



Ensuring Sustained Access to Telehealth in the Post-Pandemic Period

Jointly developed by the New York State Council for Community Behavioral Healthcare and the Community Health Care Association of New York State



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EXECUTIVE SUMMARY

Prior to the COVID-19 pandemic, poor reimbursement, complex regulatory structures, rigorous technology requirements, and limits on who could provide telehealth visits to which patients under what conditions led to modest telehealth penetration into safety net service delivery, including among behavioral health organizations and federally qualified health centers (FQHCs). Telehealth has shown great potential in expanding and ensuring access to behavioral health and primary care. In rural communities where there is no public transportation and the Medicaid cab system is dysfunctional, lack of transportation continues to be a barrier to accessing face-to-face treatment. Urban areas also face transportation challenges and a reluctance to utilize public transportation will likely outlast the public health emergency. Throughout the State, child-care and work-related difficulties also create barriers to accessing consistent mental health and primary care services. These types of barriers delay care and increase costs to the Medicaid system, because patients' symptoms may worsen to the point where hospital-based services are needed.

When COVID-19 struck New York and Governor Cuomo put the State on Pause, the benefit of telehealth options became quite clear. State regulators quickly offered flexibility. Telehealth treatment modalities that were once prohibited were suddenly encouraged. Technology requirements were waived, allowing both telephonic (audio only) and audio/visual visits. Provider types authorized to provide telehealth were expanded and reimbursement became largely aligned with payments for face-to-face visits.

These reimbursement and regulatory changes, coupled with need to innovate in order to ensure patient access, led to a dramatic increase in telehealth utilization among safety net providers. For some consumers, telehealth – including telephonic care – became a lifeline while they sheltered in place. For some providers, telehealth became a financial lifeline, as revenues associated with in-person

services cratered. However, an over-reliance on a heavily regulated telehealth system could exacerbate health inequities by making access to broadband, cell service, privacy, and technical capability new social drivers of health. In fact, in both rural and urban areas, unless access to broadband and technology is made universally accessible, the expansion of telehealth will further exacerbate health disparities based upon race, class, and other social factors.

The New York State Council for Community Behavioral Healthcare (NYSCCBH) and the Community Health Care Association of New York State (CHCANYS) have come together to develop recommendations for policymakers. We know that the people our individual members serve have historically struggled with access to services. Our patients live in communities plagued by poverty and structural racism that exacerbate health disparities. Together, we recognize that telehealth is a critical tool for improving care access and continuity. However, the sustained value of telehealth in improving access, care consistency, outcomes, and consumer satisfaction will depend on the post-pandemic regulatory and reimbursement environment.

To ensure that telehealth remains a valuable resource for people served by the safety net, we recommend that the State adheres to a set of core principles for determining telehealth regulatory and reimbursement structures:

1. Utilize telehealth to increase access and promote health equity through support for the full range of telehealth modalities.
2. Maximize regulatory flexibilities to sustain telehealth adoption.
3. Clinicians, in collaboration with clients, determine when a telehealth visit is appropriate.
4. Reimburse telehealth visits on par with in-person visits to ensure comprehensive, coordinated and integrated continuum of care.

INTRODUCTION

Prior to the novel coronavirus pandemic (COVID-19), telehealth in New York State was sparsely utilized. Nationally, only 10% of patients reported they had received care via telehealth in the past year¹ and 18% of physicians reported using the modality in 2018.² However, when Governor Cuomo put New York on Pause to mitigate the spread of COVID-19, State policymakers provided new flexibilities to expand telehealth. This resulted in an increased use among providers and enhanced access to care for patients at home. Because of the flexibility afforded to safety net providers, such as federally qualified health centers (FQHCs) and behavioral health organizations, many of the most vulnerable New Yorkers were able to maintain contact with their service providers throughout the pandemic.

In early March, recommendations put forth by the Centers for Disease Control and Prevention and Governor Cuomo encouraged individuals to stay home, resulting in a rapid and severe decrease of in-person visits at FQHCs and behavioral health organizations. However, patients still required primary care and behavioral health services. In early March and April, behavioral health and primary care providers scrambled to redesign their care models to include exponential expansions of telehealth in order to ensure ongoing access to care among their patients.

The transition to remote care has been welcomed by patients and providers alike, with several early studies demonstrating that patients express an over 90% satisfaction rate with telehealth availability.³ Providers, too, report high satisfaction with telehealth services.^{4,5} There is good evidence to suggest that appropriate telehealth services can achieve better care⁶ for less cost⁷ and greater patient and provider satisfaction. Early evidence suggests higher patient compliance⁸ with scheduled telehealth visits and greater willingness to comply with a care plan.⁹



Telehealth offers the opportunity to address long-standing State healthcare policy priorities, such as advancing integrated care and curbing Medicaid spending over the long term. The State's Medicaid program is under pressure; estimates for new Medicaid enrollees in New York as a result of COVID-related job losses range from 719,000 to 1.44 million,¹⁰ while the State is currently experiencing a \$13.3 billion budget shortfall.¹¹ Telehealth expands access to health care in underserved areas of the State. Increased access to primary and behavioral health care will reduce costly emergency room care and hospitalizations.

Given its rapid integration into primary and behavioral health care, telehealth is now an essential component of the service delivery continuum and a vital lifeline for many consumers. The New York State Council for Community Behavioral Healthcare (NYSCCBH) and the Community Health Care Association of New York State (CHCANYS) have come together to develop State policy recommendations for sustaining access to remote care in the post pandemic period. Remote care can improve access to the critical whole person healthcare services provided to the communities hardest hit by COVID-19.

EVIDENCE SHOWS TELEHEALTH IS A PROMISING METHOD OF DELIVERING CARE

Numerous peer-reviewed research studies report high patient satisfaction,¹² better patient outcomes¹³ and higher provider satisfaction¹⁴ with telehealth services in both primary care¹⁵ and behavioral health settings.¹⁶ The ability to increase provider satisfaction is critical given the workforce challenges plaguing New York State’s safety net service delivery system. According to the Health Resources and Services Administration, New York State currently has 170 Primary Care Health Professional Shortage Areas (HPSA), 174 Mental Health HPSAs, 131 Dental HPSAs, and 108 Medically Underserved Areas.¹⁷

In a study reviewing outcomes associated with telehealth from 2012 – 2015, 98% of individuals who received services via telehealth were satisfied with video and sound quality. Additionally, those participating in telehealth visits experienced shorter wait times, shorter visit times and lower travel-related costs.¹⁸ As seen in Figure 1, the findings from these peer reviewed papers are echoed in the satisfaction surveys of New York state patients conducted throughout the pandemic.

Other studies have attempted to evaluate access to and quality of care provided through telehealth. In



one study of 1,734 individuals without a regular care provider, 94% of women and 99% of people reported being “very satisfied” after receiving a telehealth visit. An additional third preferred a telehealth visit to in-person care.¹⁹ A 2017-2018 study involving 102 individuals evaluated transitions of care and compliance for patients leaving the hospital. Patients receiving telehealth were more likely to have had a medication reconciliation than those receiving in-person care. Individuals seen via telehealth were seven times more likely to adhere to medication requirements. The study found that over 99% of users reported that they were confident in the telehealth care they received.²⁰

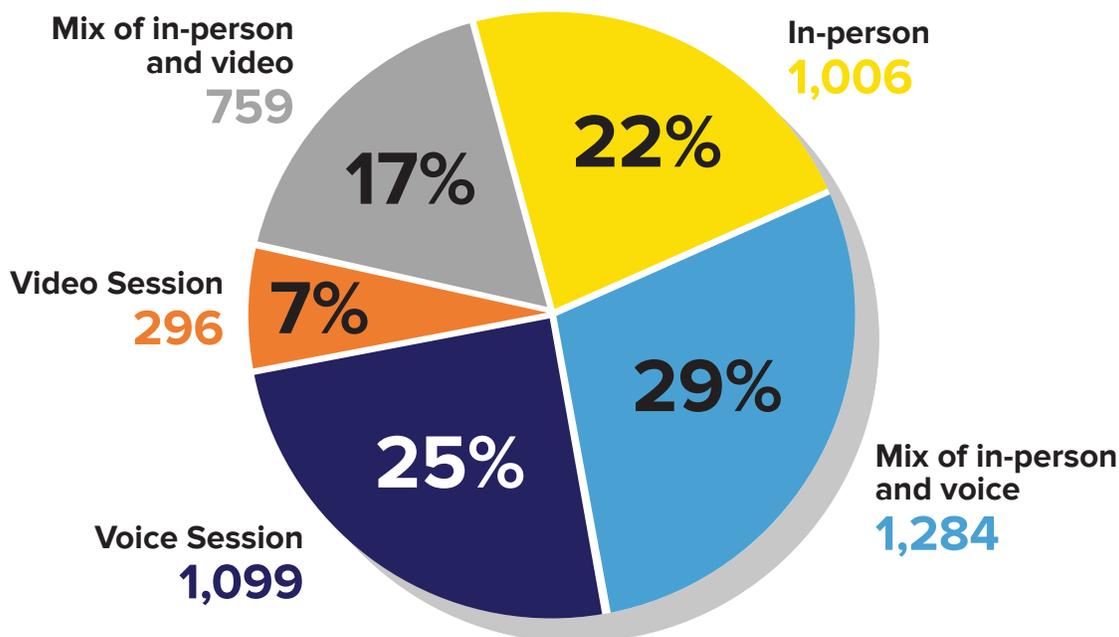


Figure 1. Preferred method of service delivery among Horizon Health clients, 5/19/2-6/8/20

TELEHEALTH IN NYS BEFORE COVID-19

State regulations prior to COVID-19 hindered widespread adoption of telehealth amongst safety net providers. Some regulations restricted the types of technology permitted and others limited the definition of originating and distant sites. Many placed restrictive requirements on what type of provider could use telehealth and which types of services they could provide. These restrictions coupled with low reimbursement rates and impermissibility of audio-only telehealth resulted in very few safety net providers meaningfully utilizing telehealth to deliver services. Results from a recent NYSCCBH member survey (n=36) found that prior to the pandemic, telehealth represented 2% of visits and 2% of revenue across behavioral health sites. Per 2018 Health Resources and Services Administration (HRSA) Uniform Data System reporting, prior to COVID-19, 35% of New York health centers (n=67) utilized telehealth to deliver services.

Restrictive regulations put forth by the Office of Mental Health (OMH) limited widespread adoption of telehealth amongst behavioral health providers. Prohibitive regulations include:

- the requirement that behavioral health practitioners have control over the client's camera,
- restrictions for qualifying originating and distant sites,
- few permissible provider types,
- time limits on patient utilization and
- requirements that a patient receive an in-person visit prior to receiving services via telehealth.

Guidance for both FQHCs and behavioral health organizations required that telehealth be provided using synchronous audio and video systems which limits use among individuals who may not have access to the appropriate technology or who face technical literacy challenges. This is especially true for individuals with intellectual or developmental disabilities, individuals with limited English proficiency, rural residents and older populations. Lack of reimbursement for telephonic visits exacerbates health disparities for individuals that do not have access to the technology, infrastructure, and technical literacy needed for audio-visual telehealth.²¹

Additionally, low levels of reimbursement hindered audio-visual telehealth adoption among safety net providers, many of which already operate on thin margins. FQHCs were not able to receive supplemental wraparound payments for telehealth delivered to patients at home. Medicaid Managed Care reimbursement rates were often much lower than fee for service Medicaid. Across the board, most visits provided via telehealth were reimbursed at much lower rates than services delivered in-person.

A common misconception is that services provided remotely are cheaper to provide than in-person services. However, there is no evidence to support this assumption. In general, 75% of a safety net provider's overhead costs are related to salary and fringe benefits. Additionally, other costs related to physical plant footprint are hard costs, either because organizations have mortgages or long-term leases. Overall, costs are not necessarily reduced in the short-term through telehealth expansion. Further, expanding telehealth requires both upfront and ongoing investments in information technology, operational systems, human resources, call centers and development of new care teams and workflows.

CHCANYS and the NYSCCBH fear that without action from the State, innovation will be stifled and providers will roll back their newly established models of care, which in turn will limit access to remote care among safety net provider patients.



TELEHEALTH IN NYS DURING COVID-19 RESPONSE

New York State responded quickly to the COVID-19 pandemic and provided reimbursement and regulatory relief to assist health care providers in expanding telehealth. However, this regulatory relief is time limited; it is only approved through the duration of the COVID-19 public health emergency. In Table 1, we have summarized a sampling of State emergency flexibilities that have been critical to expanding the adoption and use of telehealth at FQHCs and behavioral health organizations.

State Regulator	Pre-COVID Restrictions	Emergency Flexibility
Office of Addiction Services and Supports (OASAS)	<ul style="list-style-type: none"> • Required written authorization from OASAS to begin telehealth services • Required client to have on face-to-face encounter prior to telehealth • Limited practitioners eligible to provide telehealth • Had strict requirements on space occupied by both practitioner and client • Required practitioner to maintain control of client's camera • Required services be at an OASAS certified location • Telephonic services not allowed 	<ul style="list-style-type: none"> • Providers are eligible to self-certify to begin telehealth • Clients can begin care in telehealth • Scope of practice expanded to other care providers • Restrictions on space occupied are waived, but HIPAA provisions intact • Practitioner is not required to control client's camera • Waived; services can be provided remotely • Telephonic services allowed
Department of Health, Office of Health Insurance Programs (OHIP)	<ul style="list-style-type: none"> • Originating site must be at a licensed facility • To receive full PPS equivalent, distant site must be at a licensed facility • Reduced payment rate for patients located at home • Providers unable to deliver care from home • Telehealth services delivered to MMC patients are ineligible for supplemental wraparound payment • Telephonic and asynchronous visits are not billable 	<ul style="list-style-type: none"> • Definition of originating site expanded to include patient's home • Distant site definition modified to be anywhere in US, including a provider's home • Reimbursement rate was modified to ensure FQHCs receive full wraparound rate for some telehealth visits • Payment parity regardless of patient location • Telephonic and asynchronous visits are reimbursable (guidance still pending) • Any FQHC provider that is eligible to bill for an in-person threshold visit is eligible to bill for remote visits
Office of Mental Health (OMH)	<ul style="list-style-type: none"> • Provision of tele-mental health required prior approval • Limited by location of practitioner • Residential services required face-to-face encounter • Most programs required face-to-face encounters with limited tele-service • Involuntary committal required face-to-face encounter • Controlled substances cannot be provided without an in-person visit • Consent for services was required to be in-person and in writing 	<ul style="list-style-type: none"> • Prior approval requirements waived • Location limitations waived • Requirements waived and telemental health allowed • Requirements for in-person encounters waived • Telemental health services are acceptable for involuntary removal • Controlled substances can be prescribed using telehealth • Consent for services can be done via telehealth and verbally

Table 1. State restrictions to telehealth pre COVID-19 and newly issued flexibilities

TELEHEALTH IN NYS DURING COVID-19 RESPONSE

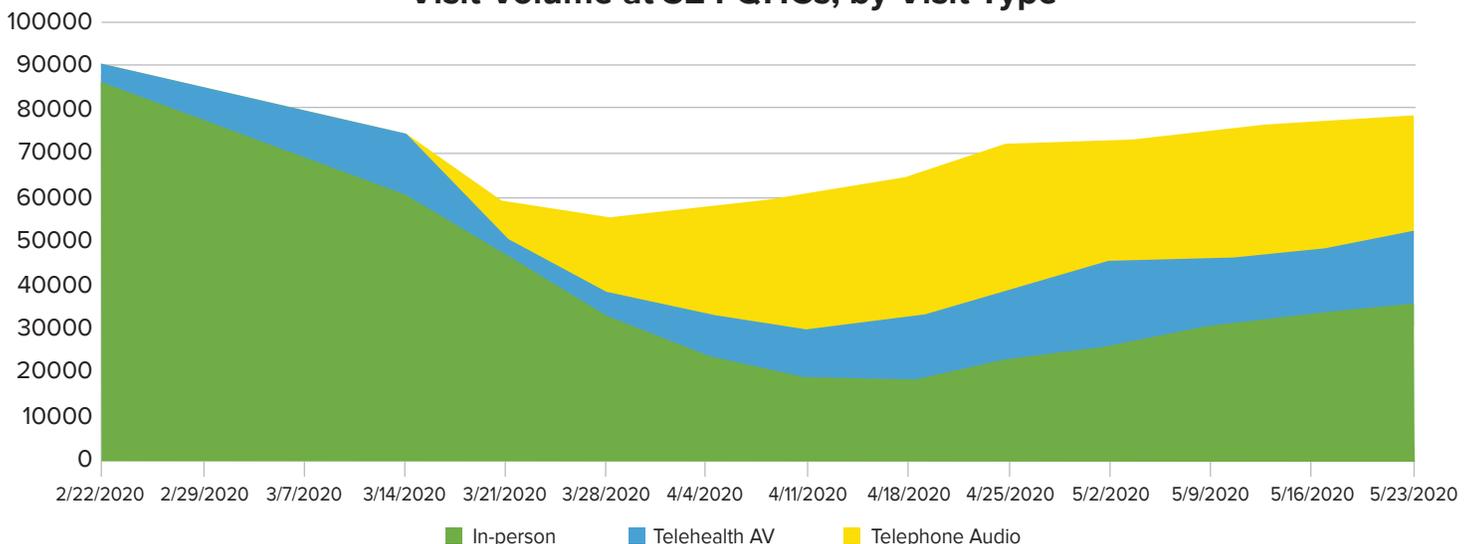
Expanded regulatory relief related to telehealth resulted in immediate improvements in access and use of telehealth to deliver care. CHCANYS reports that since March, health centers have had more than 115,800 telehealth visits, including 69,000 audio-only visits. Whereas only 35% of NY FQHCs utilized telehealth in 2018, recent CHCANYS surveys indicate that at least 88% of them now deliver care remotely. The Mental Health Association of Westchester reports that prior to COVID-19, 4.5% of their visits were conducted via telehealth, while during the pandemic that percentage increased to 92% within a span of only four days. This is consistent with other behavioral health providers in New York, who reported through a NYSCCBH survey that, as of mid-June, telehealth comprised 90% of visits and 86% of revenue. NYSCCBH reports that consumers are expressing satisfaction with their telehealth visits. Family Counseling Services of Cortland County reported that 95% of their consumers expressed satisfaction with telehealth as a service modality. BestSelf Behavioral Health in Buffalo reported that their engagement rate (as indicated by attending their first three visits) increased by 15% as a result of telehealth.

Remote access to care by telephone is a matter of health equity for disadvantaged populations, especially those located in areas that have been most adversely impacted by the COVID-19 public health emergency. Many patients face barriers to access-

ing audio-visual care, including lack of sufficient data plans on mobile phones, lack of computers, and lack of internet access. According to a recent CHCANYS survey, 68% of community health center (CHC) visits are happening remotely with 33% occurring via the telephone. Providers surveyed by NYSCCBH report that 63% of their telehealth visits are being provided with audio only. Early data indicate that consumers prefer an audio-only option. Family Services, in Poughkeepsie, surveyed their clients (n=887) and found that 83% enjoy having an audio-only option, 89% say they feel connected with their provider over the phone, and 77% feel they are able to make progress on their treatment goals by having sessions over the phone.

The impact of this rapid deployment of telehealth was significant. Many NYSCCBH members who had seen rapidly declining visit rates were stabilized. Surveyed providers reported that their in-person visit volume dropped by an average of 23% at its worst point, but that with telehealth, the current volume is only 14% lower than usual. CHCANYS members experienced a similar pattern. An early CHCANYS financial analysis found that collectively, health centers were experiencing losses of \$30 million per week at the beginning of the pandemic. After the rapid adoption of telehealth, those losses have been trimmed significantly and many FQHCs are increasing visit volume, nearing pre-COVID-19 levels.

Visit Volume at 32 FQHCs, by Visit Type



TELEHEALTH IN NYS DURING COVID-19 RESPONSE

Among behavioral health and FQHC providers, client no-show rates have dropped substantially. Barriers such as lack of transportation or childcare have been minimized thanks to telehealth, resulting in the potential for more consumers to become engaged in care. Telehealth has been essential in

helping patients avoid COVID-19 exposure both on public transportation and in the clinical setting. Finally, the ability to provide services via the telephone has been critical for establishing remote connection with patients who have historically been unable to take advantage of audiovisual telehealth.

ENVISIONING REMOTE CARE POST-PANDEMIC

Sustaining regulatory flexibilities that have led to increased access will ensure that safety net patients continue to receive care via the modality that best suits their needs. Future models of health care delivery must include a full range of care modalities, including in-person, audiovisual and audio-only telehealth. Providers must be afforded the flexibility to develop care teams and workflows that maximize efficiency and quality of care as well as provider and patient satisfaction. However, this will not be accomplished without the continued flexible regulatory and reimbursement models that allow for a full range of telehealth modalities.

Many individuals served by safety net providers lack access to the technology or resources needed to engage in audio-visual telehealth. Costs of hardware with videoconferencing capability and lack of broadband access can prevent clients from accessing telehealth.²² Removing the ability to receive reimbursement for audio-only services in a post pandemic period will likely exacerbate existing health inequities.

Even before the COVID-19 pandemic, safety net providers struggled to recruit and retain qualified practitioners, adding to existing access to care challenges. Almost 80% of New York's behavioral health workforce needs are unmet,²³ and turnover rates of 35-40% are not uncommon. Practitioners demand a healthy work/life balance, seeking flexibility in work hours and location. Pivoting to remote care could result in higher employee job satisfaction

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The insights telehealth has given into the daily lives of our patients have been incredible. We have been taken on virtual walking tours of dairy farms, shared work breaks with essential workers, ridden empty buses through distant Upstate towns, been shown awful tent living conditions and provided sleeping bags in response.

We've realized how much we'd been missing from the stories we thought we knew, and this has enabled us to provide more informed care.

—Elizabeth Ryan

Telehealth Must Stay After COVID-19 to Save Our Patients From Overdose, Filter Magazine

over the long term and may help ameliorate some of the recruitment and retention issues suffered by FQHCs and behavioral health organizations. Moreover, it will provide practitioners the opportunity to reach more patients across a larger geography, improving access for hard to reach areas.

JOINT POLICY RECOMMENDATIONS FOR A POST PANDEMIC PERIOD

To ensure that telehealth becomes a valuable resource for people served by the safety net, we recommend that the State adheres to a set of core principles for determining telehealth regulatory and reimbursement structures:

- 1. Utilize telehealth to increase access and promote health equity through support for the full range of telehealth modalities.**
- 2. Maximize regulatory flexibilities to sustain telehealth adoption.**
- 3. Clinicians, in collaboration with clients, determine when a telehealth visit is appropriate.**
- 4. Reimburse telehealth visits on par with in-person visits to ensure a comprehensive, coordinated and integrated continuum of care.**

The following policy changes are recommended to enact these principles:

- 1. Utilize telehealth to increase access and promote health equity through support for the full range of telehealth modalities.**
 - Reimburse telephonic visits post pandemic.** Lack of access to technology is an equity issue that disparately impacts poor communities, which are disproportionately people of color. Many individuals face technical barriers to care in accessing telehealth. This is true in poor communities and neighborhoods where internet access or cell service may not be a given, in rural communities where broadband coverage remains sparse, and with individuals who have developmental disabilities, don't routinely use technology or lack English proficiency. As telehealth becomes more widely available, failure to reimburse telephonic visits on par with in-person visits will reduce usage for some populations, potentially exacerbating existing health inequities.
 - Invest in strategies to address the technology divide.** Improve broadband access and cellular service in rural areas and expand free wi-fi and cellular service in urban areas. Continue

New York's plan to expand broadband access to all remote and rural communities in New York State. Continue to ensure wi-fi access in public housing and low-income neighborhoods. Ensure individuals across the State are able to utilize telephonic services regardless of location by expanding the number of cellular towers in rural and urban communities.

- 2. Maximize regulatory flexibilities to sustain telehealth adoption.**
 - Continue the emergency expansion of allowable licensed practitioners to provide telehealth care.** Telehealth is a modality, not a service, and licensed practitioners that can deliver care in-person can also deliver excellent care remotely for those services that are appropriate. In addition, the State should immediately make reimbursement for peer services provided through telephonic only and other modalities reimbursable.
 - Do not require in-person visits prior to telehealth visits.** Telehealth visits can be appropriate whether the clinician and client have met face-to-face or not. For example, across the State, lengthy travel times and childcare challenges can impede in-person visits. In such instances, telehealth serves as an appropriate first access point.
 - Support remote group and family therapy visits.** Permit telehealth visits for group therapy sessions and family therapy visits. Tele-group therapy will enhance individuals' ability to access group therapy (an effective and efficient treatment modality) in ways that enable practitioners to establish harmonious and well-balanced groups. Patients beginning outpatient group services for substance use disorder often find group sessions via telehealth to be less intimidating. Similarly, tele-family therapy can prove essential if families are spread across wide geographic areas.

JOINT POLICY RECOMMENDATIONS FOR A POST PANDEMIC PERIOD

- **Invest in workforce training and research to establish an evidence base.** Clinicians across the state have done heroic work during the pandemic making the shift to telehealth. They, and their supervisors, will need training in telehealth clinical methodologies in order to maximize telehealth's benefit for their clients. To develop effective protocols, research is needed to truly understand where and when telehealth is most impactful (and when it is not). Research of the scope and scale necessary will not be possible for any individual provider to conduct.
- **Permit electronic signatures.** Enabling the electronic and verbal signing of consents and other necessary client approvals will facilitate the efficient and rapid access that should be a hallmark of the hybrid service delivery model.
- **Allow for case conferencing and collateral visits to be done remotely.** Case conferences and collateral visits should be consistently reimbursed and permitted via videoconference.
- **Do not limit the number or percentage of visits that can be administered using telehealth.**
- **Reform CON/PAR.** As possible, consider whether safety net providers with a full operating certificate and extension clinics continue to need separate applications for extension sites when telehealth is a significant component of the service delivery model. The historically site-based licensing model needs to be reconsidered in response to this new service delivery model.

3. Clinicians, in collaboration with clients, determine when a telehealth visit is appropriate.

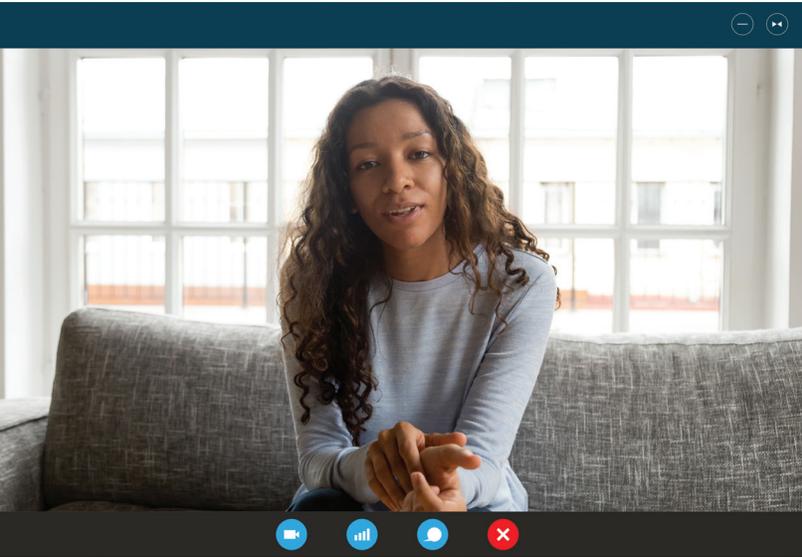
- **Treat telehealth as a “tool” in the health care toolbox and leave discretion for its use with the clinician in collaboration with the client, based on patient needs and capacity.** Industry-accepted best practices are needed to guide clinicians' decisions about treatment modalities. At the same time, practitioners will need to tailor care to promote the best outcome possible based on each consumer's need and preferences. Clinical

decision-making and consumer choice must drive care delivery. Regulations should permit the least intensive viable technology based on clinical considerations and consumer preference.

4. Reimburse telehealth visits on par with in-person visits to ensure a comprehensive, coordinated and integrated continuum of care.

- **Provide reimbursement parity for all telehealth visits.** Maintain supplemental wraparound payments for telehealth visits at FQHCs. Reimburse all Article 28, 31, and 32 visits on par with face-to-face services regardless of whether the telehealth is audio-visual or audio only.
- **Consider an Alternative Payment Methodology (APM) for primary care and behavioral health providers.** A capitated APM model would alleviate altogether the need for the state to count and pay for each different visit type and care delivery modality. If providers can be paid a lump sum amount for care of a patient, innovation can allow for more efficient models of care. Without meeting a “threshold” for billing, nurses can provide screening and education via tele phone to patients at times that are convenient to both, while only having to come to a provider site for a physical exam. The pandemic highlighted the need for a payment methodology that incentivizes providers to focus on population health rather than visit volume. An APM provides flexibility to allow practitioners to innovate with care teams and workflows, allowing all provider types to operate at the top of their profession. Additionally, a capitated APM would enhance care integration among FQHCs and behavioral health organizations. APMs allow safety net providers and the State to budget more effectively. Ultimately, an APM would safeguard the safety net against system disruptions such as the COVID-19 outbreak.

CONCLUSION



In order to sustain expanded access to care that has resulted from increased remote care delivery, the State must consider making permanent many of the flexibilities telehealth afforded during the COVID-19 pandemic. Audio-only services have reduced no-show rates, improved compliance with behavioral health treatment models and expanded access to services for patients that have historically been unable to take advantage of audio-visual telehealth due to technical and financial limitations. Safety net providers have also expanded audio-

visual telehealth, ensuring that patients are able to take advantage of a full range of care delivery options. Patients and providers cannot be expected to revert back to old care models in the face of the innovation started during the COVID-19 response. CHCANYS and the NYSCCBH look forward to collaborating with the State to ensure that all New Yorkers continue to have access to comprehensive whole person primary and behavioral health care both remotely and in person.

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