Virtual First-Care Summit

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Q&A with Linette Demers

IMPACT Program Director

Digital Medicine Society (DiMe)

What potential does Virtual-First Care have to improve the current healthcare system?

There is no question that the pandemic has accelerated the use and acceptance of synchronous virtual visits as a substitute for in-person care, and we have convincing evidence that telemedicine can expand access to acute and chronic care for previously underserved populations without duplicating services or jeopardizing clinical quality.

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However, virtual visits alone won't address the crippling inefficiencies and inequities, soaring costs and lackluster clinical outcomes in our healthcare system. This is where virtual first care comes in. V1C is defined by the IMPACT collaborative as: medical care for individuals or a community accessed through digital interactions where possible, guided by clinicians, and integrated into a person's everyday life. V1C has the potential to break the 'iron triangle' of cost-quality-access by fundamentally remodeling health care so it is aligned with patients' lived experience of their condition. This decouples the provision of care from the traditional cadence of office visits and bricks and mortar through application of digital tools, including at omnichannel communications, remote monitoring, and AI-powered analytics to support

multidisciplinary care teams. In this model, workflows are optimized for patient outcomes, rather than encounter volumes. This shift enables intentional selection of site of care and communication modes that remove barriers of time and place, as well as the misaligned incentives and operational barriers that stand between patients and providers in the traditional model of care. The result is that a patient living with a chronic condition such as heart failure or COPD has as-needed access to a complete care solution including medical care and supportive services such as nutrition, mental healthcare and skills building coaching for improved self-management.

What are the current challenges facing Virtual-First Care and what strategies must be put in place to overcome these challenges?

Inertia is one of the biggest underlying challenges facing V1C. Many established healthcare practice models and referral networks are entrenched in the status quo. While virtual first medical practices offer uniquely efficient and patient-centered care, there are misconceptions that virtual care is 'second class medicine.' This inhibits pathways to trust and reimbursement, while outdated regulatory, contracting, coding and practitioner licensing models create barriers to innovative care approaches that may be safer and more effective for patients. Despite these challenges, the overwhelming number of new entrants – both large and small -- in the space means that differentiation will be critical to attracting attention of purchasers and referring physicians. To scale beyond small direct-to-consumer pilots, V1C practices have a number of challenges to overcome. The will have to navigate existing payer networks and employer benefit schemes to demonstrate that they address access care gaps without abrading networks or duplicating services. They also must show robust evidence of value well beyond that demanded of traditional health systems and physician practices.

What steps are DiMe and ATA, through their IMPACT initiative, taking to ensure Virtual First Care fulfills its promise?

The Digital Medicine Society (DiMe) and the American Telemedicine Association (ATA) have partnered to co-host the Virtual First Medical Practice Collaboration, IMPACT, in order to bring stakeholders from across the ecosystem together to accelerate access to high quality, evidence-based virtual first care

(V1C) for patients, healthcare providers, and payers. Our goals of this collaborative are to improve clinical and health economic outcomes, enhance access, and provide a better overall patient experience. The collaborative produces open-access, industry-vetted resources such as the payer contracting toolkit and best practices for effective V1C care transitions and works to improve awareness of the model in the healthcare community.

Which areas of Virtual-First Care do you anticipate to show the most growth within the next couple of years?

Virtual 'first' doesn't mean 'virtual only'. The next phase of V1C will show us how the industry integrates with existing bricks and mortar healthcare and across V1C providers both primary and specialty care. This is table stakes for V1C, otherwise we will simply have added more options to the already fragmented system we already have. As the V1C industry matures, I am most interested to see how it evolves beyond 'point-solutions' towards truly hybrid, high value networks of care. I anticipate growth in V1C-enabled collaborative care partnerships that position primary care as fulcrum for most care but provides embedded, efficient access to specialty care support for chronic and complex conditions such as cardiometabolic, COPD, diabetes and obesity, as well as mental and behavioral health. These are emerging in risk-bearing and managed care organizations already where incentives are well-aligned for risk assessment and judicious use of specialty care, as well as in post-acute care settings to prevent rehospitalizations. Likewise, I expect to see growth in enabling solutions for virtual first care such as in-home providers and other services such as labs and imaging that provide high value downstream services in local markets.

Which conversations are you most looking forward to having at the Virtual-First Care Summit?

The incredible roster of speakers and panelists will show us what 'good' looks like from their perspectives and how they are achieving success in remodeling healthcare using principles of digitally enabled virtual first care. Given the cross-disciplinary nature of the Summit attendees, this is a rare forum for 'across the table' talk about how we can collaborate to replicate and scale success to achieve the healthsystem we all want.