CARE MODEL CASE STUDY: TELENEUROLOGY—PRIVATE COMPANY

AMERICAN ACADEMY OF NEUROLOGY®

Introduction

Telemedicine involves the use of various electronic communications to practice medicine from a location that is remote from the patient and is increasingly common in various health care settings, including in the practice of neurology.[1] Telemedicine in neurology, known as teleneurology, has been on the rise for years and is becoming increasingly integral across care settings, especially in providing urgent neurological care to rural care settings that may have limited access to neurologists and neurology advanced practice providers (APPs). Beyond providing critical patient access to care, teleneurology can be equal in care and cost-effective compared to a face-to-face encounter for many conditions while providing the neurology provider with opportunities for more career flexibility and reduced administrative burden.[2,3]

The AAN's Care Delivery Subcommittee, under the guidance of the Medical Economics and Practice Committee, set out to better understand different care delivery models, their core functions and features and the professional and personal advantages and disadvantages of such models compared to traditional fee-for-service care delivery and reimbursement. To better understand working for a private company that provides care via teleneurology, the Care Delivery Subcommittee worked with two members who work for Specialists on Call (SOC) Telemed™, Elaine C. Jones, MD, FAAN[4] and Eric Anderson, MD, PhD[5] to provide insight into their work in a teleneurology care delivery model. Responses below represent the individual experiences of the contributors and are not the official opinion of the AAN or SOC Telemed. The AAN does not specifically endorse specific companies that provide care via teleneurology, including SOC Telemed. Responses have been edited and condensed for clarity.

This case study examines telemedicine outside the context of the COVID-19 pandemic, which has greatly increased the use of telemedicine.

The Care Model

The telemedicine company offers telemedicine to hospitals in three service lines – **neurology, psychiatry, and neurointensive care.** It contracts directly with hospitals across the United States to offer around the clock emergency coverage, and sometimes, routine care coverage for inpatient consultation. Neurologists are contracted as either full-time employees or as independent contractors with a subsidiary company and are paid an hourly rate with scheduled shifts and are considered medical staff. As medical staff, they must adhere to bylaws and procedures laid out by several committees within the company such as its Medical Executive Committee, Credentials Committee, Quality Committee, and Electronic Health Record (EHR) Oversight Committee. Additionally, a Neurology Leadership Council, which consists of key neurology leaders, is established to work with company administration to guide growth in areas such as strategic planning of Information Technology (IT), services lines and quality. At time of publication, advanced practice providers (APPs) including physician assistants and nurse practitioners are not employed by the telemedicine company for neurology services, however some APPs are employed for psychiatry services.

The Value Proposition

As with most anything, there are upsides and downsides to any care model. Based on the insights Dr. Anderson and Dr. Jones shared, the Care Delivery Subcommittee evaluated the model and distilled elements of this private teleneurology model into three symbiotic value propositions.

Value Proposition to the Patient

+ Greatly increased access, especially due to geographic barriers and supply and demand issues
+ Increased access to subspecialists
+ High patient satisfaction

Value Proposition to the Provider

+ Increased career flexibility and work-life balance
+ Reduced administrative burden related to billing
- Increased administrative burden related to credentialing
- Few physical exam limitations

Value Proposition to the Health System

+ Decreased fixed costs
+ Maintain high-quality consultation for many conditions
+ Increased opportunity for improved outcomes and patient satisfaction

For more information related to care models, visit *AAN.com/tools-and-resources/practicing-neurologists-administrators/value-based-care/*.

For questions, please contact *practice@aan.com*.

How It Works

When a neurology consultation is generated by a hospital or facility, the telemedicine company's call coordination center intakes the case and assigns it to a provider who is on shift and credentialed at that facility. That provider is sent the assignment and begins the consultation process by logging onto a real-time, two-way video-audio conferencing platform and performs a history and physical with the patient. The telemedicine company provider calls the referring provider to discuss the case and writes a consultation note that is sent to the facility for inclusion in the medical record. Most cases are emergent, so conclude with one consultation with the telemedicine company provider, however follow-up consults can be requested by either a telemedicine company provider or the facility.

The hospital pays a flat fee to the telemedicine company based on volume of consults per month and providers are paid a flat rate for their shifts.

When comparing the company's teleneurology model to a traditional fee-for-service model, the greatest difference is the fact that the company's model is contract based, thus largely eliminating billing, except for stroke services now that these are billable via telemedicine codes under Medicare. Barriers related to insurance and prior authorizations are nearly non-existent, given the contract-based nature of the model. However, similar to traditional fee-for-service, providers must continue to meet all documentation requirements for Evaluation and Management (E/M) codes. Additionally, there are some elements of remote examinations that limit providers and the level of services that can be billed. For example, the telemedicine company providers cannot perform reflex and fundoscopic exams.

The Provider Experience

The personal benefits of working under a teleneurology model like SOC Telemed, at least anecdotally, are seemingly great. Dr. Anderson and Dr. Jones both cite that the implications for work-life balance under the private company model as the biggest benefit to such a model. Dr. Jones notes that, "work shifts are well defined, and when off shift, providers have no responsibilities or requirements," and went on to share that, "work can be done from any location as long as there is privacy and a reliable, high-speed Internet connection." Beyond the flexibility in terms of schedule and not being tied to a physical building, or even city and state, the model "provides rapid, immediate access for patients to a neurologist while still allowing live visual assessment of the patient." Dr. Anderson describes what he considers the main perks of the model succinctly as "no commute, no prior authorizations, and no insurance hassles."

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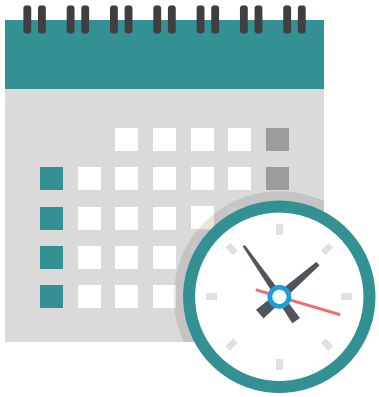
Beyond the work-life balance flexibility and opportunities for individual providers working in this model, the care model is well-received by patients and providers in facilities that contract with the telemedicine company. It gives patients and providers in facilities that contract with the company the opportunity to receive and provide rapid care that expands access in the outpatient and non-emergency settings, respectively. The feedback for the model is anecdotally, overwhelmingly positive, with both groups expressing appreciation to immediate access to neurology, whereas in the past this may not have been readily available. Dr. Jones notes that "the improved access clearly has appealed to everyone in the healthcare community" and that evidence shows that outcomes for cases that included teleneurology consults are not inferior to those provided live and on-site.



Of course, there are unique challenges for providers under this model as well. Dr. Anderson sees the biggest challenge for him as the difficulty in "turning it off" or transitioning from working at home to being at home. Dr. Jones shared some of the systematic frustrations with the model, which include requirements to be licensed in every state and credentialed at every individual facility they may see patients. These requirements generate a significant amount of redundancy and paperwork and generate more opportunity for errors in documentation. She also notes that given the emergent nature of most consultations that the telemedicine company providers perform, she can feel dissatisfied with the lack of continuity in care, although there are current efforts to formalize a follow-up process with patients.

For more information, visit *AAN.com/tools-and-resources/practicing-neurologists-administrators/value-based-care/*

[1] American Academy of Neurology. (2014). AAN Position Statement on Telemedicine. *AAN.com/policy-and-guidelines/policy/position-statements/telemedicine/*

[2] Hatcher-Martin JM, Adams JL, Anderson ER, et al. (2019). Telemedicine in neurology: Telemedicine Work Group of the American Academy of Neurology update. Neurology. *n.neurology.org/content/early/2019/12/04/WNL.0000000000008708*

[3] Shaw, G. (2019). A New AAN Report Details Where There Is Evidence for Teleneurology—And Where There Are Gaps. Neurology Today. *journals.lww.com/neurotodayonline/fulltext/2019/12190/a_new_aan_report_details_where_there_is_evidence.9.aspx*

[4] Dr. Jones has nothing to disclose beyond her employment at SOC Telemed.

[5] In addition to his employment at SOC, Dr. Anderson is a consultant for Corticare and an owner of Intensive Neuromonitoring LLC.