Barriers Providers Face in Providing Equitable Virtual Care to Patients

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May 17, 2022

EXECUTIVE SUMMARY

In addition to being a key aspect of care delivery during the pandemic, virtual care is seen by many as a potential long-term fix for inequities in the health care system, such as inadequate convenience of care, preventative care, rural health care access, provider shortages, and transportation needs. However, not all providers have been able to leverage virtual care benefits to the same degree. Safety net settings, or places with health care providers that organize and deliver a significant level of health care and other needed services to low-income, uninsured, or geographically underserved populations, face especially high hurdles to virtual care adoption due to financial, logistical, and workforce constraints.

At USofCare, we recognize the urgency with which a virtual care system of the future that focuses on people's needs and removes barriers to equitable access needs to be built. As we continue to work toward a virtual care system that closes gaps in access for all people, this brief spotlights the unique challenges and experiences of providers—with a particular eye toward safety net providers—in providing equitable virtual care to patients.

Based on our preliminary research to date, including academic research, national polls, and our listening work through focus groups and one-on-one conversations with our Voices of Real Life members and other communities, we have identified the following barriers that providers face regarding virtual care, grouped into three broad categories:

1. Barriers to virtual care adoption
   - Expensive to establish
   - Patient access to technology
   - Patient lack of digital literacy
   - Adapting provider workflows
2. Barriers to providing quality virtual care
   - Technology infrastructure and access

   ○ Patient lack of digital literacy
   ○ Virtual care requires nuanced communication strategies
 3. Barriers to virtual care sustainability
   ○ Establishing a strategic blended care model
   ○ Net impact on provider workflow is unclear
   ○ Costs of maintenance

To mitigate these barriers that providers face regarding virtual care, we recommend the following policy actions:

★ Ensure adequate coverage reimbursement, especially for safety net systems
★ Permanently remove geographic barriers on distant sites and originating sites for giving and receiving care
★ Make available training materials and resources for both providers and patients to improve their digital literacy
★ Expand workforce capacity and identify additional support for individuals with complex needs
★ Establish standardized virtual care competencies and training materials for providers

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INTRODUCTION

Virtual Care and the COVID-19 Pandemic

Before the COVID-19 pandemic, virtual care–including telehealth, remote monitoring, and other remote forms of digital communication–was not widely utilized. The primary consumers of virtual care were often large health systems with existing technology infrastructure to support virtual care practices. However, since the start of the pandemic, virtual care has emerged as a critical tool for getting people access to the care they need while abiding by quarantine and stay-at-home orders. Traditional and safety net health care systems started to use virtual care driven by the desire to avoid COVID-19 exposure risk in clinic settings, maintain continuity of care, and, in some cases, support remote COVID-19 care and monitoring. Virtual care is now widely utilized as part of the pandemic response and will undoubtedly

leave a lasting impact on our health care system as [temporary policies are beginning to become permanent](#).

Equity Implications for Virtual Care

In addition to being a key aspect of care delivery during the pandemic, virtual care is seen by many as a potential long-term fix for inequities in the health care system, such as inadequate [convenience of care, preventative care, rural health care access, provider shortages, and transportation needs.](#)

However, not all providers have been able to leverage virtual care benefits to the same degree. Safety net settings, or places with health care providers that [organize and deliver a significant level of health care and other needed services](#)to low-income, uninsured, or geographically underserved populations, have increasingly become [at risk for financial strain](#) during the pandemic. Faced with these financial challenges and other logistical and workforce-related barriers, safety net providers and their patients are up against especially high barriers to virtual care adoption.

USofCare's Approach

At USofCare, we recognize the urgency with which a virtual care system of the future that focuses on people's needs and removes barriers to equitable access needs to be built. Therefore, we are embarking on a national listening tour and bringing together diverse stakeholders to provide policymakers with evidence for making informed decisions on how best to use virtual care to close gaps in people's ability to access care. Virtual care is seen not as an outcome, but one strategy to help people—especially those who have been historically marginalized—access the care they need. Currently, our virtual care initiatives [highlight the needs of people to ensure access to care is improved via virtual care](#), especially for populations like [older adults](#), [people who use behavioral health care](#), and [other communities historically underserved](#)by the health care system.

In order to fully understand the overall impact and potential of virtual care to close gaps in access, it is important to also highlight health care providers' experiences with virtual care and how they affect patient experiences. Existing research shows that providers in health care systems that had either already adopted virtual care pre-pandemic or possessed the financial and logistical infrastructure for implementing virtual care were able to expand virtual care more rapidly and comprehensively to the benefit of their patient populations. However, provider barriers such as workforce challenges and low digital literacy among patients limit the full potential of virtual care, especially for safety-net providers who face additional financial constraints.

As USofCare continues to work toward a virtual care system that closes gaps in access for all people, this brief spotlights the unique challenges and experiences of providers–with a particular eye toward safety net providers–in providing equitable virtual care to patients.

Based on our preliminary research to date, including academic research, national polls, and our listening work through focus groups and one-on-one conversations with our Voices of Real Life members and other communities, **we have identified barriers that providers face in 1) adopting virtual care, 2) providing quality virtual care, and 3) achieving a sustainable virtual care practice.**

The brief that follows summarizes our research on each of the barriers that providers face regarding virtual care and provides policy recommendations aimed at mitigating the barriers that our research has uncovered.

1. Barriers to Virtual Care Adoption

The pandemic brought a wave of providers implementing virtual care in their practices for the first time. This uptick in virtual care adoption brought to light key challenges that providers face in establishing a virtual care practice for their patients.

Expensive to Establish

Virtual care is **expensive for providers to establish,** including obtaining the appropriate technology, training providers, and developing the workflows and physical infrastructure to accommodate virtual care visits. This barrier is especially hard for small, independent practices and rural health care systems to overcome:

★ Most of the money from the federal Provider Relief Fund went to hospitals and large health systems, not independent primary care practices (PCPs). Many independent PCPs did not realize they received it at all, or received so little they deemed it as having no significant impact.

★ Initial fixed costs for equipment range from $17,000-$50,000, the average annual subscription fee is $60,000, and connectivity/maintenance costs incur another $3000-$8000 per year. Smaller rural hospitals often do not have the cash flow for telemedicine to be financially beneficial.

The cost of establishing a virtual care practice is also a challenge for **federally-qualified health centers (FQHCs):**

★ According to a [RAND Corporation study](#) pre-pandemic that analyzed interviews from Medicaid officials from seven states and representation from 19 different FQHCs, safety net providers cited insufficient reimbursement and unclear state virtual care policies as main barriers to virtual care use.

Patient Access to Technology

In implementing a virtual care practice, providers face uncertainty about whether their patients have **access to the appropriate technology:**

★ Between April and June 2020, providers treating homebound patients in NYC via [video-based telehealth](#) frequently did not know whether their patients had stable internet connectivity at home (72%), ability to pay for cellular plans (65%), or access to a device with video capability (48%).

Patient Lack of Digital Literacy

For patients who have access to the appropriate technology, their **lack of digital literacy** can still be a barrier for providers to successfully adopt virtual care:

★ Among homebound patients using [video-based telehealth](#) for the first time in NYC between April and June 2020, providers deemed 27% (n = 153) "unable to interact over video" for reasons including cognitive or sensory impairment and 14% lacked access to a caregiver to assist them with technology.
★ 72.6% of [rural medical providers](#) working at a Pennsylvania teaching hospital in March 2020 reported patients' lack of technological literacy as a major barrier to virtual care implementation.

The **modality of virtual care** (video vs. audio-only) impacts how easily providers are able to overcome their patients' lack of access to technology or gaps in digital literacy:

★ [New York City Health and Hospitals](#) reported early in the pandemic "...telephone visits were our most scalable modality because of their ease of use for both patients and providers. In contrast, video visits were more challenging and ultimately required in-person and virtual navigators to facilitate the service for patients."

Adapting Provider Workflows

To implement virtual care, providers report an increase in their workload, as they have to address **unique considerations for clinic flow and workforce capacity** such as integrating additional screening procedures and recruiting telehealth-specific staffing:

> *"For nurses, preparing a patient for a telehealth appointment is completely different than preparing a patient for an in-person appointment. They are constantly on the phone trying to reach patients to begin their appointments prior to the provider seeing them. If the patient is physically in the office, they are much easier to call from the waiting area to an exam room, do their assessment, and let the provider know they are ready. For virtual appointments, patients don't always answer their phone when the nurse calls, and there is little to no downtime between patients to address any follow up needs. When one patient is handed off to the provider, you have to start the process with the next patient immediately because it takes much more time and energy to prep a patient for virtual appointments."*
>
> *- Amanda Wosman, Clarity Healthcare*

★ Pre-pandemic, a [systematic review](#) of health care safety nets revealed telemedicine implementation barriers include "...fewer existing staff and leadership resources to develop and standardize processes for working with new technology" and "reduced technical support and access to devices for staff and providers."

Additionally, providers report challenges with virtual care platform design and **integration with electronic health records:**

★ A [systematic review](#) of health care safety nets revealed that a telemedicine implementation barrier is that health care safety nets have "...less-robust electronic health record infrastructure to integrate telemedicine tools and track their use."

For providers who are trying to launch a virtual care practice, insufficient staffing and inefficient clinic flow may lead to delays in appointments and further difficulties for patients with limited digital literacy, while the lack of interoperability and access to medical records may especially affect rural and low income communities.

Altogether, these barriers prevent some providers from being able to offer virtual services to patients who would otherwise benefit from the increased convenience of virtual care.

2. Barriers to Providing Quality Virtual Care

Virtual care has already shown success in eliminating barriers that patients face to accessing care, [such as transportation, stigma, and time-loss](#). However, without deliberate effort and careful attention to providing high quality care for all patients, a rapid move to virtual care could worsen health inequities rather than reduce them. In scaling virtual care, it is important for providers to consider barriers to providing high quality virtual care and how these barriers

may interact with existing health inequities, in order to avoid exacerbating disparities.

Disparities in Technology Infrastructure and Access

Similar to the barrier we outlined above under Patient Access to Technology, we know that both providers and patients must have sufficient technology to facilitate successful virtual care. Expanding on that barrier, this section discusses how disparities in technology infrastructure among providers and disparities in access to technology among patients create barriers to providing quality virtual care that reduces health inequities.

From a provider perspective, **rural health care systems often lack sufficient technology infrastructure** for virtual care, creating disparities in access to virtual care by geography:

> *"You're going to have various hospitals and various clinics scattered around [Minnesota] that are in old facilities and not even wired to be able to do any type of telemedicine... We're rural. It's still got a long ways to go as you go around throughout the whole state. There's still going to be a lot of areas that are, you know, on their own or left behind."*
>
> *- Gary Wertish, Minnesota Farmers Union President*

★ [Pre-pandemic](), rural hospitals were "significantly less likely to adopt telehealth services overall, and... they adopted fewer telehealth services compared to metro area hospitals." For example, compared to urban hospitals, rural hospitals were less likely to have patient engagement capabilities such as viewing health information online or submitting medical information electronically to a third party. Rural hospitals also were less likely to be able to be able to send and receive clinical information electronically with outside providers.

★ A [study]() conducted in July and August of 2020 found that 68.2% of rural providers were not able to access telehealth technology directly from an EHR system, compared to 57.9% of urban providers. The same study found that rural providers were more likely than urban and suburban providers to report concerns about integrating virtual care into existing technology and lack of technical support.

To deliver effective virtual care, providers need their patients to have access to the appropriate technology. A key challenge is that many patients lack the technology needed to engage in a virtual care visit–specifically, **sufficient phone minutes for audio-based visits, or stable broadband and a device with video capabilities for video-based visits.** These challenges disproportionately affect low-income, disabled, and multilingual patients:

- ★ "As of early 2021, 27% of adults living in households earning less than $30,000 a year are smartphone-only internet users – meaning they own a smartphone but do not have broadband internet at home. This represents a substantial increase from 12% in 2013."
- ★ A 2021 study included 202 patients from a multilingual urban safety net setting where over half of the participants (n = 112) reported barriers to video visits, notably 24.8% stated that internet and data access was their greatest barrier to engaging in video visits.
- ★ During the early pandemic, a study analyzed health care providers' experiences at a health care safety net with telemedicine where "...clinicians raised equity-related concerns about... access to a reliable phone number, video visit capacity at home (which requires a smartphone and Internet)... and patient education regarding expectations for a telemedicine visit."
- ★ "Approximately 20 percent of people with disabilities are likely to not have access to a computer, tablet, or smartphone that would enable them to access a telehealth platform."

Patient Lack of Digital Literacy

Low digital literacy decreases the quality of virtual care interactions and disproportionately affects individuals who are, on average, older, less educated, and more likely to identify as Black, Hispanic, or foreign born.

- ★ "Those in households earning incomes below $50,000 are more likely than those earning more... to report concerns about technology and to think help using technology and accessing the necessary devices would be beneficial" (AP-NORC)
- ★ "Even with access to a computer, 52 million Americans do not know how to use it properly... Furthermore, older and black patients are much less likely to use their patient portal—websites where patients and physicians can communicate—than younger and white patients."

Virtual Care Requires Nuanced Communication Strategies

In a virtual environment, **providers report losing nonverbal nuances and body language cues** that can be important tools for building mutual understanding, respect, and rapport with their patients:

> *"You're used to sitting in the room with a patient and reading their nonverbals, you see the foot tapping and see how their, you know, their body expresses change. When you talk about a particularly tough topic, sometimes it's really hard to see these subtleties in virtual land."*

> *- Dr. Benjamin Miller, Well Being Trust, Panelist on USofCare and Well Being Trust's <u>recent webinar</u>, "Action Steps on Virtual Care Access: Focus on Behavioral Health"*

> *"I would say rapport building has always been important for my profession. But I feel like with mental and physical health, it's becoming more important because it does feel very impersonal, to not have somebody in that room to have a really hard time reading body language, all that, all those different cues that we may subconsciously rely on... Virtual care forces you to do way more planning ahead than on the fly, like you can do in the clinic. And just really focusing on that rapport building."*
> *- Summer Moss, Interview for Virtual Care: From a People's Perspective blog series*

★ More than half (69%) of mental health clinicians surveyed reported it was more difficult to manage patients' nonverbal nuances in communication, with 70% reporting difficulty effectively interacting with patients without body language cues.

★ Over half of surgery providers reported they were either only somewhat satisfied (38.3%) or neutral (25%) regarding their ability to break bad news during virtual visits.

This is particularly significant for patients with **limited English proficiency:**

★ Only 27% of clinicians who work with interpreters to deliver virtual care for patients with limited English fluency reported being able to interact with these patients as effectively as in-person.

★ Another challenge that providers face when working with patients with limited English proficiency virtually includes the lack of language-friendly virtual care platforms, as these platforms may not have directions or queues in patient's preferred languages or make medical interpretation easily accessible.

★ New York City Health and Hospitals, a health care safety net system, identified that "...both video and text messaging platforms cater to English-speaking populations and require additional patient technical support or vendor changes to be made accessible to all patients. Incorporating language access and interpreter services is a high priority in establishing these platforms."

Significant barriers also exist for patients with **speech, hearing, or cognitive disabilities,** who may depend more heavily on nonverbal cues to communicate with providers:

★ During the early pandemic, a study analyzed health care providers' experiences at a health care safety net with telemedicine where "...clinicians raised equity-related

concerns about patient speech, hearing, or cognitive ability, … [and] reliable access to language interpreters.

Some patients also express concerns regarding the **accuracy of an assessment via virtual care,** which requires providers to be transparent about which services are appropriate to offer through virtual care and why:

★ During the early pandemic, a [study](#) analyzed health care providers' experiences at a health care safety net with telemedicine where "…over half of respondents had concerns about the diagnostic safety of telephone visits." Respondents reported concerns about relying on a telephone visit when "objective vital signs or exam findings are required, considering diagnoses of higher urgency such as acute abdominal pain, or privacy concerns limiting diagnostic information gathered." These concerns can be magnified for patients who face language barriers or have limited health literacy, especially among patients at safety net clinics.

Furthermore, while **audio-only visits** present a good alternative for patients who may otherwise be unable to access care at all, providers face unique challenges in offering audio-only virtual care. In particular, many providers cite the need for training specific to audio-only visits in order to provide high-quality care. If providers lack adequate training and resources to deliver quality audio-only visits, patients who only have access to phones for audio-based visits or do not have access to stable broadband may be less likely to receive quality care.

> *"When you can't have that video connection, you lose a little bit of that… overall relationship-building with the patient that you're talking to. And so how do we phrase things a little bit differently on the phone than if we were on video? Just being very clear about the decisions and next steps… just really making sure [the patient has] a true, clear understanding."*
>
> *- Josh Hofmeyer, Avel eCare*

★ This potential for discrepancy in quality due to lack of training can exacerbate existing disparities given that federally qualified health centers (FQHCs) serving [Medicaid and uninsured patients](#) have reported being more likely to use audio-only visits.
★ 59.9% of surveyed clinicians using telehealth to deliver [opioid use disorder treatment](#) in fall 2020 stated they believe their patients receive higher quality of care through video visits rather than audio.

These barriers stand in the way of providers being able to provide personalized, quality virtual care for everyone. Without solutions that specifically take digital inclusivity and modality-specific communication strategies into account, many patients–particularly patients

from rural, low-income, disabled, and limited English proficiency communities—may be left behind.

<p align="center">**3. Barriers to Virtual Care Sustainability**</p>

As providers develop and expand their virtual care practices, factors like costs, workforce, and quality of care will impact the sustainability of their virtual care model.

Establishing a Strategic Blended Care Model

Not all services are appropriate to conduct via virtual care, and some simply must be conducted in person due to the nature of the service. Our research shows that a blended care model—in which patients have a mix of in-person and virtual care—is desirable for both patients and providers. However, providers may face challenges in ensuring that virtual care visits supplement, but do not replace, necessary in-person visits. Finding a strategic and transparent "blended care" balance will be essential for providers to develop a sustainable virtual care practice.

The remote nature of virtual care prevents providers from being able to perform **physical examinations and diagnostic imaging,** which has led to delays in diagnosis and difficulties carrying out treatment:

★ 73.3% of rural medical providers reported that their inability to perform a physical examination via virtual care interfered with their patients' care.
★ From April-May 2020, 50% of urologists surveyed moved at least half of their originally scheduled visits from in-person to telemedicine. Despite this, 68% of all urologists surveyed believed that at least 50% of their appointments needed to be in-person.

In particular, virtual care alone is not an adequate substitute for patients who need in-person services such as **physical therapy:**

★ In 2020, pain physicians reported that the difficulty of performing physical exams virtually and deferrals of diagnostic imaging have resulted in delayed diagnosis and treatment. Services like physical therapy and aquatherapy are challenging to deliver virtually and are ideally offered in-person, although it is possible to offer them virtually through coaching models and guided care.

Unclear Net Impact on Workflow

While implementing a virtual care system may initially disrupt and slow down provider workflows, our research indicates that some aspects of virtual care **may improve provider workflows.**

In particular, the **modality of virtual care**—audio-only vs. video visits—has an impact on appointment time:

★ [According to a Nov-Dec 2020 survey](#), audio-only visits were more likely than video visits to be associated with reduced overall consultation time and reduced time for patient note-taking compared to in-person visits.

★ A [2020 study of geriatric primary care telemedicine appointments](#) found that audio-only appointments were, on average, 7 minutes shorter than video-based appointments.

Furthermore, the **COVID-19 pandemic** brought to light the ways in which virtual care can impact the provider workforce and their workflows:

★ "Disaster credentialing enabled us [[New York City Health and Hospitals](#)] to quickly leverage our physician workforce across the system, augmenting where necessary. Safety-net systems face chronic clinician shortages. We benefited from policy changes that allowed us to engage our providers who were isolating at home and to receive help from volunteers located in states not as deeply affected by COVID-19."

For providers to create a sustainable virtual care model, they will have to overcome the initial barrier of adapting provider workflows and strive for a model that mitigates the burdens and highlights the efficiencies of virtual care.

Costs of Maintenance

Virtual care is expensive for providers to maintain. While emergent funding has helped to soften the financial blow on health systems, the question of how virtual care will be sustainably funded in the future has not yet been resolved.

Without adequate reimbursement and funding, the benefits of virtual care in increasing access to care cannot be reaped, **especially for rural, low-income, and uninsured populations.**

★ Through federal legislation (i.e. Coronavirus Aid, Relief and Economic Security (CARES) Act), targeted support, and emergency grant funding, community health centers have received [$1.98 billion in relief funds](#). However, [this emergent funding is only a fraction](#) of the $175 billion Congress has allocated to address pandemic needs. The Department of Health and Human Services (HHS) had to provide an additional [$10](#)

million to health care safety nets due to growing concern that the financial aid was not reaching these settings. There has not been follow-up analysis of whether the additional funding has been sufficient.

★ Providers at health care safety nets express their concern with CARES ACT funding distribution where "...several [safety net] hospital leaders felt the formula used to allocate the first $50 billion through the general distribution disadvantaged their hospitals. Between the two general distribution waves, funds were released in proportion to a provider's share of 2018 net patient revenue. But, safety net hospitals generally have lower patient revenue than other hospitals..." A hospital health care safety net executive stated, "When you get to the safety nets, there are these conditions... 'We want to pay you, but not too much.'"

Providers face another hurdle to creating a sustainable financial model for virtual care when **virtual care services are reimbursed at a lower rate** than in-person services:

★ According to McKinsey & Company, in an April 2021 survey, 84% of physicians reported offering virtual care visits, and 57% would prefer to continue offering virtual care. However, 54% reported that they would not offer virtual care if it were only reimbursed at 85% of the in-person reimbursement rate.

As long as these barriers to sustainability remain, virtual care may not be a viable long-term solution for many of the patients who stand to benefit the most from virtual care's potential to increase access to care, such as rural and low-income individuals.

<p align="center">**Policy Recommendations to Address Provider Challenges**</p>

Based on the research presented above, we have identified several key policy recommendations to help providers utilize virtual care modalities to address gaps in access for patients. It is important to note that there is significant overlap between these recommendations and our previous suggestions for virtual care legislative policy areas and considerations surrounding older adults and virtual care. As part of USofCare's work moving forward, we will continue evaluating the extent to which the policies listed below and future policy areas and legislation are meeting the needs of people, and recommending changes where necessary.

★ **Ensure adequate funding and coverage reimbursement, especially for safety net systems:** Allow for adequate provider reimbursement for multiple care modalities so patients are able to choose the combination of video-based, phone-based, and/or in-person care that is right for them. Particular attention should be paid to the unique challenges faced by safety net providers (i.e., Medicaid reimbursement challenges), and remaining COVID-19 relief funds should also be distributed appropriately. Furthermore,

COVID-19 relief funds should be used to offset the high start-up costs that providers face when establishing a virtual care practice. An example of an application of this type of funding relief is the [FCC COVID-19 Telehealth Program](#) funding, which distributed $200 million to 539 grantees in 2020 and $256 million to 447 grantees in 2022 to support infrastructure, equipment, and other technology costs to expand virtual care use during the pandemic.

- ○ **Barriers Addressed:**
    - ■ Expensive to establish
    - ■ Adapting provider workflows
    - ■ Patient access to technology
    - ■ Technology infrastructure
    - ■ Costs of maintenance

★ **Permanently remove geographic barriers on distant sites and originating sites for giving and receiving care:** The originating site refers to the location of the patient and the distant site refers to the location of the health care provider. There have historically been reimbursement restrictions on where patients and providers are physically located to receive and give necessary care. These restrictions have created a barrier for people to use virtual care, such as in their own home, during the pandemic However, policymakers at the federal level continue to explore opportunities to permanently remove these site restrictions, particularly in the Medicare program. There is a recognition of the importance of meeting people where they are to fulfill care needs and increase access, including through the allowance or reimbursement for audio-only services delivered in a patient's home.

- ○ **Barriers Addressed:**
    - ■ Technology infrastructure and access
    - ■ Costs of maintenance

★ **Make available training materials and resources for both providers and patients to improve their digital literacy**: As virtual care technology continues to develop and change, it will be even more important to help both providers and patients take full advantage of the available technology. When possible, engage community organizations such as patient advocacy groups or libraries that are experienced in providing digital literacy training to community members.

- ○ **Barriers Addressed:**
    - ■ Patient lack of digital literacy
    - ■ Virtual care requires nuanced communication strategies

★ **Expand workforce capacity and identify additional support for individuals with complex needs:** Build in and scale up support for sustainable consultation and

integration capabilities, both through staffing and clinic workflow. Expanding workforce capacity may also be accomplished through:

- ○ Exploring and permanently allowing for provision of services across-state-lines
- ○ Implementing sustainable reimbursement models to support provider-to-provider virtual consultation services
- ○ Revisiting disaster provider credentialing legislation and how it can be adapted for national provider credentialing
- ○ **Barriers Addressed:**
  - ■ Net impact on provider workflow is unclear
  - ■ Costs of maintenance

★ **Establish standardized virtual care competencies and training materials for providers:**

> "Clinicians... in graduate school, we're not always taught what it's like to intervene through a camera... I think that as we begin to enter into this next phase of wherever we're going within health care, that competencies around virtual care should be something that [is] prioritized... We should be thinking about standards for telehealth delivery."
> - *Dr. Benjamin Miller, Well Being Trust, Panelist on USofCare and Well Being Trust's recent webinar, "Action Steps on Virtual Care Access: Focus on Behavioral Health"*

Training materials should include but not be limited to: improving webside manner, delivering culturally competent virtual care, and establishing trusting and open communication with patients even with reduced access to nonverbal communication cues.

- ○ **Barriers Addressed:**
  - ■ Establishing a strategic blended care model
  - ■ Virtual care requires nuanced communication strategies

You can join USofCare in our initiative to create a virtual care system that works for all of us by following the latest from us on Twitter **@USofCare** or reach out through our website at **unitedstatesofcare.org/contact**.