Association of Community Cancer Centers

ONCOLOGY ISSUES

The Official Journal of the Association of Community Cancer Centers

Editor-In-Chief
Jennie R. Crews, MD, MMM, FACP

Executive Director
Christian G. Downs, JD, MHA

Managing Editor
Monique J. Marino

Associate Editors
Amanda Patton
Will True

EDITORIAL BOARD
Nadine Barrett, PhD, MA, MS
Jennifer Bires, LICSW
Stephen Cattaneo, MD
Linda Corrigan, MHE, RHIT, CTR
Sigrun Hallmeyer, MD
Robin Hearne, RN, MS
Sarah Hudson-DiSalle, PharmD, RPh
Jeff Hunnicutt
Bridget LeGrazie, APN
Anne Marie F. Rainey
Chad Schaefer, MS, FACHE
Bryan Schmalhofer, MBA, RT(R)(T)
Kelay Trentham, MS, RDN, CSO
Gretchen Van Dyck

ACCC EXECUTIVE COMMITTEE

President
Thomas A. Gallo, MS, MDA

President-Elect
Ali McBride, PharmD, MS, BCOP

Secretary
Krista Nelson, MSW, LCSW, OSW-C, BCD

Treasurer
Randall A. Oyer, MD

Immediate Past President
Mark S. Soberman, MD, MBA, FACS

ACCC Board of Trustees
Olalekan Ajayi, PharmD, MBA
Nadine J. Barrett, PhD, MA, MS
Catherine Brady-Copertino, BSN, MS, OCN
Melanie Feinberg
Amanda Henson, MSHA, MBA, FACHE
Una Hopkins, RN, FNP-BC, DNP
Barbara Jensen, RN, BSN, MBA
Laeton J. Pang, MD, MPH, FACR, FACRO
Kashyap Patel, MD
David Penberthy, MD, MBA

Oncology Issues serves the multidisciplinary specialty of oncology care and cancer program management.

Oncology Issues (ISSN: 1046-3356) is published bimonthly for a total of 6 issues per year by Taylor & Francis Group, LLC, 530 Walnut Street, Suite 850, Philadelphia, PA 19106, on behalf of the Association of Community Cancer Centers (ACCC), 1801 Research Blvd, Suite 400, Rockville, MD 20850-3184, USA. US Postmaster: Please send address changes to *Oncology Issues* c/o Taylor & Francis Group, LLC, 530 Walnut Street, Suite 850, Philadelphia, PA 19106. Copyright © 2019 by the Association of Community Cancer Centers. All rights reserved. No part of this publication may be reproduced, stored, transmitted, or disseminated in any form or by any means without prior written permission from the publisher, Taylor & Francis Group, LLC.

FROM THE EDITOR

Telehealth: Cancer Care at a Distance

BY JENNIE R. CREWS, MD, MMM, FACP

There is growing enthusiasm for the use of telehealth in oncology. In addition to patient-driven factors, for example the need to mitigate transportation challenges for cancer patients and families, and economic factors—payers believe that utilization of telehealth may help reduce healthcare costs—new cancer treatments, such as immunotherapies, require greater patient monitoring and tracking that may be more conveniently (and economically) provided via telehealth.

Telehealth may even lead to better outcomes. A study published online in May 2017 in the *Journal of Clinical Oncology* showed improved survival in lung cancer with remote symptom monitoring, and use of such patient-reported outcomes in other tumor types is under evaluation.

Patient satisfaction with telehealth is well documented in primary care. Anecdotally, the same is true in oncology. In my previous practice, we had a robust tele-oncology consult service. Our surveys showed that most patients were “satisfied” to “highly satisfied” with the service and would recommend it to others.

However, broad adoption of telehealth in the field of oncology is low due to both perceived and real barriers, including operational expertise and acceptance by patients and providers. Most cancer programs are familiar with teleconferencing but have less experience with other forms of telehealth, such as:

- Asynchronous store-and-forward technology for reviewing patient data
- E-consults between providers
- Remote patient monitoring
- Virtual visits.

However, patient demand for convenience and research demonstrating improved outcomes is driving cancer programs to think outside the traditional model of cancer care and consider these technologies as crucial components to care delivery.

Arguably, the largest barriers to adoption of telehealth are regulatory and legal constraints. There are state-to-state differences in licensing requirements, allowed services, definition of the originating site (where the patient is located), and payment. Forty-nine states currently have some form of Medicaid reimbursement for telehealth, and 39 states have laws governing payment for telehealth by private payers; however, specifics vary by state and few states have strict payment parity laws. The burden of provider licensing has decreased with the creation of the Interstate Medical Licensure Compact, but not all states currently participate.

Traditionally, Medicare had limited reimbursement for telehealth, but the 2019 Hospital Outpatient Prospective Payment System and Physician Fee Schedule rules are broadening coverage. Reimbursement will be allowed for virtual check-in visits between a provider and an established patient following consent, if the virtual visit does not occur seven days prior to an E&M visit, one day following an E&M visit, or on the soonest available date (a term that the Centers for Medicare & Medicaid Services acknowledges is not well defined but will be defined by monitoring. For more on this, see the “Compliance” column on pages 8-25). Starting Jan. 1, 2019, the Medicare program will also cover certain medical services delivered via asynchronous telemedicine technologies.

Overall, I believe that these regulatory updates are a win for telehealth, and I hope that they will encourage broader adoption of this technology in oncology care delivery. Getting patients the care they need—without the burden of arranging travel or taking time off from work or school—will increase patient satisfaction and improve efficiency of care delivery. OI