COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES
An affiliate of the AMGA Foundation

A Roadmap to Telehealth Adoption: From Vision to Business Model

INTRODUCTION

Telehealth has become ubiquitous in the last several years,[1] igniting the imaginations of patients and providers alike. At its most basic, telehealth is the "remote delivery of health care services and clinical information using telecommunications technology."[2] In other industries, the use of telecommunications technology is routine; one can hardly imagine any more a world in which banking, airline reservations, business meetings, shopping, even registering children for school, must be done in-person. But health care is different. Deeply ingrained in our psyches is the notion of the physician as one who literally lays hands on the patient – and that notion is hard-wired into the health care delivery system through tradition, culture, and payment. However, that notion is out of sync with modern clinical science and technology. Sometimes there *is* no substitute for the laying on of hands, but in many cases, the physician's primary job is to manage and guide patients through vast amounts of information; he or she must listen, measure, balance, consult, teach, and weigh risks and rewards – all tasks that can be accomplished and enhanced with the help of telecommunications tools.

The physicians of the **Council of Accountable Physician Practices (CAPP)** believe that telehealth tools have the potential to transform health care delivery. We strongly support the use of these tools to improve access, quality, and efficiency. Achieving such lofty goals, however, is not a given. We are at a pivotal time in the diffusion of telehealth technology, which must be *transitioned from a vision to a business model* – a significant challenge, given entrenched cultural, regulatory, and payment barriers. In the spirit of easing that transition, the CAPP physicians offer stakeholders our thoughts about the most six most critical issues they must consider as providers, consumers, and regulators of telehealth tools.

WHAT IS TELEHEALTH?

Telehealth technologies can be divided into three broad categories:

1) **Audio, visual, or web-based technologies** that facilitate two-way, real-time communication between patients and providers or among providers (e.g., telephone and video visits and consults)

2) **Remote monitoring** that allows providers to "observe" patients, using telecommunication technology (e.g., off-site clinicians using a roving, remote-controlled video camera to monitor patients in an intensive care unit)

3) **Asynchronous "store-and-forward" technology** that transmits information from patients to providers or among providers without requiring simultaneous engagement (e.g., patient email or transmission of blood pressure data from a wearable device; a physician transmitting an EKG to another physician for review and diagnosis)[3]

Another way to categorize these tools is based on whether they link patients to clinicians, clinicians to other clinicians, or both.[4] In all cases, the goal is to remove time- and distance-related barriers to care. CAPP member groups and systems use all of these types of telehealth within our practices.

SIX CRITICAL TELEHEALTH CONCEPTS FOR STAKEHOLDER CONSIDERATION

The health care delivery system is still in the early stages of telehealth diffusion. Stakeholders' decisions and actions in each of these areas will determine whether telehealth transforms care delivery, or simply "electrifies" old and inefficient ways of doing business.

1. Telehealth must integrate, not fragment, care

Telehealth tools can be categorized based on whether they are an integral part of a given clinical practice or "layered on top" as a freestanding service. In some cases, CAPP groups and systems have developed (or purchased) their own telehealth capabilities, which enable expanded access to their own providers or to providers with whom they have contracted. Use of such tools may be a covered benefit for insured patients or may be sold "a la carte" to patients whose insurance does not cover it. In other cases, the patients of CAPP member groups may be offered (by their employers or insurers) access to freestanding telehealth vendors that are unrelated to the practice from which they receive routine care. These freestanding vendors typically provide only urgent care but may also engage in primary or behavioral health care. These two models are not equally beneficial for patients; the former integrates care, while the latter fragments it.

We believe telehealth tools are most effective when they are used in the context of an already-established relationship between a patient and an accountable health care delivery system. Like in-person visits, telehealth encounters *with a patient's own provider or system* are simply another means of delivering integrated, comprehensive care – another touchpoint for patients to connect with their medical "home."

We are concerned by the proliferation of third-party, national telehealth companies that many employers offer as a freestanding benefit to their employees. In many cases, such third-party telehealth vendors do not have access to patients' medical and pharmaceutical records, are unable to consult with patients' regular physicians, and may be unfamiliar with local resources (a serious problem if the remote clinicians are advising patients about whether and where to seek in-person care). Further, it is rare for third-party telehealth providers to share information about patient encounters with patients' regular physicians, making follow-up and coordination impossible. Quality is frequently sub-optimal when there is such a disconnect between telehealth providers and patients' established providers. For example, without accountability to a patient's regular providers or an ongoing relationship with the patient, we have found that contracted third-party providers are often biased towards patient-pleasing quick fixes, such as antibiotic or steroid prescriptions for conditions that don't require such medications.

When payers offer employees or plan members improperly-incentivized telehealth access from third-party companies, they disrupt the relationship between those members and their regular source of care. Such a move is contrary to the push for "value-based payment" – a model we strongly support[5] – under which payers hold providers financially responsible for meeting a variety of cost and quality targets for groups of patients. It is understandable that employers want to recruit and retain talented employees by offering them 24/7 access to telehealth services. However, a more effective strategy to achieve that same end would be to support employees' own physicians and groups – primarily through plan design and payment policy – in developing or deploying their own telehealth capabilities (as described in item #3 below).

2. Telehealth improves quality, access, and convenience; cost-savings are not paramount.

While critics and supporters of telehealth alike may call attention to its cost-saving (or some may say "cost cutting") potential, short-term savings for payers are not the most salient feature of these tools. In fact, in the experience of most CAPP member health systems, telehealth visits (via phone or video) do not replace but rather augment in-person use of care. We would expect any cost savings to payers to accrue primarily in the longer run, as telehealth tools expand access to preventive care and disease management, eliminating the need for more costly interventions down the road. From the perspective of an employer or insurer that will likely no longer be responsible for a given patient by the time such savings materialize, this cost-saving aspect of telehealth is not compelling. Much more compelling is the notion that telehealth tools can improve access and quality while making care more convenient for patients.

Telephone and video visits, as well as asynchronous messaging between providers and patients, can be used safely to provide care to many patients. Not only do these tools improve access to care for patients who use them, but they also free up in-person visits for patients whose conditions require them (or who simply prefer them). Because information and advice are readily available, telehealth-supported visits may also help reduce unnecessary emergency room or urgent visits, which not only improves access in those settings but may also improve quality. Telehealth tools can also be used during in-person visits to improve access to follow-up or specialist care. Consider the instance in which a primary care provider and patient together consult via phone or video with a specialist in real-time, during the primary care visit. Such arrangements give the patient immediate access to the specialist with zero wait time, and virtually eliminate the possibility that the patient will not follow through (for any number of reasons) with a recommended specialist visit. In such situations, access and quality are improved.

Telehealth tools can also vastly improve quality of care by getting the right care to the patient in the right setting, quickly. This is particularly true of tools that link clinicians to one another. For example, under telestroke programs, used by many of the CAPP groups, emergency room physicians in hospitals without in-house stroke neurology units can connect with a remote neurologist, often before the suspected stroke patient arrives via ambulance to the emergency department.[6] The remote neurologist can access diagnostic images and begin the patient's assessment immediately, which is particularly critical in stroke care, where treatment is more effective the sooner it begins and seconds matter. At Kaiser Permanente, the use of a life-saving tissue plasminogen activator (tPA) treatment for patients with acute ischemic stroke increased by 73 percent following the implementation of a telestroke program.[7] Similar quality gains may be expected through the use of telehealth tools to support clinicians in other settings where a specialist cannot be physically present at all times – such as eICU programs, e-psychiatry consults in emergency departments, and remote clinician services provided to patients in skilled nursing facilities.

Finally, while the jury is still out on telehealth's long-term cost-savings for payers and health systems, it can clearly be cost-saving for patients, in terms of the opportunity costs of missing school and work, and the associated stress and hassle. While it is easy to understand that distance and time are barriers to care in rural areas, the same is often true in urban areas as well, where public transportation challenges and congestion can make getting to the doctor inordinately time-consuming. In short, it is not just rural people who are inconvenienced by going to the doctor. To

the extent that the use of telehealth reduces that inconvenience and causes patients to seek care sooner or more regularly and adhere to prescribed therapies, quality and access are also improved.

3. Fee-for-service payment policies are often the primary barrier to optimal, widespread use of telehealth technology.

As noted previously, telehealth technology can be used most effectively, efficiently, and safely in an existing, coordinated care environment where the patient is known. As payers increasingly demand better value in health care, it makes little sense for them to support freestanding, third-party telehealth vendors whose physicians are not engaged with patients' regular providers. Instead, payers must use their resources to incentivize accountable medical groups and health systems to develop and deploy these tools. They can do this by liberalizing the rules under which they reimburse for telehealth using fee-for-service (FFS) arrangements, and by expanding the use of capitation, bundling, and other risk-sharing arrangements.

Many of the CAPP groups receive at least some reimbursement via capitation or other risk-bearing models. Under such arrangements, providers are in fact incentivized to implement telehealth technologies – and other innovations that enhance value. However, for many provider groups and systems, particularly smaller ones, capitated patients do not make up a large enough proportion of the patient population to allow for investment in these expensive capabilities. For these groups, and for the majority of physicians in the U.S., FFS payment still rules the day, and FFS policies regarding telehealth are far too restrictive to result in the optimal and widespread use of these tools across the delivery system.

Many FFS payers follow the lead of Medicare in establishing telehealth payment rules. Perhaps the most problematic aspect of Medicare's rules is that payment is restricted to services when the originating site (where the patient is located) is outside of a metropolitan statistical area or within a designated rural health professional shortage area.[8] There are significant access, quality, and convenience benefits to telehealth that should also be available to people in urban areas. Medicare also requires that the originating site must be one of several types of clinical settings and cannot be the patient's home. Finally, the only types of providers that can receive payment for providing care via telehealth are physicians, advanced practice nurses, physician assistants, clinical psychologists, clinical social workers, and registered dietitians. Many other types of providers – including pharmacists, speech and language pathologists, and occupational therapists – could also deliver care effectively via telehealth but cannot be reimbursed under Medicare for doing so. To its credit, Medicare has recently signaled its intent to loosen some of the telehealth payment restrictions in rural areas[9] and to ease some provider billing challenges,[10] but it is not yet clear what impact the changes will have.

In addition to being restrictive, FFS payments for telehealth are often inadequate to cover providers' costs of delivering the service. Many payers pay less for telehealth care than for the same care delivered in-person, assuming that providers' costs are lower for the former. This may be the case when telehealth care is delivered by a third-party vendor operating a phone bank of doctors, but it is not necessarily the case when care is delivered by providers who are an integral part of a bricks-and-mortar practice. Many states have telehealth coverage parity laws, which require insurers to cover telehealth in the same way that they cover in-person visits, but such rules rarely require parity of payment.[11]

When used appropriately, telehealth services are equally valuable as in–person services, and FFS payments must reflect that value. The perception that telehealth is of lower value than face-to-face care can also impact other policies that ultimately affect payment. For example, under Medicare Advantage (where the restrictive Medicare FFS payment rules do not apply), diagnoses made during telehealth encounters cannot be used for calculating risk adjustment payments. Medicare also does not include telehealth encounters in its patient satisfaction surveys – again, potentially discounting its value and under-incentivizing providers to use it.

4. Lack of uniformity in public and private regulatory structures also challenges the widespread use of telehealth.

Even in a supportive payment environment, widespread deployment of telehealth can be stymied by conflicting and sometimes outdated regulatory structures. A myriad of public and private entities have a hand in determining which providers are allowed to give care to which patients in what locations. For example, to protect patient safety and ensure inpatient quality, state regulators, insurers, and accrediting organizations dictate procedures for hospital credentialing and privileging of physicians. Such procedures must be updated to streamline privileging processes for remote physicians – particularly in the rarer specialties – caring for patients who may be scattered across dozens of different hospitals. It is simply not feasible (nor cost efficient) for a single physician to undergo credentialing and privileging in dozens of locations. While accreditors and most payers do permit or recognize some reciprocal credentialing among certain sites of care, each has its own set of restrictions on such practices. This lack of standardization among payers places a high administrative burden on providers.

Lack of reciprocity in state medical licensing is also problematic for telehealth implementation when a provider system spans multiple states, or when patients travel frequently outside of their "home" states – for example, in the case of "snowbirds" leaving the Midwestern and Northeastern states for the winter to live in Florida and other, warmer states. Currently, a telehealth provider must be licensed in the state in which the patient is located. Some states have established reciprocal licensing agreements, but many have not.[12] State licensing boards must work together to overcome this challenge to telehealth, either by expanding reciprocity to all fifty states, or by establishing limited reciprocity for the purpose of enabling telehealth in certain, defined circumstances.

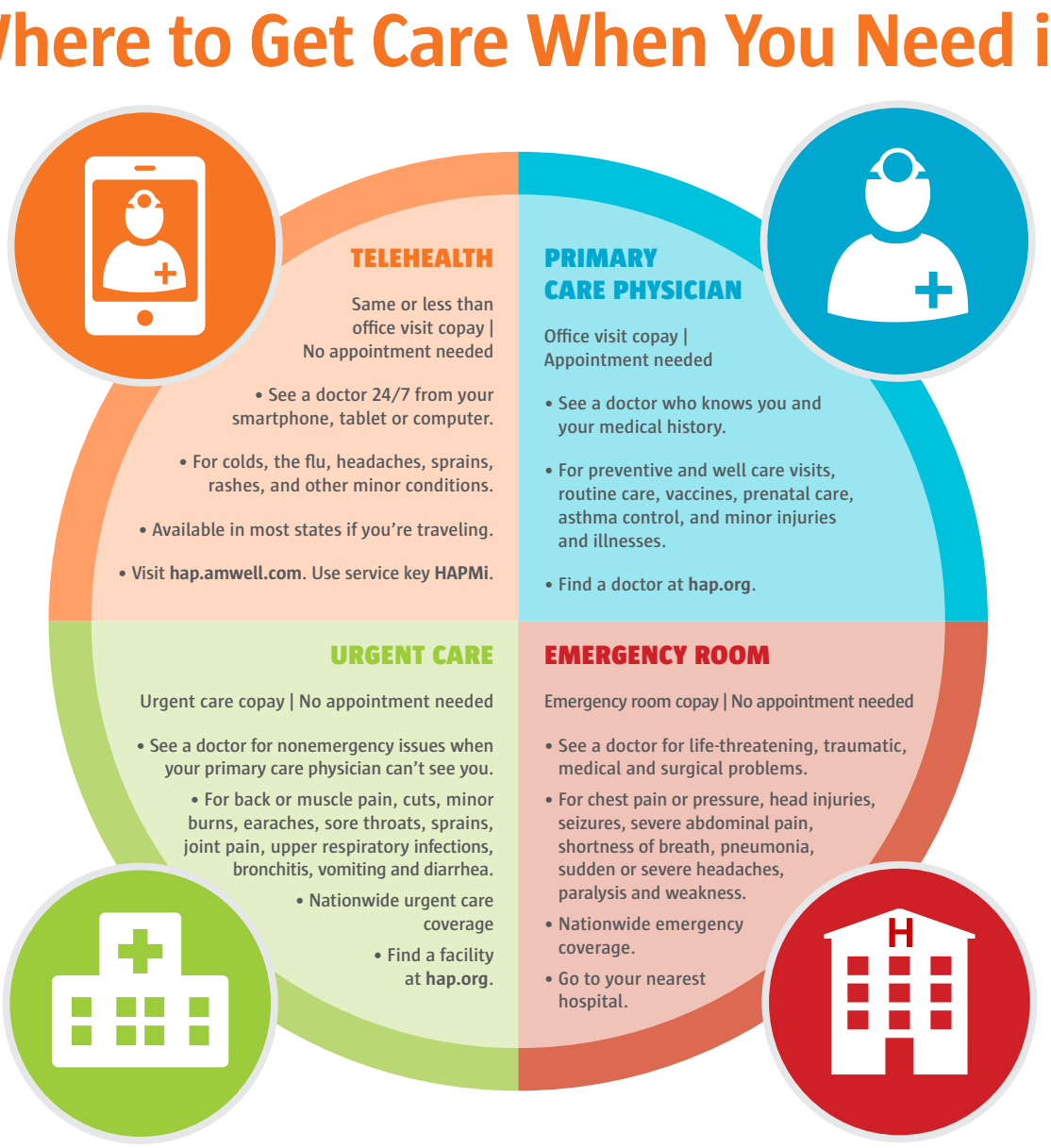
5. Patients need education about the value of telehealth tools and how to use them.

The value of telehealth will not be realized if patients don't want or don't know how to use it. It is the responsibility of providers to educate patients about the benefits of using telehealth to stay connected to a practice with which they already have a relationship. In many of the CAPP groups, we have found that patients are more willing to try telehealth services when their own doctor or familiar clinic staff tell them about it.

Patient education must include information about what can and cannot be accomplished with telehealth. Patients should know that in different situations, telehealth care can either complement or substitute for in-person care, but in some cases, it can do neither. Exhibit 1 is an example a simple decision-making guide that can help patients decide which modality is right in any given situation. Such decision-making tools are especially important when patients face very different levels of out of pocket cost-sharing for the different modalities.

Patient education about telehealth should also address concerns regarding the technology. On one hand, patients may not want to use email, telephone, or video visits because of concerns that they are not secure. Conversely, patients may not understand why they must use secure platforms for these modalities, rather than just texting or video-chatting directly through existing apps on their phones.

EXHIBIT 1: EXAMPLE OF A PATIENT TELEHEALTH DECISION GUIDE



Source: Health Alliance Plan, Henry Ford Health System

6. ***Stakeholders must continue to invest in research on best practices.***

In the application of telehealth, as with the use of any new technology in health care, providers must be armed with evidence-based research about best practices. To a large extent, the American Telemedicine Association has led the important work of developing and promulgating clinical guidelines in telehealth.[13] These include guidelines regarding the use of these tools in certain specialties (pediatrics, dermatology) and for certain conditions (burns, stroke), as well as general best practices related to issues such as eye contact and optimal lighting. We hope that these scientific endeavors will continue to expand, to include more conditions and specialties, and to focus on issues such as optimal workflows for incorporating telehealth into daily clinical practice.

When such guidelines are developed with appropriate expert input, their use improves quality and safety of care. In addition, because payers often rely on reputable guidelines in setting payment policy,[14] guidelines are an important tool for nudging the payment system to allow more efficient and widespread use of telehealth. It is critical for providers from diverse specialties to be involved in guidelines development and research on best practices in telehealth, and we encourage health systems and other funders to support such activities.

WHAT IS THE COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES?

The Council of Accountable Physician Practices is a coalition of the nation's highest-performing medical groups and health systems. We believe we are better together. Our organizations are places where doctors from all disciplines practice together and learn from one another, backed by integrated services, systems, data, and technology. We recognize the importance of the patient-doctor relationship and know that, together, we can achieve the highest quality and ensure that patients come first.

ENDNOTES

1 The most recent data from HIMSS Analytics indicates that 71 percent of all inpatient and outpatient providers are using some form of telehealth tools (HIMSS Analytics. Is lack of clarity stunting outpatient telemedicine growth? 2017, https://asiapac.himssanalytics.org/asia-pacific/news/lack-clarity-stunting-outpatient-telemedicine-growth

2 American Telemedicine Association. What is Telemedicine? http://www.americantelemed.org/about/telehealth-faqs-

3 R. Copeland et al. Using Information Technology at Kaiser Permanente to Support Health Equity. In M. Edmunds, C. Hass, and E. Holve (Eds.), Consumer Informatics and Digital Health: Solutions for Health and Health Care. Springer. Forthcoming, Fall 2018.

4 While CAPP also supports the use of telehealth tools to link patients to one another through various types of patients communities, such tools are not the focus of this brief.

5 Council of Accountable Physician Practices. Moving the Needle on Value-Based Payment. Winter/Spring 2018, http://accountablecaredoctors.org/wp-content/uploads/2018/04/capp_vbp_primer.pdf

6 Kaiser Permanente. Kaiser Permanente Telestroke Program Closes Gaps in Treatment, Increases Access to Timely Stroke Remedy. Press Release, July 29, 2016, https://share.kaiserpermanente.org/article/kaiser-permanente-telestroke-program-closes-gaps-treatment-increases-access-timely-stroke-remedy/

7 K. Sauser-Zachrison, et al. Safe and Effective Implementation of Telestroke in a US Community Hospital Setting. The Permanente Journal. 2016 Fall; 20(4):15-217

8 Centers for Medicare and Medicaid Services – Medicare Learning Network. Telehealth Services. MLN Booklet, February 2018, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

9 Centers for Medicare and Medicaid Services. CMS Announces Agency's First Rural Health Strategy. Press Release, May 8, 2018, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-05-08.html

10 Centers for Medicare and Medicaid Services – Medicare Learning Network. Summary of Policies in the Calendar Year (CY) 2018 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List. MLN Booklet, January 2, 2018, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10393.pdf

11 Health Policy Brief: Telehealth Parity Laws," Health Affairs, August 15, 2016, https://www.healthaffairs.org/do/10.1377/hpb20160815.244795/full/

12 See: Interstate Medical Licensure Compact, http://www.imlcc.org/

13 See, for example: American Telemedicine Association. Practice Guidelines and Resources, http://hub.americantelemed.org/resources/telemedicine-practice-guidelines

14 E.A. Krupinski and J. Bernard. Standards and Guidelines in Telemedicine and Telehealth. Healthcare. 2014 Mar; 2(1): 74–93, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4934495/