Telehealth at Yet Another Cros... Present and Potential Futures

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Aria Javidan
hello everyone. My name is Aria Javidan, and I'm the project manager for the National Consortium of telehealth resource centers. Welcome to today's webinar, telehealth at yet another Crossroads analysis of our present and potential futures. Today's webinar is hosted by the Great Plains telehealth resource and Assistance Center. These webinars are designed to provide timely information and demonstrations to support and guide the development of your telehealth programs, just to provide a little bit of background on the consortium. Located throughout the country, there are 12 regional telehealth resource centers and two national one focused on telehealth policy and the other on telehealth technology assessment. Each serve as focal points for advancing the effective use of telehealth and supporting access to tele services in rural and underserved communities. And then a few tips. Before we get started today, your audio has been muted. Please use the Q and A function of the Zoom platform to ask questions. Questions will be answered at the end of the presentation. Please only use the chat feature for communicating issues with technology or communication access issues. Please refrain using the chat feature to ask questions or make comments. Please note that closed captioning is available and that is located at the bottom of your screen. Today's webinar is also being recorded, and you will be able to access today's and past webinars on the nctrc YouTube channel and the nctrc website at telehealth resource center.org. With that, I will pass it over to Jonathan Neufeld, director of the Great Plains telehealth resource and Assistance Center.

Jonathan Neufeld
All right. Thank you, Aria. I am going to share just a couple of slides to get us going here, through our introductions, and then we're going to do most of this webinar slide free. As ARIA said, We are the Great Plains telehealth resource and Assistance Center. We're at the University of Minnesota. We it's our turn to host this national webinar series that all of the TRCs do. As you saw the map that he put out. We, like all the TRCs, host a lot of information on our website. Would love you to check it out sometime. But let's, let's get started in our conversation here. I'd like us to have as much time as possible, and so I will start to just, I'll give you a little overview of what we want to talk about here, or what we intend to talk about now. We could end up talking about a lot of things in addition, or as well other than these, but we want to just set a little bit of a stage of how we got here, because there, there, there is some history here, and it's and it's not just you know one thing after another that you know this happens to have happened first, but there are reasons why we're kind of in the bind that we are in the world of telehealth. And so we just want to touch on that a little bit, give you a little sense of what that is, where that comes from. Talk a little bit about the rapid transition that we all went through. Because for a lot of people, that was the beginning of telehealth. It's not for those of us who've been in the field a little longer, but it is. It wasn't a formative, a major formative experience. Maybe, maybe you can call it

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telehealth. Adolescents are coming of age. But then we'll talk a bit about permanent policies, current current current policies, and what's happening in the world of permanent policies, as well as flexibilities, as you all know, and we'll probably say this a couple times, the temporary flexibilities have been kicked down the road that can has been kicked down the road six months, but it will it still is there like it has been. So we're going to talk about some of the effects of that ongoing situation on providers. All right, so I want to introduce some folks here. You have got an incredible group of people to hear from today. First is Karen Rubin. Karen is from the University of Virginia. She's pediatric cardiologist, researcher, Administrator, former president of the American Telemedicine Association. She's current director of the UVA center for telehealth, which does over 100,000 direct encounters in over 60 specialties every year. Karen goes back to that generation of telehealth leaders that brought us from the what I call the pre 1834 period into the modern era. It is not 1834 the year, but 1834 the Code of Federal Regulations. Sorry, Karen, and I appreciate the sensitivity there. I'm in that boat as well, but it's from where it's it's from the federal regulation that established telehealth, and we are in some ways still beholden to that. It was in 1997 the first time, and then modified in 2000 and we haven't had much movement since. So we'll look, I'm looking forward, and my first question is going to be to you, Karen, about where this a little bit about where we started, but I want to get through my introductions first. So safe karat is the is an informaticist and researcher at the University of North Carolina at Chapel Hill. There, he directs the Vive center, Research Center at UNC that focuses, focuses on advancing virtual care research to improve healthcare access and opportunity for patients across the healthcare spectrum, doing some fantastic work there. He's also a graduate of the University of Minnesota Institute for Health Informatics, where I currently work, and where GP track is hosted. And in fact, safe has some history with our program as well while he was here, and so that's where we first met, though that was before I came to the center. Thank you for joining us today. Also safe and then Nikki parach, I want to introduce Nikki parishau. She is a critical care nurse and a health policy student at UC Berkeley, director of the Northwest Regional telehealth research telehealth Resource Center at the University of Utah, Nikki previously led a rural hospital telehealth program in Montana, speaks widely on the needs of perspectives of rural populations, specifically with regard to telehealth and virtual care. Welcome and thank you for joining us. Also. Nikki Aria, did I just heard that the recording stopped? Is that correct? Do we need to do anything about that? Oh, no, I got it all right. Thanks. We will continue on. Oh, lastly, that's me. I'm a clinical psychologist, the director of the telehealth Resource Center at GP track, the great plain telehealth resource and System Center at the University of Minnesota. All right, so let's stop the share, and let's talk about where we are and where telehealth is at this crossroads, today's crossroads, I want to start with some context. We won't spend a lot of time, but I think it's important. Dr Rubin, can you get us started and tell us a little bit about the original vision and intent of the Medicare statute and the context in which it was crafted. Okay,

Karen Rheuban

well, thank you. Thank you so much, Jonathan for inviting me to join I do represent the Mid Atlantic telehealth Resource Center with my wonderful colleague, Kathy wiberly, who's our amazing executive director. And yes, I wasn't born in 1834 but I will say I feel like I have been a road warrior in this process. So we at UVA began our telemedicine program in the early 1990s when there was zero reimbursement, and it was kind of a brave new world. So back then, there was again no reimbursement. We petitioned Virginia Medicaid for coverage, recognizing that Medicaid covered transportation. And we thought, you know, why not? At least use that that's not necessarily the same

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for Medicare. And there had been some pilot programs by a number of Medicaid programs and a few hicfa health. The hiccup was Medicare before it was Medicare demonstration projects, but the Balanced Budget Amendment that you alluded to in 1997 provided a limited on ramp for Medicare coverage of telemedicine services, and we were so excited to get anything back then right, but that legislation required that hicc Establish reimbursable mechanisms for telemedicine services delivered to Health Professional Shortage Areas by January 1, 1999 and authorized $27 million to fund these demonstration projects, it was restricted and required Medicare practitioners to actually be there with a patient and serve as a tele presenter, physically located at a rural healthcare facility. Only certain types of healthcare facilities as the originating site and the distant site practitioner would be reimbursed, and had to share the fee with the originating site practitioner and all other aspects of healthcare. Fee splitting is not allowed. No asynchronous services were permitted. And by 2000 Medicare reported payments of only $14,000 nationwide for telemedicine services. So fast forward to 2000 then BIPA 2000 and Joe Tracy and I, and I forget who else was with us, had the privilege of testifying at the BIPA house hearings. And that amended 1830 4m and expanded Medicare coverage a bit. So it expanded eligible geographic areas from rural hips is to include counties that were non MSAs. It eliminated the telepresenter requirements and enabled an originating site fee because they felt appropriately funds should also go to the originating site, and eliminated the challenges of fee splitting. But asynchronous services were not permitted, other than for Alaska and Hawaii, and they expanded the covered services and identified specific eligible providers. You know, subsequent to that, and we can talk about that, but there were other bills that codified expansion beyond the service services that were codified in BIPA, like the FAST Act, the support act, and others. But it really wasn't until the public health emergency that we really saw the promise of telemedicine actually effectuated. So that's sort of a historical perspective for everyone. Yeah,

Jonathan Neufeld
yeah. And it, I think it was, the main characteristics of telehealth back then is, basically it was, it was conceptualized as a specialty center somewhere, a rural site somewhere, where the patient would be presented by somebody, or at least hosted by a staff, presented to a provider, the provider would get paid. Originating site gets a little bit for their trouble to keep the lights on, whatever and and that's really what telehealth was. I mean, at the time, we had no internet. You, we were paying, I don't know about you, but when I was UC Davis, we were paying $1 a minute for our connectivity. So nobody's going to make any money on this, and certainly the patient's home and audio only telephone, none of that that was specifically ruled out.

Karen Rheuban
Yeah, I might also add, though, you know, one of the things that was really helpful another piece of federal legislation was the Telecommunications Act, right of 1996 that helped us get discounts to connect these facilities. You know, you're paying $1 a minute. We were being charged $6,000 a month for a 1.54 megabit connection to a rural community hospital. So, you know, there were a lot of things that needed to happen back then in order to enable and the devices. You know, the endpoints were really expensive, 150,000 you know, who would be incentivized to do this, especially in the climate of non reimbursement, right,

Jonathan Neufeld

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right? Or even conceive of doing it from home? Yeah, correct. So I think what? And so as as we've people have talked about technology sort of continue to pace, but the rule kind of stuck there until the pandemic, right until public health emergency, and impacted it impacted so many things, and I'm just wondering, so let's, let's spend just a little time talking about that. I want to go to Nikki Nikki tell us about. And I know we all have stories about transition. You know, people who stood up telehealth over the weekend or stood up in a week during the early parts of the of the public health emergency and the pandemic, tell us a little bit about some of your experience with experiences with that, and how, how people were just basically coming alive to the idea of telemedicine so much In 2020

Nicki Perisho
Yeah. Thanks Jonathan for that question. It's actually giving me a little some palpitations, bringing back some of that real time moment and just anxiety and excitement and all of the things that we were feeling back in 2020. At the time, I was running a telehealth department in a regional hospital in northwestern Montana, and we were very fortunate to have been involved in specialty telehealth. We had a very strong telestroke program. We had a tele NICU, a telepeds. So we had our specialist at least knowing what telehealth was, utilizing, telehealth, utilizing, you know, the devices, the endpoints and the the cameras and so very small part of our, you know, the hospital organization. So when the pandemic hit, I remember two things instantly coming to mind. One is, it was a Sunday morning, and I got called into the hospital for an administrative meeting. And I looked at my husband, I said, this is not good. I do not get called into the hot lake. I am not one of the key players to get called into the hospital. And the second thing is a good friend of mine who's a trauma surgeon, she said, You know what, Nikki, it's like, you went from selling liver reverse sandwiches to BLTs. Because prior to the pandemic, when a provider would see me walking down the hallway, they would do a 360 so quick, because they knew I was going to talk to talk to them about telehealth and how they should really invest in telehealth and learn more, because it would help our patients get access to care, because we have big mountains and we have long roads and just like all of the Northwest regions, so many barriers to getting access to care. So what I really remember the most, though, is getting together a team to bring all of the ambulatory clinics and primary care providers on video within like three days to see some of their critically ill patients, those with chronic disease that needed frequent updates, that couldn't come into the clinic, and putting, you know, quickly Putting workflows into place in training office staff, from front office to Ma's to nurses, and then the physicians themselves, having one on ones with the physicians, and training walking through how to use the technology and the importance of eye contact with the patient and the Video, and just feeling fortunate that our organization had been forward thinking and supportive enough to invest in telehealth with the specialty programs so we weren't starting from scratch, because I think there were a lot of entities out there that were starting from scratch and had to lean on vendors and other methods to bring the education to their providers.

Jonathan Neufeld
Yeah, yeah. I know we were, I was in the middle of a telehealth demonstration and research project with some primary care clinics across the Northwest and across the upper the Great Plains region Minnesota and North Dakota, and they, they they said, oh my goodness, the thing that saved us is that we've been working on this for a year already, with you, with us, you know, with the with the team, so that they weren't caught totally off guard. Yeah, the folks who had to start from zero, I'm sure, had it

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even worse, safe. Tell us. Tell us about some of the transitional stories that that you came across in your work?

Saif Khairat
Sure. Yeah, thank you, Jonathan, for having me on this exciting panel. Yeah, it was definitely, I'd say, traumatizing times that also brings palpitation to my heart. I guess one of the fondest memories or stories is the time when during the pandemic, UNT is a public institution, and it is it has a contract with North Carolina DHHS to provide care for correctional facilities. And at the height of the pandemic, providers did not want to go to correct correctional facilities anymore because it was the number of COVID 19 cases at the time was just skyrocketing, and we, you know, somehow I found an email saying, we need to, we need your, you know, we need to be part of the team. And so I got called on and started participating in this design thinking workshop, I feel like with DHHS and people in the department of public safety and we quickly stood up a telehealth system that allows UNT providers to offer care to incarcerated individuals. Of course, deep down, I was thinking, this may be killing my career in telehealth, because the outcomes may not be positive. I was coming at this from the hypothesis that incarcerated individuals, their chance of getting fresh air to be outside of the facility is that time when they go seek care, and so they're probably going to resist wanting to use telehealth and basically kill the whole idea. Surprisingly, we did, I think, about 800 surveys, and I want to say close to 90% positive satisfaction, high satisfaction rates among incarcerated individuals. So we, we asked why, and we did some follow up qualitative analysis, and we found that people were saying, Well, you know what, you saved me from having to spend so many hours on a van waiting time. And then the one thing that really was very interesting to me is they said telehealth saved me the embarrassment of walking up and down the hallway in the hospital and in shackles and people looking at me and giving me, you know, looking me up, you know, you know, up and down, and just not, I don't feel comfortable. And so telehealth was a great, a great value from different standpoints, from access, from satisfaction and experience, and also during the height of the pandemic, we also then did some cost effectiveness, and so that telehealth saved DPS, Department of Public Safety close to $600,000 In the first six months of implementation, and about 25,000 hours of transportation. And so this would this, you know, this was published, and some of it was in JAMA and others, and actually also got an award from the mid atlantic telehealth Resource Center for breaking barriers. So thanks for for that recognition. But I think that was a fun story. The two key lessons learned to wrap up was I was struck by how quickly regulations can adapt and change if there's an urgency, because we typically have this idea that it takes a long time. And number two, it was outstanding to see telehealth shift from being perceived as a second class care model to being a primary viable option for patients in urban and also rural settings.

Jonathan Neufeld
Yeah, yeah. No, I that those are the two things that surprised me the most, to how quickly it changed and and how different it looked when it wasn't just something you might do to help a few of your patients out. It was like the only game in town. And you, if you're going to see a patient, you're going to do it by telehealth. I think the third thing now that I'm reflecting on it, though, and I wonder what any the rest of you think I was I had, kind of in the back of my head, had this impression a little like what you alluded to, Nikki, that the providers didn't really want to do it right, and that was kind of the problem. But all of a sudden, everybody wanted to do it and and it changed the whole way people approached it and leaned into it. Karen, go

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Karen Rheuban
ahead, oh, I was just going to say my Well, our experience was slightly different in that we had a long standing program, and we had participation by, you know, almost 60 specialties, but they were still, it was still a niche program. It was not integrated into everything. And ironically, in 2019 our CEO of our medical center asked us to do a strategic plan for greater integration of telemedicine. So we did a year long process. We had all these deliverables, and then she left, and we had a new EVP for Health Sciences, who arrived February 2020, and I went to see him. I brought the strategic plan, and he looked at he said, I don't have the funds to do this right now. And you know, what's, you know, what's the reimbursement model and, and, you know, what's the business plan? I was like, I'll be back in touch. And, you know, three weeks later he was called me. They said, Okay, now we have to do it, but it was an environment where surgical revenues were cut, were cut. We cut back on procedures, so we had to rely on COVID Relief dollars to help build the infrastructure that we had intended to build in our strategic plan. And I also had palpitations. I was drinking so much coffee, it was like, oh, to get this done was as a heavy lift, even though we had willing providers. Now,

Jonathan Neufeld
yeah, yeah. So, okay, so come back that background is that fast forward now, whirlwind of the past five years. I mean, a lot has happened over the past five years. And granted, things have, the urgency has receded. We're not drinking quite as much coffee, I don't think. And we had, and we experienced what it was like the wide open waivers. We're still doing the coffee. Okay, okay, I take that back, but we had one of the things I used to say in my presentations, it's like, during the waivers, like everything got slammed up against the top of the graph right wide open, do every do whatever it takes. And of course, you got good clinicians figuring out how to be responsible doing it. But we had those waivers. And then gradually it kind of shut back down a little bit, and it started to fragment a little bit, you know, with this payer covering this and that payer covering that, and coding not quite all aligned, but I think that it at least showed us what was possible when we had to do that. So now, coming to the present, where this, this is a we have now a couple of times, sort of what looked over the cliff of those flexibilities all going away, and even though, in the meantime, state policies have seemed to kind of get ahead of federal policy anybody. So I'll just throw this one out there. We We talked about it a little before we came on. What's been happening in state policy before we start talking about Medicare and the Medicare situation here, what's been happening in state policy over the last five years? Anyone? Karen, I think you're muted, or at least we're hearing you. I

Karen Rheuban
CAN I HAVE TO There we go. There we go. Yep, okay. I know I was sitting on my still in Virginia. We in 2010 we codified commercial plan coverage. We already had Medicaid coverage without originating site. Well, we didn't have it to the home, but we had no geographic restrictions, but the Virginia General Assembly stepped up and codified, you know, all the pandemic waivers, actually, all but, yeah, all the pandemic waivers and for Medicaid and for the commercial plans. So that was amazing for us, and the people who were left behind with his Cliff now are the Medicare beneficiaries potentially. So we've done a lot, and I know a number of the other states have taken the same approach. We also have codified coverage of E visits. And, you know, in the definition of telemedicine and some of the other

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asynchronous tools, not E consults, haven't been codified in Virginia yet, but we hope to see those happen as well.

Jonathan Neufeld
Yeah, there certainly was a period of time there where telehealth, which is a lot of different things, we had to kind of figure out, okay, what do these words mean? Because there was a lot of proprietary usage, you'll remember, of certain words or branding, of certain services and and one of the roles, and I guess this will can segue us into the influence of Medicare. But one of the roles of a national payer like Medicare is to sort of set the standard. I mean, the AMA does the same with CPT, but there are standards for what a visit, what it means, what this term means, what an E visit is, what a what a virtual consult is, what a, you know, even a telemedicine encounter, what that means so, so tell me a little bit about how, how the, what is the influence of Medicare across other payers? I mean, we had in our six states, the Medicaid also moved forward and established a lot of policies, making them permanent. How does it what's the effect of Medicare in doing that? But also then, what's the effect when Medicare changes or fluctuates back on on the on the payer, on a landscape for payers. Anybody want to say, Give have some experience or some thoughts about that?

Saif Khairat
Yeah, I, you know, I think Medicare as it's, although technically it's supposed to only affect Medicare reimbursement and the Medicare population. I think it's, it's a significant, it has a significant impact on telehealth adoption because it gives a sense of security and stability. And so when Medicare stops covering certain telehealth services, it creates a ripple effect, in my opinion, to healthcare systems and providers and clinics. And so people look at Medicare reimbursement and policies as a benchmark to kind of dictate, Okay, should we be expanding and investing in more in telehealth infrastructure and and also private payers are looking closely and monitoring the Medicare changes. And then some of them are following that, although it's not some binding for them, but they do follow. So, for example, if Medicare stops covering primary health telehealth, primary care, telehealth services the end of this year, that could lead to a reduction in telehealth offering across the board, even for people with private payers, safety net hospitals, and we'll talk about that in the in later, rural areas and and people in remote locations. So I think it's it really dictates, although it doesn't have direct impact. I think many people are looking at Medicare as, okay, what should we be doing? What should we be expecting in the future, well

Speaker 4
and safe, to piggyback on that. And as we look at, as, you know, Karen and Jonathan talked about with you know, this has been going on since the late 90s, early 2000s but most recently, since 2020, all of the temporary extensions that we have and that we're currently in the middle of, it creates so much uncertainty around what is going to be reimbursed. So what that really does is it really sets back telehealth growth and adoption, because organizations are skeptical to invest and put it in their strategic plan, because it's unsure of what the reimbursement landscape is going to be. And so, I mean, it just directly, these, these six month extensions, really just, I mean, while it's great because we continue in the short term, there's no certainty of what the future holds without these extensions becoming permanent.

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Karen Rheuban
Yeah, I couldn't agree more. I just want to comment. We did an analysis as we were facing the April 1 cliff, and 20 of our approximate 100,000 per year ambulatory telemedicine visits, 20, almost 25% were Medicare for Medicare patients, and probably most of them were not in rural areas, although certainly a certain number are. I mean, that's a huge drop off for patients and for us. For you know, regularly, it was a lot of work to identify every patient that we were going to call and either cancel or have an alternative strategy for managing and converting them to in person visits. And then I would say also, you know, we safe sort of refer to reference it. We consider what, what Medicare does as having a multiplier effect. So when with the pandemic waivers, it enabled us to be able to create new and innovative programs that were important for care delivery for patients of all from all payers, and that regulatory uncertainty makes health systems uncertain about whether or not they want to continue or develop those programs, right,

Jonathan Neufeld
right? And I've heard from from a number of providers that say, you know, yeah, we could run a program that was covered by three out of four payers, three out of four major payers, but probably aren't going to right, because it's just, how do you how do you tell certain patients, oh no, no, your your services aren't covered, but, but these people are. It's just, it's really a challenge to do that. And I don't know about the rest of you, I'm also wondering, is probably not the best place to ask it, but I wonder, what about the Medicare Advantage plans? Where are they going to go? You know, are they going to follow traditional Medicare. They're going to follow the commercial payers. I think some of them probably already have state regulations, as they're going to have to do, but, but yeah, in a more direct way, even the Medicare Advantage plans could be influenced by this, as well as all the indirect ripple effect.

Karen Rheuban
My understanding is they can decide to cover telemedicine services. And then you also wonder about value based contracting, which we still haven't as a nation, move forward with sufficient numbers that these services would not be covered in fee for service models, but in value based so, yeah, yeah.

Jonathan Neufeld
So what a let's we've we're steeped in this stuff. We think about it all the time. We talk about all the time, but let's just review a few things about where we are. I want to hone in a bit on the current state and what's at risk come september 30. Now, I guess is where we're is the next cliff that we've artificially built for ourselves. But because over the last few years, though, CMS has actually made some pretty significant changes to permanent policies for telehealth. For example, CMS decided that for behavioral health care, telehealth services can be delivered from anywhere, including non rural areas, including the patient's home. Also, behavioral health services can be delivered via any technology, or at least audio and video technology. So within the world of behavioral health, mental health, substance use care, we're pretty much CMS has pretty much gone out of on a bit of a limb here, I guess. And said we're going to count that as regular standard of care, and it's not going to run a differentiate between virtual care and in person care and make that permanent. How does that permanent availability potentially impact I suppose we're asking the converse question. How does that potentially impact providers in the behavioral health space?

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Karen Rheuban
Well, from our perspective, obviously, the stability has been great, and it's also enabled us, across all the payers, actually, to develop innovative models like providing services mental health services to patients in homeless shelters or, you know, while it's not a Medicare covered service, you know maternal postpartum depression models, you know, more more care delivery models for substance use disorders. So I think it's been an amazing transformation, and I'm hopeful, oh, even behavioral health care collaborations in primary care, you know, models that otherwise might not have been deployed had we not had that regulatory certainty. So I'm all in favor of it, and hope we can see more well

Speaker 4
then from my per Thank you, safe, and from my perspective, in the rural area, by allowing audio only that for for areas that don't have broadband or don't have the internet strength to run the video, it allows them to have their behavior health services, and then also something that Safe had mentioned with their telehealth or incarcerated persons program, is that stigma, not only around incarceration, but but other diagnosis is that, you know, has have certain stigmas, and that people sometimes feel judged by in rural areas if their car is parked at a building that is providing those services. So it really gives the individual that protection and privacy as well. So I think that's that's very important, yeah,

Saif Khairat
and these are great comments, just to add the to them, I think to for providers, this means that they're able to see more patients without the limitations of location or geographic barriers or broadband access in one of our studies here in North Carolina and one of the in rural city, one of the participants said, you know, I have to drive up to the bridge just to get cell signal, so, let alone internet, Internet access and broadband. So having the audio only option being permanent and waived. Jonathan, like you said, I think it's great value to a significant minority of the population that we typically not forget about but don't, are not usually in the front and center in the decision making, right,

Jonathan Neufeld
right. And you know, to that to that point, to the innovation point, and the and the, you know, the edge of technology point. I I say a lot that telehealth is, is right? Is a train riding on two rails. One is healthcare access, and the other is technology access. And both are poorly distributed in the reaches, in the in the far rural reaches and then across society there, we have distribution issues there. And I suspect, to your innovation point, Karen, what a lot of people that I see, at least the real innovative thinkers that I see in the behavioral health space, what I've heard back from them is that, you know, we don't really like audio only services, but we sure don't want to have them go away. And what it allows us to do with patients is sort of mix and match. You're going to be in town next week, stop by. We'll do an in person call you want to do. We'll do live video in between, and at a certain time you can't your video is not working, or you're not at home, we'll call, we'll do our our session over the phone, and and it's really the first time, at least in my experience, I've been thinking about this for a while, but the first time you see providers starting thinking it's not just either or, it's like, by any means necessary, I can do all these things, and contact is the issue, not the billable hour. And in behavioral health, that's a game changer. It really is a big difference. Go ahead, safe. Yeah,

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Saif Khairat
I think that's a great point. And I think that is the future of telehealth is an integrated care delivery model. It's not one or the other. It's not in person or telehealth like we used to think in the past. I think the future is going to be, how do we integrate both of them? What constitutes an in person visit versus a telehealth and one patient could be doing one or the other every other week or however many times they need. And what we're currently lacking, from a knowledge and expertise standpoint, is a framework or a set of guidelines of how to pursue an integrated care delivery model. And I think that the next iteration of telehealth science and evidence should focus on not one or the other, but how do you bring and to what extent do you integrate telehealth within your system? Yeah,

Jonathan Neufeld
yeah. I really think it's a parallel to my way of thinking. And maybe I'm getting ahead of the science yet, but it's, it's, it's a parallel to the personalized medicine sort of effort going on on the medical side is, you know, this, this, it. There may not be one formula I know early on in the in the pandemic, I'd also get the question, So, what's the what's the ideal balance of video versus in person, or video versus audio? It's like, I don't think there's an ideal balance. If the patient needs certain things. You need to meet the patient where they are, using the technology they have, whatever that is. All right, let's so we talked a little about behavioral health. I want to hone in on another content area, sometimes called the safety net or the the really edge cases, the rural, the hard to serve, the folks that have a hardest time getting into care for for multiple reasons, and specifically in this domain, for those aware of the federal designations, the federally qualified health center world, the world of FQHCs is was designed and critical access hospitals, for that matter, little more of a rural focus there, but is designed to meet the needs of folks who live in those areas where it's the hardest to deliver services, whether it's because of rurality and and there just isn't enough of a population base to support something as as expensive as A hospital, or whether it's because healthcare coverage. Insurance Coverage kind of drives access to healthcare. And there are folks in large communities, folks who don't have access, who don't have coverage, certainly didn't. And certainly they were larger back before the Acia Medicaid expansion. But these clinics originally going back to the 2097 and 2000 laws. They were specifically excluded again, because, from what you said, Karen, the idea was there's no doctors there. So they're just presenting the patient. The doctors are all in the city, or all at the university or whatever. And now what we found during the pandemic was that, what do you know there are doctors in these FQHCs, but they still have the same access issues that others are during the pandemic. It's not that, it's not that they're that the challenge is getting them to a specialist. The challenge is getting them to a doctor at all. And so again, the flexibility stepped in. Said, Hey, we're going to let those FQHCs and RHCs and critical access hospitals, we're going to let those folks not only present the patient, but actually see the patient at home and get paid themselves by their own doctors for seeing that patient to their own doctors, but for seeing that patient. How has that? How is that those specific openings in this, in allowing the safety net, clinic, FQHCs, RHCs, clinical doctors, hospital doctors, physicians, providers of all kinds, getting them to be able to build Medicare. How does that change the world of telehealth for those or the world of healthcare access for those folks? Nikki, do you want to, you want to start us off there?

Speaker 4
Sure? You know, I think there's a couple of very, you know, basic areas, but it expands patient access, right? Patients have more access to care, whether it's primary or specialty, financial stability for those

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FQHCs and RHCs, by being able to bill, you know, these rural facilities are on very tight margins, right? They they're any sort of reimbursement that they're able to capture is going to help them continue to serve their communities and workforce flexibility, right? So if providers in FQHC, RSC critical access hospital can provide telehealth services. You know, they can leverage that workforce and decrease extirpated, you know, chronic disease hospital readmissions, saving the community members travel time. So a you're looking at cost of travel, gas, food, care, if you have young children, or say you're the care provider for your spouse or your, you know, parent, all of those things, I think help, and then just access, right? And I guess it just comes back to to access. And I, you know, I think back to when, you know, I've reside in the state of Montana, and I look when we would talk about, I think there's like, there at the time, maybe 10 years ago, there was one nephrologist in the state, and somebody living in what was deemed an urban center could not have a telehealth visit with the one nephrologist in the state because they were, they were not in a federally qualified originating site. They weren't designated hipsa. But in when you would compare us to say, you know, an East Coast city or something, the geography, the mileage was so vast that, you know, patients couldn't have a telehealth visit because, you know, they were in a city that was 40, you know, had a population of 45,000 people. So just the unfairness of access to specialty care via telehealth at that time was it was tough. So I think it's a game changer for those safety net hospitals to be able to provide telehealth,

Jonathan Neufeld
yeah, yeah, I think we really somebody said during that time, it's like we knew that there were that there was a gap, but the pandemic drew the lines really dark, and we realized that travel is not just a problem when you got big mountains and long roads, but but travel to the doctor was a challenge for lots of different populations and and travel is one of the major costs involved, one of the major sort of costs borne by the patient involved in in accessing health care. So we could really minimize that by leveraging telehealth wherever we could. So

Karen Rheuban
just another addition to exactly what Nikki said is a number of our we have a partnership with probably about 50 FQHCs, some of which are in networks of an FQHC network that's manages 12 facilities. For example, one of them is one of the largest black lung clinics in the nation, and their black lung specialist should be able to provide services to patients at home. Another network comes to mind that has a number of behavioral health providers. Why shouldn't they be able to provide that? And so those flexibilities have meant the world to those FQHCs and to the patients they serve.

Jonathan Neufeld
You know, you point out something that I think is often overlooked. It's not just you know me, providers seeing my patients, but as a at a community level, at a at a national level, at a large level, telehealth can aggregate services or distribute services in ways that that in person care never could. I talk with a with a special, a specialty dermatologist who sees a lot of kids with very rare diseases, because those rare diseases present as skin diseases. So she's managing a bunch of you know, kids with rare diseases, and they're all over the country, and it's like they can never drive to her clinic to get that ongoing care. I also have a good friend who's a pediatric cancer doc, and he said, you know, once these kids have cancer as a kid, every primary care issue, every cold, every flu, everything ends up coming back to me. But, you know, he was, he was in Houston, and it's like we have kids from all over

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the state I can't manage, you know, they can't come to me for every primary care visit. So, yeah, telehealth allows that super expertise, that super specialty expertise, to be distributed so much more widely if we can, if we can, just get the barriers, barriers down. So all right, so let's talk about what's actually at risk here. And I don't want to minimize it at all, but if you look closely, CMS has done hard work to try and you first of all, they pushed behavioral health out of the out of the target area zone, right? Behavioral Health is okay. We're gonna we're gonna be able to do behavioral health under Medicare. First of all, should recognize it's just Medicare, right? The commercial payers have their policies. Most of the states have done their Medicaid homework, and we have coverage with state Medicaid. The thing that keeps coming up against the cliff is just Medicare. And within Medicare, we've, we've managed to get, get behavioral health off of, off of dead center, and we're just talking about medical care paid for by Medicare. But of course, it's pretty big deal. It's not. It's not. I mean, it's great that it's not any bigger, but it is still plenty big in that at risk area there. What are the things that we're what is, what are the challenges there that we're talking about? What's, what's at risk of going away? If these flexibilities go away? Let's just hone in on that for a little

Saif Khairat
bit. Yeah, I can start. And I think the biggest area that risk is primary care and like on demand services. So like at UNC, for example, we have an on demand telehealth clinic, you can speak to a provider any day at any hour, but basically the ability to speak to a provider and have prescription refill or to receive a prescription in the middle of the night or on the weekend or even during the day, when you can take time off of work that can go away, because if it's not included in the permanent changes, that is, you know, you can't bill for primary care services. I think that's going to be a big hit to telehealth and to the adoption and and to patients as well. So I think that's a big area. I think also need to be thinking about other areas of where telehealth could be helpful, like PT, physical therapy. A lot of people, especially in rural areas in North Carolina and across the country, who get or occupational therapy, get injured on the job, can't move, can't go anywhere, they you know, they could benefit from having a physical therapy session through telehealth. So again, a lot of these are at risk. Are we? You know, thinking of the unintended consequences of discontinuing reimbursement for primary care and these services and ancillary services? Well, you'll have more people go to the medical centers, to the EDS, you have limited number of beds, growing demand across the populations. You're not going to be able to and the cost is going to be these are prevent. Some of them are preventable visits that you could have prevented, and save that bet for someone who doesn't who needs it the most. So there's cost implications, and there's access and and disparities in the horizon if we discontinue some of these services. Yeah,

Jonathan Neufeld
yeah, we've known for a while that when when people face restrictions on access, they end up waiting longer, and when they finally do show up, they're sicker, and when they show up, they're showing up to a higher cost area of care like the ED right. Couldn't

Karen Rheuban
agree more. I mean, so it's medical specialty services, primary care, ancillary provider services, audio only services, oh yeah, diabetes self management training, medical nutrition therapy for patients in their home and provided by hospital based providers there should, and there's reauthorization recertification

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for hospice. There's a lot of hospital at home services, because hospitals are not eligible providers, right?

Jonathan Neufeld
Oh, we saw so much innovation going on in the acute care hospital at home space. I mean, a lot of a lot of spaces, but that was one that I thought, Oh, wow, this is, this is the future, and then it could go away and chill all of that

Speaker 4
well. And I also think going like, which affects all everything that we've just discussed, is that going back to the the originating site, being in a federally qualified, you know, health

Jonathan Neufeld
center, rural area, yeah, non metropolitan physical area, and

Speaker 4
the hipsa designated, and all of those things which put so many restrictions on access to care, yeah,

Karen Rheuban
who's going to type in? Am I rural? Was every year it was sketch. You know, our access scheduler is going to be typing in. Oh, sorry, your zip code is urban. It is a problem, a real challenge.

Jonathan Neufeld
Yeah, yeah. I for it really started to seem like for years this was understood, and I think it still is understood across across the domain, that that these services make a lot of sense, right? There was bipartisan support for years and years and years and years to do this, but not, I guess, not quite enough to do it permanently. So we ended up with, in some ways, maybe the pandemic bailed us out from having to make a permanent change. We could do it all on emergency basis, and then, and then stick with the and then extend the emergency, or at least send the coverage a little further. I think, Jonathan, I

Karen Rheuban
just want to make a comment. Well, you know, one of the things that behooves us to do is to provide CB, the Congressional Budget Office, with real data. You know, May's group has published some University of Michigan data. That's the pre print or pre publication that shows that that that telemedicine services have been primarily substitutive, not additive. Virginia, Medicaid did an analysis early in the public health emergency showed the same thing, you know, whatever. And also, I guess, Michigan also did an analysis that showed that Medicare costs actually did not go up through the use of telemedicine. So, you know, whatever we can as a group in terms of provision of data that would be trusted by the Congressional Budget Office with for for moving along standalone telemedicine legislation between now and the next cliff we face would be imperative, yeah,

Jonathan Neufeld

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yeah, agreed, and I had mentioned too earlier that the state of Minnesota did a really nice analysis as well to decide whether they were going to continue to cover under Medicaid all of these services. And interestingly enough, I mean, they didn't find they found that that for the most part, services were substitutionary, although, you know, it's not cut and dried, but they also they it was a two part study, and there was a there was a quantitative analysis, and then they did an extensive series of interviews and surveys of both providers and patients. And what they found, overwhelmingly, from everyone they talk to is, please don't take it away. We're using this now we it's not the greatest thing in the world, but when, when it is the thing we need, it is the thing we need, and there's no substitute. So don't take it away. And I think that that that both of those, both of those perspectives, are really valuable going forward as we think about this. So Okay, last structured question here, let's, let's reflect a little bit on the challenge of the instability. What? How does that impact folks for for years, even when telehealth coverage wasn't you couldn't necessarily say it was unstable. It still was a patchwork, right? It was like this payer with this with this population group in this area, or whatever, we had to kind of mix and match and consult the tea leaves to see whether this particular service was going to fly or not. And now we add to that matrix of coverages, we add the change over time. How does all that instability, and we touched on this, I know a little bit, but say a little more about how does that instability impact groups that are trying to do this?

Nicki Perisho
Well, besides what we said before about the uncertainty and investment in telehealth, I think it decreases innovation, right? Because there's not as much excitement and thinking outside the box as there was, you know, the in 2020 and 21 and 22 because you just you don't have that, you don't have that drive, because you're unsure of where it's going to land. So lack of innovation, I think, and and providing quality care to individuals and beneficiaries?

Karen Rheuban
Yeah, I think we've certainly discussed all of those, those factors. I would say the federal government has invested so much money on telemedicine, both even prior to the public health emergency and certainly following the public health emergency. You know, and COVID Relief dollars and health systems have integrated into our patient portals and set up new programs just to see that fall by the wayside for our nation's seniors. It would be a tragedy. It would be a real tragedy. Yeah,

Jonathan Neufeld
yeah.

Saif Khairat
I think the constant uncertainty around telehealth has been a problem. It's been a chronic problem for telehealth for like 2030, years, as Karen was mentioned, it needs to change, because uncertainty really hinders innovation, like Nikki mentioned, but also investment into infrastructure, into training individuals, into supporting processes and workflows that supports telehealth. So it needs to come to an end, to a certain degree that there's uncertainty around telehealth. I think telehealth is here to stay, as we're seeing. You know, new models of telehealth, virtual nursing, is taken off across the country. The use of AI to help with coaching and providing assisted coaching bots and chat bots and other things for asynchronous care delivery. So I think that uncertainty is a problem. I also think that lack of clarity and

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direction affects patients. Because, you know, can you keep changing policies? How that the effect on the on the, you know, regular person is they're not up to date, and so they just get to a point where, okay, this telehealth thing is gray. I don't know if it's if I'm going to get reimbursed or not for the providers, and for them if their insurance will cover this or not, and so they may just steer away from telehealth, and then again, end up with a bigger problem, like you were saying, John. So I think uncertainty for patients, for providers, for health systems, is just a, not a healthy environment, and it's it's difficult to flourish and improve and build on. So we probably need more permanent policies. Yeah,

Jonathan Neufeld
yeah, no, I can't agree more that the I, one of my undergrad profs, taught me the classics, and they were, and there was this, the saying in the in the in the classical studies, that leisure is the mother Mother of innovation, or leisure is the mother of culture. This is a kind of a Greek notion, but, and it's not that we want leisure, but we need a little bit of breathing space, if you've got some breathing space, and that translates into stability. Really, what it translates into is I don't have to worry about where this month's payroll is coming from, or where you know whether or not we're going to be reimbursed for this. You get a little bit of stability. And then you can start thinking, okay, what can we do with this? Because we've, we've seen this right when, as we at first, it was like, Okay, how do you operate on a video call? And then people start getting good at it, and they say, You know what? We can use this for this too. Oh, I bet we can do this. And you get all these creative people solving problems, and then, and then the biller says, oh, or the CFO, or whatever says, well, sorry, three months from now, that's not going to get covered anymore, at least we don't know. So you can't go there, etc, you know, it's just such a chilling thing. All right, we've just got a couple of minutes, and, you know, we have blown through our Q and A time. I'll tell you what. I'm going to make a promise to the to the questioners. We have your questions. We can't answer them online right now, but we will follow up with those one or more of us on the team. We'll take a look at those and respond to you directly if you're signed in, and if we can get your if we have your email address, if not, we'll try and include something in the recording, or whatever that that will manage those, get those answers to you. And I'll also say the best way to get answers to your questions is to follow up with one of the telehealth resource centers. That's what we do. We're easy to contact. We're easy to talk to. Go to one of our websites. Go to telehealth Resource centers.org, that's all 14 of us. Reach out to any of us, and we will make sure and find you the answer that you need. All right, Aria, I'm going to turn it back to you. Thank you again. To our panelists. Thank you everybody for coming out and listening. Aria, anything to close out, Thanks,

Aria Javidan
Jonathan. Just a reminder that our next webinar is going to be held on Thursday April 17, that will be hosted by the South Central telehealth Resource Center on virtual nursing innovations to mitigate a healthcare workforce crisis. Registration information is available on the nctrc events page. And then lastly, we do ask that you take a few short minutes to complete the survey that will pop up at the conclusion of this webinar, as your feedback is very valuable to us. Thank you again to Jonathan and the Great Plains tells resource, and Assistant Center for hosting today's webinar and to Karen Nikki and safe for sharing their expertise. Have a great day everyone.

Thank you. Thanks, everybody.

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