



# Improving Access to Care in Rural and Underserved Communities: State Workforce Strategies

Health

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The shortage of certain provider types and inadequate distribution of the health care workforce overall creates challenges for patients trying to access health care services. Providers are an important component of access to health care services, along with things like having insurance coverage, accessing affordable and appropriate services, and having the ability to reach a location where services are provided.<sup>5</sup>

Having limited access to health care services affects physical, mental and social health status, quality of life and life expectancy. When access to care is not available, it can lead to unmet health needs, a lack of preventive services and preventable, costly hospitalizations.<sup>6</sup>

Rural areas disproportionately experience diminished access to health care, including provider shortages. In fact, as of July 2017, 59 percent of all primary care HPSAs were located in rural regions.<sup>7</sup> Rural hospital closures also threaten communities' access to emergency care and other health services. At least 81 rural hospitals closed between January 2010 and May 2017 across the country, with many more at risk of closure.<sup>8</sup>

Rural communities also face significant health disparities—including higher rates of chronic disease and indicators of poor overall health—compared to urban communities.<sup>9</sup> For example, rural counties have higher rates of births by teen mothers, diabetes and preventable hospital stays.<sup>10</sup> Rural adults are less likely to practice healthy behaviors, such as not smoking and maintaining a healthy body weight.<sup>11</sup> They are also, on average, older and poorer than their urban counterparts and have a lower life expectancy. Mortality rates in rural areas have decreased at a slower pace, resulting in a widening gap between urban and rural areas, according to the Centers for Disease Control and Prevention.<sup>12</sup>

The high burden of chronic disease in rural and other underserved communities, as well as limited access to needed care, can lead to significant costs to families, health care systems and states. Chronic disease treatment comprises 86 percent of national health care costs, with rural areas disproportionately affected due to their higher rates of many costly chronic conditions.<sup>13</sup> Lack of access to care results in medical care costs, as well as costs from reduced productivity and absenteeism, due to its association with poorer health status and higher burdens of disease and disability.<sup>14,15</sup> Preventable hospital admissions, also more common in rural areas without sufficient access to primary care services, cost an estimated \$32 billion nationally in 2010.<sup>16</sup> In addition, research shows that a higher percentage of rural residents are enrolled in Medicaid compared to urban residents, contributing to high health costs for states.<sup>17</sup>

Improving patients' access to quality health care can help counter these public health challenges. Due to the public health and financial consequences, many states have explored health workforce policy solutions to address access to care challenges and health disparities in rural and underserved areas. This report outlines several strategies that policymakers have pursued to improve access to care, including recruiting and retaining health care providers, considering the role of non-physician providers, and expanding delivery of services via telehealth.

## Provider Recruitment and Retention

State recruitment and retention policies aim to bring health care providers to—or keep them in—underserved areas to maintain and increase access to care. Two common efforts in this area include health career pathway programs and scholarship and loan repayment programs.

### Pathway Programs

Pathway programs aim to engage students, from kindergarten through college-age, and introduce them to health care careers. These pathway or pipeline programs often focus on recruiting students from backgrounds that are historically underrepresented in health care professions, with the goal to promote greater diversity in the health workforce. Students in pathway programs may be more likely to return to practice in their communities, such as rural or other underserved areas.<sup>18</sup>

States such as Virginia, Arkansas and South Dakota, among others, have developed pathway programs. For example, in 2010, the Virginia General Assembly established the Virginia Health Workforce Development Authority (VHWDA), whose purpose is to “facilitate the development of a statewide health profes-

sions pipeline that identifies, educates, recruits and retains a diverse, geographically distributed and culturally competent quality workforce for all Virginians.”<sup>19</sup> The Virginia Department of Health received a \$1.93 million State Health Care Workforce Development Implementation grant from the Health Resources and Services Administration (HRSA) to begin and support the initiative.<sup>20</sup> The VHWD supports several community pathway initiatives, such as the Health Career Explorers Program, a 15-week program in two Virginia high schools.<sup>21</sup>

The Arkansas legislature created the Health Care Student Summer Enrichment Program for Underrepresented Student Populations within the Department of Education. The pathway initiative is an intensive six-week program aimed at providing meaningful experiences in health-related fields and increasing awareness of medical career opportunities for racial and ethnic minority college students. In addition, the University of Arkansas for Medical Sciences’ Center for Diversity Affairs provides several summer enrichment programs for students from underrepresented groups or disadvantaged backgrounds. Program activities may include standardized test preparation, professional shadowing, advising and mentoring.<sup>22</sup> Similarly, South Dakota’s Health Occupations for Today and Tomorrow, operated through the state Office of Rural Health, brings together local universities, regional Area Health Education Centers and other partners. The program provides health career camps and immersion opportunities for youth to learn about health care careers.<sup>23</sup>

## Scholarship and Loan Repayment Programs

States may also consider scholarship and loan repayment programs as a strategy to increase provider recruitment and retention. These programs typically provide students in health professions—such as primary care physicians, dentists, dental hygienists and nurses—with scholarships or loan repayment or forgiveness. In exchange, the students commit to practice in a Medically Underserved Area/Population, Health Professional Shortage Area (HPSA) or rural region for a specified period of time, often at least two years.

The National Health Service Corps (NHSC), a major funder of loan repayment and scholarship programs, provides loans and scholarships to medical and dental students with the goal of bringing primary care providers to underserved areas. In addition, through the State Loan Repayment Program (SLRP), at least 36 states and D.C. receive federal cost-sharing grants from the NHSC to assist in their operation

### Area Health Education Centers

Area Health Education Centers (AHECs), an initiative developed by Congress in 1971 and funded in part by the Health Resources and Services Administration, are centers that introduce students to health professions and connect underserved communities with care. AHEC programs have introduced a combined total of more than 379,000 students to health career opportunities and have provided more than 33,000 students with in-depth health career exposure, information, and academic assistance and opportunities. Currently, more than 235 centers operate in almost every state and the District of Columbia.

For example, the Huli Au Ola AHEC on the Hawaiian island Molokai, provides a Summer Leadership Institute for students. The curriculum includes health career presentations, training on taking vital signs and performing CPR, medical robotics information, and cultural content. Students completing the program receive college credit. Program organizers report that local students recruited into health professions are more likely to return to Molokai—a primary care Health Professional Shortage Area—to practice.

*Sources: National AHEC Organization; Hawaii/Pacific Basin AHEC Office; Rural Health Information Hub, 2011; Health Resources and Services Administration.*

### Effectiveness of Scholarship and Loan Repayment Programs

Emerging evidence demonstrates that scholarship and loan repayment programs are effective in achieving long-term retention of participants in the communities in which they serve. Recent surveys and reports have found that:

- 87 percent of National Health Service Corps (NHSC) participants practiced in underserved areas two years after service completion.
- Six years after NHSC completion, 35 percent of participants were practicing in the same Health Professional Shortage Area (HPSA), and 72 percent of them were practicing in any HPSA.
- The 10-year retention rate for providers practicing in underserved areas was 55 percent in 2012.

Ongoing research aims to determine which elements of programs are the most meaningful for encouraging long-term retention. A 2016 systematic review identified significant associations between financial factors (e.g., incentives) and underserved or rural practice.

*Sources: Health Resources and Services Administration, 2016; Office of the Assistant Secretary for Planning and Evaluation, 2014; NHSC National Advisory Council, 2013; A. Goodfellow, et al., 2016.*

## Workforce Innovation and Opportunity Act

The Workforce Innovation and Opportunity Act (WIOA), a federal law enacted in 2014, aims to expand access to worker training, education and support services, as well as help employers find skilled workers. WIOA authorizes funds for federal grants to states for public employment service programs, which are primarily provided through state and local workforce development systems. States may use WIOA funds to support job training and development for allied health professionals, such as X-ray technicians and pharmacy technicians, who may be in short supply in underserved areas. For more information on WIOA and related state action, visit NCSL's WIOA Bill Tracking Database.

*Source: NCSL, 2015*

## International medical graduates

Using international medical graduates is another way states address health care provider shortages. International medical graduates typically complete their training on J-1 visas, which usually allow holders to remain in the country until they complete their graduate medical education. After completing training, the graduates are required to return to their home country for two years before applying to return to the United States.

Waiver programs allow international medical graduates to stay in the U.S. and practice in a HPSA or medically underserved area for at least three years. Following the service period, these physicians can apply for additional visas or permanent residence. The Conrad 30 Waiver Program, one type of waiver, allows state health departments to request J-1 visa waivers for up to 30 international medical graduates each year.

*Sources: Rural Health Information Hub; U.S. Citizenship and Immigration Services, 2014.*

of state loan repayment programs for primary care providers practicing in HPSAs.<sup>24</sup> Eligibility for the program varies by state, and may include opportunities for a variety of health care providers. Similarly, the minimum service commitment for providers is two years, but states may choose to require longer commitments.<sup>25</sup>

Other federal opportunities include HRSA's Scholarships for Disadvantaged Students program, which awards funds to health professions schools that grant scholarships to students from disadvantaged backgrounds with financial need. HRSA's Grants to States to Support Oral Health Workforce Activities program awards grants for states to develop and implement innovative oral health workforce programs to address the needs of dental HPSAs.

Arizona receives federal funds to help support its National Health Service Corps program. In addition, Arizona has its own state-run loan repayment program. The Arizona legislature established the Primary Care Provider Loan Repayment Program, which repays the educational loans of physicians, dentists, pharmacists, advance practice providers and behavioral health providers who commit to practicing in a HPSA for at least two years. The legislature also created the Rural Private Primary Care Provider Loan Repayment Program for primary care providers with a current or prospective rural primary care practice in a HPSA or Medically Underserved Area/Population. To qualify, participants must agree to provide discounted, sliding-fee scale services to uninsured patients with family incomes below 200 percent of the federal poverty level. In 2015, the state increased service award amounts to providers, added new provider types to the program and removed the four-year service cap.<sup>26</sup>

## PROVIDER RECRUITMENT AND RETENTION POLICY OPTIONS

- Evaluate available resources to recruit students from your state into health care careers, including students from underserved areas or underrepresented racial and ethnic backgrounds. Conduct a needs assessment to identify groups most in need of services, and consider creating or expanding pathway programs for students based on these findings. States may also consider evaluating their recruitment and retention efforts in order to determine which programs are most effective in promoting sufficient access to health care providers.
- Look into whether your state participates in the National Health Service Corps State Loan Repayment Program and other health care provider loan repayment programs. Consider options for participating in the NHSC or creating a state-sponsored loan repayment or scholarship program, based on state needs and current efforts. Determine existing gaps in loan repayment and scholarship opportunities, provider types and geographic areas, and potential funding mechanisms.
- Explore opportunities to partner with health professions schools to recruit and place students in areas of need upon graduation. Consider creating arrangements that students, schools and states can agree to prior to graduating or completing training.

## Graduate Medical Education

An additional state strategy to recruit and retain physicians focuses on the next step after medical school graduation: residency programs, also known as graduate medical education. Physicians typically complete hands-on, clinical residency training over three to seven years at hospitals and connected outpatient health care facilities. Medicare is the primary funder of graduate medical education positions across the country, though states and other entities may also fund residency training. And where doctors complete their residencies matters. A 2016 report from the Association of American Medical Colleges found that more than half of physicians who completed residency training between 2006 and 2015 were practicing in the state where they completed their training, and a 2015 study found that more than half of family medicine physicians practice within 100 miles of their residency program.

Rural Training Track programs are another mechanism to bring doctors to rural areas for their graduate medical education, with the hope that they practice in rural communities after completing their training. While there are a variety of program models, each involves a combination of training at an urban hospital and a rural health care setting. Program outcomes show that 75 percent of Rural Training Track participants subsequently practice in rural areas. As of July 2017, at least 30 states offered accredited Rural Training Track programs, or similar programs.

*Sources: Association of American Medical Colleges, 2016; Ernest Blake Fagan, et al., 2015; The RTT Collaborative.*

## Scope of Practice for Non-Physician Providers

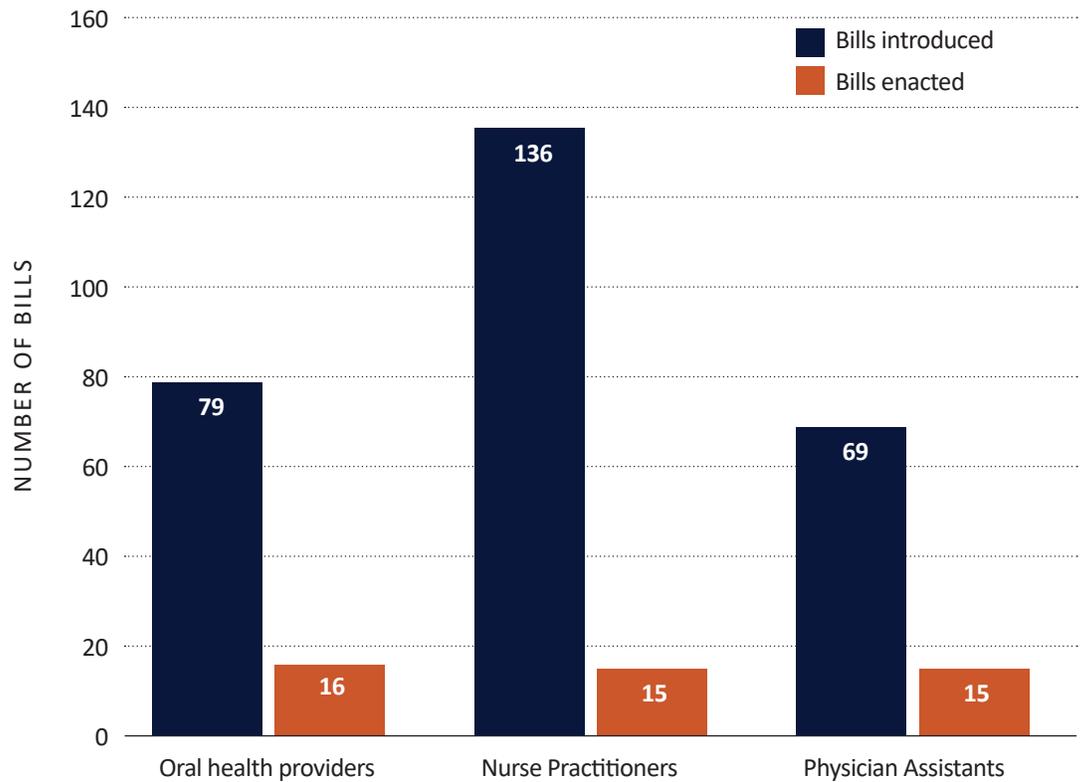
Another common state strategy to meet the needs of rural and underserved areas involves using a range of health professionals to collectively meet an area's health care needs. By 2030, the demand for primary care services will outpace the supply of physicians, partly due to an aging population and higher rates of chronic diseases.<sup>27</sup> Providers such as nurse practitioners (NPs), physician assistants (PAs) and midlevel oral health providers, among others, can help provide needed primary and oral health care services in underserved areas. State policymakers can examine the scope of practice for certain types of providers to determine if state laws allow them to practice to the full extent of their education and training.

Non-physician professionals increasingly address workforce shortages by providing care independently or with physician or dentist oversight.<sup>28</sup> Incorporating non-physician providers like nurse practitioners into primary care can help alleviate the pressures of physician shortages. For example, the years of education and training required for a nurse practitioner are less than those of physicians so they are able to enter the workforce more quickly than a physician.<sup>29</sup> Since each state has its own specific laws and regulations regarding the responsibilities of these providers, the range of services performed varies from state to state.

State scope of practice laws and regulations define the roles and responsibilities for health professionals' licenses in each of these occupations. Dozens of bills considered by state legislatures over the past two years have focused on scope of practice, some of which have been enacted into law. Many states have taken steps to increase the procedures, treatments, actions, processes and authority that are permitted by law, regulation and licensure for non-physician primary care providers.<sup>30</sup> Proponents of these laws say providers such as nurse practitioners and physician assistants can be trained quicker and less expensively than physicians without compromising quality. Some physician groups disagree and argue that physicians' longer, more intensive training equips them to diagnose more accurately and treat patients more safely.

States continue to consider legislation to address providers' scope of practice, including requirements for nurse practitioners, physician assistants and oral health providers, as outlined below.

## Number of Bills Introduced and Enacted in State Legislatures Addressing the Roles of Each Provider, 2015-2017



Note: As of July, 2017.

Source: [scopeofpracticepolicy.org](http://scopeofpracticepolicy.org)

### Nurse Practitioners

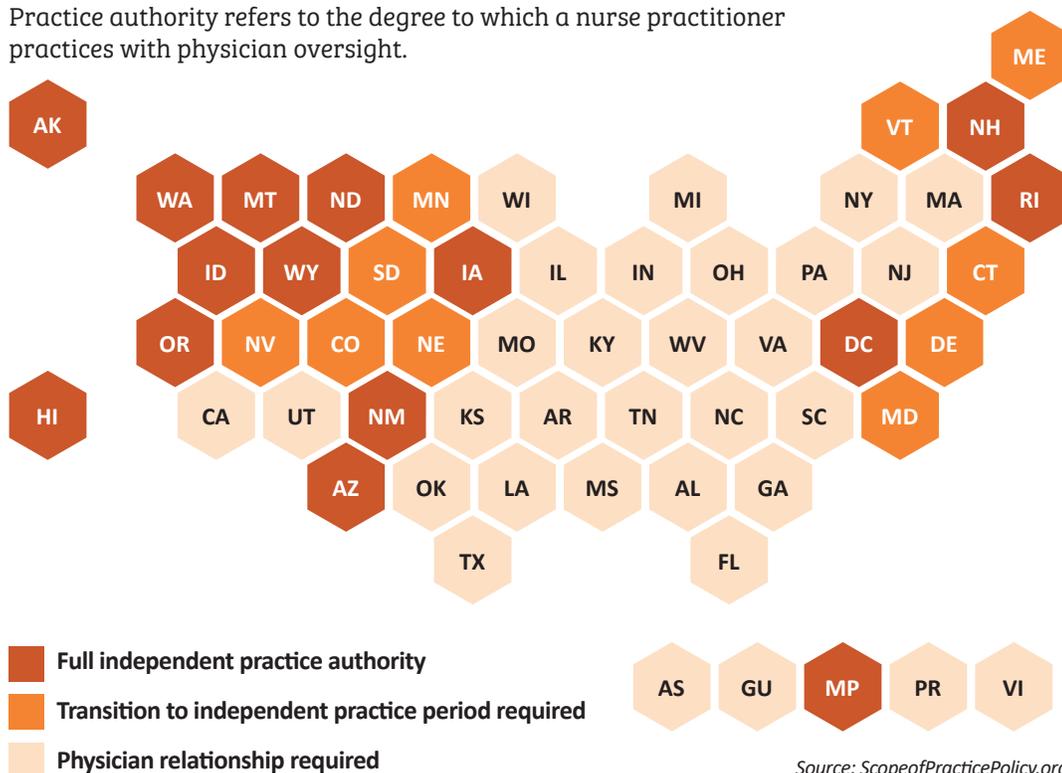
Nurse practitioners (NPs) are one type of advanced practice registered nurse (APRN) who are prepared, through advanced graduate education and clinical training, to provide a range of health services, including diagnosing and managing both common and complex medical conditions. As of June 2017, there were more than 234,000 licensed nurse practitioners in the U.S.<sup>31</sup> and almost 90 percent of NPs work in primary care settings.<sup>32</sup> The projected number of nurse practitioner graduates entering the workforce is expected to grow by 21,230 by 2025.<sup>33</sup> The Association of American Medical Colleges reports that “the ratio of physicians to APRNs and physician assistants is projected to fall over time as APRN and PA supplies grow at faster rates than physician supply.”<sup>34</sup>

According to the American Association of Nurse Practitioners, 22 states and the District of Columbia allow nurse practitioners to diagnose, treat and prescribe medications without physician supervision.<sup>35</sup> Another seven states allow nurse practitioners to diagnose and treat patients independently, but not prescribe medications. The remaining 21 states require either collaborative agreements that outline an NP’s practice authority, or direct physician supervision of nurse practitioners to diagnose, treat and prescribe.

The landscape for nurse practitioners’ scope of practice is evolving. The three most recent states to pass legislation changing scope of practice for nurse practitioners were Maryland and Nebraska in 2015 and South Dakota in 2017—NPs in those states are now allowed to practice without physician oversight.

## Nurse Practitioner Practice Authority

Practice authority refers to the degree to which a nurse practitioner practices with physician oversight.



## Physician Assistants

Physician assistants are nationally certified and state-licensed medical professionals, and practice on health care teams with physicians and other providers. They are formally trained to examine patients, diagnose injuries and illnesses, and provide treatment.

According to the National Commission on Certification of Physician Assistants, at the end of 2016, at least 115,000 physician assistants were practicing in the U.S., working in all areas of medicine.<sup>36</sup> In rural and underserved areas, physician assistants may be the primary care providers at clinics where a physician is present only a few days a week. Physician assistants collaborate with physicians as needed and as required by law, often relying on a collaborative agreement that outlines the specific activities permitted and defines the relationship between the physician and the physician assistant.

Supervision requirements for physician assistants are determined either at the practice level with a physician or outlined in state statute or administrative rule. Some states are moving toward allowing physician assistants to have a collaborative relationship with a physician instead of a direct supervisory relationship. In 2015, New Jersey lawmakers voted to allow greater flexibility in the way physician assistants provide care. The requirement that a physician must always be present was removed and PAs may now work with a physician to define his or her personal scope of practice.

## Oral Health Providers

Dental hygienists are oral health professionals working together with a dentist to provide preventive and routine care. The American Dental Hygienists' Association (ADHA) reports approximately 185,000 dental hygienists working in the U.S. in 2015.<sup>37</sup>

Traditionally, dentists provide direct oversight of the services dental hygienists perform in the dental office. Many states have now expanded dental hygienists' licenses to allow greater practice parameters or practice in community-based settings, such as a school.<sup>38</sup> In 2016, 39 states allowed dental hygienists

to provide certain preventive services to patients, such as fluoride varnish, often without the need for the dentist to be present, and 18 states allowed direct Medicaid reimbursement for services rendered by a dental hygienist, according to the ADHA.<sup>39</sup>

In addition to dental hygienists, Alaska, Maine, Minnesota and Vermont now allow additional provider types, such as dental therapists, dental health aide therapists and advanced practice dental hygienists to address oral health care access issues. Dental therapists, as members of the dental team, provide preventive and restorative dental care, such as fillings and root canals on baby teeth, and non-surgical dental extractions, usually for children and adolescents. They perform more advanced services than dental hygienists, but their precise roles vary and are dependent on the therapist's education and the state's particular dental regulations and guidelines.

Dental hygienists, dental therapists and dental health aide therapists practice in private settings, community-based clinics and rural areas. They all practice under varying levels of supervision by dentists, allowing these providers to meet needs in nontraditional, tribal, school-based and community settings.

### Scope Of Practice Policy

NCSL's new Scope of Practice Policy website is designed to provide state leaders with resources about scope of practice issues for nurse practitioners and physician assistants, as well as dental hygienists and dental therapists. The website features interactive policy maps, a legislation database and case studies in scope of practice policy. For instance, the website tracked 135 bills in the 2015-2017 legislative session related to nurse practitioners, physician assistants, dental hygienists and dental therapists.



SCOPE OF PRACTICE POLICY

This resource is designed by NCSL and the Association of State and Territorial Health Officials (ASTHO) to provide policymakers with a tool to explore the range of scope of practice legislation introduced around the country. This easily accessible source of information helps state leaders as they consider ways to meet the health care needs of their constituents at the right place, right time and right cost. Learn more at [www.ScopeofPracticePolicy.org](http://www.ScopeofPracticePolicy.org)

### SCOPE OF PRACTICE POLICY OPTIONS

- Assess the existing state policies related to scope of practice, licensure and prescriptive policies for the non-physician workforce. For example, examine physician supervision requirements for nurse practitioners and physician assistants, including whether policies require direct or in-person supervision. Consult with your state's health professional regulatory boards and other stakeholders about potential changes.
- If allowing dental therapists to practice is appropriate for your state, convene various stakeholders to discuss options. Work with your state dental board and dental associations to ascertain what revisions are desired or necessary to your state's dental practice act.
- Evaluate barriers and opportunities to expand access to care through non-physician providers. Assess Medicaid reimbursement for these providers and consider settings in which they can provide services, such as allowing dental hygienists to provide preventive services in community settings.

# Telehealth

Enhancing and increasing access to services through telehealth is another strategy widely viewed as a way to help address workforce shortages and reach patients in rural areas. Telehealth is a tool—a means—that capitalizes on technology to remotely provide health care and other health-related services, such as communication and education between patients and providers. It can also be used in a public health setting by, for example, assisting with disaster management or sending text alerts for emergencies.<sup>40</sup> While it does not increase the number of health care providers, telehealth can help leverage the existing workforce through various mechanisms.<sup>41</sup>

Telehealth can help provide health care services in remote or underserved areas that lack practitioners. For example, patients can engage in live video visits with primary care providers for acute issues or have chronic conditions monitored from their homes with devices that connect to providers. Patients can also access specialty care—such as for mental health, substance use disorders and oral health care—from providers who may be physically located hours from their homes. Telehealth has the potential to reduce costs and other burdens (e.g., transportation, lost work) for patients as well as the health care system.<sup>42</sup>

Telehealth also allows for consultation between providers, which can build capacity among rural practitioners, and often helps people in rural areas stay in their own communities for care.<sup>43</sup> Consultation through telehealth also can allow providers to offer care in various settings, with remote supervision or other support. In addition, telehealth may help increase efficiencies for health care professionals, allowing them to see more patients. This is especially the case for providers who serve in rural areas and may spend a lot of “windshield time” traveling between various locations.

As state leaders seek to capitalize on the potential for telehealth to support the health care workforce and improve access to care, a number of state policy issues arise. Reimbursement, licensure and practice standards are among the key topics addressed in state legislatures.<sup>44</sup>

## Telehealth Modalities

Telehealth is defined as the “use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration.” The primary types of telehealth applications are real-time communication, store-and-forward and remote patient monitoring, as well as mobile health.

- Real-time communication allows patients to connect synchronously with providers via video conference, telephone or other devices.
- Store-and-forward refers to transmission of data, images, sound or video from one care site to another for evaluation.
- Remote patient monitoring involves collecting a patient’s vital signs or other health data while the patient is at home or another site, and transferring the data to a remote provider for monitoring and response as needed.
- Mobile health (mhealth) is an emerging field that includes health education, information or other services via a mobile device. Mhealth references are much less common in state policy.

*Sources: Health Resources and Services Administration; NCSL, 2015.*



## Licensure

Because technology crosses borders, licensure of providers becomes an issue when considering telehealth as a solution to workforce shortages. Generally, health care providers must be licensed in the state where the patient is receiving care, and states retain oversight of providers within their borders. Practitioners traditionally apply for a license in each state in which they wish to practice. However, some policymakers have considered other ways to allow out-of-state providers to offer services in their states. For example, some states have agreements with other, often neighboring, states allowing reciprocity. At least nine states have created telehealth-specific licenses that allow out-of-state providers to offer services in the state via telehealth, if they abide by certain requirements (e.g., not setting up a physical location in the state).<sup>47</sup>

Recently, licensure compacts for various providers have been gaining traction as a means to allow interstate practice, in particular with an eye toward promoting telehealth. The Nurse Compact, created nearly 25 years ago by the National Council of State Boards of Nursing, was revised for the 2016 legislative sessions and 25 states have passed the new version.<sup>48</sup> The physicians' version—the Interstate Medical Licensure Compact—was created in 2015 with the help of the Federation of State Medical Boards. It has been enacted in 22 states, and under the guidance of a commission, is active and preparing for issuing licenses.<sup>49</sup> Key differences exist in the compacts. For example, the nurse compact operates like a driver's license with one license for all participating compact states, whereas the physician compact provides an expedited path to a separate license in each participating state. Emergency medical services personnel, psychologists, physical therapists and other providers are also pursuing compacts.

## Practice Standards

In addition to differences in payment, providers delivering health care services through telehealth may encounter different state laws regarding practice standards. Many lawmakers are concerned with balancing appropriate guardrails to ensure patient safety without creating unnecessary constraints. For example, there is some concern about fragmented care from different providers and ensuring that patients' primary providers are aware of any services provided via telehealth.<sup>50</sup> On the other hand, ideally, telehealth is integrated into the health care delivery system and is being coordinated with other providers. Some of the concerns about telehealth also include ensuring that services provided remotely are as safe and as comprehensive as in-person care. Policies related to practice standards include applying the standard of care, establishing a patient-provider relationship and ensuring informed consent.

The standard of care—what another similarly trained and equipped provider would do in a similar situation—should apply regardless of the means of service delivery. However, some states are also considering policies stating that the applicable standard of care applies in telehealth. In many cases, provider regulatory boards also set policy and practice guidelines.

A large majority of states allow a patient-provider relationship to be established via telehealth.<sup>51</sup> Some state laws clearly allow this practice, while some do not specifically address patient-provider relationships via telehealth, in which case administrative code or regulatory boards may determine policy. Provider boards in some states also create additional rules or guidelines for practice. A patient-provider relationship is necessary to write a prescription for a patient in most states. While the majority of states permit establishing a relationship through telehealth, most states are explicit in prohibiting prescribing based solely on the basis of an online or internet questionnaire.<sup>52</sup>

States are also looking at informed consent policies—a process by which a patient is made aware of any benefits and risks associated with a particular service or treatment. At least 29 states have some type of informed consent policy, many requiring verbal consent and others requiring written consent.<sup>53</sup> Consent requirements may also apply to different arenas—e.g., all providers or just the Medicaid program, or even specific services, depending on the origination (statute, administrative code, Medicaid policy) and intent of the policy.<sup>54</sup>

## Effectiveness of Telehealth

Telehealth is widely cited for its ability to increase access to health care services—and for its ability to help achieve the triple aim (improve health outcomes, improve patient and provider experiences, and reduce costs). Much of the research on telehealth’s effectiveness is still evolving. While many studies have found positive clinical outcomes and/or cost savings, it is challenging to make generalized statements about telehealth overall. A systematic review of randomized control trials concluded that the effectiveness of telehealth may depend on different factors, including patient population (e.g., disease or condition), how telehealth is used (e.g., clinical visit, remote monitoring), and the health care providers or systems involved in delivering telehealth. Similarly, in a recent technical brief, the Agency for Healthcare Research and Quality concluded that “there is sufficient evidence to support the effectiveness of telehealth” in specific circumstances. In terms of both clinical outcomes and cost effectiveness, many note that more research is needed.

With improvements in access can come increased use of health care services. Most agree that the services provided using telehealth would be more appropriate and less costly (e.g., primary care instead of emergency room care). A RAND study of direct-to-consumer telehealth, just one type of telehealth, found that it may increase access to care for some, and may also increase utilization and health care spending. While telehealth can provide initial remote access, there is some discussion that many patients require in-person follow-up care and can still face challenges in accessing that care.

*Source: Agency for Healthcare Research and Quality, 2016; Cochrane, 2015; Health Affairs, 2017; NCSL, 2015.*

## TELEHEALTH POLICY OPTIONS

- Examine telehealth policies for gaps and opportunities. Consider what policies might facilitate telehealth in a way that fits the needs and context of your state. Engage various stakeholders (e.g., providers, hospitals, payers, consumers) in this conversation.
- Look at reimbursement policies for Medicaid and private payers. Consider which providers and services are eligible for reimbursement, and how that aligns with your state’s needs. Examine the use of telehealth under public and private insurers, and the potential barriers or constraints to the use of telehealth by providers and patients. If data on telehealth utilization are hard to access, consider a modifier for billing codes in Medicaid to track services.
- Consider other policies that may promote or hinder telehealth in your state. For example, look at providers and workforce issues, such as practice standards and license portability, if these issues are applicable to your state.

# Conclusion

A number of strategies exist for state policymakers seeking to address workforce issues, including provider recruitment and retention, scope of practice policies and using telehealth to deliver services. While no single solution will solve all of the issues, legislators have adopted many of these strategies to remove barriers and enhance access to health care in rural and underserved communities. As challenges persist in these areas, legislators will surely continue to grapple with these issues and consider innovative strategies to improve individual, community and population health.

## Notes

- 1 U.S. Department of Health and Human Services, Health Resources and Services Administration, Data Warehouse, “Shortage Areas” (Rockville, Md.: HRSA, n.d.), <https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx>.
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