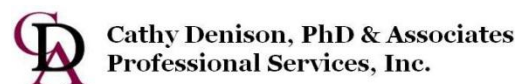# Telemedicine Program Funding & Sustainability Webinar

Q&A Session Summary

Q: Regarding the RUS DLT grant, have you heard rumors that this year's awardees will only be pooled from last year's applicants?

A: Yes, we have heard the rumors, and were able to confirm directly with the USDA that this is in fact a rumor. They are going to hold the 2014 DLT competition and anticipate the 2014 DLT Grant Program Notice (NOFA) will be published around the end of April, in the Federal Register, and that application materials will then be available on their Website, http://www.rurdev.usda.gov/UTP_DLT.html.

Q: Are there funding sources that support institutes that are involved in building international presence and collaborators ---for telemed equipment and support services?

A: Most traditional U.S. federal funding is not usually for international Telemedicine projects. You might contact equipment/software vendors directly, reach Foundations, and private donors. Also, you might talk to some International and World Health related funders who might consider funding Telemedicine projects.

Q: How easy is it for rural clinics to adapt and own the process after project funding ceases? What is the viability and how to improve?

A: Telehealth is never easy. You must have institutional buy-in and support from leadership, including clinical and administrative champions. As challenging as the technology may seem, the most significant challenge is to engage the clinicians. Patients are

very accepting of the technology if the clinical/staff people on the patient side of the encounter and the providers who are connected via telehealth are positive and upbeat about the use of the technology. It is often difficult to quantitatively justify the financial model for telehealth, so it is incumbent upon the telehealth leadership to be creative and leverage the technology to solve a range of problems. Make others look good and make your organization look good and you will build political capital. Your goal is to make telehealth "necessary infrastructure", just like the air conditioning system. If you can accomplish that goal, any incremental revenue you can generate is an added bonus.

Q: Is grant funding mostly steered toward large health systems, or is their grant funding available for community based multi-specialty medical groups with core services of primary care?

A: Each project is different and many times Rural Health programs provide funding for rural Primary Care, like the USDA RUS DLT grant program. Grant funds can be available for large health systems and community based groups with primary care. Sometimes, collaborative efforts are beneficial.

Q: My client has an ongoing consumer focused telemedicine service. They are concerned about financial sustainability in the Obamacare future. Any suggestions regarding positioning and marketing and potential grant opportunities?

A: Telehealth should flourish in a reformed healthcare system. Don't think of the highly politicized "Obamacare" moniker, but think of the intent of a reformed healthcare system that rewards value over volume and is aligned with the Triple Aim. Telehealth can bring the right care to the right people at the right time in the right place. That goal aligns perfectly with the Triple Aim of improving the patient experience, improving population health and reducing the per-capita cost of healthcare.

Q: We have used several l Grants to kickoff initiatives, but have found barriers around physician engagement and recognition of the value add of telemed. What do you recommend?

A: If you do not successfully leverage your grant-funded pilots to excite the base of providers to the potential of telehealth, you need to focus on why the providers are not adopting the technology. Telehealth will never be adopted by providers if you cannot deliver a sound foundation of reliable and acceptable technology, appropriate reimbursement for clinical encounters and proper support to develop the policies and procedures that adapt the technology to the provider's style, rather than asking the provider to adapt their style to the technology. It is easy to emphasize the technology, but

fundamentally, telehealth is a people project and if you can make things easy for the provider and solve the challenges they face in an evolving healthcare marketplace, you will see improved adoption. Providers will never feel the same passion and urgency as the telehealth staff, so you must understand that some providers will never use the technology and you have to focus on "low hanging fruit", those from both the patient and provider's perspective, generate revenue and will be the proof-of-concept to help you launch other initiatives.

Q: We have a program but are looking for financing opportunities for upgraded equipment. How can we go about doing this?

> **A:** See the list of possible funders presented during the Webinar and many of them should be able to let you know if they will provide funding for upgrading equipment. If your upgrade is to expand your Telemedicine or Distance Learning Program, then the USDA RUS DLT grant program funding can be used for upgrading or expansion projects. Neither services and equipment, nor, costs and expenses can be duplicated. You might consider reaching Foundations, vendors, and private donors.

Q: We utilize Telemedicine through the State of Louisiana program but some services are not covered. I would like specific information on emergency room services and OB service.

> **A:** I cannot answer your state-specific question, but Medicare reimbursement is the same in every state. Medicaid and commercial insurance providers differ in every state. More and more states are mandating that telehealth be a covered service. I would talk to the Center for Telehealth and e-Health Law (CTEL) and the American Telemedicine Association (ATA) for state specific information.

Q: "What are the available grants for private for-profit telemedicine companies? Available List? (Cathy)

> **A:** Private, for-profit Telemedicine companies can be included in many federal and state healthcare grants. In many cases, for-profits can be included as a consortium or alliance member, but in most cases, the for-profit entity probably can't be the lead agency or fiscal agent in Telemedicine implementation projects. To start off, please see the list of sources discussed during the Webinar or feel free to contact me. The Telemedicine Resource Centers are good resources, as well.

Q: Would like to hear ideas on how Public Health can be more engaged.

> **A:** The 2nd focus of the Triple Aim is to improve Population Health, and that is the focus of Public Health Departments. Many health departments are moving away from traditional clinical services and are focused on the more global population health issue. Health Departments are also being squeezed by tight state budgets and every state health department will react differently to the changing model of health delivery. I would suggest you contact local health departments and your state Department for Public Health to discuss their strategy for the future and you should suggest how you can interject telehealth. Potential options include disaster preparedness and response, global health issue education for providers and patients, including diabetes, heart disease, lung disease and other chronic conditions and school health services which are often connected to public health departments.

Q: Under the new Affordable Health Care law, is there a requirement for insurance companies to cover telemedicine? Where can we get info on the insurance coverage for telemedicine?

> **A:** The ACA does not mandate telehealth coverage. CTeL and ATA are good sources for Medicare (federal) and state-specific reimbursement information (question #8).

Q: Where do I start when looking for partners to collaborate with our organization? We operate clinics in rural East TN and would be interested in providing access to specialist consults in these communities.

> **A:** If I understand correctly, you have the patients in your clinics and you want to use telehealth technology to "import" medical specialist from larger healthcare centers. First determine all the reasons why patients are travelling away from your clinic to see a specialist and find where those specialists are located. Then, contact those specialists to determine whether they are willing to see these patients via telehealth technology. Begin with those specialists that receive a significant number of referrals first, so they understand the scope of what you are asking. It is much easier to recruit a specialist if you have a lot of referrals that may be in jeopardy if they do not agree to use telehealth.

Q: Can a practice of two start this type of practice, get grant funding and still operate like a regular LLC, or is there some sort of Non-Profit attached to grant funding?

A: Small medical practices can participate in grant funding projects. Private, for-profit Telemedicine companies can be included in many federal and state healthcare grants. In many cases, for-profits can be included as a consortium or alliance member, but in most cases, the for-profit entity probably can't be the lead agency or fiscal agent in Telemedicine implementation projects. It is beneficial to work with non-profit organizations. To start off, please see the list of sources discussed during the Webinar or feel free to contact me. The Telemedicine Resource Centers are good resources, as well.

Q: What is the range of the COST (to the patient) to provide telemedicine service between a physician and a patient in a remote location. Including the cost of the network/broadband connection, telemedical equipment, staff to assist on the patient side, etc.

A: Patients will not bear any of the cost. Telehealth encounters are billed as any other clinical encounter by the consulting provider, with the exception that Medicare and some other payors that will allow a "facility fee" be paid to the site where the patient is seen via the technology.

Q: How about programs that can be self-funded (ie Telestroke) that can have an ROI that will pay for the program itself with 1-2 strokes per month ?

A: I would be surprised if you could justify a full telehealth program based on 1-2 strokes/month. The reimbursement model for stroke care, especially the traditional "drip and ship" model of using the technology to administer thrombolytic medication at a community-based ED and then immediately transporting the patient to a stroke center is not favorable, as the fairly lucrative DRG payment is only paid to a facility that administers the medication and then does after-care.

Q: We are located in rural Maine and experience a great deal of barriers for coverage but have been told this is driven on a federal level as well. What groups would you recommend we become part of to help drive that catalyst of change you talked about to address Medicaid changes.

A: From Question #8, I would recommend CTeL and ATA**.**

Q: What are the available funding sources for developing country to start Telemedicine and eHealth in rural areas as well as to set up eHealth research centers in Universities.

A: Most traditional U.S. federal funding is not usually for international Telemedicine projects. You might contact equipment/software vendors directly, reach Foundations, and private donors. Also, you might talk to some International and World Health related funders who might consider funding Telemedicine projects and e-Health research centers. Foundations and World Health funders are probably your best source. You might talk to American Telemedicine Association's International groups to see if they might offer some assistance.

Q: Do you see financial viability of tele specialty clinic beyond initial project and grant funding?

A: Financial viability may be in the eye of the beholder. For some, it is showing a positive revenue stream to the telehealth program that exceeds the cost of the program. For others, viability may mean that revenue to others in the medical system (providers, labs, radiology…) is greater than the cost of the program. Some may find that the intangible benefits, including Public Relations/Marketing/competitive advantage may be sufficient to justify the ongoing funding of the program. The University of Kentucky's telehealth program has been active for 19 years and we have had grant support for much less than half of that time and most of that support was dedicated to programmatic expansion and not to fund operations. As I have often said, you must fully integrate telehealth into every aspect of the medical center so it becomes necessary infrastructure.