Telehealth in Kansas During COVID-19: A Status Report

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Telehealth Working Group

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Disclaimer

- The information in this presentation is the product of my and my team's research. Nothing in this presentation should be construed as an official position of the University of Kansas Medical Center.
- The study results presented here have been funded by the United Methodist Health Ministry Fund (UMHMF). I have also received funding from UMHMF and the REACH Healthcare Foundation for telehealth patient focus groups, currently ongoing.

Overview

- Stakeholder groups convened:
  - American Academy of Pediatrics
  - Association of Community Mental Health Centers
  - Behavioral Health Network of Kansas
  - Community Care Network of Kansas
  - Kansas Academy of Family Physicians
  - Kansas Association of Osteopathic Medicine
  - Kansas Hospital Association
  - Kansas Medical Society
- Survey with open- and closed-ended questions
  - 247 respondents; 231 answered the majority of the questions
- Interviews with providers and administrators
  - 14 interviewees
  - 2 from each of the first 7 groups listed (physicians were considered dually represented by KMS)

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Key Survey Takeaways

- Respondents indicated mostly physicians, NPs, PAs, and behavioral health professionals are providing telehealth
- Videoconferencing is the most common modality across settings
- Primary care, patient education, chronic care, and counseling/therapy are the most commonly provided telehealth services
- Respondents' top policy priority is payment parity
- They perceived insurance coverage of telehealth has become more prevalent from 2019 to 2020
- Perceptions of reimbursement across payers have become more positive from 2019 to 2020
- All 2020 policy changes largely characterized as having somewhat or very positive impact
- They perceive that their patients, their organizations, and they have all had largely positive experiences with telehealth

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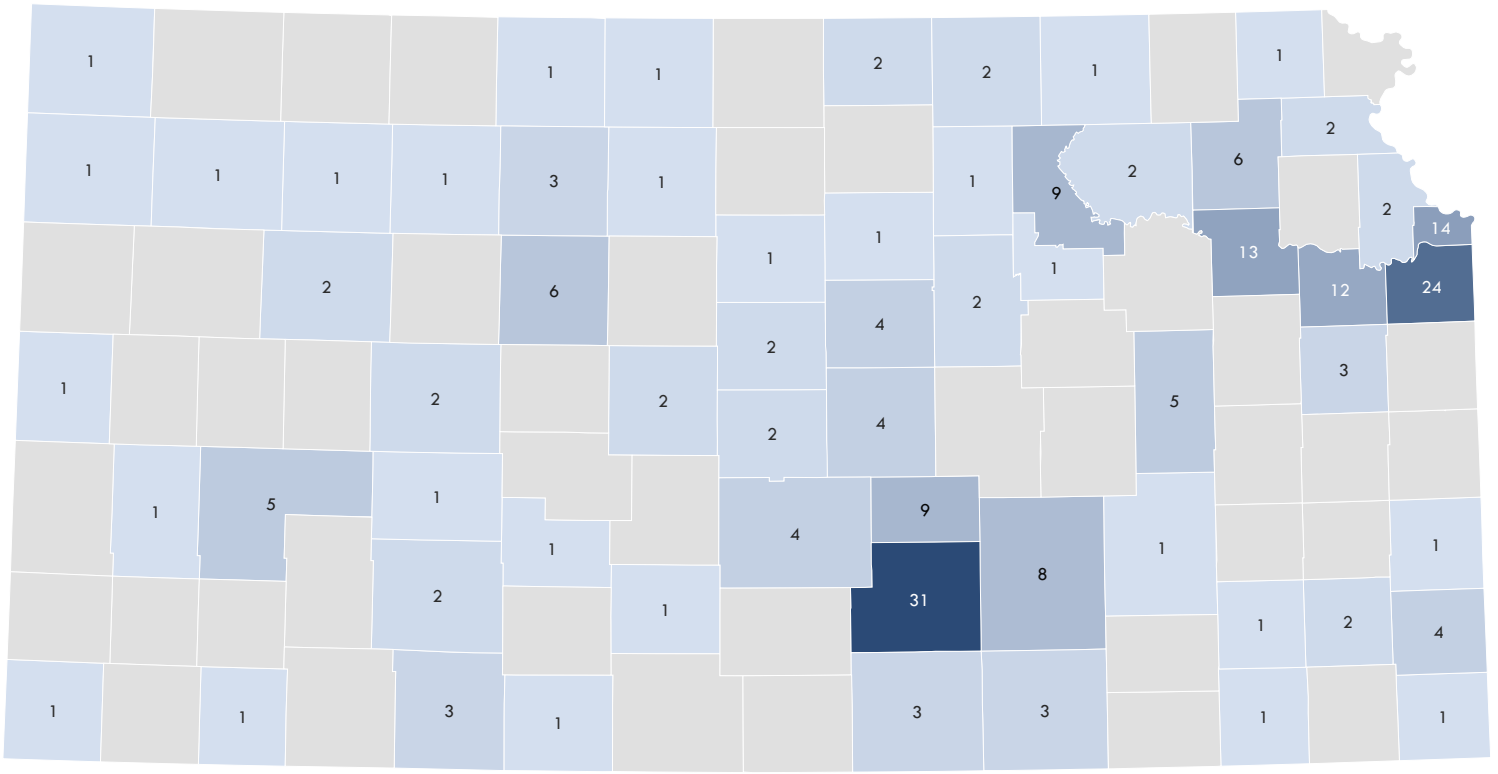
Geography of Survey Respondents



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Provider and Administrator Interviews

- Participant characteristics
  - 50/50 women and men
  - 50/50 administrators and providers (clinicians)
  - Geography: 42.9% (6 people) from **urban** counties – 35.7% (5) from **rural** – 21.4% (3) located in **both**
- 6 primary themes emerged, 5 of which also had secondary themes
  - Telehealth and access to healthcare
  - Barriers to implementing telehealth vary
  - Scheduling logistics and no-show rates
  - What can and cannot be done via telehealth
  - Parity with in-person visits
  - Looking ahead: telehealth's role post-COVID

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Theme: Telehealth and access to healthcare

- **Access during the pandemic specifically**
  - COVID forced telehealth to advance, drove volumes early on
- **Telehealth increases access**
  - Some saw established patients and new; some only saw established
  - In rural areas, telehealth overcame the barriers of distance and travel
- **Importance of patients accessing from home**
  - Home access assisted with barriers like childcare, limited mobility, and transportation
- **Some have had low uptake of telehealth services**
  - A clinic that had challenges implementing telehealth had not done many telehealth visits

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Theme: Barriers to implementing telehealth vary

- **Patients' tech savviness**
  - Some struggle more than others; not necessarily age-related
- **Connectivity and device availability**
  - Internet, devices/device types, effects of living situation (ie, home vs. long-term care)
- **Communicating with patients about telehealth**
  - Educating about platform and what can/cannot be done via telehealth
- **Cost to patients**
  - Device-related costs (purchase, data plans); insurance coverage, co-pays

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Theme: Barriers to implementing telehealth vary, cont.

- **Provider difficulties with platforms or health information technology**
  - Desire for different functionalities; platform is too complicated; difficulties integrating with the electronic health record (EHR)
- **Cost to providers**
  - Start-up costs; pay for platform; some assistance; annual service and/or subscription costs
- **Telehealth-related policies are sometimes cumbersome or unclear**
  - Temporary vs. permanent policies; uncertainty of temporary policies; standards that are old and not easily adapted to telehealth

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Theme: Scheduling logistics and no-show rates

- No secondary themes
- Example quote:
  - *"So, you know, traditionally, if somebody no-showed, I'd come back in my office, I'd try to call them. Well, even if I reach them, they still weren't going to get here. Where now, if I reach them, they answer, and I say, 'You want to do it over the phone?' […] now I can catch them a lot easier, and we can fill that."* -Rural CMHC administrator

Theme: What can and cannot be done via telehealth

What telehealth is good for
(examples; not an exhaustive list)

- Basic triage
- Quick follow-ups, including medication follow-ups
- Patient education
- Reviewing lab or radiology results
- Transitions of care post-hospitalization
- Chronic care management

What in-person is good for
(examples; not an exhaustive list)

- Any physical exam
- Procedures
- Detox services
- Residential services
- Injectable medications
- Group therapy
- Hospital-based specialties

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Theme: Parity with in-person visits

- **Payment parity and comments on payors**
  - During pandemic, payment has largely been same; payor mix is different by provider; skepticism about insurers' altruism
- **Similarities with in-person visits**
  - Logistics and costs largely similar; most practices hybrid; overhead/staff costs remain
- **Lack of knowledge about billing and reimbursement**
  - Some providers are involved with their practice's billing, some are not
- **Differences from in-person visits**
  - Some have experienced less reimbursement for telehealth; one concerned about quality of care in telehealth

Parity with in-person visits – Example quotes

- Payment parity
  - *"As far as I know, I believe the rates at least right now are the same. And I think all insurance companies are reimbursing for telehealth right now as well."*
  - Urban-rural SUD administrator
  - *"We have a lot of Blue Cross Blue Shield out here, and I don't feel like we have felt the pinch at all as far as reimbursement. I think they've done pretty good. I haven't paid attention to a lot of the miscellaneous commercial ones to see, so honestly, I can't [say] because I haven't paid much attention."*
  - Rural clinic administrator

- Similarities with in-person
  - *"[E]ven with that, you still have the medical assistant to set it up. You still have to have the person answering the phone […] the person who checks their insurance to make sure how much they're going to pay. And someone to collect the payment. So, you really don't eliminate anybody in the office. You just eliminate the patient being present in the office."*
  - Urban-rural primary care physician

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Theme: Looking ahead: telehealth's role post-COVID

- **Continue telehealth reimbursement and supportive/ enabling policies**
  - Want telehealth to be feasible; recognize models vary
- **Telehealth is here to stay**
  - While can be mutually beneficial, it's not for every visit
- **Ways telehealth could be expanded**
  - Remote monitoring; school-based telehealth; mental health services in nursing homes
- **The need for regulatory clarity and simplification**
  - Do not want to be overburdened by paperwork; would like clarity around location and type-of-provider details
- **Support reimbursement for audio-only visits**
  - Medical advice/education is work deserving compensation; internet can be risky for some patient populations

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Looking ahead – Example quotes

- Continue supportive policies
  - *"[I]t costs big money to have a platform that is somewhat capable of doing what you want it to do. I don't know what the exact policy implications of that are, but I do know that if there is a Draconian reduction in the reimbursement, then those two things together could be really devastating to any small group of physicians, no matter their subspecialty."*
  - Urban inpatient pediatrician
  - *"Medicaid is like 75 percent of our fee revenue. […] So, any little wiggle up or down, we feast or famine. […] the degree of our electronic interventions and treatment will be dependent upon public policy."*
  - Urban CMHC administrator

- Telehealth here to stay
  - *"I think it's another arrow in the quiver, if you will. It isn't like, 'hey, you know, I'd love to do this full-time every day.' But it's like, you know, if we could get Mrs. Jones's medications filled with the telehealth visit, it's going to give me more time to get my charts done or see another patient [and] it saves her the hassle of driving, and so in that way it's very helpful."*
  - Rural primary care physician

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Key Interview Takeaways

- Providers have experienced a variety of telehealth volumes; very dependent on patient population
  - Telehealth use is tied to the kind of care needed; some care is better suited than other care
- Up-front investment in telehealth technology was significant
  - The technology is still evolving and needs to do so
- Reimbursement policies affect providers differently because of payor mix
  - And this is tied back to patient population
- Therefore, public policies will not affect providers uniformly
- Telehealth is an important option, but it will never replace in-person care

Questions?

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Telehealth and access: Example quotes

- Access during pandemic:
  - *"Definitely during COVID [telehealth] made it easier earlier on because a lot of people really didn't want to come to a hospital setting. So that helped a lot."*
  - Urban outpatient pediatrician

- Accessing from home:
  - *"A real plus with the telehealth stuff is it allows us to engage people who can't get here. I mean, you can imagine in a rural seven-county area, a lot of people we serve don't have driver's licenses or cars. A lot of times no income, so it's hard for them to get here. But almost all of them have a smartphone."*
  - Rural SUD administrator

- Telehealth increases access:
  - *"I think it just provides a greater level of access to especially vulnerable members of our community. […] I think some maybe higher income or higher resource individuals might have already had access to things like...[…] a teledoc. […] But the expansion through community health centers really helps people of lower access in general be able to utilize our services."*
  - Urban CHC administrator

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Barriers to implementing vary – Example quotes

- Connectivity and device availability:
  - *"I think the negative is just the internet. There's always comments about, "Well, I tried to do telehealth, but the internet wasn't any good." And struggles with getting some […] of our patients on. They don't necessarily have the newest, latest, greatest iPhone out on the market, and so that makes sometimes for a difficult phone call."*
  - Urban-rural primary care provider

- Cost to providers:
  - *"We did have to invest in the hardware, software. […] [C]ost-wise, equipment... more IT time. Staff training time. You know, that kind of thing. System maintenance. Some of that we were able to get some COVID grant money to support."*
  - Urban CMHC administrator

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Barriers to implementing vary – Example quotes

- Policies cumbersome or unclear:
  - *"Yeah, we're doing fine right now because of the waiver. They can declare it an emergency, I guess, and so we're able to do it with […] quote, "non-secure" devices. And you know how secure the medical record systems are now and how we have to ensure the security, and of course that's expensive."*
  - Rural primary care physician
  - *"[O]ur state standards for SUD providers had not been updated since 2006. And in 2006, they never dreamed of telehealth."*
  - Rural SUD administrator
- Cost to patients:
  - *"[I]f you're paying per text or per minute on your phone, if you're paying every minute on a card […] Well, first of all, it would be frustrating then. We've experienced concerns where it's a patient who has like a pay-per-use plan, […] and either the provider's not ready or there's back and forth about how to do it. That doesn't' work well. So, if you're paying money to go back and forth and try to figure this out, or even, just, I think people would rather just then come in person, where they don't have to pay."*
  - Urban CHC administrator

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What can and cannot be done

- Can:
  - *"But like refilling medications, […] that would not be any different whether it's a pandemic or not. There's a percentage of […] patient visits that could be done by way of telehealth very expeditiously and safely."*
  - Rural primary care provider
  - *"I always think of every visit as sort of patient education. I'm really telling people stuff that maybe they don't know or maybe they've got sort of a cursory knowledge of. Or maybe they've got the wrong knowledge of. So I mean, most of my visits are spent talking to people."*
  - Urban outpatient pediatrician

- Cannot:
  - *"You know, I can't do joints over the phone because I can't manipulate those to see what's going on with them."*
  - Urban-rural primary care provider
  - *"We had stop-smoking groups and some pain clinic groups. […] that's pretty tough electronically. So, I think it's a tool that people may want to use even when they don't have to. We're going to have to strike a balance with that."*
  - Urban CMHC administrator

Next: Telehealth Patient Focus Groups

- Seeking a wide variety of perspectives, across ages, genders, races/ethnicities, and types of care received
- Criteria are:
  - Over age 18
  - Resident of Kansas
  - Have had at least one telehealth visit
  - Speak English or Spanish as primary language

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