



Partnership Aims at Improving Care Access, Quality

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Ramesh Balakrishnan, cochief executive officer and president, UpHealth, and Jamey Edwards, chief executive officer and cofounder, Cloudbreak, discuss how the new partnership between Cloudbreak Health and Thraysis aims to improve the health care industry with regard to telemedicine, care access for patients, and integration of the full health care team.

Read the full transcript:

Ramesh Balakrishnan: Ramesh Balakrishnan, I'm the coCEO of UpHealth. My background in health care is about a little over 10 years ago, I founded a company, Thrasys, Inc, that is part of the Integrated Care Management Division of UpHealth.

Essentially, we built a platform for an integrated payer-provider network where you could integrate information, deploy analytics, and coordinate workflows across the managed care side and the provider side. We launched this initially with a licensing agreement with Siemens in the international market.

We're running hospitals and clinics, and also helping ministries of health manage populations. In 2014, came into the US market to try to pioneer a new model of care with integrated information care teams workflows, a social model of health.

That's the specific background in health care. Pretty deep into the provider side workflows, pretty deep into the managed care side, and also on the public health side. What we're looking to do with UpHealth is integrate all of this into one integrated system of care.

Personally, my training is in technology, did my undergraduate work at the University of Madras, did my graduate work, including a doctoral degree at Stanford. Essentially worked on building mission-critical technologies for a wide variety of industries. Started to do entrepreneurial startups and launching them in the mid-90s, before the .com, during and after, with some successful ventures.

So, entrepreneur background, ran divisions of large companies and founded Thrasys, brought it into UpHealth. That's the basic background.

Jamey Edwards: For me, started off my career as an investment banking and private equity professional. I always knew I wanted to be an entrepreneur ever since I took an entrepreneurship class my senior year at Cornell, from a professor named Professor David BenDaniel.

I got hooked on the idea of taking an idea in your head, making it real, and having an impact on people and the power that that had. Second I wrote my first business plan, I was hooked, but I realized I was lacking a finance skill set and accounting skill set.

I grew up in the time of Enron and never wanted a CFO to be able to pull the wool over my eyes, so I wanted to understand how numbers told the story as well and understand all that stuff in capital raising.

I went into investment banking and private equity, did that for 10 years, left to go run a family business, which was in the ER hospitals and anesthesia space. Grew that business to a leading group in the southwest with the rest of the team there.

Then while I was working on that business, came across a company called the Language Access Network, which was founded by a gentleman named Andy Panos back in 2003. I met him in 2007 as he was raising capital and we linked

arms on his business. He had actually been a public company prior. He had done a reverse merger into a public shell.

I spun him out of his public shell and we locked arms to grow his company, which eventually became Cloudbreak Health, where we did our series A financing round in the 2015 timeframe with a firm called Kane Partners out of Los Angeles.

Language Access Network pioneered the video medical interpreting market, so the first company to bring a medical interpreter to the point of care over a telemedicine platform in the country, and over time have grown to an industry leader in the space.

Maintained our innovative edge and pioneering spirit and grown the platform and redefined ourselves as a health disparities solutions platform using telemedicine to address social determinants of health.

We not only do language interpretation services but now do telestroke, telepsychiatry, teleurology, during COVID launched telequarantine solution into market to protect frontline health care workers from the risk of infection and reduce the isolation of what was a very isolating diagnosis.

Today, we're in 1800 hospitals across the country doing over 100,000 encounters a month and over 14,000 video endpoints.

Can you talk about the current challenges many patients face regarding access to health care nationwide?

Ramesh: I think that there's a structural issue we have in the United States and how we've set up health care that contributes to this extreme challenge and disparity in access to care. Essentially, there's the one big thing of, you have access to a provider network that is given to you as part of the benefit of the coverage you get from your plan.

One of the challenges, obviously, is there's still a section of the population that doesn't have good coverage benefits that provide access to care. There's narrow networks, there's restricted networks. That's one piece of it.

Apart from that, there are populations where we just simply don't have the coverage. We don't have universal coverage in any comprehensive way in the US. There's that structural issue.

The other problem is that the delivery side is very variable in terms of access to care. The obvious case being parts of rural America, but even parts of cities where the access to care is limited, not only because you have to travel far to get access to care, but also the times for getting appointment visits scheduled.

Even if you have a primary care provider, it could be weeks before you are able to see somebody. We have a

tremendous shortage of physicians in the United States. The number of physicians per capita, one of the lowest in the developed world.

The combination of these structural elements in how we've set up the health care system, as well as a serious shortage of clinical providers, contribute to this difficulty and tremendous disparity in access to care.

Jamey: Yeah, I think that's a great answer. The things that I would add to it are, we have a system, Julie, that was built around the in person visit. Everything is built around going. showing up in that doctor's office or showing up in an ER, waiting, driving, paying for parking for what might be, for all intents and purposes, a very short visit.

When you've got a revenue model that's built around that and a bricks and mortar infrastructure that's built around that, we would all agree that if you were going to build a new health care system in the United States today, it would look very different than what we have.

It would be digital first. It would allow patients to wayfind to the exact resources they need. It would meet patients where they are on their terms. Right now, we don't have that. The dream of UpHealth is to make that more of a reality and increase access. This health disparities theme is something that we've wired into the DNA of the business.

The other challenge is the sheer cost and complexity of the system. Here in the United States, we're about 4 trillion dollars of GDP. Globally, it's an 8 trillion dollar market. It gives you an idea of the cost and balance that we might have in terms of rationalizing some of our health care costs here in the United States.

Despite that spend, we don't have the best outcomes if you take a look at our World Health Organization rankings. The other thing is as we move to now, what could be a digital-first health care system, we need to make sure that we don't embed a lot of the same biases and a lot of the same issues that we have in our bricks and mortar system into the digital health system.

An example of that is if you feed an AI data and that data is biased, then that AI is going to be biased. We need to make sure that we're very conscious as we build out our new digital health future here in the United States that we are ensuring a level playing field.

Making sure that everyone has equal broadband access, making sure that smartphone penetration is where it needs to be so that people all have equal access to high quality care.

How will the new partnership between Cloudbreak Health and Thraysis simplify health care access?

Ramesh: If you look at what Cloudbreak does, Cloudbreak has established this large footprint in the health care provider space, initially by bringing in a critical resource needed for managing a patient in that setting of care, or the language interpreters, and then expanding from there.

What Cloudbreak has established is a footprint across health systems and a model in which we can bring in critical resources to the point of care and follow that patient as they travel through various settings. Those settings have expanded beyond the hospital and the resources have expanded beyond language interpretation.

Every one of those health systems is now in the middle of a transformation, both in terms of how they get paid, which is this whole value-based care movement, but also how to deliver and coordinate services outside the walls. To do that, that's the core of the partnership between Cloudbreak and Thrasys.

Because what Thrasys does is we provide a platform in which we can extend the hospital care team outside the inpatient walls, or the facility walls, into the entire continuum of care and be able to integrate information, run analytics, stratify populations, and coordinate workflows of these care teams around the shared care plan.

As these health systems are getting into programs to prevent readmissions, programs to transition patients back home after a hospitalization, or bundle payment models in which they are responsible for everything that happens in the next 90 days, whether that's in the hospital, or in the SNF, or in our home, or community-based setting.

A variety of programs that require, now, these health systems to expand the care team, expand the scope of services that they manage, and the information that they need to get and integrate, and the care team that they need to coordinate. And it's a care team that's no longer just a medical care team. It's care teams managing behavioral health conditions, managing social factors, etc.

The Thrasys platform provides that ability. Cloudbreak has already established itself inside these venues as a critical element of infrastructure, and we're broadening that infrastructure now to support these health systems' move into these new models of care and new models of payment.

Jamey: Julie, from our perspective, our customers were asking for this. They had realized that through our teleinterpretation use case, that it's the most widely used in-hospital use case in terms of telemedicine. It's used more than telepsych. It's used more than telestroke. It's used more than teleICU.

As a result of these, LEP and deaf patients being treated in every hospital department, it meant our platform was everywhere. Hospitals a few years ago started saying, "You guys can bring us a language interpreter to the point of care. Can you bring us a psychiatrist? Can you bring us a urologist? Can you bring us a telestroke doctor?" The answer to all of that was yes.

We started building out our solution for that purpose, but we were missing a population health and integrated care management leg of the stool.

What makes us very excited about this relationship and partnership, and I've learned through our collaboration with Ramesh the strategy of where we're going, it's about building a digitally enabled care community.

That care community is about breaking down silos that previously have existed in the health system between a health system, community organizations, the payer, and being able to tie them together, all in a single care continuum, and be able to surround a patient with the exact care team that they need, something that we would refer to as a precision care team.

In this mission to provide what I would say is great clinical support at the point of care, we can now live our mission to humanize health care and restore the joy of calling back to the patient and the provider and make this a trusted encounter by putting all of the information that they need at their fingertips.

Tying in all the clinical resources they might need to support that encounter and bring underserved communities the resources that other communities might be able to benefit from where that underserved community can't attract them.

In some of our nation's biggest cities, we have medical deserts. People talk about the applications for digital health and telehealth in rural environments, but we need them in urban environments as well. Living here in Los Angeles, not everybody gets to go to Cedars and UCLA.

They go to their local community hospital, which might not benefit from the same size and scale of services that those Taj Mahal institutions can offer.

For us, tying together with Thrasys now allows us to deliver those types of services in those communities and provide information around, you know, a lot of hospitals and health systems were managing their patient bases without a dashboard. Now they have that dashboard through that partnership.

Where do you see the future of care going following this partnership launch? How will the telemedicine or integrated medicine help connect more patients to care over time?

Ramesh: I think there's a couple of dimensions to how we see health care evolving. The first thing is the model of health that we operate under.

We've operated under both a reactive model, meaning you don't proactively manage health, you're managing

sickness after it has happened, kind of a post symptomatic model of care, and it's a very medical model of care. There's general consensus about that.

One dimension along which we're going to see change is that we're moving to maintaining and managing health than managing sickness, and to a social model of health where we understand that this is not just a medical problem, there are all these factors that affect an individual's health and we need to consider all of those factors and how we manage that. That's one dimension along which I think we're going to see some change.

The second thing is we've got a system where the delivery of services has been intentionally or unintentionally shaped by the payment models we have. We've got a setup of how we pay for health care services that are oriented towards paying more for dramatic interventions.

Procedures and things that have shaped a model of how services get delivered, what services got delivered, what you prioritize, and we're seeing a reshaping of how we pay for services. We're just in the early stages of that.

We've come up with various ideas, and I think value-based care is trying to get at something, not entirely quite there yet, and that will evolve, but I think we'll eventually align towards a better alignment of how we pay for services that aligns with this model of care that we're trying to move towards.

There's also a lot that we've been talking about in terms of person-centered care. It's kind of an odd term, right? If I said I'm a garage, and I'm an auto-centered garage, you'd think, "What else could you be?" It's kind of odd that we even have that word, person-centered care, for health care.

I think we need to move to a model of the patient, not just as the object that receives care, but as a full-fledged member of the care team. We've got to restore the patient as an active—even the word patient care carries that passive connotation to it—but this active participant in their health.

Not in just the quantified self-consumer version of that, but rather as a full-fledged member of the care team in collaboration with their clinical and community-based care teams, in managing health.

These are some of the vectors that are going to shape... Under all of this, we're going to use technology to deliver higher and higher acuity of care in low cost settings.

We've got CMS pushing this hospital-at-home program. We have various initiatives to manage individuals with nursing level requirements for care in home and community-based settings.

All of these things, what technology will allow us to do is manage higher acuity of care enabled with technology in

settings that are not just more affordable, but in many ways, even safer. Some of the trends that we see emerging here.

Jamey: From our perspective, you take a look at the future of health care, and it's all about this care now being pushed as close to the patient as we can. A decentralization of care, if you will, in terms of location.

Let's meet patients where they are, whether that be at work, whether that be at home, whether that be in a mobile environment, whether camping. Everyone's walking around with a supercomputer on their hand, and that technology enablement means that we can do more earlier in the acuity curve to treat these patients and make sure they get the care that they need.

If you take a look at the market today, and you take a look at closed end systems, like the Kaiser, or like the VA, those two organizations have done an incredible job of rolling out digital health tools and have done so and now do well north of 50% of their visits using some sort of digital health encounter.

What we're seeing now is the gold standard is no longer that in-person visit. It's the right modality for that patient's complaint. Right care, right time, right provider, if you will. It was time for the community to catch up to that type of care model where we've integrated digital health into part of the practice of daily care.

To Ramesh's point, we don't call someone using a stethoscope "stethoscope medicine." It's just part of the visit of how things get done.

The same is now true of digital health tools and we believe that the digitally driven encounter in whatever way, shape, or form that might exist, in email, chat, even if you're onsite bringing in a specialty consult over a telemedicine platform, is the future of how this all should work.

It should be a model that ties everything together into a single care continuum. COVID helped us catch up in terms of trying to emulate a Kaiser or a VA type of model, but there's still a lot of work to be done.

What are you most excited about regarding this partnership?

Ramesh: The fundamental thing we're excited about, Julie, is something that's been a part of the mission at Cloudbreak and at Thrasys for a long time, which is to improve the experience of patients, particularly individuals that have complex conditions or are in vulnerable situations. There's a tremendous hardship right now in their encounter with the health system and we want to improve that.

Whether it's disparities, or just the convenience, the outcomes, there's so many things about it. The core thing that

excites us is to take this massive piece of infrastructure we have—we don't think of health care as infrastructure, but it is a giant piece of infrastructure we have, 4 times as big as defense in the United States.

It doesn't serve individuals well. Many people falling through the cracks, and not getting the kind of outcomes we should get for spending upwards of \$11,000 per person per year, a considerable amount. We're going to be hitting 20% of GDP pretty soon, we're going to be at 20% plus on state budgets, and it's 25% of family budgets to pay for.

It's a massive infrastructure that everybody is contributing at the individual level, at the state level, at the federal level, at the employee level, and we're not getting the outcomes, and it's not as humane in the sense that it imposes a tremendous amount of unnecessary hardships.

That's the thing we're excited about, is moving this infrastructure, not in one hop, but slowly into a new model that ultimately will do some good.

Jamey: What gets me most excited is that this is a partnership that moves the needle. A lot of times we talk about changing health care and how long of a process that takes, to Ramesh's last point, but this partnership is going to make an impact in health care this year.

We're going to be able to roll out new solutions that affect what is a very broad client base when you're talking about 1800 US health care systems, Ramesh's and Thrasys' presence in the payer and the government market, we're going to impact a lot of patients rapidly.

From that standpoint, when you're talking about mission-driven entrepreneurs who care about resolving health care disparities and increasing access to care, this partnership accomplishes exactly that. We're looking forward to continuing to pioneer new solutions in market and lead the way and be very progressive in terms of pushing health care more quickly along this digital transformation path.

Is there anything else you would like to add to the conversation?

Ramesh: The only thing we want to add is that even while this partnership is rooted here in the customer base we have, we are looking at all of this globally. We want to add that dimension. There are greenfield opportunities globally, internationally, that we will be a part of as well. That's one thing we do want to add.

Anything on your side, Jamey?

Jamey: Yeah, I would say fundamentally, one thing that I would add is that the problem in health care today isn't about having the right technologies. It's a culture change issue. We have all the technologies at our fingertips today

to build a better health care system.

If you look at COVID and the rapid adoption of things like telemedicine and digital health, it wasn't that any new technology came out like the hologram or anything like that, that all of a sudden people said, "Hey, I'm going to adopt the system now." We had all of these tools at our fingertips that we finally just started using for the task at hand.

We remain very excited about being able to deliver our platforms more broadly and resolve health care disparities and solve what is ailing this health care system in this country, which largely isn't a technology problem. It's a cultural and people problem.

Those types of shifts end up taking time, but because we support all of our technologies at the point of care with a lot of culture change personnel who are there to effect people moving to what is this new behavior integrating digital health, we think that the future is very bright.