Why Telemedicine Is About To Take Off

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Much like driverless cars are expected to upend transportation, telemedicine is going to transform not just our healthcare, but our communities. For years, investors have seen the potential in the industry, and in the next 18-24 months they're going to start seeing a significant return on their investment. As an attorney, the fast normalization of this industry gives you a forward-thinking option for your hospital clients. I expect the number of telehealth integrations and sales to increase substantially in the near future, reshaping dealmaking in healthcare as we know it.

It comes down to a simple reason: rural health. Rural and community hospitals, already suffering from declining patient demographics, are struggling to attract and retain doctors. The struggle has put many in jeopardy of a potentially unfavorable restructuring, or, as we're starting to see this year, bankruptcy. Telemedicine tackles these issues by improving physician lifestyle and making quality care accessible in all areas. In many cases, telemedicine programs can be an integral part of these hospitals' path to achieve financial stability, making it the linchpin between hospital bankruptcy and a favorable hospital restructuring.

The Doctor Dilemma

For the past several decades, one of the biggest challenges for community and rural hospitals has been attracting doctors. It's an unfortunate side effect of the urban shift we've seen throughout the country, where young people have chosen to build their lives in cultural urban areas instead of rural communities. Today, 20 percent of the U.S. population lives in rural areas, while only 10 percent of doctors make the same location choice. The problem has become so dire that, despite substantially lower cost of living, doctors in rural areas are often offered higher starting salaries.

The staffing problem is most acute for specialists. For these staffing requirements, even when rural facilities are able to garner interest, the patient base often isn't large enough to justify full time positions. This has led hospitals to the hub and spoke model, where a specialist works with several partner hospitals instead of a single facility. In these cases, doctors get the locations they want while still having the appearance of servicing a rural community. However, given the lack of continual physician presence at these "spokes," patients are often transferred to "hubs," resulting in loss of patient revenue.

The Money Problem

Increasingly high physician salaries are just one reason rural hospitals are strapped for cash. They are also grappling with the rollout of the Affordable Care Act, pricey technology upgrades, cost of care that outpaces consumer price index, and a progressively complex reimbursement system. While telemedicine offers a solution to the doctor problem, it opens a can of worms in the world of reimbursement.

As things stand today, insurers often won't pay nearly as much for a telemedicine consult as they would for a traditional in-person visit. This drastically impacts the incentive structure: why would a doctor choose to do the same work for less? Simply put, they won't.

While reimbursement trends are improving, the incentive structure still isn't there: why would a doctor choose to do the same work for less? Simply put, they won't.

Keeping Patients

Hospitals, however, will. The saying goes it's cheaper to maintain a customer than acquire a new one, and rural facilities are using this thinking as they implement lower-reimbursement telemedicine practices.

It goes back to the doctor problem. While the hub and spoke model has saved hundreds of hospitals around the country (and we'll continue to see the expansion of this model), it isn't ideal for patients or hospitals.

Let's say an individual has a stroke and goes to a nearby emergency room. Likely, the patient will need a neurologist to quickly diagnose the event, administer clot dissolving tissue plasminogen activator, and implement other stroke protocols. If that hospital doesn't have the required neurologist, the hub-and-spoke models sends the patient to a partner hospital in a nearby city — a longer drive for the patient and his or her family. If the patient needs ongoing care, that patient must continue going the longer distance to the city. Given that rural communities have a disproportionate share of the elderly, who are less mobile and more frequently require care, it's clear why this is an important point to address in patient need.

The local hospital, too, loses out on business, both in the immediate term as well as in the future, for any peripheral conditions that happen through the course of treatment. Many rural facilities have decided that they'll absorb the incremental physician expense in exchange for keeping an admitted patient, recuperating money over time.

In short: keeping patients local is better for everyone.

Why Now

As healthcare is changing rapidly from both the rollout of the ACA and changing technology, patient demographics and care costs, rural hospitals are feeling a pinch stronger than ever before. This year we've seen dozens of restructurings and bankruptcies — more than ever before — and I expect that number to at least double next year.

Since telemedicine can be the saving grace for these facilities, it's growing at a similar clip. According to IBIS World, telemedicine revenue is expected to grow from $645 million in 2015 to well over $3.4 billion by 2020, approaching a 40 percent annual growth rate. With electronic medical record requirements mostly completed due to national ACA mandates, hospitals nationwide have jumped the patient data hurdle that once made telemedicine seem like a longshot.

On the legal reimbursement front, things are changing quickly as well. The Benefits Improvement and Protection Act of 2000 improved Medicare telemedicine reimbursement, albeit with limitations. Medicaid paints a brighter future, with 48 state Medicaid programs and that of the District of Columbia providing for some area of telemedicine reimbursement. For commercial insurance providers, 29 states have enacted telemedicine parity legislation to some degree, and 22 of these states authorize state-wide coverage without any provider or

technology restrictions. 15 of these states require private insurers to reimburse telemedicine services at the same levels as Medicaid.

Lobbying dollars are piling up, and I expect a strong push for further legislation in the coming year. By 2022, I expect telemedicine reimbursement to be on par with in-person consultation.

Where It Matters Most

As a middle market healthcare restructuring specialist, I've seen first-hand the impact of losing a single patient to a nearby hospital. In a recent case, the hospital was losing over $12,000 in revenue reimbursement alone. Since the telemedicine program was created in 2008 with a focus on telepsychiatry, business has grown exponentially. By 2018, I expect the hospital to reach 3,000 patient admissions annually — that's more than 140% growth in annual admission averages. The hospital's practices now serve dozens of clients nationwide.

This case isn't a lark — nationwide, telemedicine has proven especially useful in neurology, oncology and psychiatry. Telehealth services provider InTouch Health has robotic telemedicine equipment that is increasingly gaining traction with both hospitals and the U.S. Food and Drug Administration. Today a stroke patient can go to a local emergency room, and using teleneurology, a stroke specialist can read the chart through a television to an emergency room doctor or nurse practitioner that's in the room with the patient. A specialist is looking at the vitals, checking the drugs, examining the blockages — all remotely.

Similarly, telemedicine is revolutionizing one of the most underserved areas of medicine: mental health. Today more than half of U.S. counties have no behavior health professionals, and as a result, 62 percent of Americans coping with mental illness never receive treatment. Telehealth hospitals are implementing psychiatry areas staffed by nurse practitioners that have direct lines to psychiatrists, who are far better equipped to deal with patient issues than an ER doctor. This enhanced care has reduced costs by avoiding prolonged visits in emergency department or the intensive care unit, and improved the lives of thousands of previously underserved Americans.

We're also seeing telemedicine relieve overworked doctors in communities that have a shortage in primary care. Because of the recruitment problem, the rural community doctors that we do have tough workloads, working both day shifts at the hospital and night shifts on call. With telemedicine, the physician is relieved of night call, as a remote physician takes over that coverage. Similarly, the local doctor no longer needs to be stretched thin, since a telehospitalist can work with a nonphysician provider to provide complete care.

This greatly improves the physician lifestyle, making recruitment and retention easier. Additionally, as nights and weekends are when most physician errors occur — likely due to burnout — this also improves the quality of care. Hospitals utilizing telemedicine at night have seen improved patient satisfaction and emergency department patient flow, in addition to reduced lengths of stay and declining readmission rates. Patients no longer have to wait until the morning to get the nonemergency care they need, as has been the case with the unpopular but often used nighttime call model.

The Future: Nationwide Networks

Despite being in the early stages, hospitals with telemedicine are already evaluating potential returns. A system I recently spoke with expects a 76 percent return on investment by the end of the year from a teleneurology expansion alone, thanks to a reduction in transfer to tertiary centers. Imagine the possibilities of a more robust program.

As telehealth continues to gain traction, I think we will most frequently see the distributed model. Under this structure, each hospital has a small "pod" of specialists dedicated to that particular hospital, making it easier to build relationships than models that pull from a pool of hundreds of doctors. However, the doctors within the pod can be located anywhere, making staffing easier than in models that require physicians be within a certain geography. The only necessity is that all providers are credentialed and appropriately licensed in the state where they are providing services.

As more rural facilities open their minds and wallets to telehealth, it will become standard. Unshackled by geographic parameters, rural patients of tomorrow will be able to receive the care they need while rural care facilities will be able to improve margins.

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