



Telehealth, IT'S NOT THE TECHNOLOGY

BY: DAVID SNIFF, NRHA PRESIDENT

For rural hospitals, telecommunications remains and continues to grow importance. Of equal significance is telehealth, which has had mixed results but remains a valued tool — particularly with the growing workforce shortage.

The business applications in technology, relevant to both telecommunications and telehealth, are pretty straightforward for the most part and have made significant improvements. Interactive communications via technology is also proving to be effective and promotes efficiency as it also improves. Recently, I made a presentation where six sites were connected and more than twenty hospitals participated simultaneously. Although there were some “bugs” with connecting a couple of the sites and there remains at times “stuttering” of image and a fractional lag with the audio portion, this technology will only improve and grow.

However, there is another observation that needs to be made about interactive technology. Due to the shortage of health professions faculty and classrooms in many parts of the country, it is going to be necessary to bring the class to rural sites to teach students and to provide continuing education for established health professionals. With the acute shortage in many health related careers, we are going to have to find ways to make it easier for students to get their education — particularly rural resident students. It is well established that one of the best recruiting methods for rural providers is to educate local residents who desire to return to their roots. Additionally, our existing employees must be able to maintain their licensure through continuing education, which continues to be problematic for budgets and time spared from work. Moreover, while employees wouldn't mind attending classes at a neighboring hospital or community, they are reluctant to expend the windshield time plus class time to go outside the local area.

With regard to telehealth delivery of services, there appears to be a correlation between sparse population and willingness to use technology to provide patient care. Telehealth goes back to at least the 1940s, granted it was elemental, but it has developed well in pockets of the U.S. Particularly in the frontier states and where there are physician champions. Therein lies the key, creating widespread physician acceptance.

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For a variety of reasons, many physicians will not use telehealth capability. The impersonal nature of technology versus in person, the always stated liability exposure, a reluctance to change compounded with a lack of time to learn about new delivery methods and an attitude of why bother if the patient can get there are all contributing thoughts. Hesitance to change also includes the possible staff addition of a technical "expert" and the onslaught of problems if the system breaks down. Moving to a telehealth system requires a strong commit-

ment of time, effort and of course funding.

Technology is not the issue. Patient acceptance is not the issue. Moreover, insurance carriers are not the issue. Medicare and in many states Medicaid provide reimbursement for televisits. However, one continuing drawback is that payors don't pay for the hardware, software, or connectivity required, so it becomes an issue of cost versus benefit. A second payor problem is that reimbursement is not provided unless there is face to face interaction. Medicare won't pay for store and forward visits though it

is brought forward annually in Washington by NRHA Advocacy efforts as something that needs to be done.

Telehealth can offer very beneficial and needed alternatives in rural and frontier areas as indicated in the stories of this issue of Rural Roads. The principal lesson I've learned is to be sure adequate planning is undertaken and that there are physician champions who are committed to use technology to offer services otherwise not readily available — that's what makes telehealth successful!

SUBURBAN MORTGAGE