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Caring for New York's School Children: The Potential of Telehealth.

Report to the New York School-Based Health Foundation (NYSBHF)

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II. INTRODUCTION

Across New York State, 262 school-based health centers (SBHCs) serve nearly 250,000 K-12 students. SBHCs provide a safety net for communities that face barriers to accessing quality mental and physical health services. The clinics are placed in K-12 schools and offer care regardless of a patients' ability to pay. When New York State directed all schools to close on March 18, 2020, students, teachers, and clinicians transitioned to a home-learning environment. Although telehealth was not widely used by SBHCs before this year, virtually all SBHCs were forced to quickly adopt the mode of care in response to virtual schooling.

SBHCs are defined as a health clinic that 1) is located in or near a school facility of a school district or board, or of an Indian tribe or tribal organization; 2) is organized through school, community, and health provider relationships; 3) is administered by a sponsoring authority; and 4) provides primary health services to children in accordance with state and local law, including laws relating to licensure and certification. A sponsoring facility can be a hospital, a public health department, a community health center, a non-profit health care agency, a local educational agency, or a program administered by the IHS or tribal organization.

This report was commissioned by the New York School-Based Health Foundation (NYSBHF) to examine the transition to telehealth in New York State's SBHCs, anticipate the future outlook of telehealth in SBHCs, and identify areas of opportunity for using telehealth in SBHCs. A team of five student consultants at the Columbia University Mailman School of Public Health interviewed 19 key stakeholders for input, including nine SBHCs in New York; SBHC experts from Connecticut, North Carolina, and Colorado; the New York City Department of Education; Greater New York Hospital Association (GNYHA); Healthcare Association of New York State (HANYS); Community Health Care Association of New York State (CHCANYS); and the national School Based Health Alliance. Unfortunately, the New York State Department of Health did not reply to requests for an interview.

For a comprehensive overview on SBHCs in New York State, please refer to a 2009 paper prepared by the New York State Coalition for School-Based Health Centers.

III. SECTION 1: POLICY

1.1 Definitions

At the onset of the New York State of Emergency declaration, the New York State Department of Health updated their definitions of telehealth, telemedicine, originating site and distant site under Medicaid guidance to reflect the needs of patient and provider populations during COVID-19. Under Executive order 202, these new definitions will remain until the State of Emergency is over (NYSDOH, 2020).

An interview with a telehealth policy consultant revealed that it is imperative for organizations to have a common understanding of these relevant definitions, as New York's definition of telehealth is not universal. Syncing definitions among staff becomes imperative when aligning services with billing and coding practices, especially in smaller organizations without centralized billing departments. This ensures that claims do not get rejected so each SBHC will get fully reimbursed for all services performed.

Today, New York State School Based Health Centers have an opportunity to play a role in what definitions of telehealth, telemedicine, originating site and distant site will look like at the end of the State of Emergency. SBHC's should consider how they understand these definitions and if any changes should be made. Then with a common understanding of current definitions and desired changes, they can begin advocating and influencing the future of telehealth in New York State.

Appendix 2 contains New York State Definitions of telehealth, telemedicine, originating and distant sites, and changes made during the public health emergency.

1.2 Telehealth Modality & Provider Restrictions

Under Executive Order 202.1, for the duration of the COVID-19 State of Emergency, an expanded list of eligible modalities and providers has been authorized by the Medicaid program. New York's Public Health Law 2999-cc(4) modalities now includes:

- Telemedicine
- Store and Forward Technology
- Remote Patient Monitoring
- **Telephonic communication (audio-only)**

Eligible providers for FQHCs offsite Licensed Practitioner services includes:

- Physicians
- NPs

- PAs
- Midwives
- Other Licensed Practitioners who have historically been billed under rate code 4015 for SBHCs including social workers and psychologists
- **Dentists**
- **School supportives**

1.3 HIPAA, Confidentiality & Consent

Laws governing consent and confidentiality were relaxed during the State of Emergency to allow for flexible use of telehealth services. The practitioner is not required to obtain written consent, however it is expected that the patient's identity is confirmed and they are provided with information on the services the patient will be receiving via telehealth. For providers in SBHC's, patients who cannot legally give consent must obtain verbal consent from a legal guardian (DOH, 2020).

While it is still expected that services performed via telehealth are in compliance with HIPAA and other relevant privacy laws, the enforcement of such laws at this time is relaxed. The Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency allows providers to perform telehealth services using non-compliant platforms, however they are encouraged to inform the patient of the associated risks. In good faith, the Office for Civil Rights (OCR) and the Department of Health and Human Services (HHS), which serve as the enforcement body, will not impose penalties on providers for noncompliance (HHS, 2020).

These relaxations allow for flexible use to telehealth services during times of uncertainty. **Interview insights revealed that post COVID-19, the government is likely to crack down on noncompliance causing organizations using platforms such as phone calls and basic zoom accounts to suffer. Organizations are urged to invest in compliant platforms before these regulations change.**

1.4 Policy Outlook

School Based Health Centers must carefully monitor the Center for Medicare and Medicaid Services (CMS) policy changes related to telehealth, as state Medicaid agencies often mirror CMS decisions. CMS has been carefully assessing key telehealth trends to determine which regulations should remain and which should be altered post COVID-19. These assessments have been focused on access, health outcomes, Medicare spending, impact on health care delivery and protection from misuse (Verma, 2020). While the rapid adoption of telehealth by providers has made it clear to CMS that telehealth is here to stay, there still remains a huge degree of political uncertainty.

IV. SECTION 2: REIMBURSEMENT

2.1 SBHC Medicaid Reimbursement Background

SBHCs are not a recognized Medicaid facility benefit. However, SBHCs may qualify as a Medicaid facility if they meet the requirements of the clinic benefit or the Federally Qualified Health Center (FQHC) benefit. Some states have taken the step to enroll SBHCs as Medicaid providers. New York State has considered doing this but has not yet taken the step of putting SBHCs under the managed care umbrella. However, New York State has laid out a plan to transition the provision of SBHC services into the Medicaid Managed Care benefit package beginning January 1, 2021. This is unlikely to occur given the current focus on the COVID-19 pandemic.

2.2 COVID-19 Reimbursement Changes

During the COVID-19 emergency, federal policy changes were made to improve access to telehealth. At the federal level, several changes were made to billing and reimbursement of telehealth services under Medicaid, but the majority of changes happened at the state level.

As part of the COVID-19 policy response, states had the option to reimburse telemedicine services the same way and in the same amount that they paid for face-to-face services. If they did this, they did not need to get approval from the Federal government. However, if they wanted to provide reimbursement differently for telemedicine than for face-to-face services, states must submit a separate State Plan Amendment (SPA). Keeping the rates equivalent was the path of least resistance in a time where capacity was extremely stretched. In New York, telemedicine services are currently being reimbursed in the same way and amount that in-person visits were reimbursed under Medicaid.

For the duration of the State Disaster Emergency declared under Executive Order 202, New York State Medicaid will reimburse evaluation and management services delivered via telephone and telehealth in cases where face-to-face visits are not appropriate. These services will be covered when provided by any qualified practitioner or service provider and must be documented as appropriate for payment purposes in Medicaid Fee-for-Service or Medicaid Managed Care. For FQHCs specifically, the full Medicaid wrap rate/PPS rate will be paid for telehealth and telephonic services. Of note, there is no difference in the way that telephone and televideo services are currently being reimbursed. Additionally, capital costs for telehealth equipment are not currently reimbursable by Medicaid. All of these enhanced Medicaid reimbursement rates for telehealth in New York will expire when the State Disaster Emergency Declaration ends.

2.3 Reimbursement Implications

The enhanced reimbursement rates have truly allowed SBHCs in the state to continue to provide essential care to patients despite a virtual environment. One provider from an independent SBHC noted, "In order to continue to provide a high level of service via telehealth, video and phone reimbursement rates have to remain equivalent to in-person visits." This sentiment was echoed by a provider at an upstate SBHC, noting, "Without the current level of reimbursement, I don't know how we would carry on providing telehealth services." As long as the state of emergency continues, these enhanced reimbursement rates are likely to stay. However, once students and providers are back in the schools full-time, reimbursement changes will follow. Providers noted that telehealth is a powerful tool, but if reimbursement is lower for telehealth than in-person, it will be impossible to rationalize taking time out of a clinician's schedule for telehealth when that time could be used for an in-person visit. The new reimbursement flexibilities have also allowed providers to bill for services previously provided for free, such as provider follow up calls.

2.4 Reimbursement Policy Outlook

It is unlikely that telehealth will continue to be reimbursed at the enhanced levels of 2020, beyond the COVID-19 pandemic. However, the value of telehealth has been made clear during the crisis, and this should be reflected in future policy changes. One interviewee from a large sponsoring SBHC organization noted that they anticipate video but not audio-only telehealth sessions to continue to be reimbursable. Interestingly, multiple policy advocacy groups in New York State noted a concern that increased access to telehealth services would lead to overutilization of care and increased healthcare costs. There has yet to be an analysis of the impact of telehealth reimbursement changes on costs yet, so the direction of the change is to be determined. However, all SBHC providers noted a clear decline in utilization of services after switching to telehealth. Once these cost analyses are performed, it is not expected that the state will find an increase in costs.

V. SECTION 3: CODING & BILLING

3.1 Key Considerations

Although reimbursement levels for telehealth visits were on par with in-person visits during the COVID-19 public health emergency, coding and billing for telehealth visits provided its own challenge. Coding for telehealth visits remains different from in-person visits and proper coding will be crucial to optimizing an SBHC's telehealth performance and to maximizing revenues. Telehealth claims billing requires **1) a Place of Service (POS) code equal to what would have been used in-person and 2) a modifier to indicate the service took place over telehealth.**

Additionally, telephone visits and audio-only telehealth were made reimbursable for certain services during the public health crisis. These audio-only visits are coded differently than audio-video visits and present an additional challenge to the billing process. Coding for evaluation and management services provided by phone differ for visits of varying lengths (eg. 5-10 mins, 11-20 mins, 21+ mins). Telephonic services were reimbursed on par with tele-video services during the public health crisis, though it's important to note that these changes are expected to be temporary and CMS is establishing new billing guidelines and payment rates to use after the emergency ends.

3.2 Training

SBHCs have indicated that figuring out coding and modifiers was the biggest learning curve as part of telehealth implementation. Additionally, the dynamic nature of Medicaid reimbursement policies can lead to confusion with billing amongst providers. Thus, proper and continuous training will be imperative to the success of the telehealth program. It Is recommended that SBHCs have their centralized billing office conduct best-practice training with providers to help staff understand coding and modifier usage to ultimately maximize reimbursements per visit. Furthermore, for smaller SBHCs without centralized billing, it is recommended to have one experienced Medicaid biller assigned to SBHC telehealth. Proper training will be crucial in the event of visit complexities such as if technical difficulties arise, and the visit shifts from audio-visual to audio-only.

VI. SECTION 4: SERVICES

4.1 Traditional SBHC Services

A select list of traditional SBHC services is outlined below. The services are categorized by their current suitability for telehealth. It is important to note that although some services are not yet suitable for telehealth, advancements and additional technology can make these services suitable for telehealth in the future.

Suitable for Telehealth

- Mental & Behavioural Health
- Chronic Disease Management (eg. Asthma & Diabetes)
- Reproductive Health
- Social Work
- Nutrition
- Substance Use Counselling
- Health Education
- Prescriptions
- Primary Care Services

Not Yet Suitable for Telehealth

- Physicals
- Vision & Dental
- Acute Illness Treatment
- Immunizations
- Blood & Urine Collection

4.2 Primary Telehealth Services

The most commonly offered telehealth services at SBHCs are mental & behavioural health, reproductive health, and chronic disease management (Appendix 3). Mental health and behavioural health were the top telehealth services and comprise the vast majority of telehealth visits at interviewed SBHCs. Reproductive health and chronic disease management also remain popular as routine follow-ups and prescription refills are easily conducted via telehealth. The key implication is that telehealth tends to work better for existing patients rather than new patients as it's challenging to establish an initial rapport and comfort virtually. With wider adoption of telehealth going forward, it is recommended to have students attend their visits in-person initially, utilizing telehealth for follow-up purposes.

4.3 Opportunities

Screening: Screening and self-assessments can be used to evaluate whether an in-person visit is needed. Some SBHCs have been using phone screens before an appointment is made to triage students between in-person and telehealth.

Parental Involvement: Telehealth allows for providers and social workers to better support and connect with parents. A significant number of SBHCs indicated that telehealth allowed the parent to be involved in mental health consults. This allows providers and social workers to increase coordination and provide parents with additional resources to help the student. A Medicaid waiver has currently made meetings with parents billable.

Peripheral Devices: Peripheral devices are devices and attachments that share diagnostic data with providers. Peripheral devices may expand the scope of a providers' ability to perform assessments virtually. Initial reviews from SBHCs on the use of peripheral devices were mixed. Further research will need to be conducted on the peripheral device cost compared to the expanded diagnostic abilities.

VII. SECTION 5: TELEHEALTH SYSTEMS

4.1 Traditional SBHC Services

Selecting a telehealth system platform that consists of a multitude of features and offers a variety of services, while also being cost efficient and user friendly, is critical for maintaining positive user experience and a sustainable virtual practice. There are numerous modalities that have been used across various SBHC's (Appendix A3)

There are 3 major pricing models to be considered when selecting telehealth system platforms:

1. **Commercial Open Source:** Software purchase by the customer and maintenance of this software is the sole responsibility of the customer. This kind of model refers to a dual licensing contract. There are no major upfront costs but there are high recurring costs due to ongoing maintenance.
2. **Subscription**: Software accessed over the internet and partnership with a third party is critical. Subscription is the most common pricing model utilized by SBHC's. There is a low upfront cost and a high recurring cost due to ongoing maintenance.
3. **Perpetual License**: Owning the software for a fixed term and premise installment. There is a high upfront cost with a single fee but low recurring since maintenance is internal and the program can be used indefinitely.

While speaking with and surveying various SBHCs, many pointed out similar sentiments towards what to consider when deciding upon a telehealth system to use:

- **HIPAA compliance**
- **Price**
- **Telephonic and video features**
- **Translation options**: Since SBHC's serve a high number of non-English speaking families/students, it is important to consider telehealth systems that offer their services/have the potential to offer their services in another language, such as Spanish.
- **Peripheral device options**: As telehealth services continue to advance and become a fundamental aspect of SBHC platforms, thinking about the use of peripheral devices and which telehealth systems could support this extension would be beneficial as services begin to expand.

VIII. SECTION 6: OPERATIONS/STAFFING/ TRAINING

4.1 Traditional SBHC Services

School based health centers must be cognizant of the training they provide staff members on the virtual platforms. In our interviews with various institutions, it became very apparent that time spent towards training caregivers on navigating through telehealth system platforms is essential for not only the efficiency of the appointment but also crucial for the patient's experience. Time spent towards training for the various features of the system, engaging in cross-training of other caregiver workflows (Appendix A4), providing bedside manner within a virtual platform and offering ongoing in-service training can lead to effective telehealth platform use. It is also highly recommended to ensure there are experts on site who have received rigorous training in using the telehealth system so that they can troubleshoot any issues that may occur.

IX. SECTION 7: BARRIERS TO ACCESS

In conversation with numerous School Based Health Centers, four major barriers to access in telehealth services came to surface; domestic privacy, network reliability, device accessibility and patient reimbursement.

7.1 Domestic Privacy

While engaging in telehealth services from home, students have had to take their appointments in privacy, away from family members and from parental surveillance. Students have taken appointments in the bathroom or leave their homes to go to a nearby park. This is especially prevalent with mental health services, as some students prefer not to keep their family informed of their engagement in such services.

7.2 Network Reliability

An uptake in more individuals staying at home has resulted in that much more internet use. This has resulted in an inability to access a high speed, stable internet connection, which impedes the ability to have steady and consistent appointments. Not only does this serve as an issue with access, but also compromises patient experience and having a meaningful, virtual experience. Family's could invest in high internet speed but this comes at a cost that many cannot afford. School based health centers are therefore encouraged to seek partnerships with telecommunication companies that have started offering system-wide deals for multiple members to enroll.

7.3 Device Accessibility

Access to devices such as smartphones, tablets, laptops and computers have served as major barriers for several students since they are sharing one device between various family members. The inability to access these devices impede the students' ability to engage in their telehealth appointments and unfortunately, students who utilize school based health centers come from families that cannot afford multiple devices for every family member.

7.4 Patient Reimbursement

There is a lack of widespread coverage and reimbursement for telemedicine services across states and insurers with low to no cost sharing for patients. Therefore, SBHCs must strategize towards finding a balance between telehealth and video health visits with in-person visits to ensure reimbursement, especially for new patients.

X. SECTION 8: EVALUATION

8.1 Evaluation Program Usage

Due to the rapid adoption of telehealth during the COVID-19 public health crisis, SBHCs had limited time and resources to perform extensive program evaluation. Although a handful of SBHCs had metrics to measure patient satisfaction, there continues to be a lack of evaluation in aspects of utilization, efficiency, and completion. Moving forward, it will be crucial for SBHCs to monitor and evaluate their telehealth programs to determine whether they are successfully meeting program objectives.

8.2 Key Areas for Evaluation and Recommended Indicators (Appendix 6)

Six primary areas were identified for evaluation: utilization, completion, technical disruption, reimbursements, time and duration, and satisfaction.

1. *Utilization*: evaluates the overall utilization of telehealth visits as a proportion of in-person visits and by type of service.
2. *Completion*: evaluates the proportion of scheduled telehealth visits that are ultimately completed and the proportion of visits that don't require an in-person follow-up.
3. *Technical Disruption*: evaluates the technical infrastructure and systems performance.
4. *Reimbursements*: evaluates telehealth claims data against in-person claims data.
5. *Time and Duration*: evaluates visit length and scheduling to optimize staffing and efficiency
6. *Satisfaction*: evaluates overall patient and provider satisfaction

Nine preliminary evaluation indicators have been recommended for measurement (Appendix 6). Although it is recommended that all SBHCs adopt these indicators into their evaluation programs, SBHCs may wish to incorporate additional metrics that meet their individual program needs.

XI. SECTION 9: CROSS-STATE TRENDS

No two states are alike in how telehealth is defined and regulated, making the policy environment for SBHC's difficult to navigate. While federal policies are important to understand, especially during a pandemic, understanding how New York State's policies impact the opportunities and constraints of SBHCs is even more critical. In order to provide recommendations on how to navigate the rapidly changing political environment, the team looked at telehealth policies across all 50 states, concentrating on a few states that displayed notable developments in telehealth implementation for SBHCs. Cross-state trends and unique state highlights are described below.

9.1 Policy Changes Pre/Post Public Health Emergency (PHE)

States continue to exert a great deal of flexibility around their adoption of telehealth services. After all, states have the option to choose which services will be covered, how the services will be implemented, what types of providers can deliver these services, and how they will code them for tracking and reimbursement. Therefore, the success of telehealth implementation is extremely geographically sensitive. According to a 2017 report by the American Telemedicine Association, 23 states had addressed telehealth in schools through some sort of legislative action (CMS, 2020). With the arrival of COVID-19 in the spring of 2020, all 50 states now have policies in place allowing telehealth to become reimbursable by Medicaid and other payers (CMS, 2020). As states quickly adjust their telehealth legislation, it becomes extremely important to understand which flexibilities will stay and what opportunities they will offer for the expanded role of telehealth in SBHCs.

A comprehensive review of state telehealth laws and reimbursement policies from the Center for Connected Health Policy (CCHP) provides rich information for health advocates and policymakers who are trying to understand telehealth implementation across America. Findings suggest that, in general, most states view telehealth positively and are considering extending some or all of the flexibilities adopted during the COVID-19 pandemic (CCHP, 2020). Thirty-three states are now reimbursing either a transmission, facility fee, or both, but only nineteen state Medicaid programs explicitly allow the home to serve as an originating site. Similarly, sixteen state Medicaid programs reimburse for store-and-forward, but only eight states, including New York, allow an out-of-state licensed provider to render services via telehealth (CCHP, 2020). Reimbursement policy is not the only variance across states. Privacy and confidentiality laws (HIPAA and FERPA), Children's Health Insurance Programs, funding, SBHC policies, local school-board policies, and many other factors are important to consider when analyzing telehealth initiatives for SBHCs in New York.

9.2 State Spotlights: Exploring Key Findings from Colorado, Connecticut, and North Carolina

In order to offer the Foundation a list of recommendations for New York State telehealth implementation in SBHCs, the team chose three states with progressive telehealth models in place to examine; Colorado, Connecticut, and North Carolina. Interviews with SBHCs in all states and telehealth consultants were conducted, as well as extensive secondary research to capture key findings. This next section will examine the varied approaches and strategies that the states have developed, highlighting successful practices and perceived barriers.

Colorado SBHCs have experienced multiple challenges and triumphs during the pandemic. Prior to COVID only two SBHCs had telehealth capabilities whereas today all centers now offer some sort of telehealth service (MacLean, 2020). The state sees telehealth as an extremely important role in increasing access for rural communities and their updated policy reflects that (Gostlin, 2020). After enacting the Colorado State Bill 215 in May 2020, changes to existing Medicaid laws and billing requirements have provided financial incentives for SBHCs to expand telehealth, particularly their behavioral health services. Colorado's hybrid approach to telehealth allows for some in-person visits to remain, delivering a full range of primary and specialty services between both models of care. The Colorado Association of School-Based Health Care created a resource compilation for SBHCs regarding billing information, staff support, community resources, and more to aid individual centers in their response to COVID and their reopening processes (MacLean, 2020).

In contrast to Colorado's hybrid model, Connecticut is operating under an exclusively telehealth approach for their Community Health Center (CHC) sponsored SBHCs. CHC is a statewide Federally Qualified Health Center (FQHC) in Connecticut that sponsors nearly 180 SBHCs across the state (Masselli, 2020). Prior to the PHE, SBHCs in Connecticut were already utilizing telehealth for behavioral health services and other small pilots. Therefore, when COVID hit they quickly transitioned all services to telehealth except dental care, where patients were referred out to clinics (MacLean, 2020). Since dental care was outsourced, SBHCs restrained those staff members to work in other sectors and services, such as working in call centers or taking temperatures (CT.gov, 2020). Some of the addressed challenges in Connecticut provide great lessons learned. For example, contact with students was problematic in the beginning, and therefore investing in Zoom Phone allowed them to have caller ID so patients knew who was calling. Access problems were addressed as well, as many districts handed out Google Chrome books to students without devices (WTNH, 2020).

North Carolina proved to be an interesting state to observe due to their utilization of funding streams. As a state, North Carolina had historically placed a large emphasis on improving child health, and the state's academic affiliations with institutions such as Duke University, UNC, and others proved to be key in their transition to telehealth for SBHCs. Additionally, in January 2020, the North Carolina Integrated Care for Kids (InCK) Model received a multi-million-dollar grant from the Center of Medicaid and Medicare Services (CMS) to improve child health and the integration of care in schools and communities (Sprigg, 2020). Therefore, the state seemed to demonstrate a mature and smooth transition to telehealth services during the pandemic.

9.3 Commonalities in telehealth implementation success across states

Some of the differences in state telehealth approaches are highlighted above. With all

three states being pioneers for SBHCs across the US, many similarities between states were found as well. For example, all states mentioned an expansive role for their SBHCs to serve as resource hubs for both patients and parents of the community. Two states even expanded their websites to not only include COVID-19 information, but also resources addressing social determinants such as housing, food insecurity, job postings, etc (CASHBSC, 2020). As a result they mentioned that providers and staff seemed engaged with the community in new ways (MacLean, 2020). Additionally, all states noted repeatedly that audio-only visits were one of the most important factors of telehealth success during the PHE, especially in rural areas. As far as services, all states found a significant increase in the need for behavioral health services, some even offering virtual group therapy in the SBHC to keep up with demand. Similarly, all states expressed concerns about confidentiality, particularly with behavioral health services and non-HIPAA compliant platforms such as FaceTime. Lastly, all states recognized the need for improvement on capturing quality measures and noted the critical importance demonstrating measurable results, a capability that many SBHCs are not equipped to currently measure.

XII. SUMMARY OF RECOMMENDATIONS

Policy

- SBHCs should establish common state-wide definitions
- Important to invest in the HIPAA compliant platform now before regulations change
- Nudge patients from audio only to audio-visual services
- Continue to develop and codify telehealth capabilities regardless of future reimbursement policy changes

Training

- Conduct training so staff understand the usage of modifiers in telehealth billing
- Encourage cross training so that all stakeholders are aware of each others' workflow and responsibilities

Evaluation

- SBHCs should implement evaluation programs to monitor and improve their telehealth program

System

- The chosen system should be HIPAA compliant, contain both video and telephonic features and be user-friendly from the patients' and providers' side
- A subscription payment model is ideal as it is more flexible and enables adaptations, changes and developments along the way.

XIII. NEXT STEPS & OPPORTUNITIES

COVID-19 has forced swift action on telehealth adoption. Prior to this year, many SBHCs and providers in general had placed telehealth implementation on the back burner. However, telehealth now has the world's attention. Telehealth has been a powerful tool for SBHCs, and as a result, there are several key areas of advocacy that SBHCs may focus on.

Advocacy Priorities:

- Permanent expansion of telehealth Medicaid coverage
- Push for reimbursement rates for telehealth to be as close to in-person rates as possible
- Continued flexibility for phone-only visits in order to protect access for high-risk students
- Expanded internet access for students at home via increased funding and/or partnerships with broadband providers
- Coordination with the American Telemedicine Association, Alliance for Connected Care, and the National Committee for Quality Assurance (NCQA), who are spearheading the "Taskforce on Telehealth Policy" to lobby for permanent policy changes to telehealth reimbursement

Beyond advocacy for continued protections of telehealth access for SBHCs, the Foundation may look into future applications of telehealth. The potential for telehealth utilization in SBHCs was largely untapped until this year, and the opportunities are vast. For one, peripheral devices could be implemented so that more services can be amenable to telehealth. Additionally, a hub and spoke model using telehealth could greatly expand access to care for New York students. In this model, providers in SBHCs can use telehealth to connect students with specialists who may not be available at the clinic. This could have vast implications for rural patients and patients who face barriers to specialized care.

XIV. CONCLUSION

This paper, written for the New York School Based Health Foundation by the Columbia Mailman School of Public Health Consulting Workshop, provides valuable insights and recommendations on school-based health center implementation of telehealth services during COVID-19. This report compiles knowledge from interviews with SBHCs, policy and advocacy organizations and a review of the literature to uncover information on policy, reimbursement, coding and billing, telehealth systems, operations/staff/training, access and evaluation. In addition, the report includes a section on next steps and opportunities for the New York School Based Health Foundation and SBHC organizations alike to engage in advocacy efforts to push for maintaining appropriate telehealth regulations and reimbursements.

Telehealth offers a unique solution for SBHCs to continue to provide needed care for an underserved population during a global pandemic. Successful implementation of telehealth will allow the opportunity to better serve students and engage parents when schools are not in session, now during COVID-19 and in the future.

XIV. APENDIX

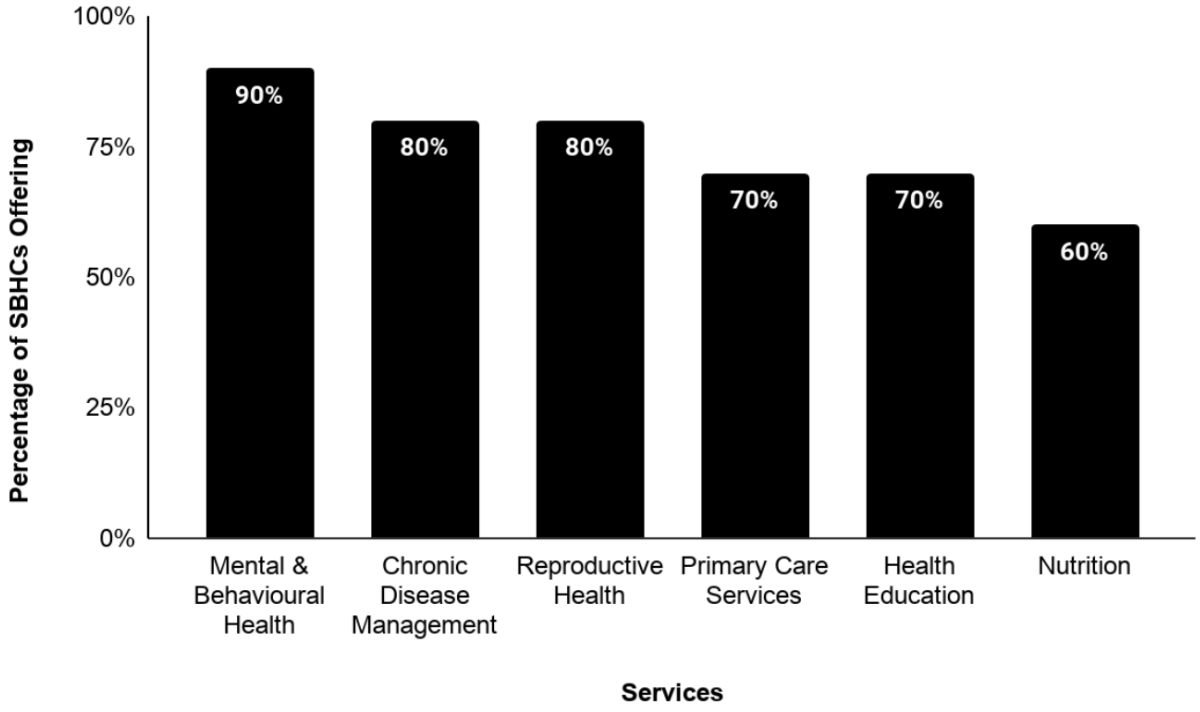
A1. Interview Guide Questions

Stakeholder	Questions
School Based Health Centers	Systems: What kind of telehealth system does your organization have implemented and how did you choose?
	Services: Tell us about the services and types of visits delivered via telehealth, how they have shifted with COVID, and what can't be delivered via telehealth?
	Challenges: What challenges did you face using telehealth? Were there any regulatory barriers? What would you have done differently?
	Equipment: What kind of telehealth equipment did your organization acquire? What was the capital cost of this equipment?
	Staff/Operations: Who is permitted to offer telehealth services? What kind of support staff is required? What kind of training is required? How did workflows change?
	Billing: Did telehealth coding and billing practices differ from in-person services?
	Access: Have you encountered issues regarding patient access to telehealth (eg. internet, devices, environment, etc)?
	Evaluation: Have you conducted evaluations on the effectiveness of telehealth vs. in-person service visits? If so how?
Policy/ Advocacy Organizations	Regulations: Many Medicaid and other regulations are relaxed during the COVID-19, which relaxed regulations are essential to the sustainability of SBHC telehealth services going forward? What is the outlook for these changes becoming permanent?
	Reimbursement: Reimbursement rates were enhanced for telehealth visits, what is the nature and extent to these enhancements? Are these rates sustainable for telehealth services? What is the outlook of these changes becoming permanent?
	Systems: What are the leading, compliant, reimbursable telehealth systems? Do you recommend any?
	Internal Changes: What internal practice changes are required for successful telehealth implementation (e.g., changes in staff roles, responsibilities, workflow, training)?
	Coding, Billing & Revenue: How does coding and billing for telehealth visits differ from in-person visits? What burdens does this impose on the provider?
	State SBHC Telehealth Models: Some states are highly advanced in SBHC telehealth services (particularly North Carolina). What have they done in terms of policy and implementation?
	Access: Providers have encountered issues regarding patient access to telehealth (eg. internet, devices, environment, etc), how do you suggest mitigating these access barriers?

A2. New York State Definitions (NYSDOH, 2020)

Term	Definition	Changes During COVID-19
Telehealth	The use of electronic information and communication technologies to deliver health care to patients at a distance. Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Medicaid member.	During the State of Emergency, telehealth includes telephonic services, in addition to telemedicine, store and forward, and remote patient monitoring.
Telemedicine	Two-way electronic audio-visual communications to deliver clinical health care services to a patient at an originating site by a telehealth provider located at a distant site.	Telemedicine includes teledentistry.
Originating Site	Where the member is located at the time health care services are delivered to him/her by means of telehealth.	During the State of Emergency can be anywhere the member is located including the member's home or out of state.
Distant Site	The site where the telehealth provider is located while delivering health care services by means of telehealth.	During the State of Emergency, any site within the fifty United States or United States' territories, is eligible to be a distant site for delivery and payment purposes, including Federally Qualified Health Centers and providers' homes, for all patients including patients dually eligible for Medicaid.

A3. Commonly Offered Telehealth Services

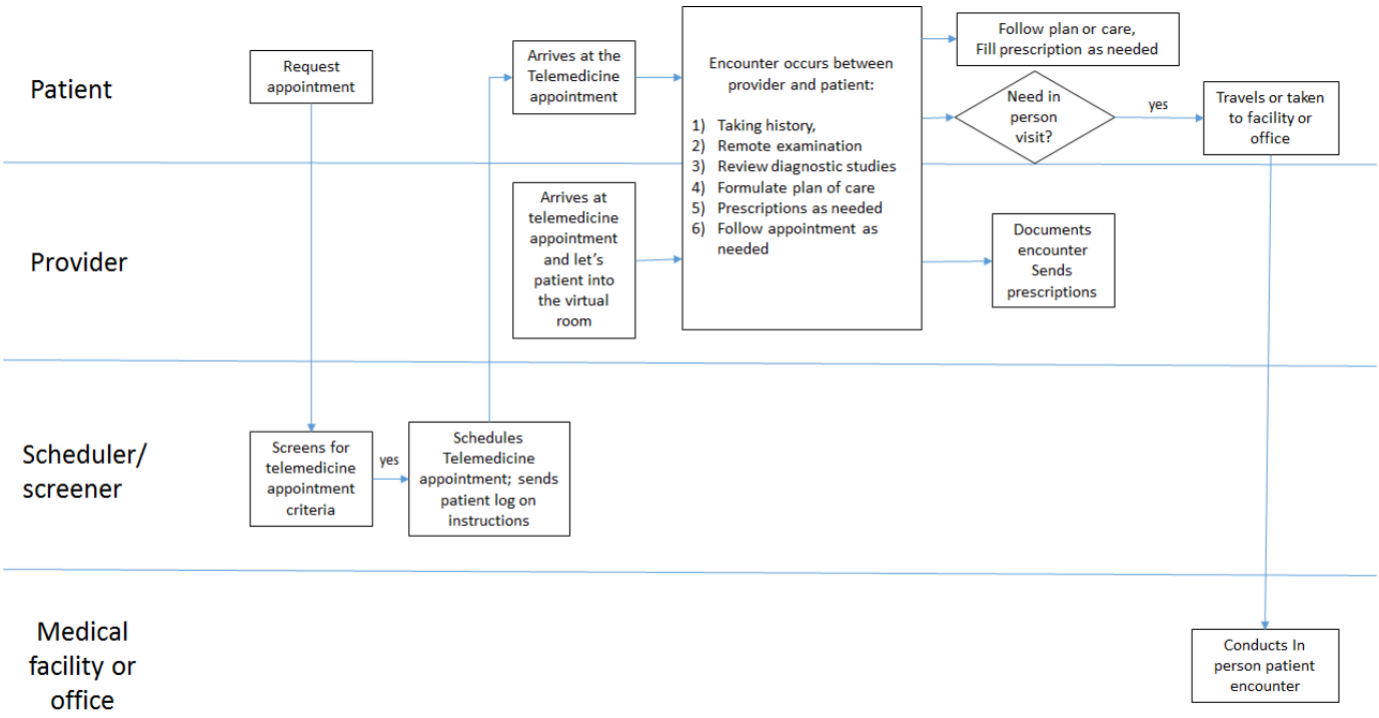


A4. Telehealth Platforms

System	HIPAA Compliant	Telephonic features	Video features	Translation	EMR Integrated
Doximity	✓	✓	✓	✓*	✓
MyChart Connect	✓	✓	✓	✓	✓**
Zoom	✓	✓	✓		
Amwell	✓	✓	✓		✓
Curogram	✓	✓	✓		✓
Microsoft Teams	✓***	✓	✓		
Google Hangout	✓***	✓	✓		
Phone/Facetime		✓	✓		

*Translation available only with Epic
** Integrates with Epic only
***With the purchase of Business associate agreement

A5. Caregiver Workflow



A6. Recommended Evaluation Indicators

Indicator	Data Needed	Purpose
Utilization		
1. % of all services performed using telehealth: total and by specific service type	● **Services provided through telehealth** - Total number, total by service type ● **Non-telehealth services** - Total number, total by service type	Indicates overall utilization of telehealth at the SBHC
Completion		
2. % of scheduled telehealth visits completed	● **Telehealth visits scheduled** - Total number, total by type ● **Telehealth visits completed** - Total number, total by type	Low completion rates may indicate issues around patient no shows, home privacy concerns, and patient technical/equipment problems
3. % of telehealth visits that were followed by an in-person visit	● **Total number of telehealth visits** ● **Total number of telehealth visits with no subsequent in-person required**	Provides information on how often telehealth visits completely replaced the need for an in-person visit
Technical Disruption		
4. % of telehealth visits impacted by a technical issue	● **Visits with technical issue reported** - Total reports - Total by specific reason	Performance improvement measures can be implemented to address dropped calls, poor video quality, poor audio quality, etc
Reimbursements		
5. Actual telehealth reimbursements as a % of expected reimbursements and as a % of in-person reimbursements	● **Expected telehealth reimbursements** ● **Actual telehealth reimbursements** ● **Actual in-person reimbursements**	Helps to evaluate the long-term financial viability of telehealth services
Time and Duration		
6. Most frequent times for telehealth services delivery	● **Visit start time**	Provides insight to identify optimal staffing patterns for telehealth visits and opportunities to extend service hours
7. Average time per telehealth visit (including prep and charting); all services and by specific service type	● **Start time of visit** ● **End time of visit** ● **Specific service type**	Provides information on total encounter time that can be useful to optimize scheduling
Satisfaction		
8. % of patients indicating overall satisfaction with telehealth visits compared to in-person visits: by total and by visit type	● **Feedback responses collected** - Telehealth - In-person ● **Feedback responses collected that indicate satisfaction** - Telehealth - In-person	Identifies overall patient satisfaction. Reasons for differences in satisfaction can include - Efficient use of time - Reliability in technology - Patient comfortability
9. % of providers indicating overall satisfaction with telehealth visits compared to in-person visits: by total and by visit type	● **Feedback responses collected** - Telehealth - In-person ● **Feedback responses collected that indicate satisfaction** - Telehealth - In-person	Identifies overall provider satisfaction. Including and incorporating provider feedback can improve staff buy-in.

XVI. REFERENCES

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