COVID-19 & Rural Health Equity in Northern New England

Summary of Findings on Telehealth

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Telehealth has emerged as a powerful tool for health equity

The other thing that I hope comes about, is that I hope that tele-health does not become a moment in time, Healthcare Executive, North Country

Research Overview

In mid-March, researchers at Dartmouth's Center for Global Health Equity launched the first phase of a study on the COVID-19 pandemic and rural health equity in Northern New England. The first phase of the study sought to assess the immediate impacts of the COVID-19 pandemic on rural health equity in Northern New England, identify mid- to longer-range concerns and opportunities for rural health and health systems, and identify priorities for future research, action, and policy. The first phase of research consisted of 50 qualitative interviews conducted with key informants from health systems, social service organizations, public health entities, mutual aid groups, and town and city/governments from across Vermont and New Hampshire. The research focused on four geographic areas that included the Upper Valley, the Greater Sullivan/Windsor County area, the Northeast Kingdom (NEK) of Vermont, and the North Country of New Hampshire. Additional interviews were conducted with representatives of state and regional organizations as well as some organizations outside of these focus areas. The second phase of research examining the next period of pandemic response will begin in June 2020.

This brief summarizes the research findings on telehealth. A full report is available at: https://www.covid19healthequity.com/rural-health-equity.

Expansion of Telehealth

Prior to the pandemic, many rural hospitals in New Hampshire and Vermont benefited from growing telehealth collaborations with Dartmouth-Hitchcock's Connected Care program, the University of Vermont Medical Center, and other academic medical centers; however, telehealth was primarily limited to the provision of specialty care between academic medical centers and rural settings. Very few primary care and behavioral service providers had telehealth services in place at the start of the pandemic, and licensing requirements limited the utilization of telehealth across the NH/VT state border.

"I think if there's any good that's come out of all this, Telehealth, the genie is out of the bottle. And so, it will definitely be a part of the way care is delivered in the future. And, I think that's probably a good thing."
Health Care Leader, North Country

"...thinking about going forward, I think we're all kind of excited. I know my colleagues nationally, most of us share this sort of opening up of a future of medicine that allows us more flexibility in terms of meeting people's needs via teleconference or even telephone care and actually getting paid to do that. It would be nice. So we're hopeful that continues."
Primary Care Provider, Northeast Kingdom

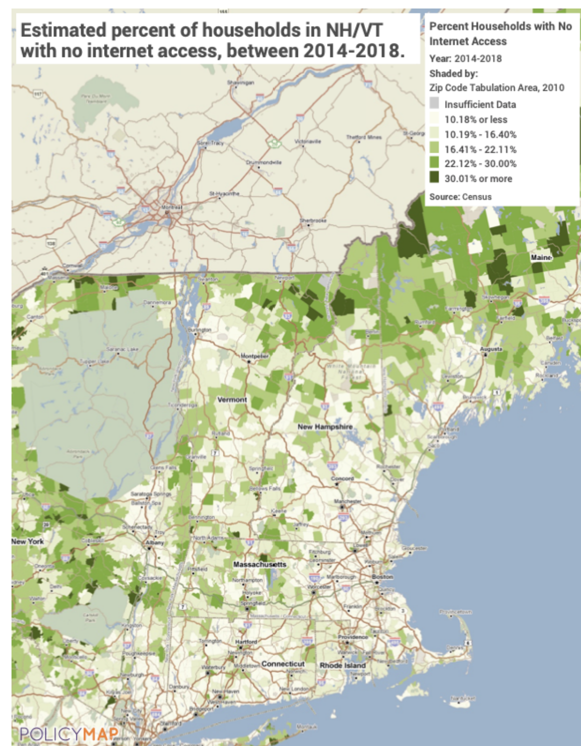
"Many, many of us have the feeling that we're never going to provide care in exactly the same way again. That this has been something that has upended the paradigms of care so radically, so dramatically, and so quickly. And many of us in primary care, of course, have called for this kind of change long ago because we've been aware. And it's been the payment models, unfortunately that have predicated, you don't get paid unless you see people in person. So, as you probably know, everybody in the face of the pandemic emergency had to relax those rules. We're getting paid for those visits. It's pushed patients into recognizing, gee, there's a lot that can be done this way."

Primary Care Provider, Upper Valley

Relaxation of telehealth regulations, including the lifting of privacy restrictions and reimbursement for telehealth and telephone visits, enabled a vast expansion of telehealth across a broad spectrum of clinical and social services across the region. In the bi-state region, a temporary waiver on state licensing requirements also enabled the delivery of care by telehealth across the NH/VT border. Most healthcare organizations converted most of their in-person activities to telehealth within the span of a few days. Social service organizations also migrated large parts of their in-person operations to virtual platforms. Remote visits employed a range of technologies, from videoconferencing to telephone-based visits. One behavioral service center also reported using Facebook to deliver some of its services.

Opportunities and Limitations for Rural Health Equity

Health systems leaders and providers from New Hampshire and Vermont consistently described the expansion of telehealth within their systems as a promising tool for addressing long-standing rural health equity challenges. Many highlighted its effectiveness in increasing access for patients with transportation constraints, including elderly patients. Behavioral healthcare providers across the bi-state region consistently reported a precipitous drop in no-show rates. Telehealth may be a strategy to address the stigma of seeking care for mental health and substance use. Stigma is a significant barrier in rural areas as people worry about being seen at clinics in small towns in which "everyone knows everyone." Behavioral service providers further described it as an effective platform for delivering behavioral services for teens and adolescents. In addition, geriatric providers described it as an important tool in closing gaps in access to care at skilled nursing facilities that struggle to recruit providers.



Health systems leaders and providers also described areas of limitations and structural challenges related to telehealth. Participants found telehealth to be a less effective substitute for in-person care for some vulnerable populations, including persons in early stages of substance use recovery, patients with severe mental illness, patients requiring home health services, and socially vulnerable patients. Providers saw in-person visits as critical for establishing trusting relationships for patients in the early stages of recovery and noted that some telehealth platforms prompted paranoia in some patients with severe mental illness. Health centers also described challenges in converting wrap-around patient support/social work services for vulnerable populations to virtual platforms. Providers also encountered challenges related to privacy and confidential delivery of care remotely to patients in home environments with

> "Pretty universally though, the success of telehealth is rate limited by the patient or client's access to the infrastructure that allows them to engage in that mode. So, in pockets of Coös County, for example, where there is no broadband internet, that's a very real issue for patients."
> *Public health leader, North Country*

limited personal space. They believed that some patients were reluctant to have healthcare providers view their home and family environments. Others noted more limited success in utilizing telehealth in pediatric settings with young children.

One of the key barriers to the success of telehealth was limited access to digital infrastructure. Twenty-three percent of Vermonters lack access to broadband internet, and around half of addresses in the Northeast Kingdom do not have high-speed internet.[1] In some areas of the North Country of New Hampshire, close to twenty percent of the population lacks access to the internet (Figure 3[2]). Additionally, many rural households lack access to computers and digital technology. To address this, providers reported delivering some care using the telephone. Early in the pandemic, lower rates of reimbursement for telephone consultation represented a significant concern for providers in regions with low internet coverage. In addition, providers reported that older populations preferred telephone-based visits, particularly for behavioral health services.

"I've had more than a few situations that I've heard about where people are getting better service because of tele-health. One gentleman ... car broke down, can't get anywhere. It's okay because he wants to be isolated with the COVID, anyway, right now. But I wouldn't have been able to meet with him. And other things, kids and childcare and money and gas money ... There are a lot of people who are able to participate more as a result of this."
Mental Health Leader, Upper Valley

"Interestingly, one of the clinics that we work with says that they've had a significantly reduced no show and cancellation rate in their primary care clinic and they think that it's because transportation is a non factor when you're conducting telehealth visits."
Public Health Leader, North Country

"Interestingly, one of the clinics that we work with says that they've had a significantly reduced no show and cancellation rate in their primary care clinic and they think that it's because transportation is a non-factor when you're conducting telehealth visits. So that's a piece of it. People who've been challenged by transportation are even more so now."
Social Service Leader, North Country

"The nursing homes for example, you can't get medical directors in rural nursing homes. You cannot get providers in rural nursing homes. But you know what, now that we can do this, or we can do the visits through telehealth and get reimbursed for them. So...the biggest barrier was that we could do these, but we couldn't get reimbursed. Now that you can make money doing this, we see there are some companies that literally have expanded overnight to be able to provide. Is this a great thing? All of a sudden now, rural nursing homes will actually get much better medical care than what they were getting."
Geriatric Leader, Upper Valley

Implications for Rural Healthcare Delivery

A key component of the successful migration to telehealth has been its integration into existing healthcare delivery systems. Primary care patients accessing telehealth were already medically homed and continuing care with a provider familiar with the clinical and social histories of patients and community resources. Few practices reported enrolling new patients via telehealth. Both providers and health systems leaders cautioned against viewing telehealth as a solution to the deficit in primary care providers. Many also reflected concern that an increase in standalone telehealth services delivered from outside the region might weaken the health system and compromise patient health.

Second, one of the central successes in the bi-state region, where many healthcare organizations serve patients from both states, was the ability to use telehealth across the NH/VT border enabled by the temporary waiver on licensing requirements. Ensuring continued ability to deliver telehealth across state lines to increase access to care represents a priority. In addition, access to telehealth may help to limit travel and contact with the health system for highly vulnerable patients reliant on distant academic medical centers as reopening occurs.

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[1] Sims, "Katherine Sims"; "Emergency Broadband Action Plan | Department of Public Service."
[2] PolicyMap, "Estimated Percent of Households with No Internet Access, between 2014-2018"; "U.S. Census Bureau QuickFacts: New Hampshire."

Key Policy Priorities for Telehealth

Achieving permanent reform to enable rural healthcare institutions to continue to use telehealth represents a key policy priority for the rural health system and community. Rural hospitals cited the following three key policy priorities for the bi-state region related to telehealth:

1. Parity in reimbursement for telehealth services
2. Inclusion of telephone-based services as a modality to ensure equity of access.
3. Ability to use telehealth across the Vermont-New Hampshire state line
4. Increasing access to broadband across both states

"For a couple of weeks, we were not getting paid for phone based care for Medicare which is a problem because here in Vermont and general rural America, we have a lot of old people and those are the people less likely to be comfortable using this format or others similar. So that was a real challenge."
Primary Care Provider, Northeast Kingdom

"[Telemedicine] is a huge bright spot. Yeah. I mean, even Medicare today I guess said that they would reimburse phone only, maybe starting in July with some special code that retroactive all the way to March 1st. … That's huge because I mean, how many of our Medicare patients are comfortable using technology and getting a video connection. I mean, we're still doing those visits of course and we would have done them for free because, just yesterday I talked with a woman who's recently lost her husband, her daughter's on hospice. I mean, she's struggling and she needs to talk to her primary and she can't establish a visit over the video. She doesn't have that technology. She just has a phone. She doesn't want to come in. And I don't blame her. So, I needed to talk with her and any amount of time, whatever it took, but it would have been free versus being able to bill, whatever they'll let us bill for it."

Primary Care Provider, Northeast Kingdom

"I think that that's important that we continue to offer [phone]...We would still like to have that option because it's much more convenient for some people, especially if they have somebody sick in their home. And so, without this relaxation if we go back to the old way, that means if somebody's sick in the home they just don't get any services, and that's just not the way we want it to go."

Social Service Leader, Sullivan/Windsor Country

"One thing I wanted to add, too, about insurance coverage, I think we were talking about equity issues. And I think there are some class issues and equity issues that are involved here, which I'm sure you've already thought about. I was talking. [with a colleague] about how important I think it is to continue to have telephone services. And to not have telephone services is biased against who? It's biased against poor people who don't have equipment and don't have money to get equipment."

Mental Health Leader, Upper Valley