Expert Perspectives on Telemedicine in Urgent Care

Urgent message: Telemedicine—or "at-home" medicine—affords unique business opportunities to urgent care providers who can overcome barriers to adoption such as reimbursement.

Introduction

Telemedicine is a topic that frequently comes up among UCAOA's membership as an area of interest. Some urgent care providers view telemedicine, or "at-home" medicine, as an opportunity; others see a threat. A lot of questions exist about telemedicine and with this roundtable, we've pulled together the unique experience of individuals who are offering telemedicine as a stand-alone service, have integrated it into their delivery models, and who bring legislative, regulatory or policy perspectives.

Telemedicine Business Models

Alan Ayers: Telemedicine is an umbrella term that encompasses many different technologies and services. What specific telemedicine business model stands to impact urgent care?

Karen Mathura: For better or for worse, depending on your viewpoint, telemedicine is having an impact on a lot of urgent care center visits. Many apps are available that individuals can use to get an assessment by a health care provider via an electronic connection. I think the trend is toward patients logging on from home, putting in their credit card information, and initiating a telemedicine session. But urgent care centers like the one down the block from me really thrive on the individuals who need a strep culture, have a rash that needs to be appreciated, or need a check for head lice. In many cases, those encounters start with telemedicine. In some states, it would be a breach in the standard of care to prescribe antibiotics to a patient during a telemedicine session. Urgent care centers can be the "boots on the ground," so to speak, for telemedicine providers in that situation. That's why I encouraged urgent care providers to partner with telemedicine providers during my presentation at the UCAOA conference.

Alan Ayers: What Karen described is similar to the ZoomCare model. Kit, how would you respond to the

© corbis.com

PARTICIPANTS: **Alan A. Ayers, MBA, MAcc** (moderator), Content Advisor, Urgent Care Association of America, Associate Editor, *JUCM*, and Vice President, Concentra Urgent Care; **Ralph Derrickson**, CEO of CarenaMD; **Karen Mathura**, RN, JD, CPHRM, Claims & Risk Management Consultant at RCM&D, Inc.; **Katherine (Kit) Sandstrom**, FNP, a Family Nurse Practitioner at ZoomCare; and **John Shufeldt**, MD, JD, MBA, FACEP, CEO of MeMD and Urgent Care Integrated Network.

question about telemedicine's potential for impacting urgent care?

Kit Sandstrom: There is going to be some overlap between telemedicine and urgent care, but as Karen said, there will always be some things that will require a physical exam or a point-of-care test or a send-out test for accurate diagnosis and treatment. At ZoomCare, we have a list of conditions for which patients can be seen virtually and we have standard questions about history of present illness that we ask patients. Answering "red flag" questions in a certain way results in conversion of a telemedicine visit to an in-clinic visit. The care is standardized and we don't double-charge a patient whose care is converted to in-clinic. That process is the way we ensure patient safety and access to care while allowing consumers to drive their own health care choices.

Alan Ayers: Ralph, I am very intrigued with CarenaMD's model of partnership between direct public health medicine models and health systems. What's your perspective on specific telemedicine business models that will impact urgent care?

Ralph Derrickson: At Carena, we empower hospital system brands and other organizations to take advantage of telemedicine. Our clients' business objectives vary from patient acquisition to increasing access, improving convenience, and providing care that makes sense for patients, on their time and schedule. Classically what urgent care centers have done is offer patients a place to get care in person without having to go through the trouble of getting an appointment with a provider and planning treatment around the provider's schedule.

I think telemedicine is going to have a huge impact as consumers become more responsible for the cost of the health care they receive and are encouraged to choose their own insurance plans and providers. More and more, their expectation will be that medicine should be like the experience of the Internet—on their terms, when and where they want it and how they want it. If it is clinically appropriate to do it virtually, then that's what the patients are going to want.

"I think telemedicine is going to have a huge impact as consumers become more responsible for the cost of the health care they receive and are encouraged to choose their own insurance plans and providers."

Ralph Derrickson

Carena started working with large self-insured companies before we started working in the hospital systems. We've seen a lot of patients transition from PPO-type insurance plans to high-deductible plans. When patients face making both medical and economic choices, their care-seeking behavior changes. If they can get something taken care of virtually, without an in-person exam, great. If they need an in-person exam, they want the full spectrum of services, whether that's the strep test we've talked about or other specialty care. So we think there's a huge opportunity to use telemedicine in a service offering that is going to challenge the urgent care space as a stand-alone set of clinical services.

John Shufeldt: I've been involved in the teleradiology business for a while, and at the end of the day, teleradiology is telemedicine. At MeMD, we are looking at having mental health and employee assistance program products in telemedicine as well. There are many areas of medicine with potential crossover for telemedicine and urgent care. For example, through a HIPAA compliant telemedicine portal, a hand surgeon could be shown a patient's x-ray and perform a virtual exam and then discuss with the urgent care provider when the patient can be seen in clinic or scheduled for surgery. Direct-to-patient, and direct-to-employer and then to employee or health system member models also are possible and they all affect what has traditionally been done in-clinic, in person.

Ralph Derrickson: I think the most obvious model that we talk about is direct-to-consumer. Technology changes the paradigm from with whom we do things in medicine to how we do them. I have a tremendous amount of respect for what's happening in ZoomCare. They don't think about a traditional doctor/patient relationship or about how hospital systems and health systems have traditionally thought about health care. ZoomCare's focus is on a consumer who is working 5,6,7 days a week and has to work their health care in and around their schedule. Banking is a great proxy for the way consumer behavior and perspective on technology have morphed in a business model. Technology hasn't changed who a person banks with but it certainly

has changed how you bank with them. And it created an opportunity for new brands to emerge. ZoomCare is a great example of a brand that is very smartly putting services on the Web where they make sense, and in person where that makes sense.

"When telemedicine becomes widespread, I really fear for urgent care providers because we will be taking their bread and butter away from them."

John Shufeldt

Telemedicine as a Direct-to-Consumer Delivery Channel

Alan Ayers: How would you describe the adoption or maturity of telemedicine as a direct-to-consumer delivery channel for treatment of minor illness and injury? Kit, as you roll that out in your markets, how have consumers responded to your retail clinics and what are some of the challenges you've run into?

Kit Sandstrom: Patients love our telemedicine visits. At the end of their first visit, they're smiling because they can't believe how easy it was with all of the unnecessary barriers removed. To give you an anecdote, I had a telemedicine visit with a woman who worked in a hospital and was on a Smartphone. She had terrible allergic rhinitis and was self-conscious about sniffling and coughing around patients even though she was not infectious. Our visit was during her lunch hour and I was able to assess the woman's symptoms, rule out anything more serious, and call in some prescriptions for the woman. She didn't need to miss work, was able to get better faster, and it was a financially sound and safe visit. Toward the end of it, the woman looked around at the other people in the room with her and said, "This is amazing. I just had a doctor's visit." On my end as a provider, getting a reaction like that is unique and exciting and I hope that the technology and innovation is more widespread, because I think it's great for patients.

It's interesting how long it has taken to adopt telemedicine because *The Journal of Telemedicine and Telecare*, which is solely dedicated to studying this topic, has been in publication since 1995, but it is still perceived as new technology. The barrier that we've struggled with most at ZoomCare is lack of reimbursement from private insurers. Some private insurance will cover a visit to the emergency room (ER) for a simple urinary tract infection (UTI) but won't cover the same treatment delivered via telemedicine. That certainly is a very big barrier that we struggle with right now but culturally that will change.

John Shufeldt: Consumers that use telemedicine love it. Our Net Promoter scores are always over nine and I get more praise treating someone with a UTI virtually than I do literally saving someone's life in the ER. It is the weirdest thing. When telemedicine becomes widespread, I really fear for urgent care providers because we will be taking their bread and butter away from them. They may be forced to do more of the higher-level care that has typically gone to the ERs and the providers will be ill-prepared to do it.

Karen Mathura: During my presentation at UCAOA, I encouraged urgent care providers to adapt their business model to work hand-in-hand with the telemedicine providers. They need to think out of the box and to try to form relationships with entities that are partnering and, as I previously said, be the "on the ground" people that telemedicine providers can go to. I agree that ZoomCare's model is really phenomenal.

The Growing Availability of Telemedicine Solutions

Alan Ayers: Consumers have historically valued urgent care due to its shorter wait times and lower costs and other options including the ER, but telemedicine is prospectively cheaper and more convenient than urgent care. How do you feel that the growing availability of telemedicine solutions will affect urgent care in the future?

Ralph Derrickson: A factor that will impact business for physicians in clinics and traditional medicine will be the revelation of what health care really costs. One of the things that we're seeing is a dramatic shift in patient care-seeking behavior because of enrollment in high-deductible plans under the Affordable Care Act. Patients are realizing that a trip to the doctor isn't really a $25 or $35 affair. It's a $150 to $175 event and it was difficult to make happen because of scheduling, parking, etc. Primary care physicians are under pressure as patients look at what it costs to receive care in the clinic setting and how unpleasant the visit logistics were and consider other alternatives. It's not just urgent care providers who are going to be pressured to provide the highest-quality care clinically and meet patient needs and objectives in a constrained-time and constrained-

dollar world. I think the best comparison I can make is to airline ticketing before Expedia; it's going to be about purchasing health care after the cost is transparent. I think there's going to be some very interesting shifting in what doctor-patient relationships look like and what system-patient relationships look like as the costs of care become transparent and the real costs of these services start to be borne by patients in significantly large volume.

"If urgent care successfully incorporates with telemedicine that could potentially be a way for urgent care centers to expand their business by bringing in those additional patients."

Kit Sandstrom

Kit Sandstrom: Our telemedicine visits are discounted, so patients can get the same outcome for a lower cost. But as I mentioned earlier, with the lack of insurance reimbursement, it is still more expensive for people with private insurance to pay the full amount for a telemedicine visit than just the co-pay for a covered office visit. What's exciting about telemedicine is that it broadens access to care. For example, this winter, we had terrible weather in some areas of the country. In those areas, primary care offices and urgent care clinics were closed and people couldn't leave their house even if they wanted to get to a doctor. In those situations, patients either delay treatment or end up seeking it in an inappropriate setting such as an ER. Telemedicine has the capability to improve outcomes through improving access. So if urgent care successfully incorporates with telemedicine that could potentially be a way for urgent care centers to expand their business by bringing in those additional patients.

Karen Mathura: I live in Washington, DC, where we have ERs and urgent care centers all over the place. A lot of physicians in the area are thinking about taking urgent care on the road. They want to cater to people who don't have Internet and don't have anyone living with them who can arrange for the service and handle the set-up for a Skype visit. These physicians are looking at an on-call service for urgent care matters. If a person has, say, an allergic condition or ear infection and they don't have an Internet access and don't want to get in a car and drive to the ER or an urgent care center, a mobile urgent care provider would go to them. The target market is patients aged 80 and older.

Telemedicine as a Business Opportunity

Alan Ayers: What business opportunities do you see for urgent care providers with the growing potential of telemedicine in the United States?

John Shufeldt: The reason I started the telemedicine service was because I would go around to our urgent care centers and see some physicians practicing their golf swings for lack of patients. They were willing to see patients if we brought them to them. So we came up with a telemedicine model that allows providers to see patients in any states in which they are licensed. I thought it was the greatest thing since sliced bread, but when I went out to sell it, urgent care providers thought they would be cannibalizing their own business. Maybe, but with telemedicine, you are only going to potentially lose some patients from within a radius of a 10-minute drive to a particular clinic. However, if those patients see you virtually, I would argue that the margins for that care are better than for in-clinic care. But from the rest of the state, with telemedicine, you get patients who may never use your clinic and who would never have heard about it otherwise. So telemedicine is a great way to market and also to see patients who are remote. I see virtual medicine as a way for providers to fill up their downtime in urgent care, help cover high fixed and provider overhead, and add a few more patients and a few more dollars to the bottom line.

Ralph Derrickson: We're happy to partner with urgent care providers that want to use virtual medicine as an entry point for their clinics. Patients are likely to find an urgent care center in the first place by doing a directed search online for a specific clinical condition or for medical care in their area. The question is what can urgent care centers do to increase their relevance to a patient who starts with that kind of search? The best thing to do is convert that search into a transaction right then and there, the same way Google and Amazon work together to turn a problem-focused search into an economic transaction. I think there are huge opportunities for partnering with the urgent care market for us and we certainly welcome the chance to empower an urgent care brand. As has already been mentioned, that allows us to increase a brand's reach because it is no longer material that the actual clinic is located at the corner of,

say, Pike and Fourth in Seattle. Anyone in business today should be constantly looking at ways to use technology to improve and innovate their business model and not relying on protectionism or pricing or non-reimbursement to drive business their way. Urgent care providers need to be increasingly ready for patients who behave irrespective of what their plan will or won't pay for because they are on the hook for the deductible. I'm curious if others are seeing care-seeking behavior driven by patients' willingness to absorb costs regardless of the design of an insurance plan.

"Telemedicine companies have to make sure that the physicians and care providers involved are licensed not only in the state where they're physically located but also in the states where their patients are physically located."

Karen Mathura

Kit Sandstrom: We've found that some patients with private insurance opt to self-pay for a telemedicine visit just because it's convenient for them and they feel like that's the most appropriate way to treat their condition. Unfortunately only a small segment of our patient population can afford to do that and we would like telemedicine to be accessible to more people.

Barriers to Adoption of Telemedicine

Alan Ayers: What barriers are there to consumer adoption of telemedicine solutions?

Karen Mathura: Telemedicine companies have to make sure that the physicians and care providers involved are licensed not only in the state where they're physically located but also in the states where their patients are physically located. So, just getting the licensures in and of itself is a challenge. Making sure that physicians are credentialed and privileged is trickier if they are going have virtual visits with patients in a hospital setting because they have to be credentialed at the site where the patients are located as if they are actually, physically there on staff. Many states have different requirements for whether doctors can prescribe medication without conducting in-person, physical examinations. Privacy and security issues regarding other people who might be in the room with a physician on the other side of the computer also are a concern. Patients sometimes worry that about whether dissemination of information through a telemedicine portal is compliant with the Health Insurance Portability and Accountability Act (HIPAA). A lot of the physicians at the UCAOA conference were concerned about whether billing under Medicare and Medicaid in areas that are not medically underserved area. Identifying and overcoming challenges before crafting a telemedicine program is very important to avoid losing money.

Kit Sandstrom: Probably the biggest barrier to telemedicine that we've been struggling with is lack of reimbursement by private insurance. We hope that will change and insurers will recognize that it is a great way to decrease cost and the burden on ERs.

I think it's notable that in a lot of ways, home medicine visits actually enhance patient privacy. For example, for certain psychiatric issues, leaving the house alone to go into a medical facility for care is a huge barrier. Telemedicine eliminates that and the Veterans Affairs system has used it for psychiatric illnesses such as post-traumatic stress syndrome. Veterans can go online and participate in support groups without having to leave home and the outcomes are a lot better. Eliminating any stigma associated with going outside the home and decreasing administrative staff associated with a visit are ways that telemedicine can contribute to enhancing privacy.

Ralph Derrickson: Reimbursement is obviously frustrating for everybody. I think it's ridiculous when Medicare and Medicaid will pay for UTI treatment in an ER and not over the telephone or via Skype at a fraction of the cost. Technology is doing what it always does, which is running well ahead of regulatory and business rules; I hope they catch up quickly.

The other potential barrier I see is patient comfort with the use of technology. At Carena, we find that patients most often use Skype, FaceTime, or a webcam on devices into which the technology is well integrated. Telemedicine sessions on a laptop or a desktop are unusual, whereas use of a tablet or Smartphone is common. When the technology is well integrated, there is no need for a download or installation. Making technology dead easy to use is a big thing. We have a BYOV—bring your own video— approach to webcam visits. We offer integrated solutions, but if you want to bring your own Skype or FaceTime, we'll use that.

Another barrier is making sure that what is being done virtually is high-quality medicine and communicating that to patients. The providers are credentialed and licensed and are in the United States. They're not in a call center in some far-off place. Patients need to understand the credentials and capabilities of the providers and that they are going to be receive clinically appropriate medical care from a qualified provider, just as if they had gone to an in-person facility down the road. These issues are not gender- or age-related. There is a general perception that young people adopt technology quickly and seniors do not, but a lot of seniors are doing some pretty interesting things with iPads.

"Providers are ultimately responsible for knowing what the standard of care is and how and where they need to be licensed to practice telemedicine."

Karen Mathura

John Shufeldt: I agree that telemedicine issues, for the most part, are not gender- or age-sensitive. Generally speaking, the patients who I personally have treated virtually are raving fans of the technology and completely get it. In the ED, I still see patients who really don't need to be there and that's a problem that we have all been trying to solve for years. Oddly enough in virtual medicine, very rarely do I see patients whose conditions aren't suitable for management with through telemedicine. For whatever reason, people seem to intuitively get what can and can't be treated virtually. They aren't calling in with the worst headache of their life, crushing chest pain, or a bone sticking out of their skin. For example, I'm not a believer in rapid strep testing because the test lacks sensitivity. Maybe I'm just old school, but if a patient's throat has been red for a couple days, it's covered with pus, and there is no history of exposure to mononucleosis, I'll treat for strep without a test. Is that below the standard of care? I don't know and I think it can be argued both ways. But the patients who call us seem to have conditions that are suitable for telemedicine.

Legal, Privacy, Regulatory and Payor Considerations

Alan Ayers: John, you have a unique perspective as a provider, an operator, and an attorney. I am curious about your view of some of the legal, privacy, regulatory, and payor considerations for urgent care operators who are exploring telemedicine.

John Shufeldt: The standard of care is the standard of care and it doesn't really change because the setting is virtual. Standard of care does not vary from state to state. It is what a typical provider with similar background and training would be expected to do in a face-to-face encounter involving a similar problem. The regulatory aspects are pretty black & white in many respects because you have to have a license to treat a patient in the state in which they are residing or visiting. The challenge, however, is what constitutes an exam? Everyone on this panel is an expert in telemedicine and we've all looked at these laws ad nauseum, but they are still pretty gray. Is a face-to-face exam me looking at somebody through a HIPAA-compliant video interface? I would argue it is, but I don't think that's what the law meant. Unfortunately a lot of this is going to be vetted when there is a bad outcome associated with telemedicine. As the panelists know, bad facts make bad laws. Unfortunately, at some point we're going to have some bad facts and we may be forced to deal with some bad laws that come out of it.

Karen Mathura: One of the issues that comes to mind for me is how the Centers for Medicare and Medicaid (CMS) regulate urgent care centers. Under Medicare and Medicaid, an urgent care center is classified as a medical treatment facility. The offices of physicians or practitioners are qualified as CMS originating sites regardless of geographical location yet getting paid by Medicare or Medicaid for telemedicine is a challenge. The other thing is state-by-state variation in requirements for licensure. For example, 36 states now require a full medical license to provide direct care, including telemedicine. In 10 states, telemedicine is considered a special licensure practice. In 43 states, practice across state lines requires licensure in that other locality. You really have to know who you are reaching with telemedicine. I talked to an urgent care provider from Boston who was looking into working with a telemedicine company in Florida that had users in various states. The company told the urgent care provider that it wasn't necessary for him to be licensed in those states. I told him that it was dangerous and potentially problematic. Providers are ultimately responsible for knowing what the standard of care is and how and where they need to be licensed to practice telemedicine. If you are having a virtual encounter with a patient in Alaska, do you need to be

licensed in that state and can you order a prescription for that patient without conducting an in-person physical examination that literally involves laying hands on the patient? There are many different governing entities related to telemedicine and my best advice is to seek out an expert in it before embarking on use of the technology.

"Telemedicine providers also need to adhere to rules regarding commerce and privacy on the Internet, such as safe transmission of a patient's credit card and personal information."

Ralph Derrickson

Alan Ayers: Kit, you mentioned some of the payor issues. I believe that Oregon is the only state in which ZoomCare offers take-out visits or telemedicine. Are there any other legal, privacy or regulatory concerns that you'd like to address?

Kit Sandstrom: Yes. Currently ZoomCare is only providing telemedicine visits between our providers located in clinics in Oregon and patients in the State of Oregon. We hope to expand these services to Washington State where we currently have neighborhood clinics where patients can be seen in person. The lack of reimbursement by private insurers is our biggest obstacle both in Oregon and in the State of Washington in expanding these services to a wider patient population. Patient privacy should always be a priority, but as I mentioned earlier, it is important to note that in many instances, telemedicine is often a tool to enhance patient privacy because it delivers are to patients in the privacy of their homes. We think that it's important that the benefits of telemedicine get equal time in debates surrounding regulatory concerns.

Ralph Derrickson: The other issue that I'd like to address is understanding insurance obligations. You have to understand that when you're treating a patient, you have to be licensed where that patient is located at the time you're treating them, not where they are domiciled or collect their bill. There's a great deal of variation in licensure and professional obligations for providers. That's why we look at telemedicine on a state-by-state basis and tell everybody that there is no such thing as "national" telemedicine. The intentions and objectives of local regulatory medical boards and insurance commissions always need to be taken into consideration. Telemedicine providers also need to adhere to rules regarding commerce and privacy on the Internet, such as safe transmission of a patient's credit card and personal information. In some states, the Internet rules are as restrictive as or more restrictive than HIPAA rules. That's another area of complexity that people should explore before they just start taking credit card payments on the Internet and bringing things online.

Karen Mathura: Urgent care providers exploring telemedicine may be interested in reading about a legal case involving telemedicine Internet prescribing that I mentioned as an example during my presentation at the UCAOA conference. *Hageseth v. Superior* Court (150 cCal.App.4th 1399, 59 Cal. Rptr.3d 385) revolved around purchase of Prozac through a website outside the United States by a 17-year-old in California. The company outside of the United States forwarded the request for the script to a Colorado physician, who then worked with another company in Florida for processing. Two months after the prescription was filled, the teenager committed suicide. The physician was prosecuted for and found guilty of prescribing without a license in California. He surrendered his license and served a 9-month sentence in Colorado. The Prozac was not found to have caused the patient's death. The take-home message is that a provider sitting in an urgent care center in one state who is dealing with a patient in a second state and a company in yet another location can be prosecuted in any of those jurisdictions. In *Hageseth*, the provider got into big, big trouble and ended up losing his license because of what he did in telemedicine. ■