

TELEHEALTH IN KANSAS DURING COVID-19: A STATUS REPORT

United Methodist Health Ministry Fund (UMHMF)
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Phase 2 Results: Provider and Administrator Interviews

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EXECUTIVE SUMMARY

Phase 2 of the “Telehealth in Kansas During COVID-19: A Status Report” study was comprised of semi-structured interviews of healthcare providers and administrators around the state. It followed Phase 1, which was a survey of providers and administrators, and Phase 3 will follow, which will be focus groups with telehealth patients.

A total of 14 participants were interviewed, 7 (50.0%) providers and 7 (50.0%) administrators. They were asked a series of questions regarding utilization and reimbursement, payment parity, workforce issues, and patient experience. These domains were chosen based on responses to the survey in Phase 1. Similarly, potential interviewees were chosen from among survey respondents. See Table 1 for characteristics of participants.

Interviews were digitally recorded and transcribed verbatim. The transcripts were analyzed inductively for common themes, meaning themes were allowed to emerge, rather than having a pre-set list of themes. 6 primary themes are presented here, 5 of which also had secondary themes. See Table 2 for a detailed list of primary and secondary themes with representative quotes.

- **Telehealth and access to healthcare**

In this theme, participants discussed how telehealth helped patients access care during the pandemic, how telehealth may broaden access for vulnerable populations, the value of patients accessing telehealth from their homes, and 2 participants commented on the low uptake of telehealth they have experienced.

- **Barriers to implementing telehealth vary**

The barriers to implementing telehealth mostly varied by participant characteristics, but some were universal. In this theme, participants discussed difficulties with their telehealth platforms and other health information technology (HIT), struggles with internet connectivity and web-enabled device availability, the cost to providers of providing telehealth, the role of patients’ “tech savviness,” cumbersome telehealth-related policies, the complexity of communicating with patients about telehealth, and the potential costs to patients for telehealth.

- **Looking ahead: telehealth’s role post-COVID**

Our participants offered many perspectives on the post-COVID future of telehealth. Most were in favor of continued reimbursement and other public policies that would make continuing telehealth feasible. The general consensus was that telehealth is here to stay, and several participants offered ideas on how telehealth services could be changed or expanded. Some expressed a desire for regulatory simplification, and a few favored reimbursement for audio-only visits.

- **What can and cannot be done via telehealth**

Participants were clear that some health services are well-suited for telehealth and others are not. Among those well-suited were basic triage, quick follow-ups, 1-on-1 counseling, and chronic care management. Among those not well-suited were anything requiring a physical examination, procedures, residential services, and group therapy.

- **Parity with in-person visits**

In this theme, participants described their experiences with telehealth reimbursement – or lack of experiences – as well as the similarities and differences between in-person and telehealth services that could be considered in the development of telehealth policy.

- **Scheduling logistics and no-show rates**

In this theme, participants discussed the logistics of scheduling telehealth and in-person visits, including how they integrate into their normal workflows.

Several themes were interrelated, such as providers' telehealth platforms and HIT barriers, how telehealth could look post-COVID, and scheduling logistics.

The participants in this study conveyed that they are judicious in choosing what patients – and for what conditions – they will see via telehealth. Overall, participants' views of telehealth were positive, but they were pragmatic and measured. The clear consensus is that while telehealth is an important option for increasing access to care and improving patients' experiences with the health care system, it is not a cure-all.

STUDY DESIGN

This was a qualitative interview study that utilized purposive sampling to achieve maximum variation in participant professional experience. This means we strived to interview providers and administrators from a wide range of settings: primary and specialty care practices; hospitals and outpatient clinics; urban, suburban, and rural settings; and organizations that care for adult and pediatric populations.

At the conclusion of Phase 1, 82 survey respondents had self-identified as willing to participate in follow-up interviews. From that list, potential participants were divided into groups according to their professional association membership. The seven associations were: Association of Community Mental Health Centers of Kansas, Behavioral Health Association of Kansas, Community Care Network of Kansas, Kansas Academy of Family Physicians, Kansas Academy of Pediatrics, Kansas Association of Osteopathic Medicine, and the Kansas Hospital Association. Staff at these associations used the list of self-identified survey respondents and matched it to their membership lists. Out of 82 respondents, association staff were able to match 68 names to their rosters. The reason we utilized professional associations was to increase the odds that providers and administrators would agree to participate in our interviews.

Once potential participants were grouped by their association membership, they were randomly ordered within those groups. In most cases, the potential participant's professional association reached out and asked if the person would be willing to participate in a 45-minute interview via Zoom. If the person agreed, the professional association staff forwarded the message to the study team. In some cases, the professional association asked the study team to reach out to potential participants directly. If there was no response to the initial email and/or the scheduling email, we sent two follow-up emails. If there was still no response, or if the participant declined to participate, we moved on to the second potential participant from that professional association, and so on. As interviews were completed, we continually assessed whether we were reaching thematic saturation. After interview 12, we determined we were nearing saturation but were unsure whether we had achieved maximum variation in our sample. We conducted 2 more interviews, after which we were confident we had achieved our goals of maximum variation and thematic saturation.

All interviews were conducted via Zoom and recorded using Zoom's recording function. The audio files were professionally transcribed verbatim. Transcripts were uploaded to NVivo to facilitate analysis. Transcripts were inductively analyzed by a single coder (DH), meaning themes were allowed to emerge, rather than working from a pre-set list of themes.

RESULTS

Out of the 68 potential participants matched to professional association membership lists, 22 were contacted to participate in an interview. Of these, 1 declined to participate, and 7 did not respond. Because we reached maximum variation and thematic saturation, we did not continue to contact any more potential participants. Our final sample is comprised of 14 participants. Characteristics of our sample can be found in Table 1.

Taken together, the qualitative data from our provider and administrator interviews reflect a pragmatic outlook on telehealth. While participants generally stated that telehealth increases access to care, especially for those who face distance and mobility-related barriers, they also acknowledged a number of barriers to telehealth implementation on the provider and patient side. They offered many examples of health services that are well-suited to telehealth visits, and they also cited many services that cannot or should not be done via telehealth.

Table 1. Participant characteristics

Characteristic	N = 14 (100.0%)
Gender	
Female	7 (50.0%)
Male	7 (50.0%)
Type of professional	
Administrator	7 (50.0%)
Provider	7 (50.0%)
Geography	
Urban (RUCC 1-3)	6 (42.9%)
Rural (RUCC 4-9)	5 (35.7%)
Both (multi-site)	3 (21.4%)
Professional association represented	
Association of Community Mental Health Centers of Kansas	2 (14.3%)
Behavioral Health Association of Kansas	2 (14.3%)
Community Care Network of Kansas	2 (14.3%)
Kansas Academy of Family Physicians	2 (14.3%)
Kansas Academy of Pediatrics	2 (14.3%)
Kansas Association of Osteopathic Medicine	2 (14.3%)
Kansas Hospital Association	2 (14.3%)

Table 1 does not delineate whether participants were from primarily inpatient or outpatient organizations because there was too much overlap. Many participants offered perspectives relevant to both inpatient and outpatient services. For example, some outpatient behavioral health or substance use disorder (SUD) providers also had inpatient or residential components at their organizations. In addition, 1 outpatient organization was a Rural Health Clinic owned by a Critical Access Hospital. Still another provider was a hospitalist but works at a multi-site organization that includes outpatient clinics.

Table 2 is a comprehensive list of all primary and secondary themes with representative quotes. The primary themes are listed by how many interviewees brought up that theme (from largest to smallest), as are the secondary themes. All themes are discussed below.

Telehealth and access to healthcare

Access during the pandemic specifically

All but 1 participant discussed how telehealth had been helpful in providing patients with access to care during the pandemic. Most highlighted that telehealth volumes followed the COVID peaks and valleys, with higher volumes during times of high case numbers in their areas. Only a few participants talked about shutting down services entirely right at the beginning of the pandemic; most remained open throughout with a varying mix of in-person and telehealth services.

So, we always had a mix. Our clinic was open through the whole thing for patients who were healthy to come in. But we did have anybody who had ill symptoms do telemedicine.

-Urban/rural primary care physician

This is an example of a participant talking about making the switch to telehealth very quickly because of the pandemic, but this was not the only instance of a quick change:

But the COVID came and we just had to make that switch. So, we stood up a telehealth and a telephone treatment system in a matter of days. And just got with it. And so, most of our prescribers work from home over secure electronic means.

-Urban CMHC administrator

For some, the change to telehealth and decisions about its implementation were linked to specific aspects of the pandemic, such as limited testing and the unknowns about COVID-19 itself:

[E]arly in the pandemic [...] we had inadequate testing. [...] So, we kind of had to guess, and so the guessing made us uncertain whether that was safe to go into certain rooms [...]. So, we tried to do video chats with the parents, the caregivers, of our pediatric patients if we could, if we could manage that.

-Urban inpatient pediatrician

Several participants talked about patients' fear of COVID-19 as a driver of their telehealth volume:

[P]robably at the max we were doing ten or so telehealth visits a month. Now it's down to a few. And mostly those were used for patients who were too scared to come into the clinic, for the most part.

-Rural clinic administrator

Telehealth increases access

Of our 14 participants, 10 talked about how telehealth increases access to care. Almost all participants said they took new patients via telehealth, not only patients previously established at their organization or practice. Most talked about it as an important option, and some pointed out specific patient populations who could benefit, such as those without transportation, those who are homebound, those with social anxiety, and vulnerable populations who have not previously had access to telehealth services. For example:

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

In rural areas, geography and travels times were important facets of access, and these discussions were not always linked to a patient connecting to telehealth visits from home. The issue of work location came up as well:

So, when we think of a rural community, before telehealth, if somebody wanted to see our physician that prescribed psychiatric medicine, we had people that were driving an hour to do that. So, if that's an adult, typically in those little tiny towns, you don't work there. So, they already were driving somewhere else. [...] Now they can go to our office that's in that area and televideo to a prescriber that's here.

-Rural CMHC administrator

Participants were consistently pragmatic in their perspectives on how beneficial telehealth could be. They pointed out that while it may help some – and increase access overall – it is not always the right solution.

We've done some new patients. If someone is high risk [for COVID] and they call up and they need help for any reason we'll take care of them. It doesn't matter whether we've ever seen them or not. It depends on what the problem is.

-Rural primary care physician

The above physician took into account a person's current health status (whether they are at high-risk for COVID) and what their main reason for seeking care was in order to determine whether they could or should receive telehealth services.

Importance of patients accessing from home

10 of our participants also talked about the importance of patients being able to access telehealth visits from their homes. Not only did they mention that this is a convenient option that cuts down on patients' travel time, but they also discussed transportation issues and other circumstances

like juggling child care responsibilities or being on oxygen. Some participants also brought up that seeing a patient in their home setting can be beneficial as they consider treatment options. For example:

[I]f the people with challenged mobility would have a helper that could do their technology stuff for them, I mean, it certainly has some very good potential benefits for that homebound person if they've got someone to do that. It's kind of interesting. I like seeing what's behind them. You can kind of see a little bit of a glimpse into what their home is like, and so that kind of can be a good thing.
-Urban primary care physician

Another participant brought up the issue of safety during winter or other adverse weather situations, and they went on to say avoiding unsafe road conditions is beneficial for both patients and providers:

While we typically said it's telehealth is convenient during the pandemic, it also is convenient if the weather is cruddy. People don't have to get out in the snow and we can still continue services.
-Urban/rural SUD administrator

When it came to transportation, participants said that access to a vehicle is one thing, but sometimes patients or clients do not even have a driver's license. While possession of a valid license, a vehicle, or gas money seemed to vary, access to a smart phone seemed ubiquitous to this participant:

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. Go figure.
-Rural SUD administrator

This physician talked about the challenges that a mother with a new infant may face in trying to physically get to a doctor's appointment:

[T]here was one mom who had a question about her infant, and she was thrilled because she didn't have to wake him up from his nap. [...] It was a simple question. [...] She showed me what she was concerned about. He slept through the whole thing. You know, and then her whole day isn't messed up with her infant not getting the nap when he was supposed to.
-Urban/rural primary care physician

While an infant's nap may seem like a small thing to some people, for this new mother, it made a tremendous difference, according to our participant. Access to telehealth, from home, meant no barrier to care for the infant.

Low uptake of telehealth services

Two participants noted that they had experienced low uptake rates for telehealth services they offered. An administrator specified that they would like to increase their telehealth uptake:

We have not had a great uptake on telehealth. We're still working on that, because you know, we hear on a national level clinics [...] similar to us [...] in the height of the pandemic were seeing 80 or 90 percent of their visits as telehealth visits. And we have not achieved even 1 percent of our visits being telehealth. [...] there's some challenges that we've identified [...] and are working to try and resolve those quickly so that we can see more, have more telehealth visits.

-Urban CHC administrator

Another participant, a rural clinic administrator, said their volumes had followed the ebb and flow of COVID cases. They started offering telehealth in May or June of 2020, then had almost no telehealth visits each month until October. She said “it really started picking up” in October through December, but by the time of the interview (April 2021) volumes had dropped again.

It is important to note that there were many differences in perspectives on access that depended on the participant’s location, specialty, and patient population. Since we were able to interview inpatient and outpatient pediatricians, for example, we were able to understand how telehealth plays a role in working with children and families in both kinds of settings. The inpatient pediatrician was able to offer insights about connecting with other providers – including trainees in the hospital – as well as connecting with families and caregivers who may not have been able to be physically in the hospital with the child. The outpatient pediatrician, on the other hand, had more insights about the value of educating parents during telehealth visits, especially about concussions, and was able to talk about the potential health benefits of dialing in from home or school. In a similar vein, it was valuable to talk with primary care physicians and administrators who were located in urban as well as rural settings. For example, while rural settings may typically come to mind when we discuss transportation or travel time, these issues are present in urban settings as well. Telehealth had a role to play for all of our participants, but it looked slightly different in each participant’s specific situation.

Table 2. Primary and secondary themes with representative quotes

Primary theme	Secondary theme	Representative quote
Telehealth and access to healthcare 14 (100.0%)	Access during the pandemic specifically 13 (92.9%)	<i>Definitely during COVID it 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.</i> -Urban outpatient pediatrician
	Telehealth increases access 10 (71.4%)	<i>I know that [clinic], that's the federal clinic in [...], they're in about five or six counties now. In fact, I guess they're doing well over 90% of the primary care in those five counties. [... and] They use it [..], whenever they don't have access to psychiatry. I know that. And have for years.</i> -Rural primary care physician
	Importance of patients accessing from home 10 (71.4%)	<i>I do think being able to see behind the client in their home, to see the interactions that are going around and how chaotic it is, what does it look like, could [...] help with some insight into their situation. But I don't think that's true every time.</i> -Rural CMHC administrator
	Low uptake of telehealth services 2 (14.3%)	<i>Once it really started picking up, October, November, December [...] we were only 10 to 12 visits a month even during then, so it was never a huge piece for us. And now we're back to maybe three to five a month, so just kind of depending.</i> -Rural clinic administrator
Barriers to implementing telehealth vary 14 (100.0%)	Provider difficulties with platforms or HIT* 13 (92.9%)	<i>[T]he way that the telehealth format that we're using right now is set up is that only 1 person can log on. That doesn't match well with our typical appointment workflow.</i> -Urban CHC administrator
	Connectivity and device availability 13 (92.9%)	<i>But the biggest thing for us on the technical difficulties has just been internet connection problems. People's houses. Even in our building every once in a while, it's just bad.</i> -Urban outpatient pediatrician
	Cost to providers 12 (85.7%)	<i>[W]e had no laptops at all, and at the time that we ordered them, we still didn't have clear direction from the state. So, I went ahead and got laptops and set them up myself, which was a real learning curve for me.</i> -Rural SUD administrator

	Patients' "tech savviness" 7 (50.0%)	<i>[W]ith Medicare patients, we did a lot of telephone, because I got tired of playing IT tech person for a lot of elderly folks. And God bless them, the last thing they want to do, if you're talking about stress and anxiety with COVID, is have to mess around on a phone that you don't even know.</i> -Urban primary care physician
	Telehealth-related policies are sometimes cumbersome or unclear 7 (50.0%)	<i>When it first kind of came out, [...] I don't know if everybody quite understood what and how it was allowed and if you were truly going to get reimbursed.</i> -Rural CMHC administrator
	Communicating with patients about telehealth 5 (35.7%)	<i>That's what we're working on right now, is talking points for every point of the care team. And then even we want people at the end of an appointment to say, "hey, did you know your next...you could consider telehealth for your next visit?"</i> -Urban CHC administrator
	Cost to patients 5 (35.7%)	<i>[M]ost of our insurances are paying for telehealth, we have [a] major one in the area that does not, though. So, we have to be real careful [...] or the patient gets stuck with the bill."</i> -Urban-rural primary care physician
Looking ahead: telehealth's role post-COVID 14 (100.0%)	Continue telehealth reimbursement and supportive/enabling policies 12 (85.7%)	<i>It would be pretty tragic if we set up this entire infrastructure and then people change the way that they reimburse or said that this was no longer allowed.</i> -Urban CHC administrator
	Telehealth is here to stay 10 (71.4%)	<i>That telehealth component is always going to be there. It's not going to go away. It's been a big service to a lot of people.</i> -Rural SUD administrator
	Ways telehealth could be expanded 5 (35.7%)	<i>[There are eight or ten nursing homes where the only people who live there are people with mental illness. [...] there's really no payer system to get specialized mental health services counseling, case management, rehabilitation kind of programs. And so, could some of that be done electronically? Probably.</i> -Urban CMHC administrator

	The need for regulatory clarity and simplification 4 (28.6%)	<i>[W]e've got some questions ourselves about whether insurance would cover [certain] telehealth visits.</i> -Urban outpatient pediatrician
	Support reimbursement for audio-only visits 3 (21.4%)	<i>I would love to be able to bill for audio only, which right now we still can't.</i> -Urban-rural primary care physician
What can and cannot be done via telehealth 14 (100.0%)	What telehealth is good for 13 (92.9%)	<i>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.</i> -Rural primary care provider
	What in-person is good for (or telehealth is not) 12 (85.7%)	<i>You know, I can't do joints over the phone because I can't manipulate those to see what's going on with them.</i> -Urban-rural primary care provider
Parity with in-person visits 13 (92.9%)	Payment parity and comments on payors 9 (64.3%)	<i>Obviously, the payment issues with Medicare come up, especially when we're talking to other rural health clinics. And I do feel like as we've gone on maybe that has lessened as far as the concerns from the providers.</i> -Rural clinic administrator
	Similarities with in-person visits 6 (42.9%)	<i>I think it's pretty comparable because we're providing all the same touch points in a visit.</i> -Urban CHC administrator
	Lack of knowledge about billing and reimbursement 6 (42.9%)	<i>[Billing staff] take care of it, [...] we [physicians] always ask for a little more clarity. Are we charging the right things? Are we putting the right things in our notes? But I don't think we get enough feedback, which has been something we've been saying for years.</i> -Urban outpatient pediatrician
	Differences from in-person visits 3 (21.4%)	<i>[D]efinitely the thoroughness and the quality of care that we've been able to give or that patients have been able to receive over the last year has been markedly decreased.</i> -Rural primary care physician
Scheduling logistics and no-show rates 12 (85.7%)	No secondary themes	<i>But overall we've had pretty good success with the show rate for telemed, we really have. Early on we identified some glitches here and there. And that was more just technical, learn the system, ironing them out.</i> -Urban-rural CHC physician

Barriers to implementing telehealth vary

The barriers to telehealth implementation varied from participant to participant. The differences hinged mainly on their practice or organization's characteristics, such as their specialty, patient population served, and geographic location. Some barriers, though, were universal, such as occasional provider resistance to technological changes and challenges with patients' "tech savviness."

Provider difficulties with platforms or HIT

Participants used a range of platforms to deliver telehealth services. Some used Zoom, Google Meet, or Microsoft Teams, while others had service through their electronic medical record (EMR). Difficulties in this secondary theme included: a desire for different functionalities in the platform they have; the platform is too complicated, or it is too complicated to integrate into existing information systems; platforms required training, which providers sometimes resisted; patients had to learn the platform; and there was occasional resistance to any kind of expansion of health information technology (HIT).

[T]here was an initial telemedicine platform [before COVID]. It was like very few people had access to it and I think it probably cost per physician or something like that. [...] [W]hen the sort of deregulation of the telehealth stuff happened, they just used Teams.

-Urban outpatient pediatrician

An urban inpatient pediatrician said, "I think it would be great if we had a platform that was easier to use and more user-friendly." The kind of functionalities that administrators and providers described needing were: using two screens, one for the video and one to look at the medical record; integrating consent forms into an electronic process; and allowing multiple providers, such as nurses and medical assistants, to dial into the same telehealth visits before or with physicians. For example:

Probably the biggest challenge was the forms that we needed to change or edit. [...] We use Google Meet for our platform, and that was something that the agency had been using before. So it just was training our clinicians on how to use that format.

-Urban/rural SUD administrator

Participants talked about their EMRs and their telehealth platforms together, even if the two were not actually integrated. This speaks to the important role both systems play and how crucial electronic and online systems have become to delivering healthcare services. The fact that these two pieces – EMR and telehealth – are intertwined is also relevant to provider costs (see the "Cost to providers" secondary theme, below).

Connectivity and device availability

All but 1 participant discussed barriers to telehealth related to internet connectivity, device types, and device availability. This quotation summarizes well the combined concerns about connectivity and devices:

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 the...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

Participants also drew attention to patients' different living arrangements and the limitations some faced if they were in nursing homes:

Some [the barrier was] their living arrangements. They live in the residential care center, and they didn't have access there. You know, the technology just wasn't there. And then in other cases, they didn't have the telephone or the internet access just individually.

-Urban/rural SUD administrator

A few participants said they or their organizations took it upon themselves to try and overcome these barriers. Some provided devices, and others tried providing Wi-Fi hot spots.

A lot of our folks don't have bandwidth. They don't have connectivity. They don't have any devices at all. So, we've been able to buy them a cell phone or get them a flip phone or help them get connectivity in some way, in addition to trying to see them in person.

-Urban CMHC administrator

Another example of providing devices appeared in an outpatient program run by a rural hospital:

[O]ur group personally owns [the devices] and we rented them out to them, not for them to keep, but we did have them sign a paper, keeping it in their chart that they will return that to us.

-Rural hospital administrator

These technology-related issues often came up when participants were asked, "If you could change one thing about telehealth, what would that be?" One urban primary care physician said, "I would make it work all the time." The lack of access to a reliable internet connection, devices with sufficient audiovisual capabilities, and the lack of reliability in telehealth systems broadly were consistent problems discussed by our participants. For those who tried to provide connectivity and/or devices to patients, that added to the costs they incurred to make telehealth services available (again, see "Cost to providers" secondary theme, below).

Cost to providers

The cost to providers of implementing telehealth were multi-faceted. Most incurred start-up costs at the beginning of the pandemic that included purchases of equipment. Most also had to start paying for some kind of teleconferencing platform, and a few received assistance with that through their accountable care organizations (ACO). On an ongoing basis, our participants face monthly or annual service/subscription or software license costs and technology-related maintenance costs, such as on their network, servers, or equipment. One participant summed up these factors by saying:

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

A rural SUD administrator talked about the initial startup costs this way, “[W]e spent a fair pile of money that we didn't have. We're not a big facility at all. In fact, we laugh about being mom and pop all the time. But that's what it is. We're the only help people had for quite a distance.” They went on to talk about future costs:

The biggest maintenance cost is going to be keeping our computers updated. [...] other than paying for the secure video, it's more than paid for itself. I can tell you that. So far, we haven't had to replace any more computers. I'm sure I'm going to have to rotate them out every year or two at least. The new stuff today is going to be obsolete in a year.

-Rural SUD administrator

Another participant had a similar take on future costs:

When they come along and need a secure system and we put in all of the safeguards that we always seem to have to do anymore I have a feeling that the cost is going to skyrocket. And then the little clinics are going to get squeezed out, I think. That would be me, because I'm a little clinic.

-Rural primary care physician

Some participants noted they had received financial assistance through COVID-related federal funds; however, they also knew that was not a permanent solution. As the quotes above reflect, participants know there will be ongoing costs to continue offering telehealth services.

Patients' tech savviness

Half our participants discussed patients' “tech savviness” as a barrier to telehealth use. Some noted that older patients struggled more with technology, but others said struggles were not age-specific. Some wanted to see the telehealth process become easier for patients, though one said, “it's pretty simple, so I'm not sure how we're going to make it any easier.” Another shared:

It would be nice if they had the same technology. Everybody had the same type of equipment so that we're not trying to explain to somebody, "Well, on my machine, here's where you go." [...] because not everybody is tech savvy.

-Urban-rural SUD administrator

Another participant talked about walking patients through the process of connecting to a telehealth visit:

[W]e always had to reassure them that there's not an app you have to download, it's a web-based program. You basically have to do two clicks. We send you a text. And so that was probably the biggest hesitancy. It had to do with logistics and tech. They were actually receptive and happy they could see me and relieved they didn't have to expose themselves and come to the clinic.

-Urban primary care provider

Telehealth-related policies are sometimes cumbersome or unclear

Half of our participants talked about cumbersome public policies that hindered a smooth adoption of telehealth or were ongoing concerns. Some of these discussions revolved around regulations that had been temporarily lifted because of COVID, and participants were unsure whether those changes would be permanent or not.

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

In other cases, participants talked about adapting to telehealth-related billing and coding policies:

Once we figured out the language of the coding—there was a lot of uncertainty in the first month or two, especially as it relates to private insurance versus Medicare.

-Urban primary care physician

Still others said they were operating under antiquated regulations not designed to include telehealth.

[O]ur state standards for SUD providers had not been updated since 2006. And in 2006, they never dreamed of telehealth.

-Rural SUD administrator

Communicating with patients about telehealth

Only 5 of our participants talked about the complexities of communication with patients about telehealth options. These discussions included educating patients about what can and cannot be done via telehealth, what their expectations should be for a telehealth visit, how the telehealth platforms work, and why telehealth was being offered.

For example, one physician described her organization's process this way:

I think that that was really key for the success at least of our program, was giving the patient almost like a screen shot directional sheet of, "This is what you should see, this is what you do next," very basic, very step by step. And [for patients] to know that somebody was going to call them ahead of time and go over it with them so that if there are any glitches everything was going to be ironed out ahead of time. And so, I think those were probably the two selling points for patients, just that they knew that they weren't thrown into the fire and expected to survive.
-Urban-rural CHC primary care physician

While that participant felt their organization had figured out what to communicate to patients and when, others were far less comfortable with their communication processes and wanted to work on improving them in the future.

Cost to patients

As with providers, the potential costs to patients relative to telehealth are both on the insurance coverage side and on the technology (connectivity and devices) side. 5 participants discussed the cost of telehealth to patients.

Another participant talked about potential device-related costs:

[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

In that situation, potential patient costs are also tied into the previous themes regarding tech savviness and platform complexities. This was one way in which we found our themes were interrelated.

Looking ahead: Telehealth's role post-COVID

Most participants had not done any telehealth prior to the pandemic, and several specifically cited the lack of reimbursement in the past as the reason. Most also said there had not previously been demand from patients for telehealth services, but now that they are available, our participants are largely in support of policies to continue telehealth and believe it is here to stay. All of our participants offered perspectives on what telehealth might look like going forward; they discussed relevant public policies and how telehealth could change or expand going forward.

Continue telehealth reimbursement and supportive/enabling policies

12 out of our 14 participants discussed wanting to continue reimbursement for telehealth services or other public policies that they support in order to continue making telehealth services feasible. Participants were pragmatic in their outlook on policies, and they understand that telehealth is not one-size-fits-all. Telehealth models may vary, and therefore reimbursement and policies may vary depending on the model a provider uses. For example:

I think it kind of depends on which model you use. [...] if they can do it from their home, there probably should be a different price point or a different cost. I don't know exactly what those numbers should be because I really don't know the specifics. But that would make sense to me, that it would be a little bit different.
-Urban outpatient pediatrician

One participant offered an insight that they felt applied to medicine broadly, not only to their specialty, regarding the costs of infrastructure and services going forward:

[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

A couple participants talked about public insurance specifically, for example:

Medicaid is like 75 percent of our fee revenue. [...] So, any little wiggle up or down, we feast or famine. So, part of our...the degree of our electronic interventions and treatment will be dependent upon public policy.
-Urban CMHC administrator

Others branched out beyond reimbursement and talked about other public policies, like licensing, that pertain to delivering telehealth services:

[M]y understanding is that it's where the patient resides that I have to have that license. It doesn't matter where I am. As a provider I could be anywhere. But if

I'm working with a patient in Kansas, I have to have a Kansas license. Compacts will help improve that. So, I think that's going to be a part of telemedicine that we need to keep an eye on and support.

-Rural hospital administrator

Again, the key takeaway regarding public policies going forward is that providers and administrators were pragmatic. They want to find a path forward that allows them to continue providing services at a reasonable cost to them and to payors, without unnecessary red tape or other bureaucratic barriers.

Telehealth is here to stay

10 participants talked about telehealth being here to stay. One participant stated succinctly, "It's part of our fabric now," referring to telehealth (Urban CMHC administrator). Participants were pragmatic in this secondary theme as well, as they were with reimbursement and public policies.

One primary care physician said that telehealth can be mutually beneficial for providers and patients alike, although they do not want to do telehealth for every visit:

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

Another physician said that while telehealth is here to stay, it is also important to continue educating patients about what is feasible, and the technology needs to continue to improve:

I think it's a tool that patients are going to demand in the long run. [...] I think the demand will stay. [...] And I think as long as people are realistic about what we can and cannot do on it, I think that's it. And then it's just going to be getting the technology better so that it more consistently works like it's supposed to.

-Urban primary care physician

On a different note, one administrator pointed out that telehealth will allow their organization, as an employer, to handle employee health and safety better.

We're always told [before COVID], "if you just have a cold, come to work. You're fine." And now it's like, "you have a sniffle? Stay away." So, I think that's probably the biggest thing that we would probably continue to monitor individual and staff's physical health to make sure that they're not spreading any communicable disease.

-Urban-rural SUD administrator

Ways telehealth could be expanded

5 of our participants offered some ideas about how telehealth services could be altered or expanded with brief explanations. In short, these ideas were:

- Remote monitoring devices
- Greater use of school-based telehealth
- Providing mental health services in nursing homes
- Greater utilization of image- and video-clip-sharing

The need for regulatory clarity and simplification

Depending on their organization or practice's characteristics, the 4 participants represented in this secondary theme cited different concerns regarding telehealth regulations going forward. For example, mental health and SUD providers want to be sure that they are not overly burdened with telehealth-related paperwork and treated too differently from other types of providers in the future. Also, an urban outpatient pediatrician sought clarity about regulations around school-based health and whether they can be reimbursed for telehealth services that have a provider present on both ends of the call.

When asked what policy changes they would like to see, 1 urban-rural CHC physician stated, "Just it being an accepted form of practice going beyond the pandemic without all the red tape and all of that, that it would be an open and accepted form of...a tool in your tool box that you could use ongoing." That sentiment is an excellent summary of this secondary theme overall.

Support reimbursement for audio-only visits

3 of our participants talked about the need for audio-only visits. 2 of them spoke generally about this, saying that physicians giving medical advice or providing medication education is work that should be compensated. The third participant brought up the potential dangers of the internet for certain patient populations:

[S]ome of our folks just can't have computers. [...] there are people with some kinds of mental illnesses that access to the internet could be a problem for them. And maybe their paranoia or their fears, or their vulnerabilities. We have to consider how vulnerable people are with a mental disability to some forms of abuse or manipulation or identity theft.

-Urban CMHC administrator

When considering reimbursement policies, like whether to pay for audio-only visits, it is important to keep in mind all patient populations and how specific health conditions could pertain to the telehealth modality.

What can and cannot be done via telehealth

What works well via telehealth

All but 1 of our participants (13) discussed the kinds of services that are well-suited to telehealth. First, we will provide a list of the services mentioned throughout our interviews, then we will give a few illustrative quotes.

Services that work well:

- Basic triage, including with emergency dental and optometry services
- Transitions of care, post-hospitalization
- Quick follow-ups
- Reviewing laboratory or radiology results
- Patient education
- Medication follow-ups
- 1-on-1 counseling by mental health and SUD providers
- Mental health follow-ups by primary care physicians
- Reviewing care with family members who could not be present with the patient
- ADD check-ups
- Initial, brief assessments
- Chronic care management
- Interpretation of imaging (having a remote radiologist)

Patient education:

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

Basic triage:

Actually, surprisingly most of the smartphones are now good enough that I can actually look in throats. Yeah. I've been amazed. There's a few people out there who still have the old stuff and I can't see anything in there, but I'm like, "turn your light on and hold it up to your kid's throat." It's as good or better than looking at it in the office.

-Urban-rural primary care physician

Individual SUD-related counseling sessions:

We're still doing straight telehealth at this point. Individual sessions, it's easy. It works pretty good.

-Rural SUD administrator

Mental health follow-ups:

[W]e tried to use it more for mental health and follow-ups that way. We

proactively started calling patients, just checking in to make sure they were okay.
-Urban primary care physician

Chronic care management and medication refills:

The patients that we know that are, say, hypertensive patients and they need to have routine medication refills, they have a blood pressure cuff at home. They can take their own blood pressure. We can very accurately tell whether the medicine is working or not, because I think these automatic blood pressure cuffs, that's a no-brainer, they're going to be fine.

-Rural primary care physician

What does not work well via telehealth

Participants were clear that services that required them to physically examine patients could not be done via telehealth. These included any symptoms or illnesses that necessitated palpations or joint manipulations. Also, any exam that required specialized instruments, like an otoscope for looking into ears, could not be done. While patients do have access to some medical devices at home, like scales and blood pressure cuffs, providers still have access in their offices to far more tools for diagnosis and treatment. We list here some services participants said did not work well via telehealth, follow by a few illustrative quotes.

What does not work well via telehealth:

- Anything that needs to be a physical exam
- Procedures
- Detox services
- Residential services
- Injectable medications
- Wrap-around services like an employment support program
- Group therapy (dynamics are different, usually not as productive)
- Hospital-based specialties
- New complaints that have the potential to imminently become emergencies (beyond basic triage)

Physical exams:

So, people still want to come in person. They want us to get our hands on them, see their swollen knee, and all that kind of stuff. And I like that, too. So, the initial visit, I still kind of like doing that in person.

-Urban outpatient pediatrician

Group therapy:

We had stop smoking groups and some pain clinic groups. So, we just can't...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

Hospital-based specialties:

[I]f it's a hospitalized patient, I normally need to do a pretty thorough exam. One, because these are sick children, or else they would not be on my service.

-Urban inpatient pediatrician

New complaints that have the potential to imminently become emergencies:

[W]hen someone calls up with a new complaint, particularly involving pain or shortness of breath or bleeding, acute emergency room types things, or they potentially could evolve into an emergency, we do a lousy job of caring for that [via telehealth].

-Rural primary care physician

Parity with in-person visits

In this secondary theme, participants discussed their experiences with reimbursement for telehealth services and, in some cases, experiences with specific payors. Overall, most participants said they were currently being paid for telehealth services on-par with in-person visits; however, several admitted they did not know much about billing and reimbursement at their organizations. They also discussed how the logistics of telehealth and in-person visits were similar in some ways and different in others and in their eyes necessitating similar or different compensation.

Of note, 1 physician brought up the fact that their practice competes with other “teledoc” services. They maintained that if providers like those interviewed cannot get reimbursed for telemedicine services, patients may use alternatives that are cheaper and more disconnected, resulting in a loss of continuity of care and movement away from patients having a regular medical home.

Payment parity and comments on payors

The overall experience with telehealth reimbursement seems to be that at the beginning of the pandemic, there was confusion, but eventually policies became more clear, and now, there is payment parity. Our participants recognized for the most part that this could be temporary, though, depending on policy choices made when the pandemic is declared over. 1 participant talked about the Medicaid management care organizations (MCOs) at the beginning of the pandemic this way:

[W]e had all kinds of problems with the MCOs trying to get them to pay. We ended up fighting to get reimbursements. We probably went through...we went through at least a month and a half of having to fight before we could finally get reimbursed for that past month and a half.

-Rural SUD administrator

Then another participant acknowledged that reimbursement is currently the same for in-person and telehealth visits:

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

For some participants, some insurers are more important than others. Rural areas tend to have a higher percentage of the population covered by Medicare, as reflected in this statement:

And most of ours [patients] are Medicare based [...]. And that's the thing about our [rehabilitation] program, is that it's an expensive program, but their secondary insurances always pick up what Medicare doesn't pay. We haven't had any trouble with that.

-Rural hospital administrator

Another rural participant mentioned Blue Cross Blue Shield as their dominant payor:

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

Offering a slightly contrasting view, a physician expressed skepticism about insurance companies' willingness to reimburse services for any reason other than financial reasons:

I think insurance companies are all about saving money, so if they think that this is going to be a less expensive thing for them then I think they'll be in favor of it, and if they think it's going to cost them more money they're going to be opposed to it. That's my own bias about insurance.

-Urban primary care physician

Similarities with in-person visits

Several of our participants (6) said that the logistics of telehealth and in-person visit costs were largely similar. Some went to far as to say they were basically equivalent in costs because providers are in a hybrid setup; none are exclusively doing telehealth, so they still have overhead costs and have to pay staff.

As these quotes demonstrate, experiences in this secondary theme are remarkably alike:

I think it's pretty comparable because we're providing all the same touch points in a visit.

-Urban CHC administrator

[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

Really, we still have to open the doors. We still have to be here, and we still have to pay the overhead.

-Rural SUD administrator

I think one of our biggest struggles with that is it really doesn't cost us any less to do these visits. It takes the same amount of staff time to schedule it [...]. We do the same intake on the patient, so we're not taking vitals, but they still are checking meds and doing a depression screening and a fall risk and all those other things that we would do in a normal visit.

-Rural clinic administrator

Lack of knowledge about billing and reimbursement

Of the 6 participants who expressed a lack of knowledge about telehealth billing and reimbursement, 5 were providers who were insulated from administrative processes by their organization's structure, and 1 was an administrator who has a billing department responsible for these issues. The quotes in this secondary theme are not particularly illuminating but are available upon request. One quote is located in Table 2.

Differences from in-person visits

3 of our participants noted differences between in-person and telehealth visits. 2 people noted that either payors are approaching reimbursement differently or they are being reimbursed less for telehealth visits. 1 person had concerns about telehealth visits potentially being of lower quality than in-person care. As in the previous secondary theme, the quotes available are not notable but are available upon request. One quote is located in Table 2.

Scheduling logistics and no-show rates

12 of our participants discussed the logistics of scheduling telehealth visits and how that fit into their normal workflows. This theme also includes discussions of no-show rates for telehealth visits compared to in-person. There were no secondary themes.

1 participant, whose organization faced low telehealth uptake, said, "We have some workflow challenges like...well, it's very hard for a provider to transition between in-person and telehealth visits" (Urban CHC administrator). They followed up by saying that the only reason for no-shows is if the person had issues with connectivity. That was a consistent message across participants; most said their no-show rates for telehealth were better than for in-person visits.

Another participant experienced smooth transitions between telehealth and in-person visits. They described this process as follows:

So, we schedule them in the schedule just as if they're going to be an in-person visit. [...] I go room to room, and if it's a telehealth visit, then my staff just puts the computer in that room with the patient up on the screen. So, they're basically sitting in the room waiting just like they would [in-person]. And there's a ticket in the door and I knock on the door just like I do for any other, and my staff laughs at me because there's no one in the room. [...] and so, it just flows like it's part of the normal day. And it works really well.

-Urban-rural primary care physician

That kind of process seemed to be the most successful in terms of efficiency, among all the processes described by interviewees. Some had tried blocking off several hours at a time for telehealth visits, and for some it worked well but for others it did not, and it was unclear why.

Another participant said that telehealth allowed their organization to turn what would have been a no-show in-person visit into a realized telehealth visit:

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?" And a lot of them did. [...] now I can catch them a lot easier and we can fill that.

-Rural CMHC administrator

The other aspect of scheduling telehealth visits, though, was building in tech support time:

The way we've set it up, we actually have one of our call center staff talking to the patient the day before, and she will go through with them in great detail how to use Zoom, [...], here's your instructions, let's practice, that sort of thing, so there's truly almost like a mock visit before the actual visit happens. And so that's nice. It helps the provider. But it's also time consuming from a staff standpoint.

-Urban-rural CHC physician

FUTURE DIRECTIONS

We will be conducting focus groups with patients around the state in the coming months, striving again to achieve maximum variation in our sampling. We are seeking input from patients of all ages, races, ethnicities, and geographies in an effort to understand the full range of experiences with telehealth services. We recognize that one of the themes raised here – device availability – is at the heart of any future research on telehealth. If a person does not have a device and has not been able to participate in telehealth, then research conducted virtually is likely inaccessible as well. We and other researchers need to give careful thought to how we reach vulnerable populations safely, as we come out of the pandemic, as we continue to investigate access to care and, more specifically, access to telehealth care services.