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87%

say if reimbursement for telehealth is restricted by the government or commercial payers after the public health emergency declaration ends, the restriction will impact their organization's telehealth plans.

INTELLIGENCE REPORT

NOVEMBER/DECEMBER 2021

ENHANCING, EXPANDING, AND FACILITATING THE TELEHEALTH EXPERIENCE

An Independent HealthLeaders Report Powered by:

healthleaders Council

TELEHEALTH HAS ARRIVED! NOW WHAT?

It is well established that the coronavirus public health emergency supercharged the use of telehealth. Numerous polls are showing that the public—and especially seniors—have embraced virtual care during the pandemic and plan to use that remote option in the years ahead.

The focus is no longer about public acceptance. Telehealth is here to stay. Instead, the emphasis has shifted to enhancing, expanding, and facilitating the virtual care experience for patients.

Steven Sheris, MD, FACC, FACP, president and chief physician executive at New Jersey–based Atlantic Medical Group, part of Atlantic Health System, says it's now up to the medical community to make the case for telehealth by identifying and defining situations where telehealth improves patient access and outcomes and present those findings to policymakers and government and commercial payers.

"No patients should be isolated from care if we have telehealth," Sheris says. "That's a basic and broad problem that we still have in this country. We have pockets of patients who can't get healthcare, and hopefully, telehealth can help bridge the gap."

The immediate problem for providers is improving patient access.

John Commins
Senior Editor
HealthLeaders

In the *HealthLeaders 2021 Telehealth Survey,* 51% of 103 healthcare executives say that patients' inability to access or use technology is the biggest obstacle to implementing teleheath (Figure 1).

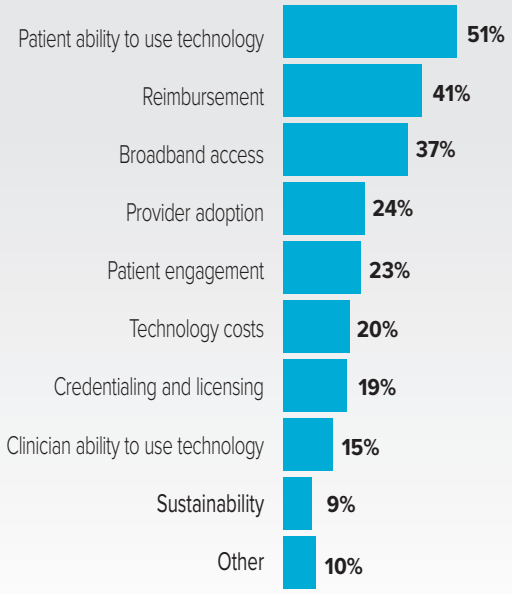
That response upends what historically have been the biggest barriers to telehealth: regulatory red tape, low—if any—reimbursements, lack of provider training, and spotty infrastructure.

Sheris says COVID-19 has rearranged the pain points.

"Now we're left with a certain segment of patients who require a lot of training to get on whatever platform you're using," he says, "and there is a broad correlation, although it's not 100%, between those folks who have difficulty getting to the office for various reasons tacked on to not being used to having technology."

ANALYSIS AND SURVEY RESULTS

Figure 1 | **What do you see as the biggest obstacle to implementing telehealth?**



Base = 103, Multi-response

Accessibility

To address patient access to telehealth, 69% of respondents say their top strategy is educating and training patients and providers to overcome the barriers, followed by using the telephone instead of video (46%), and asynchronous communication/text messaging (27%) (Figure 2).

Sheris says that providers realize that most segments of society are adapting to the technology, just as the technology is adapting to users, and so teaching patients how to use telehealth makes sense.

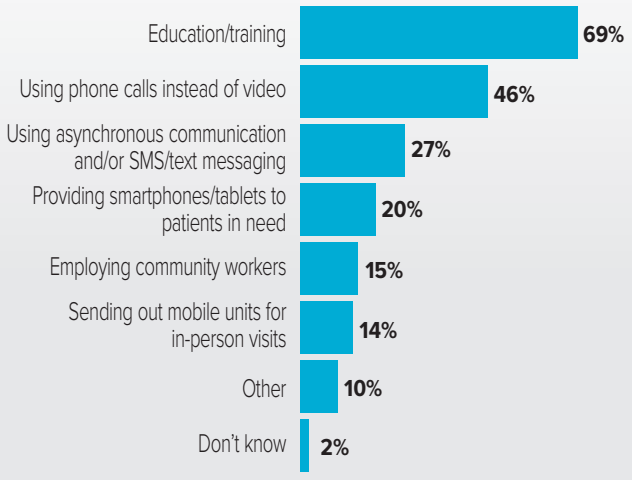
"Even older Americans are adopting technology and learning on the fly," he says. "Increasing adoption is a product both of training users, and the continued work on applications to make them more accessible and easier to use."

Sheris says Atlantic Medical Group is constantly tinkering with its telehealth infrastructure to improve access and ease of use.

"As we integrate our systems, from a digital standpoint, we've moved from having to log on to multiple sites to having to press one button," he says. "As we removed the frictions from our old systems, obviously it becomes easier for patients to use telehealth as a platform."

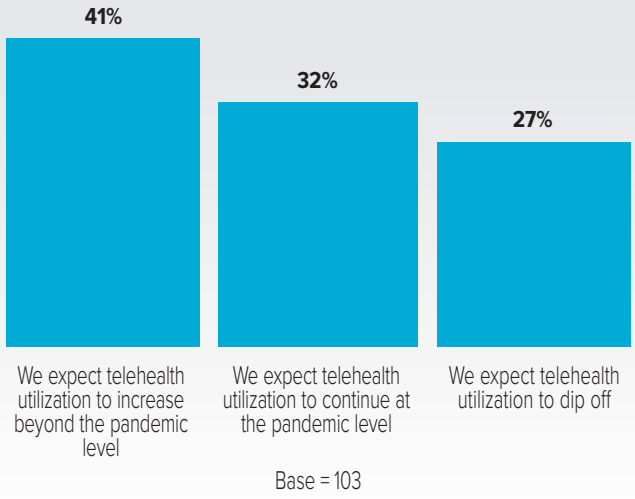
A McKinsey & Co. report issued in July found that telehealth use spiked in April 2020, with the onset of the pandemic. Use has declined somewhat since

Figure 2 | **What are you doing to address barriers to patient accessibility and engagement with telehealth?**



Base = 103, Multi-response

Figure 3 | **What is your vision for telehealth and the future?**



then but stabilized at levels 38 times higher than pre-pandemic.

Future use

Respondents to the HealthLeaders survey are bullish on the future of telehealth post-pandemic, with 73% saying that they expect telehealth use will either increase beyond the pandemic level (41%) or continue at the pandemic level (32%), and only 27% saying usage will decline (Figure 3).

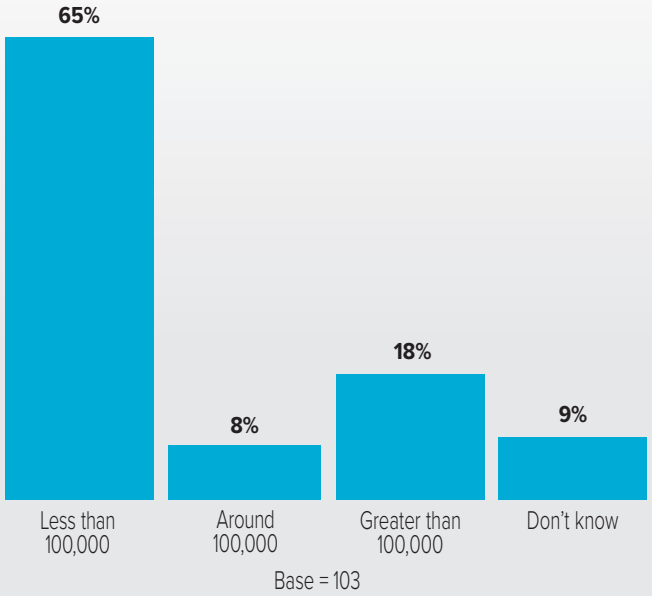
"As more health systems and providers assume some financial risk for the total cost of care, there will be pockets where telehealth is a more effective way to deliver care at lower cost and also to leverage scarce resources in delivering care across multiple domains," Sheris says.

"But in a predominantly fee-for-service world, as it currently is, utilization will be static just as long as the government and commercial payers will reimburse it."

While telehealth use has declined in some parts of the country during the pandemic, Sheris says it mostly "depends on where you are in the waves of the pandemic."

"Some telehealth has been delivered as a virtual necessity due to the inability for patients to get out if they're in a pandemic wave," he says. "From our standpoint, it's what is the patient's desire for access for care, is it an appropriate delivery method, and what is the payer environment for getting reimbursed."

Figure 4 | **How many telehealth encounters has your organization experienced between mid-March 2020 and today?**



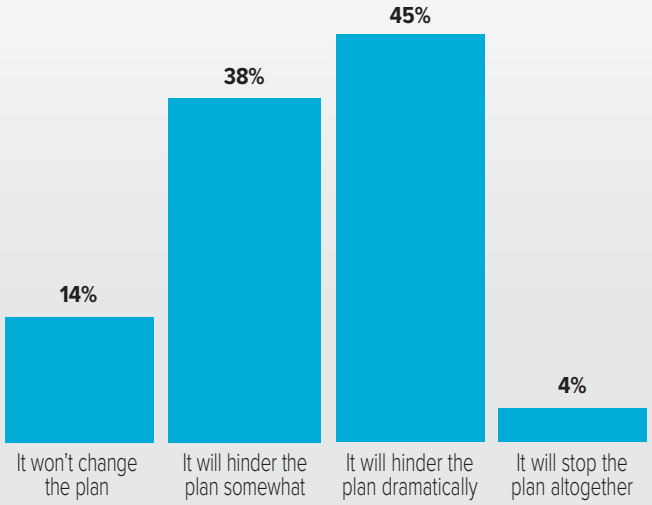
"We'll do telehealth if that's what the patients want. We'll do telehealth if that's the only way we can leverage scarce resources. Behavioral health is a good example of that," Sheris says. "But there's no set target for how much we need to deliver by telehealth. It's a fluid situation."

Plans and reimbursement

Survey respondents made it clear that the biggest threat to telehealth expansion would be to reduce or eliminate reimbursements post-pandemic.

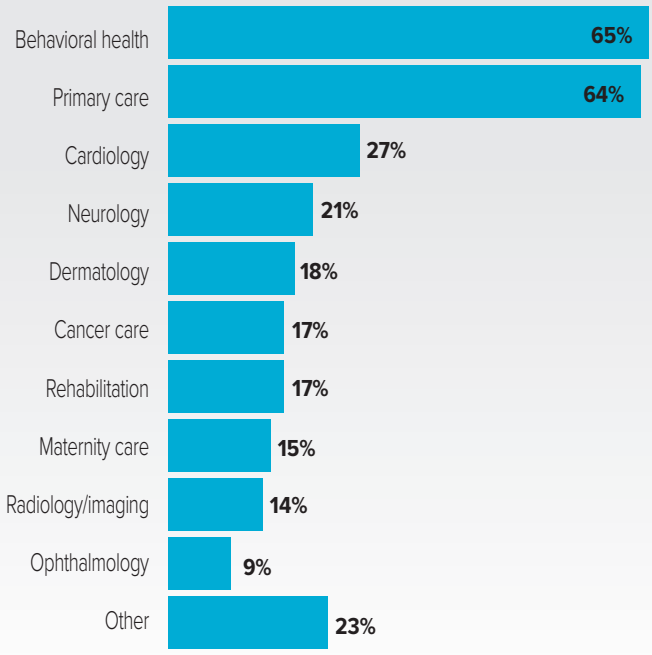
Nearly nine in 10 respondents (87%) say that doing so would either hinder their organization's telehealth plan somewhat (38%), hinder the plan dramatically (45%), or end the plan altogether (4%) (Figure 5).

Figure 5 | **If reimbursement for telehealth is again restricted by the government or commercial payers after the public health emergency declaration ends, how will the restriction impact your organization's telehealth plan?**



Base = 103

Figure 6 | **In which areas are you currently allocating telehealth resources?**

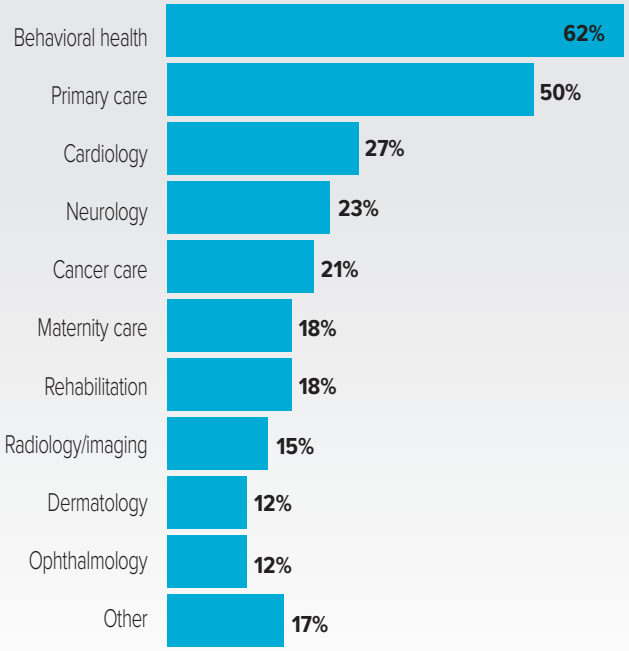


Base = 103, Multi-response

"There needs to be payer relief for being able to provide these services," Sheris says. "The initial concern from both the government standpoint and commercial payers was that broad payer acceptance of telehealth would increase unnecessary utilization. But they have found in the last year and a half that, by and large, it has been used appropriately in the right settings, and to maintain patient access when burdened by a pandemic."

Sheris says he doesn't believe the Centers for Medicare & Medicaid Services will end telehealth reimbursements.

Figure 7 | **Over the next 12–18 months, in which specialty areas do you hope to make a telehealth investment?**



Base = 103, Multi-response

Allocation

Unsurprisingly, behavioral health (65%) and primary care (64%) are the two areas where respondents say they are allocating resources now (Figure 6), and also in the next 12–18 months at 62% and 50%, respectively, as specialty areas (Figure 7).

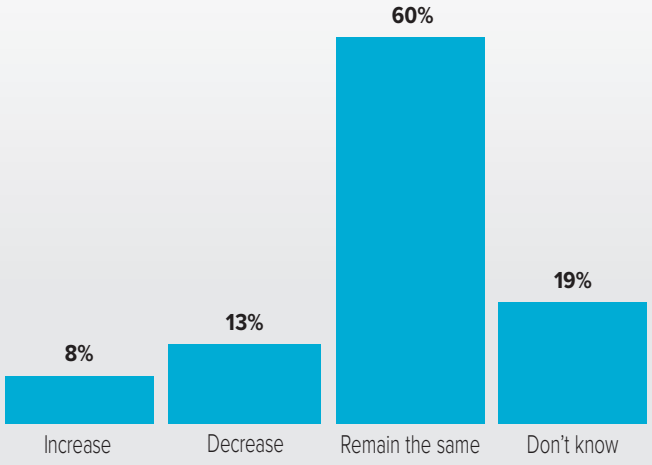
Sheris says behavioral health and primary care are the low-hanging fruit of virtual care.

"One of the obvious barriers to telehealth is the limited ability to do a physical examination on a patient, but behavioral health and some primary care set up nicely for that," he says. "Within each specialty there will be conditions for which telehealth is appropriate, and as more tools are developed to help supplement the virtual visit, you'll see it emerge in more settings."

"Paying for telehealth services is broadly consistent with CMS' desire to reward the right care at the right cost in the right place and at the right time," he says. "It's not a yes-or-no or all-or-none question. It's under what situations and for what conditions will telehealth be reimbursed and at what amounts."

"Right now, telehealth is at parity with in-person visits," he says. "I don't think it's in the best interest of medicine to have providers choose between 'should I deliver care in an in-person setting or telehealth based upon how much it's reimbursed.' That's a perverse incentive."

Figure 8 | **How will the growth of telehealth affect your brick-and-mortar investments?**



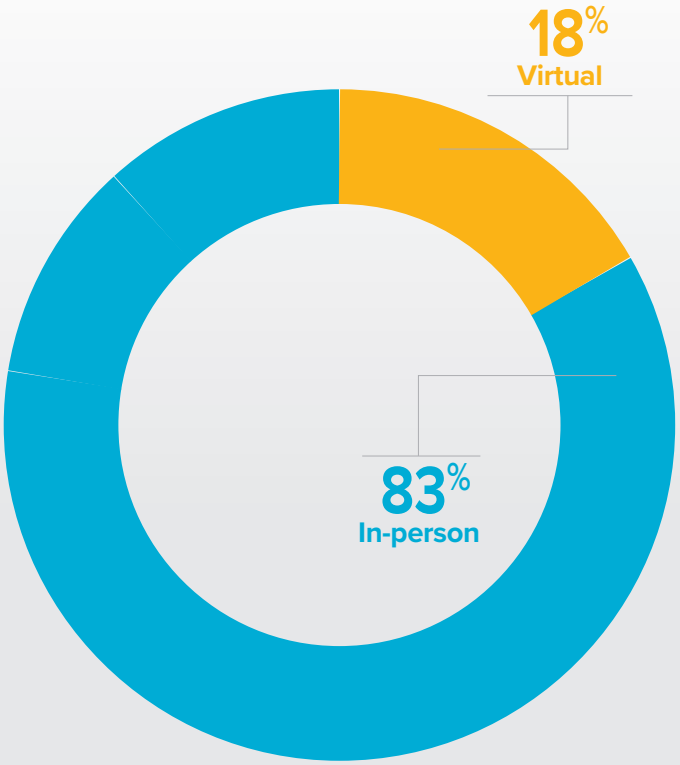
Base = 103

ANALYSIS AND SURVEY RESULTS

Growth

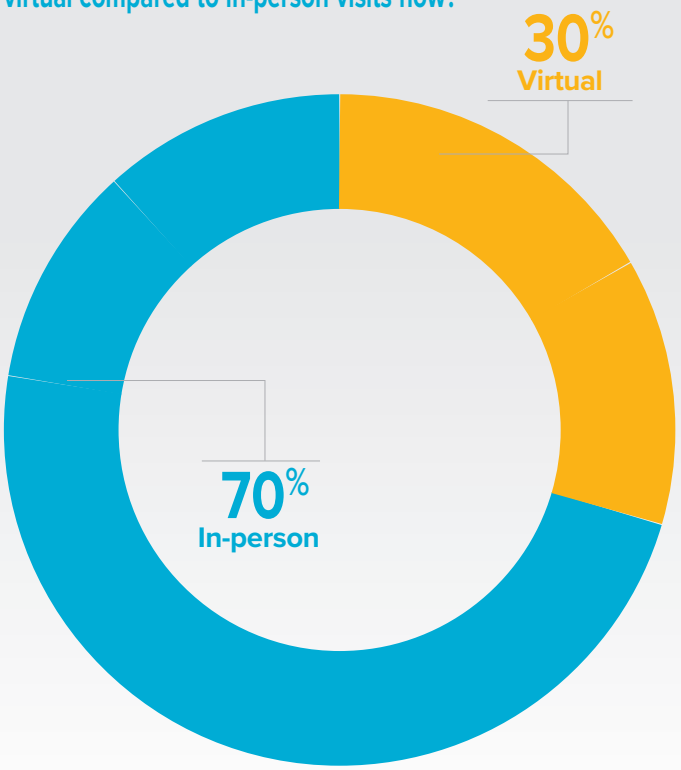
More than half (60%) of respondents say expanding telehealth will not affect their brick-and-mortar investments (Figure 8). Sheris says the size of the brick-and-mortar footprint needed to deliver care is "highly dependent upon what will be delivered from a centralized location and then broadcast over a wide geography via a telehealth platform. That seems to be a natural correlation."

Figure 9 | What percentage of your outpatient volume was virtual compared to in-person visits in 2019?



Base sizes = 88 and 90, respectively, of those who know the virtual and in-person visit volumes in 2019

Figure 10 | What percentage of your outpatient volume is virtual compared to in-person visits now?



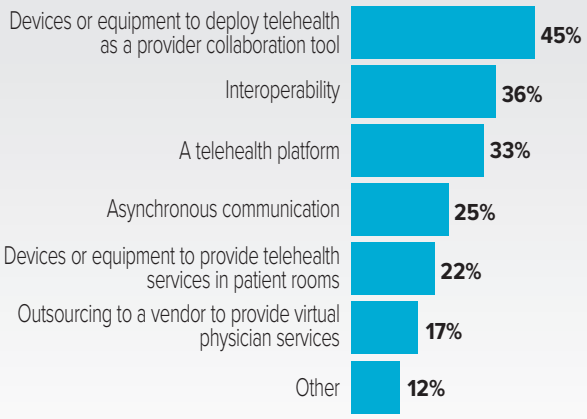
Base = 92, of those who know the volume of virtual and in-person visits currently

"We went [to] 90% virtual and 10% in-person. Now, it's around 10% or 15% virtual and now we're back to at 85% to 90% in-person."

Expansion investments

In the next 12–18 months, 45% of respondents say their most likely investment will be in equipment and devices to deploy telehealth as a provider collaboration tool, followed by interoperability (36%), building a telehealth platform (33%), and asynchronous communication (25%) (Figure 11).

Figure 11 | **Where are you most likely to make an investment to launch or expand telehealth services in the next 12–18 months?**



Base = 103, Multi-response

Sheris counts Atlantic Medical Group as one of the provider groups that saw telehealth use explode during the pandemic, although it has since tapered off.

"We're a 1,000-clinician, multispecialty medical group across 11 counties in northern New Jersey. If we were doing 30 telehealth visits a week before the pandemic, that would be a lot," he says. "Within three days, we needed to pivot and be connected to our patients and ramped up quickly to 14,000 visits a week."

"With an aggressive training regimen and with regulatory relief and with payer relief, it shows what can be done in times of great challenge and with support from the government and payers," he says.

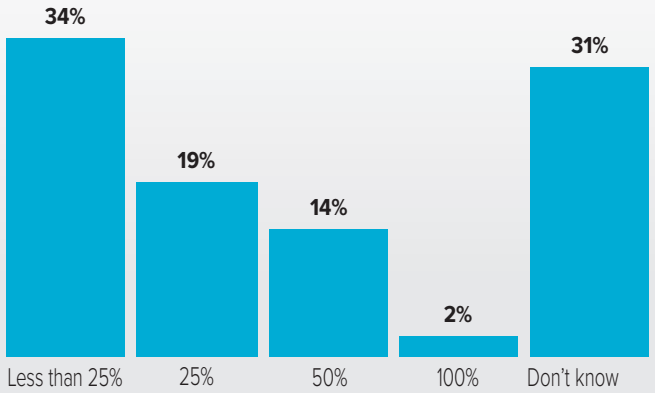
Sheris says it makes sense to invest in devices that improve patient access to telehealth and enhance the quality of care.

"Bluetooth devices for blood pressure or heart rate; electronic stethoscopes that can be hooked into the phone so the clinician can listen on the other end to the patient's heart and lungs; developing those devices that enhance the capability of telehealth and broaden its applicability, those are the things to look at," he says.

As for return on investment, Sheris says the "financial case for telehealth is self-evident."

"If you can leverage a scarce resource and apply it to more patients who can benefit from it, clearly, there is a financial benefit from it," he says.

Figure 12 | **What is your predicted ROI from investing in telehealth?**



Base = 103

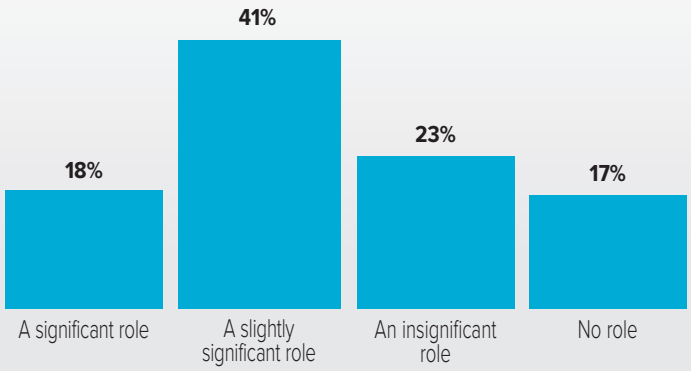
Role of asynchronous communication in telehealth

Nearly two-thirds (59%) of respondents say that asynchronous communication has played a significant (18%) or slightly significant (41%) role in increasing efficiency in their telehealth programs, while 40% say it has had an insignificant role (23%) or no role (17%) (Figure 13).

Sheris says that asynchronous communication in telehealth programs can enhance access and affordability in the right settings, "but it's not the one solution for every problem."

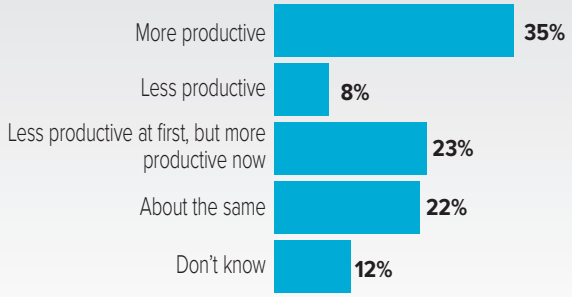
Nearly two-thirds (58%) of respondents say physician productivity has improved with telehealth, compared with 22% who say productivity has remained the same and 8% who report that productivity has decreased (Figure 14).

Figure 13 | **What role has asynchronous communication played in improving the efficiency of your telehealth program?**



Base = 103

Figure 14 | **By their own reports, how productive are your physicians who are engaging in telehealth compared to when they are not using it?**



Base = 103

"We've gotten to the point where it's not a negative, but it's also not a windfall for efficiency," Sheris says. "Getting the patient connected on time requires the coordination of resources to do telehealth that will make you efficient. It depends on the skill set of the clinician and the volume of telehealth visits they're doing."

Overall, Sheris says the survey responses "reflect our experience here in Northern New Jersey and the Atlantic Health System."

"It has not been the panacea that we have thought could solve problems," he says, "but in selected cases in the right setting, in the right hands, with the right support, and the right reimbursement, it enhances the healthcare delivery system."

John Commins is a senior editor for HealthLeaders. He can be contacted at jcommins@healthleadersmedia.com.

METHODOLOGY

The *HealthLeaders 2021 Telehealth Survey* was conducted by the HealthLeaders Intelligence Unit, powered by the HealthLeaders Council. It is part of a series of thought leadership studies. In August 2021, an online survey was sent to the HealthLeaders Council and select members of the HealthLeaders audience at healthcare provider organizations. A total of 103 completed surveys are included in the analysis. The margin of error for a base of 103 is +/- 9.7 at the 95% confidence interval. Survey results do not always add to 100% due to rounding.

What Healthcare Leaders Are Saying

Here are selected comments from leaders who describe the novel ways in which their organizations are using telehealth.

"COVID advanced care at home."

—CEO of a large health system

"MD psych visits with an advanced practice provider in the room. Psych consults in the emergency department."

—Chief nursing officer at a small hospital

"Allowing the providers to work from home to decrease physician burnout."

—Chief operations officer at a medium-sized physician organization

"Providing services to correctional facilities."

—Chief quality officer at a large physician organization

"Role-playing between staff and physicians to get more comfortable when engaging with an actual patient."

—CEO of a small physician organization

About the HealthLeaders Intelligence Unit

The HealthLeaders Intelligence Unit, a division of HealthLeaders, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

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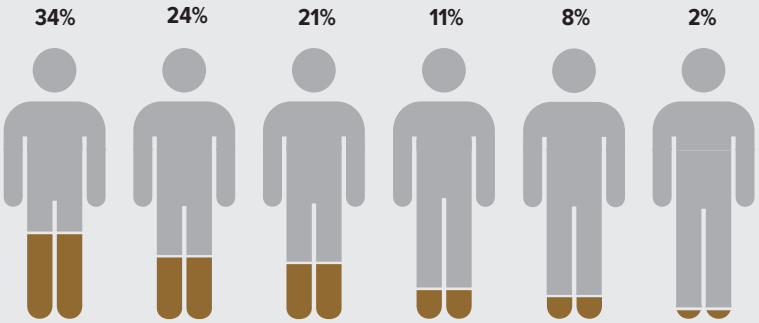
RESPONDENT PROFILE

TITLE

Base = 103



CEO, PRESIDENT

- CEO, President
- Chief Executive Administrator
- Chief Administrative Officer
- Board Member
- Executive Director
- Managing Director
- Partner

OPERATIONS LEADERSHIP

- Chief Operations Officer
- Chief Strategy Officer
- Chief Compliance Officer
- Chief Purchasing Officer
- VP/Director Operations Administration
- VP/Director of Compliance
- Chief Human Resources Officer
- VP/Director HR/People
- VP/Director Supply Chain/ Purchasing

FINANCIAL LEADERSHIP

- Chief Financial Officer
- VP/Director Finance
- VP/Director Patient Financial Services
- VP/Director Revenue Cycle
- VP/Director Managed Care
- VP/Director Reimbursement
- VP/Director HIM

CLINICAL LEADERSHIP

- Chief Medical Officer
- Chief Nursing Officer
- Chief of Medical Specialty or Service Line
- VP/Director of Medical Specialty or Service Line
- VP/Director of Nursing
- Chief Population Health Officer
- Chief Quality Officer
- Medical Director
- VP/Director Ambulatory Services
- VP/Director Clinical Services
- VP/Director Quality
- VP/Director Patient Safety
- VP/Director Postacute Services
- VP/Director Behavioral Services
- VP/Director Medical Affairs/ Physician Management
- VP/Director Population Health
- VP/Director Case Management
- VP/Director Patient Engagement, Experience

MARKETING LEADERSHIP

- Chief Marketing Officer
- VP/Director Marketing
- VP/Director Business Development/Sales

IT LEADERSHIP

- Chief Information Technology Officer
- Chief Information Officer
- Chief Technology Officer
- Chief Medical Information Officer
- Chief Nursing Information Officer
- VP/Director IT/Technology
- VP/Director Informatics/Analytics
- VP/Director Data Security

TYPE OF ORGANIZATION

Base = 103

Health System (IDN/IDS)	**34%**
Physician Organization (MSO/IPA/PHO/Clinic)	**25%**
Hospital	**21%**
Payer/Health Plan/Insurer (HMO/PPO/MCO/PBM)	**5%**
Ambulatory Surgical Center	**4%**
Convenient Care/Retail Clinic (including retail pharmacies with clinics)	**4%**
Ancillary Services Provider (Diagnostic/ Therapeutic/Custodial)	**3%**
Third-Party Administrator, Pharmacy Benefits Manager	**2%**
Occupational Therapy	**2%**

NUMBER OF PHYSICIANS

Base = 103

1–9	**14%**
10–49	**19%**
50+	**66%**
N/A	**1%**

NUMBER OF BEDS

Base = 103

1–199	**41%**
200–499	**7%**
500+	**29%**
Do not have a standard number of beds	**23%**

PROFIT STATUS

Base = 103

Nonprofit	**58%**
For-profit	**42%**

NET PATIENT REVENUE

Base = 103

$1 billion or more (large)	**18%**
$250 million–$999.99 million (medium)	**17%**
$249.9 million or less (small)	**52%**
None of above	**13%**

RESPONDENT REGIONS