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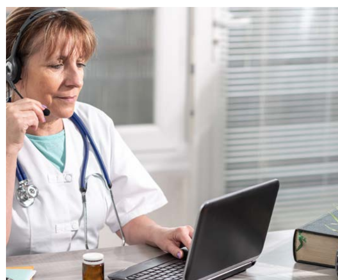

# Policy Brief

## Telehealth in Rural North Dakota

This is a two-part policy brief on rural telehealth in North Dakota. It analyzes the implications associated with how telehealth is used, barriers to full implementation, perceptions for its development, and recommendations for health policy. A key informant study was conducted in August/September 2022, of 19 Critical Access Hospital (CAH) CEOs and representatives from key health associations, consultant experts, and academic centers. Part 1 explores the telehealth framework e.g., definitions, common telehealth applications, Public Health Emergency (PHE), and more. Part 2 discusses the future development of telehealth, barriers that hinder its use, and policy recommendations.

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## Part 1: The Telehealth Framework

### What is telehealth?

Telehealth uses telecommunications technology and other electronic data to assist with clinical healthcare services provided at a distance, which can also include providing education, administrative functions, and peer meetings. While one of the most common images of telehealth is for a patient speaking by videoconference with a healthcare provider who is located remotely, telehealth can take other forms, including: 1) remote patient monitoring (RPM), 2) storage and forward transmission of medical information, and 3) mobile health communication (mHealth). (Source: RHI Hub)

### What are common telehealth uses/ applications

National studies find that telehealth can augment direct, face-to-face services. It allows specialists to interact with rural patients virtually when it is difficult or impossible to provide direct contact. Under those circumstances, it can expand access to necessary services by addressing distance issues and, to some extent, the shortage of health professionals. Telehealth can address the following services: radiology, mental and behavioral health, ophthalmology, dermatology, audiology, cardiology, oncology, emergency care, home monitoring, intensive care, pharmacy, chronic disease management, school-based care, obstetrics, and medication for opioid use disorder (MOUD).

### How did the Public Health Emergency (PHE) rule changes affect telehealth and its usage?

At the outbreak of COVID-19, the Center for Medicare and Medicaid Services (CMS) modified geographical and reimbursement rules to allow enhanced telehealth opportunities to more safely address health access during a pandemic. This afforded flexibility for the location of the originating

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site (i.e., where the patient is located) and the distant site (i.e., where the provider is located). This allowed patients to be in their homes and to access, via telehealth, a medical provider located in a local clinic, local hospital, or a facility many miles away.

Additional services that could be performed over telehealth were added. Broader provider types were included along with increased reimbursement for providers and services. This produced positive effects in terms of continued access for patients and maintained the operations of providers. The PHE has been extended numerous times; however, the concern has been, what happens when the PHE actually ends? There are numerous bills in Congress to extend PHE telehealth protections which commonly include: removing geographic requirements that hinder rural access (e.g. originating and destination sites); expanding the list of eligible providers; providing greater flexibility for mental health services; maintaining audio-only covered services; and inclusion of telehealth for hospice recertification. Some proposed legislation addresses the issue of Medicare parity (e.g. Connecting Rural Health to the Future Act sponsored by North Dakota Congressman Kelly Armstrong).

Telehealth usage surged during the pandemic. One study (Chu, Cram, et al., 2021) found telemedicine (or telehealth) was low in both rural and urban areas although slightly higher in rural (11 visits per 1,000 patients in rural vs 7 visits per 1,000 patients in urban) in 2019. By June 2020, the rural rate increased substantially to 147 visits per 1,000 patients with an even steeper increase for urban populations at 220 visits per 1,000 patients. PHE changes expanded the utilization of telehealth.

## What was telehealth's role during the pandemic and how has it changed?

Fifteen North Dakota CAH CEOs and four representatives of North Dakota health associations, consultants, and academic centers were interviewed in a qualitative study of key informants in August/September 2022. An area of interest was how telehealth was used during the pandemic and post-pandemic. Respondents found that the use of telehealth increased significantly during the height of the pandemic; however, as the health environment returned to pre-pandemic levels, the use of telehealth has declined. It was stated by some as "it is back to the way it was before the pandemic."

Many rural facilities essentially closed during the pandemic peak and patients and guests were not allowed on-site. This was intended to protect the public, health professionals, and other staff; nevertheless, some level of healthcare needed to proceed and the Public Health Emergency (PHE) rules allowed this via telehealth, especially for routine care. While the PHE is still in effect, the attitude of much of the public appears to have returned to "normal" and telehealth demand has declined. As one respondent commented, during the pandemic "it kept us viable, not ideal as you really need direct one-on-one care, but in an emergency, it was a life saver." There was also the view that the pandemic served a purpose for telehealth in that it offered the chance "to experiment with it" and to test it. While usage may have returned to pre-pandemic levels, there is also a sense that valuable groundwork has been made and if the barriers are addressed, then rural telehealth can move forward.

## How is telehealth being used in rural North Dakota?

Data from North Dakota respondents supported a finding that utilization was not consistent - some used it more than other providers and some did not use telehealth. The perceived barriers (discussed later) were seen by some rural facilities as too high at this stage to warrant investment. While federal policy changes toward telehealth during the PHE has allowed greater utilization of telehealth (e.g., distant and originating sites), there are still concerns regarding payment parity (i.e., payment commensurate with an on-site office visit). Some rural providers find it more financially beneficial to move a patient down the hall from the Rural Health Clinic to a telehealth room in the hospital and code it as an outpatient service. This is seen as not optimal and is a sign of what rural providers view as the inequity within the system; is it beneficial to physically move the patient in order to incur better financial payments?

Facilities using it tended to identify tele-emergency care as the most common type. Under this format, CAHs connect with a tertiary emergency department, such as Avera Health in South Dakota, and other North Dakota based tertiary providers. E-care, as it is sometimes called, not only provides needed emergency specialty care, but also offers reassurance and support to a solo rural provider working by themselves, possibly on an infrequent type of case. E-care is viewed as a significant process to support rural providers. The specialist "is in the room with you but on the screen seeing what you see. This helps quality as our providers feel more confident, trust, and can work with experts."

The next frequently mentioned form of telehealth was wound care. Other outpatient services identified included diabetes, other chronic disease management conditions, routine care, and oncology. Swing bed patients were noted (e.g. pre and post-surgery). Some facilities are using it for behavioral and mental health, which is viewed as a possible growth area.

## What are health workforce implications?

A common observation from North Dakota respondents was the workforce shortage compounds the telehealth situation as rural facilities typically lack the luxury of a full-time equivalent telehealth staff person, such as a telehealth registered nurse (RN). Someone whose sole responsibility is telehealth. The way facilities generally operate is if an RN is assigned for a telehealth visit, then that takes a professional nurse off the floor or out of the emergency department (ED). The workforce supply is not robust enough to compensate for staff shortages. As a rural respondent noted, "You can't drop your other areas like the floor [patient care at the bedside] or the ED."

Center for Rural Health data indicates that the highest health professional demand for North Dakota rural hospitals is in nursing, especially RNs; thus, provider supply issues are also a barrier. There are some positive implications too, one perspective noted was that for some medical providers, having more telehealth options can extend their careers. For some the option to be semi-retired may be facilitated by telehealth in that they would not have to be on-site at the hospital or clinic. They could use technology to see patients from home for example. Some may decide to extend their service rather than retire.

***For more information***

Visit the CRH webpage for additional rural health publications and information.
**https://ruralhealth.und.edu/publications**

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