

Use of Telehealth in NHSC Grantee Sites

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BACKGROUND

Telehealth has long been viewed as an important pathway for increasing access to care for underserved populations, while providing high quality care at low cost. The spread of telehealth in the United States, however, has been hampered by a range of reimbursement, equipment costs, and licensure barriers. In this study we examine the extent to which telehealth is being used in settings that are among the locations most in need: the National Health Service Corps (NHSC) approved grantee sites.

METHODS

Building on an annual survey administered by HRSA to all NHSC participants, several additional questions specific to telehealth use were asked of NHSC participants who were currently fulfilling their service obligations. HRSA provided a dataset of individual responses from 3,744 NHSC participants (response rate 26%), of which 2,418 were currently fulfilling their service obligations, and answered the question about whether telehealth is used at their site. Telehealth usage rates were compared to state telehealth coverage and reimbursement ratings provided by the American Telehealth Association (ATA) and to 2010-2015 state funding levels for two grant programs sponsored by the Federal Office of Rural Health: the Telehealth Network Grant Program (TNGP) and the Telehealth Resource Center (TRC) Grant Program.

FINDINGS

We find that 35.6 percent (861) of respondents reported telehealth is used at their practice site, with 46.8 percent using telehealth only as an origination site (i.e. where the patient is located), 15.5 percent as a distant site only (i.e. where the clinician is located), and 37.5 percent use both. We also find that only 24.5 percent (214) of the respondents practicing at sites that offer telehealth reported they personally use some form of telehealth services. Respondents who indicated that telehealth was offered at their site but that they did not personally use telehealth were asked why. Only 395 respondents answered the open ended-question. The most common answer was that it was not available to them, with some specifying that telehealth services were limited to particular types

KEY FINDINGS

1. Findings from the study point to variation in the use of telehealth services across regions, but overall a potentially lower than expected rate of telehealth usage among sites with NHSC providers. In particular, it is alarming that the 2010 study of CHC telehealth use found a slightly higher prevalence (38%) than we find in 2015 (35.6%).
2. Sites located in states with more favorable telehealth coverage and reimbursement policies, were more likely to use telehealth, as were sites located in states with telehealth grant funds.
3. Perhaps the most actionable finding for HRSA is that states with the lowest grant funds and the most restrictive coverage and reimbursement policies have the lowest telehealth usage rates. These may provide an opportunity for HRSA to target funding to sites in those states.

of patient care at their site, such as psychiatry only or medication management only, which they did not provide. The next most common theme was that there was “no need.” Three respondents listed National Health Service Corps rules as the reason (“NHSC rules”, “not allowed by NHSC”, “Not recognized by NHSC as counting toward clinical hours.”). The most common form of telehealth provided was behavioral health. In addition, analyses reveals important regional variation in the use of telehealth services, the types of telehealth services provided, and in the location of services.

NHSC respondents located in states with the most favorable telehealth coverage and reimbursement policies, i.e. those that received an overall “A rating” from the ATA, were the most likely to offer telehealth services, compared to states with a B or less (50.8% versus 33.4% respectively). Similarly, states that received HRSA telehealth grant funds were more likely to participate in telehealth (36.9%) than those with no telehealth funding (29.6%). However, we do not find a relationship between the amount of grant dollars a state received and telehealth use.

CONCLUSION

The findings could provide compelling evidence that improvements in state policies or increased grant funding leads could lead to greater adoption of telehealth services. That information could help galvanize states to revise their telehealth policies and/or HRSA to increase their grant funding, and thereby, hopefully, improve access to care for our most vulnerable populations.

POLICY IMPLICATIONS

The findings of this study point to potential avenues for increasing telehealth usage at NHSC sites. There is evidence that favourable coverage and reimbursement policies and higher levels of HRSA grant funding lead to increase use of telehealth. Targeting telehealth funding to states with the lowest telehealth grant funds and the most restrictive coverage and reimbursement policies will allow HRSA to focus on states with the most room for improvement.

As HRSA improves its data collection efforts, we anticipate that there will be future opportunities to refine this line of inquiry. The use of surveys requires a more robust response rate and must include response rates by states. Ideally, a unique identifier should be included to facilitate linkages with other data sources like the Uniform Data System. Using the same questions that were used in a 2010/2011 “Readiness for Meaningful Use and HIT and Patient Centered Medical Home Recognition Survey” would also make it possible to do a longitudinal analysis.

Multivariate regression models could then be used to explore what factors are affecting telehealth usage. The findings could provide compelling evidence that improvements in state policies or increased grant funding leads to greater adoption of telehealth services. That information could help galvanize states to revise their telehealth policies and/or HRSA to increase their grant funding, and thereby, hopefully, improve access to care for our most vulnerable populations.