TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
KA ʻOIHANA O KA LOIO KUHINA
THIRTY-SECOND LEGISLATURE, 2023

ON THE FOLLOWING MEASURE:
H.B. NO. 907, H.D. 1, RELATING TO TELEHEALTH.

BEFORE THE:
HOUSE COMMITTEE ON CONSUMER PROTECTION AND COMMERCE

DATE: Thursday, February 16, 2023 **TIME:** 2:00 p.m.

LOCATION: State Capitol, Room 329

TESTIFIER(S): Anne E. Lopez, Attorney General, or
Erin N. Lau, Deputy Attorney General

Chair Nakashima and Members of the Committee:

The Department of the Attorney General provides the following comments.

This bill amends a medical assistance statute and several insurance statutes to require reimbursement for services provided by a physician to a patient through the use of an "interactive telecommunications system." It includes audio-only technology for behavioral health services and defines "two-way real-time audio-only communication" as the same definition with the same conditions for reimbursement as the Medicare federal regulations at title 42 Code of Federal Regulations (CFR) section 410.78.

The bill amends four different statutory sections to add the same definition of "interactive telecommunications system" as follows:

> "Interactive telecommunications system" has the same meaning as in title 42 Code of Federal Regulations section 410.78**, as amended**. For purposes of this definition, "two-way real-time audio-only communication" **has the same meaning** and is subject to the same conditions as in title 42 Code of Federal Regulations section 410.78**, as amended**.

See, page 3, lines 14-19; page 6, lines 12-17; page 9, lines 6-11, and page 12, lines 3-8 (emphases added). The words "as amended" in reference to the federal law makes the definition ambiguous because 42 CFR § 410.78 has been amended several times, and the bill does not specify the amendment it relates to or whether it is intended to incorporate all prior and future amendments. Incorporating the future law of another jurisdiction has been subject to challenge as an unlawful delegation of legislative power.

See State v. Tengan, 67 Haw. 451 (1984). In addition, the amendment to require that "two-way real-time audio-only communication" has the same meaning as the federal regulation is ambiguous because the federal regulation does not specifically define this term. Moreover, any conditions for reimbursement should be included in the reimbursement section rather than within the definition of "interactive telecommunications system." To clarify the definition of "interactive telecommunications system," we recommend striking the "as amended" and the revision to include "two-way real-time audio-only communication" so that the definition would read as follows:

> "Interactive telecommunications system" has the same meaning as in title 42 Code of Federal Regulations section 410.78.

And with that change, we recommend revising the reimbursement amendments on page 2, line 10; page 5, line 8; page 8, line 5; and page 10, line 20, to include the conditions for reimbursement of a "two-way real-time audio-only communication," so that the reimbursement section would read as follows:

> Reimbursement for services provided through telehealth by way of an interactive telecommunications system shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient, provided that reimbursement for the diagnosis, evaluation, or treatment of a mental health disorder delivered through an interactive telecommunications system must meet the requirements of title 42 Code of Federal Regulations section 410.78.

The current definition of "telehealth" explicitly excludes the use of "standard telephone contacts, facsimile transmissions, or email text[.]" See, sections 346-59.1, 431:10A-116.3, 432:1-601.5, and 432D-23.5, Hawaii Revised Statutes. This bill sets forth and amends the definition of telehealth in these four statutory sections as follows:

> "Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for

> the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. [~~Standard~~] Except as otherwise provided for in this section, standard telephone contacts, facsimile transmissions, or [~~e-mail~~] electronic mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this section."

See page 4, line 8, through page 5, line 3; page 7, lines 5-21; page 9, line 20, through page 10, line 15; and page 12, line 17, through page 13, line 12. This amendment is ambiguous because it seems to reference an exception for the use of telephone contacts, facsimile transmissions, or e-mail text that are otherwise excluded. Yet neither the bill nor the statute provides a clear exception set out for these methods of communication. Instead, the bill adds a new term to the statutes, "interactive communications system" (as set out above), which includes a "two-way, real-time audio-only communication technology." Because different wording is used, it is not clear that "interactive communications system" includes telephone contacts, facsimile transmissions, or e-mail text, or that those are things that should be included in reimbursement.

To address the ambiguity, we recommend revising the amendment in the definition of "telehealth" on page 4, lines 20-21; page 7, lines 17-18; page 10, lines 11-12; and page 13, lines 8-9, to read as follows: "[~~Standard~~] Except as provided through an interactive telecommunications system, standard telephone contacts . . . . "

We respectfully ask the Committee to consider the recommended amendments.

JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA

CATHY BETTS
DIRECTOR
KA LUNA HO'OKELE

JOSEPH CAMPOS II
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

STATE OF HAWAII
KA MOKU'ĀINA O HAWAI'I
DEPARTMENT OF HUMAN SERVICES
KA 'OIHANA MĀLAMA LAWELAWE KANAKA
Office of the Director
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February 14, 2023

TO: The Honorable Representative Mark M. Nakashima, Chair
House Committee on Consumer Protection & Commerce

FROM: Cathy Betts, Director

SUBJECT: **HB 907 HD1 – RELATING TO TELEHEALTH.**

Hearing: February 16, 2023, 2:00 p.m.
Conference Room 329 & Videoconferencing, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) appreciates the Committee on Health and Homelessness (HLT) adopting the department's proposed amendment.

PURPOSE: The bill authorizes reimbursement of telehealth services provided by way of an interactive telecommunications system be reimbursed. Effective 6/30/3000. (HD1)

DHS appreciates the Committee on Health & Homelessness (HLT) amendments:

(1) Clarifying that "interactive telecommunications system" includes two-way real-time audio-only communication;

(2) Changing the effective date to June 30, 3000, to encourage further discussion; and

(3) Making technical, nonsubstantive amendments for the purposes of clarity, consistency, and style.

DHS supports the ongoing use of telehealth, including the Medicare definition and rules for an "interactive telecommunication system" that also specifies the use of "two-way real-time audio-only communication" for mental health services. DHS appreciates the HLT committee

adopting the DHS amendment, which clarifies the definition of “interactive telecommunications system” and ensures that Hawaii's law will now remain aligned with federal regulations by referring to the CFR without requiring additional state law amendments.

Thank you for the opportunity to provide comments on this measure.

JOSH GREEN, M.D.
GOVERNOR | KE KIA'ĀINA

SYLVIA LUKE
LIEUTENANT GOVERNOR | KA HOPE KIA'ĀINA

STATE OF HAWAII | KA MOKUʻĀINA ʻO HAWAIʻI
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NADINE Y. ANDO
DIRECTOR | KA LUNA HOʻOKELE

DEAN I. HAZAMA
DEPUTY DIRECTOR | KA HOPE LUNA HOʻOKELE

Testimony of the Department of Commerce and Consumer Affairs

Before the
House Committee on Consumer Protection and Commerce
Thursday, February 16, 2023
2:00 p.m.
State Capitol, Conference Room 329 and via Videoconference

On the following measure:
H.B. 907, H.D. 1, RELATING TO TELEHEALTH

Chair Nakashima and Members of the Committee:

My name is Gordon Ito, and I am the Insurance Commissioner for the Department of Commerce and Consumer Affairs' (Department) Insurance Division. The Department offers comments on this bill.

The purpose of this bill is to authorize reimbursement of telehealth services provided by way of an interactive telecommunications system be reimbursed.

We support efforts to improve access to health care services.

By inserting the phrase "by way of an interactive telecommunications system" at page 5, line 8, page 8, line 5, and page 10, line 20, this bill would exclude any telehealth services from reimbursement that do not meet the new definition of "interactive telecommunication system", essentially requiring a service to be both "telehealth" and an "interactive telecommunications system" to be eligible for reimbursement.

Further, the amendments to the definition of "telehealth" at page 7, lines 17 to 19; page 10, lines 11-13; and page 13 lines 8 to 10, presume that the bill brings standard telephone contacts, facsimile transmissions, or electronic mail text not the definition of

"telehealth". However, the bill makes no such amendment. This may lead to confusion and statutory interpretation issues.

Finally, this bill was amended in H.D. 1, in part, by inserting the phrase "'two-way real-time audio-only communication" has the same meaning and is subject to the same conditions as in title 42 Code of Federal Regulations section 410.78[.]" See page 6, lines 14-17; page 9, lines 8-11; and page 12, lines 5-8. This amendment would suggest that 42 CFR § 410.78 includes a definition for "two-way real-time audio-only communication[;]" however, this rule includes no such definition. Therefore, the meaning of this insertion is vague and it will lead to statutory interpretation issues.

Thank you for the opportunity to testify on this bill.

An Independent Licensee of the Blue Cross and Blue Shield Association

February 16, 2023

The Honorable Mark Nakashima, Chair
The Honorable Jackson Sayama, Vice Chair
House Committee on Consumer Protection and Commerce

Re: HB 907 – Relating to Telehealth

Dear Chair Nakashima, Vice Chair Sayama, and Members of the Committee:

Hawaii Medical Service Association (HMSA) appreciates the opportunity to provide comments on HB 907, which authorizes reimbursement of telehealth services provided by way of an interactive telecommunications system.

HMSA supports the intent of this legislation; however, we do not support this bill in its current form. As an early supporter of telehealth access for our state, we believe in increasing access to health care services in Hawaii, especially for kupuna who may have limited digital literacy and for those living in rural and underprivileged communities where broadband coverage is lacking.

Here are some of our concerns regarding this legislation:

- There's currently no data to show that the quality of care provided by way of an interactive telecommunications system *without* a visual element is as effective as in-person or telehealth visits. Because of that, reimbursement for an audio-only visits should not be equivalent to when that same service is provided service via face-to-face contact.
- Additionally, behavioral health providers obtain valuable insights during a face-to-face interaction. These include facial expressions, body language, and even a patient's living conditions. In light of that, HMSA supports requiring guardrails similar to those observed by CMS, which include an in-person visit 6 months prior to audio-only interactions and every 12 months after these visits. [1] To acknowledge the challenge that in-person visits could present for some patients, HMSA would support substituting a telehealth visit as a way of fulfilling the in-person requirement.
- We also support including a sunset date to this legislation of 12/31/24, the same date that CMS is ending several temporary telehealth extensions. This will allow time to gather data to better determine the value and effectiveness of audio-only visits for behavioral health.

We respectfully request revisions to the following sections:

Page 2, Section 2, line 9: Section 346-59.1, Hawaii Revised Statutes, subsection (b),
Page 5, Section 3, line 7: Section 431:10A-116.3, Hawaii Revised Statutes, subsection (c),
Page 8, Section 4, line 4: Section 432:1-601.5, Hawaii Revised Statutes, subsection (c), and
Page 10, Section 5, line 19: Section 432D-23.5, Hawaii Revised Statutes, subsection (c) will be amended to say:

[1] MM12549 - CY2022 Telehealth Update Medicare Physician Fee Schedule (cms.gov)
https://www.cms.gov/files/document/mm12549-cy2022-telehealth-update-medicare-physician-fee-schedule.pdf

An Independent Licensee of the Blue Cross and Blue Shield Association

Reimbursement for services provided through telehealth by way of an interactive telecommunications system shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient, except for two-way, real-time audio-only communication technology for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in their home as defined in title 42 Code of Federal Regulations section 410.78, which shall be paid at 80% of the same services provided via face-to-face contact between a health care provider and a patient, and only so long as the health care provider has conducted an in-person or telehealth visit with the patient no longer than six months prior to the audio-only service and every 12 months after these visits. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary."

Page 13, Section 7, line 15: is amended by adding: *"This Act shall take effect upon its approval with a sunset date of December 31, 2024.*

Thank you for the opportunity to provide comments on HB907.

Sincerely,

Jennifer A. Diesman
Senior Vice President
Government Policy and Advocacy

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The State Legislature
The House Committee on Consumer Protection and Commerce
Thursday, February 16, 2023
Conference Room 329, 2:00 p.m.

TO: The Honorable Mark Nakashima, Chair
RE: Support for H.B. 907 HD 1 Relating to Telehealth

Aloha Chair Nakashima and Members of the Committees:

My name is Keali'i Lopez and I am the State Director for AARP Hawai'i. AARP is a nonpartisan, social mission organization that advocates for individuals age 50 and older. We have a membership of nearly 38 million nationwide and nearly 140,000 in Hawaii. We advocate at the state and federal level for the issues that matter most to older adults and their families, including telehealth. **AARP strongly supports H.B. 907 HD1** which clarifies that telehealth services provided by way an interactive telecommunications system including real time audio-only communication(telephone) be reimbursed.

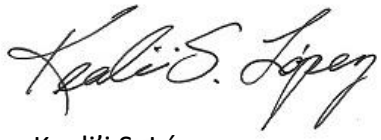
AARP fights for issues that matter most to families such as healthcare, family caregiving and independent living and believes no one's possibilities should ever be limited by their age and seeks to find new solutions so that more people can live and age as they choose. Among these issues is access to meaningful healthcare coverage.

AARP believes that telehealth is an important tool that can help people access health care in new ways and can make it easier for family caregivers to care for their loved ones. More and more of our members, especially those aged 50-59, are using their mobile devices and tablets to access information about their health. The use of telehealth technologies (especially those that include family members in virtual visits with providers) has the potential to result in better access to care, reduced transportation barriers, and improved outcomes for the care recipient.

With the continued presence of COVID-19, many people are still reluctant to leave their homes for an in-person visit with their health provider. Some are not comfortable using telehealth even with access to a computer and internet connection, while a telephone remains the preferred mode for communication for many especially kupuna. Therefore, it is critical that audio-only is recognized as a valid telehealth modality.

Thank you very much for the opportunity to testify in support of H.B 907, HD1**.**

Sincerely,



Keali'i S. López
State Director

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

Testimony to the House Committee on Consumer Protection and Commerce
Thursday, February 16, 2023; 2:00 p.m.
State Capitol, Conference Room 329
Via Videoconference

RE: HOUSE BILL NO. 0907, HOUSE DRAFT 1, RELATING TO TELEHEALTH.

Chair Nakashima, Vice Chair Sayama, and Members of the Committee:

The Hawaii Primary Care Association (HPCA) is a 501(c)(3) organization established to advocate for, expand access to, and sustain high quality care through the statewide network of Community Health Centers throughout the State of Hawaii. The HPCA **SUPPORTS** House Bill No. 0907, House Draft 1, RELATING TO TELEHEALTH.

By way of background, the HPCA represents Hawaii's Federally Qualified Health Centers (FQHCs). FQHCs provide desperately needed medical services at the frontlines to over 150,000 patients each year who live in rural and underserved communities. Long considered champions for creating a more sustainable, integrated, and wellness-oriented system of health, FQHCs provide a more efficient, more effective and more comprehensive system of healthcare.

This bill, as received by your Committee, would:

(1) Require insurance reimbursement for services provided through telehealth by way of an "interactive telecommunications system"';

(2) Specify that the definition of "interactive telecommunications system" include "two-way real-time audio-only communication"; and

(3) Define "interactive telecommunications system" to be consistent with 42 CFR 410.78, as amended.

This bill would apply to Medicaid (Chapter 346, Hawaii Revised Statutes (HRS)), accident an health or sickness insurance contracts (Article 10A of Chapter 431:10A, HRS), benefit societies (Article 1 of Chapter 432, HRS), and health maintenance organizations (Chapter 432D, HRS).

This bill would also take effect upon approval.

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We believe this issue is fundamentally one of equity for the patients who are covered by private insurance with those who are covered by Medicare and Medicaid. As we stated last year, what is good for Medicare should be good for private insurance. To that end, we firmly assert that private insurers cannot justify why benefits that are required under Medicare and Medicaid should not likewise be required for private insurers.

Last year, we tried to work a compromise that would ensure access while addressing concerns on loss costs. However, HMSA declined to participate. Since then, we successfully reached out to HMSA and have engaged in constructive discussions that are ongoing. It is our hope that these discussions will result in an outcome that will be agreeable to all. For that, we thank HMSA for working with us and commend them for their efforts in this regard.

Accordingly, for the purpose of facilitating continued discussions on this issue, the HPCA respectfully urges your favorable consideration of this measure.

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact Public Affairs and Policy Director Erik K. Abe at 536-8442, or eabe@hawaiipca.net.

The Hawaiian Islands Association for Marriage and Family Therapy (HIAMFT)
We know systems.
We know relationships.
We know FAMILY MATTERS.

COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Mark M. Nakashima, Chair
Rep. Jackson D. Sayama, Vice-Chair
February 16, 2023 10:30 A.M. - VIA VIDEO CONFERENCE –329

Testimony in STRONG SUPPORT of HB907 HD1 RELATING TO TELEHEALTH

The Hawaiian Islands Association for Marriage and Family Therapy (HIAMFT) strongly supports HB907 HD1, which promises an overall improvement and increased access to quality mental health services by incorporating the federal Centers for Medicare and Medicaid Services definition of "interactive telecommunications system" to allow:

"services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in their home, [where] interactive telecommunications may include two-way, real-time audio-only communication technology if the distant site physician or practitioner is technically capable to use an interactive telecommunications system but the patient is not capable of, or does not consent to, the use of video technology . . ."

HIAMFT believes this language achieves a well-reasoned balance based on robust research, analysis, and deliberation on audio-only telehealth conducted at a federal level.

RESEARCH SHOWS AUDIO-ONLY WORKS

HIAMFT also appreciates the clinical outcomes achieved by audio-only mental health treatment through "talk therapy", such as frequently provided by Marriage and Family Therapists. Not only does audio-only talk therapy help our patients just as effectively, (and sometimes more effectively) than in-person or video meetings, the telephonic services allowed in this proposal will increase access to and utilization by several marginalized and/or remote populations who otherwise would not seek or be able to maintain service. In one study published in Clinical Psychology: Science and Practice (v15 n3, September 2008), researchers concluded that: "telephone- administered psychotherapy can produce significant reductions in depressive symptoms. Attrition rates were considerably lower than rates reported in face-to-face psychotherapy."

In a 2006 study published in the British Medical Journal entitled "*Telephone administered cognitive behaviour therapy for treatment of obsessive compulsive disorder: randomized controlled non-inferiority trial,*" researchers concluded **"[t]he clinical outcome of cognitive behaviour therapy delivered by telephone was equivalent to treatment delivered face to face and similar levels of satisfaction were reported."**

Further, in the Journal of Neurotrauma 32:45-57 (January 1, 2015), researchers concluded that "In-person and telephone-administered CBT [Cognitive Behavioral Therapy] are acceptable and feasible in persons with TBI [Traumatic Brain Injury] . . . [T]elephone CBT holds particular promise for enhancing access and adherence to effective depression treatment."

In another study published in American Journal for Geriatric Psychiatry in 2012, entitled "A Randomized Controlled Trial of Telephone-Delivered Cognitive-Behavioral Therapy for Late-Life Anxiety Disorders," doctors used audio-only therapy and concluded "These results suggest that CBT-T [cognitive behavioral therapy delivered by telephone] may be efficacious in reducing anxiety and worry in older adults."

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In 2011, the American Psychological Association's Journal, Professional Psychology: Research & Practice Vol. 42, no. 6, 543-549, published a study entitled "Benefit and Challenges of Conducting Psychotherapy by Telephone" concluded that with audio-only therapies: "Results of randomized, controlled trials indicate high client acceptance and positive outcomes with this method of delivering psychotherapy.

"TELEHEALTH" INNOVATION SHOULD NOT FORFEIT ACCES TO THOSE INCAPABLE OF USING THIS TECHNOLOGY

While devasting to public health and our economy, the COVID 19 Pandemic has spurred revolutionary developments in telehealth. However, as much as we need to embrace change, we should not turn our back on old reliable tools for meeting our most vulnerable where they are.

Across the country multiple jurisdictions are making permanent many of the pandemic-prompted changes to the way health care is provided. However, certain measures have been necessary to assure access and connection to those who are otherwise out-of-reach from this quickly-advancing technology.

As is confirmed by recent research, telephonic service is critical to improving access to several **vulnerable groups of patients: (1) the elderly; (2) low-income; (3) mobility- challenged; (4) limited English proficient; and (5) rural residents.** The disparities evident between the patients who use audio-only/telephone calls vs. the video-conferencing technologies of telehealth – during the pandemic - has been thoroughly researched and recognized by DHHS. The DHHS policy brief (entitled "National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services" reported:

"[O]ur study findings are consistent with research studies that show **disparities in audio-only vs. video- enabled telehealth modalities by race/ethnicity, age, education, income, and health insurance coverage**. In a recent survey study, patients with a household income of $50,000 or more were 34 percent more likely to choose a telehealth visit than those making less than $50,000. . . . Although research shows that video visits offer some additional benefits compared with telephone visits, they require more complex setup, video-enabled devices, and broadband internet access, which may present **barriers for older adults, lower income households, and those with limited English proficiency.** In addition to these factors, patients with lower incomes may be more likely to use audio-only services because they are at work during appointments or lack privacy at home. Consistent with these concerns, **we also found lower use of video-enabled telehealth services among adults with low-incomes and those without a high school degree**."

FOLLOWING THE FEDS ASSURES BEST PRACTICES:

HIAMFT believes if we "follow the feds," we benefit from the research and deliberations determined by CMS to be best practices; and incorporate these best practices in Hawaii's private insurance plans. If it's good enough for Medicare and Medicaid, it is good enough for private insurance. We therefore support any amendment executive agencies request to ensure this proposal is unambiguous and consistent with federal law. We are also otherwise available and open to further deliberations with stakeholders on other approaches to improve access and utilization of mental health services through telephonic telehealth; and respectfully request that your committee pass this bill to continue these discussions.

Nevertheless, we believe audio-only treatment is a critical measure in reaching vulnerable groups who do not have access to digital telehealth, either because they: lack of the financial means to obtain the necessary equipment or broad band service; live in rural and remote areas; do not have an adequate command of the English language to navigate the online platforms; or maybe because they are uncomfortable using high technology.

Thank you for the opportunity to testify in STRONG SUPPORT on this critical access to care legislation.

Sincerely,

John Souza, LMFT, DMFT

Dr. John Souza, Jr., LMFT, DMFT, President
The Hawaiian Islands Association for Marriage and Family Therapy

NASW HAWAI'I CHAPTER
National Association of Social Workers

COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Mark M. Nakashima, Chair
Rep. Jackson D. Sayama, Vice Chair

Thursday, February 16, 2023 - 2:00PM - Via Videoconference – Rm 329

Testimony in Strong Support on HB907 HD1 RELATING TO TELEHEALTH

The National Association of Social Workers – Hawai'i (NASW- HI) strongly supports this measure, which conforms state telehealth law to the medicare and medicaid standards for the reimbursement of audio-only mental health treatment by using the federal definition of "interactive telecommunications system".

Under Title 42 Code of Federal Regulations section 410.78:

> "***Interactive telecommunications system*** **means, except as otherwise provided in this paragraph, multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. For services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in their home, interactive telecommunications may include two-way, real-time audio-only communication technology if the distant site physician or practitioner is technically capable to use an interactive telecommunications system as defined in the previous sentence, but the patient is not capable of, or does not consent to, the use of video technology. A modifier designated by CMS must be appended to the claim for services described in this paragraph to verify that these conditions have been met." [Underlining added.]**

As we pivoted to a socially distant way of life over the last few years, we've come to appreciate the breadth and utility of telehealth services. However, several members of our community are unable to avail themselves of these services because they may not live in an area equipped with broadband coverage; or they may lack the resources to purchase a smartphone, tablet, or computer; or they are elderly or disabled and cannot operate equipment that require technological know-how or manual dexterity.

RESEARCH:

This bill removes barriers to access for so many disenfranchised members of our society who do not use the video technology required for telehealth. Recent studies have indicated that several vulnerable populations prefer audio-only treatments; and that expanding coverage in this way will the meet the needs of the elderly, disabled, low-income, disenfranchised racial, ethnic, and linguistic groups, and many others who may simply utilize and respond better to telephonic treatment. On this access matter, the Dept. of Health and Human Services recently issued policy brief (entitled "National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services"**,** reporting that:

> "[O]ur study findings are consistent with research studies that show **disparities in audio-only vs. video-enabled telehealth modalities by race/ethnicity, age, education, income, and health insurance coverage**. In a recent survey study, patients with a household income of $50,000 or more were 34 percent more likely to choose a telehealth visit than those making less than $50,000. . . . Although research shows that video visits offer some additional benefits compared with telephone visits, they require more complex setup, video-enabled devices, and broadband internet access, which may present **barriers for older adults, lower income households, and those with limited English proficiency.** In addition to these factors, patients with lower incomes may be more likely to use audio-only services because they are at work during appointments or lack privacy at home. Consistent with these concerns, **we also found lower use of video-enabled telehealth services among adults with low-incomes and those without a high school degree**."

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Likewise, the research indicates strong efficacy of Audio-only treatment. It is well-established in the research that behavioral health services administered over the telephone is not only as effective, but **sometimes more effective than face-to-face therapy**. For example, in one study published in Clinical Psychology: Science and Practice (v15 n3, September 2008), researchers concluded that: "**telephone- administered psychotherapy can produce significant reductions in depressive symptoms. Attrition rates were considerably lower than rates reported in face-to-face psychotherapy.**"

In a 2006 study published in the British Medical Journal entitled "*Telephone administered cognitive behaviour therapy for treatment of obsessive compulsive disorder: randomized controlled non-inferiority trial,*" researchers concluded **"[t]he clinical outcome of cognitive behaviour therapy delivered by telephone was equivalent to treatment delivered face to face and similar levels of satisfaction were reported."**

Further, in the Journal of Neurotrauma 32:45-57 (January 1, 2015), researchers concluded that "**In-person and telephone-administered CBT [Cognitive Behavioral Therapy] are acceptable and feasible in persons with TBI [Traumatic Brain Injury] . . . [T]elephone CBT holds particular promise for enhancing access and adherence to effective depression treatment.**"

In another study published in American Journal for Geriatric Psychiatry in 2012, entitled "A Randomized Controlled Trial of Telephone-Delivered Cognitive-Behavioral Therapy for Late-Life Anxiety Disorders," doctors used audio-only therapy and concluded "**These results suggest that CBT-T [cognitive behavioral therapy delivered by telephone] may be efficacious in reducing anxiety and worry in older adults."**

In 2011, the American Psychological Association's Journal, Professional Psychology: Research & Practice Vol. 42, no. 6, 543-549, published a study entitled "Benefit and Challenges of Conducting Psychotherapy by Telephone" concluded that with audio-only therapies: "**Results of randomized, controlled trials indicate high client acceptance and positive outcomes with this method of delivering psychotherapy.**"

THE FEDERAL APPROACH ASSURES BEST PRACTICES:

By "following the feds," and using CMS's definition to determine the contours of telephonic telehealth coverage, NASW-Hawaii believes we can ensure best practices will always be followed in the administration of private health insurance, as CMS's deliberations and policies evolve. If it's good enough for Medicare and Medicaid, it is good enough for private plans.

Accordingly, we support any amendments state agencies have requested to assure this proposal is clear, unambiguous, consistent with the legislative purpose of expanding audio-only access, and avoids conflicts of law.

We are also open to consider alternative approaches with stakeholders that improve access and utilization of mental health services through telephonic telehealth; and respectfully request that your committee pass this bill to continue these discussions.

There is such great demand and such a limited supply of providers, we want to enable and bolster all the methods that can be employed in addressing Hawaii's mental health needs. We therefore strongly support this proposal as it improves access to quality mental health services – especially to our vulnerable populations. If they prefer and respond most favorably to treatment administered via the telephone, we should be removing barriers to such care.

Thank you for the opportunity to provide this testimony in support.

Sincerely,

Sonja Bigalke-Bannan, MSW, LCSW

Sonja Bigalke-Bannan, MSW, LCSW
Executive Director,
National Association of Social Workers- Hawai'i Chapter

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COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Mark M. Nakashima, Chair
Rep. Jackson D. Sayama, Vice Chair

February 16, 2023 10:30 A.M. - VIA VIDEO CONFERENCE – Rm 329

The Hawai'i Psychological Association (HPA) strongly supports HB907 HD1 RELATING TO TELEHEALTH

Conclusive Research on Disparities in Access to Telehealth Access without Audio-only

Recent research indicates strong disparities between those who use audio versus video health and mental health services – particularly along racial, ethnic, linguistic, financial, and age-specific lines. On February 2, 2022, the United States Department of Health and Human Services (DHHS) issued a policy brief entitled "National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services"[1] which reported:

> "[0]ur study findings are consistent with research studies that show **disparities in audio-only vs. video-enabled telehealth modalities by race /ethnicity, age, education, income, and health insurance coverage**. In a recent survey study, patients with a household income of $50,000 or more were 34 percent more likely to choose a telehealth visit than those making less than $50,000. . . . Although research shows that video visits offer some additional benefits compared with telephone visits, they require more complex setup, video-enabled devices, and broadband internet access, which may present **barriers for older adults, lower income households, and those with limited English proficiency**. In addition to these factors, patients with lower incomes may be more likely to use audio-only services because they are at work during appointments or lack privacy at home. Consistent with these concerns, **we also found lower use of video-enabled telehealth services among adults with low-incomes and those without a high school degree**."

This bill recognizes these disparities and adopts the solution adopted by the Federal Centers for Medicare and Medicaid Services (CMS) in its definition of "interactive telecommunications system." The CMS approach promises to expand access and improve patient outcomes.

Conclusive Research on the Strong Efficacy of Audio-only Treatment for Mental Health

It is well-established in the research that behavioral health services administered over the telephone is not only as effective, but **sometimes more effective than face-to-face therapy**. For example, in one study published in Clinical Psychology: Science and Practice (v15 n3, September 2008), researchers concluded that: "**telephone-administered psychotherapy can produce significant reductions in depressive symptoms. Attrition rates were considerably lower than rates reported in face-to-face psychotherapy.**"

In a 2006 study published in the British Medical Journal entitled "*Telephone administered cognitive behaviour therapy for treatment of obsessive compulsive disorder: randomized controlled non-inferiority trial*," researchers

[1] https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf

concluded "**[t]he clinical outcome of cognitive behaviour therapy delivered by telephone was equivalent to treatment delivered face to face and similar levels of satisfaction were reported**."

Further, in the Journal of Neurotrauma 32:45-57 (January 1, 2015), researchers concluded that "**In-person and telephone-administered CBT [Cognitive Behavioral Therapy] are acceptable and feasible in persons with TBI [Traumatic Brain Injury] . . . [T]elephone CBT holds particular promise for enhancing access and adherence to effective depression treatment."**

In another study published in American Journal for Geriatric Psychiatry in 2012, entitled "A Randomized Controlled Trial of Telephone-Delivered Cognitive-Behavioral Therapy for Late-Life Anxiety Disorders," doctors used audio-only therapy and concluded "**These results suggest that CBT-T [cognitive behavioral therapy delivered by telephone] may be efficacious in reducing anxiety and worry in older adults."**

In 2011, the American Psychological Association's Journal, Professional Psychology: Research & Practice Vol. 42, no. 6, 543-549, published a study entitled "Benefit and Challenges of Conducting Psychotherapy by Telephone" concluded that with audio-only therapies: "**Results of randomized, controlled trials indicate high client acceptance and positive outcomes with this method of delivering psychotherapy."**

(Abstracts of some of the relevant research are attached.)

Following Federal Legislation in Telehealth Policy Assures Best Practices in Hawaii

Based on the foregoing, we believe it prudent to "follow the Feds" – as the research, analysis, and advocacy at the Federal level are ongoing and robust. Whatever best practices CMS ultimately determines are necessary for meeting the mental health needs of our most vulnerable; these practices should likewise be incorporated into Hawaii State statutes for private plans.

If it's good enough for Medicare and Medicaid, it is good enough for private insurance. In this regard, we have no objection to amendments recommended by State Executive Agencies to avoid ambiguities or conflicts in law.

We are also open and amenable to further discussions with other stakeholders on alternative approaches that will advance access and utilization of mental health services through telephonic telehealth. Accordingly, we encourage your committee to pass this bill to continue this dialogue.

Nevertheless, we believe this bill is crucial to improving patient outcomes, expediting timely service, and ultimately reducing costs and unnecessary administrative functions. HPA greatly appreciates legislative action to ensure old tools, like the standard telephone, are available to keep lines of communication open to provide necessary treatment to those who are: not comfortable with video-conferencing platforms; not equipped with the necessary technology or equipment due to expense; or those who live on more remote neighbor islands or in rural areas - out of reach of necessary broadband network capabilities.

Thank you for the opportunity to provide testimony in strong support of this important bill.

Sincerely,

Alex Lichton, Ph.D.
Chair, HPA Legislative Action Committee

ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HEALTH POLICY

ISSUE BRIEF

February 1, 2022

HP-2022-04

National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services

Madjid Karimi, Euny C. Lee, Sara J. Couture, Aldren Gonzales, Violanda Grigorescu, Scott R. Smith, Nancy De Lew, and Benjamin D. Sommers

KEY POINTS

- Telehealth use increased dramatically during the COVID-19 pandemic, but research suggests that access to telehealth was not equitable across different population subgroups.
- This report analyzes data regarding telehealth use from the Census Bureau's Household Pulse Survey from April to October 2021.
- Overall during the study period, we found that one in four respondents (23.1%) reported use of telehealth services in the previous four weeks.
- Telehealth use rates were similar (21.1-26.8%) among most demographic subgroups but were much lower among those who were uninsured (9.4%) and young adults ages 18 to 24 (17.6%).
- The highest rates of telehealth visits were among those with Medicaid (29.3%) and Medicare (27.4%), Black individuals (26.8%), and those earning less than $25,000 (26.7%).
- There were significant disparities among subgroups in terms of audio versus video telehealth use. Among telehealth users, the highest share of visits that utilized video services occurred among young adults ages 18 to 24 (72.5%), those earning at least $100,000 (68.8%), those with private insurance (65.9%), and White individuals (61.9%). Video telehealth rates were lowest among those without a high school diploma (38.1%), adults ages 65 and older (43.5%), and Latino (50.7%), Asian (51.3%) and Black individuals (53.6%).
- Policy efforts to ensure equitable access to telehealth, in particular video-enabled telehealth, are needed to ensure that disparities that emerged during the pandemic do not become permanent.

BACKGROUND

The use of telehealth services surged during the COVID-19 pandemic. A 2020 study found that telehealth use during the initial COVID-19 peak (March to April 2020) increased from less than 1 percent of visits[1] to as much as 80 percent in places where the pandemic prevalence was high,[2] and a recent ASPE report found that Medicare telehealth utilization increased 63-fold between 2019 and 2020.[3]

The Health Resources and Services Administration (HRSA) defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration.[4] Telehealth is comprised of two forms: 1) two-way, synchronous, interactive client-provider communication through audio

JAMA Network Open.

Research Letter | Diversity, Equity, and Inclusion

Disparities in Use of Video Telemedicine Among Patients With Limited English Proficiency During the COVID-19 Pandemic

Loretta Hsueh, PhD; Jie Huang, PhD; Andrea K. Millman, MA; Anjali Gopalan, MD; Rahul K. Parikh, MD; Silvia Teran, MD; Mary E. Reed, DrPH

Author affiliations and article information are listed at the end of this article.

Introduction

Telemedicine expands health care access for patients facing barriers to in-person care,[1] but may also inadvertently widen existing care disparities[2,3] for the 25 million people living in the US with limited English proficiency (LEP)[4] because of overlapping low digital literacy and health literacy.[5] Data on differential video vs telephone visit use by patients with LEP are needed to inform telemedicine equity strategies. In patients self-scheduling a primary care visit during the COVID-19 pandemic, we hypothesized that LEP would be associated with lower video use compared with telephone, especially among patients without prior video visit experience.

Methods

The retrospective cross-sectional study received institutional review board approval at Kaiser Permanente Northern California (KPNC) and waived informed consent because this was a data-only study with no participant contact. We followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

This study included all patient portal self-scheduled primary care telemedicine visits within KPNC from March 16 to October 31, 2020. In-person visits were only available by clinician recommendation after an initial telemedicine visit. Visits were accessible via any internet-enabled device. We extracted patient sociodemographics, technology access factors, and whether the patient visited their own primary care physician from automated data sources. Multivariate analyses examined the association between scheduling a video visit (vs telephone) and LEP, which was defined as needing an interpreter. An LEP × prior video visit interaction term was added to the multivariate regression to examine whether barriers to the initial video visit can potentially explain video visit use differences by LEP (ie, no video visit use differences by LEP among those with prior video visit use experience would suggest patients with LEP were not dissuaded by their initial video visit experiences).

We report adjusted video visit use frequencies generated from model coefficients for comparisons using Stata, version 14.2 (StataCorp LLC). Two-sided χ^2 tests were used to calculate P values for patient sociodemographics, technology access, and provider factors for interpreter need (**Table 1**). Two-sided logistics regressions were used to calculate P values for odds ratios from multivariable model of the association between the patient's need for a language interpreter and video vs telephone telemedicine visit. Statistical significance was set at $P < .05$. Data were analyzed between February and April 2021.

Results

Among 955 352 primary care telemedicine visits (video: 379 002 [39.6%]; telephone: 576 350 [60.3%]) scheduled by 642 370 patients. There were 22 476 (2.4%) with EHR-documented interpreter need, 454 741 (47.6%) White patients, 216 788 (22.7%) Asian patients, and 196 483 (20.6%) Hispanic patients; 720 338 (74.5%) patients aged 18 to 64 years, 409 632 (42.4%) men, and

Predictors of Audio-Only Versus Video Telehealth Visits During the COVID-19 Pandemic

Julia Chen, M.D.[1,2,3,4], Kathleen Y. Li, M.D., M.S.[1,5,6], Juan Andino, M.D., M.B.A.[1,7], Chloe E. Hill, M.D., M.S.[1,8], Sophia Ng, Ph.D.[1], Emma Steppe, M.P.H.[1], and Chad Ellimoottil, M.D., M.S.[1,7]

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BACKGROUND: Most health insurance organizations reimbursed both video and audio-only (i.e., phone) visits during the COVID-19 pandemic, but may discontinue phone visit coverage after the pandemic. The impact of discontinuing phone visit coverage on various patient subgroups is uncertain.

OBJECTIVE: Identify patient subgroups that are more probable to access telehealth through phone versus video.

DESIGN: Retrospective cohort.

PATIENTS: All patients at a U.S. academic medical center who had an outpatient visit that was eligible for telehealth from April through June 2020.

MAIN MEASURES: The marginal and cumulative effect of patient demographic, socioeconomic, and geographic characteristics on the probability of using video versus phone visits.

KEY RESULTS: A total of 104,204 patients had at least one telehealth visit and 45.4% received care through phone visits only. Patient characteristics associated with lower probability of using video visits included age (average marginal effect [AME] −6.9% for every 10 years of age increase, 95%CI −7.8, −4.5), African-American (AME −10.2%, 95%CI −11.4, −7.6), need an interpreter (AME −19.3%, 95%CI −21.8, −14.4), Medicaid as primary insurance (AME −12.1%, 95%CI −13.7, −9.0), and live in a zip code with low broadband access (AME −7.2%, 95%CI −8.1, −4.8). Most patients had more than one factor which further reduced their probability of using video visits.

CONCLUSIONS: Patients who are older, are African-American, require an interpreter, use Medicaid, and live in areas with low broadband access are less likely to use video visits as compared to phone. Post-pandemic policies that eliminate insurance coverage for phone visits may decrease telehealth access for patients who have one or more of these characteristics.

KEY WORDS: telehealth; video visits; COVID-19.

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INTRODUCTION

Telehealth is the use of telecommunications technology (e.g., video visits, telephone visits) to diagnose, treat, and manage health. During the COVID-19 pandemic, telehealth use surged as a result of the need for social distancing and the introduction of federal and state regulatory and insurance changes.[1] As a result, approximately 1.3 million Medicare patients received care via telehealth in April 2020, compared to 11,000 just over 1 month prior.[2] One key change was that audio-only telehealth (referred to as "phone visit" in this paper) was permitted. Prior to the COVID-19 pandemic, most insurance organizations required providers to perform telehealth using both real-time video and audio. Medicare and many commercial insurance programs temporarily waived the requirement for video so that patients without video-enabled devices, sufficient data to complete a video session, or adequate Internet access could receive medical care while reducing their COVID-19 exposure risk. While most stakeholders agree that video visit coverage should remain after the COVID-19 pandemic, there is disagreement on whether phone visit coverage should continue.[3–5] In fact, the Medicare program announced that they will discontinue coverage for phone visits after the COVID-19 pandemic.[6] On one hand, opponents of continuing phone visit coverage argue that phone visits limit the ability of a clinician to deliver high-quality care. On the other hand, proponents of continuing phone visit coverage argue that phone visits are an essential option for patients who lack access to video-enabled devices.

Because telehealth was not routinely used prior to the COVID-19 pandemic, little is known about the characteristics of patients who rely on phone visits versus those who can use video visits. Given the widespread prevalence of smartphones, it is plausible that most patients, or their caregivers, can

in limited conditions.[2] Nevertheless, the pandemic caused the use of telehealth to skyrocket. One study found a 3,806 percent increase in the volume of telehealth claims from private payers from July 2019 to July 2020, largely due to the increased flexibility that the temporary regulatory suspensions allowed.[3] Further, the Centers for Disease Control and Prevention (CDC) found that 95 percent of health centers funded by Health Resources and Services Administration (HRSA) used telehealth for services, whereas previously 43 percent of HRSA-supported health centers were capable of using telehealth in 2019.[4] In addition to an increase in use, satisfaction with telehealth services increased. One survey found that the percentage of consumers who said they would continue to use telehealth services going forward increased from 11 percent pre-pandemic to 40 percent.[5]

However, these surges in telehealth use were a result of temporary guidelines. As these allowances expire, the telehealth market is forced to comply with pre-pandemic restrictions on its use, and patient satisfaction and convenience will suffer.[6] For telehealth to remain a healthcare mainstay post-pandemic, the changes made to temporarily increase telehealth access must be seriously considered as permanent reforms to continue giving patients better autonomy and flexibility with their healthcare decisions.

TEMPORARY TELEHEALTH CHANGES DURING THE PANDEMIC: AN OVERVIEW

Audio-only Telehealth

Prior to COVID-19, most states did not allow audio-only telehealth, which does not employ video. In fact, only two states allowed audio-only telehealth, and only in specific cases. In 2019, Maine declared that insurance carriers must cover telephone-only services if video technology was unavailable to an existing patient, and if the medical service requested was appropriate for audio-only telehealth.[7] Additionally, Alaska regulations effective in 2020 allowed for some audio-only psychiatric and psychological services if video communication was unavailable.[8]

During the pandemic, audio-only telehealth became crucial to health care access. In March 2020, the Centers for Medicare and Medicaid Services (CMS) announced that Medicare would temporarily allow "virtual check-ins" via telephone.[9] States quickly followed suit, with some pointing to CMS guidance and some issuing more specific guidelines.[10] In 2021, with executive orders related to telehealth expiring, 18 states have made permanent changes that allow for some forms of audio-only telehealth.[11]

For this analysis of audio-only telehealth, we focus on five categories of medical services: evaluation and management (E/M) services; telepsychiatry and behavioral health services; substance use disorder services; teledentistry; and physical, occupational and speech therapies.

Evaluation and Management (E/M) Services

E/M services cover many types of health care appointments, but are most generally thought of as office visits and preventive services.[12] Prior to the pandemic, only Maine allowed for audio-only telehealth visits for E/M services.[13] However, in 2020, all 50 states and Washington, D.C. temporarily expanded telehealth coverage to include audio-only communications for general E/M services. States issued short-term billing codes that physicians and other qualified health professionals could use to conduct audio-only check-ins with

2. See, e.g., "A Multilayered Analysis of Telehealth: How This Emerging Venue of Care Is Affecting the Healthcare Landscape," FAIR Health, July 2019. https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/A%20Multilayered%20Analysis%20of%20Telehealth%20-%20A%20FAIR%20Health%20White%20Paper.pdf; Thiru M. Annaswamy et al., "Telemedicine barriers and challenges for persons with disabilities: COVID-19 and beyond," Disability and Health Journal 13:4(October 2020). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7346769.

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4. Hanna B. Demeke et al., "Trends in Use of Telehealth Among Health Centers During the COVID-19 Pandemic—United States, June 26 - November 6, 2020," Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, Feb. 19, 2021. https://www.cdc.gov/mmwr/volumes/70/wr/mm7007a3.htm.

5. Oleg Bestsennyy et al., "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?" McKinsey & Company, July 9, 2021. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.

6. See, e.g., Frances Stead Sellers, "Patients and doctors who embraced telehealth during the pandemic fear it will become harder to access," The Washington Post Sept. 15, 2021. https://www.washingtonpost.com/national/telehealth-doctors-waivers/2021/09/10/fb6619a0-f6e1-11eb-9738-8395ec2a44e7_story.html; Larissa Scott, "Patients frustrated over changes to telehealth services after state executive order expires," ABC Action News, July 9, 2021. https://www.abcactionnews.com/news/state/patient-frustrated-over-changes-to-telehealth-services-after-state-executive-order-expires.

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8. "Behavioral Health Services," Alaska Medicaid, Aug. 13, 2020. http://manuals.medicaidalaska.com/FQHC_RHC/fqhc_rhc/behavioral_health_services.htm.

9. "Medicare Telemedicine Health Care Provider Fact Sheet," Centers for Medicare & Medicaid Services, March 17, 2020. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

10. "COVID-19 Audio-Only Delivery," Center for Connected Health Policy, last accessed Sept. 25, 2021. https://www.cchpca.org/topic/audio-only-delivery-covid-19.

11. "Telephone Medicaid Reimbursement," Center for Connected Health Policy, last accessed Sept. 25, 2021. https://www.cchpca.org/policy-trends.

12. "What Are E/M Codes?" American Association of Professional Coders," last accessed Oct. 4, 2021. https://www.aapc.com/evaluation-management/em-coding.aspx#EMCodeCategories.

13. "S.P. 383- L.D. 1263, An Act Regarding Telehealth." http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0383&item=3&snum=129;%20https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/pdfs_doc/COVID-19/MaineCare-Telehealth-Summary-New-Codes-and-Info-041620.pdf.

patients.[14] Guidance on audio-only E/M services typically allowed providers to hold visits with established patients via telephone. Indiana explicitly mentioned that providers could also consult new patients via telephone.[15] Otherwise, state guidance on E/M services via telephone was uniform and allowed all qualified providers to use audio-only telehealth.[16]

Telepsychiatry and Behavioral Health Services

E/M services cover a lot of ground for health services, but many states made specific allowances for behavioral health professionals to consult patients via audio-only telehealth. Prior to the pandemic, only Alaska allowed audio-only delivery of some behavioral health services if video telehealth was unavailable to patients.[17] However, all states made temporary audio-only allowances for behavioral health professionals and their patients once CMS issued guidance allowing audio-only behavioral telehealth.[18] States provided their own guidance on a spectrum of detail; for example, Arizona advised that "all services that are clinically able to be furnished via telehealth modalities (including telephone) will be covered."[19]

Other states gave more pointed guidance on which behavioral health professionals could temporarily use audio-only telehealth. For example, Mississippi enabled psychiatrists, psychologists, licensed professional counselors and licensed certified social workers to use audio-only telehealth.[20] Finally, New Hampshire explicitly named Clinical Psychologists and School Psychologists licensed by the Board of Psychologists, Clinical Social Workers, master's level psychiatric nurses, Pastoral psychotherapists, marriage and family therapists and clinical mental health counselors as able to use audio-only.[21] This represented a dramatic increase in the use of telehealth for behavioral health services.

Substance Use Disorder Services

Substance use disorder (SUD) services faced particular setbacks with the pandemic. Programs for SUDs are usually based on group treatments, regular face-to-face visits, frequent monitoring and developing interpersonal relationships, which were all inaccessible due to stay-at-home orders.[22] However, the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) issued guidelines allowing flexibility for providers to prescribe and dispense controlled substances, as well as provide consultations via audio-only telehealth.[23]

Services for SUDs did go audio-only, usually with explicit guidance from states for SUDs, but some under the umbrella of behavioral health guidelines that states issued. Since the two are often regulated under the same state agency, audio-only telehealth for behavioral health services extended to SUD treatment. One notable distinction was found in Kentucky, in which the state's Medicaid program did not allow residential SUD treatment services or residential crisis services to use telehealth.[24] Otherwise, every state permitted audio-only telehealth for SUDs relatively openly.

Teledentistry

Teledentistry is an innovative component of traditional dental care. While teledentistry was part of the industry prior to the pandemic, many states did not explicitly include teledentistry in existing telehealth regulations, making its use challenging. However, due to the pandemic 28 states made specific mention of teledentistry allowances when it came to audio-only telehealth expansion in state-level executive orders.[25] Illustrated in Map 1, this change allowed dentists, and in some cases hygienists, to consult with patients over the phone regarding their oral health.

14. See, e.g., "Oregon Health Plan coverage of telephone/telemedicine/telehealth services," Oregon Health Authority, March 20, 2020. https://www.oregon.gov/oha/HSD/OHP/Announcements/Oregon%20Health%20Plan%20coverage%20of%20telemedicine%20services.pdf.

15. Courtney Joslin and Chung Yi See, "Audio-Only Subcategories," R Street Institute, last accessed October 24, 2021. https://www.rstreet.org/2021/10/24/telehealth-database.

Note: This database is intended to be a living document. Information included in this paper is reflective of the data available as of Nov. 12, 2021.

16. Ibid.

17. "Behavioral Health Services." http://manuals.medicaidalaska.com/FQHC_RHC/fqhc_rhc/behavioral_health_services.htm.

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19. "Frequently Asked Questions (FAQs) Regarding Coronavirus Disease 2019 (COVID-19)," Arizona Health Care Cost Containment System, last accessed Sept 24, 2021. https://www.azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html#telehealth.

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22. See, e.g., Tyler S. Oesterle et al., "Substance Use Disorders and Telehealth in the COVID-19 Pandemic Era," Mayo Clinic Proceedings 95:12 (Dec 1, 2020), pp. 2709-2718. https://www.mayoclinicproceedings.org/article/S0025-6196(20)31195-2/fulltext; Lewei (Allison) Lin et al., "Telehealth for Substance-Using Populations in the Age of Coronavirus Disease 2019: Recommendations to Enhance Adoption," JAMA Psychiatry 77:12 (July 2020), pp. 1209-1210. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2767300.

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24. Andy Beshear, "Provider Letter # A-106," Cabinet for Health and Family Services Department for Medicaid Services, March 17, 2020. https://chfs.ky.gov/agencies/dms/ProviderLetters/behavioralhealthcovid19.pdf.

25. Joslin and See, "Audio-Only Subcategories." https://www.rstreet.org/2021/10/24/telehealth-database.

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Telemedicine implementation and use in community health centers during COVID-19: Clinic personnel and patient perspectives

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ABSTRACT

In March 2020, federal and state telehealth policy changes catalyzed telemedicine adoption and use in community health centers. There is a dearth of evidence on telemedicine implementation and use in these safety net settings and a lack of information reflecting the perspectives of patients with limited English proficiency. We conducted in-depth interviews with clinic personnel and patients during the pandemic in two federally qualified health centers that primarily serve Chinese and Latino immigrants. Twenty-four interviews (clinic personnel = 15; patients who primarily speak a language other than English = 9) were completed remotely between December 2020 and April 2021. Interview scripts included questions about their telemedicine experiences, technology, resources and needs, barriers, facilitators, language access, and continued use, with a brief socio-demographic survey. Data analyses involved a primarily deductive approach and thematic analysis of transcript content. Both FQHCs adopted telemedicine in a few weeks and transitioned primarily to video and audio-only visits within two months. Findings reveal third-party language interpretation services were challenging to integrate into telemedicine video visits. Bilingual personnel who provided language concordant care were seen as essential for efficient and high-quality patient telemedicine experiences. Audio-only visits were of particular benefit to reach patients of older age, with limited English proficiency, and with limited digital literacy. Continued use of telemedicine is contingent on reimbursement policy decisions and interventions to increase patient digital literacy and technological resources. Results highlight the importance of reimbursing audio-only visits post-pandemic and investing in efforts to improve the quality of language services in telemedicine encounters.

1. Background & significance

The coronavirus disease 2019 (COVID-19) pandemic catalyzed rapid adoption and implementation of telemedicine beginning March 2020 (Eberly et al., 2020; Koonin et al., 2020). The pandemic drastically shifted health care from in-person to remote to mitigate risk of infection. Federal and state telehealth policy changes were adopted as temporary measures, including financial incentives (i.e., changes to reimbursement like payment parity between in-person and telemedicine visits), licensing modifications, and relaxed privacy standards, to increase utilization (Keesara, Jonas, & Schulman, 2020; Shachar, Engel, & Elwyn, 2020).

Steep telehealth increases during COVID-19 presents a unique opportunity to investigate factors that influence telemedicine use in safety net settings. Pre-pandemic, there was limited adoption and use of telemedicine live video communication (and other modalities) among low-income and marginalized populations and safety net healthcare organizations (Anthony, Campos-Castillo, & Lim, 2018; Park, Erikson, Han, & Iyer, 2018; Rodriguez, Saadi, Schwamm, Bates, & Samal, 2021). Community health centers like Federally Qualified Health Centers (FQHCs), who predominantly serve patients who are uninsured or are Medicaid recipients, have historically lagged in adoption and use due to reimbursement and licensing issues. In 2016, only 37.6% of community health centers reported using telehealth (Shin, Sharac, & Jacobs, 2014).

Telemedicine can improve healthcare access and health outcomes in medically underserved communities by addressing structural barriers like transportation, excess wait times, childcare responsibilities, inconvenient appointment times, and regional medical provider shortages (Bashshur et al., 2016; Donelan et al., 2019; Gordon, Solanki, Bokhour, &

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Association of Race and Neighborhood Disadvantage with Patient Engagement in a Home-Based COVID-19 Remote Monitoring Program

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BACKGROUND: COVID-positive outpatients may benefit from remote monitoring, but such a program often relies on smartphone apps. This may introduce racial and socio-economic barriers to participation. Offering multiple methods for participation may address these barriers.
OBJECTIVES: (1) To examine associations of race and neighborhood disadvantage with patient retention in a monitoring program offering two participation methods. (2) To measure the association of the program with emergency department visits and hospital admissions.
DESIGN: Retrospective propensity-matched cohort study.
PARTICIPANTS: COVID-positive outpatients at a single university-affiliated healthcare system and propensity-matched controls.
INTERVENTIONS: A home monitoring program providing daily symptom tracking via patient portal app or telephone calls.
MAIN MEASURES: Among program enrollees, retention (until 14 days, symptom resolution, or hospital admission) by race and neighborhood disadvantage, with stratification by program arm. In enrollees versus matched controls, emergency department utilization and hospital admission within 30 days.
KEY RESULTS: There were 7592 enrolled patients and 9710 matched controls. Black enrollees chose the telephone arm more frequently than White enrollees (68% versus 44%, $p = 0.009$), as did those from more versus less disadvantaged neighborhoods (59% versus 43%, $p = 0.02$). Retention was similar in Black enrollees and White enrollees (63% versus 62%, $p = 0.76$) and in more versus less disadvantaged neighborhoods (63% versus 62%, $p = 0.44$). When stratified by program arm, Black enrollees had lower retention than White enrollees in the app arm (49% versus 55%, $p = 0.01$), but not in the telephone arm (69% versus 71%, $p = 0.12$). Compared to controls, enrollees more frequently visited the emergency department (HR 1.71 [95% CI 1.56–1.87]) and were admitted to the hospital (HR 1.16 [95% CI 1.02–1.31]).
CONCLUSIONS: In a COVID-19 remote patient monitoring program, Black enrollees preferentially selected, and had higher retention in, telephone- over app-based monitoring. As a result, overall retention was similar between races. Remote monitoring programs with multiple modes may reduce barriers to participation.

KEY WORDS: ambulatory monitoring; COVID-19; race factors; facilities and services utilization.

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INTRODUCTION

Infections caused by SARS-CoV-2 have caused a pandemic that has pushed healthcare systems worldwide to their limits. Fortunately, most patients present with mild symptoms that can be managed via home quarantine.[1,2] Patients require careful monitoring during their quarantine, because deterioration requiring hospitalization may occur after a period of apparent stability.[3,4] Remote monitoring at home is an attractive management strategy because it reduces transmission risks associated with in-person follow-up[5,6] and because it eliminates transportation barriers for economically disadvantaged or geographically distant patients.[7–9] Traditional home monitoring programs are labor-intensive, requiring nurses to call patients daily to assess symptoms.[10] Emerging technologies have enabled automation of this process via smartphone apps, engaging staff only when medical intervention might be warranted.[11,12]

Although automated home monitoring programs are attractive due to their scalability, these programs may create barriers to patient engagement. Patients must have access to a smart device and a reliable internet connection to participate. The well-described "digital divide" may prevent Black, economically disadvantaged, or older patients from participating in an app-based remote monitoring program.[13–16] Accordingly, we designed a program that allowed for either app-based or

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The Internet: Barrier to Health Care for Older Adults?

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Insurers, institutional and independent providers of health care have made increasing use of websites for patient communication, in the absence of data indicating that patients, especially older adults, utilize information technology (IT). The current study was designed to determine patient frequency of Internet and IT utilization across age groups. It was hypothesized that use of websites for patient communication might represent a barrier to health care for older adults. Data from 423 preexisting deidentified clinical records were used to determine whether there are differences between age groups in frequency of Internet and other IT utilization across 5 functional domains including health care. Internet and other IT utilization declined significantly with increasing age beyond 60 years. The findings indicate that people over age 65 are not a homogenous population regarding IT use. The decline in frequency using IT also advanced differently for each of 5 functional domains, suggesting that IT use is not a homogenous category. Decreasing frequency of Internet use to access health care showed the strongest association with increasing age. Findings support the hypothesis that use of websites for communicating with older adult populations might create a barrier to access to health care. It is suggested that health care protocols for working with older adults should include Internet and IT utilization as a specific area of assessment or treatment.

Clinical Impact Statement
This study adds to the literature by demonstrating specifically that use of the Internet for communicating with insurers and health care providers creates a potential barrier to health care for older adults. This finding has broad implications for Medicare, private insurers, and health care organizations, as well as clinicians in independent and small-group practices, using websites for patient access and communication.

Keywords: digital inequality, Internet, older adults, access to health care

Significant disparities in Internet and information technology (IT) utilization have been associated with numerous variables, including ethnicity, age, and socioeconomic status (SES; Hunsaker & Hargittai, 2018; U.S. Census Bureau, 2016).

Internet and IT utilization for people with intellectual and developmental disabilities is also much lower than that of the general population (Dobransky & Hargittai, 2006), despite efforts to engage young adults with intellectual disability with social media and other IT (Davies et al., 2015). The disparities in Internet use and access to IT have been variously described as the digital divide (Hoffman & Novak, 2000)

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Chapter

COVID-19, Telehealth and Access to Care

Charles M. Lepkowsky

Abstract

Telehealth has become increasingly prominent during the COVID-19 pandemic, highlighting limitations in access to care for older adults less fluent in information technology (IT). Although the 20 percent disparity in IT use between younger and older adult cohorts remains unchanged over several decades, insurers, institutional and independent providers of health care have made increasing use of IT for patient communication. Data demonstrate an age-related decline in the frequency of IT use for accessing health care. Restrictions on reimbursement for the use of the telephone for accessing health care during the COVID-19 pandemic are discussed as a barrier to access to care. Recommendations are made for assessment of media most available to older adults for accessing health care, as well as providing funding to support increased access to care.

Keywords: COVID-19, older adults, access to health care, information technology (IT), FACETS

1. Introduction

The COVID-19 virus (SARS-CoV-2) was first identified in December of 2019 [1]. COVID-19 spread rapidly, and by the end of January 2020, the World Health Organization (WHO) had officially labeled the COVID-19 outbreak a pandemic [2]. At risk populations were soon identified, including older adults [3–6]. In an effort to contain the growth of the contagion, in early 2020 shelter in place practices were adopted in many countries, forcing the closure of routine businesses including schools, restaurants, and outpatient healthcare facilities [7–11]. Patient care rapidly shifted to virtual contact using telehealth platforms including internet-based videoconferencing software [12]. In the United States (US), the Center for Medicare and Medicaid Services (CMS) made changes liberalizing standards allowing reimbursement for videoconferencing telehealth, increasing access to care [13, 14]. However, the rapid shift to telehealth brought to the forefront an access to care issue that had been simmering for some time: compared with younger age cohorts, most adults over the age of 65 make limited use of information technology (IT) [15–18]. The intersection of the rapid growth of telehealth, age-related declines in IT utilization, and access to care is a growing area of concern for the health care systems with strong implications for the future of healthcare delivery.

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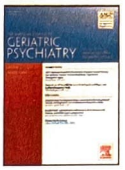

Letter to the Editor

Telehealth Reimbursement Allows Access to Mental Health Care During COVID-19

Dear Editor,

Older adults belong to the cohort most at risk for serious illness reactions to COVID-19, for whom shelter in place is most strongly recommended.[1] In order to make remote services more accessible, the Center for Medicare and Medicaid Services (CMS) announced nonenforcement of some telehealth policies, e.g., those limiting the patient's location to approved rural facilities, or requiring HIPAA compliance of audio-visual platforms used for telehealth.[2] While these measures increased access to care to Medicare subscribers with IT fluency, they failed to address access to care for Medicare subscribers who lack IT fluency. Around 93% of people over the age of 70 and 98% of people over the age of 80 (an average of 95.5% of people over the age of 70) do not use the internet to communicate with health care providers, and instead rely entirely on face-to-face or telephone interactions with health care providers.[3]

The American Psychological Association has made repeated appeals to CMS to allow reimbursement for the use of telephonic psychotherapy services during shelter in place. On April 30, 2020, CMS responded by allowing reimbursement for telephonic contact with patients using CPT codes for routine psychotherapy.[4] This important change in Medicare policy makes health care temporarily accessible to 95.5% of Medicare subscribers over the age of 70. However, the change is only temporary and will expire when the COVID-19 crisis has been resolved.

Valid and reliable instruments are available for assessing the media people use for accessing health care.[5] Such instruments might be employed with older adults, in order to determine the most effective means through which they can access health care. Hospitals, community health clinics, government-funded health agencies and private practices might gather additional data that a) inform health care providers about the most effective media for communicating with older adult patients, and b) provide a more broad-based sample to contribute to the existing data demonstrating patterns of IT use by older adults for communicating with health care providers, as well as accessing social contact, financial management, and other business functions.

CMS's decision to reimburse telephonic psychotherapy[4] is an important acknowledgement of the potential barriers to health care IT represents for older adults. Reimbursing providers for telephonic delivery of ongoing psychotherapy and other services make health care accessible to an average of 95.5% of Medicare subscribers over the age of 70.[3] Although the duration of shelter in place and the future trajectory of COVID-19 remain uncertain, the data suggest that substantial and permanent CMS policy changes allowing reimbursement for telephonic access to health care for older adults will be increasingly important in the near future.

AUTHOR CONTRIBUTION

The author warrants that he has reviewed and approved the manuscript prior to its submission, and assumes responsibility for the contents of the manuscript.

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The author declares no conflicts of interest in the manuscript, including financial, consultant, institutional,

Audio-Only Telehealth Now Approved Permanently for Mental Health/Substance Use Services

MARK MORAN

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Experts say the expansion of telehealth to include audio-only services for mental health and substance use disorders will improve access for underserved communities.

The Centers for Medicare and Medicaid Services (CMS) has expanded the definition of telehealth services that are permanently eligible for reimbursement under the Medicare program to include audio-only services for established patients with mental illness/substance use disorders (SUDs) who are unable or unwilling to use video technology.

The final rule on telehealth services for mental illness/SUDs is part of the 2022 Medicare Physician Fee Schedule, which covers updates to physician payment and other regulations regarding Medicare's Merit-Based Incentive Payment System (MIPS) each year. It was published in the *Federal Register* on November 19, 2021, and went into effect on January 1.

The expansion of telehealth to include audio-only services applies only to mental illness/SUDs. These services had been temporarily reimbursed as part of the government's response to the COVID-19 public health emergency, beginning with the presidential emergency declaration in March 2020 (*Psychiatric News*). In December 2020, Congress approved the Consolidated Appropriations Act (CAA) of 2021, a $1.4 trillion dollar package that—among many other provisions—permanently expanded mental health services provided via telehealth by easing geographic and site-of-service restrictions under the Medicare program (*Psychiatric News*).

The rule is an enormous victory for patients and psychiatrists for which APA had advocated unceasingly for months.

"I am delighted at the inclusion of audio-only telehealth reimbursement," said Peter Yellowlees, M.D., a member of the APA Committee on Telepsychiatry and a past president of the American Telemedicine Association. "This is likely to be especially important for patients who are already underserved, homeless, and from racial and ethnic minorities and may be one approach to reducing the inherent longstanding institutional racism and bias that we now acknowledge has existed in our health systems for many years."

Grayson Norquist, M.D., a member of the APA Council on Quality Care, also underscored the importance of audio-only services for advancing equitable access to care. "The ability to use audio-only is critical for providing access to mental health services for people who lack resources or the skills to use video technology," he said. "This increases our capacity to engage and treat those who have been underserved in the past in both rural and urban environments."

Norquist is also vice chair of psychiatry and behavioral sciences at Emory University and chief of the Grady Behavioral Health Service in Atlanta.

In July 2021, CMS proposed that in-person visits take place every six months for all patients—whether new or established patients—after the initial telehealth encounter; in the final rule, the administration extended this provision to every 12 months for established patients, with exceptions at the discretion of the treating psychiatrist. As mandated by the CAA, there is no exception for new patients. They must be seen by physicians or other practitioners in an in-person visit within six months prior to initiation of mental health services via telehealth.

POLICY NEWS

Examining the Benefits and Challenges of Audio-Only Telehealth

The recent debate over audio-only telehealth coverage centers on the value of the phone call. Is it a proper method for healthcare delivery, and should doctors be reimbursed for it?

By Eric Wicklund

July 27, 2021 - With the pandemic limiting access to in-person healthcare, audio-only telehealth has surfaced as a popular platform for care delivery. But it's not good for all (or even many) services, and that's forcing providers and lawmakers to take a close look at what can and can't be done by phone.

COVID-19 pushed the modality – basically defined as telehealth without the video - into the spotlight, but the debate over its value has been going on for much longer. And it's tied to a long-standing barrier to telehealth expansion and one of the oft-mentioned social determinants of health: broadband.

Advocates have long argued that telehealth will struggle in parts of the country where broadband is either unreliable or unavailable, because patients won't be able to access an audio-visual platform and providers won't want to spend the money creating one. But in those areas – often rural, with their own challenges to accessing care – they will and do connect by phone.

And in that context, a landline telephone might be the only way for someone to get in touch with a care provider.

That said, a telephone conversation isn't always the best format for healthcare. Opponents argue that a provider should be able to see the patient to establish a basic doctor-patient relationship, and that many diagnoses and treatments rely on visual observations and cues. On the other hand, providers can and do gain valuable information from a phone call, and there are certain instances where that may be enough to push a care plan forward.

SETTING MEDICARE COVERAGE FOR A PHONE CALL

READ MORE: New Letter Urges Congress to Establish a Post-Pandemic Telehealth Policy

Among those wrestling with guidelines is the Centers for Medicare & Medicaid Services, which has proposed covering audio-only telehealth services for mental healthcare in its 2022 Physician Fee Index. The agency had announced temporary coverage for audio-only telehealth during the pandemic and even issued a list of services for which audio-only could replace audio-visual telehealth.

Taking a cue from providers who took advantage of COVID-19 emergency waivers to use the modality during the pandemic, CMS included permanent audio-only telehealth coverage in the proposed 2022 PFS under the following conditions:

- The services are limited to diagnosis, evaluation or treatment of mental health disorders;
- They involve established patients;
- They're preceded by an in-person visit within the six months prior to using telehealth;
- They take place in the patient's home;
- The care provider has the technical capability at the time of service to use an audio-visual telehealth platform with the patient;
- The patient can't access the resources for an audio-visual telehealth visit or doesn't want to use that modality; and
- The care provider documents the claim as an audio-only telehealth service.

CMS has historically been slow to embrace telehealth, often saying it needs more proof that these care pathways improve clinical outcomes, reduce costs and improve provider workflows, as well as proof that providers wouldn't overuse the platform to collect reimbursements. The agency had in fact all but banned audio-only telehealth services until the pandemic, when the modality was included in a batch of waivers aimed at boosting access and coverage.

What CMS and many others found, however, was that audio-only telehealth was among the most popular services during the pandemic, **with an estimated one in three telehealth encounters being conducted by phone**. And many of those encounters were for mental health or substance abuse care.

This prompted the decision to propose permanent coverage for specific services.

READ MORE: As State Emergencies End, Providers Look for New Telehealth Limits

"Clinically, mental health services often differ from most other Medicare telehealth services in that mental health care often involves verbal conversation, where visualization between the patient and practitioner may be less critical," Nathaniel Lacktman, a partner with the Foley & Lardner law firm and chair of the firm's Telemedicine & Digital Health Industry Team, **wrote in a recent blog explaining the proposed CMS coverage**. "Considering the social determinants that affect an individual's ability to receive mental health care, assessing clinical safety, and recognizing that patients may have come to rely upon the use of audio-only technology to receive mental health care, CMS opined that terminating the audio-only flexibility at the end of the PHE could harm access to care."

SUPPORTERS: AUDIO-ONLY TELEHEALTH HAS VALUE

Among those supporting audio-only telehealth coverage is the American Medical Association, which **weighed in on the matter in an April 2021 letter to CMS**.

"Many of the same patients who cannot access audio-video telehealth services also face barriers to accessing timely in-person services," AMA Executive Vice President and CEO James Madara, MD, pointed out. "The decision about whether an in-person office visit is needed is very different for a patient in a rural area who may have to travel for hours to reach their physician's office than for patients who are located close to the medical practice and do not face barriers such as functional limitations. Similarly, the decision about whether a patient should continue to try and stabilize an acute problem at home or travel to a distant emergency department is a more complicated decision without access to timely in-person care or audio-video telehealth services. The availability of timely audio-only services has made a huge difference to these patients and their physicians."

The Medicare Payment Advisory Commission (MedPAC) **also supports permanent coverage for audio-only telehealth** "if there is potential for clinical benefit." But it also notes that researchers haven't studied the value of audio-only telehealth against audio-visual telehealth or in-person care, so the benefits so far are anecdotal rather than proven.

There have been a handful of studies on the matter. The RAND Corporation, for instance, **studied telehealth traffic at federally qualified health centers during the pandemic** and found a majority of the visits were conducted by phone.

READ MORE: Congress to Debate Medicare Coverage for Audio-Only Telehealth Services

"While there are important concerns about the quality of audio-only visits, eliminating coverage for telephone visits could disproportionately affect underserved populations and threaten the ability of clinics to meet patient needs," Lori Uscher-Price, a senior policy researcher at RAND, said in a press release accompanying the study.

"Lower-income patients may face unique barriers to accessing video visits, while federally qualified health centers may lack resources to develop the necessary infrastructure to conduct video telehealth," she added. "These are important considerations for policymakers if telehealth continues to be widely embraced in the future."

IS A PHONE CALL THE SAME AS A VISIT?

Aside from allowing providers to deliver healthcare via telephone, there's the question of how much they should be reimbursed for using it. Opponents argue that a simple phone call doesn't have the same value as an in-person or audio-visual exam, while proponents point out that it may be the only way for a patient and provider to connect.

This taps into the argument about payment parity. Some worry that providers will stay away from using a telehealth service that's reimbursed at less than an in-person service, even if there are other reasons to use that service.

In California, that's what prompted the California Medical Association **to oppose a plan by Governor Gavin Newsom** to establish Medicaid reimbursement for audio-only telehealth services at 65 percent of in-person care.

"Overwhelmingly, Medi-Cal patients opt to utilize audio-only telehealth over audio-visual telehealth," the organization said in a May 2021 press release. "This could be due to a lack of good broadband connectivity, a need to take those

telehealth visits on their mobile phones that have data limits, or for privacy reasons. Whatever the reasons, it makes little sense to eliminate an option for access to care, for those individuals who already lack it the most, further exacerbating existing inequities."

Among the states that are supporting audio-only telehealth is New York, where S8416, passed in the summer of 2020, ensured permanent coverage for the modality. That state is one of more than 20 to expand telehealth coverage after the pandemic to cover the modality, **according to a recent survey by the Commonwealth Fund**.

But that survey also noted the challenges faced by lawmakers in regulating coverage.

"Regulators observed that some providers have begun to charge for short, three- to four-minute phone calls (for example, to answer a brief question of convey test results) that previously would not have required an in-person visit and thus would not have been billed," researchers wrote. "Regulators noted that these short calls can leave patients with unexpected cost sharing."

Lawmakers in Arkansas and **New Hampshire**, meanwhile, have pushed back against expanding coverage, saying the phone isn't a good modality for treatment. They envision instances in which providers bill Medicaid or Medicare for every little phone call or make incorrect diagnoses based on what they hear from a patient.

Some groups have suggested even stricter regulations on coverage for audio-only telehealth. In May 2020, **America's Physician Groups t told CMS** that diagnoses obtained from the modality should be eligible for risk assessment if they met certain conditions:

- They are restricted to established patients;
- They are limited to pre-existing conditions previously submitted for risk assessment purposes;
- They are limited to visits initiated by the patient, unless a provider or health plan had requested the visit to share specific lab results;
- Diagnoses must be captured by two care providers from different practices;
- They're supported by additional documentation in the medical record beyond the diagnosis;
- Any diagnoses should be tied to specific lab test results;
- All audio-only telehealth visits must be self-audited using an independent auditor and reported back to CMS; and
- CMS should impose a cap on how much the diagnoses can affect average risk scores from the previous year.

Regardless of the arguments, most agree that there's enough value in the phone call – and there are enough people in the country for whom the telephone is the only modality to access care – to merit some sort of coverage. The challenge lies in identifying which specific services can be delivered and how they can be reimbursed.

The Effect of Telephone-Administered Psychotherapy on Symptoms of Depression and Attrition: A Meta-Analysis

David C. Mohr, Northwestern University, Hines Veterans Administration Hospital
Lea Vella, San Diego State University
Stacey Hart, Ryerson University
Timothy Heckman, Ohio University
Gregory Simon, Group Health Cooperative

Increasingly, the telephone is being used to deliver psychotherapy for depression, in part as a means to reduce barriers to treatment. Twelve trials of telephone-administered psychotherapies, in which depressive symptoms were assessed, were included. There was a significant reduction in depressive symptoms for patients enrolled in telephone-administered psychotherapy as compared to control conditions ($d = 0.26$, 95% confidence interval [CI] = 0.14–0.39, $p < .0001$). There was also a significant reduction in depressive symptoms in analyses of pretreatment to posttreatment change ($d = 0.81$, 95% CI = 0.50–1.13, $p < .0001$). The mean attrition rate was 7.56% (95% CI = 4.23–10.90). These findings suggest that telephone-administered psychotherapy can produce significant reductions in depressive symptoms. Attrition rates were considerably lower than rates reported in face-to-face psychotherapy.

Key words: **depression, meta-analysis, psychotherapy, telemental health.** ***[Clin Psychol Sci Prac 15: 243–253, 2008]***

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The telephone was invented by Alexander Graham Bell in 1876. The first report of telemedicine in a major medical journal, which described the use of the telephone to diagnose a child's cough, occurred three years later in 1879 ("The Telephone as a Medium of Consultation and Medical Diagnosis," 1879). The telephone quickly became a widely used tool in the practice of primary-care medicine. In contrast, providers of psychotherapy were slow to adopt the telephone to deliver mental health–related services. To the best of our knowledge, the first report of the use of the telephone in the administration of psychotherapy was published in 1949, 70 years after the first telemedicine report (Berger & Glueck, 1949). In 1996, a report developed by an American Psychological Association task force found that empirical evidence concerning telephone-administered psychotherapy was scant to nonexistent (Haas, Benedict, & Kobos, 1996). In the last decade, this has changed considerably.

Most of the work in telephone-administered psychotherapy has focused on treating depressive symptoms. Depression is common and is a significant cause of disability (Murray & Lopez, 1997). Psychotherapy is an attractive treatment option for many patients, as evidenced by the finding that approximately two-thirds of depressed patients prefer psychotherapy over antidepressant medication (Bedi et al., 2000; Brody, Khaliq, & Thompson, 1997; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; Priest, Vize, Roberts, Roberts, & Tylee, 1996). However, only 20% of all patients referred for psychotherapy ever enter treatment (Brody et al., 1997; Weddington, 1983) and, of

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Telephone and In-Person Cognitive Behavioral Therapy for Major Depression after Traumatic Brain Injury: A Randomized Controlled Trial

Jesse R. Fann,[1] Charles H. Bombardier,[2] Steven Vannoy,[3] Joshua Dyer,[2] Evette Ludman,[4] Sureyya Dikmen,[2] Kenneth Marshall,[1] Jason Barber,[5] and Nancy Temkin[5]

Abstract

Major depressive disorder (MDD) is prevalent after traumatic brain injury (TBI); however, there is a lack of evidence regarding effective treatment approaches. We conducted a choice-stratified randomized controlled trial in 100 adults with MDD within 10 years of complicated mild to severe TBI to test the effectiveness of brief cognitive behavioral therapy administered over the telephone (CBT-T) ($n=40$) or in-person (CBT-IP) ($n=18$), compared with usual care (UC) ($n=42$). Participants were recruited from clinical and community settings throughout the United States. The main outcomes were change in depression severity on the clinician-rated 17 item Hamilton Depression Rating Scale (HAMD-17) and the patient-reported Symptom Checklist-20 (SCL-20) over 16 weeks. There was no significant difference between the combined CBT and UC groups over 16 weeks on the HAMD-17 (treatment effect=1.2, 95% CI: −1.5–4.0; $p=0.37$) and a nonsignificant trend favoring CBT on the SCL-20 (treatment effect=0.28, 95% CI: −0.03–0.59; $p=0.074$). In follow-up comparisons, the CBT-T group had significantly more improvement on the SCL-20 than the UC group (treatment effect=0.36, 95% CI: 0.01–0.70; $p=0.043$) and completers of eight or more CBT sessions had significantly improved SCL-20 scores compared with the UC group (treatment effect=0.43, 95% CI: 0.10–0.76; $p=0.011$). CBT participants reported significantly more symptom improvement ($p=0.010$) and greater satisfaction with depression care ($p<0.001$), than did the UC group. In-person and telephone-administered CBT are acceptable and feasible in persons with TBI. Although further research is warranted, telephone CBT holds particular promise for enhancing access and adherence to effective depression treatment.

Key words: behavior; clinical trial; head trauma; rehabilitation; TBI

Introduction

TRAUMATIC BRAIN INJURY (TBI) occurs in >3,500,000 people in the United States, and 10,000,000 people worldwide annually.[1,2] With TBI being the "signature injury" of the conflicts in Iraq and Afghanistan, the need for effective treatments for the sequelae of TBI is increasing significantly.[3,4] Rehabilitation aims to help TBI survivors resume their roles in work or school, with family or friends, and in the larger community. However, mental health problems such as depression, anxiety, and substance abuse are common, and may interfere with successful recovery.[5–9] Psychosocial problems are often more predictive of poor outcomes than the physical sequelae of TBI in both civilian[10] and military[4] populations. Major depressive disorder (MDD) is the most prevalent psychiatric disorder accompanying TBI[7,8] and is associated with poorer health status,[11–13] including physical complaints,[11] cognitive[14–18] and social[14,19,20] problems, and increased costs[21] among persons with TBI.

Despite the prevalence and adverse impact of depression after TBI, the science and practice of treating depression in this population lack a solid evidence base. Depression is undertreated in this population, with only 20% of those with MDD receiving counseling, and 41% receiving antidepressants during the 1st year after injury.[22] In order to decrease morbidity and improve functional outcomes after TBI, effective treatments for MDD must be developed, tested, and disseminated. Recent reviews of depression treatment literature in people with TBI conclude that serotonergic antidepressants and cognitive behavioral therapy (CBT) appear to be the most promising approaches to treating depression following TBI; however, there is an absence of high quality depression

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Research

BMJ

Telephone administered cognitive behaviour therapy for treatment of obsessive compulsive disorder: randomised controlled non-inferiority trial

Karina Lovell, Debbie Cox, Gillian Haddock, Christopher Jones, David Raines, Rachel Garvey, Chris Roberts, Sarah Hadley

Abstract

Objectives To compare the effectiveness of cognitive behaviour therapy delivered by telephone with the same therapy given face to face in the treatment of obsessive compulsive disorder.
Design Randomised controlled non-inferiority trial.
Setting Two psychology outpatient departments in the United Kingdom.
Participants 72 patients with obsessive compulsive disorder.
Intervention 10 weekly sessions of exposure therapy and response prevention delivered by telephone or face to face.
Main outcome measures Yale Brown obsessive compulsive disorder scale, Beck depression inventory, and client satisfaction questionnaire.
Results Difference in the Yale Brown obsessive compulsive disorder checklist score between the two treatments at six months was −0.55 (95% confidence interval −4.26 to 3.15). Patient satisfaction was high for both forms of treatment.
Conclusion The clinical outcome of cognitive behaviour therapy delivered by telephone was equivalent to treatment delivered face to face and similar levels of satisfaction were reported.
Trial registration Current Controlled Trials ISRCTN500103984.

Introduction

Obsessive compulsive disorder is a disabling mental health illness that tends to be chronic unless adequately treated.[1] The economic burden of this disorder is high—the estimated direct and indirect costs are $8.4m (£4.5m, €6.6m) in the United States each year.[2] Cognitive behaviour therapy, particularly graded exposure and response prevention, is effective in treating obsessive compulsive disorder.[3] The current mode of delivery is a 45-60 minute face to face session with the therapist each week, during the hours of 9 am and 5 pm. Such a mode of delivery results in long waiting lists and precludes access to treatment. Recent mental health policy in the United Kingdom demands more accessible and effective treatments. Thus, alternative models of delivery have been proposed that aim to reduce contact with therapists and make services more accessible.[4] Innovations such as computerised cognitive behaviour therapy and facilitated self help still often require patients to attend scheduled clinic appointments.[5 6] Although useful, these systems increase throughput and access only for patients who can attend the clinic. Providing treatment over the telephone could increase access to patients who cannot attend clinic appointments for geographical, social, medical, or economic reasons. Telephone delivery of cognitive behaviour therapy is growing.[7-9] A pilot study of telephone delivery of such treatment in obsessive compulsive disorder showed potential with regard to effectiveness and reduced therapist time, and a larger open study found a good outcome.[10 11]

Methods

Design, objectives, and randomisation

We carried out a randomised controlled non-inferiority trial that compared exposure therapy and response prevention delivered either face to face during traditional 60 minute appointments or by telephone with reduced contact with the therapist. We hypothesised that exposure therapy and response prevention delivered by either of these methods will have similar clinical outcomes in the treatment of obsessive cognitive disorder.

Participants

We recruited patients during 2001 and 2002 from two psychology outpatient treatment units in greater Manchester. All patients were assessed at screening clinics, and patients whose main problem was obsessive compulsive disorder were invited to take part. Inclusion criteria were diagnosis of obsessive compulsive disorder; obsessive compulsive disorder as the main presenting problem; score of 16 or more on the Yale Brown obsessive compulsive checklist; and age 16-65. We excluded patients who had obsessional slowness (a variant of obsessive compulsive disorder), organic brain disease, a diagnosis of substance misuse, or severe depression with suicidal intent, and patients who had been on a stable dose of antidepressants or anxiolytics for less than three months.

Outcomes

Primary outcome measure was the Yale Brown obsessive compulsive checklist (self report version).[12] This is a 10 item questionnaire, and each question is scored between 0 and 4 (0 no symptoms, 4 severe symptoms). The total score range is 0-7 very mild, 8-15 mild, 16-23 moderate, 24-31 marked, and 32-40 severe. A secondary outcome measure was the Beck depression inventory.[13] Satisfaction with treatment was measured using the client satisfaction questionnaire at the initial follow-up visit.[14]

Procedure

To establish baseline data we assessed patients twice, with four weeks in between. We used permuted blocks with a block size of

A Randomized Controlled Trial of Telephone-Delivered Cognitive-Behavioral Therapy for Late-Life Anxiety Disorders

Gretchen A. Brenes, Ph.D., Michael E. Miller, Ph.D., Jeff D. Williamson, M.D., W. Vaughn McCall, M.D., Mark Knudson, M.D., Melinda A. Stanley, Ph.D.

Objectives: *Older adults face a number of barriers to receiving psychotherapy, such as a lack of transportation and access to providers. One way to overcome such barriers is to provide treatment by telephone. The purpose of this study was to examine the effects of cognitive behavioral therapy delivered by telephone (CBT-T) to older adults diagnosed with an anxiety disorder.* **Design:** *Randomized controlled trial.* **Setting:** *Participants' homes.* **Participants:** *Sixty participants age 60 and older with a diagnosis of generalized anxiety disorder, panic disorder, or anxiety disorder not otherwise specified.* **Intervention:** *CBT-T versus information-only comparison.* **Measurements:** *Coprimary outcomes included worry (Penn State Worry Questionnaire) and general anxiety (State Trait Anxiety Inventory). Secondary outcomes included clinician-rated anxiety (Hamilton Anxiety Rating Scale), anxiety sensitivity (Anxiety Sensitivity Index), depressive symptoms (Beck Depression Inventory), quality of life (SF-36), and sleep (Insomnia Severity Index). Assessments were completed prior to randomization, immediately upon completion of treatment, and 6 months after completing treatment.* **Results:** *CBT-T was superior to information-only in reducing general anxiety (ES = 0.71), worry (ES = 0.61), anxiety sensitivity (ES = 0.85), and insomnia (ES = 0.82) at the posttreatment assessment; however, only the reductions in worry were maintained by the 6-month follow-up assessment (ES = 0.80).* **Conclusions:** *These results suggest that CBT-T may be efficacious in reducing anxiety and worry in older adults, but additional sessions may be needed to maintain these effects.* (Am J Geriatr Psychiatry 2012; 20:707–716)

Key Words: Anxiety, cognitive-behavioral therapy, elderly, generalized anxiety disorder, panic disorder, telephone-delivered psychotherapy

Received August 10, 2010; accepted March 29, 2011. From the Department of Psychiatry and Behavioral Medicine (GAB, WVM); Department of Biostatistical Sciences (MEM); Department of Internal Medicine Section on Gerontology and Geriatric Medicine (JDW); Department of Family and Community Medicine (MK), Wake Forest University School of Medicine, Winston-Salem, NC; and Menninger Department of Psychiatry and Behavioral Sciences, Michael E. DeBakey Veterans Affairs Medical Center, Houston Center for Quality of Care and Utilization Studies (MAS), Houston, TX. Send correspondence and reprint requests to Gretchen A. Brenes, Ph.D., Department of Psychiatry and Behavioral Medicine, Wake Forest University School of Medicine, Medical Center Blvd., Winston-Salem, NC 27157. e-mail: gbrenes@wfubmc.edu

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BMC Research Notes

RESEARCH ARTICLE Open Access

Randomized trial of telephone versus in-person delivery of a brief psychosocial intervention in post-stroke depression

Catherine J. Kirkness[1], Kevin C. Cain[2], Kyra J. Becker[3], David L. Tirschwell[3], Ann M. Buzaitis[4], Pamela L. Weisman[1], Sylvia McKenzie[5], Linda Teri[6], Ruth Kohen[7], Richard C. Veith[7] and Pamela H. Mitchell[1,8*]

Abstract

Background: A psychosocial behavioral intervention delivered in-person by advanced practice nurses has been shown effective in substantially reducing post-stroke depression (PSD). This follow-up trial compared the effectiveness of a shortened intervention delivered by either telephone or in-person to usual care. To our knowledge, this is the first of current behavioral therapy trials to expand the protocol in a new clinical sample. 100 people with Geriatric Depression Scores ≥ 11 were randomized within 4 months of stroke to usual care (N = 28), telephone intervention (N = 37), or in-person intervention (N = 35). Primary outcome was response [percent reduction in the Hamilton Depression Rating Scale (HDRS)] and remission (HDRS score < 10) at 8 weeks and 12 months post treatment.

Results: Intervention groups were combined for the primary analysis (pre-planned). The mean response in HDRS scores was 39% reduction for the combined intervention group (40% in-person; 38% telephone groups) versus 33% for the usual care group at 8 weeks (p = 0.3). Remission occurred in 37% in the combined intervention groups at 8 weeks versus 27% in the control group (p = 0.3) and 44% intervention versus 36% control at 12 months (p = 0.5). While favouring the intervention, these differences were not statistically significant.

Conclusions: A brief psychosocial intervention for PSD delivered by telephone or in-person did not reduce depression significantly more than usual care. However, the comparable effectiveness of telephone and in-person follow-up for treatment of depression found is important given greater accessibility by telephone and mandated post-hospital follow-up for comprehensive stroke centers.

Clinical Trial Registration URL: https://register.clinicaltrials.gov, unique identifier: NCT01133106, Registered 5/26/2010

Keywords: Behavioural therapy, Psychosocial intervention, Depression, Randomized controlled trial, Stroke, Nurse therapist

Background

It is now well established that depression is a significant risk factor for having a stroke and also complicates recovery from stroke [1]. Further, meta-analyses show that roughly 30% of people with strokes suffer from clinical depression [2]. We previously showed that a brief psychosocial behavioural intervention delivered in-person by psychosocial nurse practitioners to community dwelling ischemic stroke survivors is efficacious in reducing depressive symptoms rapidly and sustaining that reduction over time [3]. At the time we began the previous study, Cochrane Database reviews showed few adequately designed studies of psychosocial and non-pharmacologic interventions, with relatively small effects [4, 5]. Our previous study was cited as one of those in progress that might add to support for such interventions [5].

Since the publication of the Cochrane review, our initial study, living well with stroke (LWWS) brief psychosocial

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Benefits and Challenges of Conducting Psychotherapy by Telephone

Gretchen A. Brenes, Cobi W. Ingram, and Suzanne C. Danhauer
Wake Forest School of Medicine

Telephone-delivered psychotherapy has increased utility as a method of service delivery in the current world, where a number of barriers, including economic hardships and limited access to care, may prevent people from receiving the treatment they need. This method of service provision is practical and has the potential to reach large numbers of underserved people in a cost-effective manner. The aim of this article is to review the state-of-the-art of telephone-delivered psychotherapy and to identify improvements and possible solutions to challenges. Results of randomized, controlled trials indicate high client acceptance and positive outcomes with this method of delivering psychotherapy. Nonetheless, psychotherapists wishing to deliver psychotherapy by telephone face a number of challenges, including a lack of control over the environment, potential compromises of privacy and confidentiality, developing therapeutic alliance without face-to-face contact, ethical and legal issues in providing psychotherapy by telephone, handling crisis situations at a distance, and psychotherapist adjustment to conducting psychotherapy in an alternative manner. There remains a need for further research, including direct comparisons of face-to-face psychotherapy with telephone-delivered psychotherapy and feasibility of telephone delivery of psychotherapies other than cognitive–behavioral therapy.

Keywords: telehealth, telephone, psychotherapy, mental health, health care access

Overview of Telehealth

Telehealth refers to "the use of telecommunications and information technologies to provide access to health information and services across a geographical distance" (Glueckauf, Picket, Ketterson, Loomis, & Rozensky, 2003, p. 160). Use of telehealth, especially for mental health care, has increased rapidly because of the desire to provide health care to underserved populations, reduce health care costs, and meet consumers' desires (Glueckauf et al., 2003). A number of barriers to traditional face-to-face psychotherapy may prevent people from obtaining the help they need, including transportation issues, need for childcare, perceived stigma, and difficulty leaving work (Bee, Lovell, Lidbetter, Easton, & Gask, 2010; Mohr et al., 2005). Over two-thirds of depressed patients in a primary care setting reported at least one practical barrier (e.g., transportation difficulties) that hampered their ability to attend psychotherapy regularly (Mohr, Hart, Howard, et al., 2006). Telephone-delivered psychotherapy can minimize such barriers, either as the primary method of delivering psychotherapy or as an adjunct to face-to-face psychotherapy.

Telephone-delivered psychotherapy offers increased client convenience with respect to location and flexible timing of appointments (Simon, Ludman, Tutty, Operskalski, & Von Korff, 2004; Tutty, Ludman, & Simon, 2005; Tutty, Spangler, Poppleton, Ludman, & Simon, 2010). Clients can complete sessions at home in privacy, which may reduce concerns about stigma related to mental health treatment (Mozer, Franklin, & Rose, 2008; Simon et al., 2004) and potentially be less threatening than face-to-face sessions for some clients.

Clients who could benefit from improved access to psychotherapy include older adults, individuals who lack local service pro-

Editor's Note. This is one of 19 accepted articles received in response to an open call for submissions on Telehealth and Technology Innovations in Professional Psychology.—MCR

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SUZANNE C. DANHAUER received her PhD in clinical psychology from the University of Kentucky. She is an associate professor in the Department of Social Sciences and Health Policy in the Division of Public Health Sciences at Wake Forest School of Medicine. Her research interests include behavioral and mind-body interventions for cancer survivors to reduce symptom burden and improve quality of life, psychosocial oncology, and development of various telehealth approaches to intervention delivery, particularly for individuals residing in rural areas.

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DEPRESSION AND ANXIETY 33:415–423 (2016)

Research Article

BEHAVIORAL ACTIVATION AND THERAPEUTIC EXPOSURE FOR POSTTRAUMATIC STRESS DISORDER: A NONINFERIORITY TRIAL OF TREATMENT DELIVERED IN PERSON VERSUS HOME-BASED TELEHEALTH

Ron Acierno, Ph.D.,[1,2]* Daniel F. Gros, Ph.D.,[1,3] Kenneth J. Ruggiero, Ph.D.,[1,2] Melba A. Hernandez-Tejada, DHA,[1,2] Rebecca G. Knapp, Ph.D.,[1,3] Carl W. Lejuez, Ph.D.,[4] Wendy Muzzy, MRA, MLIS,[1,2] Christopher B. Frueh, Ph.D.,[5] Leonard E. Egede, M.D.,[1,3] and Peter W. Tuerk, Ph.D.[1,3]

Objective: *Combat veterans returning to society with impairing mental health conditions such as PTSD and major depression (MD) report significant barriers to care related to aspects of traditional psychotherapy service delivery (e.g., stigma, travel time, and cost). Hence, alternate treatment delivery methods are needed. Home-based telehealth (HBT) is one such option; however, this delivery mode has not been compared to in person, clinic-based care for PTSD in adequately powered trials. The present study was designed to compare relative noninferiority of evidence-based psychotherapies for PTSD and MD, specifically Behavioral Activation and Therapeutic Exposure (BA-TE), when delivered via HBT versus in person, in clinic delivery.* **Method:** *A repeated measures (i.e., baseline, posttreatment, 3-, 6-month follow-up) randomized controlled design powered for noninferiority analyses was used to compare PTSD and MD symptom improvement in response to BA-TE delivered via HBT versus in person, in clinic conditions. Participants were 232 veterans diagnosed with full criteria or predefined subthreshold PTSD.* **Results:** *PTSD and MD symptom improvement following BA-TE delivered by HBT was comparable to that of BA-TE delivered in person at posttreatment and at 3- and 12-month follow-up.* **Conclusion:** *Evidence-based psychotherapy for PTSD and depression can be safely and effectively delivered via HBT with clinical outcomes paralleling those of clinic-based care delivered in person. HBT, thereby, addresses barriers to care related to both logistics and stigma. Depression and Anxiety 33:415–423, 2016.*

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Clinical Trial Registration number: NCT01177488.

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MARCH 2021

Testimonials from Patients and Providers on the Value of Audio-only Tele-behavioral Health Services

DEBORAH CAGLE (A PATIENT WHO RECEIVES AUDIO-ONLY TELETHERAPY)

"I live on a boat with my husband, but we have very iffy WiFi. I have been taking care of my husband who has had a couple of surgeries. I just had a surgery myself. The reason we did telehealth, besides the coronavirus, is that it was just hard for me to leave my husband while I was going through some of my sessions... (Teletherapy) saved my life and saved my marriage. If I hadn't had this opportunity to do the audio I don't know where I'd be right now or if I'd even be here."

MONICA KRAMER MCCONKEY, LPC (A RURAL MENTAL HEALTH SPECIALIST)

"I work primarily with farmers and their families as well as agricultural industry personnel. I spend several hours each week with clients in an audio-only setting. With COVID came the move to virtually based counseling and therapy sessions. However, this has proved to be challenging to several of the farmers/ranchers I meet with for three reasons. 1) broadband connection is insufficient to provide a clear and uninterrupted session, 2) there is a lack of either technology or training in how to log into and utilize a format such as Zoom, and 3) many farmers call me from mobile locations such as the tractor, barn, yard, vehicle, etc. I always give the option of in-person meetings, Zoom sessions, or phone conversations. Several of my clients prefer phone conversations for the flexibility and accessibility that they afford."

JIM BROYLES, PHD (A PSYCHOLOGIST)

"Audio-only telehealth has really benefited (my patients) tremendously. It has expanded the ability of many of the potential consumers of psychological services to access the help that they need. A lot of people who are Medicare recipients either don't have the access to the technology that allows both audio and video connection to their service provider, or they are not technologically sophisticated enough to really make that an easy or readily available means of accessing that service. For people who are less sophisticated with technology, it's very difficult for them to shorten that time. It also impacts the stress that clients are experiencing. They're already living in very stressful times right now or they wouldn't be reaching out for help."

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Telephone Counseling and Home Telehealth Monitoring to Improve Medication Adherence: Results of a Pilot Trial Among Individuals With Multiple Sclerosis

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Jodie K. Haselkorn
VA Puget Sound Health Care System, Seattle, Washington, VA MS Center of Excellence West, Seattle, Washington, and University of Washington

Objective: To evaluate the impact upon medication adherence of brief telephone-based counseling using principles of motivational interviewing and telehealth home monitoring. ***Design:*** Randomized controlled pilot trial of 19 veterans with multiple sclerosis (MS) currently prescribed disease modifying therapy (DMT) who endorsed missing doses. Follow-up was conducted at 1, 3, and 6 months. ***Results:*** Participants in the intervention condition reported better adherence relative to controls at 6-month follow-up [*M* (*SD*) = 1.3 (2.1) vs. 8.2 (12.3) past month missed doses]. All participants in the intervention condition completed all 3 telephone counseling sessions and 90% or greater rated the program as highly successful. ***Conclusion:*** Brief telephone counseling represents a promising mechanism for improving medication adherence. The primary components, motivational interviewing and home telehealth monitoring, provided complementary mechanisms for initiating and sustaining behavior change over time. The intervention was well tolerated and provided an opportunity to extend access and reduce barriers to care by bringing it into the homes of participants.

Keywords: multiple sclerosis, medication adherence, motivational interviewing, self-management, telehealth

Impact and Implications

- Preliminary evidence suggests that brief telephone counseling based upon motivational interviewing is an effective means of promoting self-management and health behavior change.
- The flexibility of telephone-based counseling has considerable potential to extend the reach of psychological interventions outside of traditional practice settings.
- There is considerable opportunity to incorporate telephone-based counseling and self-management into both chronic illness management and rehabilitation care.

Introduction

Medication adherence represents a significant challenge to the efficacy and cost-effectiveness of health care. Problems with medication adherence are well documented in many common conditions, including hypertension, chronic obstructive pulmonary disease, depression, and diabetes. Existing literature suggests that typical rates of adherence are often as low as 50% (Haynes,

This article was published Online First April 7, 2014.

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This research was supported by Department of Veterans Affairs Rehabilitation Research and Development Service Career Development Awards (B3319VA) and (B4927W) to Aaron P. Turner. Additional support was provided by the VA MS Center of Excellence West and the VA Center of Excellence in Substance Abuse Treatment and Education. Trial Registration clinicaltrials.gov Identifier: NCT00118547.

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California Initiative for Health Equity & Action (Cal-IHEA)
HEALTH POLICY REPORT

Evaluating Medi-Cal Telehealth Policy for Audio-Only Visits Post-Pandemic

Pablo Cuadros, MPH
UC Berkeley School of Public Health

July, 2021

EXECUTIVE SUMMARY

The COVID-19 pandemic accelerated the adoption of telehealth services for many California health care providers and systems. While many of the flexibilities to telehealth service delivery may remain permanent, the California Department of Health Care Services (DHCS) proposed removing payment parity for telephone/audio-only services after the public health emergency ends. This could have a negative impact on access to health care services for underserved populations with limited internet access, access to live video technology, or transportation or employment flexibility for an in-person visit. This policy analysis examines the impact of regulations that allow for an incremental transition from payment parity for audio-only visits to a reimbursement schedule that promotes live video visits. This approach can help to safeguard the reimbursement and availability of audio-only services for Medi-Cal providers while allowing for adequate investment in technological infrastructure that would allow safety net providers and systems to adopt and tailor accessible live video services for their populations. As more research is being conducted on the effectiveness of telehealth services through audio-only modalities, it is critical to maintain equitable access to telehealth services for all Medi-Cal patients. California's DHCS must synthesize information from critical stakeholders to guide current telehealth policy proposals with the goal of lowering barriers to access to telehealth for Medi-Cal patients while providing high-quality services.

POLICY BACKGROUND

Prior to the pandemic, the Department of Health Care Services (DHCS) had coverage restrictions on telehealth service delivery based on organization, location, patient eligibility and modality. Medi-Cal restricted coverage for live video and asynchronous telehealth services while excluding audio-only services, e-consults, and remote patient monitoring. Providers were reimbursed at parity for both asynchronous and synchronous live visits. Federally Qualified Health Centers (FQHC) & Rural Health Centers (RHC) only offered coverage for telehealth to established patients and limited the services that could be provided through asynchronous modalities to ophthalmology, dermatology and dentistry. Previous regulations also limited the location that patients could receive telehealth services, which excluded them from being able to receive care in their own homes.

After the declaration of a state of emergency, implementation of 1135 waivers led to increased flexibility of telehealth service delivery. DHCS covered audio-only services, lifted location restrictions so patients could communicate with their providers from their home (if medically

ALZHEIMER'S ASSOCIATION®

Testimony to the House Committee on Consumer Protection and Commerce
Thursday, February 16, 2023, 2:00 p.m.
Hawaii State Capitol, Conference Room 329 and Videoconference

RE: House Bill No. 907 House Draft 1, RELATING TO TELEHEALTH

Chair Mark Nakashima, Vice Chair Jackson Sayama, and Members of the Committee:

I am Ron Shimabuku, Director of Public Policy and Advocacy for the Alzheimer's Association. I am here to testify in **support of HB907 HD1.**

The Alzheimer's Association was established to assist those facing Alzheimer's disease and other dementias by providing local support groups and educational resources while advancing crucial research and public policy initiatives.

Alzheimer's disease is a public health crisis across the country. In Hawaii, approximately 29,000 individuals aged 65 and older live with Alzheimer's. By 2025, this figure is projected to increase by 20.7%. In addition, many are experiencing subjective cognitive decline — one of the earliest warning signs of future dementia. In 2020, 6.7% of individuals aged 45 and over reported an increase in confusion or worsening memory loss, putting them at risk of later developing dementia.

Although the Alzheimer's Association has not taken an official position on telehealth for patients with dementia, we recognize the significance of access to healthcare services, most especially in rural areas and vulnerable populations. We also acknowledge that certain communities throughout the state have limited to no broadband access. Telehealth via telephonic means has been a mode of access to bridge this digital divide, allowing individuals with limited broadband to receive healthcare services.

With this, the Alzheimer's Association respectfully urges your favorable consideration of this bill.

Mahalo for the opportunity to testify. If you have questions, please contact Ron Shimabuku at 808.451.3410 or rkshimabuku@alz.org.

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HAWAII SUBSTANCE ABUSE COALITION

HB907 HD1 Telehealth and Telephone
COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Mark M. Nakashima, Chair; Rep. Jackson D. Sayama, Vice Chair
Thursday, Feb 16 2023: 2:00 am : Room 329 Videoconference

Hawaii Substance Abuse Coalition Supports HB907 HD1

Recommendation:

Please amend Hawaii's law to Medicare standards to address the full spectrum of requirements listed under 42 CFR 438.10 (b). The current Medicare definition is:

"Interactive telecommunications system" means, except as otherwise provided in this paragraph, multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. For services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in their home, interactive telecommunications may include two-way, real-time audio only communication technology if the distant site physician or practitioner is technically capable to use an interactive telecommunications system as defined in the previous sentence, but the patient is not capable of, or does not consent to, the use of video technology. A modifier designated by CMS must be appended to the claim for services described in this paragraph to verify that these conditions have been met." 42 CFR 410.78(a)(3).

The use of "two-way, real-time audio-only communication technology" is Medicare's description of telephone calls specific to the treatment of a mental health disorder. Further, we would note that Medicare only allows telehealth under certain additional conditions.

Telehealth

Telehealth is not meant to totally replace face to face for those who have more chronic conditions, but it certainly allows us to treat more people who are in need of services that otherwise would not have access to services, especially for rural areas.

U.S. Congress has stated that preliminary evaluations have demonstrated that telehealth and when needed telephonic practices does save money and improve care:

- Especially for the elderly and behavioral health,
- For checkups for both specialty care and primary care.
- In certain cases, it's a more efficient use of time for care givers and patients.

People with chronic conditions need follow-up care to prevent ongoing ER and hospital care, but if they have limited access to care, then Telehealth is crucial and if not available, then telephonic care becomes essential.

Telephone services are an integral part of Medicaid and Medicare and with this legislation it can be for commercial plans too, subject to financing and authorizations.

We appreciate the opportunity to provide testimony and are available for questions.
to provide testimony and are available for questions.

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

Thursday, February 16, 2023, at 2:00 PM
Via Video Conference; Conference Room 329

House Committee on Consumer Protection & Commerce

To: Representative Mark Nakashima, Chair
Representative Jackson Sayama, Vice Chair

From: Michael Robinson
Vice President, Government Relations & Community Affairs

Re: Testimony in Support of HB 907, HD1
Relating to Telehealth

My name is Michael Robinson, and I am the Vice President of Government Relations & Community Affairs at Hawaiʻi Pacific Health. Hawaiʻi Pacific Health is a not-for-profit health care system comprised of its four medical centers – Kapiʻolani, Pali Momi, Straub and Wilcox and over 70 locations statewide with a mission of creating a healthier Hawaiʻi.

HPH writes in SUPPORT of HB 907, HD1 which clarifies that telehealth services provided by way of an interactive telecommunications system be reimbursed, conforming State law on telehealth to the Medicare standards, and specifies that "interactive telecommunications system" includes two-way real-time audio-only communication.

Since 1999, the use and expansion of telehealth services and technology in Hawaii has been recognized as a strategy to increase patient access to healthcare by overcoming the geographic challenges across our state. Many of Hawaii's geographically access challenged patients reside in Medically Underserved Areas (MUA), are part of Medically Underserved Populations (MUP), or reside in federally designated health professional shortage areas. Elderly, as well as medically- and socially complex patients often face transportation barriers, limited broadband access and personal difficulty navigating the technological requirements of accessing traditional video telehealth care services. In these instances, telephonic communication becomes a viable alternative for many in these communities to overcome barriers enabling them to access healthcare remotely.

HPH supports the development of a provider reimbursement system that also incorporates reimbursement for telephonic services. We have experienced challenges with our patients accessing acute care services (limited means to travel, poor or absent internet coverage, residence remote from care providers, infirm with limited mobility, immune compromise in the age of COVID, etc.) across our system. As a related example, within HPH charges for telephonic services represent 12-15% of total charges for remote physician to patient acute care service charges indicating a need for telephonic services as an alternative care modality. In the absence of telephonic services being provided or available, these at-risk individuals would have had to resort to travel from their residence to clinics and emergency departments at great personal expense or choose to do without care guidance altogether. Therefore, we foster a telehealth environment in Hawaii that allows both patients today the ability to access behavioral health

services remotely without unnecessarily foreclosing future opportunities to develop alternative reimbursement structures for other remote access modalities to flourish.

Thank you for the opportunity to testify.

American Cancer Society
Cancer Action Network
2370 Nu'uanu Avenue
Honolulu, Hi 96817
808.460.6109
www.fightcancer.org

House Committee on Consumer Protection and Commerce
Representative Mark Nakashima, Chair
Representative Jackson Sayama, Vice Chair

Hearing Date: Thursday, February 16, 2023

ACS CAN SUPPORTS HB 907 HD1 – RELATING TO TELEHEALTH.

Cynthia Au, Government Relations Director – Hawaii Guam
American Cancer Society Cancer Action Network

Thank you for the opportunity to **SUPPORT** HB 907 HD1 – RELATING TO TELEHEALTH.

The American Cancer Society Cancer Action Network (ACS CAN), the nonprofit, non-partisan advocacy affiliate of the American Cancer Society advocates for public policies that reduce death and suffering from cancer. ACS CAN works with federal, state, and local government bodies to support evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem.

ACS CAN recognizes that telehealth increases access to quality cancer care among populations that are underserved (e.g., residents of rural communities, individuals with limited income, patients with low health literacy, and people of color). It is especially important for access to healthcare services in rural areas or areas on the neighbor islands with limited broadband access. Audio only telehealth can also improve health outcomes.

A particular benefit of telehealth emerged during the coronavirus pandemic -cancer patients vulnerable to COVID-19 could conduct a video or audio visit with their providers from the safety of their home without risking additional exposure to the virus. The pandemic has demonstrated the importance of adaptable policies around telehealth that allow patients to reap the optimal benefits of telehealth.

ACS CAN, through the Survivor Views program, asked a cohort of cancer patients and survivors about their experience with and interest in telehealth. Overwhelming majorities of cancer patients and survivors who have had telehealth visits believed their issues and questions were well-addressed. 55% of respondents had a phone visit and 43% had a video visit with a telehealth provider about an issue related to their cancer care that otherwise would have been an in-person office visit (not a prescription refill or appointment booking). In both cases, 94% said their issues and questions were addressed well.

The Department of Human Services offered technical amendments referencing federal regulations, they are good amendments. We believe that private insurance should cover this healthcare cost. For purposes of continued discussions, ACS CAN urges the committee to move this bill forward.

Thank you again for the opportunity to provide testimony in SUPPORT on this important matter. Should you have any questions, please do not hesitate to contact Government Relations Director Cynthia Au at 808.460.6109, or Cynthia.Au@Cancer.org.

Hawaii Medical Association
1360 South Beretania Street, Suite 200 • Honolulu, Hawaii 96814
Phone: 808.536.7702 • Fax: 808.528.2376 • hawaiimedicalassociation.org

COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Mark M. Nakashima, Chair
Rep. Jackson D. Sayama, Vice Chair

Date: February 16, 2023
From: Hawaii Medical Association
Beth England MD, Co-Chair, HMA Public Policy Committee

Re: HB907, HD1; RELATING TO TELEHEALTH.
Position: Support with Comments

To allow for safer and easier patient-provider interactions during COVID-19, there was a dramatic increase in telehealth. Patients who are elderly, have public insurance, are of Asian, African-American, or Hispanic heritage, and/or of a lower socioeconomic status were more likely to use audio-only communication for medical appointments[1]. Audio-only services provide an invaluable means for marginalized populations that may not have access to internet to receive the healthcare they need.

Reducing barriers to care enables patients to continue to see their providers, even in times of hardship. A large review study of federally qualified health centers (FQHC) during the pandemic found that the number of patient visits for behavioral health appointments, which used a larger proportion of audio-only visits, remained unchanged, while specialties using a higher percentage of video appointments had a 6.5% decrease in visits[2]. This indicates that telephone-based visits allowed more patients to continue their care. Audio-only telemedicine visits are also associated with a reduced time to follow-up visits[3].

As we work to address the complex socioeconomic factors that lead to health disparities, providing an accessible means for disadvantaged populations to receive care is a step in the right direction. This need has been recognized at the federal level; the Center for Medicare and Medicaid Services (CMS) covers audio-only services for established patients receiving mental health or substance abuse disorder treatment as long as certain conditions are met[4].

Widespread use of audio-only telehealth services is a relatively new phenomenon that requires thorough research and risk assessment. There is data to support its use for behavioral health, but additional studies are needed to ensure its quality and safety in other settings. For this reason, the HMA respectfully recommends that the bill be amended to reflect the current language in 42 CFR § 410.78, including the bolded and underlined words as follows:

"For services furnished for purposes of diagnosis, evaluation, or treatment of a **mental health disorder** to a patient in their home, interactive telecommunications may include two-way, real-time audio-only communication technology **if the distant site physician or practitioner is technically capable to use an interactive telecommunications system as defined in the previous sentence, but the patient is not capable of, or does not consent to, the use of video technology**."

Physicians have rapidly adopted telemedicine technologies to better serve our population. Payment parity for audio-only telemedicine care for treatment of a mental health disorder is fair and appropriate. This will increase access to care, improve health, and in doing so, reduce long-term costs.

Thank you for allowing Hawaii Medical Association to offer comments and testify in support of this measure.

REFERENCES

1. Hsiao, V., Chandereng, T., Lankton, R. L., Huebner, J. A., Baltus, J. J., Flood, G. E., Dean, S. M., Tevaarwerk, A. J., & Schneider, D. F. (2021). Disparities in Telemedicine Access: A Cross-Sectional Study of a Newly Established Infrastructure during the COVID-19 Pandemic. Applied Clinical Informatics, 12(03), 445–458. https://doi.org/10.1055/s-0041-1730026

2. Martin, R., Ambia, A. M., Holcomb, D. S., Wells, C., Nambiar, A., Roberts, S. W., McIntire, D. D., Harms, M., Duryea, E. L., & Nelson, D. B. (2022). Postpartum Audio-Only Virtual Visits Versus In-Person Followup in Women with Severe Hypertension. American Journal of Obstetrics & Gynecology, 226(1), S741–S742. https://doi.org/10.1016/j.ajog.2021.11.1219

3. Uscher-Pines, L., Sousa, J., Jones, M., Whaley, C., Perrone, C., McCullough, C., & Ober, A. J. (2021). Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic. JAMA. https://doi.org/10.1001/jama.2021.0282

4. Calendar Year (CY) 2022 Medicare Physician Fee Schedule Final Rule | CMS. (n.d.). Www.cms.gov.https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-finalrule

EPILEPSY FOUNDATION Hawaii

February 14, 2023

House Representative Mark Nakashima, Chair
House Representative Jackson Sayama, Vice Chair
Testimony to the House Committee on Consumer Protection & Commerce
Thursday, February 16, 2023; 2:00 pm. State Capitol, Conf. Room 423 & via Videoconference

RE: House Bill 907 HD1 – RELATING TO TELEHEALTH

Aloha Chair Nakashima, Vice Chair Sayama, and Members of the Committee:

On behalf of the Epilepsy Foundation of Hawaii (EFH), we urge your **SUPPORT** of House Bill 907 HD1, RELATING TO TELEHEALTH.

The Epilepsy Foundation of Hawaii is an independent 501(c)(3) non-profit organization whose mission is to advocate and provide services for the almost 14,000 individuals living with epilepsy throughout Hawaii, along with their caregivers and community. Collectively, we foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services. Epilepsy is a medical condition characterized by seizures, which are sudden surges of electrical activity in the brain, that affects a variety of mental and physical functions. Approximately 1 in 26 Americans will develop epilepsy, and approximately 1 in 10 people will experience a seizure, at some point in their lifetime.

Telehealth services can prove extremely useful in supporting healthcare in persons with epilepsy, particularly for their role in facilitating the interactive exchange of information between patients and physicians. We want to ensure accessibility and equity for all patients and that benefits required under Medicare and Medicaid should justly be required for private insurers.

On behalf of the Epilepsy Foundation of Hawaii and our Board of Directors, we humbly thank you for the opportunity to testify and urge your support for House Bill 907 HD1.

Mahalo nui loa,

Naomi Manuel

Naomi Manuel
Executive Director
Epilepsy Foundation of Hawaii

HB-907-HD-1
Submitted on: 2/14/2023 2:34:50 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Marion Poirier	Individual	Support	Written Testimony Only

Comments:

TO: House Committee on Consumer Protection and Commerce

FROM: Marion Poirier, M.A. R.N.

SUBJECT: SUPPORT H.B. 907 for 02/16, 2023 Hearing

Chair Nakashima and Members of the Committee:

My name is Marion Poirier, and I am an R.N. whose career has been largely as a non-profit executive director. I cannot begin to name the many citizens who will receive healthcare because of passage of this legislation. In particular, it is applicable in mental health. Also, it is efficient and effective. Please see that it is reimbursed equivalent to visual modes.

Thank you for affording me the opportunity to support healthcare for all.

JUNE W. J. CHING, Ph.D., ABPP
Diplomate in Clinical Psychology
American Board of Professional Psychology
1833 Kalakaua Ave., Suite 206
Honolulu, Hawaii 96815

Secretary (808) 955-7372
Fax: (808) 951-9282

February 14, 2023

Testimony in Strong Support for HB907: Audio-Only Tele-Mental Health Treatment

Audio-only Telephonic Tele-Mental Health is so necessary and needed in Hawaii. This is critical as a matter of clinical effectiveness: patient choice, compliance, & financial means; and access – particularly in low broadband and rural areas for mental health.

Through the pandemic, patients and physicians alike have embraced telehealth technology to effectively and broadly increase access to healthcare and serve Hawaii's population in new ways. However, these advanced technologies fail to reach several vulnerable groups due to limited understanding, access, comfort, and the expense of the technology and internet services needed to make telehealth work. Many people in need prefer audio-only treatment or would otherwise forego treatment altogether.

Research has shown that the efficacy of Audio-only treatment in mental health contexts is on par with video visits. Telephone contact for telehealth purposes is endorsed nationally by the American Psychological Association.

The Federal Department of Health and Human Services surveyed the research during the pandemic and concluded that patients who are elderly, on Medicaid, mobility-challenged, non-English speaking, and/or having limited internet access are more likely to use audio-only services than video visits.

Audio-only telehealth for mental health treatment provides a means for our most marginalized communities to access care. Payment parity for audio-only tele-mental health will increase access to care for Hawaii's most vulnerable communities.

Thank you for the opportunity to provide support for this important bill.

Sincerely,
June W. J. Ching, PhD, ABPP
Board Certified Clinical Psychologist
Licensed Hawaii

HB-907-HD-1
Submitted on: 2/15/2023 2:16:09 AM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Ruth Love	Individual	Support	Written Testimony Only

Comments:

Support but request addendum stating that audio only consults/discussions are covered as well.

Thank you,

Mrs Ruth Love

HB-907-HD-1
Submitted on: 2/14/2023 9:55:44 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Teresa Juarez	Individual	Support	Written Testimony Only

Comments:

Through the pandemic, patients and physicians alike have embraced telehealth technology as a means to effectively and broadly increase access to healthcare and serve Hawaii's population in new ways. However, these advanced technologies fail to reach several vulnerable groups due to limited understanding, access, comfort, and the expense of the technology and internet services needed to make telehealth work. Many people in need prefer audio-only treatment, or would otherwise forego treatment altogether.

Research has shown that the efficacy of Audio-only treatment in mental health contexts is on par with video visits.

If some patients can receive therapy through the telephone, there is hope they'll receive any treatment at all.

The Federal Department of Health and Human Services surveyed the research during the pandemic and concluded that patients who are elderly, on Medicaid, mobility-challenged, non-English speaking, and/or having limited internet access are more likely to use audio-only services than video visits.

Audio-only telehealth for mental health treatment provides a means for our most marginalized communities to access care. Payment parity for audio-only tele-mental health will increase access to care for Hawaii's most vulnerable communities.

Thank you for this opportunity to support this critical access bill.

HB-907-HD-1
Submitted on: 2/15/2023 8:47:49 AM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Brian Goodyear	Individual	Support	Written Testimony Only

Comments:

Please support this bill, which will help increase access to essential mental health services for some of our most vulnerable communities. Mahalo!

HB-907-HD-1
Submitted on: 2/15/2023 7:08:08 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
James Spira	Pacific Behavioral Health	Support	Written Testimony Only

Comments:

Through the pandemic, patients and physicians alike have embraced telehealth technology as a means to effectively and broadly increase access to healthcare and serve Hawaii's population in new ways. However, these advanced technologies fail to reach several vulnerable groups due to limited understanding, access, comfort, and the expense of the technology and internet services needed to make telehealth work. Many people in need prefer audio-only treatment, or would otherwise forego treatment altogether.

Research has shown that the efficacy of Audio-only treatment in mental health contexts is on par with video visits.

If some patients can receive therapy through the telephone, there is hope they'll receive any treatment at all.

The Federal Department of Health and Human Services surveyed the research during the pandemic and concluded that patients who are elderly, on Medicaid, mobility-challenged, non-English speaking, and/or having limited internet access are more likely to use audio-only services than video visits.

I serve persons with disability in remote settings. They often cannot come into the office, and during videoconferencing sessions the video may not always connect, or they don't know how to connect. These patients deserve treatment as much as anyone else.

Audio-only telehealth for mental health treatment provides a means for our most marginalized communities to access care. Payment parity for audio-only tele-mental health will increase access to care for Hawaii's most vulnerable communities.

Thank you for this opportunity to support this critical access bill.

James L Spira, PhD, MPH

Former Positions:

Professor, Department of Psychiatry, University of Hawaii

Director, Department of Veterans Affairs, National Center for PTSD

Member, State of Hawaii DCCA Board of Psychology

HB-907-HD-1
Submitted on: 2/15/2023 8:15:30 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Grace Barrientos	Wai Kahe Counseling	Support	Written Testimony Only

Comments:

To Whom It May Concern:

Through the pandemic, patients and physicians alike have embraced telehealth technology as a means to effectively and broadly increase access to healthcare and serve Hawaii's population in new ways. However, these advanced technologies fail to reach several vulnerable groups due to limited understanding, access, comfort, and the expense of the technology and internet services needed to make telehealth work. Many people in need prefer audio-only treatment, or would otherwise forego treatment altogether.

Research has shown that the efficacy of Audio-only treatment in mental health contexts is on par with video visits.

If some patients can receive therapy through the telephone, there is hope they'll receive any treatment at all.

The Federal Department of Health and Human Services surveyed the research during the pandemic and concluded that patients who are elderly, on Medicaid, mobility-challenged, non-English speaking, and/or having limited internet access are more likely to use audio-only services than video visits.

Audio-only telehealth for mental health treatment provides a means for our most marginalized communities to access care. Payment parity for audio-only tele-mental health will increase access to care for Hawaii's most vulnerable communities.

Thank you for this opportunity to support this critical access bill.

Thank you for your time and consideration,

Grace M. Barrientos, MA, MSW, LCSW, Mental Health Therapist

HB-907-HD-1
Submitted on: 2/15/2023 8:24:01 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Dr. Shawna Ledward	Clinical Psychology Services	Support	Written Testimony Only

Comments:

Since the pandemic, mental health providers have demonstrated great success with audio-only treatments. Firstly, it has provided greater access to care. Individuals with limited finances, lack of internet, limited technical knowledge, and those on outer islands. Secondly, it has provided greater access to care for those who may be significantly impacted by their mental health issues, such as patients who struggle with extreme anxiety/depression and do not feel comfortable utilizing telehealth or in-person visits. Audio-only treatments provide greater comfort to those who might not otherwise seek treatment. Lastly, research has also shown audio -only treatments are on par with telehealth audio and visual sessions. For these reasons, I strongly support this bill to make payment parity for audio-only telehealth to increase access to care and assist more individuals in obtaining the mental health treatment deserve.

Sincerely,

Dr. Shawna Ledward

HB-907-HD-1
Submitted on: 2/15/2023 10:04:38 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Alexander Bivens, Ph.D.	Pacific Psychology Partners, Inc.	Support	Written Testimony Only

Comments:

Access to mental health services is a serious problem in Hawaii. This measure will improve citizen access to essential services. Please pass this bill!

HB-907-HD-1
Submitted on: 2/15/2023 10:15:28 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Joy Quick	HIAMFT	Support	Written Testimony Only

Comments:

Regarding HB907 CPC Committee Hearing 2-16-23 @ 2pm

Throughout the pandemic, clients and mental health professionals alike have embraced telehealth technology as a means to effectively and broadly increase access to healthcare and serve Hawai'i's population in new ways. However, these advanced technologies fail to reach several vulnerable groups due to limited understanding, access, comfort, and the expense of the technology and internet services needed to make telehealth work. Many people in need prefer audio-only treatment, or would otherwise forego treatment altogether.

Research has shown that the efficacy of Audio-only treatment in mental health contexts is on par with video visits.

If some clients can receive therapy through the telephone, there is hope they will be able to receive needed treatment too.

The Federal Department of Health and Human Services surveyed the research during the pandemic and concluded that patients and clients who are elderly, on Medicaid, mobility-challenged, non-English speaking, and/or have limited internet access are more likely to use audio-only services than video visits.

Audio-only telehealth for mental health treatment provides a means for our most marginalized communities to access care. Payment parity for audio-only tele-mental health will increase access to care for Hawai'i's most vulnerable communities.

Thank you for this opportunity to support this critical access bill,

S. Joy Quick, MA, LMFT, HIAMFT Board Member/Secretary

HB-907-HD-1
Submitted on: 2/15/2023 6:37:16 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Alan R. Spector, LCSW	Individual	Support	Written Testimony Only

Comments:

Aloha and thank you for allowing me to testify in SUPPORT of HB907 HD1. I am a mental health provider in private practice. The COVID pandemic has forced all of us to adapt to a new way of delivering mental health care through telehealth. While video is preferrable, there are some instances when it's not possible. Sometimes a client lacks a computer and/or broadband access. In these instances, mental health care delivered via telephone is the only option otherwise a client will go without needed treatment. In my experience, I have seen that audio only sessions are quite effective.

Sincerely,

Alan R. Spector, MSW, LCSW

HB-907-HD-1
Submitted on: 2/15/2023 6:53:36 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Cheryl N Prince	Individual	Support	Written Testimony Only

Comments:

As a Licensed Clinical Worker I strongly support this measure. During the COVID crisis I was able to provide mental health services to numerous individuals via telehealth. Both my clients and myself appreciated the real value of this mode of service delivery.

It was a concern to me, at the outset of providing telehealth sessions, that the therapeutic connection would be difficult using technology. Quite the opposite has been true as there is actually a closer eye to eye contact than when sitting across the room from one another.

A substantial portion of my caseload are seniors caring for another family member with a serious illness or disability. These clients deal with anxiety, depression and other menal health conditions and would not be likely to continue therapy if teleheath were not available. The time away from home and transportation issues would make coming to an office extremely difficult and would only add to their day to day stresses.

I urge you to pass HB 907 out of committee and support its enactment into law.

Mahalo nui,

Cheryl Prince, LCSW

559 Paakiki Place Kailua, HI 96734

HB-907-HD-1
Submitted on: 2/15/2023 7:19:27 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Noelani Rodrigues	Individual	Support	Written Testimony Only

Comments:

As a psychologist who has been providing tele-mental health services since 2018 and quite robustly through the pandemic I have found that there are times when an individual is not able to connect via video. Especially, in some of the rural locations on our island of Hawaii. In these cases, we have conducted sessions by audio and in my experience it has been generally just as benefical for the patient as the video session would have been. Furthermore, there have been an occasional patient here and there that is not comfortable with video sessions. I have seen this occur with patients that have severe paranoia as well as with others for a variety of other reasons. Although, I prefer as a clinician to provide sessions via video - in these cases I think the patients would have forgone therapy if they were not given the option of audio only sessions. There is no harm in audio only sessions. I think we do our community a dis-service by limiting the modalities by which they can receive treatment. Please vote in support of this bill. We really need this, especially for some of our more vulnerable populations.

HB-907-HD-1
Submitted on: 2/15/2023 8:08:32 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Judith White	Individual	Support	Written Testimony Only

Comments:

Telehealth is a vital option for a significant portion of our population. Especially in rural areas, like Kaua'i, where I am a mental health provider, audio only telehealth offers accessibility to many clients without internet or devices.
please support!

HB-907-HD-1
Submitted on: 2/15/2023 8:23:01 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
marie terry-bivens	Individual	Support	Written Testimony Only

Comments:

Dear Committee,

Teleheath has been an amazing tool to help support and reach more citizens, particularly on our neighbor islands. Through the pandemic, patients and physicians alike have embraced telehealth technology as a means to effectively and broadly increase access to healthcare and serve Hawaii's population in new ways. However, these advanced technologies fail to reach several vulnerable groups due to limited understanding, access, comfort, and the expense of the technology and internet services needed to make telehealth work. Many people in need prefer audio-only treatment, or would otherwise forego treatment altogether.

Research has shown that the efficacy of Audio-only treatment in mental health contexts is on par with video visits.

If some patients can receive therapy through the telephone, there is hope they'll receive any treatment at all.

The Federal Department of Health and Human Services surveyed the research during the pandemic and concluded that patients who are elderly, on Medicaid, mobility-challenged, non-English speaking, and/or having limited internet access are more likely to use audio-only services than video visits.

Audio-only telehealth for mental health treatment provides a means for our most marginalized communities to access care. Payment parity for audio-only tele-mental health will increase access to care for Hawaii's most vulnerable communities.

Thank you for this opportunity to support this critical access bill.

HB-907-HD-1
Submitted on: 2/15/2023 10:47:44 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Emily Malate	Individual	Support	Written Testimony Only

Comments:

To whom is May concern:

I am a therapist on the Big Island who serves East Hawaii. Many of my clients in the Puna District hve unstable internet service and in order to ensure the clearest and most consistent, effective communication sometimes phone is the only reliable means to connect. Clients can be low income and lack transportation to come into HIlo. Also I have one in the Puna District who is immunity compromised and can't do office visits. t
Through the pandemic, patients and physicians alike have embraced telehealth technology as a means to effectively and broadly increase access to healthcare and serve Hawaii's population in new ways. However, these advanced technologies fail to reach several vulnerable groups due to limited understanding, access, comfort, and the expense of the technology and internet services needed to make telehealth work. Many people in need prefer audio-only treatment, or would otherwise forego treatment altogether.

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Audio-only telehealth for mental health treatment provides a means for our most marginalized communities to access care. Payment parity for audio-only tele-mental health will increase access to care for Hawaii's most vulnerable communities.

Thank you for this opportunity to support this critical access bill.

Sincerely,

Emily Malate, LCSW

Hilo, HI

HB-907-HD-1
Submitted on: 2/15/2023 10:51:01 PM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Brian	Individual	Support	Written Testimony Only

Comments:

Please support audio-only telemental health. Based upon my experience, the option of audio-only telemental health is an extremely important resource, indeed lifeline, for many patients/clients. Thank you very very much.

HB-907-HD-1
Submitted on: 2/16/2023 1:10:09 AM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
joan Levy	Individual	Support	Written Testimony Only

Comments:

I am a licensed clinical social worker in both the state of hawaii and in california. I have an active private practice here in Hawaii since 1992. I think this bill is important because in my experience there are substantial numbers of people who for various reasons are either uncomfortable using a video format or don't have access to a smart phone or a computer for video consultation.

Before the pandemic and even before telehealth was a technical possibilty I have offered phone only sessions to clients when either I was out of town or they were unable to get themselves into my office. I do prefer the intimacy of an inperson client/therapist experience however in terms of providing a relatable and effective service, the phone was just fine. It is the quality of the interaction that determines the effectiveness of the session - not the format of the technology that might be used.

I think it is only right to allow the client to have the choice of audio only therapy calls as well as video telehealth when it is viable for them.

HB-907-HD-1
Submitted on: 2/16/2023 2:59:21 AM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Mary Myers	Individual	Support	Written Testimony Only

Comments:

Audio only tele-mental health provides a means for the most marginalized communities to receive care, who would otherwise have no access to treatment at all. Many elderly, and those having no access to internet who lack the skills or understanding to utilize video services are more likely to prefer audio only tele mental health service. Research has shown that audio only treatment in mental health contexts is on par with video visits. Thank you for the opportunity to support this critical access bill.

HB-907-HD-1
Submitted on: 2/16/2023 9:55:10 AM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Sandra Takamine	Sandra Takamine, PhD	Support	Written Testimony Only

Comments:

Good morning,

I am a psychologist on the Big Island submitting testimony in support of HB907. I treat elderly, disabled & limited income clients from rural areas who do not have smart phones, internet connections or reliable transportation for office visits. During the pandemic, they benefitted from audio telehealth & continue to receive treatment via that mode.

Thank you for considering my testimony.

Dr. Sandra Takamine

HB-907-HD-1
Submitted on: 2/16/2023 11:01:11 AM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Janet Taylor	Individual	Support	Written Testimony Only

Comments:

Audio-only mental health treatment has been proven to be as effective as video sessions and allows those populations in the most need - rural, economically cahllenged and elderly people who may not be able to use internet options - to have access to needed help. This includes many of my clients in remote Big Island locations. Please pass this bill so that needed services can be accessed by all.

HB-907-HD-1
Submitted on: 2/16/2023 11:09:06 AM
Testimony for CPC on 2/16/2023 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
ELIZABETH K TAITANO	Individual	Support	Written Testimony Only

Comments:

Through the pandemic, patients and physicians alike have embraced telehealth technology as a means to effectively and broadly increase access to healthcare and serve Hawaii's population in new ways. However, these advanced technologies fail to reach several vulnerable groups due to limited understanding, access, comfort, and the expense of the technology and internet services needed to make telehealth work. Many people in need prefer audio-only treatment, or would otherwise forego treatment altogether.

Research has shown that the efficacy of Audio-only treatment in mental health contexts is on par with video visits.

If some patients can receive therapy through the telephone, there is hope they'll receive any treatment at all.

The Federal Department of Health and Human Services surveyed the research during the pandemic and concluded that patients who are elderly, on Medicaid, mobility-challenged, non-English speaking, and/or having limited internet access are more likely to use audio-only services than video visits.

Audio-only telehealth for mental health treatment provides a means for our most marginalized communities to access care. Payment parity for audio-only tele-mental health will increase access to care for Hawaii's most vulnerable communities.

Thank you for this opportunity to support this critical access bill.