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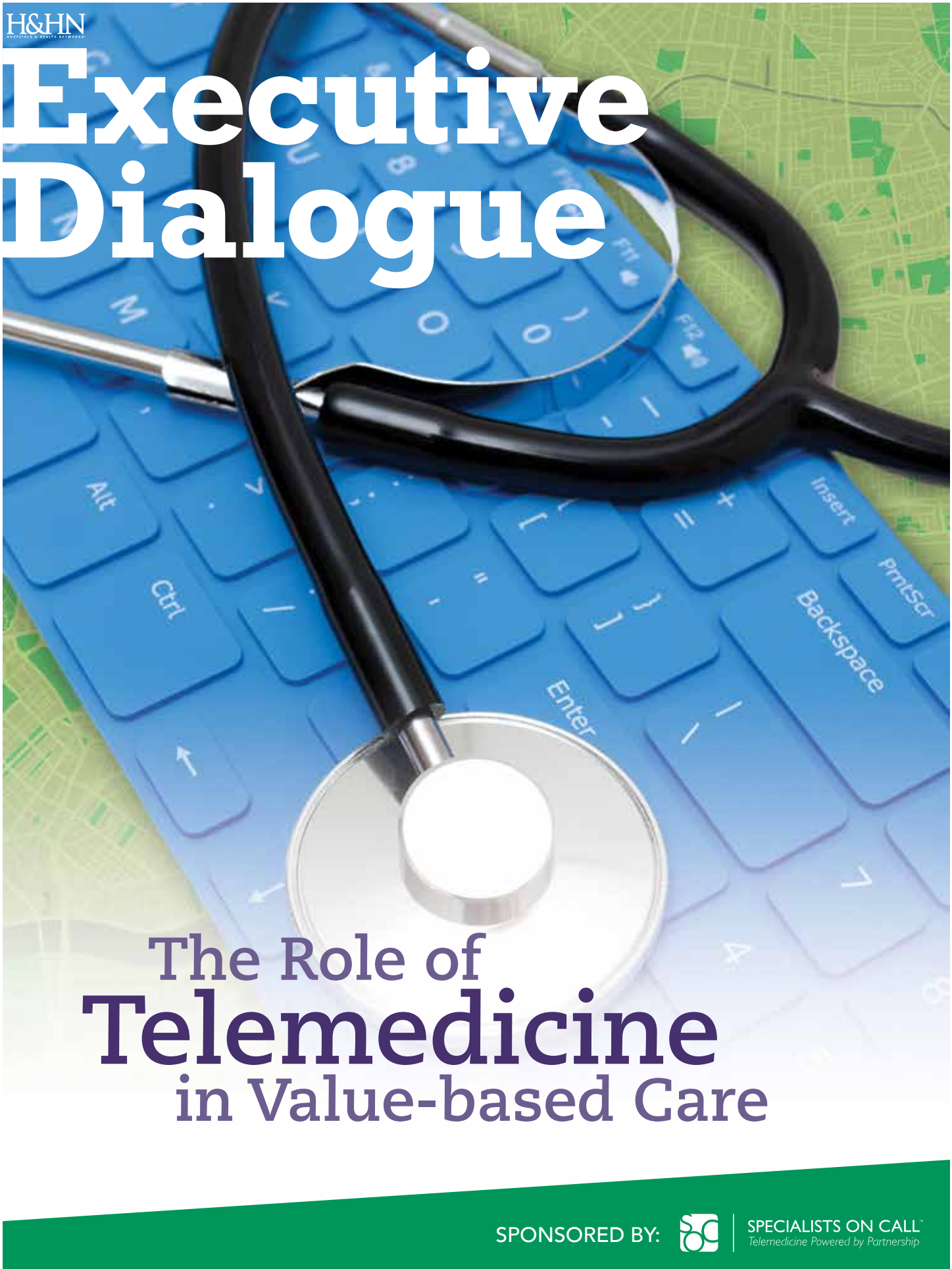
Executive Dialogue



The Role of Telemedicine in Value-based Care

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Hospitals and health systems increasingly are turning to telemedicine as a tool to increase patient access to care, enhance quality and lower costs. Telemedicine enables clinicians to proactively work with patients, monitoring transitions in care and helping patients to manage chronic conditions. As the list of telemedicine services continues to grow, hospitals and health systems can focus on population health management and treating patients in the most appropriate setting. AHA's Health Forum convened a panel of hospital and health care executives in New York City to explore how hospitals and health systems are using telemedicine services to improve care and enhance the patient experience. The panel highlights the importance of clinician buy-in and building telemedicine into the clinical workflow among the keys to success.

{ strategy }

MODERATOR (Doug Shaw, AHA Health Forum): Our topic today is telemedicine services. Let's start with a simple question: What telemedicine services are you currently offering or considering offering?

PEGGY SANBORN (Dignity Health): At Dignity Health, we have the Dignity Health Telemedicine Network that provides telemedicine services to various service lines, including telestroke and telemental health. It also provides specialists on call for specific services. It supports both our rural and urban facilities, as well as provides services to non-Dignity-affiliated organizations.

CHRIS YOUNG (Ascension Health): We have telemedicine offerings that fall within three categories: direct-to-consumer offerings, specialty consults and remote monitoring. Remote monitoring is emerging as a means to reduce readmissions. As the 65-and-older population grows, we will benefit from a significant investment in home monitoring.

MARK SOLAZZO (Northwell Health): We use a slightly different categorization: internal; business to business and then business to consumer. Internally, we've wired our emergency departments for telepsych and telestroke. Among the things we're considering are the use of telehospitalists and eSNFs, as well as connecting all of our urgent care patients with our urgent care partners for telemergency medicine. We are taking a deliberate, focused approach, making certain the platform that we use is robust enough.

JEFFREY BAHR, M.D. (Aurora Health Care): We're using telemedicine to expand our pharmacy services, including the provision of pharmacy services to areas where pharmacists aren't available. We place medication dispenser units equipped with interactive video to provide consultations between patients and pharmacists. It's allowed us to expand our services to areas where this is in high demand, but in low supply.

JEFFREY FLAKS (Hartford HealthCare): One of the issues that we face in our market is that there's not a business model yet to truly make this sustainable and viable, although we are of the belief that this is an essential part of care delivery. We have invested significantly in what I characterize as small tests of change, piloting these services in purposeful and discrete areas. As others have described, we're using it for interhospital services such as stroke. It has immediate value. We're also using it between our nursing home and acute care operations. There is clear value to doing that relative to readmission, care coordination and various quality initiatives.

We have several providers who are tertiary or quaternary in nature, who draw either national or international patients. In these situations in which people are paying out of pocket for their services, it has been enormously impactful. It's cut down on travel, increased care continuity and accessibility, and improved patient satisfaction. Those are discrete areas. Over time, we see the connection to home care and in-home monitoring to be the most impactful space, but there is reluctance on the payer side.

We're using telemedicine to expand our pharmacy services, including the provision of pharmacy services to areas where pharmacists aren't available.

Jeffrey Bahr, M.D.

{ buy-in }

MODERATOR: Could you say more about the reluctance and what's driving it?

FLAKS: I think utilization is a concern. We're looking at this from a total cost of care perspective. Our pilot projects have shown that use of telemedicine can increase affordability and improve access to care. Payers are trying to understand how they would manage utilization. There's just a clear reluctance at this early stage.

SOLAZZO: We're also getting the same pushback, not only on the payer side, but on the regulatory side.

SANBORN: When we look at the economic side of the B2B piece, the support that it provides our inpatients has added value. The real challenge has been in commercialization. The economics of that are not well-fleshed out. But it does makes sense. We'll be able to care for patients in the appropriate setting — rather than having them come in at a higher cost of care.

SOLAZZO: To be honest, we don't really know where the B2C component is going. The market, and consumers, will drive that.

JAY BHATT, D.O. (American Hospital Association): Another implication concerns what impact telemedicine has depending on the scope of illness. If the illness is advanced, how do you think about it within the context of the care team? How does the team use it? That has implications for costs.

SANBORN: It has to become integrated, right? It can't just stand in isolation. Without good integration of what's happening on the digital platform and during face-to-face interactions and their overall arc of care, then it's just an incremental cost and not a value-added service.

BAHR: That speaks to the nature of the reluctance, though. Early going, there have been

many suboptimal iterations of telemedicine, especially in the B2C realm. It wasn't integrated. It has to be part of the integrated system to include the full continuum of care. The biggest reluctance that I see among providers is that it may be used as a surrogate for the clinician-patient relationship, rather than an enabler of the clinician-patient relationship. That's what we saw in some of the earlier iterations. The technology became a surrogate for that relationship, rather than the enabler.

HAMMAD SHAH (Specialists on Call): From my perspective, it seems that the industry was dominated by hardware-software players when it started. Great products, but hardware-software only solved part of the problem. Then, on the other side of it were basically staffing companies. If you don't have X type of clinician, we've got it for you. The evolution the industry is going through now is really focusing on workflow integration and analytics. Analytics is a key driving force. If you can truly measure the effectiveness of what you're doing, and compare that to your standard model, then you'll get an idea of the true impact. There's an opportunity for cost reduction, but there's also a revenue opportunity which involves the ability to effectively pull patients into your system and generate additional revenue. There's a rapid evolution underway.

Our pilot projects have shown that use of telemedicine can increase affordability and improve access to care.

Jeffrey Flaks

SANBORN: I agree that we can use the digital platform as an entryway into the organization, much like we use urgent care. But there's a generation that is going to expect telemedicine to be as easy as using their phones. If we're not positioning ourselves to meet that demand, someone will. That is the push. There's a whole generation that's going to want to minimize those face-to-face interactions and get as much of their care as possible in a convenient way.

FLAKS: That's consumerism. This generation wants everything on demand. What we're all attempting to do is to make it a part of our own health care ecosystem. Our integrated health records become part of this process. It's not simply an episodic relationship; it's part of the collective nature of how we care for individuals. That's where the value is because otherwise, as you can imagine, it could be counter to good health management if used improperly.

YOUNG: Virtual care opens up new opportunities to interact with patients by enabling care for almost everything except trauma. We can use this as a way to better triage, better manage, better connect. At the end of the day, we can use telemedicine to increase access and engage them early. It's a more affordable approach. People are starting to shop, especially those in a high-deductible plan. If it's a difference between a $200 in-person visit and a $49.99 virtual visit, it will have significant appeal. As Jay mentioned, there's uncertainty as to how it will play for more advanced illness. Will it work with really complex, chronic cases? Not immediately but, over time, I think it will.

SANBORN: One challenge is the availability and quality of the provider base that's going to lead this. Not every provider translates well to a digital platform. It's a different way to practice. That's a big challenge, particularly when we start to scale, because it's a resource-intensive process.

MODERATOR: Are others here seeing reluctance among providers or patient groups?

BAHR: It's all about meeting our patients where they are. Not every community, and not every payer milieu, is favorable toward advancing in this realm. We used to assume that millennials were going to jump into this but, actually, it's our patients in their 50s and 60s who are jumping in headlong. You can assume that people with dementia or complex health issues may not be willful participants in telemedicine, but their caregivers certainly are. Imagine virtual rounding on hospitalized patients so that family members are aware of what's happening. At the core of it, it's still a relationship between the care provider and the care recipient. While this started as a way to provide care to reach patients in rural areas, that's not the case anymore.

SOLAZZO: We conducted a national clinical trial on schizophrenia and found that the engagement was much higher through a telemedicine component. It surprised us. We're going to continue to have these "aha" moments as we continue down this path of engaging different populations. Each marketplace is different, and there are submarkets. What I can do in Manhattan, I can't do out on Long Island. The engagement would be different even in those two submarkets.

There's an opportunity for cost reduction, but there's also a revenue opportunity which involves the ability to effectively pull patients into your systems and generate additional revenue.

Hammad Shah

Virtual care opens up new opportunities to enable care for almost everything except trauma.

Chris Young

FLAKS: You have to change your practice for sure. We have a renowned headache specialist who's embraced telemedicine. Forty percent of his practice is from outside of the Northeast. For him, he sees telehealth as a very important tool to manage his patient population because he couldn't connect with people internationally as effectively as he can with telehealth. He's willing to significantly adjust the way he operates to embed this in his practice. Basically, some people will be innovative, earlier adapters and others will be more resistant to change.

MARVIN O'QUINN (Dignity Health): So how does he deal with the malpractice risk for this type of arrangement?

FLAKS: He is basically private pay. For telehealth, we use a shared platform through a service provider. A lot of the infrastructure we use is not unique to us, but we're leveraging the platform's capabilities.

BHATT: One consideration is training. How many hospitals and health systems have held

focused training around telemedicine to help clinicians use it more effectively?

SHAH: That's a key point, Jay. There are a couple of ways to make sure that you get that acceptance. First, you have analytics to reinforce value and drive behavior. Second, you have to make it easy for the provider. Many of the providers with whom I've spoken have to deal with so much complexity just to be able to see the patient they want to see. They want it made easier.

SANBORN: It's an evolving process. During beta testing, we took those that were most engaged with the concept, helped them to understand the technology behind it and how to create schedules around it. As scale increases, education is becoming more formalized. There's an increasing number of providers and specialties that are coming into the network, and we are looking at how we onboard them. Also, we are looking at how we translate that to available services. How do we sell that to the customer? It is a learning curve, but the rate and speed at which it's happening in terms of the demand is pretty incredible.

SOLAZZO: The number of people providing this service is still relatively small. The distribution is wide, but the push is contained. When we started in our emergency departments, telepsych and telestroke, etc., all worked on different platforms. We had to make it easier for our end users. It's a quality issue if the nurse is running around the ED to find the right cart to open up telestroke. From a clinical perspective, we have to standardize and make certain it's a safe environment. It's important to have clinical champions. If you don't have clinical champions, it's not going to work.

How many hospitals and health systems have held focused training around telemedicine to help clinicians use it more effectively?

Jay Bhatt, D.O.

If you don't have clinical champions, it's not going to work.

Mark Solazzo

BAHR: The pace of play can be more robust if we remove the patient from the equation. If it's simply a tool that we're using internally among clinicians, the pace of play is more rapid. As soon as we bring consumerism into it, the pace of play slows down a little bit. We have to wait for consumers to catch up.

BEN KLEMZ (Citi): Has any thought been given to forming a group that does just telemedicine because that's how they want to practice and they are good at it?

SOLAZZO: That's been our approach. We've sought those people who want to do it. They become the champions. We're not touching 15,000 physicians, we're touching about several dozen.

BAHR: In the future, as we onboard new physicians, I would like to set an expectation that telemedicine become part of their practice. I can imagine a time when there will be a hybrid schedule, where physicians come into the clinic

and see patients in the office and then later dedicate time to see patients telephonically. That's a very real schedule in the future. Right now, we have volunteers, which is important because we want people who are already engaged in the process doing it. Eventually, others will see what they are doing and will want to try it out.

SANBORN: Those who are most engaged are most likely to help perfect the product. They won't get frustrated; they'll work with you until they perfect the process. I agree that we'll move to a hybrid workflow. We'll have to have a willing and engaged workforce around that.

YOUNG: I've been pleasantly surprised with the people who are willing to adopt this. Most recognize that this can be a better way to provide care faster and more efficiently. We all have stories about telestroke and the impact that it has had. It's saving lives. It's improving quality of life. If you think about what happens when people go untreated, it impacts population health. Their care will be costlier and their quality of life will not be as good. When you focus on access to care and quality of care it creates a comprehensive win.

O'QUINN: It works on multiple fronts. It can expand access to your patient population, and serve as a way to control costs. I don't see insurance companies paying for this in the short run, but likely in the future. It's a valuable capability to have.

Has any thought been given to forming a group that does just telemedicine because that's how they want to practice and they are good at it?

Ben Klemz

It works on multiple fronts. It can expand access to your patient population, and serve as a way to control costs.

Marvin O'Quinn

SOLAZZO: The economic model really depends on the market demographics, too. For us, about 7 percent of our revenue is in value-based contracts, so we have to look at it a different way to make it work for us. But we do see it as a way to reduce expenses in many areas of our health system with regard to reducing on-call coverage or enhancing efficiencies. For telepsych, for example, we have the benefit of additional resources, including access to a psychiatric social worker and an administrative assistant to support patients. Those services would not be available in the ED. We're looking for components in this kind of economic model to be able to reduce expenditures.

FLAKS: This has the potential to be a massive disruptor. When you think about the traditional access points where the vast majority of people in our communities receive care, the geographic limitations keep people within their existing ecosystem. Through telemedicine, however, people can get second opinions and have access to national brands. When that starts to happen, it will redefine who we think of as our competitors today. It's something we need to pay close attention to. Some systems will be better situated to be more aggressive in that model and expand their capabilities, while some could then find

themselves in a more defensive position.

BAHR: It's a wonderfully disruptive innovator, but it may also disrupt the integration of care as well. I think a telehealth program is a strength, but any strength taken too far to the extreme becomes a weakness. Unfortunately, the person who pays for that is the person seeking the care. We have these wonderful tools at our disposal to reach our patients in new ways, but there's some responsibility that comes with that.

YOUNG: Telemedicine does expand the patient base. In the past, the catchment area may have been a 50-mile radius around the facility. Now it's statewide and, in some instances, it crosses statelines. In the U.S., few providers have figured out how to take this internationally. What if we became really good as a nation at taking care of people virtually? We could project that to the rest of the world. This could be something that, rather than being one of the biggest costs for our society, could become one of the biggest revenue generators.

SOLAZZO: There's both threat and opportunity here. From a provider perspective, if we don't aggressively figure out how to use this technology, we will become third-party players. Then, once again, we just become a commodity for that dot-com company. The opportunity lies in getting ahead of this technology and understanding our clinical model and when to integrate care, reduce costs and create new revenue streams.

We need to think about how telemedicine creates better connection, not just disruption.

Peggy Sanborn

I believe it's going to come like an avalanche. We're absolutely at an advantage point right now.

Marc Harrison, M.D.

BAHR: It goes back to a point made earlier that if this technology is offered as a surrogate for the clinician-patient relationship, it fails. We've seen this time and again. When it's an enabler of the clinician-patient relationship, that's where it's most powerful and most meaningful. If we maintain that focus of enabling relationships, and looking at the patient over the care continuum, that's where we really provide better care and not just bang the bottom line.

SANBORN: It has to be connected. Any new disruptive technology can become problematic from both the consumer and clinician perspectives because it's opportunistic. There's a demand, but it's not connected to a system of care. We have to connect the dots and have it be fully integrated. We need to think about how telemedicine creates better connection, not just disruption.

MARC HARRISON, M.D. (Intermountain Healthcare): Telemedicine is about keeping people in the least restrictive, least expensive environment possible, even when it's bad for the bottom line.

We're obviating transfers of critically ill kids, we're obviating neonatal transports and NICU [neonatal intensive care unit] admissions. We're obviating the transfer of patients who've

had simple strokes, who can be cared for in their home hospitals. Each of the scenarios actually affects our revenue to a small extent, but we're doing a lot of good for the community in keeping patients close to home. In the long run, I believe this will bear fruit economically as well. Doing the right thing for patients is always a good business decision. It generates goodwill, particularly among our unaligned hospitals. Instead of swooping in and taking patients away, we're telling them they are competent enough to care for those patients. We're also benefiting from enhancing access to specialists. We have a huge catchment area with a relatively small population and it's hard to recruit enough subspecialists to provide adequate care across the entire system unless we provide it virtually. We're actually doing teleoncology now. Following an initial visit with the oncologist, patients receive their infusions at their local hospitals. They see the oncologist every time, but the visit is over a screen.

{ strategy }

MODERATOR: **How do you frame this for your investors because these are capital-intensive endeavors? What is the strategy that's driving this both from an investment perspective, as well as from the care coordination perspective?**

YOUNG: The issue of access to specialists will continue to be an ongoing challenge. Being able to spread them over a larger geographic area is essential. The question is how well we can interconnect everything to make the workflow as seamless as possible. That's going to be the driver. How do we load-balance resources?

SOLAZZO: There's definitely a value proposition here that we can demonstrate. Take the eICU, for example. We can demonstrate improved quality, even when we have full intensive care services on-site. The eICU is reducing mortality, morbidity and readmissions.

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FLAKS: It's an issue not to be looked at discretely. If you were to evaluate this discretely, you might draw one conclusion. But if you evaluate it in the context of the organization's strategy to enhance access to care, it becomes essential. That's the way this has to evolve. How can the health care delivery systems change to use telemedicine to deliver care more effectively? At Hartford HealthCare, our vision is to be the most trusted source for personalized, coordinated care. You can imagine how this technology allows us to deliver on that promise more effectively. But if you were evaluating discretely, you might say it doesn't have the level of return today that would need to stand up on its own.

YOUNG: What I'm most optimistic about is that when I hear providers talked about it, the first focus is always quality. That's what we care about and it drives everything else. That will help gain traction. It's just a question of time and letting the technology evolve and the people evolve into it.

HARRISON: I believe it's going to come like an avalanche. We're absolutely at an inflection point right now. In our market, about 90 percent of patients with high-deductible plans never make it through their deductible over the course of the year. As a result, they're acting like true consumers. We have a health plan, too, and we price things to be really thoughtful so that telehealth is less expensive than primary care, which is less expensive than urgent care, which is less expensive than ED care.

People are voting with their wallets. For people who are barely making it, they want to be seen by a clinician for $40 in time for them to make it to their shift at the plant. This is coming really fast, whether we like it or not. Anecdotally, I'm hearing people say, "I've just had my first telehealth appointment. I am never going to a waiting room ever again." It's not a choice, it's a must-do.

KLEMZ: The younger generation will expect this. They will expect this to be the norm. If you aren't doing it, it's a negative.

BHATT: When will this evolve to telehome care where people from around the world can order services on demand in their home?

HARRISON: We're actually wiring some apartments right now in one of our markets to support medically fragile older people. It will monitor these patients and reduce unnecessary hospital stays. We're also placing kiosks in homeless shelters. Some of our shelters have two to three ambulance runs a day. Having an on-site person helping the homeless use the kiosk should be good for everyone.

SOLAZZO: The challenge is that payers most likely will lag. Because of the utilization issue, they will lag. But this is something the consumer will demand. They are going to want the ease of access, the quality of care and the convenience. ●

KEY FINDINGS

1 Integration is paramount to the success of telemedicine. True integration with patients' health records and coordination across the care continuum will enhance patient satisfaction, quality of care and outcomes.

2 Identify champions to test and improve your telemedicine offerings and share their results with their peers. Getting clinicians comfortable with providing telemedicine will also be a success factor.

3 Consumer demand for telemedicine services will continue to grow. Hospitals and health systems should consider developing multiple access points for telemedicine services to be out in front of consumer expectations.

4 Telemedicine is integral to population health management, enabling organizations to provide the right care in the right setting at the right cost.

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