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Stone-Age Policies Stifle Modern Solutions

Health care leaders must advocate for regulatory and reimbursement changes to unlock the potential of innovative technology and care team approaches to Parkinson's and other suitable conditions.

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April 3, 2019

This article appeared in NEJM Catalyst prior to the launch of the NEJM Catalyst Innovations in Care Delivery journal. [Learn more.](#)

America's health care providers routinely practice *Star Wars* medicine, but on a *Flintstones* delivery platform, as a current saying goes. The U.S. health system needs to advance, at least, to *The Jetsons* futuristic vision as depicted in the 1960s, when [one of the first U.S. telemedicine programs](#) actually came into existence in Boston. More than 50 years later, it's only now that telemedicine and other forms of virtual care are becoming more widespread. Although the evidence suggests that patients could benefit if it spread even faster, we still need to make light-years-long leaps over multiple barriers to get there.

Although the evidence suggests that patients could benefit if [virtual care] spread even faster, we still need to make light-years-long leaps over multiple barriers to get there. To understand the possibilities, imagine all the people who might have trouble getting to a doctor's office for care. Patients with Parkinson's surely would be near the top of the

list. They frequently have issues with gait and mobility; they may be unable to drive. Now, situate these patients in rural areas of the country, where they may need to travel long distances to the nearest medical facility. If patients have caregivers, the burden will probably fall on them. Small wonder that more than 40% of Medicare beneficiaries who would almost certainly benefit from visits to neurological specialists don't get them.

The Proven Solutions

There is an effective alternative: virtual visits with a specialist. A recent large national clinical trial studied the feasibility and efficacy of having patients consult with a neurologist four times a year via online video, from a computer, tablet, or smartphone in their homes, in addition to their usual neurology care. Compared to a group receiving usual in-person care only, the virtual visit group saw no difference, positive or negative, in health outcomes — in effect, disproving any notion that the virtual care was inferior.

What's more, the patients who participated in the virtual visits actually *preferred* them to their in-patient visits — no doubt partly because they were collectively spared an estimated 35,000 miles of travel by "seeing" their doctors from home. "The [online] visits provide most patients the care that they prefer, the convenience that they need, and the comfort that they value," the study's authors wrote.

These results aren't unique. A growing number of studies — many of them funded by the Patient-Centered Outcomes Research Institute (PCORI) — demonstrate the usefulness of telehealth and other virtual care in expanding access to primary and specialty care, addressing disparities, and promoting patients' self-management of chronic conditions. The patients who benefit include those with severe plaque psoriasis who need to consult with dermatologists, as well as those with serious mental illness such as schizophrenia who can benefit from smartphone-based cognitive interventions. Yet despite the

growing evidence of the benefits of virtual care in terms of <u>access for patients</u> — and the realization that, at minimum, virtual care may be no worse or no better than in-person care — the U.S. health care system as a whole is still taking only baby steps toward providing it.

The Persistent Obstacles

The <u>Network for Excellence in Health Innovation</u> (NEHI), the nonprofit organization that I led as CEO until February 2019, recently published *Health Care Without Walls*, a book of which I was the editor and lead author. It resulted from a year-long analysis examining the movement of more distributed care outside of conventional institutional settings. We examined the enormous opportunities that can enable this movement and expand access, particularly for high-need <u>patients in underserved settings</u>. Granted, because much of health care involves the direct "laying on of hands," clearly not all care can or should move in this direction. But for the portion that involves mainly exchanges of information, why should it not move the way most of our informational exchanges occur nowadays — virtually — when doing so would be appropriate and achievable for all concerned?

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The answer, we found, is *not* that there is a shortage of available technology. Although much more will come to market in the future, key technologies to enable virtual care, such as telehealth, already exist and are broadly available. The challenge is that there are innumerable barriers in public policy and in the broad health care, education, regulatory, and financing systems that will require a major push to overcome. Consider:

- Most payment models used by public and private payers have not, until recently, supported provision of distributed care, and only now is the situation changing. The Centers for Medicare and Medicaid Services (CMS), for example, only recently announced that, in 2019, it will pay clinicians under the Medicare Physician Fee Schedule for virtual check-in visits, for evaluating photos submitted by patients, and for delivering some preventive services by telehealth. CMS has also just recently proposed loosening previous telehealth restrictions on Medicare Advantage plans, and in 2020, will grant the plans more flexibility to cover enrollees' telehealth visits with providers from their homes, whether the enrollees live in rural or in urban areas. These are welcome steps, but still a long way from creating the incentives to move care to more distributed settings that would benefit many patients.

- Well-intentioned regulations designed to ensure high quality and safety in health care can pose inadvertent barriers to innovations in distributed care. An example is Hospital at Home programs that are neither conventional inpatient nor home care, and thus can fall into a regulatory no man's land from the standpoint of state licensure programs. In New York, Mount Sinai medical center's Hospital-at-Home program was forced into a workaround because nurses licensed to provide hospital care couldn't be sent into patients' homes. And increasingly, other regulations far afield from health care are likely to impinge on virtual care delivery, such as the Federal Communications Commission's recent move to end net neutrality, which could aggravate existing inequities in Internet access and affordability nationwide.

- Today's health care workforce is not necessarily educated, trained, or well-equipped to deliver more virtual and technology-enabled care. Health professions' education trails changes in clinical practice, with relatively few programs training individuals to work in teams to provide virtual care. What's more, amid the urgency to reduce health care costs is the critical need to make more efficient use of expensive labor. Yet almost every health care workforce projection we reviewed made no allowance

for any greater productivity or efficiency from use of virtual care. With state licensure and other regulatory provisions that often impede both intrastate and interstate provision of telehealth, and scope-of-practice restrictions that bar nurse practitioners and others from working at the top of their licenses, it is as if a kind of conspiracy exists to keep the health care workforce functioning in a bygone era.

The NEHI Recommendations

The NEHI report made multiple recommendations for overcoming these barriers at the local, state, and national level. Perhaps the foremost challenge, not surprisingly, will be developing payment models that support care innovation and that encourage substitution of virtual care for in-person care when appropriate, without expanding the volume of care inappropriately.

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In the meantime, the gradual spread of virtual care delivery should provide further proof-of-concept, as well as multiple opportunities to refine and improve virtual care models.

For example, the Parkinson's trial referenced above has led in part to Parkinson's Disease Care New York, a largely virtual care network created by the University of Rochester to continue studying and refining the care model. A multidisciplinary team, consisting of neurologists, nurses, and a telemedicine coordinator, aims to provide care at no cost to up to 400 patients. The program aims to recruit more ethnic and racial minorities, patients over the age of 80, and those who are in nursing homes and homebound, to demonstrate its applicability to diverse types of patients. A separate

study, also aimed at relatives and caregivers of people with Parkinson's, will employ an iPhone app to monitor disease symptoms.

Leaving the Stone Age

As laudable as it is to build the evidence base for virtual care, U.S. clinicians will need to do more. They will also have to become advocates for the multiple policy changes that will support a modernized U.S. health care infrastructure. The most obvious of these is eliminating the digital divide that characterizes so much of the United States, because universal access to health care could soon mean having universal access to modern communications technology.

But at a time when even Botswana has a plan for providing universal Internet service, the United States doesn't, and about one-third of U.S. adults lack broadband Internet access at home. Smartphones with access to dependable wireless service could help compensate, but smartphones can be out of reach or difficult to use for many, and wireless coverage can be spotty — and there's no U.S. plan for universal wireless service, either.

As with so much else that is incongruous about U.S. health care, it is hard to imagine a wealthy country in which care is so compromised that nearly half of Parkinson's patients can't, or don't, see a neurologist. It's time to harness modern information and communication technologies like telehealth to help right this wrong, and to drag more of our health care system out of the proverbial Stone Age and into the present.

- Susan Dentzer

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