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Health Care Law Today Podcast

Episode 4: Direct to Consumer (DTC) Telehealth: Does the Industry Need More Regulation?

In this episode, Nathaniel Lacktman, Chair of Foley & Lardner's national Telemedicine & Digital Health Industry Team, visits with Quinn Shean, Managing Director at Tusk Strategies. They discuss the current state of direct to consumer (DTC) telehealth services, advice for entrepreneurs, what makes for good asynchronous telemedicine policy, and what the virtual care industry can expect to see in 2020.

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Read and download a free copy of Foley's recent 50-state telemedicine law research survey at New 50 State Survey of Commercial Insurance Laws Reveals Progress.

Please note that the interview copy below is not verbatim. We do our best to provide you with a summary of what is covered during the show. Hyperlinks to resources and documents mentioned in the interview are contained in the transcript below. Enjoy the show!

Nathaniel Lacktman

With me is a particularly distinguished guest, Quinn Shean, Managing Director at Tusk Strategies. Quinn provides regulatory advisory services, and devises and implements solutions for clients to achieve their mission, including engagements in telehealth and technology sector.

I have heard you speak at conferences on telehealth and DTC services, and just generally talk shop in the industry, but I would presume that most of our listeners haven't met you yet. Maybe tell us a little bit about yourself and your role at Tusk.

Quinn Shean

I am currently at Tusk and I work as a regulatory and policy advisor to both large corporations, as well as start-ups. My initial background is I worked in politics for about three years on state campaigns, and my favorite types of projects were always around health policy.

I then practiced law for about five years at two major law firms doing pharmaceutical and medical device work, primarily product liability on the defense side. Then when I had enough of that, I had the opportunity to join Tusk.

I had worked with our founder, Bradley Tusk, back in my political days, and when he offered me the opportunity to get out of the law firm and try something new, of which I really wasn't sure what I'd be doing, I said, "That sounds good!"

Tusk is an interesting model. We started out as a company that served as a political and regulatory strategist for large corporations. If you were a corporation and you were facing a tax issue in many different states, we would come up with the strategy, build the team on the ground, and run a campaign to either fight it or support it, depending on what the issue was. Our founder realized that this model, and how we work, was particularly well suited to start-ups, who are often fighting entrenched interests or incumbents. Their innovations might not align with whatever the current regulatory structure was. He was brought on as Uber's first political consultant about eight years ago, and when that went well, decided to expand the practice to also be advising these types of entities.

With both start-ups and big corporations, we do everything from shaping policy, helping them tackle regulatory hurdles, helping with communication strategy, supporting or opposing legislation, securing partnerships, and working on procurement.

Nathaniel Lacktman

The CEO might get all the attention for the idea, but the team behind the idea ... Is that you? Is that fair to say?

Quinn Shean

No, we have a great team here and it's a lot of people that formerly worked in government, who know how regulators and government and legislators think. When I was practicing as a litigator you only have a certain number of tools at your disposal within the confines of how the legal system operates, and what I love about Tusk is when we form campaigns, or we're helping companies trying to shape and change regulations, your toolbox is kind of endless. No idea is too far out there. It allows you to be really creative.

Nathaniel Lacktman

What is DTC medicine, and where do you think it fits into the healthcare industry at large?

Quinn Shean

That's a really good question. I don't know how much that's been unpacked yet—before we go on to what are the benefits and questions we have about that model—but DTC telemedicine is being framed as kind of the new rise of companies that are engaging with patients directly without a brick and mortar presence, and often in an integrated model that combines everything from the patient initiation, diagnosis, treatment, and then ultimately, prescription fulfillment for those customers that want it. The concept of DTC is not entirely new, in my opinion, and I see it as these companies are building on a kind of established infrastructure of initiating care directly with patients and meeting them where they are.

Nathaniel Lacktman

Essentially, a different way of approaching medical services.

Quinn Shean

I think what they've done well, if we're talking about this kind of new crop of venture backed companies, is they've taken different elements of established, approved upon infrastructure—like asynchronous structured interviews that we've seen health systems do, and ideas of mail order pharmacy fulfillment that we've seen pharmacy companies being able to do—and they've incorporated that with a customer experience that's really personalized to users.

They've done that very well, and they've found a way to bring in new patients into the healthcare system, or patients who've been away from the healthcare system for a while. I think the new part of this model that we're seeing is really the integration of everything, and the ways that they have been able to engage new patients in this mode of healthcare delivery.

Nathaniel Lacktman

Well, it's certainly popular, right? I would think that traditional hospitals and medical groups have been advertising, right? They put up billboards, they take out ads in newspaper, they send letters to people's house saying, "Hey, I'm going to do a chat at the library. Why don't you learn about spinal fusion?" But it's nothing of the type of scale, or almost like a hockey stick in the popularity of this DTC telehealth. What do you attribute to that rise in popularity?

Quinn Shean

I think it's a confluence of things. We've already seen healthcare generally finding more appeal in the, for lack of a better term, convenient care market. We've seen the rise of urgent care clinics. We've seen retail

care clinics. We've seen, alongside that, care outside maybe the traditional brick and mortar primary care physician.

But alongside all of that, we've also seen customers or patients being asked to take more control over their own healthcare by being more in the driver's seat of having to make decisions and pay out of pocket. Then the third part of that is, we're seeing a more informed populace across the sphere, of wanting to be more accountable about their own health and make decisions.

Nathaniel Lacktman

What do you think about the advertisements for DTC telehealth, as compared to maybe just traditional brick and mortar medical practices? How are they doing it different, and maybe better, or worse?

Quinn Shean

I think one of the things I would say about coverage of DTC generally, is some are taking more risks than others, so it's hard to necessarily generalize.

What I do think that they're doing is speaking directly to patients, and they're using marketing techniques that have been taken up across a variety of industries in this new digital space. They're meeting and engaging patients in ways they understand, sometimes in a way that breaks down numerous stigmatized conditions. But I also think, when we talk about the marketing, we need to make sure that whatever critiques or questions we might have about marketing, those don't necessarily equate to poor care delivery. I think there's been a conflation of the two, that if you're uncomfortable with how somebody is marketing on a subway, or reaching patients in that way, therefore, they're receiving substandard care. I think that's a misplaced criticism.

I would be interested in what you think, Nate.

Nathaniel Lacktman

I think they're doing a great job. I think health plans, for years, have been pulling out their hair saying, "Please engage with your primary care. Go to your doctor. Don't let conditions go untreated."

Now, finally, we have a wave of healthcare companies saying, "You know what? They're right. Let's do a better job getting people excited, getting people engaged in medical care." Now, it may be condition specific or nuanced on this sort of 1.0 wave, but there's a multitude of DTC telehealth companies that are offering primary care, or concierge complete care offerings.

Quinn Shean

And I think Ann Mond Johnson made the same point earlier this year when she wrote a short, pithy, great blog post, that what can we learn about the ways these companies are engaging people?

You can still ask questions saying, "Here are my concerns," or, "This is where I'm uncomfortable," or, "What about this?" Those are fair questions, but we can't just have skepticism about the care based on how they're bringing patients into the fold.

Nathaniel Lacktman

What if it just shut down? What if all that DTC advertising stopped? What would happen with the patients?

Quinn Shean

I often think, when I see these criticisms about the DTC companies, there's this myth that the alternative to the care that they're providing is going to be in-person care, and that's just not true. It's more likely than not going to be no care at all. So, we are missing the opportunity to have people take control of their health, speak with a physician or a clinician, and figure out what actionable next steps might be. I think there's a real lost opportunity to engage with new markets, build access, and take some lessons from what these companies are doing to bring more patients into the fold.

Nathaniel Lacktman

Do you think that the more DTC telehealth companies become available to patients is going to remove primary care physicians from the equation? Will it cause patients not to see their PCP anymore?

Quinn Shean

If we're just talking about more DTC condition specific companies, or those that only treat a couple of conditions, many of these companies see themselves as a complement and not a replacement to the primary care physician.

One thing going forward, I hope, is the next iteration of these companies will be how do they work in coordination with primary care physicians? How does that handoff work? How does follow-up work to encourage a primary care relationship?

But going back to the lessons learned, or where PCPs can get in the market, I see t the direct-to-consumer experience with the full integration, and what they've been able to do in bringing in new patients, as the future of care. I think more primary care physicians should be thinking about both ways to engage patients, but also as a way of care delivery itself in their own practices.

You work, probably, more with these types of practices than I do, just based on the nature of our firm. Sometimes, in venture, we deal with many companies in what I'll call the grey space—like electric scooters, or we have, now, a new market for cannabis—and what's that going to look like. There's bigger questions of do we want this, yes, or do we want this, no?

That's not the case with this new crop of DTC healthcare companies. They're here, they can work together with our existing infrastructure. They're not in a grey space, they're in a heavily regulated space. They're providing a new care delivery on established infrastructure.

My hope is that a strong primary care physician model, for some, can work in conjunction with these companies.

Nathaniel Lacktman

The rise in popularity, do you think it's attributable to things that these new companies are doing right, or that some of the established, traditional medical providers are doing wrong?

Quinn Shean

There's clearly an unmet need in the primary care market with what some of these companies are doing. To take a step back, when you see some of the criticism, the questions of, "Well, what is lost in a DTC encounter and what are we missing," underneath all that, and ignoring the rise of popularity here, is there's a romanticization of primary care and what that experience is like for the majority of people.

I'm not sure the exact set, millennials under the age of 30, 40% don't have a primary care physician. It's 30 days, on average, for an appointment. I think 40% of the time is spent only on clinical needs. If we are going to really look at the needs that the direct-to-consumer model is addressing, we have to have a realistic sense of where the primary care experience is for people right now. Often that is no connection to a provider. There's not a continuity of care.

It's wanting to get in where you know you have an issue that you want to get taken care of, and you want to do so on your own time, in a convenient, affordable, and accessible way. The system, right now, is not set up for that.

That is where these companies have been able to build on existing practices, bring them together, and focus on the patient and the customer-patient experience in a way that's been very receptive.

Nathaniel Lacktman

It sounds like what you're saying, at least in part, is that the rise of DTC telehealth, it's not like an invasive species, but rather the result of shortcomings in the existing way that traditional healthcare is provided, and new expectations of the upcoming patient population.

Quinn Shean

Absolutely. Lots of people have talked about this, that we do E-banking, we do E-shopping. The rise of the new population, or the younger population, is expecting a care delivery in a certain way. It's not unusual for them to be filling out a type of interview and expressing themselves that way. A lot of people still prefer

face-to-face, in-person care, but it's not accessible and it takes quite a bit of time to get an appointment, so you lose the convenience.

You're filling out forms four times and then the doctor is also entering them. It's understandable how a streamlined model like this, where you can have something like your birth control taken care of, is really appealing to a lot of people.

Ann Mond Johnson, who's CEO of the American Telemedicine Association, wrote a great, short blog post this past Spring that really challenged readers to look at these DTC companies and think about what we can learn from them, because they're clearing resonating with consumers and patients, and they're engaging them in new ways.

Rather than solely criticizing them and questioning their care delivery, she called for an understanding in trying to bridge the gap there, to help better understand how they're engaging patients and how they're delivering care.

What's your take on a lot of the recent, I'll call it criticisms or critiques, of these emerging models? Leaving aside the marketing critiques.

Nathaniel Lacktman

I think that's a fair concern. People, in general, whether it's in-person or virtual, they put a certain amount of faith in their treating professional, physician, NP, whatever, and the treating professional needs to step up.

When you scale it in such a way that you have a lot of companies offering these online services, even if they're not the medical provider themselves, I do feel that they embrace their obligation to ensure that the patients or consumers or users are getting safe and appropriate care.

It depends on the patient's specific clinical use case and scenario since not every condition is appropriate for virtual, just like it would be inappropriate to do an in-person care without required diagnostics and just shoot from the hip. The big but is, I think if we actually were to take a look at the data, it would show that this isn't widespread panic or patients getting hurt.

So, we could talk about a couple points. The first is malpractice claims in general. The premiums typically are equal or lower for virtual services than they are for identical in-person. Why is that? Premiums are a direct result of payouts and settlements by the malpractice carriers. If there aren't a bunch of payouts and settlements, the premiums aren't very high. Right now, it's pretty affordable to get malpractice insurance for telehealth and virtual care services.

The second is Doctor Joe Kvedar, the current president of the American Telemedicine Association, and a physician at Partners HealthCare, Mass. General Hospital, did a very interesting study that was published in a JAMA Note, I think in May or April of this year, in which he and his colleagues took a look at one random month from 2018 and said, "Let's unpack this idea of DTC telehealth and malpractice."

They found every publicly available DTC telehealth case that was adjudicated by a judge, or arbitrator, or whatever, that alleged med-mal, and there was about 500 of them. They did the literature review, and every single one of the scenarios, the judge determined that there was not medical malpractice.

Now, that doesn't mean there's a causal correlation that there's no malpractice in DTC telehealth, but it does show that of that entire month in that selection there was zero. The authors speculated that some of the reasons may be that it's low acuity, by and large, but also, that the DTC companies in particular are really dialing it in. They're not playing shortstop, trying to handle every random patient need that comes across their desk, like you see in walk-in clinics, which can be a nightmare for a junior doctor to kind of pick up weekend shifts of that. That's just, "Do your best, kid," and hope they don't die. But these telehealth companies say, "You know what? We're not going to treat everybody or everything. We're going to do one or two things and we're going to really dial it in very well to minimize the likelihood that there will be mistakes or patient harm." I actually appreciate that concept; it's almost like the fox versus the hedgehog kind of philosophical idea. Do one thing. Do it really, really well, and repeat.

Quinn Shean

I agree. They're operating almost like specialists in the condition specific arena that, as you said, do one thing and do it really well. I also agree with you that it's fair to ask questions. The stakes are high. Their care delivery should meet certain standards.

I think where I get frustrated is when there's always this kind of comparison. How was patient X treated versus how would they be treated in person? There's so many assumptions that always go into that whenever that kind of model is set up, particularly in the media, but we saw it in the recent JAMA piece, which asked really good questions. I think if they spent more time with some of the DTC companies you and I both work with, there'd be more comfort.

But in it [the JAMA piece] they gave the example of a woman who gets birth control through one of these ads, and the question is, what is lost. What's lost in this encounter? So, they say, "If someone is getting birth control via an app, they perhaps are losing the chance to speak with a provider about longer term options, birth control options, such as an IUD." That's an example that they give.

I think there's a lot in there to unpack. The first is, which we've said before, this kind of romanticization of what the primary care experience is going to be like, that I bet if you talk to a lot of women, they've seen a doctor about birth control and had no questions, had no suggestions about an IUD, that's just not something that always happens, leaving aside whether that's the ideal standard.

The second kind of assumption built in there is that the alternative to care for that patient is going into the brick and mortar, because that's just not true. So, the alternative to the care there is more than likely no care at all.

There was a study that came out about pharmacists prescribing an Organa birth control, and it showed that, I think, for 75% of the Medicaid patients who were getting their birth control from the pharmacist, they were not currently on any. In the absence of that new, innovative care delivery model of pharmacists prescribing, there very likely would not have been contraception. We need to rethink that assumption.

Then the third is what is gained? I know, especially in some of these specialist conditions, they're stigmatized. Some of the providers that I've spoken with said, "People are much more upfront and honest in these asynchronous type of structured interviews than they would be in the office."

So, what might be gained is more information and more data points to make a decision. What might be gained is clinicians not having to remember every possible question to answer or every interaction to think about, because a good asynchronous interview is going to have built-in clinical protocols, evidence based guidelines, and other checks to really help direct the patient's attention to the patient's core need.

Nathaniel Lacktman

Here's a hot take: DTC telehealth does not, itself, contribute to the siloization of medical services, rather we could solve that by having an interoperability and a unified medical record. Agree? Disagree?

Quinn Shean

Agree. I think fragmented care, siloed care, generally, it's not just DTC? Again, I was talking about the rise of convenient care.

Sometimes people have said, "Well, what if somebody is on one of these DTC platforms and gets an acne medication, or medication for their migraines, and then their other doctor isn't aware of that visit?" Well, the same thing can happen if they go to a retail clinic or an urgent care clinic with a similar issue. The interoperability is not something that is specific to the DTC market.

Nathaniel Lacktman

Let's talk health policy and DTC. You're still a lawyer, right?

Quinn Shean

Yes.

Nathaniel Lacktman

DTC telehealth: does the industry need more regulation?

Quinn Shean

I think the industry needs better regulation and more thoughtful kind of patient-centric regulation. That's going to be the challenge going forward. We've spent a lot of time talking about consumers, that patients, as consumers, are playing a different role in this new ecosystem, and so how are we going to continue to have that right balance between providing patients more options and more choice, but also ensuring that safe, quality care.

That's always going to be the tension. I think on the telehealth front right now, we need better thoughtful regulation. Someone wrote in an article that DTC telemedicine companies are operating in a regulatory vacuum. It's been picked up a few times, and I think that is incredibly surprising to the DTC companies and the lawyers that they pay because they're not. You know this. I know this. There's 51 medical boards, there's 51 pharmacy boards, there's state AGs, we have the FDA, we have the FTC, there's HIPAA, there's HHS, and then we have the unofficial regulators of payers. So the idea that there's kind of no regulation here in this space is just not accurate.

We need more consistency and predictability between the states as to, across the board, what are acceptable modes of care when we're delivering care via telemedicine. I think we're getting there. I think you and I agree that eventually all states, hopefully, will have some uniformity and that the modality of care is inconsequential if the standard of care is being met.

Nathaniel Lacktman

That's a really astute observation. For example, right, you have modalities? Three buckets. Audio, video, interactive audio, and asynch. What's your take on why those even came to be? Why states even had those as opposed to using something like Florida's law, secure electronic communications between a patient in one place and a doctor in another.

Quinn Shean

Which is a great law. Go Florida. I think that the evolution and the understanding of this care delivery is happening. When we moved from in-person brick and mortar, it's like we have to mirror what's happening exactly. We have a video requirement, then there's a little bit more comfort with having the information, but when there's a live kind of audio interaction, then we're okay.

Then as technology gets more sophisticated, consumer preferences are changing, and we say, "We can streamline this, and for some patients, an adaptive, interactive, structured, asynchronous interview's acceptable."

In parallel with that, there's always bad actors. We see around 2007, 2008 the uses of pharmacies having static questionnaires that lead to all sorts of inappropriate prescribing, including of controlled substances. The correction there is let's ban any type of prescribing with an online questionnaire.

The problem when you do that, in my opinion from a policy perspective, is that technology's always evolving. What did a questionnaire mean in 2008, versus what does a detailed medical interview mean right now? That's not the questionnaire they had in mind, or what they meant in 2008. They were talking about where there's eight questions and you're filling in bubbles.

When you stick to that, that requires a constant updating of rules, and I think that the other part is you can have a lot of unintended consequences. One of the big promises, obviously, was reaching people in rural areas where there's physician shortages. Well, if you're requiring that every patient interaction is going to require a video in places that have low broadband, you're furthering health inequities with a policy that you were hoping was going to broaden access.

When you push it back to the real question, which is “does the physician have the appropriate information to take the next step,” that's really what should be driving the standards of how this is practiced, versus let's pick synchronous, let's pick asynchronous, let's pick a combo of both. We lose sight of what the objective is there.

Doctor Hollander always says, or has said, and I love this quote, "It shouldn't matter whether the care is delivered on the fifth floor or the third floor of the hospital, the same way it shouldn't matter whether the care is delivered in the office or at someone's home through telemedicine. The question is whether the standard of care is being met."

Nathaniel Lacktman

Judd Hollander from Jefferson, right?

Quinn Shean

Yes.

Nathaniel Lacktman

He's hilarious. I remember was giving a speech in support of facility fees and equal reimbursement rates for telehealth, because he's like, "What? Do you expect the doctors just to stand outside in the park and put on a headset? What if it rains?"

I think those are really good points. Some people beat up on the medical boards and say, "Oh, aren't you angry at the medical boards?" No. Of course not. I think that these physicians—largely volunteer positions, by the way—are trying their best, but it's really hard. Doctors don't like other people, particularly lawyers, telling them how to practice medicine.

Doctors shouldn't be practicing law either. You have this really awkward or difficult challenge, starting about a decade ago, with a bunch of people asking boards of medicine to come up with rules for telemedicine to keep patients safe. Since then, as you said, not just technology, but a bit more of a sophisticated model language or policy has evolved, and we're starting to see it spread.

Do you think it's time, or useful or appropriate, to have an update to the Federation of State Medical Boards 2014 SMART guidelines on the use of telehealth? Do you think we're even past that?

Quinn Shean

There has to be some type of sensible guardrails put in place. There are some practices that will never meet minimally competent standards, like, for example, a static questionnaire where you answer five questions and it has nothing personalized or tailored to the patient.

But I think a broader policy, similar to Florida, that says you're expected to follow the same standards you would in-office. This is what telemedicine is. Taking the appropriate consents, making the adjustments that are needed to account for technology, but, on the flip side, are we eventually getting to a point where we're not in telemedicine versus medicine. Are we going to get to a point where there isn't even a separate set of rules? Maybe.

There was just one other thing I was just thinking about when we were talking about medical boards, because I agree with you. They are not the enemies here in crafting telemedicine policy. I think a lot of it is they understand how to practice medicine, but it's up to a lot of the companies using this, and health systems, to explain the technology part.

Nathaniel Lacktman

The internet prescribing activities, from illegal online pharmacies, almost 15 to 20 years ago, and the cast a long shadow, and those internet prescribing rules, which exist now in about 41, 42 states, are still on the books. They can be reconciled with telemedicine rules, for sure, but I think that they cast an even broader shadow as well, and that's probably the next three to five years, if not shorter, of what some of the pure asynched DTC companies will have to work on to educate the boards and lawmakers, to say, "Look, I hear why you enacted that rule a decade and a half ago, made sense then. Its application now is too broad for the current state. Let's square that circle."

Actually, if you look at the trends of how quickly these state laws and rules have changed, it really is going that way. Only about a dozen states now mandate an interactive modality to create a valid doctor-patient relationship, which is very different than how it was five years ago, to say nothing of ten.

Quinn Shean

I totally agree with that, and as I said, I encourage companies in this space, I know you do as well, to point out why it's too broad, and that there are ways to still make sure those types of actors aren't being allowed to flourish, and good actors, who want to have a safe, accessible, high quality care experience, can do so and reach new patients.

That balance is possible. Are there going to continue to be people in a “DTC market” who are not acting appropriately? Yes. Will there continue to be care providers in the brick and mortar space who are not providing appropriate care? Yes. That's always tension we are going to have.

Nathaniel Lacktman

All right Ms. Shean. You're hired. I'm a DTC company. I'm an entrepreneur. I just landed some funding from a venture capital firm, and I want to distinguish myself as a good actor. Hit me with it. What am I supposed to do? Give me some tips?

Quinn Shean

I think the first thing is, these companies come up with a way to build market share, to attract, to engage, all those marketing aspects that we hit on earlier. But where entrepreneurs can go wrong and can go right in this space is whether you have you brought on the medical talent to deliver care?

You can take some of what you've learned from selling razors and mattresses to engage patients, that type of marketing, but you better realize you're not selling mattresses and razors. Bring on a medical advisor. Build out an informal network of your medical team. Don't just put them on your website. That's who needs to be informing your process of how the conditions are going to be treated on your site, what conditions you will treat, which conditions are inappropriate to treat, what patients are inappropriate to be treated via telemedicine.

You need to have physicians or nurse practitioners, or other types of clinicians, informing what you do. With our team here, if we see somebody that only has the marketing plan, but hasn't thought through or worked with clinicians on coming up with evidenced-based protocols, , that, to me, is sometimes a red flag.

Nathaniel Lacktman

Know my lane. Know what I'm good at. Own the fact that I'm doing a medical service, and get some medical advisors for it.

Nathaniel Lacktman

Okay. Get the advisors.

Quinn Shean

Second thing is, once you're launched, continue to build out your best practices. Talk to your network of physicians, find out what's working and what is not working. Find out how you can take whatever existing infrastructure you built and made it better. Where are the patients saying that there's a need? Is there more need for the follow-up care, the care coordination part? What many of these companies do well is puttingthe patients are really at the center of their care.

So, Continue to learn of how you can improve your own processes for the best patient experience .

The third—and we've kind of hit on this—is educate. Educate your patients, educate to the extent you're getting questions from the media, educate regulators. There are information gaps all along that continuum. Some things that they might be pinpointing as problematic with your model might just be they don't understand that their brick and mortar provider is doing the same thing. They don't understand that the type of asynchronous, structured interview you're using is the same one that Kaiser uses, or the same type of technology.

I think the best companies are the ones that take the opportunity to explain what they're doing, why they're doing it, and how they're safely meeting the standard of care. Those would be my three big ones.

Nathaniel Lacktman

Get medical advisors. Offer bonafide services in a patient centered manner to continually improve. Don't stop there, but continue to educate yourself on, I guess, all the different rules.

Quinn Shean

Educating your patients as well as to how you're treating them, and why, and this is the conditions you're serving, or these are the types of services you're providing. We haven't totally talked on this but something else about the consumer today is transparency, and that goes into the patient as being more in charge of their own healthcare decisions, whether through cost or just on an information basis. Being transparent about what it is that you're providing, at a cost level, at a care level, is another thing that I think some DTC companies here have done really well.

Nathaniel Lacktman

That's really good advice. As a start-up entrepreneur, it sounds like a lot of work. Do you think I could just launch, try to bump up my evaluation, and then handle all that clinical, ethical and regulatory stuff after the fact?

Quinn Shean

It's not a break things and move fast. I think that is the wrong way in healthcare space. Some of the things that start-ups have done well have lent itself to the popularity of this model.

Nathaniel Lacktman

There's a lot of great things we can do here with healthcare, but the stakes are higher. The expectations are different.

Quinn Shean

They're way higher. I think that that is also a misperception because something is venture backed, or people point to Theranos or whatnot, that everyone's kind of operating that way, of build press, get people excited, and figure out everything later.

I do think entrepreneurs, as with in any space, are learning that being an innovator in a really entrenched industry like this, that is heavily regulated, is difficult. Even if some of these models aren't as capital intensive as other healthcare innovations, they're still regulatory intensive.

A lot of these entrepreneurs know regulation, and they should, but more than any other space that I'm in, any other space that I work in. I think they probably know more than a lot of traditional providers. So, they're cognizant of it, the good ones are, and the ones that will succeed have to understand the stakes.

Nathaniel Lacktman

I would think that's right. If you ask the question, the companies that we work with, they tend to say, "Look, we want to do things right. We might not know what the rules are but we understand healthcare's highly regulated and the stakes are high."

Also, I really like to hear from clients, sometimes, when they say, "You know what? I know we could do it this way, use this particular modality, or this scale, but we think that our best patient experience, because of the nature of the clinical services we're doing, to be a bit more hands on, or do it this particular way." Because they're not just looking for scale and a quick exit. They're saying, "I want to build something that actually matters, will make a difference in people's lives in a meaningful way."

You're giving birth to something new. I think that's a really good measure of success, more so than, oh, what'd you exit for? I mean, because it's just ones and zeros at the end of the day.

Quinn Shean

Having the freedom in the policy sphere to choose the modality or how that care delivery might be framed, doesn't necessarily mean you have to use asynchronous, for example, for all cases and for all patients. It's that type of nuance that the good entrepreneurs are recognizing, that if the patient is driving this then having, for example, both modalities, if they want to move to video, or if they want a phone call. That's another thing that separates, in my mind, the best actors in this space, is being able to be responsive to patient needs there.

Nathaniel Lacktman

Quinn, you mentioned earlier information gaps and need to educate, learn up on the rules, as well as maybe a growing effort to coalesce all the different DTC async companies, to develop more of a cohesive policy.

What are some resources or opportunities that listeners could turn to explore that?

Quinn Shean

Luckily, you and I are both working on one that I'm very excited about, which is through the ATA, the American Telemedicine Association. They have launched an initiative with DTC companies to recognize some of the information gaps we've talked about and the misperceptions around asynchronous care, or just not enough information. [Click here for ATA statement on Direct to Consumer Asynchronous Telemedicine.]

I think the goals of it are great, which is to start building consistent messaging-- for industry, for regulators, for the press---to understand what asynchronous care is and what this growing field is, to build confidence in it, and give a fuller understanding of how this quality care is being delivered and what benefits it brings to the patients. Also, which is often ignored, what benefits it has for providers.

Nathaniel Lacktman

Yeah, I think that could be a good one. Another one that is free and publicly available is the Telehealth Resource Centers. There are about 12 or 13 of them regionally and they're federally grant funded. They're a phenomenal resource for questions on all things telehealth, as well as the Center for Connected Health Policy, run by Executive Director Mei Kwong, out in California, which maintains a free, publicly available database with all sorts of telehealth laws and rules and Medicaid reimbursement information.

Quinn Shean

For those interested in California policy, they have a California Telehealth Coalition, and I know some of the other resource centers also have coalitions for specific states.

Nathaniel Lacktman

Shout out to the TRCs, for sure.

Quinn, this sounds like a boring question, but what was your first experience with telehealth? What got you into this digital health space?

Quinn Shean

I'm actually one of six kids, and five of us had asthma, but I had severe asthma as a child. We were the perfect research subjects for our immunologist, who had a research facility in the back of his doctor's office. So, we did lots of studies.

I'm dating myself here, but about 25 years ago they brought out a peak flow meter, which measures your air capacity. I'd be taking a medicine and then I'd have to register to see what my airflow would be. He brought it in and it was this little computer monitor, and was the coolest thing me, my mom, even the doctor, we were kind of all giddy about it. Then he pulled back the bottom and it had a telephone jack. He said, "You don't need to come into the office anymore to have your measurements recorded. You can send them through the phone line, through your own house."

It was something I kind of lived, so I've always had an interest in healthcare innovations and in new ways for care to be delivered. Being part of studies, I was always getting to see kind of the latest treatments.

So, I would actually say since I was seven or eight I got to experience telehealth.

Nathaniel Lacktman

I love it! People say, "Oh, yeah. I've been in the space for 10 years." You're like, "Please, I've been doing RPM since I was eight-years-old."

Quinn, where can people learn more about what you do?

Quinn Shean

You can look us up on Tusk Strategies. Please reach out, if you're in this space, if you're an entrepreneur, if you're an attorney, if you're someone interested in policy. I love meeting and sharing ideas with more people who are working in the virtual care world, and let them know what's happening on the policy front, and learning what you're up to. So, please reach out.

Nathaniel Lacktman

Quinn Shean, Tusk Strategies. Thank you for being here today. It was a pleasure.

Quinn Shean

Always a pleasure, Nate. I look forward to continuing these fun conversations. Nerding out on telehealth.

Nathaniel Lacktman

We'll pass it back to you, Judy.

END OF TRANSCRIPT

Foley would like to thank Quinn Shean for her time on our show.

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For more information on telemedicine, telehealth, virtual care, remote patient monitoring, digital health, and other health innovations, including the team, publications, and representative experience, visit Foley's Telemedicine & Digital Health Industry Team.