Dr. Ateev Mehrotra:
You go to the doctor's office, you have a 10-minute visit, check-in, say on your diabetes, and now you have a 10-minute check-in via video visit or a 10-minute check-in via phone call. It's still 10 minutes of the clinician's time. However, from a value perspective, when you get the bill for 150 bucks, if you have a high deductible help plan for that phone call, I think there are many patients who are having the experience really, really 10-minute phone call, 150 bucks? That's a lot of money and they don't perceive the relative value of that 10-minute phone call, so there's that one issue that is important to recognize that there may be some element of patient back lash.

Ellen Kelsay:
That's Dr. Ateev Mehrotra, associate professor of health care policy and medicine at Harvard Medical School and a hospitalist at Beth Israel Deaconess Medical Center. A researcher who is largely focused on delivery innovations such as retail clinics, e-visits, and telemedicine, including their impact on quality, costs, and access to health care, Ateev's articles appearing in *Health Affairs* have been on the most read list, three separate years.

I'm Ellen Kelsey, and this is a Business Group on Health podcast, conversations with experts on the most important health and well-being issues facing employers. My guest is a Ateev Mehrotra and we will be talking about cost, quality and appropriateness of integrating virtual health into the broader care continuum.

Ateev, welcome to the podcast. We're thrilled to have you.

Dr. Ateev Mehrotra:
Thanks so much for having me.

Ellen Kelsay:
For those in our audience who may not be aware, you spoke at our virtual health summit earlier in the year and you wowed our audience. When you and I spoke a week or two ago in preparation for our conversation today, we wanted to start with a couple areas that you are keeping a watchful eye on and some areas that might require a second look. One area, in particular, that I know you are really focused on is the aspect of video versus phone visits in telehealth, and in particular, how we should be thinking about the balance between those two things. Can you expand a little bit more on that?

Dr. Ateev Mehrotra:
Yes, it's fascinating how the pandemic has really changed the dialogue or conversation about this. Prior to the pandemic, doctors would provide phone consultations, you'd call the office and they'd provide it, but it was never considered a visit. Then during the pandemic, phone calls were rebranded as audio only telemedicine visits and we started paying for them and it's really led to this fascinating and important conversation about what their role is in the U.S. health care system moving forward. Maybe we could just lay out the issues really, and it's really about access and quality and fraud concerns. On the access side, it's just based on a clear realization that there are a lot of Americans out there who either lack the technology, or the skills to use the technology, to do a video visit. Those Americans are important. We need to reach them and a phone call is one way to do so. We see that many clinicians report that with many of their patients, that's what ends up happening, either because they started with a video call and you know, we have all experienced the technology doesn't work and they convert it over to a phone call or just they basically had to start with that. That's the real push for phone calls, which is we need to reach populations, and let's be clear, those populations are often underserved populations - those who are poor, disadvantaged, minorities. So what's the downside? I think there are a couple. The first is on the quality side. We don't have a lot of data on this, but I think it makes intuitive sense that there are many clinical issues where a phone call is just fine - talk about their blood pressure, see how they're doing with their mental illness, but there are other conditions for which you need the imaging, you need the pictures.

So those are going be circumstances where a phone call is insufficient. And so you have this fear that you can create a two-tiered health care system where the rich get video calls and the poor get phone calls. That's been one major concern. There has also been a concern on phone calls, whether they are more apt to both fraud, as well as overuse, in the sense that people who have bad intentions can reach a lot of patients quickly and use those phone calls to bill for, you know, expensive tests or wheelchairs, etc. So that's been one concern. It's a thought, there's not really evidence about that. Also, that what can happen is that phone calls are so convenient that providers will use it as a quick way of getting more visits and increase the number of visits in the U.S. health care system and therefore drive up spending. It's a really fascinating issue with this really critical, important role that phone calls play, but also those concerns. That's why it's become such an area of hot debate.

Ellen Kelsay:
I think some of what you said, too, also applies to video visits, right? You still can't see imaging effectively through a video visit. You can see some, but not all as effectively. You still need lab work done in person, and there are certainly some potential for inappropriate or overuse within video. I guess it's just exacerbated within a phone environment, but I think many of what you just laid out in terms of concerns would also be concerns in a video form as well. Is that right?

Dr. Ateev Mehrotra:
Yes. No, I think it's definitely the case and I really appreciate you bringing that up. If we contrast video visits versus in-person visits, a lot of the issues about overuse are certainly also of substantial concern. Then the whole idea that again, a video call, a lot of medical problems can be managed by a video call, but there's some that cannot, and some of my clinical colleagues will describe that a video visit feels like they are practicing medicine with one hand tied behind their back. A cardiologist often needs an EKG, often you need some laboratory tests, you need to listen to the lungs, examine the abdomen, and you really can't do it currently with just a video conference set up.

Ellen Kelsay:
We all are widely talking about just all the virtues of telehealth and the wonderful access that's been achieved in a time of an environment where the pandemic, where people might not have been as willing to go out of their home to see a doctor, it definitely served a need in near term, but now we're approaching this phase of kind of the second order questions and potentially longer term challenges of maybe telehealth and virtual health not always being as idealistic as we've all been discussing this past year that they are. I think balancing the virtues of telehealth, but then also these watch out items, is going to be really important for all of us as we move forward in the coming year or two ahead. Another area that you spoke about, very passionately, was about the patient experience, and that that is not always what it appears to be either in this new world. Please expand there as well.

Dr. Ateev Mehrotra:
I think that a large fraction of Americans have now experienced a telemedicine visit. Such a radical change from prior to the pandemic. I think so many of them appreciate the benefits of it, but there are also some downsides from the patient's perspective. I'll highlight two of them. The first is you go to the doctor's office, you'd have a 10-minute visit check-in, say on your diabetes, and now you have a 10-minute check-in via video visit, or a 10-minute check-in via phone call. It's still 10 minutes of the clinician's time. However, from a value perspective, when you get the bill for 150 bucks, if you have a high deductible health plan for that phone call, I think there are many patients who are having the experience really, really 10-minute phone call, 150 bucks? That's a lot of money and they don't perceive the relative value of that 10-minute phone call. There's that one issue that it's important to recognize that there may be some element of patient backlash.

A second really important one, and this is something we can also expand upon, is that a lot of the focus has been on video and phone visits, because that's what most Americans are experiencing, that's where it's most common where telemedicine is most likely used. But there are other forms of telemedicine that are growing in

popularity. Let me highlight one of those, which is what has been termed an e-visit. An e-visit is a fancy name for saying you go to your doctor, you type in say the patient portal, Dr. Jones, I'm having some back pain or I'm having foot pain, or I have a new rash; here's what's going on, what do you think we should do? And the doctor might respond the same day or next day saying this is what we should do or these are the tests we should order, don't worry about it. Prior to the pandemic, that kind of use of a patient portal was something that clinicians or doctors' offices all around the country offered as sort of a part of being a good primary care practice or specialty practice. But now, during the pandemic, there's been a real expansion of payment for those kinds of encounters and they've been relabeled e-visits. That's great actually in some ways, right? That's a pretty efficient way of getting a problem addressed, both on the patient side and the provider side, but, and where it comes to from a patient's perspective is, prior to the pandemic, I message my doc with a question, it was free. Now, all of a sudden, sometimes it's an e-visit, but only in certain circumstances, and all of a sudden I'm getting a bill in the mail for 60 bucks or 80 bucks or whatever the reimbursement is for the e-visit. You can also see another form of backlash where patients don't understand, get frustrated, understandably so, and this is going to also raise some important issues from the plan perspective, as well as the provider perspective that we need to communicate with patients about when things are going to cost them money and when things are free, because understandably patients had some expectations based on their prior experience, and things are changing so quickly.

Ellen Kelsay:
You've just laid out several different tiers of access that you said e-visit, then there's phone, then there's video, and then there's actually an in-person visit, all for the same provider. We've made access a lot easier, but in many ways we've made it a lot harder. When you just looked at the four different ways to access care from one physician that are not clearly outlined and are very confusing to the patient and in the moment could be surprising when they get a bill for something that they weren't expecting.

Dr. Ateev Mehrotra:
Right. One of the other of points about that is that on top of all of what we just described, patient choice is wonderful, there's so many opportunities and I think we should applaud that, but on top of the four ways that you could reach your primary care doctor, at the same time during the pandemic, we've seen a surge in all these other providers who can also provide you care, from direct to consumer urgent care to mental health opportunities. It is a very confusing landscape for the patient right now.

Ellen Kelsay:
We had this problem before the pandemic, before the explosion of telehealth and virtual care solutions. We were already hearing from point solution fatigue from many employers. From a patient navigation challenge, many employers were implementing advocacy or navigation services, and now that problem has gotten tenfold in terms of a challenge to navigate. Again, there's so many virtues of these solutions, but there is, I think, the unintended consequence of creating more fragmentation and more confusion. Thoughts there about how do we improve that? What do we need to keep in mind as we move forward?

Dr. Ateev Mehrotra:
It's a really key issue. It almost seems that there's two national policy trends in conflict with each other. Let me highlight what I mean. Employers across the country, and health plans, are introducing all these new telemedicine-only companies because they're reacting to what they're hearing from their employees or their enrollees. In particular, in the area of mental health, I can't get in to see anybody, so they're like, okay, so we need to offer something and so some of these vendors are coming in. That's true across a variety of different areas from chronic illness, oncology, etc. That's one trend about offering choice because access is a problem. At the same time, and this is going on for a long time, what's the policymakers talking about or researchers. We need good primary care. We need better coordination of care. Now all of a sudden you've added so many more providers on a system that already had, in some ways, too many providers and that's going make those coordination issues that much more difficult and also lead to more fragmentation. It is a substantial problem that I think we're going be facing over the coming several years.

Ellen Kelsay:
Do you think we're going to see some sort of a boomerang or a pendulum shift swinging back in the other direction? If you could look into your crystal ball three years, five years from now, are we going to have almost an overcorrection because we've swung so far in this direction of having fragmentation and virtual solutions for just about every condition, every service, that you might need. I'm curious your thoughts there and do you envision a state where we've gone too far and we are course correcting and swinging back in terms of the pendulum swing?

Dr. Ateev Mehrotra:
I think there will be some pendulum swing back. The place that I am most worried about is a number of the offerings that are out there in the vendor space that are saying we can offer a better solution for whatever problem it could be, to going directly to employers or going to health plans. Let's just focus on diabetes care, for example. I am very concerned that the evidence that these vendors provide saying that their products are effective. I'm not convinced by that evidence and I'm fearful that what we'll see is a lot of employers signing up based on face validity that they may work, finding out later that they're spending a lot of money, doesn't seem like it's really improving outcomes, and then pulling back and having to pull back from those products. I think another issue related to evidence is specifically, in what we use the term in my world of research, is risk selection. It's a fancy way of saying that, look, let's say you got a hundred patients with diabetes in an employer. A lot of them are doing great. Let's say 80 of them, they got their diabetes controlled, things are not perfect, but you know, the diabetes is better controlled, they're doing the exercises, they know what they need to do, they've got their insulin doses. Then you've got, say 20, that are not doing so well. Those are the patients who would most benefit potentially from one of these new vendors. The problem is that we're seeing that when you come in, who raises their hand when some new option emerges? It’s the 80 who are probably doing well, because they're already kind of on top of their disease and the 20 that weren't doing well before, aren't the ones raising their hand saying I love to work with this vendor to improve my care. So now you're increasing spending and that spending is going to people whose disease was pretty well controlled in the first place. You haven't addressed those patients who are still struggling, in this particular example, with diabetes care. That's another reason why a good idea may not be effective.

Ellen Kelsay:
You just hit on a lot of things that I do worry about as well. I think we've already got this environment. We have a lot of confusion, a lot of solutions, not all of them are high quality. They're not all producing better outcomes or better patient experience. They could downstream create more cost and certainly more fragmentation. We're already beginning to see that. Then you have an infusion of VC and equity money coming into even more of these solutions in the coming year ahead. I do worry that it's going to get worse in the near term before it starts to course correct, worse for patients in terms of outcomes and are they actually getting healthier, and then worse in terms of the system and more cost in the near term because of that. I kind of asked you that boomerang pendulum question, because I think we're going to reach a point where it's just untenable and we're going to have to really moderate and rationalize this ecosystem beyond where it's already beginning to head.

Dr. Ateev Mehrotra:
A related aspect of this is that currently when I talk to many of these companies, they're going directly to the employer. That's going to be another interesting aspect of this, which is that we talked about fragmentation on the patient's perspective, there's going to be fragmentation on the employer's perspective, because you got a health plan, say your self-insured, that's where a lot of the mental health care is, but then you're paying someone on the side here. It's really hard for you to figure out whether this is all being effective because the money is flowing in several different ways and it's hard for you to put it all together. I think that's another place where the pendulum might swing. I suspect that in the coming years, employers are going to say, we're not going to sign up directly with a vendor. We're going to have you go through our health plan because that's why we're paying the health plan the money.

Ellen Kelsay:
Yes, I think it goes back to integration. It's integration of services. It's integration within the ecosystem. It's sharing data across all the different suppliers an employer might partner with. Then it's integration of services to the patient. We're sitting here today talking about virtual and telehealth services, but there are in-person visits and physicians that patients need to see in an office and how effectively or not do these virtual solutions plug into a holistic care continuum, I think, is still to be determined. That will be another area to keep an eye on.

Dr. Ateev Mehrotra:
I definitely agree. One other point that your comment there really made me think about, which is that another aspect of this is that so much of the conversation, if you go to state legislatures or the Congress, is really about the video visits and the phone calls, kind of where we started. One of the other aspects of this that I worry about is in four or five years, the phone visits and the video visits will be sort of a less important part of what we think about telehealth and will be more focused on things such as apps that people are using that have a lot of integration into them, artificial intelligence in these tools that are people using, symptom checkers to help diagnose patients, wearables. I think another message that I try to emphasize is, be obviously focused on the video visits and the phone calls, but be aware that all these other things are coming down the pike and thinking about whatever policies you're implementing now can also integrate these new options that are emerging.

Ellen Kelsay:
Yes, that's a great segue because I was going to ask you, do you have recommendations for different constituencies? I know you certainly do a lot of work, you've advised policymakers, you certainly are attuned to the industry from an employer and a health plan and a provider perspective. What are the things that you would or are already advising them to do or would be advising them to keep an eye on as they move forward in the next year to two?

Dr. Ateev Mehrotra:
I'll start with one area that I am particularly worried about, as just a little bit of a focus, is remote patient monitoring. Some of the work that we've done recently has just highlighted the growth of this option, I was just kind of blown away by how quickly it's growing. It's still a small amount of money, but it's growing very, very rapidly. Let me just make sure we're on the same page. What I mean by that, remote patient monitoring is this idea that a patient with a chronic illness, sticking with diabetes, will use some sort of device to send in physiologic measurements, sugars, weights, blood pressures, on a regular basis to their primary care provider, and the doc will get those measurements and then constantly tweak the care that the patient needs. Hey, maybe go up a little bit on your insulin or decrease your blood pressure meds, etc. Great idea, however, you can see why there's a lot of growth. Some of our estimates say that if you could get a reasonable fraction of your patients as a primary care doc with chronic illness on one of these platforms, you can probably get over $150,000 to $200,000 in extra income a year. It's a lot of money for a primary care practice per doc. You can see why there's so much investment. Some of the ideas that we talked about before with venture capital funding coming in there and companies out there available to help get patients onboarded, I'm particularly worried that all of a sudden something that's a pretty small sliver of health care spending in 2, 3, 4 years will become a huge part of spending. One of the pieces of advice I have for health plans and others is keep a really close eye on that topic because you're just going to want to really watch spending growth in that area.

That raises another idea, which is at a much higher level, which is that a lot of the concerns that we've discussed about telehealth are all built on the fee-for-service system. I think, in a strange kind of coincidence, the growth of telehealth has really for me emphasized, and I think should accelerate, our switch to capitated or some sort of bundled payment, in particular, for primary care. So many of the concerns I raised with you earlier about e-visits and phone calls and video visits and this idea of remote patient monitoring also kind of become less of an issue if we're paying the primary care provider, a certain dollar, some per month risk

adjusted for the patients that they're caring for. They can choose which of these different modalities works best, the patient can choose, and we can kind of move on and worry less about the spending impact of these different options. Those are two points that I've been emphasizing to policymakers.

Ellen Kelsay:
That last point on bundles for primary care is a great one because I think most people think of bundles today for more acute, severe, transplant, going to a Center of Excellence for a significant procedure versus kind of day in and day out primary care. That is a terrific example and a great use case to see it applied. We talk about advanced primary care models, I think that would be a welcomed thing embraced by many employers to see more primary care practices move in that direction. I'm sure they'll be asking and encouraging them to do that. The point you've raised on remote monitoring, I one hundred percent agree, but I do think, back to your early point on targeting the 20% of the population, in your example of diabetes, who really need it, maybe that's where some of this remote patient monitoring is most effective, but again, it goes back to targeting and the ability to get those types of solutions to the right populations. That is certainly no small feat, but hopefully, maybe some promise there in the future as well.

Dr. Ateev Mehrotra:
I understand a lot of employers are reluctant to offer something to only a subset of their employees. It goes contrary to sort of the basic idea of HR. Everyone should be offered the same thing, but in this particular case, if there is no targeting, it's going to really undermine the use of a number of these telehealth technologies, because they are just going to be too expensive.

Ellen Kelsay:
Absolutely. It will get to a point where it's, again, not sustainable and they'll be forced to make some decisions to do things differently. I do think that more sophisticated enlightened employers understand that. I think it's the mechanism to target and the data that sometimes is challenging and the predictive modeling that's lacking. I think there's a data infrastructure that is not quite fully there, but I think that there is a desire to get there. That is certainly encouraging.

Well, I'd love to maybe close, Ateev, with your thoughts on, we talked about some things we're concerned about and we're keeping a watchful eye on, but what gives you optimism and as you look to the next 1 to 3 years in this space, what are you most excited about?

Dr. Ateev Mehrotra:
I guess there has been a bit of a theme of negativity in some of our back and forth. I appreciate you bringing this up. I first want to emphasize that there's a lot to be excited about. I guess I'll emphasize two points. First is what we've experienced over the last 18, 19 months during the pandemic has been both a surge in telehealth use, but a surge and innovation, both on the provider side, as well as all these companies. There is so much energy and money coming into this space that I'm hopeful that a number of really promising kinds of new clinical models can really emerge from that. That really does excite me. Another aspect of this that sometimes gets lost in the conversation about telehealth and spending and so forth is efficiency. Let me be a little bit clear about that. If you were to paint with a broad brush, say what's the problem with the U.S. health care system? People often say it's spending. They say why is spending a problem? One way to frame the problem is that our kind of model of care is very much the same it was 30, 40 years ago. The number of patients an endocrinologists or a rheumatologist or a primary care doctor can manage is pretty much the same as it was 30 years ago. In some cases a little bit less, because everything has gotten so much more complicated. What about focusing telehealth models that really increase efficiency? In other words, allow the same provider to manage a lot more patients, and effectively manage, not provide care for care, but provide effective care and maybe even equal or better. Now that endocrinologist, instead of having 300 patients in their panel or 500, now has 600, 1,000, 3,000 patients because they're using a number of these telehealth technologies to try to remove a lot of the mundane work and other things that doesn't require the provider's time.

Wow. If those kinds of models gain traction, we'll address so many of the issues in our U.S. health care system that providers can drop their price and still earn the wages that they're expecting, more patients can get access. We talk so much about the problems and provider supply in the United States, and all at a reasonable impact in terms of health care spending. I think that's a kind of frame on telehealth that I don't hear a lot and I think is really important, but to the degree that telehealth options emerge that can really improve efficiency, I think we might see some real positive benefits for Americans.

Ellen Kelsay:
Well, that's a great way to close and certainly there'll be a lot for us all to collectively keep our eyes on over the next year to three to five in this space and have no doubt that you will be leading the way and you and your team and your research will be ones that will be keeping a watchful eye on as you track it. Ateev, thanks so much for joining us and we look forward to having you back in the future.

Dr. Ateev Mehrotra:
Thanks so much. It was really fun.

Ellen Kelsay:
I've been speaking with Dr. Ateev Mehrotra about where we are on our journey toward the integration of virtual health into the broader care continuum. Ateev's most recent article entitled, *The Surge Of Telehealth During The Pandemic Is Exacerbating Urban-Rural Disparities In Access To Mental Health Care*, appeared in *Health Affairs* in October. We encourage you to check it out.

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