Will Telehealth Continue After the Pandemic?

John Whyte, MD; Ceci Connolly

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JOHN WHYTE: Welcome, everyone. Thanks for watching. I'm Dr. John Whyte, chief medical officer at WebMD. How many of you had had a telemedicine visit? How did it go? Were you happy with it? Are you going to do it again? What's health care going to look like in the fall?

So to help provide some insights, I've asked my good friend Ceci Connolly. She's the president and CEO of the Alliance of Community Health Plans. Ceci, thanks for joining me.

CECI CONNOLLY: John, great to be with you.

JOHN WHYTE: You wrote a commentary in the *New England Journal of Medicine Catalyst* where you say, "These new telehealth-first products support a coordinated primary care system focused on prevention, management of chronic conditions, and the delivery of appropriate affordable care." How does telehealth do all of that?

CECI CONNOLLY: Well, John, thanks for reading that column. We really love that *Catalyst* publication. We think it's such a good, timely publication now in the health care field. And all of those ingredients are so critical to health care, as you know, and highly possible in virtual care but not guaranteed. So it's very important, as we're moving forward with telemedicine, that everyone recognizes there's going to be good telehealth and not-so-great telehealth.

And by and large, we believe that when you are connecting virtually with your existing clinical team, you are going to get that sort of coordination. You're going to get the seamless kind of continuity of care that is so valuable. So then if it's just a matter of a camera or a cell phone, you're still connecting with your clinical team in a really meaningful way.

JOHN WHYTE: But is that what virtual care is going to look like 6 months from now? As opposed to the camera or a phone, we have all these other digital tools. People are doing pulse oximetry at home. We're using a lot of our smartwatches to provide data. How is that going to change in the next few months?

CECI CONNOLLY: Well, in the next few months, it will continue to evolve at the pace that we've seen throughout the pandemic because, importantly, Washington still has in place this public health emergency declared at the start of the pandemic. And it's really enabled health care providers great flexibility to almost experiment and do things that used to be prohibited in a lot of cases, say, by Medicare. So that has really unleashed all of these creative forces in the health care field to do everything that you're talking about -- the remote monitoring, for instance, getting lab results in very short order because you can now get them electronically. That's going to continue apace, we figure, for the next 6 months.

But there's a very critical issue and time period on the horizon for the future of telehealth, and it's when that public health emergency declaration ends. If Congress or the Biden administration does not extend many of those flexibilities, we are very worried that we are going to go backward because there will be issues around a lot of roadblocks again, sort of regulatory roadblocks, hassles over payment requirements, etc. etc.

And we still know that for a lot of physicians, this is new terrain. And they need some incentives, they need some flexibility, they need some payment in order to really get comfortable and skilled using these new technologies. So I can tell you the Alliance of Community Health Plans, lots of other organizations, we are talking every single week with members of Congress and the Biden administration about continuing lots of these flexibilities so that we can keep innovating.

JOHN WHYTE: Well, for patients, what makes a good telehealth visit? Because you said earlier, there's good health. There's bad telehealth. So what's good telehealth, and how do patients make sure they have a good telehealth experience?

CECI CONNOLLY: First of all, it depends on the circumstance, right? For a lot of people during this pandemic and going forward, it's going to be that quick, convenient check, you know? My kid fell. He's got some swelling on his arm. Hey, do we need to go to the emergency department? No. Take a look on the camera. So a lot of that sort of quick answering of questions, triage not in the technical sense but in the directing patients and guiding them to right place, right time for right care.

And by the way, we think that's where some of the really exciting cost-savings come in, John? Because as you know, if you can resolve an issue with a patient on, let's say it's a Saturday, and they contact their physician's office. They get a quick answer, which is put some ice, take some Tylenol, and make an appointment for Monday. Hey, great. You've prevented a visit to the emergency room department. Big savings there for everybody all around. So there's that category of how we can use telehealth.

The really exciting parts are -- I'll put them in two buckets. One are for patients that maybe don't have terrific access to wonderful health care in their community. Maybe they're in a rural area, where it's a long drive. Maybe they're in a situation where it's not super easy or safe to get to a doctor's office, and they can start to tap into telehealth to see specialists in big academic medical centers that maybe wouldn't have been available or would have been a big journey. So that's a big piece of it.

And then the other is this ongoing relationship with your clinical team. Think about patients with diabetes, asthma, heart conditions, etc. etc., that they want to have those regular touch points. And now imagine that when you hop on the iPad to say hello to your doc or your PA or your nurse practitioner, and they're saying, oh, yeah. I've seen your Fitbit data. Great that you're walking. Hmm. You got on the scale. Looks like you gained a few pounds. Let's talk about that. And on it goes. And you can save a lot of time and trouble of office visits for that kind of ongoing interaction.

JOHN WHYTE: Going to push back a little and ask you, despite some of the improvements that we've made in terms of access, some people are saying that you know what, there's the risk the telehealth, telemedicine can actually exacerbate disparities. So everyone's not going to have broadband internet, that they're going to be able to have a good connection as you and I are having today. They may not have the right phone or the right tools to be able to clearly show the clinician what's going on.

I mean, we've seen a lot of uptake in telemedicine in urban areas in dermatology appointments, in telederm, whereas really we're saying we want to improve access to pulmonologists, to cancer specialists, to cardiologists, and orthopedists that they otherwise might not have access to. So how concerned do we need to be about the potential to exacerbate disparities rather than try to eliminate them, which is really what we're trying to do with this?

CECI CONNOLLY: Right. We do need to be concerned. We need to be thoughtful, and we need to be intentional moving forward. I want to give credit to the Biden administration and Congress. Some of the recent COVID relief legislation that's been enacted included pretty large sums of money for broadband and also discounting the cost of internet for many, many millions of American sort of low-income families. So great step in the right direction. We've got to make sure that's prioritized for happening very, very quickly. That's a piece of it for sure.

We also have to, though, really work on the health care industry. In my view, too many physicians and especially big hospital systems, as soon as the COVID surge calmed down, they were on the telephone calling patients saying, hey, come on back in because they're stuck in that old fee-for-service paradigm of they only get paid if you come in, you have a visit, they touch you, they write a prescription, they do a test, all of that list of to-dos.

When really if you are in -- we call it value-based system, but let's say it's an arrangement where your clinical team and your health plan are working together. They've agreed on a set amount of money to cover Ceci Connolly. Take care of her, keep her happy all year long. And then it's up to everybody participating to do that in the most economical, efficient, effective manner. Patient, doctor talking about that.

I am very, very concerned that too many of the big entrenched health care legacy systems, the big hospital systems that are used to that volume-based revenue, they're addicted to it, John. They are addicted to fee-for-service medicine, and we've got to break that habit.

JOHN WHYTE: So let's keep in perspective. We can address payment issues, payment parity for telemedicine. Let's acknowledge in January 2020 telemedicine probably represented about 2% of all visits, if that. By May or June of last year, at one point it was almost 80% of visits. What's it going to look like, Ceci, in January 2022? What percent of visits do you anticipate that telehealth will represent?

CECI CONNOLLY: I can tell you that we have members within ACHP -- these are nonprofit, provider-aligned plans, many of them integrated delivery systems. Some of them are shooting for 50%, John. And, of course, we need to put our little asterisk. Our friends at Kaiser Permanente, they're up around 80, and they're going to stay--

JOHN WHYTE: And they've always been set up for that, and they have a different payment model as you alluded to.

CECI CONNOLLY: Absolutely. And that goes for the VA as well, right? So it can be done, especially in a value-based environment. But I've got a number of other members within ACHP who are shooting for 50. And I wouldn't be surprised if the government continues to cooperate on these flexibilities, I think they could get up around that. For most of the industry, I bet it's going to be 20% to 25%, which maybe sounds low to us now that we've been through that pandemic experience. But that'd be pretty remarkable from, as you point out, where we were in January 2019, so still terrific progress.

JOHN WHYTE: Now, since I have you here, I want to point out to our viewers that part of your current role, you were a journalist for 25 years. Many years at *The Washington Post* covering Washington. That's why you have all our insider discussion.

So I'm just going to shift it just a little. And I want to ask you, how has the news media done in terms of covering COVID? Some people will argue, Ceci, it's too much doom and gloom. Others will say it's way too partisan based on the network or the publication that you're reading. So I want you to give a grade to the news organizations overall in terms of how we've covered COVID over the past 16, 18 months.

CECI CONNOLLY: I'm going to say, and I've got my gripes and my nits, and we can touch on some of those.

JOHN WHYTE: Tell us what your gripes are. Let's hear them.

CECI CONNOLLY: Yeah. But if you push me for the grade, I'm going to A minus, and I'll tell you why. I'm talking about mainstream media.

JOHN WHYTE: Easy grader. Easy grader.

CECI CONNOLLY: Well, because I understand the challenges, right? So in the same way that our public health officials were suddenly confronting something brand new and there were a lot of unknowns, especially in those early days, it was the same for the journalists. And by the way, most journalists don't have a science or medical background, even if they're writing about health care. So they're really on a steep learning curve every single day, and this was a brand new one for most people.

They also, by the way, had their own security and their family's health and safety and security to worry about. And when most of us were curled up in our cozy, little homes, they were out in Washington state for -- I know those folks who went and got on the plane and drove to the places and ran into the burning fire, so to speak, if you will. So I've got to give them, first of all, credit for that.

Secondly, and this is something I learned. When I was a journalist, I took a CDC boot camp. I learned an awful lot in that. And one of the lessons, one of the sections that we studied was risk communication. You really understand communicating risk and communicating unknowns and uncertainty to the public.

JOHN WHYTE: You're right. Communication is important, whether we're talking about the communication of risk around coronavirus or whether we're talking about how health care is changing and the role of telemedicine and the role of virtual care. And how do we make sure that in many ways it provides greater equity and inclusion rather than excluding folks as sometimes happens when we have innovation?

Ceci, I want to thank you for providing your insights today and all that you're doing for advocating for physicians and patients.

CECI CONNOLLY: Thank you. It's been a pleasure.

JOHN WHYTE: And I want to thank you for watching. If you have questions, drop us a line. You can email me at DrJohn@WebMD.net, or post on Twitter, Instagram, and Facebook. Thanks for watching.

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