

Early Impacts of the COVID-19 Pandemic on Telehealth Patterns in Primary Care, Mental Health, and Specialty Care Facilities in Texas

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Objectives: Since the onset of the coronavirus disease 2019 (COVID-19) pandemic, many US clinics have shifted some or all of their practice from in-person to virtual visits. In this study, we assessed the use of telehealth among primary care and specialty clinics, by targeting healthcare administrators via multiple channels.

Methods: Using an online survey, we assessed the use of, barriers to, and reimbursement for telehealth. Respondents included clinic administrators (chief executive officers, vice presidents, directors, and senior-level managers).

Results: A total of 85 complete responses were recorded, 79% of which represented solo or group practices and 63% reported a daily patient census >50. The proportion of clinics that delivered $\geq 50\%$ of their consults using telehealth increased from 16% in March to 42% in April, 35% in May, and 30% in June. Clinics identified problems with telehealth reimbursement; although 63% of clinics reported that $\geq 75\%$ of their telehealth consults were reimbursed, only 51% indicated that $\geq 75\%$ of their telehealth visits were reimbursed at par with in-person office visits. Sixty-five percent of clinics reported having basic or foundational telehealth services, whereas only 9% of clinics reported advanced telehealth maturity. Value-based care participating clinics were more likely to report advanced telehealth services (27%), compared with non-value-based care clinics (3%).

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Conclusions: These findings highlight the adaptability of clinics to quickly transition and adopt telehealth. Uncertainty about reimbursement and policy changes may make the shift temporal, however.

Key Words: COVID-19, reimbursement, telehealth, value-based care

In recent years, the use of technology has become more integrated in our daily lives, and telehealth has increasingly been recognized as the next frontier in health care. Despite its convenience and benefits, telehealth implementation has been limited because of several factors, including but not limited to lack of awareness, fear of expense, and preference for in-person visits.¹ Although the use of telehealth has been on the increase for the past 2 decades—according to a US Department of Health and Human Services report to Congress, approximately 60% of all healthcare institutions in 2016 used telehealth in some capacity²—it is not the dominant method of healthcare delivery.

The emergence of the novel coronavirus disease 2019 (COVID-19) placed an unprecedented strain on healthcare systems. Outpatient clinics have had to significantly modify the way they deliver patient care; however, this watershed event emphasized an urgent need for cost-effective remote patient care to minimize the burden on already-overwhelmed hospitals and clinics. With prolonged stay-at-home orders and priority to limit overall exposure to the virus, the use of telehealth has gained momentum in the plight to safely deliver care. Because of the elevated risks of the COVID-19 pandemic, many clinics, at least in the short term, shifted some or all of their practice from in-person to virtual platforms. This study documents how clinics in Texas transitioned to telehealth during the initial COVID-19 months

Key Points

- The proportion of clinics that delivered the majority of their consults using telehealth increased from 5% in February to 16% in March, 42% in April, 35% in May, and 30% in June.
- Only 1 in 2 clinics indicated that the majority of their telehealth services were reimbursed at par with in-person office visits.
- Value-based care participating clinics were more likely to report advanced telehealth services (27%), compared with non-value-based care clinics (3%).

(March–June 2020), focusing on the use of, barriers to, and reimbursement for telehealth.

Methods

In June 2020, we administered a survey to assess how primary care and specialty clinics have transitioned to telehealth in light of the COVID-19 pandemic. The survey, administered on Qualtrics, asked respondents about how the pandemic had affected staffing; patient census; and the use of, barriers to, and reimbursement for telehealth between March and June 2020. We targeted Texas healthcare administrators via multiple channels, including the community portals in the Medical Group Management Association Web site. The Texas chapter of the Medical Group Management Association boasts approximately 500 members who work in a variety of practice settings. Respondents included clinic administrators, chief executive officers, vice presidents, directors, and senior-level managers. The clinics represented include primary care and specialty services (private clinics, retail clinics, community health centers that provide family medicine, internal medicine, pediatrics, obstetrics and gynecology services, and/or behavioral health services).

Survey Description

The survey was divided into three main sections: demographics, impact of COVID-19 on clinic operations, and the associated financial effects. Demographics questions included location, clinic name, role of the individual answering the survey, type of clinic, number of clinicians, and patient case mix. The impact of COVID-19 on clinic operations questions were focused on proportion of telehealth patient consults, type of telehealth communication available at the clinic, maturity of telehealth services, daily patient census, and staffing needs. Importantly, three levels of telehealth maturity were assessed: basic, foundational, and advanced levels, using definitions derived from earlier work by Manatt Health³ on measuring the maturity of existing telehealth services. Basic telehealth refers to fragmented technology solutions and limited electronic health record (EHR) integration; foundational telehealth refers to established technology platform standards with some EHR integration; and advanced

telehealth refers to scaled platforms with full EHR integration. These descriptions of telehealth maturity were included in survey protocol (Supplemental Digital Content, <http://links.lww.com/SMJ/A234>). Lastly, assessment of financial effects included questions about any financial assistance the clinic received since the onset of the COVID-19 pandemic, proportion of telehealth consults reimbursed, value-based arrangements, and barriers to adoption of telehealth at the clinic. The survey was open for 6 weeks, and one reminder was sent 3 weeks after the initial go-live date. We used descriptive statistics to summarize key learnings from the survey responses. This study was approved by an independent institutional review board in June 2020.

Results and Discussion

A total of 85 complete responses were recorded from Texas clinics. Of these, 79% of respondents represented solo or group practices and 63% reported a daily patient census >50. Up until February 2020, the majority of clinics appeared to have a “one size fits all” model, mainly relying on in-person office visits rather than any form of virtual service: <5% of clinics reported using video visits and >95% of clinics provided in-person office visits. The proportion of clinics that delivered ≥50% of their consults using telehealth increased from 16% in March to 42% in April, 35% in May, and 30% in June (Fig. 1). The increasing and decreasing trend is interesting because it aligns with the beginning of stay-at-home orders in March 2020 and relaxation of the orders in May 2020. Although clinics initially may have been ill-prepared to offer telehealth services to their patients once stay-at-home orders commenced in March, the swift adoption of telehealth services indicates the adaptability of clinics to quickly transition, because otherwise they may have been forced to shut down. Unfortunately, some clinics likely already took a significant hit: 42% of clinics reported having experienced a reduction in staffing since the onset of the pandemic.

Opportunities for Advancing Telehealth Maturity Remains

Telehealth maturity varied among respondents; >66% of clinics reported having basic or foundational telehealth services,

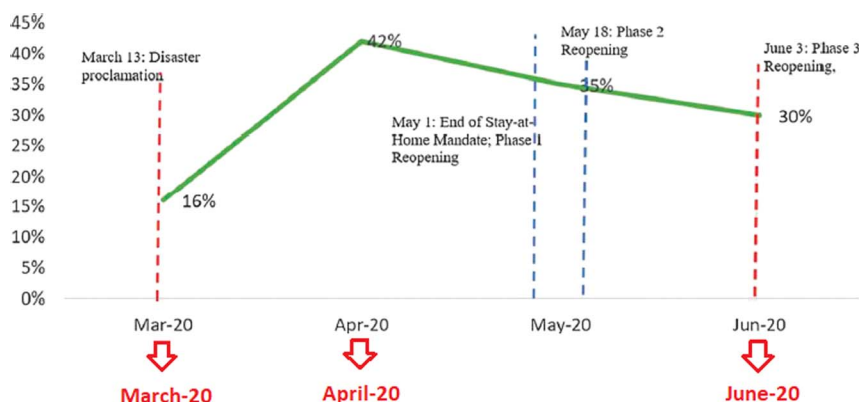


Fig. 1. Proportion of Texas clinics delivering majority of consults using telehealth, March–June 2020.

26% had not yet started telehealth, whereas only 9% of clinics reported advanced telehealth maturity. This small percentage of maturity highlights the opportunity to implement and greatly advance the field through policies that make it easy for clinics to adopt advanced telehealth services. As of August 1, 2020, seven telehealth expansion bills had been introduced in the US Congress. The Centers for Medicare & Medicaid Services (CMS), under the 1135 waiver authority, expanded Medicare telehealth benefits to allow reimbursements for office, hospital, and other visits furnished via telehealth. States, however, also need to enact telehealth policies for their Medicaid programs. Within these policies, it is important to make provisions for the advancement of telehealth systems along the maturity continuum.

Value-Based Care (VBC) Participating Clinics Reported Advanced Telehealth

Of the clinics surveyed, 25.6% of respondents responded yes to the question, “Is your clinic participating in any VBC arrangements?” Of these VBC-participating clinics, 27% reported advanced telehealth services, compared with 3% of advanced telehealth services in non-VBC clinics. Because the sample is small, we did not conduct any hypothesis testing to examine significant differences between VBC participating clinics and non-VBC clinics (Fig. 2); however, this pattern of mature telehealth in VBCs cannot be dismissed. During the last decade, there has been a shift from the traditional fee-for-service model in medicine to a value-based approach, where providers and insurance companies collaborate to reduce the overall costs of care while improving quality outcomes for the patients they serve. Clinics in VBC arrangements may be better capitalized or have access to technology resources that allow secure remote care. Hence, telehealth has the potential to help VBC clinics meet their targets because it has been shown to expand access to health care,⁴ improve outcomes and quality,⁵ increase patient engagement,⁶ and reduce unnecessary emergency department visits⁴—typical noncost targets in VBC arrangements. The increased accessibility of information through telehealth services facilitates better cooperation among actors in the healthcare system.⁷

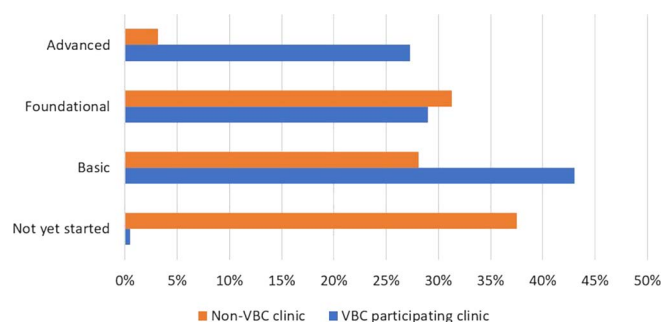


Fig. 2. How would you classify the maturity of your telehealth services? VBC participating clinic vs. non-VBC clinics. VBC, value-based care.

Leading Barriers to Telehealth Were Patient Preference and Reimbursement Issues

The administrative burden of initiating telehealth services can be large.⁸ Administrators have reported billing challenges and concerns regarding the integration of support staff into video calls to troubleshoot.⁷ The implementation of technology itself, maintenance, and troubleshooting could pose significant operational challenges, especially during the initial COVID-19 months, when several healthcare administrators/other administrative professionals were not working in the office and may have been more difficult to reach.⁷ Our results suggest that patients tend to prefer in-person visits, partially because of technology accessibility and usability challenges.⁷ These patient-related barriers suggest that telehealth gains may not be attained in certain patient populations, particularly those with technology-related challenges (eg, Internet or computer issues). As the pandemic continues to reshape our health landscape, however, these difficulties may decrease as practices and patients become more accustomed to the concept and delivery of online visits. Also, the familiarity with their healthcare provider and the accessibility that telehealth offers may allow the patient to use this modality better.

Clinics indicated that problems with reimbursement for telehealth were major barriers to the full or permanent implementation of virtual healthcare. For example, although 63% of clinics reported that $\geq 75\%$ of their telehealth consults were reimbursed, only 51% indicated that $\geq 75\%$ of their telehealth visits were reimbursed at par with in-person office visits. These findings are important because only recently did CMS expand beneficiaries' access to telehealth services under the Coronavirus Preparedness and Response Supplemental Appropriations Act (Public Law 116–123), establishing equivalent reimbursement for video telehealth visits as well as in-person consults.⁹ After this CMS announcement, many private insurers followed suit¹⁰; however, private insurer reimbursement is still dependent on policy and varies from one plan to another. Some plans restrict telehealth reimbursement by limiting the type of services provided and limiting the network of providers allowed to provide telehealth.¹⁰ In addition, in most states, telehealth is reimbursed at a lower rate than are in-person visits, disincentivizing private practices to adopt it; only six states have laws mandating equal pay for virtual and in-person visits.¹⁰

Strengths and Limitations

This is one of the first studies to our knowledge to document the early effects of the COVID-19 pandemic on telehealth patterns in primary care, mental health, and specialty care facilities in Texas. Although descriptive in nature, it provides important insight into clinic operations, highlighting the adaptability of clinics to quickly transition and adopt telehealth during the COVID-19 pandemic. Because of the descriptive nature of the study and the small sample size, our findings may not be generalizable to all clinics. The cross-sectional nature of the survey suggests that the findings may not be the same if the survey were

conducted at a different time point. This study also does not include information about clinic/patient location, which may inform the use of telehealth. Patients in rural locations may cut transportation and time costs of attending visits, but they also may have poor Internet/broadband access. Lastly, our results may be subject to recall bias because clinics were expected to report staffing, patient census and mode of healthcare delivery in the months before completing the survey.

Conclusions

COVID-19 has reshaped the healthcare landscape and the delivery of outpatient care, and it has the potential to play a critical role as more health care in the United States shifts from fee-for-service to value-based systems. More work is needed to understand the telehealth gaps between clinics participating in VBC and non-VBC clinics. Concerns remain about whether the reimbursement at par with in-person visits will continue after the pandemic ends. This uncertainty could lead to a reluctance by practices to invest in advanced telehealth practices. Although telehealth has the potential to improve access, practices need greater predictability from payers regarding reimbursement to invest the resources needed to sustain this transformation.

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