HHS Public Access

Author manuscript

Am J Manag Care. Author manuscript; available in PMC 2023 June 01.

Published in final edited form as:

Am J Manag Care. ; 28(12): e436–e443. doi:10.37765/ajmc.2022.89279.

Financial Impact of Telehealth: Rural Chief Financial Officer Perspectives

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Abstract

Objectives: To explore the perceived impacts of a variety of telehealth services on hospital finances and assess how hospital administrators make decisions about adopting telehealth programs.

Study Design and Methods: From October 2021 to January 2022, we conducted semi-structured interviews with Chief Financial Officers (CFOs) of rural hospitals. Recruitment occurred in collaboration with six rural health collaboratives and hospital associations that facilitated CFO peer-learning groups. We used inductive and deductive approaches informed by the Healthcare Innovation Adoption Model to identify themes in the qualitative data.

Results: Twenty rural hospital CFOs and other hospital administrators from 10 states participated in interviews. Seventeen (85%) represented critical access hospitals and three (15%) represented short term acute care hospitals. While CFOs believed telehealth has some financial advantages (e.g., can help to avoid patient transfers), they did not believe that telehealth improved their hospital's financial situation. CFOs, rather, seem motivated to implement telehealth services to improve quality of care and address patients' needs. CFOs reported that limited reimbursement, low volumes, preference for in-person care, and insufficient broadband were key challenges for telehealth's financial viability.

Conclusions: Understanding how CFOs think about the return on investment of telehealth can inform efforts to promote telehealth utilization in rural communities and to develop policy solutions to make telehealth more sustainable. CFOs may benefit from guidance on promising practices and cost-effective implementation strategies. Policymakers could take steps to improve telehealth's financial attractiveness (e.g., through payment parity, subsidies to improve technology infrastructure).

Précis:

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Interviews with rural hospital Chief Financial Officers showed that they perceived telehealth to have some financial advantages; however, they did not believe that telehealth improved their hospital's financial situation.

Keywords

telehealth; rural health; healthcare costs

Introduction

Telehealth is promoted as a solution to the financial challenges facing rural hospitals and a means of preventing hospital closure.[1] For example, a Health Resources and Services Administration-sponsored Toolkit for Critical Access Hospitals asserted that telehealth decreases staffing costs and increases hospital revenue by reducing transfers to other hospitals.[2] Despite these potential advantages, adoption of different telehealth services (e.g., telestroke, tele-ICU, telehealth for outpatient specialty consults) varies significantly across rural hospitals. A 2019 study from prior to the COVID-19 pandemic showed that 46% of rural emergency departments did not have telehealth services, and cost was the biggest barrier to implementation.[3]

A hospital's decision to invest in new medical technologies is a complex one; adoption decisions are typically made by hospital leadership including clinicians and chief financial officers (CFOs). The more costly a proposed innovation, the more scrutiny it will receive,[4] as leadership weigh a variety of factors, including the likely return on investment.

Despite the critical role of perceived financial impact on the decision to implement telehealth, no prior research has explored the perspectives of rural hospital administrators on the business case for telehealth. Research on telehealth has historically focused on the experiences and attitudes of clinicians and patients,[5–9] and while these stakeholders are critical, these parties do not typically have visibility on the financial impacts or sustainability of telehealth programs in rural areas. Understanding how CFOs think about the return on investment of telehealth can inform efforts to promote telehealth utilization and to develop policy solutions to make telehealth more sustainable. We conducted interviews with rural hospital CFOs to understand the perceived impacts of a variety of telehealth services on hospital finances and how hospital administrators make decisions about adopting telehealth programs.

Methods

Conceptual Framework

Our approach to data collection and analysis was informed by Flessa and Huebner's Healthcare Innovation Adoption Model.[10] In this framework, we assume that a hospital CFO is in a position to be an administrative promoter of telehealth adoption. CFO support for a new telehealth service is influenced by many factors including the inclination to innovate (which depends in part on tolerance for risk) and the perceived financial impacts, including impact on revenue and costs. Further, the model suggests that CFOs will only

support an innovation if they perceive system deficiencies. Since many rural hospitals face continued financial losses, we argue that many rural hospital CFOs will agree that change is necessary, and this will increase their support of telehealth. However, rural hospitals also have a number of characteristics that decrease the likelihood that they will embrace new innovations. For example, literature suggests that hospitals with less competition and fewer patients with private insurance are less likely to implement innovations.[4]

Study Sample

From October 2021 to January 2022, we conducted semi-structured interviews with CFOs of rural hospitals. To recruit, we contacted 16 state-level organizations (rural health collaboratives and hospital associations) that hosted peer learning networks where CFOs met regularly to share resources. Six agreed to share recruitment materials and background on the study with participating CFOs via email and in standing meetings. CFOs were asked to contact the study team if they were interested in participating. Some organizations advertised the study to all CFOs in their networks, while others selected a subset. The organizations that selected a subset were asked to advertise the study to CFOs that varied with respect to rural location (rural vs. frontier), hospital type (critical access hospital vs. short term acute care hospital), financial health, and types of telehealth programs. This instruction helped to support maximum diversity sampling. The only inclusion criterion was that CFOs represent a rural hospital.

We invited every CFO who contacted the study team to participate, and continued to recruit until we reached thematic saturation, defined as the point at which new interviews did not uncover new themes.

Data Collection

Interviews were conducted via videoconference and followed a semi-structured protocol. Topics included 1) basic hospital information (e.g., location, payer mix); 2) existing telehealth programs in the emergency department, inpatient, and outpatient settings; 3) perceptions about the financial impact of each program; 4) drivers of financial impacts; 5) the role of telehealth in strategic planning efforts; and 6) policy and other barriers to the financial sustainability of telehealth. Two members of the study team trained in qualitative research conducted the 60- minute interviews, and study staff recorded and transcribed the interviews. Each participant received a $150 gift card for their time, and they provided verbal informed consent to participate. The RAND Institutional Review Board approved this study.

Analysis

We coded interview transcripts using qualitative research software (Dedoose[11]). We developed a hierarchically organized codebook to summarize themes and identify patterns. We used standard qualitative analysis techniques, consisting of both inductive and deductive approaches to identify and characterize instances of themes arising from the domains in the conceptual framework interview guide, as well as unanticipated themes that emerged. The lead author (LUP) coded all transcripts, refining the codebook as she worked and adding relevant probes to interviews in progress.

We defined a theme as a concept noted by at least two participants. When identifying themes, we not only considered cohesiveness and prevalence across participant responses, but also incorporated perspectives that were inconsistent (i.e., negative case analysis). We achieved consensus regarding the characterization of themes through interactive discussions among the research team.

To improve internal validity and transferability, we conducted respondent validation. We presented preliminary findings to 14 CFOs in a group meeting hosted by one of the participating organizations. Respondents largely affirmed the findings and provided additional context for certain points.

Results

Twenty rural hospital CFOs and other hospital administrators from 10 states participated in interviews. Seventeen (85%) represented critical access hospitals and three (15%) represented short term acute care hospitals. Sixteen (80%) represented hospitals with 25 or fewer beds, and ten (50%) represented hospitals that operated at a financial loss in the prior three years (Table 1).

Most CFOs reported having multiple telehealth programs at their hospitals including inpatient, ED-based services, and outpatient services. The most common inpatient or ED program was telestroke and the most common outpatient service was tele-behavioral health. For inpatient or ED telehealth, the rural hospital generally served as the hosting site and connected patients to remotely located specialties. For outpatient telehealth, the hospitals sometimes served as the hosting site and at other times as the distant site (e.g., rural health clinic providers employed by the hospital delivered telehealth visits to patients in their homes).

Most CFOs believed that telehealth was a loss leader or had a neutral impact on hospital finances.

All but one hospital in the sample operated multiple telehealth programs; however, CFOs reported that they were more motivated to implement telehealth to improve quality, and in some cases to keep up with competitors, rather than to improve their financial position. While participants provided a few examples of select telehealth services that resulted in direct financial advantages, they provided more examples of telehealth programs that did not. Further, although participants felt that some specific services could have benefits, when reflecting on telehealth more broadly across multiple inpatient and outpatient services, CFOs were not enthusiastic about telehealth's direct financial advantages. Table 2 features relevant quotes. According to a CFO from Iowa, "*All these telehealth models that we're talking about are just new expenses brought on to the hospital without any kind of return on investment at all… Now, all those things are a little harder… to get your arms around the exact dollar amount. But [telehealth results in] major, major improvements in the quality of our care, the safety of our care."* A CFO from Oregon stated, *"[Telehealth] is probably a little bit of a loss leader, but I think that we are a community healthcare provider that is really honestly more concerned about offering services."*

Further, telehealth was not featured prominently in strategic planning. Only a handful of CFOs discussed their long-term plans for telehealth. A CFO from Washington stated, "*We have not specifically discussed telemedicine as part of our strategy plan moving forward… We're trying to remodel our hospital. So, a lot of our thought process is going towards that right now."* A CFO from West Virginia said*: "[Telehealth] is not a big focus. I don't see specific initiatives for next year for that, but... one of our [priorities], of course, is lowering the cost of healthcare."* A CFO from Wisconsin explained, *"In our last strategic planning cycle, we weren't focused at all on telemedicine…we were still really focused on getting physical people."* When telehealth was discussed as part of a strategic plan, the focus was on increasing specialties via telehealth and growing remote patient monitoring programs.

Despite this general belief that telehealth was not profitable, CFOs did identify several direct and indirect financial benefits of select services.

Table 3 lists financial benefits and illustrative quotes. Just under half of interview participants reported that inpatient and ED-based telehealth programs help avoid patient transfers, allowing the hospital to retain more patients. Given that hospitalizations bring in a lot of revenue, some hospitals used telehealth as a strategy to increase inpatient volume and by extension, their financial position. The next most commonly cited financial benefit applied to outpatient telehealth. Here, several CFOs believed that telehealth visits for primary care and specialty care may not generate much revenue on their own, but that they can drive more profitable ancillary services (e.g., laboratory testing). A handful of participants identified additional benefits. First, if a hospital can prevent transfers through inpatient telehealth and offer more complete services through outpatient telehealth, it can reduce the risk that it will permanently lose patients to competitors. Second, starting an inpatient telehealth program (e.g., tele-hospitalist) is less expensive than having a full-time, in-person provider and can reduce both direct labor costs as well as costs of recruitment. Third, during the pandemic, telehealth helped to sustain some outpatient practices because in-person visit volume dramatically declined.

CFOs were asked to explain the disconnect between a general belief that telehealth is a loss leader and these positive financial impacts. First, they clarified that telehealth requires substantial initial investments in the technology, and the downstream financial benefits are hard to quantify and are not always realized. A CFO from Iowa explained that some benefits "do not show up on a spreadsheet." Further, CFOs pointed out that the utilization of the telehealth service is often not high enough to have the significant downstream impact. Lastly, a belief that in-person care is generally superior to telehealth and should be provided where possible may have influenced their perceptions about financial advantages. The same CFO from Iowa explained, *"That personal connection has been a cornerstone of how care is provided [in rural communities]… and actually touching [the] patient."*

CFOs mentioned several factors that prevented telehealth from being more profitable including low reimbursement, the fact that services are often low volume, and lack of broadband.

Several participants pointed out that reimbursement was too low for telehealth, particularly for outpatient rural health clinic visits, and a few mentioned that with telehealth services,

non-critical access hospitals may forgo the facility fee. Further, within rural health clinics, telehealth visits have extra technology costs and are reimbursed less. According to a CFO from Maine, *"The rate that we get for a telemedicine visit is a quarter to a third of what we get paid for an in-person visit… But we still have to have all the staff, we still have to bill… [and] register the patient [and]… do everything just like the patient was the coming in the building. So, there's really not a lot of cost savings, but they don't allow us reimbursed cost on those visits. We only get fee schedule reimbursement. And the way that the cost reporting works, it actually pulls cost away from our other functions for those visits."*

Cost-based reimbursement from Medicare for critical access hospitals reduces some of the financial risk associated with implementing telehealth because most costs are supported; however, not all costs related to telehealth implementation are allowable. A CFO from Maine explained, "*So, there are certain things with telemedicine that are allowable, like our e-Hospitalist, one of our most expensive telehealth services that we're doing. We don't receive any support for that as it relates to cost-based reimbursement."*

Further, CFOs pointed out that telehealth services are often too low volume to be profitable. This is the case because of the fixed, limited demand for services in a small community and rural culture, in which in-person connection is valued.

Finally, limited broadband in rural communities has discouraged hospitals from growing outpatient telehealth programs that serve patients in their homes. Also, limited broadband requires that hospitals invest more in infrastructure when standing up inpatient programs. A CFO from West Virginia explained, "*I think it's [outpatient telehealth] an opportunity for us to expand, but I do feel like we're going to be limited because of the location. We're at the mercy of someone having internet or having the capability. We're not projecting increased volumes because of those limitations.* A CFO from Wisconsin explained how broadband can be challenging for inpatient programs as well: "*If you're going to be providing a tele-ICU solution, you're going to have to make sure that you have some significant redundancies in your IT infrastructure … [and]anytime you're putting in fiber infrastructure, it is a really expensive venture for a small critical access hospital... I guess that's one major risk that I see in rural telemedicine, especially when you're talking more critical levels of care; just, you can't afford to have it go down. Having significant downtime is just not an option. That part of it is a little scary, because you don't have your specialists here on-site."*

Participants also expressed a variety of views about how competition posed challenges for their telehealth offerings. One CFO from West Virginia pointed out that her hospital was concerned that if they aggressively pursued telehealth for outpatient specialty care, patients who prefer in-person care would go elsewhere for care. A CFO from Oregon echoed a similar concern: *"If you're doing telemedicine [for outpatient specialty care], you don't have to go to our hospital. You can go to those tertiary facilities that are offering the telemedicine."*

CFOs identified several policy barriers that affected telehealth financial viability including lack of payment parity, uncertainty about the reimbursement environment, and the

requirement that critical access hospitals maintain an average length of stay of less than 96 hours.

Several CFOs mentioned that lack of payment parity for telehealth and in-person visits, especially for rural health clinic visits, was a barrier to the growth of telehealth programs. As stated above, Medicare reimburses less for rural health clinic telehealth visits and as an additional challenge, telehealth visits are carved out of cost-based reimbursement so they involve additional accounting challenges. An important reason why lack of parity is a concern is that there is fixed demand for outpatient visits in many rural communities. As such, replacing an in-person visit that generates more revenue with a telehealth visit that generates less revenue is problematic. A CFO from Washington explained, *"[Telehealth] was a glaring concern, because it was approximately $110 less than what we normally get reimbursed for an in-person visit. And since we are kind of volume based, the providers… they can do quite a few more telehealth visits, if that's what they're doing. But, we have such a small volume in general that, they're replacing all the in-person visits… [and] there's not enough people [patients] to have them [providers] double up on total visits."* Several CFOs also pointed out that uncertainty about the reimbursement environment and how reimbursement will change as the pandemic evolves has prevented them from optimizing telehealth services and making them as efficient as possible. A CFO from Illinois stated, *"We just haven't felt comfortable enough to aggressively look at that service optimization."*

Finally, a few CFOs mentioned that the requirement that critical access hospitals maintain an average length of stay of less than 96 hours was a barrier to the growth of their inpatient and ED-based telehealth programs. The concern was that with a program like tele-ICU, hospitals would keep higher acuity patients with longer inpatient stays. However, there was not universal agreement on whether this rule posed a significant threat to the growth of telehealth. A CFO from California explained, *"At the critical access hospital, the average length of stay has to be less than 96 hours…So, if we're doing telehealth, we are able to treat things that are going to affect [increase] their length of stay... Ordinarily, if you didn't have telehealth, you would discharge them."* In contrast, a CFO from Maine pointed out, "*It's the overall average though for your entire population. But I don't think the one rare [telehealth] patient here or there would impact my average length of stay."*

When asked about lessons learned and advice to other rural hospitals, several CFOs suggested that rural hospitals pursue grants to cover technology costs, choose a distant site that is not in a position to cannibalize your business (i.e., don't partner with a local organization that could be source of competition for patients), and consider hidden costs when starting programs (e.g., ensure that whatever system you implement captures data elements required for external reporting so that additional funds are not needed to develop solutions after the fact).

Discussion

Telehealth has been promoted as a solution to the financial challenges facing rural hospitals; however, discussions with CFOs in our study did not support that assertion. While CFOs believed that some select telehealth services had financial advantages, they did not believe that telehealth overall improved their hospital's financial situation. CFOs, rather, seem

motivated to implement telehealth services to improve quality of care and address patients' needs. Limited reimbursement, low volumes, preference for in-person care, and insufficient broadband are key challenges for telehealth's financial viability. Given CFOs' lack of enthusiasm for the direct financial benefits of telehealth, we were surprised that so many hospitals in our sample had multiple, robust telehealth programs.

CFOs in our sample identified many of the same financial advantages that other literature has discussed including increased local revenue for ancillary services, reduced labor costs (e.g., from sharing distant site personnel with other facilities), and fewer transfers.[1, 2, 12, 13] Our results are consistent with one study by Haque et al, which also identified somewhat negative views about the financial impact of telehealth. Similar to our findings, hospital staff from frontier critical access hospitals reported the high upfront costs for equipment combined with low use would likely lead to a negative impact on financial performance.[14]

Limitations

A key limitation is that CFOs who agreed to participate in this study may have more interest in telehealth and/or more extreme views of (both in support of and against) telehealth.

Conclusions

Our study implies that CFO perceptions regarding financial impacts will be a barrier to the continued growth of rural telehealth. While we explored perceptions of the financial impact rather than quantitative data on actual impacts, we argue that CFO attitudes are highly relevant to decisions to invest in telehealth.

It is possible that telehealth does have financial advantages that CFOs have not yet observed directly. If so, they could benefit from guidance on promising practices and examples of successful programs that could in turn influence their perceptions and increase their support for telehealth. This might include a focus on more cost-effective implementation strategies. A 2015 study by MacKinney et al showed that a tele-emergency program can generate a $187,614 profit in a high revenue/low expense scenario and a $69,588 loss in a low revenue/high expense scenario.[15]

Another possibility is that the financial benefits of telehealth to rural hospitals are exaggerated. If telehealth really "doesn't pay" in the majority of cases, then policy-makers who are interested in expanding telehealth to increase access to care should take steps to improve its financial attractiveness (e.g., through payment parity, subsidies to improve technology infrastructure). Further, policy-makers can work to finalize permanent, post-pandemic telehealth policy. CFOs may be reluctant to optimize telehealth services and thus achieve their true potential until there is clear signal as to what reimbursement for different telehealth services will look like in coming years.

Funding source:

This research was supported by a grant from National Institute of Neurological Disorders and Stroke (R01NS111952)

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Take-away points:

Telehealth has been promoted as a solution to the financial challenges facing rural hospitals; however, interviews with Chief Financial Officers (CFOs) did not support that assertion.

- While CFOs believed telehealth has some financial advantages, they did not believe that telehealth improved their hospital's financial situation.
- CFOs may benefit from guidance on promising practices and cost-effective implementation strategies.
- Policymakers who are interested in expanding telehealth to increase access to care could take steps to improve its financial attractiveness (e.g., through payment parity, subsidies to improve technology infrastructure).

Table 1:

Participant Characteristics

Characteristic	N	Percent
Role		
CFO	17	85.00
CEO or COO	1	5.0
Other	2	10.0
Hospital type		
CAH	17	85.0
STACH	3	15.0
Geographic region		
Midwest	7	35.0
West	6	30.0
South	4	20.0
Northeast	3	15.0
Total unique patients in 2019		
≤25	16	80.0
26–50	2	10.0
51–75	0	0.0
76–100	2	10.0
>100	0	0.0
Total margin (average 3-year) *		
Total operating gain	10	50.0
Total operating loss	10	50.0
Current telehealth programs in place		
Telestroke	11	55.0
eICU	6	30.0
Primary care telehealth in RHC	5	25.0
Specialty outpatient	11	55.0
Urgent care	4	20.0
eHospitalist	4	20.0
Telepsychiatry (ED or inpatient)	6	30.0
Other (e.g., ePharmacy, school-based teleBH)	8	40.0

* Total margin = (Total Revenue – Total Cost)/ Total Revenue. The total margin is negative if the facility has a total operating loss. Calculations are based on an average of the three most recent years for which CMS Provider of Services and Hospital Cost Report files are available, either 2018–2020 or 2017–2019.[16]

Note: CAH = critical access hospital; CEO = chief executive officer; CFO = chief financial officer; COO = chief operational officer; ED = emergency department; eICU = electronic intensive care unit; RHC = Rural Health Clinic; STACH = short-term acute care hospital; teleBH = telebehavioral health.

Table 2:

Telehealth has no impact or a negative impact on hospital finances

Participant	Quote
CFO from Wisconsin	Economically, I would tell you that it's more of an investment at this point than it is a steady revenue stream. I'm sure we spend more on the technology and having the technology available than what we're billing, and collecting for that infrastructure that we've had to put in place.
CFO from Oregon	So, it's between a net neutral and a disadvantage only because of those concerns that I brought up [reimbursement], and I don't know what direction they're going to go.
CFO from West Virginia	I think that program [outpatient tele-cardiology] will also just lend itself more to quality [than profit]. Obviously, cardiology services are probably one of the largest services provided in the area and our patients leave here for that service because we don't provide that. And if those patients don't have to travel three hours... That service, they normally travel three hours for. If they can stay here and get a lot of their follow up appointments, that certainly helps them. As of right now, I'm not sure we would even get a technical component out of that.
CFO from Illinois	I would say that we really haven't changed our cost structure that much on the clinic side, meaning the staffing in the clinics is still pretty much about the same level as pre-COVID… so we still carrying that expense. And now we've layered on the expense of the technology. So today, not a profitable business line for us.
CFO from Iowa	All these telehealth models that we're talking about are just new expenses brought on to the hospital without any kind of return on investment at all… Now, all those things are a little harder… to get your arms around the exact dollar amount. But [telehealth results in] major, major improvements in the quality of our care, the safety of our care.
CFO from Oregon	[Telehealth] is probably a little bit of a loss leader, but I think that we are a community healthcare provider that is really honestly more concerned about offering services.
CFO from Florida	I'll call it a loss leader for us right now
CFO from California	We're losing money on that. That's the big problem. Some of these either licensed healthcare workers or psychologists or psychiatrists pay them $200 bucks an hour, but we're not getting paid that on some of these patients, but it's a service that we're willing to provide, even if we're not making money on it because it's such an important part of what the community needs right now, mental health.
CFO from West Virginia	[Outpatient telehealth] is not going to be a primary service line that is going to be profitable for us. It's going to be like a normal physician visit. And we don't have high increase, expected growth or anything at this time.
CFO from Wisconsin	I would call it neutral. I don't think that you make money off of that because the reimbursement is... It's not bad for the professional piece of it. It's not good, but it's not bad.
CFO from California	We are responding to the community needs that we know we're not going to make money on, but it's just that careful balance being a rural hospital to keep the doors open and provide as many services as possible… It's [telehealth] a great service but it's not anything that we're going to hang our hat on. We're not going to rely on the telemedicine to bring in a lot of revenue… There are some positive aspects, but it's never been something that without grants or something to support it, that it's been a really a standalone service that would stand on its own
CFO from Oregon	In general, telemedicine, honestly, doesn't pay over the long haul. It really doesn't pay. It does help provide excellent patient care.
CFO from Wisconsin	From a financial standpoint, it wasn't a huge loss [telehealth for urgent care], but we were probably talking in the tens of thousands of dollars a year that we were losing on the service at that time.
CFO from Maine	I don't know of any examples of telehealth having a direct financial benefit… I don't know that there's been enough utilization to make a huge impact.

Table 3:

Direct financial advantages

Quote	Setting to which the Quote Applies	
	Inpatient and/or ED	Outpatient
Help hospitals retain patients/avoid transfers		
I think, as we look more into the opportunity to provide telehealth services in the hospital, the opportunity to actually keep more patients here locally [will be a financial benefit for the hospital].	x	
As a rural hospital, [eICU has] helped us to retain patients… because we don't have 7/24 intensivist coverage in the ICU. With the eICU, we are able to retain the patients and prevent from transferring them.	x	
As we expand our stroke program [to inpatient from the ED], we can keep them, because now we can monitor the patient upstairs, and so the neurologist can keep an eye on them with the hospitalist. From a Medicare standpoint for us, our inpatient payment from Medicare is roughly… $8,000 a visit, and so it's a chunk of change for us.	x	
And it [tele-ED] also allows us to keep some of the patients in-house, whereas we may have had to send them out to another hospital…If we can keep these patients in the ED and treat them and then keep them in the hospital as an inpatient… that helps us immensely financially.	x	
I mean, we are reliant on it [telehealth] at this point, to allow us to have a robust inpatient program… [because] part of the issue with the decline of rural health is that the inpatient service is being relocated out, because it's difficult for a small hospital in a rural geography to employ physicians that are comfortable with such a vast range of diseases and illness…So then you start to move all of that inpatient volume out… even if you are building a large outpatient service, ultimately patients are going to go where their physicians are. So, if you don't have any specialties in your area, then you just become kind of an urgent care. So, I feel like adding the telemedicine, and that specialty service to our hospital is actually why we're growing. And it's kind of contradictory to the thought process with rural hospitals right now, but I think we're proof that that needs to change. We've tripled in size in four years from a gross revenue perspective related to these [telehealth] programs. And I really feel like the telemedicine is what has allowed us to build it, especially from the inpatient side.	x	
I don't think any of us expected the virtual ICU to have the impact [on volume] on the inpatient side that it had for us. So I think that watching the financials change from that volume, I just didn't anticipate that we'd ever go from two or three [patients] per day to full [occupancy]. And we were shooting for double digits. We were shooting for 10 to 12. And so, yeah, but I had to actually do it to be convinced.	x	
Drive ancillary services		
[Tele]Behavioral health does makes some profit but primary care, not as much. It does help get labs and other services demanded. Our primary care type services, that's a little bit more challenging. But we get through referrals back to the hospital for labs, and imaging and additional, say, surgeries, and that's what primary care clinics really drive. Primary care clinics on their own, if you just look only at that, really are not money makers, it's about... it's an entry point for your patients to support the rest of the hospital.		x
Of course initially, [the direct financial benefit of telehealth] would be the grant funding to help us provide that service, but then we're looking at [whether] they [patients] receive other services. So if they have the one visit, that visit may result in…other ancillary services. And we want to be their provider of choice. In this community, we're the only hospital, obviously, being a critical access hospital… But also it's just by out that patient relationship with their providers. So they've come in, they've had a service and then they need some type of follow up care or they're referred to another specialty. Well, we want them to stay within our system. So rather than them receiving that same visits from another provider, we're keeping it within.		x
The one thing telehealth could do is if folks [patients] stay in the [hospital] community, there should be some downstream revenue from that. For example, with tele cardiology, you'll have echos [echocardiograms], you'll have other labs, that kind of thing.		x
We're not going to rely on the telemedicine to bring in a lot of revenue. It's a great community service. There are some ancillary benefits…some of the providers or labs or some different items that they can do here, which is great.		x
Reduce the risk of permanently losing patients to competitors		
These are patients that are in our community, and they do have a primary care physician, but not an intensivist... and it is reality that sometimes when you transfer those patients out of your community, you don't just lose them for that visit, you potentially can lose them permanently. Because now all of a sudden, they're establishing a relationship with a different hospital provider and potentially [other] new physician relationships. And so that becomes a very challenging situation for us, because we're not growing [with respect to] demographics. So, each patient we lose, there's not somebody that's ready to fill that spot in there.	x	

Quote	Setting to which the Quote Applies	
	Inpatient and/or ED	Outpatient
If [we] don't provide telehealth for specialty and you refer out, you may never get them back		x
And I think as the program grows more and more, there will be more ancillary revenue created by telemedicine, but it's a lot of those specialty services that, hey, it's amazing that they can access it here and hey, maybe those people will actually come here more often that…and will utilize the services and not leave		x
Reduce labor and provider recruiting costs		
Yeah. It's positive, because again, I don't think we'll be able to recruit and retain psychiatry here. So, I think it's a very viable method for us.	x	
This program [tele-hospitalist] has big financial benefit because it is cheaper than in-person staff. And honestly, with our model, we get into some wonky things where we did lose some reimbursement along the way, but it made up for itself with again, not having someone here [in-person]... It also helps with finding people; doctors are hard to find these days.	x	
The other area that where this whole idea of telehealth really made an impact… [was in] the ability for us to [recruit and] maintain a good physician workforce… We began to see that physicians…coming out of training [were] less and less inclined to do everything…[So, now] at 6:00 P.M. the [telehealth internal medicine physicians], via the E-Hospitalist [program], take it over the night. So again, these [telehealth services] are things that I'm not being paid to do. It's a fairly significant expense. I'm being paid for the inpatient care, but I don't get extra because I brought on eDocs, right? It just doesn't work that way. So it was another expense brought on to the hospital [to start this program]. But it really helped us with our physician recruiting.	x	
Help sustain practices during the pandemic		
The only thing I will say is the telehealth visits during COVID while we were shut down did help sustain our practices, our physician practices, but that would be about the only financial impact.		x
Telehealth is a positive because it allowed us to keep up volume- I think it's a positive, ultimately. It gives us another way to see patients that we didn't really have reliably before.		x

Note: ED = emergency department; eICU = electronic intensive care unit