Telehealth Boon or Threat to Senior Care

Kelsey Mellard:

This afternoon we're going to talk a little bit about telehealth. Telehealth is probably a bit of a new topic for this conference in general, but certainly a model of care and a delivery service that is really going to be crucial to the sustainability of the senior housing community.

Kelsey Mellard:

It's really crucial to have this conversation today because telehealth can be instrumental in maintaining, sustaining and actually extending the value that senior housing has inside our communities and into the reach of homes, as we think about lead generation and connecting with our frail elderly seniors outside of a residential facility.

Kelsey Mellard:

Today, I'm joined by two incredible folks who are very steeped in the telehealth space. Michael from West Health. You may know West Health from some of the amazing research that they've produced in regards to how people age, dental care, telehealth. They have a series of topics that they cover for our aging community and Robin, who's the chief commercial Officer of Doctor On Demand. I'm Kelsey Mellard and I've had the privilege of working with the National Investment Center for Senior Housing for the past three years, as we've started to really push the envelope to think beyond the traditional bricks and mortar investment and how do we evaluate operators that are extending their services to attract and retain their residents that are crucial to their sustainability in their business model.

Kelsey Mellard:

Let's just dive right in here. First, we're just going to start with brief introductions with Michael and then he's going to really talk about some of the changes that we're seeing in the landscape today.

Mike Kurliand:

Sure. Mike Kurliand, Director of telehealth and process improvement at West Health. I started off as a clinician about 25 years ago as an RN and have stayed within healthcare in various capacities, administrator, clinician, strategist, IT department even, and had been a key part of some business development and joint venture relationships in some of the hospitals that I worked at, which started to lend themselves to exchanging data and information about the patient, which lended itself to telehealth. I became director of telehealth at a pediatric hospital. I don't know if you guys are familiar with the great state of Delaware there's DuPont Hospital for Children. Nobody. Okay. It's the second smallest state. It's on the East Coast, no worries.

Mike Kurliand:

After spending about 10 years in peds, I bounced over to geriatrics and seniors over with West Health. My job really is to work with organizations throughout the country, on research collaborations with West Health that involve process improvement, change management, but in particular around telehealth. Many hospitals have different ways and clinics have different ways of utilizing telehealth and

they need the operational expertise because there's not a lot of us out there to help implement these things. To give you a little bit of context and just dive right in... Oh, wait.

Kelsey Mellard:

No, keep going.

Mike Kurliand:

Keep going?

Kelsey Mellard:

Yap. Let's go.

Mike Kurliand:

Okay.

Robin:

I'll get them later.

Kelsey Mellard:

Yeah.

Robin:

Okay. To give you a little bit of context about just the environment we're in right now. This group probably knows that every day, people turning 65, there's 10,000 every day until 2030. Right. You also probably are aware that people are living longer. That's great news. The not so good news about that is that, we're living longer, but we have more disease processes along the way. Now, I don't know about you, but if you've made a specialty appointment or an appointment with your provider, depending upon the specialty you might be waiting.

Robin:

Now, it depends. It depends how severe the issue is. You might get in sooner than later, but I know because there's decreasing supply of providers, especially specialists. The wait time is increasing. What I want to do right now is paint a picture of the healthcare environment. If you think healthcare is ready, right now, today, to see you on a regular basis or when you're sick, think about what it's going to look like in 10 years, when we need about 40,000 more specialists, where we need maybe about 10,000 to 50,000 PCPs.

Robin:

Now, I look at the RNs and the different research says, some states will have more, some will have less, so the jury is still out. Right now, you have an increasing population of seniors, living longer, more disease processes, so that's going up. The supply is going up, but the caregivers, specifically the clinicians, right now, they are going down. That gap, right there is demand. If it's hard today, it's going to be harder tomorrow, unless our healthcare ecosystem starts to change. That changes with building better types of network and referrals, and working on innovative ways of delivering care.

Robin:

Scarier than this, to me, the decrease in the clinician, is the shortages of caregivers. Back in 2010, AARP found that there were 7:1 caregivers per person, that needed care. Now, these are unpaid caregivers. I don't know if you're a caregiver right now, but on average, they found that there are seven of them for one. Imagine the stress that you have right now as like one of seven. That number is almost going to be in half in 2030. You have a decreased number of clinicians and you have a decreased number of caregivers, and you have an increased number of seniors living longer with more disease processes.

Robin:

In addition, I don't know if you've seen, but costs just keep going up. 44 states spend more on Medicaid than they do on K-12. Do you guys know that? Those costs aren't going down anytime soon. There's a lot of talk of value-based contracting, but that still hasn't really been adopted at scale just yet. In the trifecta of people, process and technology... Whose phone is that? Tom, I'll be right there. Yeah. No, it's okay.

Kelsey Mellard:

It's a telehealth call. It's a virtual visit.

Robin:

In the trifecta of people, process and technology, if you have less people, you need to leverage process and technology more. You're going to have less clinicians, less caregivers and this is where telehealth comes in. Telehealth right now is at a stage where it's so very nimble, from a business model perspective, and from a contracting perspective.

Kelsey Mellard:

Michael, I think that's a perfect segue into telehealth has been here through all of it…hitthe next slide. Telehealth is not new. It's been around actually, for arguably 70 years in some form or fashion and was first used actually in the NASA days. As Michael was alluding to, the adoption has been pretty sporadic. I think what we're finally seeing in the market is, there's serious adoption, and it's solving serious problems, and there's actually business models and reimbursement to help us adopt this. That's some of the topics that we'll be talking about today. Go ahead.

Kelsey Mellard:

As we look at telehealth as an industry, it's massive. It's supposed to be a $64 billion industry by 2025. This is certainly something to be aware of. A really interesting thing, as Michael was alluding to, in regards to the population that's going to be entering the sweet spot of utilizing telehealth is that, that population is already one of the largest cohorts of people that are submitting insurance claims for telemedicine in 2017. Furthermore, patients not only like it, but also providers like it. We see an increase of provider adoption of these types of mechanisms to actually practice really high quality personalized medicine.

Kelsey Mellard:

Quick poll here in the audience. How many of you have used telehealth? A raise of hands? Okay, good. That's pretty good. Yeah, that is really good.

Mike Kurliand:

Our work here is done.

Robin:

Yeah. Exactly.

Kelsey Mellard:

All right. There's four types of telehealth that we want to cover today and recognize in methods of adoption and this is really to start to create some structure for how you can think about adopting telehealth and the types of telehealth that exist in the industry, for you to then bring inside your care facilities for your seniors that you care for. We're going to hear from Robin, from Doctor On Demand on… can you just leave it there.

Mike Kurliand:

Go back, sorry.

Kelsey Mellard:

On the live video chat, I'll be talking about my company, Sitka, and we do asynchronous video. Obviously, remote patient monitoring is a pretty significant area of opportunity as we think about workforce development and extending our workforce. Then of course, mobile health with, again, wearables and how we integrate this into an infrastructure that's really important called electronic medical records that can also be quite a bear at times for all of us to interface with. Those are the four models that we're going to start to really dive into today and elicit different examples and adoption strategies for each of these. How many of you liked your experience with telehealth? Okay, good, so generally pretty positive. How many of you did not like it?

Robin:

It's okay. Give it a minute.

Kelsey Mellard:

Wow, okay.

Mike Kurliand:

I've had docs yell at me that they did not like it. I mean, really like, "I was meant to use my hands, Michael."

Kelsey Mellard:

All right. Let's keep diving in here and pass the baton to Robin. Robin, if you could just introduce yourself and then share a little bit about what you guys are up to at Doctor On Demand and how these folks should be thinking about adopting a strategy and a model like Doctor On Demand inside their care facilities.

Robin:

Great. Thanks, Kelsey. Hi, everyone. It's really nice to get the chance to meet you all today. This is my first time at the NIC conference and really, really neat to see this many people gathered together, thinking about how to forge the future for a population that really needs new and innovative strategies for doing so. I've been in healthcare my whole career. I've done a variety of different things representing all different players in the healthcare ecosystem. I joined Doctor On Demand as the president and chief commercial officer actually last year, and I came to DOD from a company called Evolent Health where I was the chief customer officer. What Evolent did, was really helping provider and payer organizations navigate from a traditional fee for service medicine, to a business model of value-based care.

Robin:

Mike referenced this idea of rising costs and not seeing the great outcomes that we're all hoping to get. That's what really did at Evolent, was we looked for models of ways that we could improve that value equation. Really, the reason that I decided to join Doctor On Demand, coming out of that experience was that, what I started to realize over my seven years at Evolent, was that there were precious few interventions in healthcare that actually did that, that actually could bring costs out of the system, and at the same time, maintain or even exceed some of the quality standards that we're delivering in healthcare.

Robin:

What Doctor On Demand does, and the premise of the organization that really allows that to happen is, we bring together innovation and compassionate care. If you look at our team, we've got folks who design some of the best user experiences in the financial services world and other industries in Silicon Valley on our tech side, and then we've got some of the foremost clinicians who really understand how to take that technology and apply it to a high integrity clinical model.

Robin:

Doctor On Demand was started back in 2014. We were the first company really to launch in virtual care after the advent of the smartphone. Our approach is to start with a video experience. We can also do phone calls and text, but we really believe in the value of that face-to-face experience, to establish a relationship between a doctor and a patient. We offer care 24 hours a day, seven days a week, at the touch of your fingertip. Basically, you can be face-to-face with a physician within five minutes. That's the overall model of what Doctor On Demand does. I'm going to spend most of the time talking more broadly about what virtual care can do and offering up some examples from our work at Doctor On Demand. I think it's important really to understand, what is the value proposition of virtual care to all of the players inside of virtual care? For that reason, we have this slide here, which shows us some of the key stakeholders. Some of this is pretty specific to Doctor On Demand.

Robin:

We're going to start actually down with the providers. Mike talked about the shortage of providers. There's also a huge challenge of burnout in the physician world. I'm sure many of you have heard about this. There's sky high suicide rates among physicians right now, really, really egregious issues of physicians feeling worn out from what they're doing, and feeling like they're spending a lot of their time battling with an EMR instead of getting to deliver patient care. The virtual care setting that Doctor On Demand has created is, we employ our physicians. There are some companies that do it almost like a gig economy where they're bringing people in for shifts, but ours is a national physician practice where we have physicians licensed in all 50 states. We hire a lot of internists, family practice, we have some

emergency medicine physicians, pediatricians. We also have a very robust behavioral health practice. We hire a lot of psychiatrists and psychologists to deliver behavioral health care. They are getting to practice out of the comfort of their own home and in a reasonably flexible schedule. We also have built an entire care team to support them in their efforts, so we have nurses, social workers, dietitians, pharmacists, a myriad of different professionals who help the physicians to deliver care and also provide a lot of navigational support to patients as they're working through their care journey.

Robin:

That's the proposition for the provider side. Going up to the patient, if you think about the experience that we've created for patients, it's pretty crummy in a lot of ways. You're waiting 25 days to get to see your primary care physician. You're needing to figure out transportation to get there. You're sitting in a dingy waiting room hoping that you're not picking up the next bug while you're there. Then when you actually get into the doctor's office, you're looking at the back of your physician as she types furiously into this electronic medical record. The idea that we can take that whole experience and really transform it for patients is a pretty big deal, where you're actually able to set up a visit and experience that visit, all in the span of time that it sometimes takes just to schedule an appointment.

Robin:

We've set up our experience and you'll see this in a few minutes when we get to the slides that show the actual view of the app. We've set it up so that the patient and the physician are face-to-face throughout that entire visit. Another piece which, again, is pretty specific to Doctor On Demand is, because our physician practice is employed, you actually can build a long-term relationship with whichever physicians you see. What we found is, 30% of our patient visits are returning patients, and... Sorry, 70% are returning patients and 30% of them are actually seeing the same physician over and over again, which is part of the reason that we started to move more so into full primary care.

Kelsey Mellard:

Robin, I think that's a really good point and certainly synergistic with the senior housing community. Right? How you guys think about building the relationships and being the consistent face whether it's the CNA that’s seeing the patient, whether it's the folks that are cleaning their homes, or serving their food. Consistency of workforce has certainly been a massive topic of conversation that we've had here over the past several years and I think really complimentary to this concept of consistent face on a screen, even if it's not in person, how can you extend that into their own home? Yeah.

Robin:

Great. Great. That's an excellent point. Then lastly, for the payers, and Doctor On Demand largely works. We have a direct-to-consumer part of our business. Anyone can download the app and use it. As far as the companies that we work with, we largely partner with employers, and with health plans. They're trying to solve all these same issues that Mike laid out, so how do we expand access in a world of provider shortages? What can we do about rising healthcare costs? How can we ensure that our members or our employees feel really engaged and attached to our health plan, or employer? Doctor on Demand or really any virtual care company presents an opportunity to truly drive down costs just at the unit economics level, as well as potentially reducing downstream healthcare costs, and to do so in a way that's highly accessible, and leads to high quality care.

Robin:

That's the overall analysis of the stakeholders. I'm now going to zoom way in and talk to you about a particular patient. Maybe I'm not. Give me one more chance to do that. What we have here is Jane Smith. She's 66 years old. She has a history of hypertension. That's a known health issue that she has. She's also just come out of having a pretty high stress career and now adjusting to a retirement phase of her life. Under the surface, there are certainly some behavioral health issues that she confronts.

Kelsey Mellard:

I'm sure this case is not familiar to any of you. Right?

Robin:

Yeah. She has a daughter named Michelle. Jane lives in Southern California. Michelle actually lives in New York City, and does her best to support her mom in all of her care, but that's obviously hard to do from such a long distance. In this case, Michelle's really encouraging her mom to have her hypertension looked at again, and just to make sure that, in fact things are managed. What we'll show you in a second is a series of screenshots of what their care experience is like through Doctor On Demand. Essentially, they are able to access care through a primary care physician, that helps to establish a care plan that addresses not only the hypertension that Jane has, but also starts to get at some of the underlying issues around diet, nutrition, and then also some of the behavioral health considerations, which we all know lead to much worse health outcomes on the underlying physical conditions as well.

Robin:

In addition to getting the support of this primary care physician who can be an ongoing relationship for Jane, there's also the opportunity for her to have smaller and perhaps in some cases, text message-based or phone-based interactions with this broader care team, who can help her stay on track and then she can do these additional sub-specialty appointments that also address her health issues.

Robin:

I'm going to switch now to showing you how this comes to life using our app. We'll just walk through this really quickly. This is what Jane sees when she first goes to the Doctor On Demand app. She fills out some basic information about her health history, as well as any of the issues that she's facing, the symptoms that she has right now and she's given a choice. She can either go to, set up an appointment with her primary care physician, or she can see the first available physician if she feels as though her need is really time sensitive. She also has the chance to send a message to the broader care team that I mentioned, and also make an appointment for mental healthcare. Our mental health care, we actually train all of our primary care physicians in first line mental health care. They've been taught assessment management and they can prescribe for mild to moderate anxiety and depression. Then they can also obviously refer into our mental health practice, which is by appointment only.

Robin:

That's her first interaction. It then asks her, does she have any remote monitoring devices that she wants to synchin? We have an integration with the Apple HealthKit, as well as with Google Fit, which then, both of those platforms integrate with a number of other devices and so forth. We have now a lot of patients that are actually uploading data to our platform, often. Then this is an example of a visit that Jane has with Dr. Tong her primary care physician. You can see that, not only is Jane featured here, but Michelle, her daughter is also in the visit. This is a three way visit.

Robin:

This allows, in this instance, an adult child to be truly involved in their parent's care. There's a ton of research that actually shows, I'm sure you guys know this better than I do, that end of life decisions and care in the late stages of life, are made much better by family caregivers who are close to the patient and who actually have more day-to-day interaction to understand what's going on with them. Being able to shrink that 3,000 mile distance and really engage Michelle in the care experience is a pretty big deal.

Kelsey Mellard:

Robin, I think this is an absolute game changer for how we should think about senior living and senior housing and extending what we would historically consider a typical IL or AL into actual clinical setting that could be offered inside all of your communities today, while including the family. This is earth shattering. As an industry, from a technology standpoint, and also from a service and delivery standpoint, the opportunity has never been greater.

Robin:

Yeah. I'll go really fast here. This just shows you, one of the things that we're able to do through our platform is to really provide the provider with great data about what's going on with the patient. We've got these longitudinal graphs that show all of the patient's vitals over time. A patient like Jane who's got hypertension, the physician can very easily digest information about how her care is progressing and what the outcomes are. Again, one of the things that patients absolutely love about what we offer is that, this then becomes an entirely transparent way that they can see all of their health information.

Robin:

They can go back to our app, they can see about all the visits they've had, they can read the soap notes, they can see the results of their lab tests. It just gives them a place where all of this information resides, which is, as you can imagine a really big deal. This is the care plan that Dr. Tong produced for Jane, so that both the care team, Jane and he can really monitor the next steps associated both with her hypertension as well as her behavioral health. Then this is an example of an asynchronous message that Jane sends to the care team as she's just following up on one of the results from one of her visits.

Robin:

Then lastly here, there's also a great opportunity to provide education to patients. We use our app to send information on their diagnoses. We've got some video content that we also share with them that, again, takes what can be a pretty overwhelming and confusing moment when you're being given a diagnosis and being told to do all of that, to start living your life in a different way, being able to go back to a video and we'll talk about the power of video in this fashion when we get to Kelsey's section as well. Just having these instructional videos really helps to demystify a new care plan.

Robin:

Then, lastly, the vitals and all of this health data becomes a resource, not only for the patient and the physician, but also for the care team who can be checking in and seeing how Jane is doing in her health journey. So, right.

Kelsey Mellard:

That was pillar number one. Right? Video visits as one version of a concept into telehealth. The next one that we want to dive into is asynchronous video. This is that second bucket of opportunity of telehealth. Ironically, and coincidentally, this is the company that I founded two years ago with two other co-founders and our company's name is Sitka. I'm just going to take you very briefly through what we do.

Kelsey Mellard:

What we do is, we're a specialty provider marketplace. We are a virtual specialty provider marketplace. Unlike Doctor On Demand, we employ in-contract specialists as opposed to primary care physicians. We love the Doctors On Demand of the world because it gives us an opportunity to partner inside the community. We built an asynchronous video messaging platform so that you can actually do all of this without the tyranny of scheduling, which as we know, is a massive problem throughout our healthcare system today. What we think about doing is really powering connectivity. We love working with primary care physicians who actually need access and want to refer a patient to a specialist. What we've done is, we've taken the historic Curbside Consult and updated it via video.

Kelsey Mellard:

How this looks is that, we can actually go through and have physicians request a consult via video. This is on their app. We partner with folks like ChenMed and Iora and primary care capitated groups to actually give them access to specialty providers in less than seven clicks. This is how the workflow literally works. They request a specialty, they select it and then they actually create a video. It sounds something like, "Hi, I'm Kelsey. I have a patient, Mike, that's sitting in front of me today. Mike is 70 years old. He has nothing remarkable about his HMP, but I'm concerned of a rheumatoid arthritis diagnosis. I want to show you his hands. Mike, here's your hands. What do I need to do to get a definitive diagnosis and a care plan started?" That video is sent to one of our specialists. Our specialist reviews the video and then responds via video as well, so that the patient and the family can be included in all of this as Robin was alluding to.

Kelsey Mellard:

It really allows practitioners to stay at the helm of their patients care without having to refer the patient out, organize transportation, organize patient copays, and then to have the patient not show up. One of the things that we're most excited about is, the most frequently accessed specialties that we see, of course, totally correlate with where most of the specialty spend is across the Medicare population. What we really can do is actually reduce the total cost of care by reducing unnecessary specialty visits. Then also, as we already heard about the shortage of specialty providers, we can actually tee up those specialty providers in a way that allows them to practice high quality medicine in the comfort of their own home as well. Very similar model to Doctor On Demand, slightly different approach in that we're not a synchronous video chat. We're asynchronous and we're specialty.

Kelsey Mellard:

What we love about it is that the providers love it. Because the providers love it, it actually increases the response time. If you were to submit a consult request, if you're a primary care physician, submitting a consult request on Sitka, you'd get an answer in about six hours and 20 minutes back from one of our specialists. They love the video aspect of it because it really fosters trust and collegiality in a way that most of our electronic medical record systems have completely fragmented and really caused a lot of anxiety around using. As you can see, it was really easy to get the answer. It just makes sense. This

screenshot here is actually a physician of ours. She's a rheumatologist, Dr. Sakeba Issa. She's based in Chicago and this is just a still screenshot of her responding to one of the primary care visits.

Kelsey Mellard:

That's asynchronous video. We want to keep going down this journey and talk a little bit about remote patient monitoring and the application of remote patient monitoring in the context of telehealth and wearables and what we can do to actually create actionable data as a result of it. Robin alluded to this in some of the work that they're doing around blood pressure monitoring and uploading data. This is very similar to that. At Sitka, we partner with a diabetes management program. This diabetes management program, deploys continuous glucose monitors to all of their diabetics, type 1 and type 2. This is a DexCom G6. This is something that you wear slightly underneath the skin. It's pretty comfortable. I've actually worn one, not because I'm diabetic, but as an experiment because I wanted to see what patients went through. What happens to the data off of this continuous glucose monitor is that, it tracks your blood sugar for 24 hours a day, over a 10 day period. That's the longevity of the device.

Kelsey Mellard:

We upload that device and review it with the patient. So this patient is getting a personalized video message of their data being reviewed by a diabetic educator. This is where you can actually start to change behavior and drive adherence into chronic care management programs, which, of course, is a massive issue when we're dealing with our seniors that, as Mike pointed out, have massive chronic complex conditions, that how do you actually intervene at the right time? We know that personalized intervention is the only way to go. We all think that we're special snowflakes, and guess what? We are. If we're not treated as such, then we're totally out of luck. Everyone can completely understand that inside the communities in which you operate and invest in everyday.

Kelsey Mellard:

Not only can it create actionable data, but the personalization of it is really, really crucial. Patients love this. On average, our videos are watched 10 times. That's crazy, you guys. These videos are watched 10 times about someone's data. What does that ultimately say to us? It ultimately says that the interaction that we're having inside the doctor's office with a specialist, we're probably not retaining any of it. People can share these videos, they share it with their family members. We've had patients share the videos on Facebook, on their diabetic support groups. It's their data, they get to do this. It actually is where we can start to understand and drive adherence and education beyond one person at a time.

Kelsey Mellard:

Over Christmas, we had a patient watch their continuous glucose monitor review 33 times on Christmas Day. I was like, "Whoa. We've got to talk to this guy." We called the patient and I was just really open about it. I said, "I'm really curious. What in the world did you do with that video?" He said, "Well, my mom has diabetes, my brother has diabetes and we've never seen anything like this." He lived in the south, hence, like the accent that I'm trying to portray. When you start to really break down complex chronic disease management, there's such a lack of understanding that it does take 10 times for someone to watch a video, to actually understand what's happening inside their own body with their blood sugars, in this case for diabetes.

Kelsey Mellard:

We do very similar work when dispelling myths about MRIs, and back pain, and triage, and routing, as it relates to other chronic pain management issues as well. Patient satisfaction is what really keeps us motivated in the watch rates across our entire population. We've had patients as young as 12 and patients as old as 92 remain the same. Also dispelling the myth that seniors don't like technology and they won't figure it out, we find is totally inaccurate, which is why we're so excited to talk to everyone here about telehealth and engage with you in this conversation.

Kelsey Mellard:

The quote here about nice to have someone talk face-to-face with me, we are not a synchronous platform. We are an asynchronous platform, but that was the impression that the patient had when we asked them how was it to receive a personalized video and they said, "It was really nice to have someone talk face-to-face to me." We're like, "Huh, okay, well, interesting." That is the power of a personalized video message.

Kelsey Mellard:

We've gone through several examples of both video chat, asynchronous video, remote patient monitoring, and what we want to do now is say, those are all examples of telehealth. Now, what does this mean for adoption? What is the regulatory environment? What does the payment landscape look like? We wanted to just start to tee up several different concepts for folks to consider. One, policies. Telehealth can be a state by state regulated business and it certainly is. Another is, obviously the reimbursement strategy, which we're not going to spend much time on here because we think that there are other crafty ways that you guys as owners and operators can be employing, and adopting, and partnering with telehealth companies that we'll talk about, which lead into the business case. Then, we were prepping for this conversation with you guys today about, what are the risks of adopting telehealth? It's really the risk of not adopting a telehealth platform inside the confines of your service offering today. Mike, talk to us a little bit about the reimbursement landscape that you guys have seen at West Health and then and then we'll tee up a few other examples.

Mike Kurliand:

Sure. This is just a quick snapshot of the variations of reimbursement. If you want to go for fee-for-service, or work with an MA plan, a state Medicaid program, private and commercial insurance, all have variations. There are variations from region-to-region, state-to-state. I'm going to tell you right now, until the incentive structure changes at a large scale, don't do this. There's better ways of generating revenue. I think that's working directly with some of these very nimble telehealth companies. I can tell you that the two companies at the table up on stage right now are not your typical telehealth companies. The telehealth organizations are not all created the same. Understanding what you want for your residents and for the population that you're trying to attract is really, really important before you go in and select.

Mike Kurliand:

What you have here, on Doctors On Demand, you have almost a developing wraparound service, including primary care providers, very unusual in the telehealth space. The fact that you can find that same provider, again, through that video is a rarity. I'm not here toting Doctor On Demand-

Robin:

I didn’t pay him.

Mike Kurliand:

... but it is a rarity to find that kind of situation. Asynchronous video is still very new, but very needed in the whole healthcare ecosystem. Right now, providers, when they want to get that curb side consult, do you know what my docs have to do? They have to stop, they have to pull up the record, they have to type something out, they have to find some kind of portal to send it to a specialist and they have to make sure like, please I hope it went through the portal the right way, send it off and then get back a written document, something that then they share with their patient, which is great, that helps the provider and the patient, but think about how more powerful that is, if the provider was right next to the patient, helping conduct the assessment and they both get the feedback of that specialist. Very, very powerful, very, very unusual right now.

Mike Kurliand:

I say this, as you go and you look at the plethora of telehealth organizations, really figure out what it is that you want to gain and what you want to make available for the people that you serve. You're going to say, "Hey, why now?" I don't know if any of you have been listening to the news, but there's this virus going around. One of the things that we keep hearing is about the use of telehealth to help keep patients and residents in their place and conduct the assessment from there. It's safer. They're not traveling. It's safer for everybody.

Mike Kurliand:

Right now, a lot of organizations that were even just thinking about telehealth, are scrambling to operationalize. You don't want to be one of those organizations that are scrambling to operationalize. One of the biggest reasons folks have gotten into telehealth, from a business perspective, has been the market differentiation. We have telehealth, the folks down the street don't. That has driven a lot of business, a lot of dialogue to those organizations that have telehealth. If I could beam in, and talk to my mom, and somebody on-site, in the clinic or at the residence, I'm going to be leaning towards that site, so the market differentiation, the access to care, the timeliness of care. I mentioned that earlier. The timeliness of care is only going to get worse until healthcare changes. Healthcare changes with innovation like that's sitting beside me.

Kelsey Mellard:

Mike, talk a little bit about your experience with helping some of these facilities actually implement a telehealth strategy and what it's done for their existing staff. Because, I think some of the points of rhetoric around this is that, "Oh, I'm not going to need as many people or should I be threatened by my organization adopting telehealth? Does that alleviate the need for me to show up? Who initiates all of this? What are the care coordination features around it? What does this actually do to the frontline care support?"

Mike Kurliand:

Sure. As you're asking me that question, my mind went to this specific example of all places in South Dakota. Okay? I'll give you another example too, here in San Diego. I go to an assisted living facility, very nice one in South Dakota, with my team, because, telehealth isn't really robustly implemented within assisted living facilities. We heard rumors that there was this really successful installation and we wanted to see it, because I'm a person that's like, I'm really optimistic, but I don't believe it until I get there and see it. It might be the Philly in me. I go there with my colleagues and I should have dressed down or something, but I was dressed like this, uptight. I show up-

Kelsey Mellard:

Are you saying that the NIC conference is uptight?

Mike Kurliand:

I may have accidentally just said that. Not on purpose. I think we would probably be better off in a T-shirt or something more..anyway. I go to this assisted living facility, dressed like this, and they bring in a very, very simple, iPad on a cart with a device that allows you take to auscultate lung sounds, heart sounds and do a complete assessment. The two staff members, one was a medical assistant, one was a CNA, they looked at me and they said, "Oh, no, you're not taking this away. We love this thing. Our residents love it." I said, "No, I just want to know what you thought about it." If you think maybe it was staged, no. The look on their face was completely, "Don't take this away from me." Assisted living facilities, it's very important that you pick the right telehealth organization in order to implement the right way in any kind of facility.

Mike Kurliand:

There was another facility in San Diego, that I was part of, that we help try to implement telehealth in. I'll get to like the other staffing. The staff there, turned over from top to bottom, over and over and over. In order for us to successfully implement, we didn't really have any anchoring people. Years later, a big aha moment came to me. It wasn't necessarily just the staff that we had to work with, it was the residents. At the end of the day the residents are going to make this work. If they're not believing in it, and if you don't have a dialogue with them when you're bringing in something innovative, it doesn't matter if the clinicians or if the employees are pushing it. It's not going to happen because nothing travels faster than a resident whispering to another resident.

Mike Kurliand:

Now, you guys are probably familiar, nursing homes, assisted living facilities, skilled nursing facilities, somewhere between 30 and 50% turnover rate, RN, CNAs. It's hard to train people. My organization worked with some nationally recognized telehealth providers in the post-acute and long-term care space. That includes nursing homes and assisted living, long-term care. We heard from their experience and from site visits that staff loved it. They felt that they finally had someone or something to support them if something was happening clinically. Turnover started to decrease.

Mike Kurliand:

How powerful is that for morale? Now, telehealth, you have three advocates up here. We do know it's not the silver bullet. At least I know. It's not the silver bullet. It's just one of many things that needs to make a better healthcare system work better. You need your staff and you need your residents. All these things, resident satisfaction, the access to care, comes along with these improved processes and these innovative tools when implemented appropriately.

Mike Kurliand:

The business models is my favorite thing here because these companies are so new and flexible with how they want to make a dollar. They can partner with one another. They can partner with payers. They can partner with providers. They could partner with anyone. It's uncanny the type of savviness that the chief commercial officers and their general counsels have developed over the years, because they can talk and position themselves with anyone in the healthcare network ecosystem, unlike anybody else, because they can be provider and they can work with the payer. They can be just a platform as well. It's

unusual. If you as an organization are thinking about it, find the right telehealth organization. If you have a business model idea, pitch it. There's no one-size-fits-all. These companies are very, very savvy, like their technology, in figuring out ways to make it work for both of you.

Kelsey Mellard:

To that point, Robin, can you talk a little bit about how you would partner with a post-acute or skilled or IL facility. Would this be like something, obviously, your sweet spot historically has been insurance and the payers, but in my naive mind, it could be like a wraparound that's ultimately passed on to the resident or something along those lines.

Robin:

Yeah. Yeah. I mean, it's a great question. Certainly, my wheels have been turning ever since I started preparing for this and especially hearing both of you talk. I think there are a lot of different ways that we could support this type of model. Certainly, as you described, Kelsey, a wraparound model where we could provide coverage for nights, and weekends, and times when it's harder to access physicians. You'd imagine that, that would bias heavily toward more of an urgent care type of care, or certainly you could do behavioral health. I think also, there's the opportunity to create more of a primary care model, because what you have is a reasonably stable patient population as well as a stable provider population. I think it's no coincidence that folks in South Dakota love this because, one of our health plan clients, their service area includes South Dakota, and there are major access issues there.

Robin:

People get a little skittish at times thinking, "Is this going to replace the primary care physicians in our community?" The reality is that, in most places, there's truly a shortage and so being able to introduce a form of primary care that's not as geographically bound, has a lot of opportunity. I could certainly envision a scenario in which you could set this up to be full scale primary care. I think, Mike, you're right, that there is a lot of future possibility in terms of the financial model for how it would work. I'm not proposing any on this stage today, but I think there's a very clear path where this goes down toward value-based care, and capitation models and things like that. We're, as a company, preparing for that eventuality now and I imagine you all would have some really interesting ways that you could envision having this fit inside your own business models.

Kelsey Mellard:

Great. Mike, talk to us a little bit about, obviously, you articulated that we're all advocates for telehealth for a wide variety of reasons, but you have the most research-oriented mind without a dog in this fight like Robin and I do, but tell us a little bit about, where you see beyond the previous slide of generating better patient experience, like extending length of stay. Talk to us a little bit about the specificity around adopting a telehealth strategy inside an AL/IL facility.

Mike Kurliand:

Sure. I'll give you one example, actually, a combined example with some of these organizations that work throughout the country in this space. They have found that they could avoid unnecessary ED transportation and utilization anywhere between 40% and 60%. Now, that's their data. Then there's the peer-reviewed research data that the 40% to 60% still needs to catch up to. I'll probably see that in a peer-reviewed journal in a year or two. There's other data anywhere between 4% and 40%. These companies are close to it. They're being very, very successful. If you're a provider in an area that has one

major healthcare provider, and they are on the hook for that patient population, and you could avoid 40% to 60% utilization of the ED, now I don't know if you know this, but like when a patient gets transported or a resident gets transported in the ED, in the ambulance, they start to de-compensate. Everybody does. It's a confusing, stressful environment.

Mike Kurliand:

Then someone gets to the ED, and depending on how busy that ED is, they may not be seen for hours, also a confusing, stressful environment. Then the worst case scenario, if you ask me is, if they get admitted, just for two days even and then they go back. That person is worse off. Wouldn't it be much better if you could treat that person in-place with a mini clinic? Now, organizations throughout the country are starting to do this. They're looking at it and obviously there's levels of care that you can and you can't provide just yet because of maturity of how people deliver telehealth.

Mike Kurliand:

The data is out there. It supports treating people in-place when you can. Ultimately, understanding what you want to do when you start working with these telehealth organizations and when you start looking at your community, that is probably the place that you have to start first. If you want to be a place where you can help treat people in-place, then you have to look at technologies and processes that can do that and it's not something that you just plop in. If you're going to have a strategy, it's more about how you engage with the community that's there, the providers that it impacts and your staff. I'll pause right there.

Kelsey Mellard:

Great. Yeah, thanks. We want just to close out our comments and really start to engage with you all for the last few minutes of our time together. There's a lot of different ways to start, as Mike was just saying, but having clarity on where you want to start and how you want to start and what's important to your residents and to your staff, is the absolute most important place to start to consider which path to go down to get started, whether it's remote patient monitoring, synchronous primary care and urgent care visits, asynchronous based on wearables, specialty providers.

Kelsey Mellard:

There's obviously a ton of options here. Mike and his team have actually put together a really fantastic implementation guide for how senior housing facilities, owners and operators, should actually start to contemplate what an adoption strategy looks like and it's called the implementation guide off of the West Health website.

Mike Kurliand:

I have a card if you want...

Kelsey Mellard:

Alright, so we want to hear from you. After this and maybe before this, how important is telehealth to you in your community? Yeah.

Audience:

Well, I've seen that I think it's very interesting and it could be very, very helpful. Frankly, I'm older than the 66-year old and I'm not sure I want my children meddling in my health. [crosstalk 00:56:56]. I don't. Thank goodness I don't think they have any interest in doing that either. I certainly wouldn't want a busybody child telling me how to live my life. [inaudible 00:56:59] The thought that occurred to me, with every technology, there's always a certain resistance meaning it takes time to find out how it's going to work. For example, this meeting here is not being live streamed, even though we're in a coronavirus situation and it could be-- that technology's been there for at least the last 10 years or more, so it takes a while for it to be adopted.

Audience:

Mike pointed out that one of the pressures that will lead to more technological adoption, to improve the efficiency of healthcare delivery, is the increasing demand with the baby boomer group. I thought well Japan's way ahead of us, way ahead in that. How is telemedicine adopted in Japan? Has that been a well received response and what experience has Japan had from this trend of efficient delivery of health?

Kelsey Mellard:

Yeah, Mike, what does your guys's research show about international adoption these days?

Mike Kurliand:

Well, we haven't really looked at Japan. We've actually focused more on the United States and trying to work within the confines of our reimbursement and healthcare structure here. The lessons learned is that, telehealth does work. Then they fall flat when you start talking to large healthcare organizations and they immediately want to talk about reimbursement and how they can get revenue from it. They don't look at those other timeliness of access to care, decreasing cross contamination and anything, that has been that has been a secondary, third conversation.

Mike Kurliand:

So there is resistance, but fortunately, the resistance is starting to break down. Even in the beginning, I mentioned that I had like a doc, yell at me like, "Mike, I don't want to do telehealth." I was like, "I was going out there being the telehealth rah rah, rah, let's do it together." They're like, "No, I was trained to use these hands." There's resistance from providers, from payers, from all across the board. There are factions and the faction is growing, of folks that are accepting the idea of doing care differently, even in our reimbursement and incentive structure now.

Kelsey Mellard:

Yes, Steve.

Steve:

I have got questons.

Kelsey Mellard:

Yes, please. We would love a few questions.

Steve:

Okay, well, I've got a list of questions.

Kelsey Mellard:

We'll give you one and then we'll pass it around. Yeah.

Steve:

I got two that are sort of inter-related. If in a perfect world, reimbursement is not an issue, how much let's say in a 100 bed assisted living community, could I reduce physician visits-- by 50%, 80%, 20%? Any thoughts on that?

Mike Kurliand:

I don't, Robin, if you can go first?

Robin:

You can go first anyway.

Mike Kurliand:

I recall reading a report by an advisory board and this is a very interesting question, actually. One of the pitches for a clinic or hospital to utilize telehealth is to say, "Hey, you know what?" Again, this is around reimbursement. Okay? I know you said regardless of reimbursement. All of our level ones and twos for reimbursement, let's keep those virtualized. Let's use our physical footprint for the more complex, complicated patient that needs to be here. Like I'm practicing at a higher level, like, full scope of my license, so it's a bit more interesting than seeing the lower level patients. I'm utilizing the space that I have in my clinic or hospital for those higher, more complex patients so the revenue that that generates is better for me. For those patients that I could keep at home with the level ones and level twos, I'm keeping them happy and I might even be able to manage them with an RN or nurse practitioner or PA, which is costing me less. Now the report that I read, I think you can keep somewhere around 40% away.

Kelsey Mellard:

Yeah, Mike that actually reflects. We partner with a Medicare Advantage group and in the first three months of our partnership, we reduced unnecessary specialty utilization by 40%. Their practitioners were using us and accessing our network as opposed to sending the patient out.

Robin:

Yeah, and then inside of our scope of practice, there's two statistics that I think are important to know. The first is, we find that, of the patients who come to us, so surmising that our urgent care, behavioral health and primary care can help them, we're able to resolve 92% of the patient inquiries through our system. Another metric, though, that I think is important because there's been a lot of research done on telemedicine and in fact, some of it, there was a big report done by Rand several years back that was charging that telehealth could actually just be something being layered on top, that in essence it was additive because people were using it when they wouldn't have used something else or they were using it as a frontline triage and then going and using brick and mortar after it.

Robin:

Two of the national payers that work with us, without our permission and without our involvement, performed audits on our care, which you always love to find out later. What they did is, they did a match cohort study where they looked at 5,500 patients with diagnoses that went through Doctor On Demand, 5,500 with similar diagnoses that went through brick and mortar. They looked at what was the 14-day revisit rate of that patient population. How many of those patients re-entered the healthcare system inside of those 14 days with a same or related diagnosis? Based on the RAND study, you would expect that the virtual care setting Doctor On Demand would produce much higher 14-day revisit rates.

Robin:

It turns out that we were in fact on par. There was no statistical significance, which was actually quite stunning for us because given the 92%, you know that there are certain things like suturing, and things like that, that we will never ever be able to fully resolve or there are times when someone reaches out to us and the first thing we do is send them to an emergency room because that's where they need to be. To have that 14-day revisit rate be really parallel was quite striking.

Robin:

Another thing that came out of that audit, which I thought was interesting is that, we had a 2% lower antibiotic prescribing rate than our brick and mortar counterparts, which, frankly, flies in the face of my own preconceptions. I would have thought that a lot of people use telehealth and that there's this conservative form of treatment where we're going to just prescribe the antibiotic and that turned out not to be the case. We have been told that this is not true of all telemedicine companies, that some of the companies that they've audited, didn't produce the same type of results, but for what it's worth, that's what came back for us.

Mike Kurliand:

I have something to add real quick.

Kelsey Mellard:

Yeah, please.

Mike Kurliand:

I really want to read about that. We did not plan this. At West Health, we're on the verge of publishing a research paper. I can't disclose the organizations right now, but these are three major healthcare organizations throughout the country. We looked at similar utilization rates comparing to in-person versus telehealth for certain diagnoses. Our return number we selected was 30 days. We have found and this corroborates with what you're finding, that for those specific diagnoses, that there was maybe a 3% difference. Very, very little. Now, as an operational person, and I think about building my own business model around that, I'm going to try to push out as much as I can of those types of business through telehealth, and again, use my footprint for some other types of visits, especially because now that I have the data that says, it's about the same from an outcomes' perspective. That's without even looking at the cost outcomes of the brick and mortar footprint. It's sounds great. I'd like to know a little bit more of that.

Kelsey Mellard:

Some whispering going on up here. Yes, question in the back please.

Audience:

So specifically around remote patient monitoring, I think some of the discussion we're having now is they compare us to brick and mortar and we're very good at what we do and I think telehealth is great, honestly. Then I look at remote patient monitoring as an industry, right? With CPT codes, and [inaudible 01:06:50] direct supervision I see that as that industry is in its infancy, trying to justify its own legs. I'm just interested to think hear what you think about where that is at as compared to where telehealth was maybe ten years ago [inaudible 01:07:10].

Kelsey Mellard:

Yeah, absolutely, yes. I think a lot of this space in general, and I think the challenge with remote patient monitoring to date is that, the ownership of the data is, therefore creating the need for action. If you put a remote patient monitor device of any sort, then you ultimately become reliable for that data and to take action upon that data and actually have an intervention and therefore practice medicine. I think the connection between deployment of remote patient monitoring and practice of medicine, they haven't blended to the degree that we've seen telehealth. I completely agree with you that we are in the infancy of how do we translate all of this incredible data that's coming off of it, to, one, make it understandable because now we're seeing a lot of false positives, so like cardiogram, for instance, which is the Apple Watch.

Kelsey Mellard:

People are like, "Oh, my God, I'm having a heart attack. No, oh, wait, that's... I don't know." Those types of experiences really spiral the industry. And that's why remote patient monitoring has contained itself into this exploratory phase without broader deployment and ownership of the data to then actually drive an intervention and then a change of condition, and medication and care plan.

Audience:

[inaudible 01:08:31].

Mike Kurliand:

Yes.

Kelsey Mellard:

Yeah. Yes. We at Sitka are doing a lot of that. We're actually digesting a lot of the data, making it understood by the patient and providing medicine and practicing medicine to do that. We see a lot of, there's like Validic, a company that can aggregate all of the data off of remote patient monitoring devices and put it into the EMR. Now it's stuck in the lovely black box of an EMR, and good luck harvesting that and creating action items that actually get tended to at some level of frequency. We're starting to see the unlocking but it's early.

Mike Kurliand:

I think you both are right on and I love the prospect of rpm. There's organizations out there right now that are really doing a nice job starting to collect the data, figure out the predictive analytics about it. They're plugging in some really nice algorithms. There's other organizations that have taken it a step further, that they have built out, knowing that there's this issue, like there's all this data, but nobody to respond to it. They are building out nurse call centers or nurse response centers. Imagine doctor on demand hiring a bunch of nurses and you get data from all different types of RPM devices. If an alert goes off or something gets triggered that seems out of parameter,

Mike Kurliand:

somebody from Doctor On Demand like their nurse, is responsible for covering 200, 300 patients. They get a flag. They call that PCP office or they call that patient directly, or drop them a text. I'm seeing more and more companies taking up this space, which is a very, very good sign because, to scale these RPM organizations up, in order to do that care coordination, is very, very expensive.

Kelsey Mellard:

Alright, one more question.

Mike Kurliand:

Come on one more.

Kelsey Mellard:

Yes.

Audience:

[inaudible 01:10:37]. About telehealth in the senior living communities…in the future, we'll be more apt to resonate with the technology because [inaudible 01:11:23]. I think about an 85, 90-year old person, [crosstalk 01:11:23] who wants to stay probably alone. I think that that technology, that barrier is going to be there, at least now. Unless somebody is there that can-

Kelsey Mellard:

Facilitate it.

Audience:

[inaudible 01:11:34]. I just find that really difficult to understand now. Then also, I don't hear much about telemedicine, which is really another huge issue for people in indepdent living [inaudible 01:11:50], where we're not really allowed to go in, [inaudible 01:11:53] even a home care agency can't go in and handle the meds. [You have a home health agency [inaudible 01:12:01] that can do that, that they're going to be packed to one of these machines or whatnot. Then my real [inaudible 01:12:05] question is that we had a whole stream of different people, different companies in these different spaces. Is there any company that does it all? That does the telemedicine, telemonitoring and all of the things that you've talked about instead of…[inaudible 01:12:20].

Kelsey Mellard:

I'll let you answer first Robin and then... Yeah.

Robin:

Yeah, I mean, your last question or your ultimate question is a really good one. I think in all honesty, there probably hasn't been the full integration of everything into one part. Excuse me.

Audience:

Excuse me.

Robin:

Okay, I guess I'm defending the obvious here. I think the answer unfortunately is no and I think there are players out there and, in a very biased way, I'd put Doctor On Demand in this category of organizations that do have a platform style approach to this, and are really investing in data integration and the work that we're working on with Sitka is a good example of thiss you can start to stitch these things together.

Robin:

I think one of the risks always when you have all this innovation going on is of fragmentation. I think that's something that we have to, over time, hold the industry accountable for. To the remote patient monitoring question just before you, we have trouble at Doctor On Demand, because none of these devices have reached market share, where all of the integration work that we could do is really worth it. You have this chicken and the egg problem. I do think that that's where we're going to be headed. Unfortunately, I think your question is a little bit further out into the future than where we are today, if you want the honest answer.

Audience:

[inaudible 01:14:01]. Well just get it ready for when I get older…

Robin:

Yeah. On your home health point, that is right now. We are talking with all sorts of health plans and even employers about how can we help their home care workers, to be able to function in a different way. You're right. The 89-year old isn't going to be whipping out their iPad and registering with Doctor On Demand, but there is a person coming into their home every single day who can make that happen. The utility of that person being in the home, if now there's a physician on the other end, is dramatically different. That is happening today.

Kelsey Mellard:

Imagine if that is a branded experience, that is a funnel generator, a top of funnel generator for you. Right? Why wouldn't you as a senior housing operator partner with a home health company that's partnered with Doctor On Demand to be the eventual lead in and start to build your pipeline? All right. Thank you guys very much for spending your day one with NIC, here with us.

Mike Kurliand:

Thank you.