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Title: *Practice change amidst the COVID-19 pandemic: harnessing the momentum for expanding telehealth in transplant*

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29 **Corresponding author email:** waitss@med.umich.edu

30 **Abbreviations:** COVID-19, coronavirus disease 2019

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37 *To the Editor:*

38 On March 17, 2020, the Centers for Medicare & Medicaid Services invoked sweeping
39 expansions to the nation's telehealth capacity, authorizing providers to bill for telehealth visits
40 with Medicare beneficiaries at cost parity to in-person visits, eliminating deductibles and
41 waiving penalties for non-HIPAA compliant communication platforms.¹ While issued on a
42 temporary and emergency basis, this policy provides an opportunity for the transplant
43 community to explore permanent telehealth infrastructure.

44 Before the COVID-19 pandemic, our center's long-term goal was to increase utilization of
45 telehealth to 20% of patient visits over 5 years. COVID-19 has forced us to adapt rapidly. In
46 2019 we performed 5 telehealth visits per month – in March 2020 alone we performed 184,
47 and have had over 475 telehealth visits in April. We moved the majority of our low-acuity
48 patient visits to video or phone and are working on transitioning required transplant education
49 classes to an interactive, virtual format. During the rapid expansion we have been stressed by
50 network traffic, availability of compatible technology, and billing concerns, yet we are
51 overcoming these barriers and have made lasting progress through a team-based approach to
52 patient and provider education and technical support.

53

54 Long-term transplant telehealth plans at our institution were motivated by evidence that
55 transplant telehealth programs may reduce costs, shorten time to initial evaluation and waitlist

56 placement, improve quality of life, and decrease readmissions following transplant.^{2,3} While
57 these long-term goals still exist, the rapid roll-out has demonstrated additional benefits. Our
58 video care teams are able to frequently check-in on patients with acute medical and surgical
59 issues and reinforce education on challenges like polypharmacy or low health literacy.
60 Anecdotally, patients have been enthusiastic participants and have experienced no known
61 adverse events. We are learning and honing best practices each day but will need to be rigorous
62 in our interpretation of data and mindful of barriers.

63
64 As with any change in care delivery, telehealth services must not create or further disparities
65 for the most vulnerable populations. Utilization of telehealth requires at a minimum access to a
66 smart phone and/or internet. Demographic factors including education, age, language, and
67 culture may all impact telehealth accessibility. At the same time, some of the greatest
68 disparities in the transplantation process occur with waitlist access. Distance from a transplant
69 center has been associated with increased mortality.⁴ If implemented carefully, telehealth may
70 increase access to our rural patients and reduce travel-related time and financial costs. There is
71 also evidence that implementing telehealth measures focused on patients of lower
72 socioeconomic status, creating tools accessible across broad ranges of literacy, and aiming for
73 universal access to technology may allow telehealth expansion to be a solution rather than a
74 barrier to access.⁵

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76 As we move past COVID-19, our department is committed to advancing our infrastructure for
77 telemedicine-based transplantation care. A crisis is an impetus for transformative change, and
78 the current pandemic should be seen as an opportunity to move telehealth forward. We can
79 use this sudden change as a stimulus to discard outdated policies and innovate for the good of
80 our patients.

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