

ASCO Interim Position Statement**Telemedicine in Cancer Care****Approved by the Board of Directors July 23, 2020****Overview**

Technology impacts the delivery of health care in countless ways. It supports innovation in care delivery by delivering advancements in tools, materials, and equipment used in cancer care. Technology also has become a major vehicle for delivering health information and education to patients and their families. For clinicians, it has enabled new forms of consultation, evaluation, and treatment. Telemedicine was broadly defined by the Institute of Medicine in 1996 as “the use of electronic information and communications technologies to provide and support health care when distance separates participants.”¹ An article in the *NEJM Catalyst* defined **telemedicine** as a practice which “encompasses the use of technologies and telecommunication systems to administer healthcare to patients who are geographically separated from providers.”²

Although the terms telemedicine and telehealth often are used interchangeably, this interim position statement will use the term telemedicine, as defined in the *NEJM*. We believe this definition captures the focus on technology’s role in improving the immediate administration/management of cancer care to patients and survivors when they are remote from their care team. **Throughout this interim position statement, we will use the term telemedicine except when describing specific telemedicine services furnished under the Social Security Act or TRICARE, where we will use the term telehealth with its specific meaning in order to remain consistent with the relevant statute.**

The American Society of Clinical Oncology (ASCO) offers an interim statement to signal its positions on immediate and significant policy issues that have emerged during the COVID-19 pandemic. We will continue to explore the impact of telemedicine in oncology, with ongoing research and deeper analysis of its role in cancer care, including but not limited to emerging models of care, genetic counseling, clinical trials, mobile health devices, and telepsychiatry. In the meantime, we offer the following recommendations:

- **ASCO supports the flexibility CMS has implemented to ensure telemedicine is available to more practitioners and patients during the COVID-19 public health emergency (PHE), and we urge CMS to extend those expanded telemedicine policies after the expiration of the PHE.**
- **State and federal policymakers should make permanent coverage and reimbursement for audio-visual and when appropriate, audio-only services and continue to expand coverage for all modes of delivery of telemedicine.**
- **Policymakers should ensure broad coverage and adequate reimbursement for all telemedicine services by all plans and payers through service parity and payment parity reforms.**

- **Federal and state governments should work to promote health equity through encouraging the use of telemedicine in all care settings, including but not limited to rural and safety net providers.**
- **Patient education efforts by all providers and health care stakeholders should include information on utilizing telemedicine.**
- **Federal and state governments should promote universal access to high-speed broadband through expanding digital infrastructure.**
- **Medical liability policies should provide comprehensive coverage for telehealth, and providers should ensure they are covered across all states in which they practice.**
- **Neither public nor commercial payers should apply burdensome utilization management policies to telemedicine.**

Background Regarding Telemedicine and Cancer Care

Telemedicine has been identified both as a novel approach to care delivery as well as an additional treatment strategy in a physician's armamentarium. A major benefit has been the ability of telemedicine to provide access to care irrespective of geographic location and health care resources (facilities and practitioners). However, despite its promise, utilization rates of telemedicine have not met expectations and use of telemedicine has not been well understood.³

Telemedicine can increase access to care for patients with cancer while reducing treatment burden and disruption to patient lives.⁴ Providers who use telemedicine have reported that its benefits include decreased travel time for patients, immediate access to care, early detection of health issues, increased patient autonomy, reduced caregiver burden, and increased patient satisfaction with health care.⁵ Many aspects of telemedicine have demonstrated efficiency comparable to in-person care.⁶ Virtual visits can provide effective follow-up and enhanced convenience compared with traditional office visits. Telemedicine interventions in chronic disease management have been shown to lead to a decline in hospital admissions/re-admissions, length of hospital stays, and emergency department visits as well as reductions in mortality.⁷ Even prior to the COVID-19 pandemic, telemedicine was gaining traction in oncology, with providers citing improved documentation, better continuity of care, enhanced communication between provider and patient, greater treatment compliance, and potential availability of data for scientific evaluation.⁸ Cancer patients have reported an overall level of high satisfaction with telemedicine in radiation oncology and in survivorship care planning.^{9,10}

Critics of telemedicine have cited issues relating to uncertainty regarding medical liability, data privacy, and concerns about security of data transfer and storage.¹¹ Furthermore, many health systems and providers did not have a robust telemedicine infrastructure prior to the start of the COVID-19 pandemic. As health care providers now rely on telemedicine as part of their response to the crisis, they face a decision as to whether they should increase investment in this technology beyond this PHE.

Prior to the pandemic, reimbursement for telemedicine visits were lower than for physician office visits. However, there are concerns that increased availability of telemedicine visits could increase healthcare spending and utilization. Even if less costly, telemedicine visits may be more likely to result in additional follow-up appointments, testing, or prescriptions, and could increase overall cost of an episode of care. Increased availability of telemedicine could also prompt patients to seek care when they would not otherwise do so. This could raise costs by

increasing the total number of patient visits instead of lowering cost by replacing more expensive visits to a physician's office or emergency department.¹²

The evidence base for the acceptance and utility of telemedicine in cancer care is limited and continues to evolve. A number of COVID-19 registries have begun collecting data on clinical care, including an ASCO registry.¹³ It may well be found that patient and provider perspectives on telemedicine have changed dramatically due to the pandemic, but it will take time for research to be conducted, evaluated by peers, and ultimately published. Additional data will lead to a better understanding about how telemedicine affects access, quality and cost effectiveness of cancer care.

Legal, Regulatory and Structural Challenges

Although the identified challenges existed prior to the COVID-19 pandemic, practices have been challenged to adapt to the care delivery challenges imposed by the pandemic, necessitating widespread and increased adoption of telemedicine. With telemedicine playing a growing role in flattening the curve of infection and mortality from the COVID-19, its increased utilization is generating larger quantities of data on the interactions between doctors and their patients. As the U.S. emerges from the initial impact of the pandemic, the identified challenges and burdens associated with telemedicine adoption must continue to be addressed to ensure both patients and providers face minimal risk in the use of these tools.

Health Information and Privacy

During the PHE, the Department of Health and Human Services (HHS) announced that it was exercising enforcement discretion and waiving potential penalties for HIPAA violations against providers that were serving patients in good faith, paving the way for providers to use widely accessible audio-visual technologies, such as FaceTime or Skype. Privacy and data security issues and concerns related to health care information technology (HIT) have been key barriers to adoption of telemedicine and impact the confidence of patients and practitioners using these tools. As the use of telemedicine increases, it will necessarily generate large quantities of personal health information and data, highlighting the need for data protection. Prior focus on the adoption and meaningful use of EHRs has also constrained resources and prioritized EHR implementation over telemedicine.¹⁴ Although some electronic health record platforms allow for the use of integrated telemedicine platforms, initiation and implementation of this technology is often cost-prohibitive, especially for smaller practices. Technology interoperability for traditional- and non-traditional medical devices will overcome another significant barrier and streamline further deployment of digital health technologies in telemedicine.¹⁵ For many patients and providers, education on optimizing use of these platforms will also be necessary. Finally, clear direction on the application of HIPAA requirements and necessary liability protections for providers is needed.

Health Equity

Despite general availability and widespread use of internet services, many individuals in the U.S. lack access or are not proficient in the use of information technology. Known as the "digital divide," this gap has led to inequities in the effective use of telemedicine for certain patients.¹⁶ Some patients may be uncomfortable with the technology and may not understand HIT security, privacy, and information sharing. Individual differences in digital literacy (competency and

technical skills needed to operate digital devices and understand their functionality) can widen health disparities.^{17,18,19} Approximately half of American adults exhibit low health literacy and consequently struggle to find and use health information.²⁰ These inequities are especially present among individuals living in rural communities, individuals with lower socio-economic status and older adults, who typically experience the majority of cancer diagnoses and deaths and make up the majority of cancer survivors and the fastest growing segment of the US population.^{21,22,23} Addressing these disparities will be critical to realizing the promise of telemedicine for patients with cancer.

Licensure

Relaxed policies during the PHE has generated new energy around the potential for telemedicine to overcome geographic barriers to care. This includes the notion of dissolving state borders for practice, allowing patients and physicians to communicate across greater distances. However, inconsistent state licensing laws have hindered some access and utilization of telemedicine, including during the PHE. Differing licensing requirements across states has been identified as one of top issues preventing more widespread use of telemedicine services. State policies require medical professionals to obtain licensure for each state where they wish to practice, an administrative burden that has constrained physicians' desire to expand their digital-geographic footprint across state borders. To address this issue, interstate agreements, notably the Interstate Medical Licensure Compact (IMLC), permit physicians to practice across state lines with one medical license in a participating state, provided they comply with all state laws and related scope of practice in each state they practice. The IMLC currently includes 29 states, the District of Columbia and the territory of Guam. While not every state participates in a licensure compact, these programs have been effective in reducing the burden placed on providers to independently become licensed in multiple states.²⁴

ASCO encourages states to explore the IMLC as an opportunity to streamline the process for physicians to apply for licensure in other member states, recognizing that health care practice remains subject to state licensure laws—and state willingness to lift borders. One proposal worth further exploration is for the federal government to permit telemedicine practice across state lines while preserving the authority of state medical boards to grant licenses.²⁵

During the public health emergency, telemedicine delivered through cross-state licensure has demonstrated the ability to address patient access in the following ways:

- Patients in rural areas without a local specialist have utilized telemedicine to access providers in contiguous states, while limiting inter-state travel.
- Patients who have temporarily or permanently relocated out-of-state have been able to maintain a relationship with their preferred provider through telemedicine follow-ups.

Continued cross-state licensure after the public health emergency raises questions of appropriate state-based safeguards and unintended consolidation of healthcare providers. Respective state governments should strike a balance between expanding telemedicine access in underserved areas and populations while maintaining healthy competition among local and community practices. Larger health systems with robust telemedicine infrastructure could undermine smaller practices that may possess little to no digital infrastructure. One study found, even after controlling for specialty differences, that physicians in larger practices and ones that were not physician owned were more likely to report that their practices used telemedicine.²⁶ Out-of-state health care systems should be sensitive to longer term cooperation with local and

community providers to expand telemedicine access to underserved areas in need while avoiding imperfect market conditions. More research is needed observing the impact of cross-state licensure on smaller practices which ASCO will explore in future analyses. Above all, the goal should be expanding access to care for patients.

Federal and State Telemedicine Policies

The federal government is responsible for several areas of telemedicine policy, including nationwide privacy laws through HIPAA, federal prescribing laws for controlled substances through the Drug Enforcement Administration, and grant funding for telehealth initiatives. The federal government also runs large, public health insurance programs including Medicare, the Veterans Health Administration, and TRICARE for military service members and their families. State governments regulate the private insurance market, and in some cases, share the responsibility with the federal government for health-insurance programs such as Medicaid. Over three-quarters of Americans obtain health insurance regulated at the state level through Medicaid and private insurance.²⁷ This variation and fragmentation in the U.S. health care system has presented challenges to adoption of telemedicine. In response to the PHE, federal and state governments have stepped in to enable its broader application.

As noted in the introduction, where describing policies and services established under the Social Security Act or TRICARE we will use the term “telehealth” for consistency with the relevant statute.

Medicare Fee for Service

Prior to the PHE, Medicare could pay for telehealth services only when the patient receiving the service was in a designated rural area and when they left their home to go to a clinic, hospital, or certain other types of medical facilities for the service, known as the “originating site.” In response to the PHE, the Centers for Medicare and Medicaid Services (CMS) relaxed originating site requirements on a temporary and emergency basis under the 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act, which was signed into law on March 6, 2020. Under its waiver authority, Medicare can now pay for office, hospital, and other visits furnished via telehealth across the country including in the patient’s home. Additionally, the Office of Inspector General (OIG) at HHS provided flexibility for health care providers to reduce or waive cost-sharing for telehealth visits paid by federal health care programs.

The new waiver authority allows telehealth visits to be delivered via smartphone with real-time audio/video interactive capabilities in lieu of other equipment, as the HHS Office for Civil Rights will exercise enforcement discretion and waive HIPAA penalties against healthcare providers that serve patients in good faith. The waiver authority also removes the requirement that providers of telehealth services have treated the beneficiary in the last three years. A separate provision in the Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed into law on March 27, 2020, allows federally qualified health centers and rural health clinics to serve as “distant site” providers and provide telehealth services to Medicare beneficiaries during the COVID-19 emergency period.

CMS has also expanded coverage and increased payment for the types of services that can be provided via audio-only telephones in its federal health programs, allowing providers to

“evaluate beneficiaries who have audio phones only.” CMS also temporarily waived the Medicare requirement that providers be licensed in the state they are delivering telemedicine services, if a list of conditions is met. This change, however, does not exempt providers from state licensure requirements. Medicare also temporarily expanded the types of providers who may provide telehealth services. It is important to note that expansion of telehealth services under Medicare during the PHE is not limited to COVID-19 related services; telehealth services are available to new and existing patients regardless of diagnosis and can be used in lieu of regular office visits.

Medicare Advantage

In April 2019, CMS released a final rule outlining the requirements for Medicare Advantage (MA) plans to offer telehealth services as supplemental benefits. Starting in 2020, MA plans can offer additional telehealth benefits outside the current restrictions in FFS Medicare.²⁸ CMS also made significant changes to the MA program and telehealth benefits, including exemptions to originating site requirements and geographic restrictions, requiring covered telehealth services to be provided by an in-network physician, requiring providers to be licensed in the state in which the beneficiary is located, and prohibiting MA plans to use telehealth services to meet in-person provider coverage requirements. In order to evaluate telehealth services in MA plans, CMS requires data be made available to the agency upon request related to coverage, payment, and utilization.²⁹

Medicare Advantage plans have been able to offer additional telehealth benefits not covered by traditional Medicare and have flexibility to waive coverage requirements. In response to the PHE, CMS has advised plans that they may waive or reduce cost sharing for telehealth services, as long as plans do this uniformly for all similarly situated enrollees. The decision to act on this guidance, however, is voluntary and plans will vary in their responses to this new flexibility.

Medicaid

Prior to the PHE, all states and the District of Columbia provided some coverage of telehealth in Medicaid Fee-For-Service, but the definition and scope of coverage varied from state-to-state.³⁰ While the most commonly covered modality of telehealth was live video, a few states permitted the use of “audio-only” telephone care to qualify as a telehealth service. In some states, Medicaid reimbursement is also restricted to authorized “originating sites.”³¹

In response to the PHE, CMS issued guidance reiterating states can use existing flexibility under Medicaid regulations to change provider coverage for telehealth services.³² All states have responded to the PHE by issuing emergency policies relaxing licensing laws to make telehealth services more widely available in their Medicaid FFS programs and/or through Medicaid managed care plans.³³ Most states have allowed Medicaid beneficiaries to access services from their home and most are allowing plans to reimburse for some telephone evaluations. Medicaid programs in 46 states and DC have issued guidance to expand coverage or access to telehealth during the PHE, while 38 states and DC have granted payment parity for at least some telehealth services. Despite the changes to expand Medicaid coverage of telehealth services, the changes are not uniform across states and barriers to implement and access telehealth more broadly will likely remain once the PHE is lifted. ASCO has provided resources on Medicaid telemedicine policies by state.³⁴

Commercial Payers

Coverage of telemedicine services by commercial plans varies tremendously, with few plans covering a significant number of services. Based on an analysis of commercial plans in 2017, most commercial plans that offered telemedicine services did so because of pressure from employers and competition from other insurers rather than to lower costs or improve care.³⁵ Most telemedicine services utilized by privately insured beneficiaries are primary care and mental health services. There is some evidence that increasing the utilization of telemedicine services may not decrease overall spending as the perceived convenience of telemedicine may tap into an unmet demand for higher utilization of health care services.³⁶ While commercial payers have more flexibility in what services they offer, providers must still comply with licensing requirements and in some states, distant site restrictions still exist.

During the public health emergency, commercial plans' policies related to telemedicine coverage and payment are evolving. As of May 2020, 41 states and DC had laws governing reimbursement for telemedicine services in fully insured private plans. "Service parity," when a telemedicine service must be covered by state-regulated private plans if it is shown to be medically necessary and meets the same standards of care as in-person services, is available in approximately half of states. However, "payment parity," when telemedicine services are reimbursed at the same rate as equivalent in-person services, is only available in ten (10) states. The remaining states do not have payment parity laws, meaning they typically reimburse telemedicine at lower rates than equivalent in-person care. In response to the PHE, at least 16 states have enacted both service and payment parity requirements for fully insured private plans.³⁷

Although fully insured health plans must comply with federal and state requirements, self-insured health plans are regulated by the federal government through the Department of Labor and are not required to cover telemedicine. Analysis provided by the Kaiser Family Foundation shows that the majority of large employer plans, including those that are self-insured, cover some telemedicine services.³⁸

Military and Veteran Health System

Since 1992, the Department of Defense (DOD) has been implementing telemedicine programs to improve patient care. Although the DOD has been implementing programs with the goal of increasing the use of telehealth services, there has been recent concern that telehealth programs may be underutilized. In 2018, the DOD announced a new initiative which greatly expanded telehealth offerings through their integrated healthcare system, known collectively as the Military Health System. The Department of Veteran Affairs (VA) has one of the largest telehealth programs in the country. In 2018, the VA provided 2.29 million telehealth episodes of care to 782,000 veteran patients collectively, using the following three VA telehealth modalities: home telehealth, store-and-forward telehealth, and clinical video telehealth.

In contrast to other federal programs, the VA's requirements for telehealth services are significantly more flexible. The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 addressed barriers many veterans face in accessing telehealth services. As part of the MISSION Act, VA providers do not have to comply with different state licensing requirements to provide telehealth services, nor do veterans have to comply with any originating site requirements.

In May 2020, the Assistant Secretary of Defense for Health Affairs issued an interim final rule to provide an exception to the prohibition on telephone, audio-only telehealth services; to authorize reimbursement for interstate or international practice by TRICARE authorized providers when such authority is consistent with governing state, federal, or host nation licensing requirements; and to eliminate copayments and cost-shares for telehealth services. The changes in the rule will be effective for the duration of the PHE.³⁹

Provider-led/Health Care System Efforts

Prior to the PHE more than 50 U.S. health systems already had telemedicine programs in place. Other providers who may lack robust programs have the opportunity to outsource telemedicine services through various private companies.⁴⁰ Multiple modalities of telemedicine in oncology have been implemented, including teleoncology, telegenetics, teletrials, telepsychiatry, telepathology, teleradiology, and tele-education through virtual tumor boards. Many health care organizations have supported and endorsed the use of telemedicine as a means to improve affordable access to high-quality care. As noted in the opening section of this paper, these are all areas ASCO will explore in future analyses but lie outside of the scope of this statement.

Policy Recommendations

As the realities of the pandemic continue there remains uncertainty with regard to future federal and state telemedicine policy. Indeed, most of the regulatory flexibilities and telemedicine policies implemented under the PHE are currently structured as temporary. As the world's leading professional organization for physicians and oncology professionals that care for people with cancer, ASCO offers the following recommendations:

- **ASCO supports the flexibility CMS has implemented to ensure telemedicine is available to more practitioners and patients during the COVID-19 public health emergency (PHE), and we urge CMS to extend those expanded telemedicine policies after the expiration of the PHE.** While many of the requirements that govern Medicare telehealth services are statutory in nature and could only be revised through Congressional action, CMS does have authority to make certain permanent changes to telehealth reimbursement through proposed rulemaking. This could include promulgating alternative definitions of “interactive telecommunications” to allow for exceptions to HIPAA requirements on remote communications technologies and modifying prior interpretations of the statutory payment requirements for distant site providers.
- **State and federal policymakers should make permanent coverage and reimbursement for audio-visual and when appropriate, audio-only services and continue to expand coverage for all modes of delivery of telemedicine.** The lack of broadband and/or access to technology for both patients and physicians will not be limited to the time during the PHE; therefore, we urge that all respective agencies extend these regulatory changes beyond the PHE. Patient populations who lack computer skills or broadband access could potentially benefit especially from audio-only services.
- **Policymakers should ensure broad coverage and adequate reimbursement for all telemedicine services by all plans and payers through service parity and payment parity reforms.** Service parity and payment parity of telemedicine compared to in-office

visits would incentivize telemedicine practitioners to adopt and provide telemedicine as a model of care. Further, we should ensure patients can access telemedicine services from their home as the “originating site” rather than requiring access through a health care facility. These principles should apply throughout the cancer care continuum, from prevention to survivorship.

- **Federal and state governments should work to promote health equity through encouraging the use of telemedicine in all care settings, including but not limited to rural and safety net providers.** ASCO’s Policy Statement on Cancer Disparities and Health Equity commits ASCO to “support and promote policies, systems, environments, and practices to address persistent barriers to equitable receipt of high-quality cancer care across the care continuum.”⁴¹ Medicaid and other safety net providers should have access to the same regulatory and financial support as others, in order to prevent the unintentional exacerbation of health inequities.
- **Patient education efforts by all providers and other health care stakeholders should include information on utilizing telemedicine.** ASCO acknowledges that a digital divide pervades the health care system that is exacerbated by complex barriers including but not limited to socio-economic factors, geographic location, age, language, and a lack of health and digital literacy. Although an increasing number of resources are being developed for telemedicine under the PHE, there are few resources addressing the inequity of technology, service, utilization, and literacy required for patients confidently utilize telemedicine.
- **Federal and state governments should promote universal access to high-speed broadband through expanding digital infrastructure.** Some patients, particularly those in rural areas, may feel burdened by the physical distance it takes to meet with a provider and may welcome the use of telehealth from their home. However, reliable broadband connections are still needed in many areas of the U.S. in order to successfully make telemedicine fully realized. ASCO supports initiatives, including current work by the Federal Communications Commission, to expand broadband access across the U.S.⁴²
- **Medical liability policies should provide comprehensive coverage for telehealth, and providers should ensure they are covered across all states in which they practice.** Medical liability providers should include telemedicine and data security related risks into policy. According to the Center for Connected Health Policy, some but not all malpractice insurance will cover telemedicine services. Providers should ascertain that they are adequately covered as malpractice insurance carriers may not extend their coverage to other states.⁴³
- **Neither public nor commercial payers should apply burdensome utilization management policies to telemedicine.** Any barriers to care through telemedicine, including prior authorization or other treatment delays should be eliminated to ensure timely access for patients. ASCO’s Policy Statement on Utilization Management provides a series of recommendations for how these policies can be structured in order to promote rather than hinder patient access to cancer care; we recommend these same principles be applied to telemedicine now and in the future.⁴⁴

CONCLUSION

The COVID-19 pandemic has changed life in countless ways for all people, patients and health care providers alike. We are in the middle of a rapid expansion of telemedicine and cancer care delivery is being forced to adapt at light speed. While some systems were more ready than others, ASCO sees this health care delivery tool as something that all providers will continue to use past the resolution of this PHE.

Research is needed to determine the efficacy of emerging telemedicine models in clinical care. The health care system can learn from its experience during the COVID-19 pandemic to greater leverage the use of telemedicine and transform health care delivery for the 21st century. Further research on safety, efficacy, treatment adherence, clinical care, and cost effectiveness will be needed to transform and enable a new health care environment. The National Quality Forum has developed a Telehealth Framework to organize measures and inform target areas for measure development. Having robust measures to assess the impact on patient outcomes and care processes with special attention to the financial impact will be necessary.⁴⁵ ASCO is committed to working with stakeholders to promote increased research on telemedicine.

In the coming months and years, we will learn a great deal about how the expanded use of telemedicine has impacted care, in both negative and positive ways. ASCO will be following these developments very closely and will continue to analyze how new lessons learned can be applied to policy development with a goal of improving patient access to quality cancer care.

Questions? Contact policy@asco.org

¹ Telemedicine: A Guide to Assessing Telecommunications for Health Care Marilyn J. Field, Editor; Committee on Evaluating Clinical Applications of Telemedicine, Institute of Medicine

² <https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0268>

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