How current and potential funding models help and hinder telehealth provision

A public hospital perspective

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Overview
• Funding telehealth in the context it offers
• Brief recap current funding models – telehealth and face-to-face
• Telehealth funding considerations
  1. Telehealth as business as usual / as a mode of transport (substitution)
  2. Telehealth as a new model of care – including local clinicians

Funding telehealth in context
Telehealth benefits the patient, State and Federal governments
• Helps keep people out of hospital
  • Improves access and convenience
  • Supports patient self-management and health literacy
  • Avoiding admission
  • Earlier discharge
• Enables a more supported primary care workforce
  • Less need for referral
  • More involved, better skills locally
  • Knowledge & skills sharing
  • Less delay in follow-up
  • Better continuity of care
• Supports a more efficient health service
  • Less duplication of tests
  • Substitute for outreach
  • Growth strategy (removes physical restraint of space)
• Convenience for patients
  • Earlier intervention through easier access
  • Less time off work / school
  • Care closer to home
  • Less travel

Medicare (Commonwealth) funding to access specialist services in public hospitals
• Specialists opt for their ‘right to private practice’
• 100% donation models operate in many public hospitals

Face-to-face
• Essentially any healthcare professional can bill
• All Item numbers
• No geographical restrictions
• Clinics are Medicare billing – often multi-disciplinary
• Fully booked multi-disciplinary onsite specialist clinics offer the best revenue model
• Specialists opt for their ‘right to private practice’
• 100% donation models operate in many public hospitals

Telehealth
• Requires Specialist participation
• Specified health professionals reimbursed for being with the patient
• Specified Item numbers only
• Geographical restrictions for patient
• Clinics are Medicare billing – Specialist only
• Revenue can be an incentive depending on $$ distribution model

Victorian State funding to access specialists in public hospitals
Face-to-face
• State government funds outpatient services – Specialist and multi-disciplinary clinics
• Block funding is calculated based on previous years activity

Telehealth
• One-off telehealth initiatives run from various health services
• Follow national activity based funding guidelines
• The specialist providing the service can count the activity (eg get reimbursed)
• Health professionals with the patient during a video consultation cannot count the activity

Funding to support face-to-face access to health for rural / regional

Doctors
• Rural Health Outreach Fund pays specialist travel costs to visit regional areas (Commonwealth Funding)
• Expensive and time-inefficient
• Reliant on specialist availability
• Doesn’t guarantee access for all

Patients
• Patient Assisted Travel Schemes (PTAS) subsidise patient travel and accommodation (State funding)
• Victoria announced an increase of $13.8 over next 4 years in May 2014 budget
FUNDING CONSIDERATIONS TO EMBED TELEHEALTH AS A WAY TO ACCESS USUAL SERVICES

Potential funding options
1: Fund the appropriate providers (resources)
Open funding to all providers, reflect face-to-face equivalent
- The most appropriate provider of a telehealth service may not be the most expensive.
- Allied Health, nurses and other medical staff may be more suitable yet currently not funded through Medicare.
- The same services and skills (e.g. multidisciplinary) should be available through telehealth as face-to-face.

Potential funding options
2: Redistribute transport reimbursement
Portions of both Commonwealth and State government funding allocated to patient and clinician travel could be diverted to telehealth as an alternative to travel.
- Telehealth replaces transport – simply an alternate access mode – should not come at additional cost.
- $13.8m over 4 years VPTAS (May 2014)

Potential funding options
3: We know that telehealth saves money and time
This cost is commonly carried by Travel Assistance Schemes.
- Average cost savings per consult $602
- Maximum $4,015 for one patient across 10 consultations
- >$26,000 saved across 25 patients over 16 months
Nephrology study RCH 50 consultations (2013)

Potential funding options
Oncology Geelong
- 6 children w leukaemia in Geelong region
- Each child 8 appts pa could give chemo locally with RCH input
- Avoid an RCH visit (48 appts pa)
- Then:
  - Every month for 3.5 years – could do locally
  - 5 years surveillance – every 6-8 weeks, then 4 pa then 3 pa then 1 pa – a total of 16 appointments could manage locally
Additional benefits of using telehealth:
- Psycho-social, local involvement for other ongoing
- Use local services
- Avoid RCH……
Removing geographical boundaries would enable metropolitan patients to also benefit from the use of telehealth.

This would be beneficial to those with disabilities, mobility restrictions or frequent specialist attendances that impact on other aspects of life such as family life or work.

Comment additional cost or no incentives

Potential funding options

3: Broaden the eligible patient base

- Dual care consultations play a role in structural reform; supporting self-management of chronic conditions, workforce capacity and capability, and reduced reliance on hospital care.

- Long term benefits include: primary care capability building – shifting costs from expensive hospital care to primary care that can be delivered closer to home.

4: Fund both ends of the consultation

Higher initial costs for long term benefits

5: New models of care deliver long-term returns on investment

Higher initial costs for long term benefits

What's been happening?

Telehealth activity trends including local clinician (% Medicare billed supported telehealth consultations)

2011-12 2012-13 2013-14

In summary

1. Fund the appropriate provider / resources
2. Redistribute patient transport reimbursement
3. Broaden the eligible patient base
4. Fund both ends of the consultation
5. New models of care deliver long-term returns on investment