

Telemedicine can help safety net providers expand access to medical specialists

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Safety net medical providers can substantially increase their telemedicine services with modest investments in new staff and technology, a move that can help them expand patients' access to specialized medical care, according to a new RAND Corporation study.

But sustaining gains created by expanded [telemedicine](#) will require more-generous reimbursement policies from payers or ongoing revenue from other sources such as government grants, according to researchers.

While the study focused on the experiences of nine community [health](#) centers in California that provided telemedicine access to medical specialists from their primary care clinics, the findings have implications about how to sustain the rapid expansion of telemedicine that has been prompted by the social distancing efforts triggered by the novel coronavirus pandemic.

"We found that telemedicine services can extend care for services such as psychiatry and diabetic retinopathy screening in settings that reach underserved populations," said Lori Uscher-Pines, lead author of the study and a senior policy researcher at RAND, a nonprofit research organization. "But in order to sustain such improvements, the federal government and others who pay for [medical care](#) need to increase their long-term support for telemedicine services."

There are about 1,400 community health centers across the nation that serve 29 million patients who are mostly low-income. The federally

supported centers provide comprehensive primary care to medically underserved populations, regardless of their insurance status or ability to pay for services.

RAND researchers examined the experiences of clinics enrolled in the Sustainable Models of Telehealth in the Safety Net, which was funded by the California Health Care Foundation from 2017 to 2020. The project's goal was to help transform participating health centers from low-volume to high-volume telemedicine providers that are dedicated to improving access to specialty care through technology.

The nine community health centers in the project operated [health clinics](#) mostly in rural areas of California.

On average, the health centers had experienced a slight downward trend in telemedicine use prior to the start of the initiative. But there was a large and significant increase in telemedicine volume at the beginning of the initiative, which continued to increase over time.

The majority of participating health centers contracted with third parties (typically telemedicine vendor or independent group of specialists) for telemedicine services. In this model, a patient visits the health center where they typically receive primary care and is connected to a remotely located specialist who is employed by another organization.

Two of the health centers primarily used their own clinicians to provide telemedicine services. In this model, multisite health centers that employ specialists such as mental health providers connect patients—via telemedicine—at clinics that do not have the specialists.

The community health centers spent between \$4,400 and about \$250,000 to establish expanded telemedicine programs, with most of the money going to new equipment. During the project, telemedicine volume at the

clinics ranged from fewer than 500 visits per year to more than 7,000 per year.

Nearly half of the telemedicine visits were with a behavioral health provider, while another quarter were for eye care. Other common specialists providing telemedicine care included endocrinologists, rheumatologists and dermatologists.

Staff from most health centers reported that the telemedicine services were likely permanent, but that financial factors would determine the scope of services. Administrators at all of the clinics said that telemedicine was a cost center for their organizations and identified several factors that make it difficult for health centers to break even on telemedicine.

Barriers that increased costs include a high no-show rate, limited connectivity, restrictions that do not allow some providers to provide telemedicine services, telemedicine visits taking up space that could be used for more-profitable visits, and the costs associated with switching telemedicine providers.

The RAND evaluation recommends that clinics hire a telemedicine coordinator to head their efforts and that they consider offering telemedicine services to patients from their homes.

The home model, which has been widely implemented during the COVID-19 pandemic, allows health centers to serve patients who live farther away and may be more sustainable because it uses less physical clinic space and can allow salaried providers employed by a clinic to work at full capacity.

"Most community [health centers](#) involved in the project were committed to sustaining telemedicine programs, regardless of profitability, in order

to provide their patients access to medical specialists," Uscher-Pines said. "Nevertheless, during and after the COVID-19 pandemic, new reimbursement policies could allow for greater flexibility in the type of visits that qualify for reimbursement, which could increase revenue for these visits."

In addition to overall findings, RAND researchers prepared companion reports that provide in-depth recommendations about how to expand telemedicine services. Those reports cover the ideal duties for a telemedicine coordinator, promising practices for adoption of telemedicine and a detailed analysis of the financial costs of expanding telemedicine.

More information: The reports are "Experiences of Community Health Centers in Expanding Telemedicine," "The Case for a Telemedicine Coordinator: Lessons Learned from the Sustainable Models of Telemedicine in the Safety Net Initiative," "Promising Practices for Telemedicine Implementation" and "Costs of Maintaining a High-Volume Telemedicine Program in Community Health Centers." The reports are available at www.rand.org.

Provided by RAND Corporation

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