicine applications, using information from providers across the state who are using many different applications.
6. Facilitate development of a network of specialty consultants willing to provide care via telemedicine.
7. Explore status and feasibility of home-based monitoring systems.

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