4sight Health Roundup
Podcast Transcript 7/18/24
Making Telemedicine About Consumers, Not Providers

David Burda:
Welcome to the 4sight Health Roundup podcast, 4Sight Health podcast series for healthcare revolutionaries, outcomes matter customers count and value rules. Hello again everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, July 18th. Are you feeling united yet? I'm not even close, but that's a different podcast. On this podcast we're talking about one of our favorite topics, one that we haven't talked about in a while, and that's telemedicine. We're going to look at the latest trends in virtual care with Dave Johnson, founder and CEO, foresight Health, and Julie Murchinson partner at Transformation Capital. Hi Dave. Hi, Julie. How are you two doing this morning, Dave?

David W. Johnson:
Terri and I are just wrapping up a very successful 11 day medical visit in Rochester, Minnesota, the home of the Mayo Clinic. We're heading back to Chicago today. While we've been here, we've had thunderstorms with no tornadoes, so feeling good about that too.

Burda:
Yeah, you definitely missed that line of storms that came through here. Good for you, Julie. How are you?

Julie Murchinson:
I am well. I just spent a quick day in the land of Sun and 72 in beautiful people in Orange County, but I'm back in the reality of Seattle.

Burda:
Yeah, it's a good place to be. Thanks, Julie. Now before we talk about what's up with telemedicine, I wanted to ask you about your latest experiences with virtual care, Dave, any virtual care visits in the past three months, and if so, how did it go?

Johnson:
Well, hopefully this won't be revealing too much information. TMI, but like a lot of men my age, I've been having some issues with my prostate, and as referenced above, we use the Mayo Clinic for all our acute care. So I've had numerous video conferences over the last few months with urologists, radiologists and their support teams ever since I got an elevated PSA score and all of those visits went exceptionally well on time, so on and so forth. The only thing that was slightly annoying for me since I've got a consumer's mindset is they forced patients, Mayo forces patients like me, and I'm sure they're not alone in this to sign on to the video chats 15 minutes before the actual conversation begins. Whose benefit is that for exactly? It's certainly not for the customers.

Burda:
Wow. Wow. A virtual waiting room. Thanks Dave. Julie, how about you? Any telemedicine experiences in the past three months you want to share?

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Murchinson:
I'm just thinking about how much more boring the virtual waiting room is than the actual waiting room where you can actually people watch or look at the fish or… So no visits per se, but I do realize that I am now 100% reliant on my text chat message app thing with one medical and my doctor or the office about a prescription or what have you. That is my number one way to get primary care today. So if I can use that and avoid having to get in my car, I absolutely do it.

Burda:
Yeah, yeah, it's electronic communication. That's great. I went virtual in May after I stuck a fish hook in my finger and got an infection. The doctor diagnosed it immediately and prescribed oral antibiotics and an antibiotic cream, both work like a charm, but it was awkward holding my middle finger up to the camera on my phone to show the doctor and I apologized before I did it. So telemedicine is redefining the doctor patient relationship in many unexpected ways, I guess. So we'll see if she takes my call next time, that'll be the test.

Johnson:
That sounds like a mad magazine picture to me. Dave, I got to tell you.

Burda:
Oh, I showed her the finger over the camera and it was so big because you have to hold it close to the camera even though she was in a different room. She backed up in her chair, went, whoa. So there you go. There you go. Now, let's talk about the latest trends in telemedicine based on two new reports. I'll share the top line findings each and get your reaction. The first is from the CDC in the National Center for Health Statistics. The second is a study published in the Journal of General Internal Medicine. The CDC survey is based on data from something called the National Health Interview Survey, which is an annual survey of a nationally representative sample of US adults age 18 or older. Here are the top line findings. The percentage of adults who use telemedicine at least once over the previous 12 months dropped from 37% in 2021 to 30.1%. In 2022, it dropped more for women, 42% to 33.8% than for men, 31.7% to 26.3%. It dropped for all age brackets, all races and ethnicities, all education levels and all geographic levels. Even I could make those bar charts. Meanwhile, the study in the Journal of General Internal Medicine is based on data from the American Hospital Association's annual Hospital survey. From 2017 through 2021, more than 4,000 hospitals participated in the AHA survey each of those five years. Here are the top line findings. The percentage of hospitals offering at least one form of telemedicine service rose from 46% in 2017 to 72% in 2021. That includes everything like electronic ICUs and remote stroke care. The percentage of hospitals offering virtual consultations and visits like the kind we're mostly talking about rose from 26% in 2017 to 55% in 2021. Audio visits rose 21% to nearly 36 million in 2021 compared with 2020 video visits rose 73% to more than 71 million in 2021 compared with 2020. Dave, let me ask you about the CDC survey. Since you're a healthcare consumer advocate, what do you make of those telemedicine visit declines across the board? What are some of the root causes and what do they say about the future of telemedicine from a customer perspective?

Johnson:

Actually, I'm surprised they didn't go down further. I think if you eliminate the covid effect, it really demonstrates the increasing power of the telemedicine to really improve care delivery, access outcomes, all the things you and Julie and I were just talking about. And going forward, the telemedicine tech will just keep getting better and I think it's will continue to increase as long as we make it easy and affordable for consumers. And this is where providers need to get their proverbial heads out of their butts and stop insisting on hospital-based payment for non-hospital delivered care, particularly virtual care services, the marketplace over time, if they don't accommodate the technology advances, we'll simply do an end runaround and their unnecessary charging of high cost prices for routine service. Provision value is a managerial mindset, and let me tell you a little story you both remember Jim _____, the CEO of Advocate, remarkably effective leader. I interviewed him at a Cain Brothers conference, I don't know, five or six years ago in a fireside chat, and it was a fantastic interview. I mean, he's funny, insightful, he's a big presence. He has big ideas. The last question I asked Jim though was what keeps him up at night? And the answer he gave me was getting paid, getting paid. And I sat there thinking, despite how great Jim is in so many ways down deep, he's really just a hospital guy. And competition is supposed to be hard. You're not supposed to be sitting around thinking about how am I going to get paid for doing something? You're supposed to be thinking about how do I create value so that others want my service? That's the pull of the marketplace based on value provision. Sir John Hicks who won the Nobel Prize in economics, he, he's British, said probably like 50 years ago that the best of a monopolist profits are a quiet life. As I said, competition is not for the faint of heart because people are smart, companies are active, they're constantly looking to find advantage. And this is where providers need to shift from this managerial mindset of optimizing revenues and getting paid to value creation. When it comes to telemedicine, it's a force that's just going to keep on growing. And at the end of the day, it's not really telemedicine, it's just medicine. Listeners to this show will remember that I frequently cite the BJ Fog Institute at Stanford, which specializes in changing consumer habits. And they think, they say, you need three things to change consumer behaviors. One is it has to be important, or the more important it is, the more willing people will be to change. So how important is the behavior we're trying to change? Factor number one. Factor number two is how easy is it to make that change? The easier it is, the more likely that consumers will change the habit. And then the last thing is, how do you have exactly the right types of prompts to get people to engage in the new behavior, the new habit? So think about virtual care, telemedicine, medicine, how important is it? Well, it's really important. You needed your finger fixed, right, Dave? How easy was it? Pretty damn easy. Does anybody doubt that the marketplace is figuring this out and is going to just keep making it easier and with better prompts for consumers to access this service? So come on providers, figure out which way the wind is blowing and get with the program.

Burda:
Very stirring response. Dave. Thank you Julie. Any questions for Dave?

Murchinson:
Well, Dave, one of your favorite questions typically, which is should regulators step in or should we let the market do their thing?

Johnson:
Well, you know where I'm going to come out on this. I believe by and large, we should let the marketplace stir the pot. It's always important to think about why does regulation exist. And it's really for two reasons. One is to ensure level field competition. So new companies, new ideas can come to the marketplace and win based on value creation. And the second is to protect consumers. So on the first one, the level field competition, I think the regulators just need to stop this payment mechanism that enables providers to get hospital-based rates for providing non-hospital based services. Site neutrality is the shorthand that the industry uses for this. That's what regulators should be pushing. That's very much in promoting level field competition. And the fact we've dragged our feet as an industry, I think has held providers back from engaging in the types of changes they need to change it. Now the second one, protecting consumers. If anything, I think the regulators need to pay more attention here because the opportunities for acquiring personal health information and engaging in fraudulent activities are increasing with all of the digital connectivity in our lives. So I'd sort of amp that up. Amp up the focus on consumer protection. I'd peel back my protections for the industry as we transition to this more virtual healthcare world and let the chips fall where they may.

Burda:
Here here. That's great, Dave. Thank you Julie. You see telemedicine from the inside out. Let me ask you about these study findings. Are you surprised, not surprised at the findings of what do they say about hospitals telemedicine capabilities, and where do hospitals need to go to meet the virtual care demands of the market?

Murchinson:
Well, I'm not surprised that we're seeing usage fluctuation at the macro level in both directions. Many health systems out there have been focused in the last 12 to 24 months on just finding their financial footing and addressing acute problems. I mean, there's been a ton of frankly tail chasing to work on issues like staffing. So I'm also not surprised because health systems that are figuring this out are building virtual capacity where virtual care makes sense for the business model. And that Michigan State study found that the larger nonprofit and teaching hospitals were more likely to adopt telehealth services. So lemme give you two examples of where I've seen this in the market recently. Number one, I just spoke with a fantastic c-suite leader from a well-known health system in the South that's been doing the following. They've been using for a couple years now, a smart solution that helps them acquire new patients in their market and provides access to, I'll call smart quick care, which is getting into the right kind of doctor, the right doctor or a nurse or some other care option that is either virtual, urgent or another one of the offerings that this health system is making available through their health system. So they're actively going to seek new patients and they're treating 'em as quickly as possible as they come in the door. So after a few years of that experience, they have really seen a shift in the new patient acquisition game. I mean the top of the funnel used to be PCPs and in their region they're seeing urgent and virtual care as an even greater driver. So they're literally redesigning the funnel and how to win in the market based on the clinical areas that really drive the bottom line for 'em. And this my friends, this is running a business with the consumer at the center and revenue margin in mind. And they're leveraging smart patient matching and virtual as key levers to create immediate

stickiness and to drive downstream loyalty. I mean, that is how the game is played. And where virtual fits, in example number two, an academic health system farther north with an urban base, but a vast rural population is using telehealth to do all their pre-op process patients that are traveling long distances from those rural areas for surgery. They're using telehealth at home diagnostics and other mechanisms so that by the time that patient travels the few hundred miles to show up in that urban setting for surgery, they've completed every preparation step. They're saving the patient, I mean 12 fees and other fees related to that presurgical workup. And they're making more margin on prep services and among other benefits, creating a vastly better experience for that patient. So virtual is being used in specific ways, might I say surgical ways to become part of the business model. So how common are these scenarios among health systems? I would say that we are in early innings, maybe even the first inning. If you really think about it as health system and you don't think about it as just virtual care adoption because as Dave said, virtual care would never have had this kind of major pop if we hadn't gone through covid. It would've taken us years upon years to move the business model. In a way it's moving today and I'd say we're actually ahead of the curve thanks to Covid and the momentums. I mean really building the trend is definitely clear for me. It's just really, really early. And I invite any health system to argue why this is not the future path. And while I'm on this subject, I do want to just give a shout out, Dave, to our friend Mark Shaver, who is arguing with us and keeping us honest with his feedback and the input of the realities for health systems. And Mark, we hear you. We get it and we're going to keep pushing and we know the pain is real and we know you're smart. So we've all got to move it forward.

Burda:
Well, the examples you gave about using technology to basically eliminate two of the biggest pain points for customers is fantastic. But second example, getting rid of the paperwork and the first example, seeing the right person as soon as possible. I mean, that's brilliant. Thanks Julie. Dave, any questions for Julie?

Johnson:
It is brilliant, Dave, but it's almost like duh, right?

Burda:
Alright, yeah, good point. When I walk into Bass Pro Shop, they're like, what do you need right here? Right. Go to this. Right. I gotcha. I got you. Exactly.

Johnson:
Hey Julie. Great answer per usual. Here's where I want to go. Innovative companies like Hippocratic AI and outbound AI or developing interactive voice platforms using gen AI to engage consumers in live medical conversation for pennies on the dollar relative to human-based engagement platforms. How far are we away do you think, from the widespread use of these gen AI platforms and what, if any, are the implications of this type of human machine collaboration in diagnosis and treatment for both the marketplace and for consumers?

Murchinson:

In the kind of work we do our firm, we're diving deep into AI applications. What's out there? What's actually getting adoption where how? So it's such simple and complicated answer for me because I see traction happening all over the place with these of tools. The scale is hard right now for all the reasons I just talked about with those examples. We're still in the early innings of how to think about the business model and these kinds of applications are really advanced. They create challenges with recognizing whether you're replacing a human or you're actually creating capacity because you don't have the humans. We're still not at the place where that kind of realization is being addressed. So I am very bullish on these kinds of technologies. I think we're going to see them sprout up in almost through channels and through access points that are not a hospital or a health system deciding, oh, I'm going to use Gen RI today to engage these patients. So I think it's early.

Burda:
Yeah. Thanks Julie. I was going to say that I'm hooked on telemedicine, but

Johnson:
Oh God. Oh god.

Burda:
That would be worse than Julie's pun on what surgical they're being surgical about. I caught that. Yeah, that was good. I'll just say most seniors, maybe most people still prefer to see their doctors in person. I'm not one [00:40:00] of them. I'm so done with sitting in a waiting room for an hour, then an exam room for 30 minutes before I see the doctor for five minutes than waiting 15 minutes for the nurse to tell me I could leave and explain how I could find the door. I mean, I'm 64, I could find my way out. So thanks Julie. Thanks Dave. Now let's talk about other big news that happened this past week. It wasn't all bad, was it Julie? What else happened that we should know about?

Murchinson:
Well, this is a dark day's comment. Gail Walinski, who was the administrator of what we used to call HCVA. Do you remember that? Dave?

Johnson:
Yeah.

Murchinson:
CMS's former name; senior advisor to George H.W. Bush and amazing, amazing health economist leader, board member, incredible woman, passed this week, I'm sure as many people have seen. And I don't know, it feels like the end of an era.

Burda:
True. She was always very accessible to reporters back in my reporting days. So she will be missed. Thanks Julie. Dave, what other news is worth mentioning?

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Johnson:
Well, I'm just, since you said you were 64, I wonder if you're singing that Beatles song to Jean. Will you still need me? Will you still feed me when I'm 64? Good questions!

Burda:
I don't, because I know the answer to that already, Dave.

Johnson:
Well, anyway, At the risk of saying even more or sharing too much more personal information, I've been just this side of blown away by Mayo's treatment of my early stage prostate cancer. I qualified for radiation treatment in five sessions. Almost everywhere else in the country, it's 40 sessions over eight weeks. Mine was five sessions over 10 days, bigger dose precisely directed. And I didn't even need to take a Tylenol, I mean some minor discomfort, but I'm kind of blown away with it from it. And I rang the bell yesterday. But one of the things it was just kind of funny to me is I had several professionals within Mayo sort of make the comment that they were doing these great things for patients and figuring out how to lose money on it. Because typically they bill on a per treatment basis. And so it's 40 treatments, you get paid a lot more money than if it's five. And this is a little bit of this mindset, managerial mindset thing I was talking about earlier. It's exactly the wrong way of looking about it. If they could do me in five treatments and it takes their competitors 40, why not find more as many people like me and do eight of us and take advantage of your investment in the capital and so on. And maybe you make less per person, but overall you just make a lot more. I can see, given the way my warped brain works, writing an article called Prostate Productivity at some point in the near future. So kudos to Mayo for the advancement and a little bit of a kick in the pants to think about the marketplace a little bit differently the way the rest of us do.

Burda:
Alright, well kudos to you for ringing the bell, Dave. I'm sure everything's going to be great.

Johnson:
You can ring my bell. You can ring my bell.

Burda:
And we have that headline recorded now, so we'll expect to see that soon. So thanks Dave and thanks Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. You also can subscribe to the roundup on Spotify, Apple Podcast, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.