

Reconfiguration of Healthcare for Bottom Line Results

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Abstract: This discussion about factors that are influencing progress in telehealth and the U.S. healthcare system was recorded on March 16, 2017, during the TMT-sponsored 1st Annual Conference: Profitable, Scalable & Sustainable Tactics Transforming Long-term Care in Telehealth and Medicine.

Telehealth vs. Telemedicine

David Gruber

What is the difference between telehealth and telemedicine, if any?

Joel Reich [00:00]

The place to start is with definitions; and I think, as anybody here who's in the field knows, they're all over the place.

I prefer to think of telemedicine as direct provider of any sort to patient care, and telehealth is everything else. But if you start to look at the CMS (Centers for Medicare and Medicaid Services) definitions that they suggest, then you look at the state—the website that has all the state definitions—they start to deviate. Much of the deviation is about what they don't want to pay for. They'll specifically go through all this, and they say it doesn't include telephone or fax. In fact, the good old telephone may be very effective device.

I think the other flaw or the other issue is that as we move into more integrated technology and people systems, so what if you're using a virtual or using computer intelligence on the other end of the line, does that make it telemedicine, or does it have to be a live person that's doing interactions?

I think that for definitions, you might as well throw them out; but be very careful when you're dealing with new programs—either funding (contracting) with private payers, that you're specifying what that technology and what the people program will be, not so much trusting the term “telehealth” or “telemedicine.”

Joe, would you add anything to that?

Joseph P. McMEnamin [01:14]

I would agree, although I have perhaps a bit more optimistic outlook regarding the probability that we will see better support for telemedicine going forward.

Growing Market Acceptance of Telehealth

David Gruber [01:26]

Joe, has the telehealth market, broadly defined, reached an inflection point in terms of market acceptance? I was around in the 1990's and 2000's when telehealth really first began—lots of promise, big expectations. Tell me a little bit of what happened in the intervening 25 years? Have we met expectations? If not, why not? And, are we now reaching an inflection point with the advent of changes in the marketplace?

Joseph P. McMEnamin [01:52]

Well, I think inflection point implies a certain binary on-off analysis that I would be hesitant to embrace.

Now, Teledoc[®], which has been very successful in attracting investment dollars, as well as patients in the form of employees, does in fact, label this most recent year as an inflection point in the sense that, as I understand it, they went from a million visits over something like 14 years to two million within another year or 14 months. And that's certainly a pretty remarkable change. On the other hand, I'm not persuaded that we have an on-off switch so much as we have a continuum.

The problems that have impeded progress and growth in the field are still there. I indicated earlier, I'm a little more optimistic perhaps than some with respect to reimbursement because I'm hoping that existing legislation is not going to be the be-all and end-all of that issue. Trending in Congress presently are a number of pieces of legislation intended to encourage growth in telemedicine, in fact, and to support it more richly than has been the case in the past. To persuade the CBO (Congressional Budget Office) to score telemedicine bills more favorably, an effort is underway now to assemble the literature to demonstrate that telemedicine is no worse than budget-neutral, and that because encounters are comparatively inexpensive, it may well be budget-positive.

We still have all the legal issues that we've always had.

Privacy, I think, is going to be more complicated in the future rather than less because big data are becoming such a big deal. And with the Internet-of-Things, and robots, and remote patient monitoring, the amount of data being generated is going to grow dramatically—not all of which is subject to HIPPA (Health Insurance Portability and Accountability Act of 1996), whose applicability is limited.

I suspect that the FTC (Federal Trade Commission) will play a larger role in the privacy arena than it has to date. I also suspect there will be fights over ownership of data, which will grow more valuable as they grow more abundant.

There's a lot going on in the States, and I think we're seeing diminishing geographic restrictions in a lot of the states. We've got parity now in something like 31 states. There's been significant emphasis on home telehealth and telemedicine in Colorado, Connecticut, Kansas, New York, Washington, and a few others; and that's encouraging.

I think that, for me at least, there'll be some very interesting developments quite possible in professional liability. Emergencies are hard to deal with in a home setting, I suspect people will try to do that even if it's not appropriate. I suspect there will be

claims from a failure to respond, or at least respond timely, to signals from remote sensing devices. And there will be some interesting product liability possibilities because interoperability remains such a big problem, and, of course, perpetually. licensure.

All those things are there. All of them have been addressed to one extent or another. They still afflict us, but I don't think they will retard us, at least, indefinitely.

Effect of Emerging Technologies in Telehealth

David Gruber:

Has telehealth been proven as a cost-effective technology?

Joel Reich [04:40]

We've seen that technology works. A lot of the studies out there have had small numbers of patients, maybe not long enough, but they've shown it works. You can help people safely stay at home.

The other realm though is the direct provider-to-consumer, which of course I'm sure everywhere you are from around the country affects the major insurers. The major employers want them to have set up \$49 call-in for your teleconsult. But that's raising a lot of issues and a lot of questions. It goes right against all the efforts to capture all of your clinical data in one place because now you are collecting in a totally different system. You're also now interspersing different physicians to take care of primary care.

Last week in a health affairs publication, they looked at patients who had upper respiratory infections, who called the \$49 telehealth line, and actually had an increase in healthcare spending, probably because they added discretionary visits and didn't actually replace something. So, again, that's not the be-all answer. They didn't look at preventing people from getting sick or being more expensive. But I think we're going to see a turn, and it's beginning to happen, and that is to take the proven technology platforms but use local primary care physicians within the same network in the same

area so the data are captured locally, and the care is much more integrated into the local system. Not like going to something totally outside the system.

I believe that has to happen if we're going to be consistent with everything else we are trying to do, which is as much as you can, connect the data. And I don't think we'll get to full interoperability ever because it goes against a lot of the marketing interests of health systems. But I think that in this area we are going to see much more of we will help you set up the technology platform for your group of local regional physicians and perhaps use the distance consultation by specialists that are not available in your system. That is still a big plus.

Provider and Caregiver Perspectives

David Gruber [06:53]

Joe, from the provider's perspective, is the primary challenge looking at the continuity of care or integration of care? Are providers beginning to think about the total cost of care, for ambulatory care-sensitive conditions, such as COPD (chronic obstructive pulmonary disease) and heart failure., And lastly, how will payment reform affect future acceptance of telehealth?.

Joseph P. McMenamin [07:14]

Continuity of care has been a problem from the get-go and remains one, particularly where we're talking about home telehealth. Too often, the record generated by the encounter, assuming there is one, does not find its way into the record of the primary care doctor. And that has significance clinically, of course, because the primary care doc will not know what has happened the night before or the week before, necessarily.

And of course, it also has legal implications from a liability perspective because of the inability of the primary care person to know what has occurred at the hands of someone else. That could have an impact, and perhaps a negative one, on management decisions. And until we lick that, that's going to be a significant barrier, as it has been to date.

We are looking certainly at total cost. I've been encouraged, and you know I have to emphasize I'm now 30 years removed from clinical medicine. So, take what I say with a grain of salt. At least according to the literature I've come across, in several areas there's pretty good data now, even though admittedly the studies are small and some of them have not been well designed; but still pretty good data for not only effectiveness but cost efficacy, particularly in such areas as heart failure and management of high blood pressure, and diabetes—especially Type 2 as opposed to Type 1—and diabetes education. And when you think about how much of the U.S. healthcare dollar is devoted to just those conditions, the potential for savings, for me at least, is hard to overlook, and hard to exaggerate.

I think the evidence for COPD, for example, is a little less robust and less well established, but there have been some helpful recent papers that suggest maybe that's changing.

I've been impressed too by the value in the home telehealth setting of the availability of a service for the benefit of caregivers as opposed to the patients themselves. I think it was Michael Mann who referred to the sandwich generation. Distance care may help folks who are dealing with parents who have had strokes, or suffer from dementia, or are requiring palliative care. There are pretty good data suggesting that the caregivers benefit from the availability of telehealth and distance care technologies. I think that that is hard to quantify: it's hard to put a dollar value on it. But it's also hard to overlook the importance that such support provides to people who frankly could otherwise be overwhelmed.

Return on Investment

David Gruber

How should we think about home telehealth ROI (return on investment)? The utilization has been less than expected given the potential benefits

Joel Reich [09:48]

So, if I can add to that, and I look at this, and I didn't coin the term but it's perfect here, and that is the “wrong pocket syndrome.” And right now, if you try to do the return on investment, for many of these programs that Joe is just describing you have to look at who is paying for the equipment rental, and it's often the home health agency, families paying for it, could be the health system; but then where does a return come. And that's where the ROI gets very tricky. The return may come to the state Medicaid program may come to CMS (Centers for Medicare & Medicaid Services), or the ACO (Accountable Care Organization) that has a shared savings contract with the feds.

So, the problem is if you look at it, and we say we will we put one hundred high risk patients out there with heart failure and spend anywhere from \$80 to \$150 a month, if you look at the device costs or the whole system cost, somewhere around less than \$2000 a year you can reduce admissions 30%, 40%, 50% if it's part of a care management program with proper home care, proper coaching—the live person part of this. But who accrues the 50% savings?

The health system says we've lost all these admissions. Now, we're in trouble, so why should we support it? And right now, that's absolutely true, and it's what creates a huge ethical dilemma. If you lose one hundred million dollars in a very successful program, how you provide care for people that don't have means in our current system? Yet, if you look at it from the perspective of did we save money for the system you can easily knock off readmissions. Readmissions for heart failure average somewhere between thirteen and fifteen thousand dollars, and the patients are often on a continuing decline. So, it's probably more expensive than that.

So, it's all about where does our system moving from here? How many years do we fight for direct reimbursement, for the \$80 to \$150 a month for the unit in the services? When do the dollars become part of the same financial system under some kind of risk-sharing, so that we get the money into the same pocket or right pocket?

Aligning Interests in Healthcare

David Gruber [11:47]

It appears, at least my perspective, there's lots of good technologies, people, and data out there, so is the enemy us? "Who's the customers?" Is it the patient, caregiver, provider, payer, healthcare system, or all the above? And, how do we get an alignment of interests?

Joel Reich [12:15]

I'd say right now it's the oldest daughter who is usually responsible for caring for the aging parents; but that will shift in the future to either the insurance company or the feds or state that are bearing the largest cost of care. And depending on how much under our new reform laws, how much of the financial burden is shifted back to the patients and families.

David Gruber [12:37]

You think it's going to be a retail model?

Joel Reich [12:40]

I know it's going to be a model that is ultimately sold to whatever the local integrated network is that you financially belong to. Not selling as much to the patient and family, although they have to buy in to make it work.

David Gruber [12:51]

Fair enough. A data point for you; 55% of the determinants of premature death are not related to what the doctor does. It's related to patient behaviors, inclusive of lifestyle and psychosocial factors. and then if you look at that, It's cost effective to engage the family because it's about self-management. If a patient and their caregiver is more aware of what's potentially coming down the pike, engagement is more likely.

Joe your thoughts please.

Joseph P. McMEnamin [13:18]

I think I'd have to go with the all the above answer at least for the present time. Everybody you mentioned, David, has a voice in it, and everybody has an interest. The patients themselves, obviously, the caregivers, the providers, the insurers; everybody is involved.

At the risk of seeming a little too pessimistic, I don't think the current system is sustainable. And I think that this situation will not remain as it is indefinitely for the simple reason that we can't afford it. And I suspect that eventually we will either abandon what we have and go back to something far different from what we have today—and the kind of care that existed when I was a kid before Medicare was even invented, which I think is pretty unlikely—or eventually we will move in the direction of some single payer system just because we can't continue to do what we're doing. That's not my preference personally, but that's my prediction. I hope I'm wrong.



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