



TELEHEALTH RISING: PRACTICAL INSIGHTS AND STRATEGIES FOR SUCCESS



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EXECUTIVE SUMMARY

WHILE BARRIERS STILL STAND IN THE WAY, REMOTE PATIENT MONITORING AND VIRTUAL VISITS ARE FINALLY STARTING TO GET HEALTHCARE PROVIDERS' ATTENTION

Telehealth, which encompasses remote patient monitoring (RPM), virtual visits, and other types of connected healthcare, is still in an early phase of its evolution. Partly because of the lack of reimbursement for telehealth until recently, most physicians and hospitals are still not using these technologies to any significant extent. But that's expected to change rapidly as the healthcare industry shifts from volume-based payments to value-based reimbursement, which requires increased efficiency in the delivery of healthcare. Meanwhile, the demand of consumers for immediate service and the opportunities to interact with them on their mobile devices are also expected to affect healthcare providers' view of telehealth.

Currently, hospitals and healthcare systems that use remote patient monitoring tend to regard it as part of acute care. Among their typical use cases for RPM are telestroke, tele-ICU and teleradiology programs, and maternal/fetal monitoring during labor.¹ Despite Medicare penalties for excessive readmissions, the majority of hospitals are still not remotely monitoring high-risk patients after discharge.

Neal Ganguly, chief information officer of JFK Medical Center in Edison, N.J., notes that RPM could help his institution reduce preventable readmissions. But the IT solutions designed to avoid readmissions—starting with analytics that identify high-risk patients—have not been prioritized highly when compared with other organizational needs, he says. JFK's only remote monitoring initiative so far, he notes, has been to start a telestroke program that allows a neighboring hospital to consult with JFK's neurologists online.

Many hospitals, Ganguly argues, are “in survival mode” in very competitive markets. “The deep resources aren't there to reinvent healthcare and market it to the consumer and build tools for them,” he notes. “We're just trying to provide the services and continue to employ people to operate, and that's a challenge. When your margin is 3%-4% and that's considered good, how do you reinvest in cutting-edge technologies?”

Near-term prospects are brighter in the area of telemedicine, which involves virtual visits to physicians through audio and video teleconferencing. Telemedicine has spread more rapidly than RPM, mainly because health plans and employers view it as a way to save money. But third-party telemedicine services hired by payers still dominate virtual visits.

According to John Chelico, MD, chief medical information officer and director of medical informatics at NorthShore University Hospital in Manhasset, N.Y., virtual visits won't catch on broadly among provider organizations until value-based reimbursement justifies them economically.



“Patient-based telemedicine goes in fits and starts,” he says. “It’s a really great thing, but if you don’t get paid for it, that’s one less patient who comes to your ER or your urgent care center or to your doctors’ offices.”

A healthcare organization that takes financial responsibility for care is in a different situation, he points out. Telehealth represents an asset to healthcare systems with risk contracts, “because they get paid the same amount of money, regardless of where that patient is taken care of. So it is cheaper for you to take care of them at home and avoid them inappropriately coming to an ER or a doctor’s office. You’re not worried about putting the bill through.”

Joseph Kvedar, MD, vice president, Connected Health at Partners HealthCare in Boston, agrees that value-based reimbursement will change the value proposition of telehealth. But he also thinks that consumer demand for better service in a mobile environment will help drive the growth of these technologies.

Ganguly believes that this consumer demand will have a decisive impact on virtual visits. “There’s a heavy, consumer convenience-driven wave that is coming that will force a lot of change,” he says. “The current model is very inefficient, and the generation behind us isn’t going to wait in a doctor’s office 45 minutes for a five-minute interaction.”

This paper examines the current state of telehealth, with an emphasis on the barriers that currently prevent telehealth technologies from achieving their full potential.

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— Neal Ganguly



AMBULATORY/POST-ACUTE-CARE MONITORING

Some hospitals send high-risk patients home with remote monitoring equipment to avoid readmissions. This can be justified on an economic basis: If 30-day readmissions of Medicare patients exceed the expected rate for a facility, the hospital loses a percentage of its overall Medicare reimbursement.²

In 2015, according to a survey by the Health Information Management and Systems Society (HIMSS), 37% of hospitals used remote patient monitoring. By 2018, the report predicted, 51% of hospitals would offer RPM.³

Ambulatory care providers are less likely than hospitals to do remote monitoring, for which they're not reimbursed by commercial health plans. However, Ganguly notes, accountable care organizations (ACOs), which are rewarded for efficiency and quality, can financially benefit from RPM in some cases.

The Centers for Medicare and Medicaid Services (CMS) also pays primary care physicians for some RPM-related activities in its Chronic Care Management Service (CCM). Under this program, primary care practices can bill CMS an average of \$42 per month to provide non-visit care to Medicare beneficiaries with two or more chronic conditions. While CMS won't pay directly for the monitoring equipment, the review of remote monitoring data counts toward the 20 minutes per month that practices must devote to each patient.⁴

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ACUTE-CARE REMOTE MONITORING

As RPM technology has improved over the past decade, an increasing number of hospitals have adopted inpatient and ER remote monitoring tools. Telestroke programs, for example, use remote visualization techniques to help neurologists diagnose patients in a location different from theirs. Tele-ICUs or eICUs enable critical care specialists to monitor patients in multiple hospitals' intensive care units from a central location. Teleradiology allows radiologists in remote sites to “read” images, either during off hours or to relieve the burden on radiologists who can't cope with the volume of images they have to read. Remote monitoring during labor helps obstetricians stay in touch with the vital signs of mothers and fetuses.

Andrew Rubenstein, MD, chief of obstetrics at Hackensack University Medical Center in Hackensack, N.J., monitors mothers and their unborn children remotely from his office when he is not needed at their bedside. He can monitor the vital signs of fetuses and maternal contraction patterns from anywhere on any device, including iPhones, iPads and desktop computers, he says.

However, he stresses, the monitoring of labor requires internal exams to track the dilation, effacement, and stationing of the baby, which can't be done remotely. Nurses can do certain kinds of examinations and report back to him, “but a nurse does not replace a physician,” he notes.

Remote monitoring improves the quality of care “because the physician is able to pull up [monitor] tracings and evaluate their patients remotely,” he says. “It allows the primary obstetrician to have directed patient observation to evaluate the patient. It doesn't absolve them of responsibility for in-person care.”

RPM hasn't enabled Rubenstein to avoid going to the hospital, “but it allows me to be reassured that I can watch a maternal tracing as I'm inducing her labor. I also have an attending physician in-house who's monitoring her so I can be reassured of the maternal and fetal well-being.”

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TELESTROKE AND TELE-ICU

Northwell Health, which includes NorthShore University Medical Center, has 21 hospitals on Long Island, N.Y. Two of those are large university hospitals that have tertiary-care specialists on staff. If a patient arrives at one of Northwell's community hospitals with stroke symptoms, Chelico explains, he or she can be examined remotely by one of the eight stroke neurologists at Northshore. These experts have virtual-private-network connections to telemonitoring devices that can be rolled up to the bedside. They can also view imaging reports remotely. By diagnosing patients rapidly, they can advise ER physicians on whether to deliver clot-busting drugs within the requisite time frame, which can save lives.

Northwell Health also has an eICU facility that can monitor the ICUs of community hospitals from a central location, Chelico says. Besides gathering data on what's happening in the ICUs, this tele-ICU also includes critical care specialists who keep an eye on the ICU patients. They don't actually manage the patients themselves, but they can supervise the nurses and midlevel practitioners who do.

"Outside of doing a procedure or physically examining the patients, they do everything else, including putting in orders and managing antibiotics and fluids and fluid dynamics from this remote bunker that sits outside one of our hospitals," Chelico explains.

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WHO SHOULD BE MONITORED?

Most home monitoring today focuses on seriously ill patients with complex conditions and those recovering from surgery, notes Mark A. Caron, CHCIO, FACHE, CEO of Geneia LLC, a firm that specializes in RPM and the analytics that support it. Danny Sands, MD, a Harvard Medical School professor and a primary care physician at Beth Israel Deaconess Medical Center in Boston, says this is understandable, because “sicker patients have more money at stake. So it’s natural that you see more adoption of remote monitoring for sick people, such as patients with congestive heart failure.”

Remote monitoring of heart failure patients can result in significant savings. For example, the Geisinger Health Plan in Danville, Pa., used RPM to cut readmissions of heart failure patients by 44%, and it saved \$3.30 for each dollar invested in the program.^{5,6} Partners Healthcare had similar results with the same type of patients, generating cost savings of \$10 million over a six-year period.⁷

Nevertheless, Sands adds, “If you look at value to the system overall, we should be monitoring everybody with any kind of chronic condition. We don’t have to do it as intensively as we might for heart failure patients, but we should be exploiting patient-generated information, so we have to see patients less often.” Caron agreed, “While much of the focus has been on heart failure patients, we expect to use remote monitoring for additional disease states and increasingly in post-acute settings.”

Does remote monitoring of chronic-disease patients save money? Little data exists for conditions other than heart failure, because chronic conditions like hypertension and diabetes may not contribute or lead to costly acute events for many years. But Partners Healthcare’s Center for Connected Health has shown that monitoring patients with hypertension can help those patients control their blood pressure, which may avert major cardiac events later on.⁸ That can make business sense when organizations take financial risk.

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“Heart failure is an easier business case, because an admission is so expensive,” Kvedar says. “But we’ve been able to make the case for blood pressure, based on our risk contracts, and we’re reviewing it now for diabetes.”

Mobile monitoring is a natural adjunct of home monitoring, but is little used by people with chronic conditions. Most consumer smartphone apps and related devices are designed for fitness and wellness. Mobile apps and devices do exist for a range of chronic diseases, but few physicians prescribe them to patients. While one survey found that 30% of physicians prescribe mobile apps, many of these doctors suggest only educational apps to their patients. Kvedar estimates that just 10%-20% of physicians have prescribed mobile apps for other purposes.⁹

Aside from the lack of reimbursement, physicians are also skeptical about the efficacy and safety of most mobile apps and accompanying devices—and for good reason. Few apps have been rigorously tested, and some have been shown to produce spurious data.¹⁰ Moreover, a recent study by the Scripps Translational Science Institute in La Jolla., Calif., found there was no short-term benefit in costs or outcomes for patients who monitored their health with connected devices.¹¹ Although the study has been criticized for methodological flaws, which points to the need for more research.

MAJOR ISSUES IN RPM

The major challenges that remote patient monitoring must overcome fall into five categories: data collection and integration, screening raw data to find relevant information, adjusting analytics for individual patient differences, accounting for differences in context, and patient engagement. The latter factor, as we’ll see, is more important than the technological barriers.

Data collection has become much easier as the sophistication of monitoring devices has increased and their costs have dropped. Bluetooth features now allow wireless transmission between devices and hubs (or smartphones), and either Wi-Fi or cellular networks can be used to transmit the data. Assuming that the devices are properly installed and used, and are not defective, data collection is no longer the challenge it used to be.

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Integration of the RPM data into electronic health record (EHR) systems is another matter. One way to do it is simply to cut and paste relevant data into the record, as Partners has done. But that's a labor-intensive process. Apple HealthKit, which is being used by a number of large healthcare systems, allows remote monitoring data to be integrated with some EHRs and can recognize some clinically relevant data. Validic and Qualcomm also have platforms that integrate RPM and EHR data.

There are some drawbacks with this approach, however. For starters, HealthKit can only ingest data from devices that use the Apple operating system, notes Kvedar, and half of his research sample at Partners comes from users of Android phones. Also, Caron observes, standards for connecting monitoring devices with health IT systems are still inadequate. In addition, none of the integration platforms has a satisfactory mechanism to screen data for clinical relevance. Part of the reason is that a great deal of information about the patient is required to do that well, notes Sands.

"That's why I don't think this is going to come out of the Apple HealthKit by itself," he says. "It's going to be other systems built on top of it that know a lot about the patient in order for this to add value."

TRAINING ALGORITHMS

Not only must reliable methods be devised to separate the signal from the noise in the data, but the process must also be automated so that nurses don't have to devote too much time to the task. This is still a work in progress, experts say. Algorithms can automate it to some extent, but the algorithms must be trained well enough for physicians and patients to depend on them.

Take HealthKit, for example. Like the more sophisticated EHRs, HealthKit can detect when certain kinds of values—blood pressure or diabetic HbA1c levels, for example—are out of range. But the program bases its alerts on accepted practice guidelines, a generic filter that doesn't take individual differences into account.¹²

To make these differences actionable, the algorithms used to screen the incoming data must, first, be customizable, and second, must be capable of learning, Caron says. "The algorithms are set up to learn when to set off alerts, depending on the patient's physiology and past history," he explains. "The real key is that it's not one size fits all. There's a level of customization that takes place for each case. What works for one patient may have to be changed to work effectively for another."



Initially, the screening algorithms learn from the alert thresholds and the baselines that a physician sets for each patient, he continues. When the program alerts a care manager or a provider that something is going on with the patient, the clinician decides whether it's a real issue or not. If it's not, the algorithm can be fine-tuned so that it becomes better at detecting the patient's care needs. If the false alert is being fired for other patients as well, the algorithm may have to be adjusted in other ways.

Caron adds that different thresholds can be set for various members of the care team. Perhaps a doctor wants to be informed about every significant issue, or perhaps he or she wants to be informed only if the patient is in danger of being readmitted. A nurse care manager may have a separate threshold.

Learning machines, which consist of algorithms that get smarter from the data they receive and real-world feedback to their analyses, are being used in a variety of big data healthcare applications. Caron believes they can also help physicians tweak practice guidelines for individual patients. As learning machines develop, he says, there will be less dependence on those generic filters in sifting monitoring data.

"The algorithms will use the clinical guidelines as a baseline and then learn how those change with the patient," he predicts. "It's not necessarily going to respond after the first issue; it will learn over time."

MULTIPLE DATA STREAMS

Some kind of big data solution will be required to capture multiple streams of device data and correlate them with each other and with other patient data such as lab results and medications, Caron points out.

"That's a classic big data problem, where you capture volumes of data—which you can't do in an EHR—and not only create understanding of it, but also create algorithms that can drive the ability to predict what happens next," he says.

Kvedar agrees that learning machines can be helpful in making sense of large datasets from remote patient monitoring. "They can also learn enough about you so we can accurately message you in an automated way and keep you engaged and motivated," he says.

But Kvedar acknowledges that clinicians and researchers have a long way to go in understanding what is normal for different patients. "On one hand, we know that lower blood pressure is generally better," he observes. "That said, we don't have the equivalent of the Framingham Heart Study for ambulatory blood pressure monitoring."



The vital signs of people can also change when they encounter various situations in daily life. As Stephen Steinhubl, MD, director of digital medicine at the Scripps Translational Science Institute, told Medical Economics, “Nobody knows what a normal blood pressure should be when you’re late picking up your kids at school and you’re angry at the traffic.”¹³

PATIENT ENGAGEMENT

If patients don’t cooperate with their physicians, remote monitoring is a waste of time. As Andrew Rubenstein of Hackensack Medical Center points out, noncompliant patients are more likely to be readmitted than people who follow their doctor’s instructions, and neither telemedicine nor remote monitoring will prevent their next acute event.

The same can also be true of generally compliant patients who just get tired of measuring themselves, says John Chelico of Northwell Health. When these patients leave the hospital and take home their digital scales or digital blood pressure cuffs, he says, “they’re great about weighing themselves and taking their blood pressure every day, but their commitment tapers off over time, because there’s no human interaction and they don’t see the benefit. Then, when they really do need the monitoring, they’re not engaged in it.”

One way around this natural tendency is to implant a sensor in a patient so that the device automatically sends data to his or her provider. Northwell, for instance, recently launched a cardio-management program that monitors heart failure patients at home with a device implanted in a patient’s aortic artery. The device can identify exacerbations of heart failure nearly a week prior to the patient experiencing symptoms or seeing weight gains, Chelico says.

Kvedar acknowledges that a successful RPM program has to combine effective use of the technology with the right motivational approach to get patients involved. With heart failure, for example, “a relatively small percentage of people” find the feedback from their devices motivating enough to change their lifestyle and their diet.

Other people “need to be harassed a little by the telemonitoring nurses to stick with the program,” he says. “The early warning sign is that their weight goes up because they had something salty or missed their fluid restriction. When that happens, the nurse gets even more involved and does more coaching. In most cases, she can help them avoid getting really sick and ending up in the ER, because they can fine tune their diet and maybe make a medication change.”

“We’ve had nurses go to the home to meet with a patient and train the patient or their caregiver on how the technology works, put them at ease, and start building that relationship.”

— Mark A. Caron



Caron also stresses the need to engage patients. Speaking of his own company, he says, “We’ve had nurses go to the home to meet with a patient and train the patient or their caregiver on how the technology works, put them at ease, and start building that relationship. Often that nurse may be the ongoing interface with that patient in the care team, or it could be a nurse care manager. But it’s important to have that interaction with the patient initially, and not just something mailed to them.”

TELEMEDICINE

Telemedicine, or virtual visits to providers, has spread rapidly in the past several years. Telemedicine companies such as Teladoc, Doctor on Demand, American Well and MDLive sell their services to health plans and employers, and some firms sell directly to consumers. An estimated 20% of national employers offer telemedicine services to their employees, and national insurers such as Anthem, United, Aetna and Cigna have similar options for many of their members.¹⁴ Both the Department of Veterans Affairs and the Department of Defense utilize telemedicine; Medicare is gradually expanding coverage of it; 48 state Medicaid programs already cover it to some extent;¹⁵ 24 states reimburse it for state employees;¹⁶ and 29 states require health plans to cover it.¹⁷

With the exception of behavioral health virtual visits, telemedicine providers mostly diagnose and treat minor acute ailments. Even this limited menu of services is controversial in some states. In Texas, for example, the state medical board requires physicians to have at least one in-person encounter with a patient before prescribing medications during a virtual visit. A federal judge delayed that rule in 2015, and legal maneuverings continue.¹⁸

According to the American Telemedicine Association (ATA), care provided through telemedicine is comparable to that provided in person. A review of 93 randomized controlled trials found similar or better outcomes through telemedicine alone or telemedicine with usual care for a variety of health issues. One analysis of private payer data found cost savings of approximately \$126 for each commercial telemedicine visit, compared to in-person care, and \$45 per telemedicine visit for Medicare patients.¹⁹ However, many studies have produced varying results. According to a recent research study by JAMA Internal Medicine, there was a ‘significant variation’ in adherence to medical

\$126

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\$45

Cost savings per telemedicine visit for Medicare patients.



guidelines, for urgent care provided by commercial telemedicine companies. Ultimately the study revealed that remote physicians vary from guidelines much like regular physicians do, and outcomes produced were not significantly different through either medium—noting a need for additional research into outcomes through larger varying sample sizes.²⁰

PROVIDERS ARE INTERESTED

Despite the widespread support for virtual visits, relatively few healthcare organizations offer them to their patients today. But that is starting to change as healthcare systems, group practices, and ACOs recognize that telemedicine can help them manage population health and thrive under risk contracts. Health plan reimbursement of telemedicine in many states also makes it attractive to provider organizations, notes Kvedar.

“Even if organizations don’t have a clear path to reimbursement yet, they’re doing this to build loyalty with their patients and their referring docs and for other reasons,” he says. “They know reimbursement is coming, and they want to get their house in order to be competitive.”

Kvedar believes that most healthcare organizations will want to have their physicians do virtual visits with their own patients, rather than just hire an outside service. “That’s a market advantage they have in any given market, because those are pre-formed relationships [with patients] that they can virtualize,” he says. However, he adds, some organizations are using telemedicine firms’ doctors as a backup when their own physicians aren’t available.

If JFK Medical Center adopted virtual visits, Ganguly states, it would probably use this dual approach. But the hospital would initially contract with a telemedicine service, he says, because the firm would have a better understanding of the technology and the patient interaction aspect than the hospital does.

Northwell Health is considering hiring a telemedicine service and having its own doctors do virtual visits with patients, as well, Chelico says. In addition, he notes, “We’re developing tools so we can help people gain access to the data we have about our patients.”

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— John Chelico

One of the drawbacks of third-party services, he continues, is that they usually lack access to patient information that is stored in clinical systems, including lab results, images, medications, and other pertinent data. “Having that data would make these companies a lot more robust. And if we worked with one of them, we’d want them to be annexed to our [health IT] infrastructure.”



Ganguly says that having access to a patient’s electronic record is less important when an on-demand doctor is just dealing with that patient’s “sore throats and runny noses.” But he agrees that it would be helpful if the telemedicine doctor knew that the patient had a chronic disease along with their current acute symptoms. It’s also crucial to know what medications they’re on and what allergies they have, he points out.

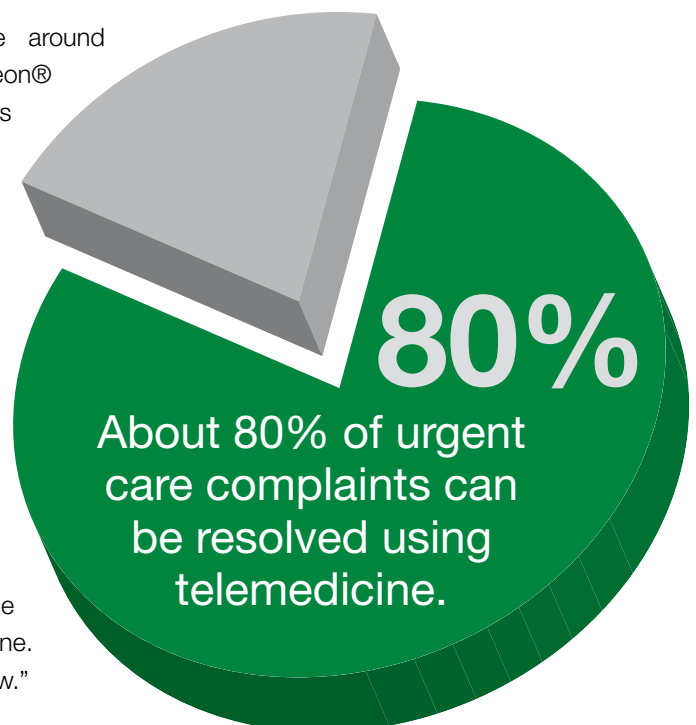
Another aspect of telemedicine that is less than ideal, observers say, is that on-demand physicians rarely share their notes with their patients’ regular physicians. The advent of standardized clinical summaries known as CCDAs makes it easier to exchange key data, even if the on-demand and personal doctors are on different EHRs. But Chelico says he’s unaware that Northwell physicians have received any CCDAs from telemedicine doctors. That kind of information exchange would be facilitated if a telemedicine firm and a healthcare provider interfaced their systems.

Meanwhile, some technology vendors are beginning to embed telemedicine functions in their products. According to field reports, athenahealth is now offering this capability. Epic has similar functionality, although it’s not fully developed yet, says Kvedar. Partners Healthcare has set up its Epic EHR so that a patient can go its MyChart portal and sign up for a virtual visit with one of its doctors. The physician can access the video application through the EHR. “It’s right in the same workflow as any other clinical function,” he points out.

The vendor community also continues to innovate around telemedicine data. Software offerings like Geneia’s Theon® platform, are now beginning to apply predictive analytics to telemedicine models, with other companies piloting similar offerings.

PORTALS AND BEYOND

In Chelico’s view, patient portals are the natural home for telemedicine. “These telehealth platforms will incorporate data that we have about the patient and data that the patient is giving you at the moment of interaction,” he says. “Given the right reimbursement models, these platforms will find a sweet spot to take care of larger populations of patients, especially as more people get insurance. The bricks and mortars will not be able to take care of everyone. So that’s the place where we’ll have to pick up the overflow.”





Other observers and healthcare organizations view mobile devices as the future of interconnectedness. For example, Cleveland Clinic is ramping up a telemedicine program that provides a virtual urgent care clinic that patients can access through a free smartphone app. In a recent interview with Health Data Management, Peter Rasmussen, MD, medical director of distance health at Cleveland Clinic, said, “About 80% of urgent care complaints can be resolved using telemedicine.”²¹

Danny Sands believes that telemedicine will become “a routine way that we connect with patients.” Eventually, he says, some of his scheduled appointments each day will be for virtual visits and some will be for in-person encounters. “We’re not nearly at that point yet,” he notes. “Some healthcare organizations are doing some forward looking things. They’re setting aside time for physicians to do telemedicine and portal work and so on—maybe an hour out of their day. But most providers haven’t figured out a way to make that work financially.

“It’s also a chicken and egg phenomenon, because there’s not enough demand for it yet from the patient side,” Sands continues. “So if doctors do that, they’re not necessarily going to make up their [lost] revenue [from in-person visits], because there aren’t enough patients who want to do virtual visits.

“We also need to get to universal reimbursement for telehealth. And doctors have to get comfortable with using the technologies and providing care for patients that way. It’s not hard to do, but it’s a different way of doing things. Practices have to appreciate that telehealth is important, and they have to set aside time for doctors to be practicing telemedicine.”

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— Danny Sands



CONCLUSION

Telehealth is at a crossroads. More and more healthcare stakeholders, including providers, recognize that remote patient monitoring and/or virtual visits can improve patient outcomes and lower health costs. Consumers are demanding the convenience that telemedicine offers, and a growing number of hospitals are remotely monitoring patients with serious health conditions at home. But provider reimbursement issues still have not been resolved, and telehealth still faces a number of cultural, technological, and legal challenges.

Undergirding the discussion of telehealth's future is the ongoing transformation of healthcare reimbursement from pay-for-volume to pay-for-value. As government and private payers drive that shift forward, and as healthcare organizations embrace the philosophy of population health management, telehealth will increasingly be viewed as an integral part of the solution. Non-visit care is a cornerstone of population health management, and telemedicine provides viable alternatives to the traditional office visit. Similarly, RPM can help providers track patients between visits.

Despite all of the barriers to fulfilling the promise of telehealth, the burgeoning support for it suggests that these obstacles will be overcome. Improved standards and application plug-ins will improve the interoperability between devices and EHRs. Screening mechanisms will alert providers and care managers only to data that is truly important in patient care. And learning machines, using big data techniques, will pull together many different data streams to provide enhanced clinical decision support at the point of care.

Chelico foresees a future in which all of the various telehealth technologies will be woven together. "It could start with an e-visit where you answer questions on a website or your iPhone, and maybe it progresses to a video interaction, and then to an opportunity to get information on a blood pressure or a weight or some other vital sign. But as long as these efforts are siloed, it's very difficult to weave the entire picture. All those things need to be brought together."



NEXT STEPS FOR SUCCESS IN LAUNCHING TELEHEALTH INITIATIVES

- » Consider telehealth as a cornerstone of population health management, which your organization will need to deliver value-based care.
- » Hospitals should go beyond telestroke programs, eICUs, and the like, and start monitoring discharged patients to reduce readmissions.
- » Ambulatory care practices should take advantage of Medicare's Chronic Care Management program to get paid for remote monitoring activities.
- » Begin by monitoring high-risk patients, but use analytics to determine which at-risk patients are most likely to engage in a RPM program.
- » Use an advanced analytics platform to integrate device and EHR data.
- » Integrate remote monitoring with traditional care coordination programs like case and disease management to engage patients more effectively.
- » Have your primary care doctors start doing virtual visits with their own patients.
- » Hire an outside telemedicine service as a backup when your physicians are unavailable.
- » Integrate telemedicine and EHR systems to exchange patient information.



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