

Chicago

MEDICINE

February 2023 | www.cmsdocs.org

Virtual Care

After taking a great leap forward during the pandemic, payment and other regulatory restrictions could slow its growth



Preparing for the End of the Public Health Emergency

Could This Be the End of Non-Competes?

How Ridesharing Improves Access to Care



Virtual Care Needs Foundation, Roadmap

Virtual care took a great leap forward during the pandemic but restrictions on coverage and payment could slow its expansion

By Delia O'Hara

TELEHEALTH is useful and popular with both physicians and patients, but the policy framework that supports its use, especially around reimbursement, must be made more intentional and permanent if digital healthcare is to deliver on its full potential, experts say.

“Many organizations are waiting for some kind of clarity around the long-term revenue opportunity before they go big,” says Joseph Kvedar, MD, a Boston dermatologist, professor at the Harvard Medical School and senior adviser for virtual care at Massachusetts General Brigham.

Telehealth's share of “claim lines” (individual services listed on an insurance claim) shot from .18% in October 2019, before Covid-19, to 7% in January 2021, according to FAIR Health, an independent organization based in New York City, that keeps tabs on health insurance data. It subsequently slipped to right above 4%, but by October 2022, had rebounded to 5.2%. More patients are being seen now in doctor's offices, but telehealth use “hasn't slipped that much from its high point,” Dr. Kvedar says.

Waivers from the federal government that loosened restrictions on Medicare payments during the pandemic have been extended through 2024, but

Dr. Kvedar, the immediate past chair of the board of the American Telemedicine Association (ATA), an Arlington, Virginia-based nonprofit advocacy organization, and others, say coverage of telehealth services must be expanded permanently if virtual medicine is to reach its full potential.

“Reimbursement is going to be key in terms of deciding the future of telemedicine,” says Rahul Sharma, MD, MBA, professor and chairman of the Department of Emergency Medicine at Weill Cornell Medicine in New York City.

Payment is not the only issue. Licensing across state lines needs to be universally allowed outside of the Covid-19 emergency, critics say. More than half of states have joined or are in the process of joining the Interstate Medical Licensure Compact. Data privacy remains an issue, electronic health record (EHR) systems are not always compatible, telehealth connections may be unreliable, which can contribute to poor communication between doctor and patient, and many patients either have inadequate access to broadband services or need help understanding how to use the technology.

The “Webside Manner”

Physicians also may not know how to competently conduct a virtual exam. They likely need training



LEFT: Dr. Joseph Kvedar is senior adviser for virtual care at Massachusetts General Brigham RIGHT: Dr. Rahul Sharma is founder and director of the Center for Virtual Care at Weill Cornell Medicine.

in what is becoming known as “webside manner.” In telehealth, as in in-person visits, labs and other tests must be coordinated, follow up arranged, diagnoses and other data resulting from virtual visits properly managed. So while the patient sees only the clinician during a virtual visit, a competent team needs to stand behind and support that provider.

“The institution has to have top-level support”

in order to make sure the telehealth program is stocked with “the right clinicians, the right technology, the right follow-up program,” and can provide assistance for patients who lack broadband or technical literacy, or who speak languages other than English, says Dr. Sharma, founder and executive director of the Center for Virtual Care at Weill Cornell Medicine.

Dr. Sharma says that medical practices interested

The TeleStroke Experience

BEFORE THE COVID-19 pandemic, Medicare generally reimbursed for telehealth visits only for patients in rural areas. TeleStroke was one of the first programs for which that distinction was eliminated, even before the COVID-19 emergency. In 2018, Congress passed the *Furthering Access to Stroke Telemedicine (FAST) Act*, which expanded Medicare coverage of TeleStroke services to patients in urban areas as well.

This change came about because time plays a critical role in the treatment of stroke, the fifth leading cause of death and the top cause of disability in the United States, and because TeleStroke has lifesaving benefits for urban residents as well. The TeleStroke experience shows that when clinicians can establish the value of a digital service, obstacles to telemedicine may tumble.

Treatment of ischemic stroke with tissue plasminogen activator (tPA) is

only possible within a few hours of the onset of symptoms, but tPA can make the difference between life and death, or disability. This tight time frame inspired the development of TeleStroke, a virtual consultation platform developed for acute stroke nearly a quarter century ago, says Sarah Song, MD, MPH, a neurologist with the TeleStroke Network at Rush University Medical Center in Chicago.

“If you’re talking about outcome-based therapies, TeleStroke is a really good example of how well telehealth can work,” Dr. Song says.

Rush, a certified Comprehensive Stroke Center, is the hub of a TeleStroke network for several community hospitals throughout the Chicago area. Since 2011, Rush neurologists have performed more than 6,500 virtual consultations with patients who come to those hospitals’ emergency departments; 33% of patients have received tPA.

tPA can clear blood clots from a blocked brain vessel, but can only be

used within a 3- to 4 1/2-hour window after the onset of symptoms—the sooner the better. A CT scan is critical for diagnosing, as tPA can only be used to treat ischemic stroke. If a stroke is caused by a hemorrhage, tPA could increase the bleeding.

Emergency physicians at the participating community hospital will expedite a CT scan of a patient’s brain and send it electronically to Rush. A Rush stroke neurologist typically meets the patient via telehealth within 15 minutes of getting a call, Dr. Song says. She herself has pulled her car off a road where she has been driving to read a CT scan on her phone, and to virtually assess a stroke patient located in a community hospital many miles away. “It’s exactly like we’re in the room,” she says.

A Rush clinical team works with the receiving ER to devise a care plan with the on-site emergency team, or to arrange to transfer the patient to Rush for advanced care.



LEFT: Dr. Maria Alkureishi is a pediatrician, researcher and educator at University of Chicago Medicine

RIGHT: Dr. Keith Horvath is the AAMC's senior director of clinical transformation.



in leaning into telehealth should do their own needs assessments on the front end, and that cost can't be the only consideration. "It has to be a patient-centered, outcome-based approach," he says.

While some proponents would like to see a more robust body of research assembled to establish conclusively that virtual medicine works, and that it serves the patient, Dr. Kvedar says there is already "a pretty significant body of literature showing that telehealth has similar outcomes to in-person care."

The Association of American Medical Colleges (AAMC), based in Washington, DC, was one of

many groups that saw telehealth's potential well before the pandemic. In 2019, the AAMC identified a number of core competencies practitioners would need for telemedicine.

Some Patient-Related Barriers

Maria Alkureishi, MD, a pediatrician, researcher and educator at University of Chicago Medicine, is part of a team that has developed a curriculum to teach residents and medical student how to practice intentional, patient-centered telehealth. She has also researched outcomes. One study Dr. Alkureishi's

ATA Envisions 21st Century Virtual Care

THE AMERICAN Telehealth Association is calling for the standardization of components it has identified as critical to the future of virtual care:

- Ensure patient choice, access, and satisfaction.
- Enhance provider autonomy. Clinicians and patients together should determine the method they will use to meet for their virtual visit, and providers should be able to choose the technology they'll use, provided it's safe, effective, appropriate, and compatible with clinical workflows.
- Expand reimbursement. Federal and state health programs, including Medicare and Medicaid, should broadly cover and reimburse for all forms of telehealth. Private payers should compensate providers for

delivering remote care, and providers and insurers should be able to write contracts for reimbursement for telehealth services based on market conditions and value-based payment models.

- Normalize telehealth visits across state lines. Permanent regulations enabling telehealth should include adoption of interstate licensure compacts, flexibility for professional second opinions, and other necessary licensure portability policies.
- Ensure access to non-physician providers. All members of the healthcare team must be able to use telehealth as appropriate.
- Expand access for the underserved and at-risk. The needs of rural and urban communities that lack healthcare services, and the uninsured, must be addressed in all state and

federal health programs undertaken to promote telehealth. Special needs, like a patient's inability to access broadband, or lack of technical literacy, must be considered, too.

- Support seniors and expand "Aging in Place."
- Protect patient privacy/mitigate cybersecurity risks. Platforms, systems and devices should be required to mitigate cybersecurity risks and protect patient safety and confidentiality. However, government regulations should allow room for innovation, and support the advancement of technology-assisted care.
- Ensure program integrity. Patients, payers and taxpayers must all be protected from fraud and other abuses.

Adapted from the American Telehealth Association's Policy Principles 2020.



LEFT: Dr. Lyle Berkowitz is founder and chief executive officer of Chicago-based KeyCare Inc. RIGHT: Dr. Carrie Nelson is the Chicago-based CMO of Amwell, a Boston, Mass.-based digital healthcare firm.

team did showed that the top three barriers to the use of telehealth were patient-related—inadequate access to technology, difficulties in using the technology, and reluctance to use it. “We recognized the need to connect [patients] with resources to potentially overcome those barriers,” she says.

Telemedicine presents challenges in education, too, Dr. Alkureishi says, both around integrating trainees into virtual workflows, and helping students adjust to a training platform that itself is virtual. Her team developed a simple system for teaching basic skills called TELEMEDS (see chart).

Some specialties appear to be more compatible with telehealth than others, says Keith Horvath, MD, the AAMC’s senior director of clinical transformation. Some, like dermatology, often

diagnose visually. Behavioral health, which has embraced telehealth more than any other specialty, involves the patient and clinician sitting down together to talk. Both those functions translate well to video. Cardiology takes advantage of remote monitoring tools.

Dr. Alkureishi sees virtual care methods as an important component of any clinician’s training going forward, because telehealth will be, in her opinion, “one item on the menu” of how to seek and provide care.

Dr. Horvath notes that the Veterans Administration, which serves a younger group than does Medicare, is a leading innovator when it comes to telehealth. And telestroke programs, which were first developed more than 20 years

Frameworks to Measure Virtual Care’s Value

AS ORGANIZATIONS take a long-term approach to virtual care, many are constructing frameworks that provide guidance and direction for measuring telehealth’s impact on care delivery and outcomes.

In 2017 the National Quality Forum developed a framework with high-priority areas viewed as critical to understanding the impact of virtual care on clinical outcomes, access to care, financial impact, patient and provider experience, and effectiveness.

An NQF Action Team, in 2021, recommended next steps to support virtual care’s continued reimbursement and to normalize this setting for safe, high-

quality care. These steps include:

- Measure the quality of virtual care.
- Develop a national strategy on virtual healthcare use and reimbursement.
- Seamlessly and securely share virtual healthcare information across care teams and organizations.
- Use virtual healthcare to expand access to care and promote health equity.

Hospitals and health systems are also designing their own frameworks. For instance, the Mayo Clinic constructed a framework with four domains around which to conceptualize value of its

virtual care programs and to measure quality. The domains are: 1) economics; 2) experience; 3) function; and 4) equity in access to clinical services.

And the American Medical Association (AMA) has developed tools to measure the value of virtual care, including six value streams: clinical quality, safety, and outcomes, access, experience of patient, experience of clinician, financial impact, and health equity.

The AMA’s comprehensive framework accounts for the various ways in which virtual care programs may increase the overall “return on health” by generating positive impact for patients, clinicians, payers and society.



Dr. Sarah Song is a neurologist with the TeleStroke Network at Rush University Medical Center.

ago, have been instrumental in changing attitudes about who might receive virtual care (see sidebar).

“There has been an enormous amount of capital invested in telemedicine,” and practitioners and patients both accept its value. “I don’t think that toothpaste is going back into the tube,” Dr. Horvath says.

The Virtualist Will See You Now

Some firms are providing telehealth exclusively, employing doctors who might actually identify as virtualists (not yet a true specialty). Lyle Berkowitz, MD, a former primary care physician and longtime innovation and informatics executive at Northwestern Medicine and other healthcare concerns, is founder and chief executive officer of KeyCare Inc., a Chicago-based firm that makes virtual urgent care available around the clock to patients in all 50 states through its client health systems. KeyCare bases its services on the connectivity offered by Epic, the most commonly used electronic health record software.

KeyCare, which serves the Corewell Health system in Michigan (formerly Beaumont Health and Spectrum Health), has the capacity to offer virtual urgent care “24/7 in all 50 states,” Dr. Berkowitz says. Urgent care is usually the first thing systems want, so that’s what KeyCare started with, he says. Primary care and behavioral health are in the wings.

Epic is critical to KeyCare, he says. “It allows the data and the patient experience to be relatively seamless,” Dr. Berkowitz says.

Carrie Nelson, MD, the Chicago-based chief medical officer of Amwell, a Boston, Mass.-based digital healthcare firm with a number of institutional clients in the Midwest, notes that virtual visits with a doctor are only one of the potential tools of digital care. Others include remote monitoring and condition management. Before

she moved to Amwell last year, Dr. Nelson was an executive for population health and outcomes at Advocate Aurora Health.

Amwell provides virtual urgent and primary care for patients of its more than 2,000 client hospitals and 55 insurance partners, using Cerner and Epic EHR software. Amwell also has an extensive behavioral health program, Dr. Nelson says.

Dr. Nelson sees telehealth as a great platform for assembling individualized teams for patients that could include not only physicians and nurses but also nutritionists, social workers and others as needed “in a much more feasible way than was ever done in brick-and-mortar settings.”



TELEMEDS: Tips to Optimize Virtual Visits

T	Test it out first	Prior to the visit, practice using your virtual visit platform. Check audio & video. Test mute & screen share. Practice splitting the screen to allow you to see your patient & the EHR at the same time.
E	Evaluate your schedule	Identify patients who should not have virtual visits. Proactively anticipate needs for the visit (outside records, translation services, etc)
L	Lay out an agenda	Contextualize your visit agenda by reviewing your patient’s interval history (last note, labs, etc). Note any outstanding orders or preventative health needs that should be addressed.
E	Establish visit rules	Introduce yourself, team members & verify your patient. Determine a technical back-up plan. Identify your patient’s goals for the visit & balance those with your agenda items.
M	Modify your speech	Vary tone & inflection. Speak slowly to allow for buffering & lag. Pause for questions often. Check for understanding.
E	Encourage patient engagement	Look for opportunities to educate patients using screen share - demonstrate websites, review EHR information. Engage patients in note writing when appropriate and jointly create an after visit summary to reinforce the plan.
D	Demonstrate positive nonverbal communication	Maintain good eye contact. Smile or express concern when appropriate. Signal active listening by nodding or shaking your head.
S	Summarize next steps	Be specific about when & how to follow up. Encourage patient portal use to review their after visit summary & chart updates for reference. Elicit direct patient feedback.

DR. SARAH SONG PHOTO BY AMERICAN ACADEMY OF NEUROLOGY