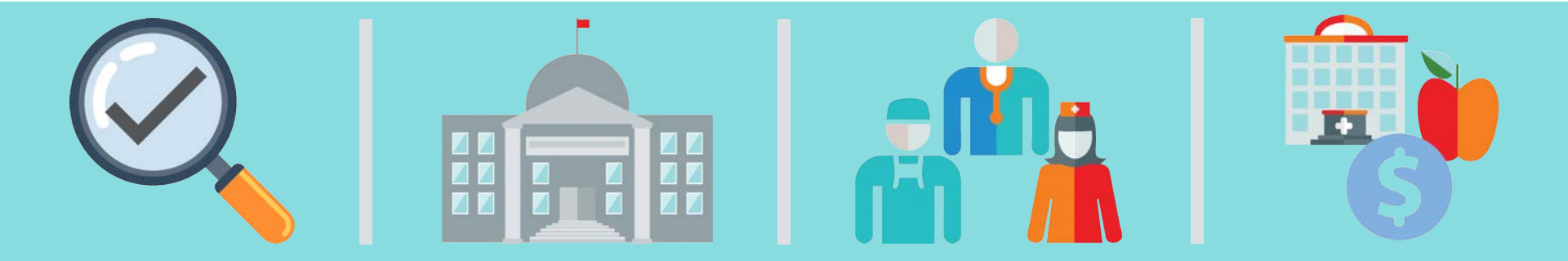
ALTARUM
HEALTHCARE VALUE HUB

The Marathon After the Sprint: Ensuring Value & Equity in the Future of Telehealth

Value Session

@HealthValueHub

www.healthcarevaluehub.org



ALTARUM
HEALTHCARE VALUE HUB

Welcome and Introduction

Annaliese Johnson
Policy & Communications Analyst
Healthcare Value Hub

Housekeeping

- Thank you for joining us today!
- All lines are muted until Q&A
- Webinar is being recorded
- Technical problems? Contact Elise Lowry at Elise.Lowry@altarum.org

Agenda

- Welcome & Introduction
- Ensuring Value in Telehealth
  - A. Mark Fendrick, MD, Director, Center for Value-Based Insurance Design, Professor, University of Michigan
- Policy & Research Agendas for Value in Telehealth
  - Nicholas L Berlin, MD, MPH, MS, National Clinician Scholars Program, Institute for Healthcare Policy & Innovation, University of Michigan
  - Christina M Cutter, MD, MSc, MS, National Clinician Scholars Program, Institute for Healthcare Policy & Innovation, University of Michigan
- Establishing a Value-Based 'New Normal' For Telehealth: The Teladoc Health View
  - Lew Levy, MD, FACP, Chief Medical Officer of Teladoc Health
- Q & A

The Marathon After The Sprint

Ensuring Value in the Future of Telehealth

A. Mark Fendrick MD
Director, Center for Value-Based Insurance Design
Professor, Health Management & Policy | Internal Medicine
University of Michigan | Michigan Medicine

Nicholas L Berlin MD MPH MS
National Clinician Scholars Program
Institute for Healthcare Policy & Innovation
University of Michigan | Department of Veterans Affairs

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Ensuring Value in Telehealth

A. Mark Fendrick MD

University of Michigan

Center for Value-Based Insurance Design

A. Mark Fendrick MD
Director, Center for Value-Based Insurance Design
Professor, Health Management & Policy | Internal Medicine
University of Michigan | Michigan Medicine

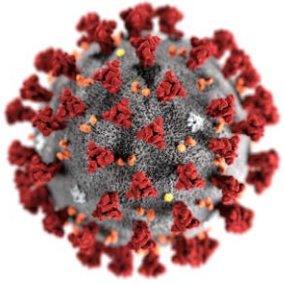
Thank you to the selfless individuals who are putting themselves at risk to successfully defeat this pandemic

V-BID

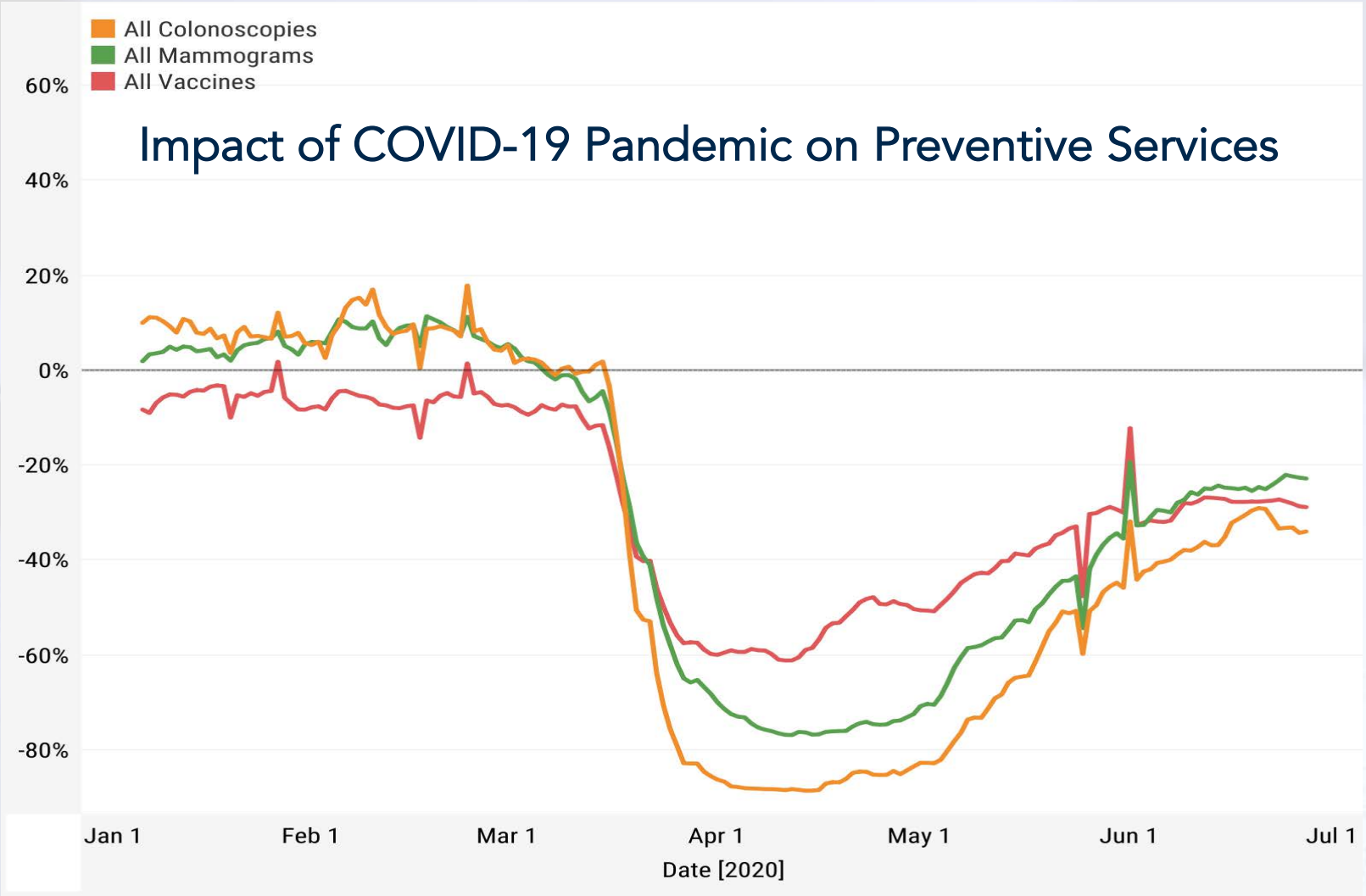
Health Care Costs Are a Top Issue For Purchasers and Policymakers: Solutions must protect consumers, reward providers and preserve innovation

- Everyone (almost) agrees there is enough money in the US health care system; we just spend it on the wrong services and in the wrong places
- Policy deliberations focus primarily on alternative payment and pricing models
- Moving from a volume-driven to value-based system requires a change in both how we pay for care and how we engage consumers to seek care

Then Came Coronavirus…



V-BID


All Colonoscopies
All Mammograms
All Vaccines
Impact of COVID-19 Pandemic on Preventive Services
60%
40%
20%
0%
-20%
-40%
-60%
-80%
Jan 1
Feb 1
Mar 1
Apr 1
May 1
Jun 1
Jul 1
Date [2020]

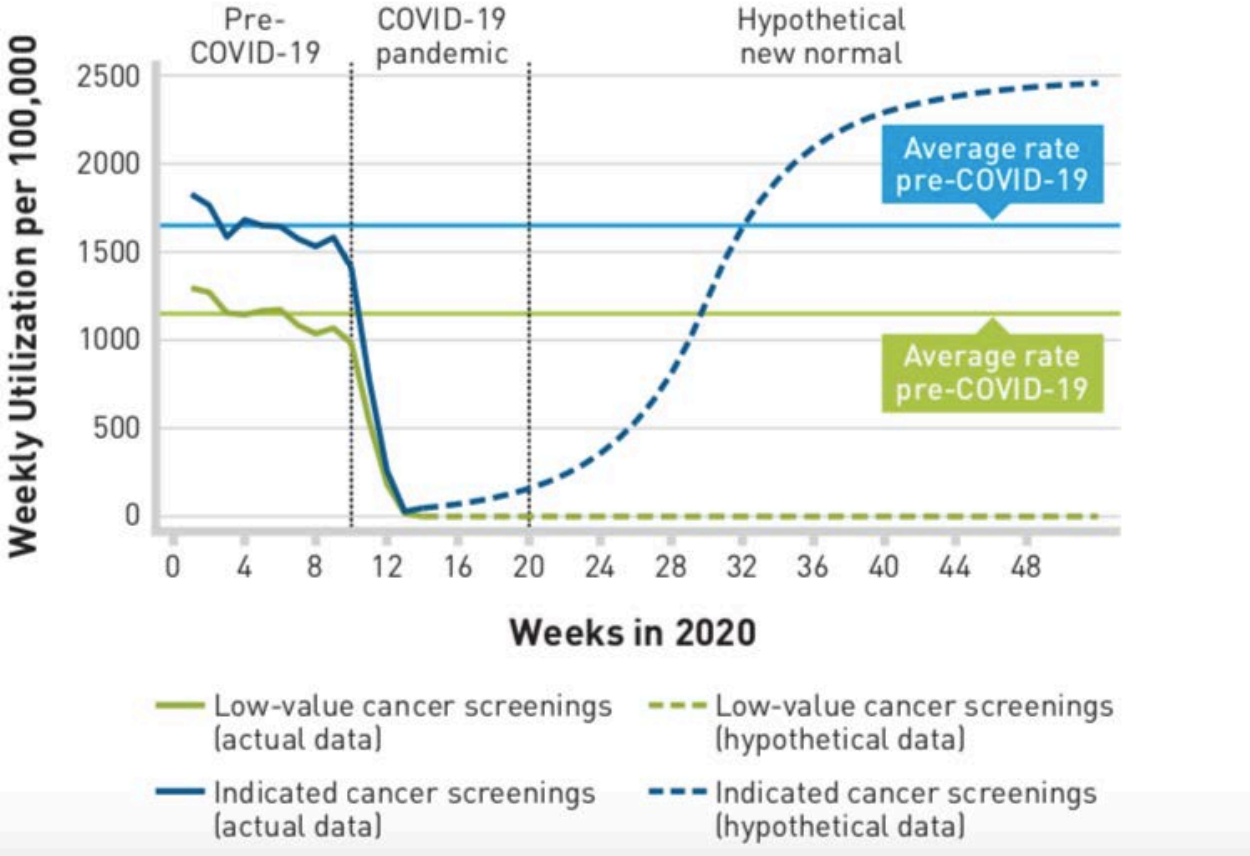
LOW-VALUE CARE

A silver lining to COVID-19: Fewer low-value elective procedures

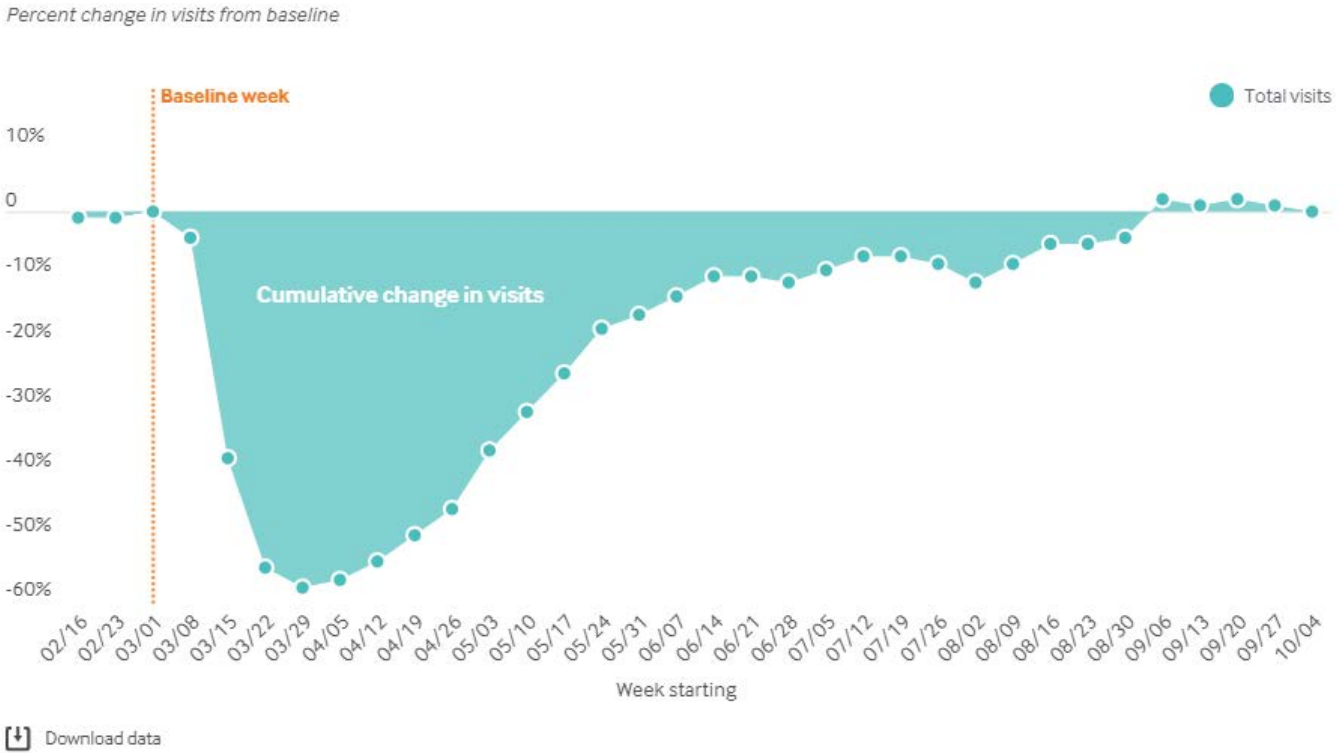
The Onion
@TheOnion

Patient Rushed Into Unnecessary Surgery To Save Cash-Strapped Hospital bit.ly/314r3zN

Crisis Into Opportunity: Can COVID-19 Help Set a Path to Improved Health Care Efficiency?



Visits to ambulatory providers fell nearly 60 percent by early April. Since then visits have rebounded, returning in the past month to prepandemic levels.



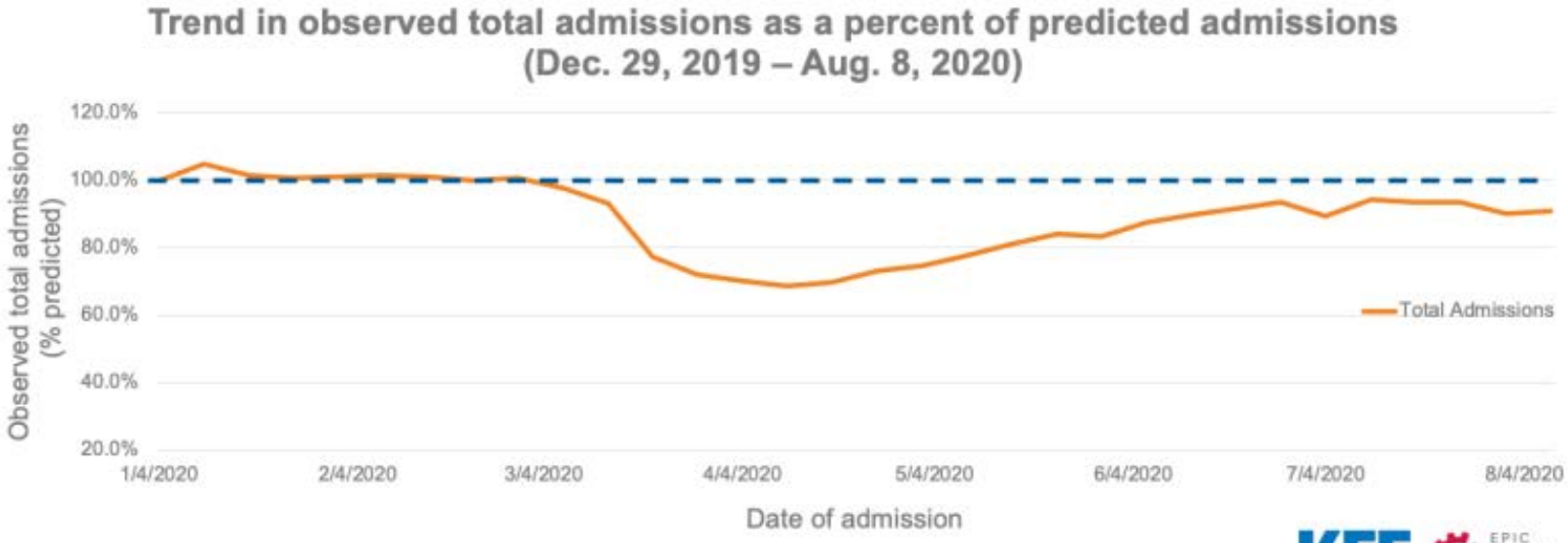
Download data

Note: Data are presented as a percentage change in the number of visits in a given week from the baseline week (March 1–7).

Source: Ateev Mehrotra et al., *The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients* (Commonwealth Fund, Oct. 2020). https://doi.org/10.26099/41xy-9m57

Figure 1

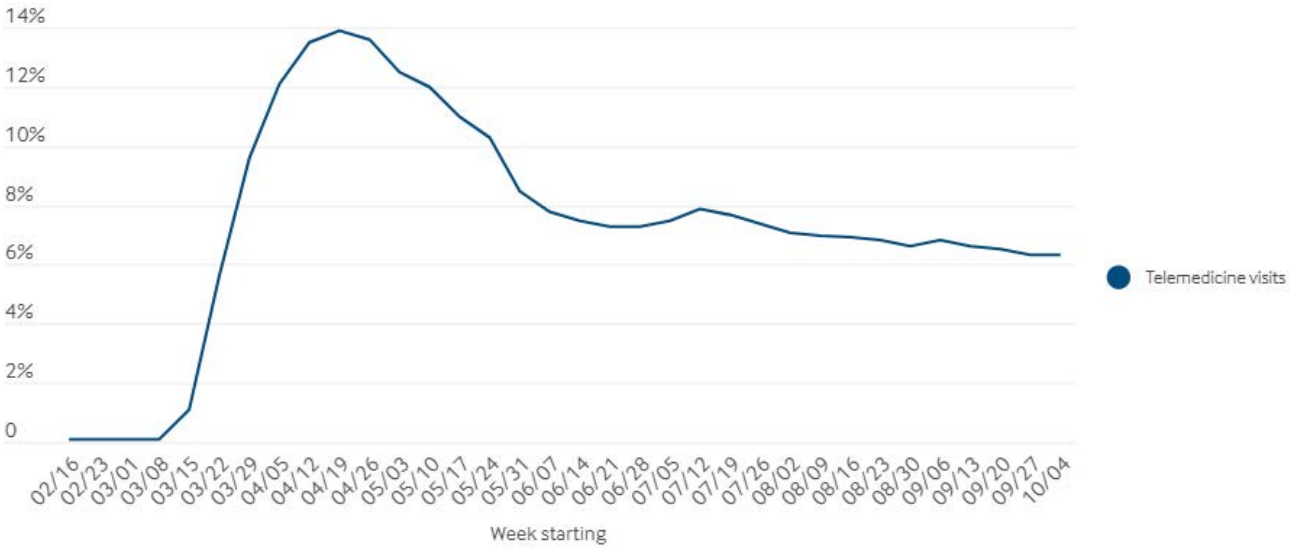
Overall Admissions Decreased in March and April but Were Back at About 95% of Predicted Admissions by July 2020



SOURCE: Epic and KFF analysis of Epic Health Record System COVID-19 related data as of September 2020.

The percentage of all visits via telemedicine visits is slowly declining from its April peak. But it continues to be well above the prepandemic baseline of very few telemedicine visits.

Number of telehealth visits in a given week as a percent of baseline total visits



Download data

Data are presented as a percentage: the number of telemedicine visits in a given week is the numerator, while the number of visits in the baseline week (March 1–7) is the denominator. Telemedicine includes both telephone and video visits.

Source: Ateev Mehrotra et al., *The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients* (Commonwealth Fund, Oct. 2020). https://doi.org/10.26099/41xy-9m57

Crisis Into Opportunity: Can COVID-19 Help Set a Path to Improved Health Care Efficiency?

- Build on existing alternative payment models that base reimbursement on patient-centered outcomes; increase reimbursement for high-value services and reduce or cease payment for known low-value care
- Align patient cost-sharing with the value of the underlying services; reduce out of pocket cost on high-value services and increase patient cost on low-value care
- Use value-based principles to leverage the widespread adoption of telehealth

Ensuring Value in the Future of Telehealth

POLICY & RESEARCH AGENDAS

Nicholas L Berlin MD MPH MS
National Clinician Scholars Program
Institute for Healthcare Policy & Innovation
University of Michigan | Department of Veterans Affairs

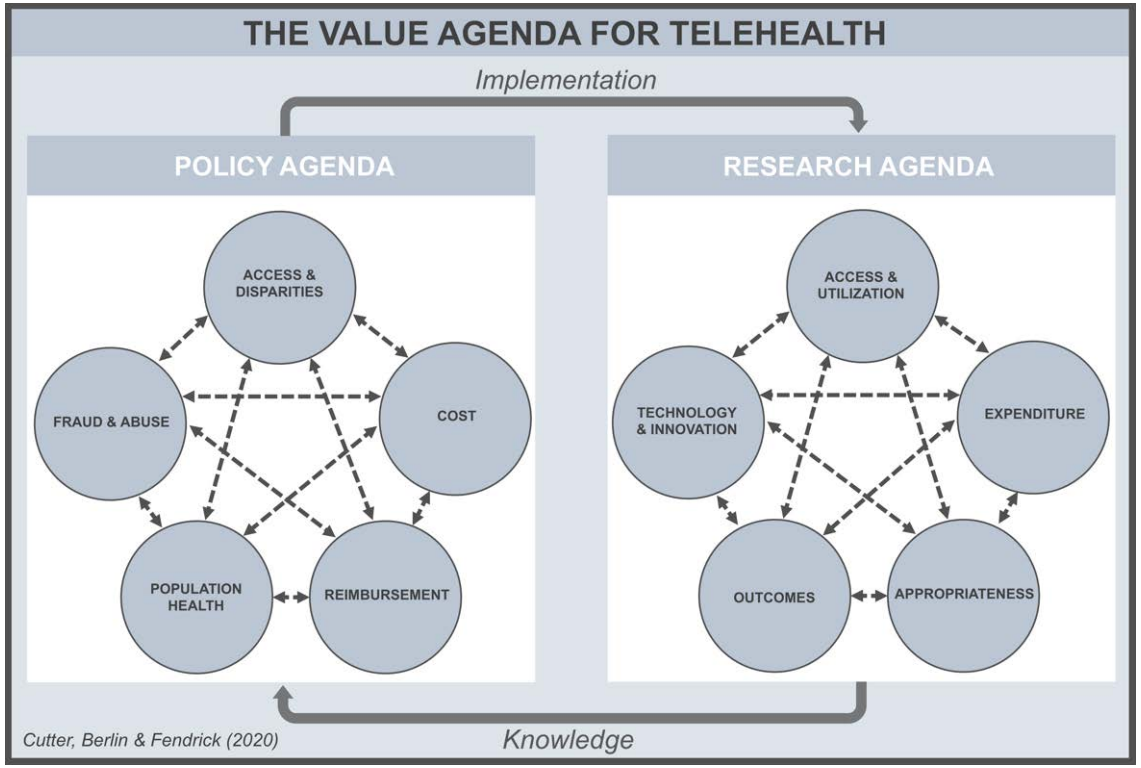
Christina M Cutter MD MSc MS
National Clinician Scholars Program
Institute for Healthcare Policy & Innovation
University of Michigan | Department of Veterans Affairs

CATALYSTS FOR WIDESPREAD TELEHEALTH ADOPTION

NECESSITY	REGULATORY	PAYMENT	BENEFIT DESIGN
			

Capitalize on this natural experiment to advance value-based care

THE VALUE AGENDA FOR TELEHEALTH



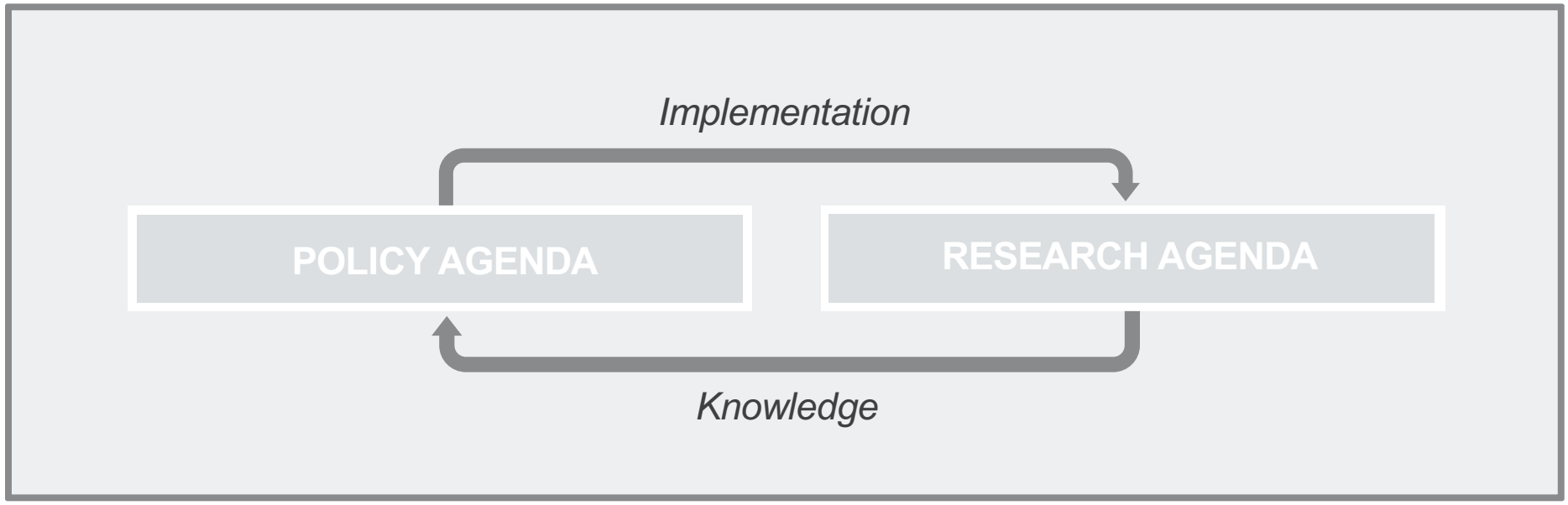
I. LEARNING SYSTEM

II. POLICY AGENDA

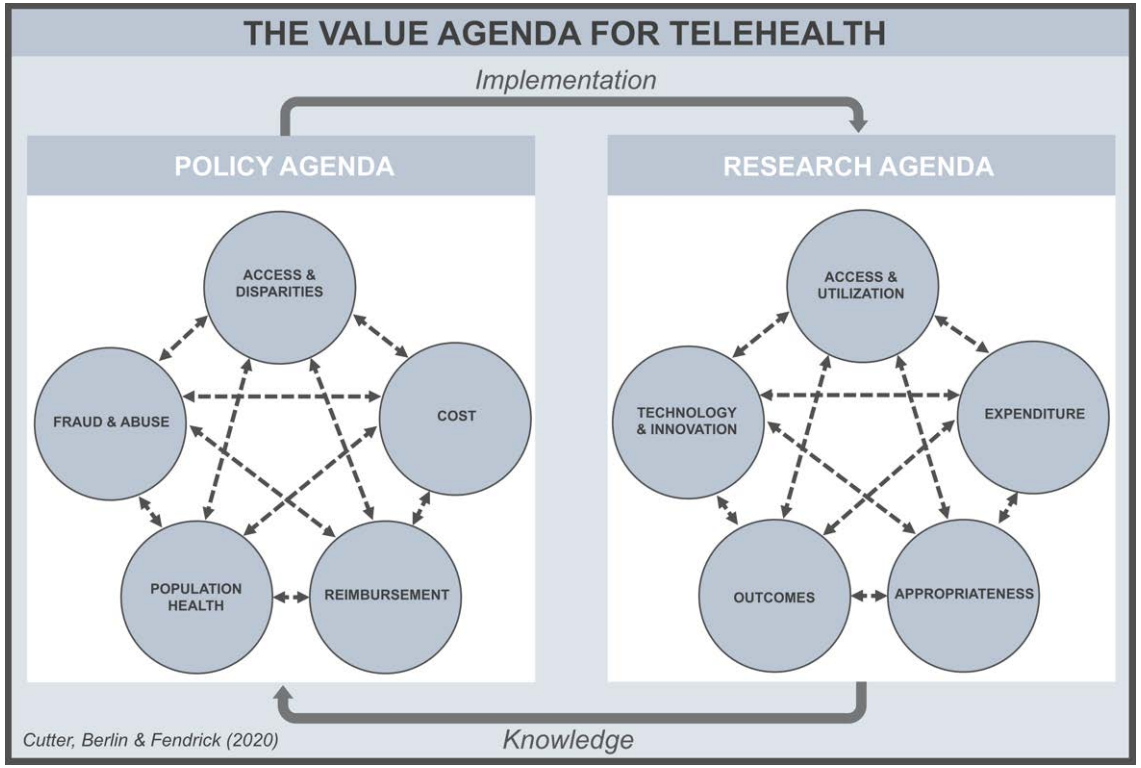
III. RESEARCH AGENDA

THE VALUE AGENDA FOR TELEHEALTH

I. CONTINUOUS LEARNING SYSTEM



THE VALUE AGENDA FOR TELEHEALTH



I. LEARNING SYSTEM

II. POLICY AGENDA

III. RESEARCH AGENDA

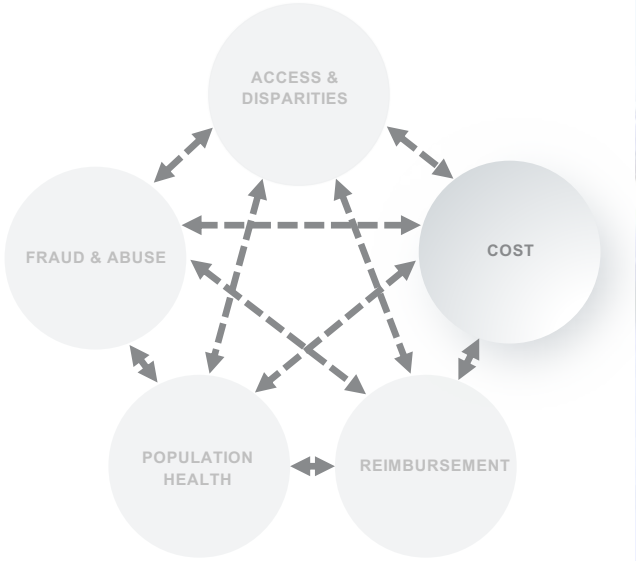
THE VALUE AGENDA FOR TELEHEALTH

II. POLICY AGENDA

1. Recognize and bridge the **digital divide**

THE VALUE AGENDA FOR TELEHEALTH

II. POLICY AGENDA



1. Recognize and bridge the **digital divide**
2. Align expanded use policies with **payment reform initiatives**

THE VALUE AGENDA FOR TELEHEALTH

II. POLICY AGENDA

1. Recognize and bridge the **digital divide**
2. Align expanded use policies with **payment reform initiatives**
3. Leverage principles of **value-based insurance design (V-BID)**

THE VALUE AGENDA FOR TELEHEALTH

II. POLICY AGENDA

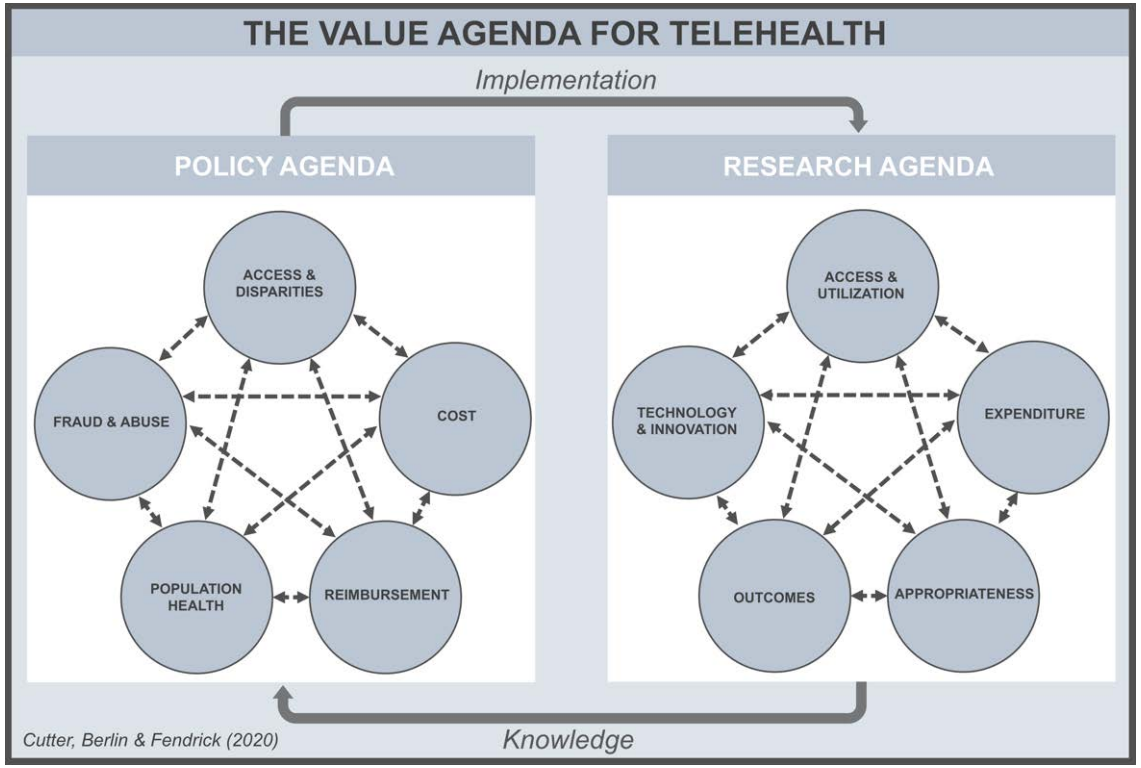
1. Recognize and bridge the **digital divide**
2. Align expanded use policies with **payment reform initiatives**
3. Leverage principles of **value-based insurance design (V-BID)**
4. Support **population health**

THE VALUE AGENDA FOR TELEHEALTH

II. POLICY AGENDA

1. Recognize and bridge the **digital divide**
2. Align expanded use policies with **payment reform initiatives**
3. Leverage principles of **value-based insurance design (V-BID)**
4. Support **population health**
5. Strengthen protections against **fraud** and **abuse**

THE VALUE AGENDA FOR TELEHEALTH



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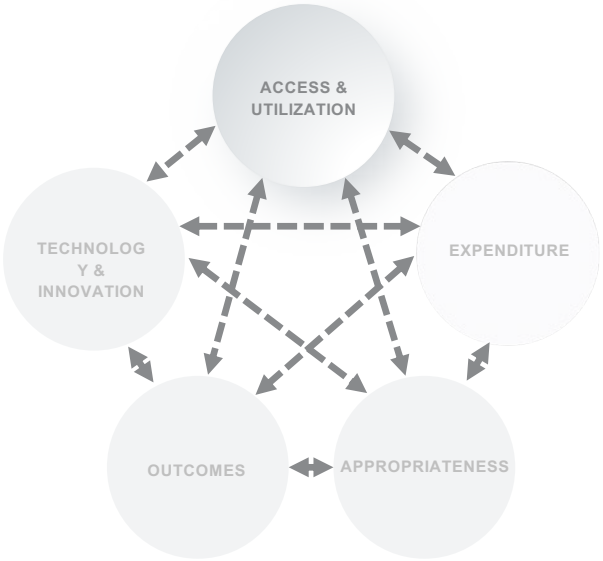
THE VALUE AGENDA FOR TELEHEALTH

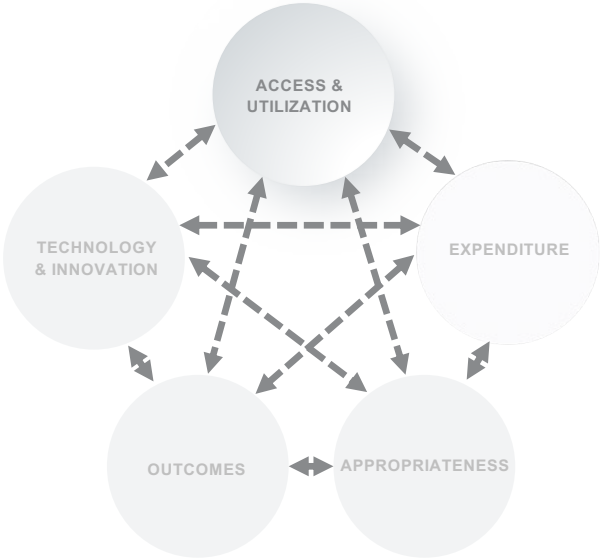
III. RESEARCH AGENDA



1. Understand telehealth impact on **access** and **utilization**

THE VALUE AGENDA FOR TELEHEALTH

III. RESEARCH AGENDA



1. Understand telehealth impact on **access** and **utilization**

People who WOULD have consumed healthcare before the widespread adoption of telehealth

"Converters"

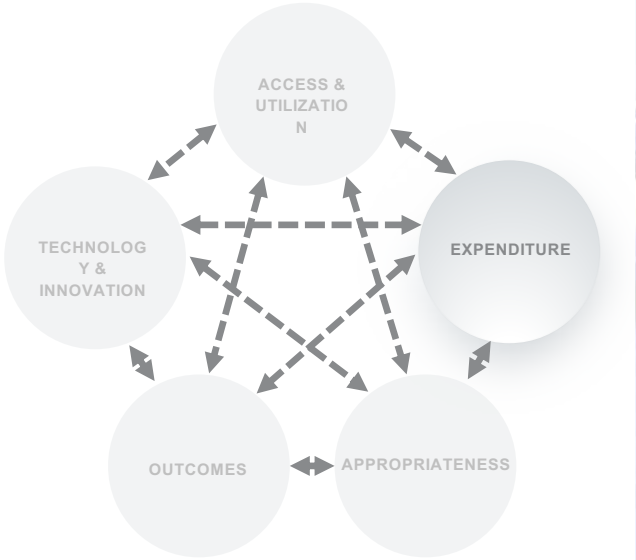
People who WOULD NOT have consumed healthcare before the widespread adoption of telehealth

"Newcomers"

Fendrick et al. 1996

THE VALUE AGENDA FOR TELEHEALTH

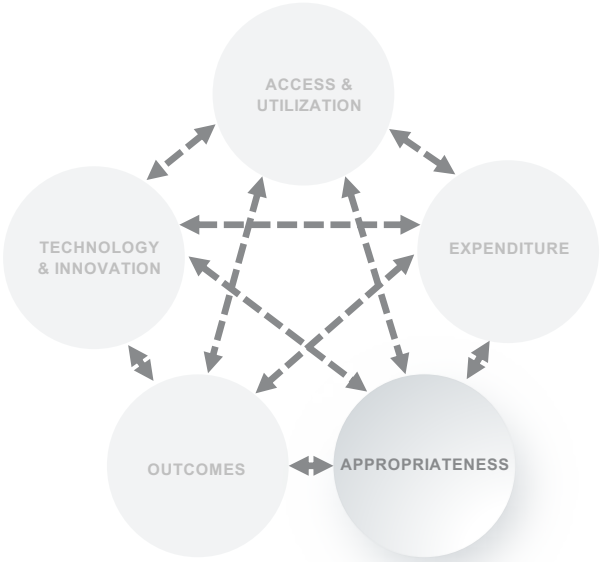
III. RESEARCH AGENDA



1. Understand telehealth impact on **access** and **utilization**
2. Assess cost per case presentation and aggregate **expenditure**

THE VALUE AGENDA FOR TELEHEALTH

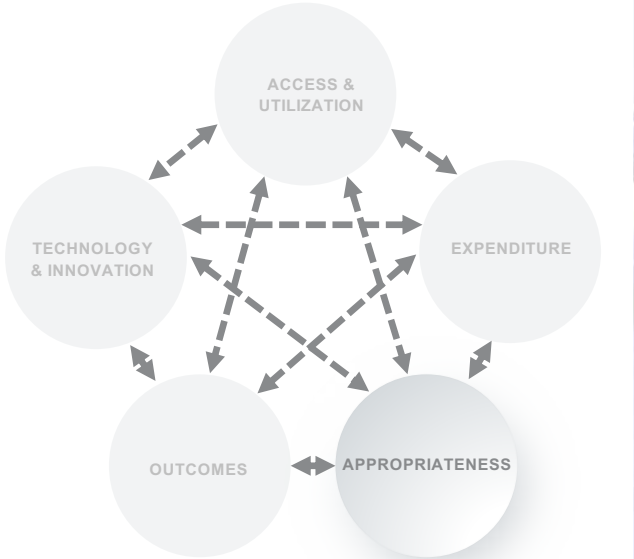
III. RESEARCH AGENDA



1. Understand telehealth impact on **access** and **utilization**
2. Assess cost per case presentation and aggregate **expenditure**
3. Evaluate telehealth influence on **appropriateness** of care

THE VALUE AGENDA FOR TELEHEALTH

III. RESEARCH AGENDA



1. Understand telehealth impact on **access** and **utilization**
2. Assess cost per case presentation and aggregate **expenditure**
3. Evaluate telehealth influence on **appropriateness** of care

Healthcare Services*	Care-Seeking Behavior§	
	Converter receiving **high-value** care	**Newcomer** receiving **high-value** care
	Converter receiving **low-value** care	**Newcomer** receiving **low-value** care

*Per-clinical case presentation, §Person may be a "Converter" or "Newcomer" and receive high- or low-value care for different clinical case presentations across time

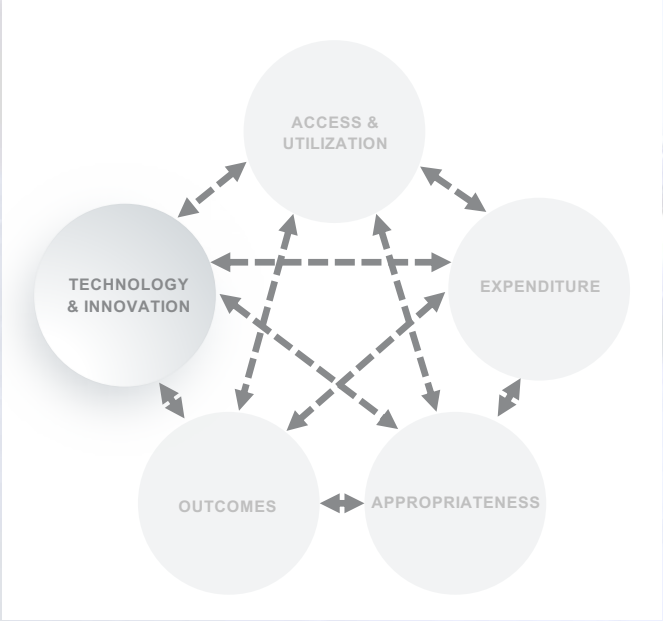
THE VALUE AGENDA FOR TELEHEALTH

III. RESEARCH AGENDA

1. Understand telehealth impact on **access** and **utilization**
2. Assess cost per case presentation and aggregate **expenditure**
3. Evaluate telehealth influence on **appropriateness** of care
4. Measure **outcomes** across settings

THE VALUE AGENDA FOR TELEHEALTH

III. RESEARCH AGENDA



1. Understand telehealth impact on **access** and **utilization**
2. Assess cost per case presentation and aggregate **expenditure**
3. Evaluate telehealth influence on **appropriateness** of care
4. Measure **outcomes** across settings
5. Explore telehealth **technologies** that improve **value**

THE NEW NORMAL OF TELEHEALTH: NEXT STEPS

SUPPORT	MEASURE	DISRUPT	ALIGN
Infrastructure required to support and sustain **equitable care delivery**?	**Operationalize platforms** that enable measurement of important outcomes?	Value agenda as a **pivotal strategy** for growth and disruptive innovation?	Dominant approach to **align stakeholders** around value-based care delivery?

Galvanize stakeholders to optimize healthcare value

M | V-BID

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ESTABLISHING A VALUE-BASED 'NEW NORMAL' FOR TELEHEALTH: THE TELADOC HEALTH VIEW

Lewis Levy, MD, FACP
Chief Medical Officer, Teladoc Health

Establishing a Value-Based 'New Normal' For Telehealth: The Teladoc Health View

December 15, 2020

Lew Levy, MD, FACP
Chief Medical Officer
Teladoc Health

About Teladoc Health

+51M

U.S. paid access members as of Q3 2020

+442K

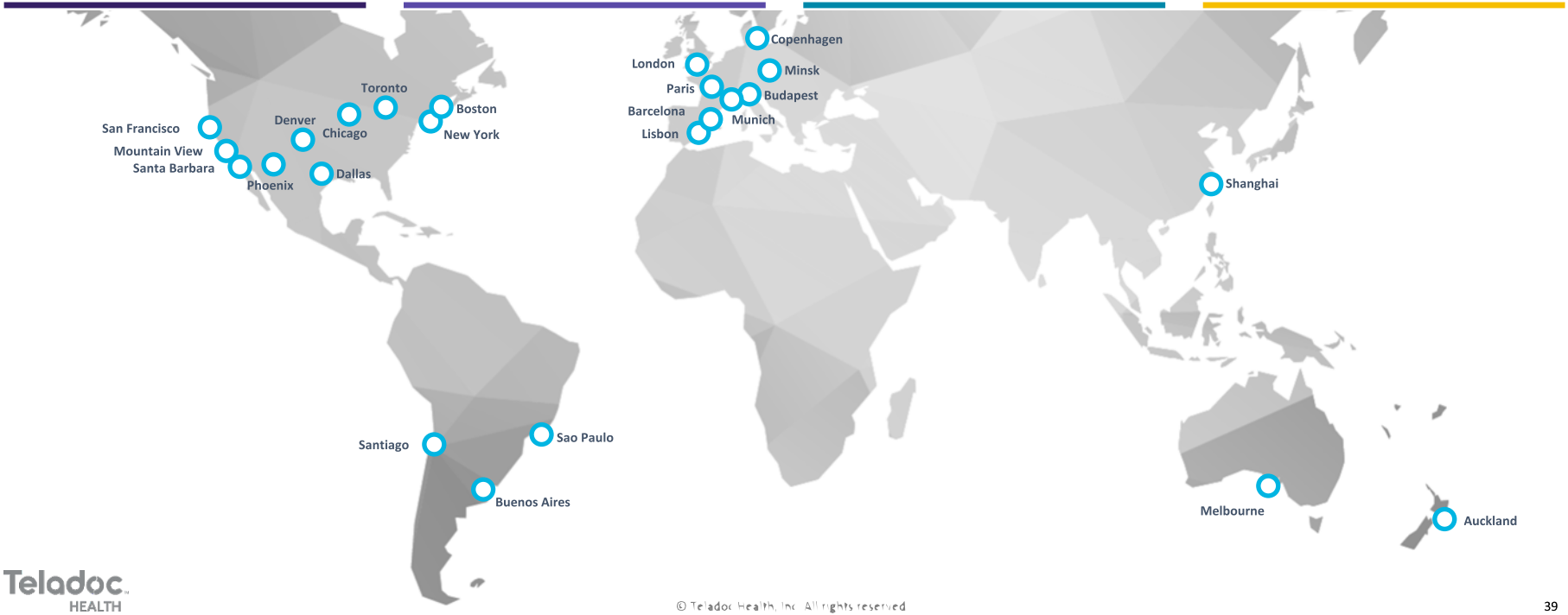
Livongo diabetes members as of Q3 2020

+15M

virtual visits since 2015

+986K

platform-enabled sessions in Q3 2020



Teladoc HEALTH

Creating Value for Consumers

- Empowering **consumers** with a single access point for whole person care regardless of clinical situation, driving better health outcomes, lower costs and consumer experience

- Reducing costs for **health plans and employers** with a broad portfolio of integrated, data-driven virtual care solutions

- Enabling **care providers** to achieve system-wide virtualization of high-quality care

Teladoc HEALTH

Future of Telehealth: Focus on Whole Person Value-Based Care

Care Coordination

Navigate across both virtual and in-person resources, ensuring access to high-quality care throughout

Wellness & Prevention

Improve nutrition, exercise and wellbeing

Complex Care

Gain advice on diagnosis, treatment plan, or surgery from world-renowned specialists

Primary Care

Serve as the quarterback for care, developing care plans and referring individuals to resources they need, both virtual and in-person

Chronic Care

Take charge of health challenges with monitoring & personalized support

Mental Health Care

Address stress, anxiety and other conditions with therapy, counseling & treatment

Specialty Care

Consult a specialist via virtual care and coordinate referrals to in-network, in-person care

Acute Care

Assess, diagnose and treat everyday health issues such as flu, infections & skin conditions

Importance of Engagement

Results-focused engagement science

Consultative consumer marketing expertise

Data-driven targeting and AI-enabled personalization

Intuitive experiences create sustainable behavior change: enrollment, re-use, satisfaction and loyalty

Policy Agenda: State

How to Enable Telehealth

1. A physician-patient relationship can be established using technology

2. A previous in-person visit should not be required to deliver care virtually.

3. Telehealth policy should be "modality-neutral" so long as the standard of care can be upheld. Decisions as to how care should be delivered should be left to patient choice/physician discretion.

4. Asynch and synchronous interactions are critical – but with appropriate safeguards.

5. The healthcare provider should have access to the patient medical history and a record must be created of the virtual visit that is accessible to the patient and shared with the patient's PCP, if patient permits.

6. All telehealth transactions must be HIPAA compliant.

Definition of Telehealth

Telehealth means the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration.

Teladoc HEALTH

COVID-19 Response: License Diversity

- No action taken
  - Ex: Mississippi, Illinois, Washington DC
- Using emergency orders used for natural disasters
  - Ex: Alabama, California, New Hampshire
  - Language such as "emergency management workers" and "entering the state" does not contemplate the existence of telehealth companies with no connection to a facility that could "enter" the state virtually
- "Come one, come all" blanket waivers
  - Ex: New York, Delaware, Idaho, Iowa, Indiana, Kansas, Massachusetts, Florida, Hawaii, Pennsylvania, South Carolina and North Carolina

Opportunity: Simplification

- A physician must be licensed in the state where the patient is at the time of the telehealth encounter unless a licensure waiver is granted for state or national emergency purposes.
- Multi-state licensure compacts were drafted in an attempt to streamline the process; however, they do not remove all regulatory burdens and still represent a revenue stream for state licensing boards.
- Conversations surrounding national physician licensure are active but are not expected to generate any real movement.
- Already states like Idaho and Alaska are looking at what Florida and Georgia has done re licensure

Expert Medical Services

The ability to use telehealth to access a specialist for life threatening and complex diseases affords patients access to resources that they have not had in the past. State code must allow for a physician to provide a professional second opinion to a patient as long as they are licensed and in good standing in their resident state provided that the physician is not involved in the treatment of the patient in the state where he/she is not licensed.

Convenience not Burdensome Terms and Conditions

- Licensure waivers with overly burdensome terms and conditions
  - Require individual applications rather than spreadsheets
  - Require photo identification
  - Require In-state facility sponsorship
  - Failure to post application process
  - Require unpaid volunteers only

Prevents the state from leveraging the agility and convenience of telehealth

Payment: Flexibility not Mandates

- Teladoc believes that a provider should be fairly compensated for services provided. However, we believe that a state should not mandate a specific payment rate or reimbursement amount.

- For visits that are entirely virtual, a healthcare plan should have the ability to negotiate and contractually agree to reimbursement rates based on market conditions
- Mandating payment and reimbursement parity for virtual care removes all savings opportunities for the patient and the healthcare system.

- The bottom line is that a telehealth provider should not be mandated by statutes to accept a higher reimbursement than they are willing to charge.

Policy Agenda: Federal

Federal | Medicare Telehealth Reform

- Congress should eliminate the geographic and originating site requirements
- Medicare should avoid imposing requirements for a prior in-person visit or other limits on the type of technology that may be used for a telehealth encounter.
- Medicare should allow telephone-based communications
- Congress and CMS should expand support for asynchronous telehealth technologies
- CMS should permanently allow Medicare Advantage organizations to use telehealth for the purposes of risk adjustment.

Federal | Medicare Telehealth Reform

- CMS should seek to broadly expand the list of eligible Medicare telehealth services that have demonstrated to be safe, effective, and clinically appropriate.
- Medicare must ensure that when the home is made an eligible originating site, payment rates must adequately compensate providers so as not to incentivize and favor in-person visits over virtual.
- Expanding flexibility to use virtual care should be a cornerstone of key payment reform initiatives moving forward.
- Medicare should enable virtual chronic condition prevention and management

Federal | DEA & Controlled Substances

- Congress must ensure that DEA finalizes the telemedicine special registration rule which would allow DEA-registered practitioners to prescribe controlled substances, such as certain kinds of medication-assisted treatment, without an in-person medical evaluation

Federal | Fraud, Waste, Abuse, & Patient Safety

- Congress should ensure HHS and CMS have the necessary tools to combat bad actors and provide robust funding for the Health care Fraud and Abuse Control (HCFAC) Program and related programs.

- States should maintain responsibility for regulating the practice of medicine to ensure the full resources of the state are available for the protection of any patients that receive services that fall short of the standard of care.

- Federal policy should support and incentivize the adoption of interstate compacts

- The FDA should apply sufficient regulatory scrutiny to high-risk telehealth devices and clinical software used in critical care environments.

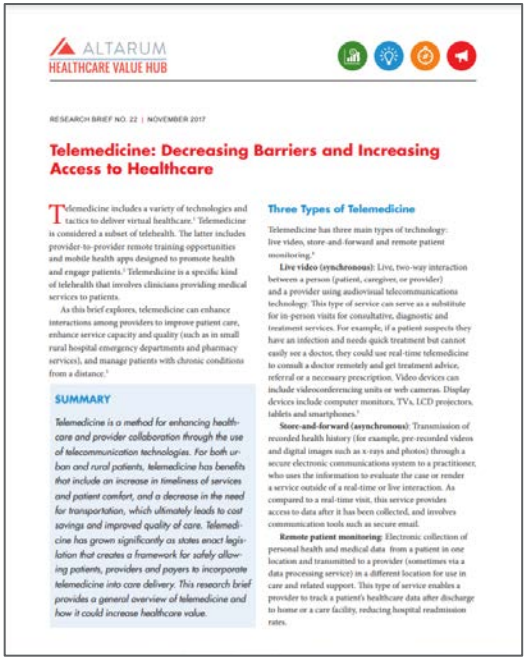
Teladoc HEALTH

llevy@teladochealth.com

Questions for our Speakers?

- Use the chat box or to unmute, press *6
- Please do not put us on hold!

Resources from the Hub



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RESEARCH BRIEF NO. 22 | NOVEMBER 2017

Telemedicine: Decreasing Barriers and Increasing Access to Healthcare

Telemedicine includes a variety of technologies and tactics to deliver virtual healthcare.[1] Telemedicine is considered a subset of telehealth. The latter includes provider-to-provider remote training opportunities and mobile health apps designed to promote health and engage patients.[2] Telemedicine is a specific kind of telehealth that involves clinicians providing medical services to patients.

As this brief explores, telemedicine can enhance interactions among providers to improve patient care, enhance service capacity and quality (such as in small rural hospital emergency departments and pharmacy services), and manage patients with chronic conditions from a distance.[3]

SUMMARY

Telemedicine is a method for enhancing health-care and provider collaboration through the use of telecommunication technologies. For both urban and rural patients, telemedicine has benefits that include an increase in timeliness of services and patient comfort, and a decrease in the need for transportation, which ultimately leads to cost savings and improved quality of care. Telemedicine has grown significantly as states enact legislation that creates a framework for safely allowing patients, providers and payers to incorporate telemedicine into care delivery. This research brief provides a general overview of telemedicine and how it could increase healthcare value.

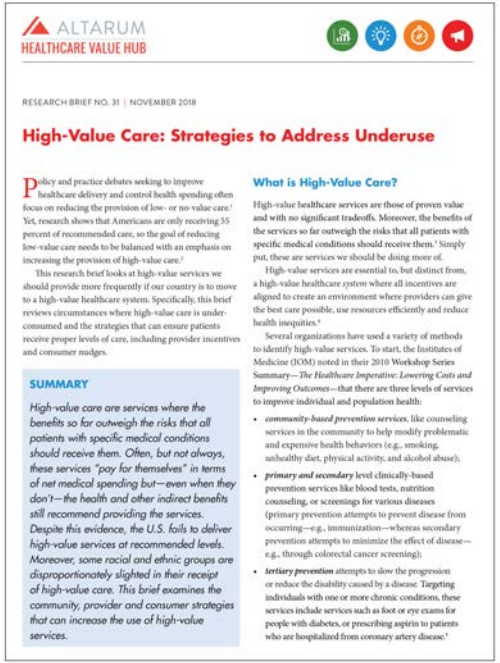
Three Types of Telemedicine

Telemedicine has three main types of technology: live video, store-and-forward and remote patient monitoring.[4]

Live video (synchronous): Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology. This type of service can serve as a substitute for in-person visits for consultative, diagnostic and treatment services. For example, if a patient suspects they have an infection and needs quick treatment but cannot easily see a doctor, they could use real-time telemedicine to consult a doctor remotely and get treatment advice, referral or a necessary prescription. Video devices can include videoconferencing units or web cameras. Display devices include computer monitors, TVs, LCD projectors, tablets and smartphones.[5]

Store-and-forward (asynchronous): Transmission of recorded health history (for example, pre-recorded videos and digital images such as x-rays and photos) through a secure electronic communications system to a practitioner, who uses the information to evaluate the case or render a service outside of a real-time or live interaction. As compared to a real-time visit, this service provides access to data after it has been collected, and involves communication tools such as secure email.

Remote patient monitoring: Electronic collection of personal health and medical data from a patient in one location and transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support. This type of service enables a provider to track a patient's healthcare data after discharge to home or a care facility, reducing hospital readmission rates.



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RESEARCH BRIEF NO. 31 | NOVEMBER 2018

High-Value Care: Strategies to Address Underuse

Policy and practice debates seeking to improve healthcare delivery and control health spending often focus on reducing the provision of low- or no-value care.[1] Yet, research shows that Americans are only receiving 55 percent of recommended care, so the goal of reducing low-value care needs to be balanced with an emphasis on increasing the provision of high-value care.[2]

This research brief looks at high-value services we should provide more frequently if our country is to move to a high-value healthcare system. Specifically, this brief reviews circumstances where high-value care is under-consumed and the strategies that can ensure patients receive proper levels of care, including provider incentives and consumer nudges.

SUMMARY

High-value care are services where the benefits so far outweigh the risks that all patients with specific medical conditions should receive them. Often, but not always, these services "pay for themselves" in terms of net medical spending but—even when they don't—the health and other indirect benefits still recommend providing the services. Despite this evidence, the U.S. fails to deliver high-value services at recommended levels. Moreover, some racial and ethnic groups are disproportionately slighted in their receipt of high-value care. This brief examines the community, provider and consumer strategies that can increase the use of high-value services.

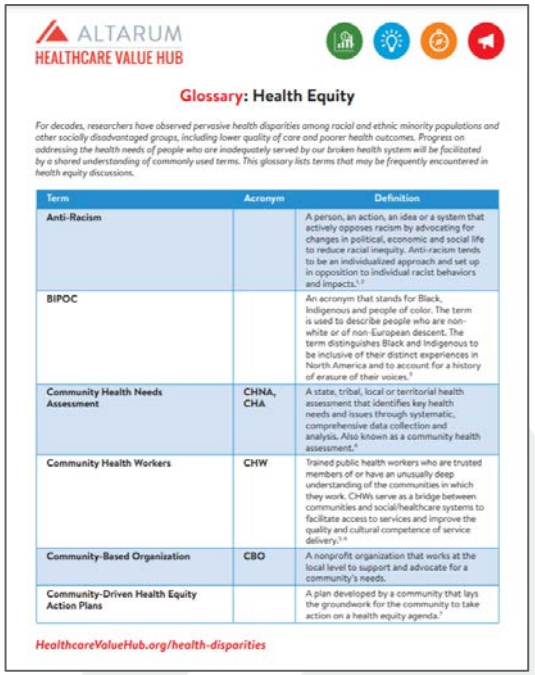
What is High-Value Care?

High-value healthcare services are those of proven value and with no significant tradeoffs. Moreover, the benefits of the services so far outweigh the risks that all patients with specific medical conditions should receive them.[3] Simply put, these are services we should be doing more of.

High-value services are essential to, but distinct from, a high-value healthcare system where all incentives are aligned to create an environment where providers can give the best care possible, use resources efficiently and reduce health inequities.[4]

Several organizations have used a variety of methods to identify high-value services. To start, the Institutes of Medicine (IOM) noted in their 2010 Workshop Series Summary—*The Healthcare Imperative: Lowering Costs and Improving Outcomes*—that there are three levels of services to improve individual and population health:

- ***community-based prevention services***, like counseling services in the community to help modify problematic and expensive health behaviors (e.g., smoking, unhealthy diet, physical activity, and alcohol abuse);
- ***primary and secondary*** level clinically-based prevention services like blood tests, nutrition counseling, or screenings for various diseases (primary prevention attempts to prevent disease from occurring—e.g., immunization—whereas secondary prevention attempts to minimize the effect of disease—e.g., through colorectal cancer screening);
- ***tertiary prevention*** attempts to slow the progression or reduce the disability caused by a disease. Targeting individuals with one or more chronic conditions, these services include services such as foot or eye exams for people with diabetes, or prescribing aspirin to patients who are hospitalized from coronary artery disease.[5]



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Glossary: Health Equity

For decades, researchers have observed pervasive health disparities among racial and ethnic minority populations and other socially disadvantaged groups, including lower quality of care and poorer health outcomes. Progress on addressing the health needs of people who are inadequately served by our broken health system will be facilitated by a shared understanding of commonly used terms. This glossary lists terms that may be frequently encountered in health equity discussions.

Term	Acronym	Definition
Anti-Racism		A person, an action, an idea or a system that actively opposes racism by advocating for changes in political, economic and social life to reduce racial inequity. Anti-racism tends to be an individualized approach and set up in opposition to individual racist behaviors and impacts.[1,2]
BIPOC		An acronym that stands for Black, Indigenous and people of color. The term is used to describe people who are non-white or of non-European descent. The term distinguishes Black and Indigenous to be inclusive of their distinct experiences in North America and to account for a history of erasure of their voices.[3]
Community Health Needs Assessment	**CHNA, CHA**	A state, tribal, local or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis. Also known as a community health assessment.[4]
Community Health Workers	**CHW**	Trained public health workers who are trusted members of or have an unusually deep understanding of the communities in which they work. CHWs serve as a bridge between communities and social/healthcare systems to facilitate access to services and improve the quality and cultural competence of service delivery.[5,6]
Community-Based Organization	**CBO**	A nonprofit organization that works at the local level to support and advocate for a community's needs.
Community-Driven Health Equity Action Plans		A plan developed by a community that lays the groundwork for the community to take action on a health equity agenda.[7]

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Thank you!

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- To our Speakers: Lewis, Mark, Nick and Christina
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