Ensuring Sustained Access to Telehealth Post Pandemic:
Patient and Provider Attitudes and Beliefs Support Use of Remote Care
January 25, 2021

Introduction

The COVID-19 pandemic has encouraged the Federal and State governments to implement policies that increase access to remote care options across a variety of health care services. Those new policies and flexibilities created a vital lifeline allowing many health care consumers to remain connected to care. At one point during the pandemic, more than two-thirds of New York's federally qualified health center (FQHC) visits were occurring remotely. In June 2020, the Community Health Care Association of New York State (CHCANYS) and the New York State Council for Community Behavioral Healthcare (NYS Council) jointly developed and released the paper: *Ensuring Sustained Access to Telehealth in the Post-Pandemic Period.* In that paper, we recommended the following principles for New York State in their efforts to improve remote care delivery and reimbursement structures that have been enabled during the pandemic:

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

CHCANYS and the NYS Council were thrilled to have the opportunity to share that paper with the Governor's Reimagine New York Commission and the Department of Health (DOH). We were also grateful to see many of our recommendations included in the Governor's 2021 State of the State proposals to expand access to telehealth. After sharing our recommendations with DOH, they requested that CHCANYS share greater detail on FQHC patient and provider attitudes and beliefs about remote care delivered both through audio-visual telehealth and the telephone. CHCANYS, funded by the RCHN Community Health Foundation, contracted with New York University Grossman School of Medicine researchers to conduct qualitative interviews with patients and providers at eight FQHCs across the State to better understand patient and provider perspectives of remote care and corresponding implications for care delivery in the post-pandemic period.[1] We have summarized those findings below, under headers of each corresponding principle.[2]

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[1] For full study methods, please see Appendix A.
[2] For additional quotes from study participants, please see Appendix B.

Utilize telehealth to increase access and promote health equity

Providers and patients alike shared that access to remote care increased their ability to receive or deliver care and decreased barriers that would usually inhibit one's ability to visit a doctor, like lack of transportation, childcare, or time off from work. The ability to receive care within the comfort of one's home resulted in widespread reductions in appointment no-show rates and, in some cases, increases in the number of patients seen per day, which remains especially important during the COVID-19 pandemic. Moreover, providers noted that remote care has allowed them to expand their geographic reach to patients they normally would not be able to see due to distance or appointment availability.

However, audio-visual telehealth alone could not meet patients' needs. Access to audio-visual telehealth is severely limited by a patient's access to broadband internet and wifi and their technical literacy. Many health center patients lack a smartphone or a computer or have limited data and minutes. Although most providers agreed that audio-visual visits are the gold standard of remote care, in instances where a patient cannot or does not have access to all the elements needed for a video connection, telephonic visits are critical to ensuring continuity of care.

> *"…a significant number of patients don't have high-speed enough internet to have a stable video connection, or they don't have any Wi-Fi at all and so it's all cellular service, and it's all cellular minutes. And, they just don't have the bandwidth and the ability to do video at all, or they have a phone that doesn't even have a camera on it. They have old phones; they don't have Smartphones. And we're talking about our poorest and our most vulnerable patients, right. So, the people who are least able to access the video are the people who need us the most. And so, it's about not having Wi-Fi, not having a Smartphone, not having the ability to know how to use a Smartphone."*
> *- Primary Care Provider*

Remote visits were not without their challenges. Connectivity issues, technology barriers, lack of access to broadband, a smartphone, or a computer all inhibited telehealth visits, reinforcing the need for a comprehensive approach to address the digital divide by improving broadband, cellular service, and expanding access to free-wifi. Additionally, providers and patients have begun hurdling the learning curve in remote care delivery; organizations, providers, and patients alike have invested time and resources to successfully adopt telehealth. The State should continue exisiting regulatory flexibilities that have enabled this learning to maximize success of remote care in the future. Patients **and** providers need access to training to increase technical literacy to enable remote care. We are encouraged by the Governor's initiative to support patients and providers through professional development and education, but those supports must be placed in the communities with the most need and should be distributed equitably across populations that have been historically underserved by the medical community to ensure that remote care mitigates disparities rather than exacerbates them.

Maximize regulatory flexibilities to sustain telehealth adoption

Prior to the pandemic, NYS applied restrictions to what kinds of FQHC providers could provide visits remotely, even in instances where the provider type in question, i.e. a Licensed Clinical Social Worker (LCSW), was permitted to bill for services delivered in-person. Since relieving those restrictions, no-show rates for LCSW visits have declined, and providers are able to continue serving their patients who are unable or unwilling to come into the office. To allow a provider to see individuals in person but not remotely is an injustice to the patient and provider relationship. New York State must continue to allow any FQHC provider authorized to bill for in-person visits to also be authorized to deliver care remotely.

> *"…when I did have my first telemedicine, I have to tell you that psychologically I felt so relieved. It was like I was looking at this person that I'm used to trusting. It was psychologically it was such an uplifting experience. Just looking at her made me feel, oh my God, there's a semblance of normalcy again. I can see her. She can take care of me. I was elated."*
> *- Primary Care Patient*

The Governor's State of the State telehealth announcement claimed it would eliminate "obsolete location requirements by requiring Medicaid to offer telehealth reimbursement for services rendered to patients regardless of where the patient or provider is located in a non-facility setting." We implore the Governor to expand this flexibility to FQHCs serving the Medicare/Medicaid dually eligible populations; currently, Medicaid is only allowing FQHCs to deliver remote services to duals during the public health emergency.

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

Providers and patients acknowledged that remote visits do not fit all visit types. Obviously, when a physical exam is needed, remote care alone will not suffice. Teledentistry, as well, is one area that is limited in its usefulness for patients and providers. However, in primary care, pediatrics, and behavioral health, patients and providers agreed that remote care used in coordination with in-person visits (as needed) is a great way to discuss lab results, conduct medication management, and for follow up care.

> *"So, I can see certain medical specialties where you're going to have to go in, but you know, if it's 'How you doing? What's your pressure? What's this, what's that?' And it could all be done verbally, [telehealth is] the future of medicine, as far as I'm concerned. And I don't know if it's going to be 30 or 60% [of visits], but it's going to be some percentage when a year ago it was unheard of."*
> *- Primary Care Patient*

In behavioral health visits especially, it was noted that remote visits are comparable to in-person visits, though preferences did vary by patient need. For example, patients that are hard of hearing might opt for a video-facing platform, while others may prefer telephone since it is more portable, allowing them to seek the privacy needed for a behavioral health visit. Gender nonconforming patients and patients

with autism spectrum disorder also noted that video visits were "uncomfortable," and often opted for a telephonic version when able. Regardless of visit type, patients and providers should be empowered to have a conversation about which modality of care is best suited for their needs in each instance of care.

Reimburse remote care (telehealth and telephone) on par with in-person visits

> *"From my perspective, it would be like cutting patients off at the knees if they ever stopped reimbursing for telephone visits because – though it's not ideal – there is still so much value in talking to the patient, accessing the patient, getting the patient the refills that they need so they don't end up having a hypertensive emergency or God forbid an asthma attack in a child."*
> *- Pediatrics Provider*

Although patients were unaware of the differences in payment for telephone and audio-visual visits, providers felt strongly that in-person visits, audio-visual telehealth, and telephonic visits should be paid at the same rate. Providers reported that telephonic visits take the same amount of time as audio-visual visits, and many times the decision to "see" a patient via the telephone was out of their hands due to a patient's technical inability to join an audio-visual call. Providers noted that FQHCs specifically serve a high-risk and high-need population, and proper reimbursement is essential to ensuring they can keep their doors open as more and more patients require telephonic visits. Lower reimbursement for telephonic visits has the potential to exacerbate health disparities for video-challenged patients, who are often the most isolated and in need of care.

Conclusion

Nearly all providers and patients want to continue to have the **option** to receive or deliver care remotely. It is clear from these interviews that providers and patients see remote care as a tool in the toolbox, one that is useful at times but not for every service. However, for remote care options to remain viable, the State must reimburse telephonic and audio-visual telehealth visits on par with in-person visits. Additionally, patients and providers alike need training, education, and IT support to bolster remote visit capacity and increase technical literacy. Finally, the State must take actions to improve access to broadband internet, free wi-fi, and other technology to ensure that telehealth mitigates health inequities rather than exacerbates them.

CHCANYS and our partner the NYS Council are supportive of the Governor's 2021 State of the State telehealth initiatives and look forward to working with the Governor, Department of Health, Office of Mental Health and Office of Addiction Services and Supports to implement and expand these proposals to ensure that all New Yorkers have continued access to high quality remote care. New York can and should be a leader in utilizing telehealth to reduce health disparities and recover from the COVID-19 pandemic.

CHCANYS
Community Health Care Association of New York State

Appendix A: Study Methods

Recruitment

Approval for this study was obtained from the New York University Grossman School of Medicine IRB.

Together, the CHCANYS and the New York University Grossman School of Medicine team selected 12 target FQHC sites in New York State that were representative of a range of key dimensions of the population, including rural/small town/suburban/urban, race/ethnicity, upstate/downstate, size of FQHC, special programs/populations, and experience with telehealth prior to COVID-19 (Table 2). CHCANYS then successfully recruited 8 of the FQHC sites to participate through outreach to established contacts. The recruited sites serve a variety of regions including urban areas like New York City (NYC), suburban areas, and rural areas. Many of the sites serve subpopulations including migrant/seasonal farmworkers, persons experiencing homelessness, immigrants, and individuals living with HIV. A significant percentage of patients at the sites are insured through Medicaid. The racial/ethnic diversity of patients at the sites varies widely, with some sites serving mostly Black and Hispanic patients, and others serving mainly White patients. Of the 8 sites, 5 had known experience with telehealth prior to COVID-19.

The sites identified providers who were interested in participating in the study from three clinical services: adult primary care (family medicine, internal medicine); pediatrics; and behavioral health. The participating providers recruited patients who were willing to be contacted by New York University Grossman School of Medicine about the study. After the providers and patients agreed to be contacted by New York University Grossman School of Medicine, CHCANYS provided contact information to the New York University Grossman School of Medicine team to verbally consent, schedule, and conduct the interviews.

Data Collection

The New York University Grossman School of Medicine team, with input from CHCANYS and RHCN Community Health Foundation, developed and revised semi-structured interview guides. The interview guides were piloted with 2 providers and 2 patients, and minor adjustments were made. The interview questions focused on the extent of telehealth use; lessons learned over the course of the COVID-19 pandemic; facilitators and barriers to telehealth; likelihood of continuing telehealth visits after the pandemic; advantages and disadvantages of in-person, video, and telephone visits; and the impact of different types of visits on access to care and quality of care during the pandemic.

Each interview was conducted by two interviewers from the New York University Grossman School of Medicine team using video or audio calls. The interviews were 30 – 45 minutes long. With permission, the interviews were audio recorded and professionally transcribed. Patients received a $25 gift card for their time and effort.

A total of 25 provider interviews and 19 patient interviews were completed. Tables 2 and 3 show the number of interviews completed by FQHC site and clinical service for providers and patients, respectively.

Table 2. Number of provider interviews conducted by FQHC site and clinical service

Site	Primary Care	Behavioral Health	Pediatric	Total
CHC1 (NYC)	2	1	N/A	3
CHC2 (Upstate)	1	1	1	3
CHC3 (Long Island)	1	1	1	3
CHC4 (Hudson Valley, NYC)	2	0	1	3
CHC5 (Western NY)	1	1	1	3
CHC6 (NYC)	1	1	1	3
CHC7 (NYC)	2	2	0	4
CHC8 (NYC)	0	3	0	3
Total	10	10	5	25

Table 3. Number of patient interviews conducted by FQHC site and clinical service

Site	Primary Care	Behavioral Health	Pediatric	Primary Care & Behavioral Health	Total
CHC1 (NYC)	0	0	N/A	3	3
CHC2 (Upstate)	1	3	0	0	4
CHC3 (Long Island)	1	1	0	0	2
CHC4 (Hudson Valley, NYC)	2	0	1	0	3
CHC5 (Western NY)	2	1	2	0	5
CHC6 (NYC)	1	0	1	0	2
CHC7 (NYC)*	0	0	0	0	0
CHC8 (NYC)*	0	0	0	0	0
Total	7	5	4	3	19

*No patients recruited

<u>Data Analysis</u>

The New York University Grossman School of Medicine team used a deductive, protocol-driven approach to conduct a rapid qualitative analysis of the interview data. The team created a codebook with domains that lined up with the interview questions. Summary templates were developed and revised based on feedback from pilot tests of the codebook with the team to capture key findings and illustrative quotes from each interview. The interview transcripts were divided across the team and

summarized using the templates. The summaries and corresponding quotes were transferred to two separate matrices, one for provider interviews and one for patient interviews, to compare findings from each domain across interviews. The team analyzed the summary data in the matrices and identified the key themes within the domains. The themes include access to care, quality of care, facilitators of telehealth, challenges of telehealth, reimbursement, and sustainability and the future of telehealth.

Appendix B: Selection of Quotes from Interviewees

Principle	Quotes
Utilize telehealth to increase access and promote health equity through support for the full range of telehealth modalities.	“I think it improves [access] for the most part because we used to have very high no-show rates for psychiatry. Yeah, we had a lot of people who just couldn’t get to the clinic because things came up in their life or they didn’t have the money for transportation or the bus wasn’t running or the train wasn’t running, so they gave up on trying to get to the clinic. So, our no-show rate used to be something like 25% to 30% and now in telehealth it’s closer to about 10%. So, it definitely cut down pretty dramatically the no-show rate.” (Behavioral Health Provider) “This has actually opened up access even more because patients don’t have to take time off from work. They can talk to us for 15 minutes during their lunch break. It just has taken away like if they have five kids and they need to get their own healthcare managed, it’s hard to bring five kids to the office to talk about your female issues or if you have one child who’s sick, you don’t necessarily want to bring all five kids with them into the office.” (Pediatrics Provider) "[Telehealth] just allows you to go places that you were not able to do it before. We have patients with transportation problems, we have patients with fear that they normally will not go to the health center because, oh, you know when you’re sick, you don’t want to go to a place that sick people go, right? So, those two I think are the factors, may be factors driving how well received telehealth have been." (Primary Care Provider) “Another good aspect of [telehealth], I think, is I can be home, and I don’t have to drive anywhere and take extra time away from work. So, all I have to do is simply switch to a portal, stay logged in for work, take my 30 minutes. My 30 minutes is done,

	I can go right back to working. I don't have to take that travel time. I don't have to be out of the office. So, that's a definite plus, as well." (Behavioral Health Patient) "I think, clearly, we're able to reach more patients with [telehealth]. In the past, when we, say, had – our centers are all over the city, except Staten Island, and so, if we had a – were full at, say, our site in Tremont and we had openings at our site in Harlem, that's easy to do from a telephone because it makes – you could just be anywhere." (Behavioral Health Provider) "For us, as a space issue where [telehealth] allows us to offer more—we have been fighting for years, the fact that we don't have enough space. So, we can't expand because we don't have enough space. So, we literally don't have the room to put in providers. We have patients who are trying to come into us, and we haven't been opening—we're finally opening a new patient's—because opened our Brooklyn site. But, if you have telehealth, some of your providers can be off-site provider quality visits to people by video and by phone. And, your other provider on-site for patients who need to come in, or want to come in, or whatever. So, you can actually expand who you offer healthcare to by being able to have more providers, because you can have them on the phone, you can have them doing video. And that's like huge for us because we haven't been able to expand physically because we don't have the physical space to expand." (Primary Care Provider) "I do think for the people the burden of video is really hard. Because, they don't have the Wi-Fi, they're going to — they're trying to steal Wi-Fi from outside the library or they're going to a McDonald's, or wherever. We actually have patients who don't have a phone at all; we don't

	even talk about that. They go to social service agencies, and call us from there and do their visits because they're inside a social service agency. So, that becomes an issue in terms of telephone but that's also for video as well…" (Primary Care Provider) "And we tried to post signs with phone numbers, but like I said, having a phone, especially at that site, I would say probably like maybe 30 percent of people didn't have phones, from what I saw, and that's like no phone number on file. I would say maybe 50 percent, you call a number and it was like phone subscriber not available; subscriber not taking calls. So, I'd say, yeah, up to 50 percent of people don't have a working phone number; 30 percent of people don't have a phone at all. And it's really hard, it's challenging to be like, okay, I'll call you with results or call me if you need anything and they're like, no." (Behavioral Health Provider) "…a significant number of patients don't have high-speed enough internet to have a stable video connection, or they don't have any Wi-Fi at all and so it's all cellular service, and it's all cellular minutes. And, they just don't have the bandwidth and the ability to do video at all, or they have a phone that doesn't even have a camera on it. They have old phones; they don't have Smartphones. And we're talking about our poorest and our most vulnerable patients, right. So, the people who are least able to access the video are the people who need us the most. And so, it's about not having Wi-Fi, not having a Smartphone, not having the ability to know how to use a Smartphone." (Primary Care Provider) "When they cannot have access to technology, it just decreases—phone session decreases frustration and time, and people, when they don't have the technology, then they feel blame

	and poor and they start to have these negative thoughts. They're no good, they're poor, I don't understand, I'm dumb. And so, they start to have all these negative beliefs reinforced by the fact that they cannot have access to the computer. Phone is easy, no complication, no drama. That's the main thing. There is no drama. Everybody knows how to work with a telephone." (Behavioral Health Provider) "But we allow the telephones when we can't get the video to work, or patients can't make it into the office or don't feel comfortable coming into the office." (Behavioral Health Provider) "Well, I, actually, don't use televideo. I just use phone. And it's more just due to the access for patients not really having their resources for phones, access to video phones." (Primary Care Provider)
Maximize regulatory flexibilities to sustain telehealth adoption	"They made sure that everything was set up. For example, we have IT available all the time. Even before telehealth, if I have any problem before, I have immediate access to IT. And they work the logistics of having the virtual visits very well organized…We have training, I have somebody come into my office and training me how to do it. . . .If I have any question I can text him." (Pediatric Behavioral Health Provider) "They called every patient before they were scheduled for a session to make sure that they had it set up, that they were able to sign all their consents on there, upload driver license, insurance card, pictures on there. So, they've been very part of this. They're absolutely engaged with our patients to make sure that they're ready if at all possible, because all we have to do is hit a little link that says send link, and then the patients have an automatic link just like the Zoom ones to get in. They don't have to

	enter any passcodes or anything like that." (Behavioral Health Provider) "…but I know that they were able to have phones allocated to different hotels that they were at, so that, if the patient didn't have a phone call or a phone, I could call that number, and they would locate them. And so, that was helpful in being able to communicate with people that didn't have phone numbers." (Primary Care Provider) "I have no internet at my house. I'm a physician. I work night and day…We pay over $450 a month to have terrible internet connectivity. And we can barely do what we need to do as a family. So you can imagine what it's like up here for people who don't have the means to do that. And it's just terrible. It's really a bad situation. It's a life and death situation for people." (Primary Care Provider) "But I think the – I live with two grandparents, they're my parents. Because I like my privacy, to go in to an appointment and have the room to ourselves. I have to be quiet. I can't be super loud because there's certain things I don't want to talk about and have my grandparents listen in on. Which they don't, but you know what I mean? I just don't. It's the privacy part of it. It would be different if you lived on your own, yeah that'd be great. And I think a lot of people – I've heard a lot of people say that is – the privacy part of it." (Primary Care Patient) "I have patients that have told me while they're in the car, with a car full of people. Not even family members. So, I said, okay, let's reschedule and what time I can call you back. Even though the patient says it's fine, I'm sorry, but you have a coworker in the car, I don't think it's appropriate to do this. And if I can allow to do it in a separate

	way, I can call you in half an hour and you're by yourself, why not." (Primary Care Provider)
Clinicians, in collaboration with their clients, determine when a telehealth visit is appropriate.	"So, in person is what we all know. I mean, in person was all the, you know, the only option for so long. And I think, that's probably optimal, but when it's not available, video is where to go. At this point, I think I've been doing so much video that I'll take either in person or video. They're, like, almost the same to me anymore. Whatever I do in person, I can do on video. The only thing about video is you can't see the whole body. You can't see head to toe, you know. You see head up. People can, you know, not show you the truth on video, same with phone." (Behavioral Health Provider) "So, telemedicine is a wonderful option, but like I said, for me the ideal would be to get back to going and seeing my doctor. Because there's so much that they can… They can look at the way you're walking and tell if something's wrong with your leg, you know?" (Primary Care Patient) "I think they look pretty much the same, same intervention, same approach to therapy is used. There may be a little extra time early on kind of talking about confidentiality and using telehealth versus sitting in an office where you know nobody else is around. But other than that, I feel we provide the same service, truthfully, that we would if someone was sitting 6 feet from us." (Behavioral Health Provider) "If they can read you their glucose logs, then that's not that much different than an in person visit if they have a pretty high health literacy. The things where I'll say is when TeleVisits don't really pan out is when people need extra support. So, we have a lot of patients who don't know how to read; who are English is their second

	language so that is really challenging." (Primary Care Provider) "…it was startling to me that I could just – there was no difference. It was as though we were just sitting together. Because I know individuals who are involved in telehealth and I had a general concept of it. But I couldn't see how it could work, necessarily. And then once I experienced it, now I can't think of any other way I'd wanna do it unless, you know, you need the doctor in-person visit. So, I'm into it now because it was so effective." (Behavioral Health Patient) "I do not see – I'm seeing both of them, but not at the same time. I always tell the parents, and that sometimes is a challenge with telemedicine. Because I don't want to talk about the child behavior in front of the child. I don't want the parent to be telling me, oh, he doesn't listen, the teacher call. I don't want that to be in front of the child. And when it's in my office, I'm able to separate that. Usually bring the parents to my office first, and then I see the child. In telemedicine sometimes that's a challenge, mostly for parents that they live in very small quarters. That everybody's sharing the same area of the living room, or bedroom. Sometimes it's a challenge. I will not say 100 percent of the time, but I will say 40 percent of the time it can be a challenge." (Pediatric Behavioral Health Provider) "I think as a medical provider I like to engage with my patients. You are able to assess a lot from looking at a patient. I was an ER nurse before I went back to school and became a nurse practitioner. So, assessing is a huge part of being a nurse and the assessments you can gather from your first encounter looking at a patient is huge. I mean, you can tell from their affect, their mood, their respiratory status, nutritional status. I

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<td>mean, there’s a lot of things you can glance at a patient and see that you can’t tell by phone.” (Pediatrics Provider)

“So, when I did have my first telemedicine, I have to tell you that psychologically I felt so relieved. It was like I was looking at this person that I'm used to trusting. It was psychologically it was such an uplifting experience. Just looking at her made me feel, oh my God, there’s a semblance of normalcy again. I can see her. She can take care of me. I was elated.” (Primary Care Patient)

“You gain a lot of information by seeing the environment that someone is in as well. For many of us, sometimes it was the first peak into their home environment or their apartments, which can give us a lot of important visual cues as well." (Primary Care Provider)

“I think that, for most people when they are about to be seen, everybody has to prepare in a whole different way for what that looks like, so whether it's what you're wearing, how you present needs to be made presentable, your living situation needs to be presentable, because the things I’ve heard and just from general in social media, what people see and you get judged or people make assumptions about you based on your living environment, so there might be embarrassment associated with that. Maybe we have some homeless clients who have never told the world that they're homeless in that way, and so you're living in a sort of situation. There's a lot of judgment that comes to what one will see when you're on a video situation.” (Behavioral Health Provider)

"Actually, remember that a lot of the clients that we have are gender nonconforming, and also people who are gender dysphoria. The fact of the video can trigger some of this dysphoria because</td>
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	what the image that they see of themselves, what they see in the video, it doesn't match, so it can be very distressing. So, a lot of my patients do prefer telephone." (Behavioral Health Provider) "... having a private place to do video is really, really challenging. And so, they're looking for... like, being on the phone you can just be more discreet; nobody questions you on the phone as much as when you're like doing a video visit, "what's that about?". Or, people can leave the house and have their visit on the phone with their provider without having to be at a computer, or in the Wi-Fi hotspot. In order to do it, they have much more privacy. It could be a 'DV' situation — a domestic violence situation, and a need for privacy from a partner. There's so many reasons people need privacy in a visit, and not everybody has it." (Primary Care Provider)
Reimburse telehealth visits on par with in-person visits to ensure comprehensive, coordinated and integrated continuum of care.	"From my perspective, it would be like cutting patients off at the knees if they ever stopped reimbursing for telephone visits because – though it's not ideal – there is still so much value in talking to the patient, accessing the patient, getting the patient the refills that they need so they don't end up having a hypertensive emergency or God forbid an asthma attack in a child." (Pediatrics Provider) "It would be a huge struggle, really. I mean, for that small percentage of patients it would be detrimental. They probably wouldn't get that care, per se. I'm not saying that we wouldn't call a patient because we're not going to get paid for. We do lots of things here that we don't get paid for; it's just part of being a provider and helping people. So, I don't think it would severely impact, but it definitely would play a role." (Pediatrics Provider)

	I think it should be the same because there's elderly people who don't use modern phones, and they don't know how to use their equipment… Right and they're getting the same care just over the phone… I think it should be reimbursed in the same, yes." (Primary Care Patient/Community Advisory Board Member) "I would immediately say that it would be an injustice at this point to not offer telehealth and virtual care. We are and have proven that these services are quality based, create patient satisfaction, and also prove better outcomes for overall health of patients. It allows the patient the opportunity to alleviate the concern and need for I have to go to the urgent care. 'Hmm, I can't get to the urgent care. I'm gonna use the emergency room for my visit.' So, we'll decrease the use of the emergency room; again, increasing patient satisfaction. It's allowing patients to engage more and to take a further step into their healthcare, where they may have, in the past, avoided dealing with their healthcare. 'I don't wanna wait in that waiting room for two and a half hours. I'm on hold for 20 minutes to try to get someone. And then it's a robotic call, and I have to push three or four different buttons. Where I can send an email, I can text message, or I can call, and that same day, I'm getting a visit virtually'." (Pediatrics Provider) "The reality is I would love to say that billing would not be an issue, but if we can't get fair reimbursement then it becomes an issue. And, we have to be able to sustain our salaries." (Behavioral Health Provider) "I think if we can improve infrastructure in the community, have a stronger internet, even the stronger internet in the health center sometimes that can be an issue also, having appropriate devices to all the providers. Now we have a

	laptop which is good. Before we were using our own phone and own personal laptops. So, that's good; and reimbursement. I think certain patients who cannot use the televideo visit and they use telephone, I don't know why reimbursement is different because it's not their fault they're not able to use televideo." (Pediatrics Provider)
Miscellaneous Comments	"Yes, I mean, that horse is out of the barn. Telehealth is here to stay." (Behavioral Health Provider) "I think it's a great thing if people are, for some reason, in difficult physical situations at home or maybe don't have a transportation, to get some – or there are different factors maybe that come into play." (Primary Care Patient) "So, I can see certain medical specialties where you're gonna have to go in, but you know, if it's how you doing? What's your pressure? What's this, what's that? And it could all be done verbally, it's the future of medicine, as far as I'm concerned. And I don't know if it's gonna be 30 or 60%, but it's gonna be some percentage which a year ago was unheard of." (Primary Care Patient) "But at any rate, no, I would not want it to be an absolute. It would have to be an option. And that's what – and that's my major concern because I'm – as I told you somewhere in the beginning of the phone call, I have a thought that they might wanna try to push it in that area. And I will most – no, I wouldn't like that. I don't know what the doctor's think about it. I would think the doctors wouldn't be too thrilled because I would imagine that they would like to see their patients physically, rather than through a computer, but again, if it's optional, I don't think I'd kick too much about it." (Primary Care Patient)