AMA

Q&A: Telehealth here to stay, but doctors' key requirements remain

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The use of telehealth has skyrocketed during the COVID-19 pandemic. Its use will continue beyond the pandemic because physicians have found that telehealth improves the timeliness of the care they deliver, has improved the health of their patients and improved their own work satisfaction.

Those were the findings of the Telehealth Impact Study led by Mayo Clinic and prepared by the COVID-19 Healthcare Coalition of more than 1,000 organizations. The AMA collaborated with the coalition's telehealth work group in the three-part study, which included an analysis of telehealth insurance claims before and during the pandemic, a physician survey, and an ongoing survey of patients who have used telehealth services during the pandemic.

The study's data will be used to inform policymakers and others about the benefits of telehealth and how the temporary waiving of regulations that was done to facilitate its use during the pandemic should be made permanent.

"How telehealth will be used after the pandemic is in the balance, and no one wants to see new access to telehealth suddenly halted," said AMA President Susan R. Bailey, MD. "The time is now for government officials, physicians, patients and other stakeholders to work together on a solid plan to support telehealth services going forward."

John Halamka, MD, president of the Mayo Clinic Platform and co-chair of the coalition, recently spoke with the AMA about the study, the work of the coalition and its impact after the pandemic has ended.

A practicing emergency physician and one of the nation's leading health IT thinkers and doers, Dr. Halamka served as executive director of the Health Technology Exploration Center for Beth Israel Lahey Health in Massachusetts prior to joining Mayo. For more than 20 years, he served as chief information officer at Beth Israel Deaconess Medical Center.

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AMA: Why did it take so long for telehealth to be widely used?

Dr. Halamka: John Kotter, an expert in change management at Harvard Business School, has written that for anything to catalyze, you need an urgency to change and then you need a guiding coalition and a vision.

Well, for a decade, though we had these technologies, they were all outside of a physician's workflow. Oh, and you may not get reimbursed for a telehealth consultation. And how do you document it?

There was no urgency. What you saw happen in March and April was sudden recognition that there was an existential survival issue for health care providers to move to a telehealth model—even if it was a little outside of workflow or slightly inconvenient. Since the onset of the COVID-19 pandemic, Mayo Clinic has conducted more telehealth visits per day than all visits combined in 2019.

And what we found was the patients loved it, the doctors got used to it and, suddenly, it's actually becoming a new normal. And maybe it's not going to be the 4% in January to 90-plus percent in April all the time, but maybe a baseline of 20%. How many times have you seen, in one year, anything quadruple in volume? It just never happens without a powerful outside shock to the system.

So, it started with this existential urgency because patients couldn't come to the doctor's office. Then what happened was a sustainable gain that has led to a cultural change—both on the provider side and on the patient side.

AMA: Temporary policies that facilitated telehealth use have been extended through the public health emergency. Will they be made permanent?

Dr. Halamka: The hashtags that were trending with the American Telehealth Association were #DontRollBack and #RetainTheGain. I'll tell you the feeling that I get when I chat with people at CMS [Centers for Medicare & Medicaid Services] and HHS [Department of Health and Human Services] is that these are not going to be rolled back. These are changes that are going to persist.

Obviously, we'll see with a new administration what regulation and regulatory guidance they put forward. But if the issue is reaching more patients with more expertise and a better value, that's certainly consistent with what we need in health care in this country—and it's not partisan.

AMA: Yes, and ultimately many of these decisions will be up to Congress.

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Telehealth is often seen as an aid to rural health care. But, according to the study, some states with large rural areas such as Arizona, Colorado, Iowa and Texas are on the low end of the adoptionscale. What are the barriers there that hinder telehealth adoption?

Dr. Halamka: I was talking to my colleagues in the Netherlands and I said: “I'm curious, what's your 5G, LTE, cellphone connectivity or internet connectivity throughout the Netherlands?” And their response was: “Well, of course, every household has broadband access.”

You ask the same question in the U.S. and you see the problem that you just described, which is, obviously, from a market-based economy, your telecom providers are going to put in fiber or put advanced cellular in markets where there are many customers. And what that implies is that rural areas still don't have access to broadband.

We experienced this in rolling out Mayo’s advanced care at home, where we do remote-patient monitoring in the home, and 30 miles out from an urban area you may get into—not only not having a broadband connection, but not even having a good cellular connection.

The two answers are: On one hand, you need good connectivity, but also it needs a public that’s aware of the potential of telehealth. And in those rural areas, without a guiding organization providing access to telehealth care, people just may not know about the options.

AMA: What will be the impact of telehealth on health equity?

Dr. Halamka: I have two answers to that question. One is a good one and the other a not-so-good one. The good one is that it democratizes access to expertise. As I said for 25 years I was at Harvard—and here I was in Boston—and I could answer mushroom and plant questions in every rural corner of this country, no matter who you were. So in that respect, it reduced disparities.

On the other hand, it requires technology literacy. And you do worry that if you build a telehealth infrastructure that requires the use of advanced technology that could be expensive or require comfort with that advanced technology, it will worsen disparity.

> What you have to do is meet the patients at their level of technological comfort and affordability.
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> It’s just really important—as we look at this telehealth future—that we address all levels of technology literacy and affordability.

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AMA: Tell our readers more about the COVID-19 Healthcare Coalition and how you’re trying to help front-line physicians?

Dr. Halamka: It started March 13, 2020, with a couple of folks chatting about the need for having a private-sector effort to share information. We started in the first few weeks, March to April, with 1,200 companies working together in every aspect of COVID—from PPE and ventilators to telehealth.

We formed several work groups, and the telehealth work group had 190 members from 75 organizations and that includes tech firms, nonprofits, academia and startups. The issue was: what are the best practices? How are you doing billing? Are there any issues that you have with either Medicare or private pay that we can all learn from? Are there vendors that are better than others? Are there tools that are easier to use?

That’s the whole purpose of this coalition. And it’s free. It required no legal agreement. Everyone came together to learn best practices from each other, and it has been a really remarkable success.

To try to help the group, we did two surveys: the one on physician impact and we also looked at claims analysis to understand various trends. Just sharing this information has probably been one of the powerful things we can do at a time of great change.

AMA: Almost 70% of the urban and suburban physicians in the survey say they practice telehealth from their home. And it’s been reported that many patients take a quick break from their workday and go to their vehicles to have telehealth visits with their physician. Are these nonclinical locations the norm?

Dr. Halamka: I'll just give you my personal example. I run Unity Farm Sanctuary, the largest animal sanctuary in New England, and I will be shoveling out a stall and my phone will beep, and I will do an emergent ingestion consultation while being surrounded by horses. It gets back to this democratization of access—I’m available in real time 24/7/365, no matter where I am.

AMA: What digital health resources, policy reforms or new knowledge are needed going forward to combat COVID-19 and to prepare for the next pandemic, whatever or whenever it might be.

Dr. Halamka: Is our sole goal combating COVID? Our goal, to be honest, is societal resilience.

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We'll deal with COVID in 2021. But there will be other emergent infectious diseases. There are going to be climate change consequences. There will be natural disasters. And we need to think broadly about societal resilience for all of these. That may very well mean that, from a technology perspective, we need to build into our electronic health record systems those kind of data queries that will help us with whatever comes next.

> Let me give you a quick example. In the COVID-19 coalition, we were interested in analyzing early effects of certain cures like antimalarial drugs. Do they work or not? So we got every hospital in this country to submit a data set in a spreadsheet. And OK—it worked. But is that really the way you want to do deal with pandemics going forward? Sending spreadsheets around?
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> It would be better to ask: For societal resilience, what do we need to know?

The number of ventilators and beds available, the number of physicians on duty, the number of infections that you have today—whatever—and have that as an automated API [application programming interface], a thing that you could just call up in real time with no human effort so that we're ready to be agile for whatever comes next, and not have to put in a complete repeat of the effort we put in in 2020.

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