



Streamlining Telemedicine Licensure to Improve Rural America

Introduction

1. America's health care system is experiencing a system wide transformation. The past 50 years have brought forth significant innovations in pharmacological therapies and medical procedures, disease and health condition management, and technological advancements in telemedicine and service delivery. In spite of the above progress the US health care system remains inequitable in terms of health outcomes, costs and access to care and results in needless suffering (Institute of Medicine, 2012). A significant portion of the US population, specifically rural Americans and multicultural minorities residing in rural areas (Bushy, 2004), are not fully benefiting from health care advancements. One method to consider in the effort to address this disparity is to make the process less cumbersome for those working to actually deliver health care services. The current physician and dentistry licensure process has been outpaced by the capabilities of the technologies currently in use. To address this disparity, we outline our rationale for the NRHA to serve as the lead advocate for telemedicine cross-state licensure. For the purpose of the policy brief, we adopt the American Telemedicine Association's (ATA; 2012) telemedicine definition. The ATA defines telemedicine as the use and exchange of medical information from one practice site via electronic communications to improve a patient's clinical health status or outcome. Videoconferencing, remote monitoring of vital signs and activities of daily living, transmission of still images, e-health including patient portals, and continuing medical education are considered aspects of telemedicine.

Issue

2. Approximately 60 million Americans, or a fifth of the US population, reside in rural areas (Okrah, Vaughna-Sarrazin, Kaboli & Cram, 2012) and compared to their urban counterparts, persons residing in rural areas have lower socioeconomic status contributing to education, income and specific health disparities. Rural areas experience primary care physician shortages (Gramm, Castillo & Pittman, 2003) and high prevalence of metabolic syndromes such as diabetes (Bailey, Manning & Peiris, 2012), decreased life expectancy and lower self-rated health (Nummela, Sulaander, Rahkonen Karisto & Uutela, 2008). Rural Americans have lower rates of health literacy (Zahnd, Scaife & Francis, 2009) and higher rates of obesity and physical inactivity (Lewis et al., 2006; Patterson, Moore, Probst & Shinogle, 2004), tobacco use (Bailey & Jones, 2009; Stevens, Colwell & Hutchinson, 2003), and alcohol abuse (Jackson, Doescher & Hart, 2006). When compared to their urban counterparts, women residing in rural areas are less likely to receive preventative care examinations including blood cholesterol tests, dental exams, and mammograms (Larson & Correa-De-Araujo, 2006). The above health and well-being profile of rural American's is concerning but opportunities exist to improve the care of persons residing in rural areas.

3. A new approach to healthcare is required to address the needs of rural Americans. Telemedicine is a vehicle which can deliver health, education and teaching services to rural areas (Smith, Bensink, Armfield, Stillman, & Caffery, 2005). Telemedicine links rural residents with urban health specialists and holds considerable promise in terms of dramatically improving health care and enhancing rural economies (Whitacre, 2011). Patients find telemedicine usage acceptable and these findings are consistent across a variety of patients and circumstances (Mair & Whiten, 2000). Pare, Jaana & Sicotte's (2007) found that home telemonitoring is widely accepted, economically viable and includes a broad range of technologies including teleophthalmology, telepsychiatry, teleradiology, and teledermatology. The researchers further noted telemedicine and telemonitoring programs improve health outcomes as measured by emergency room visits, hospital admissions, and average hospital length of stay. A subtle aspect of Pare et al.'s research should be emphasized. Implicitly telemedicine and consultation (e.g., continuing medical education) encourages and supports rural providers to continue maintaining current standards of best practice and the ongoing exposure to dynamic patient cases and medical education has the potential to improve individual patient and community health outcomes vis-à-vis consultation with physicians who perhaps more regularly treat challenging diseases and have more access to healthcare resources and novel treatments.

Though telemedicine is quite promising in terms of meeting the needs of rural Americans, a current patchwork medical license regulatory system places considerable burdens on physicians wanting to work or expand their practice in to rural areas. For example, a physician must obtain a medical license in each of the states where patients received telemedicine services (Mossquera, 2012). Some federal agencies that provide care via telemedicine, such as the Veterans Affairs and Defense Departments, are distinctive and these physicians have license portability which allows them to practice in a different state than where they reside or practice.

4. In order to address the pressing needs surrounding workforce shortages (i.e., physicians and other allied health professionals) and limited access to healthcare, rural health policy initiatives must be put forth. The constituency of the NRHA will benefit through the support and pursuit of policy encouraging a streamlined licensing process for telemedicine providers. It should be noted though telehealth licensure is outside the scope of this policy paper, it is reasonable to assume advances in streamlining telemedicine licensure will lead to expedited telehealth licensure too, a similar but distinct concept from telemedicine (Darkins & Cary, 2000). This key derivative of a balanced but forceful telemedicine licensure policy must not be overlooked.

Policy Recommendations

5. The NRHA is encouraged to lead policy discussions supporting actions which appropriately allow individual states to maintain their ability to regulate the care provided to their constituents, but in a manner that encourages access to an enhanced level of portable care for all, regardless of where a patient resides from their physician or dentist.

6. The organization has already established a precedent in this area by lending their support to the Increasing Credentialing and Licensing Access to Streamline Telehealth Act (ICLAST Act) as proposed by U.S. Senator Tom Udall (NM) in 2012. One component of this proposal was intended to facilitate a provider's ability to appropriately practice across state lines.

7. The federal government has, in some ways, led by example. The Department of Veteran Affairs (VA) has established that a veteran can receive care from a provider in the system, even if they are not in the same state. They have embraced the understanding that it is the access to quality care which is most important. If a provider is appropriately licensed in one location in the VA system, that license follows him or her through the technology to wherever the patient is receiving care. This is evidenced in the memorandum of August 3, 2006, from the VA's Office of General Counsel to VHA Office of Patient Care Services: "these (face-to-face) contract health care practitioners may practice at any VA facility, regardless of its location or their state of licensure...we can see no [basis] on which to establish different licensure requirements for VA's contractors not actually working in a VA facility, including those providing multi-state telemedicine services. In our view, such offstation contractors would not need to be licensed by the state(s) where they perform services for VA under the contract, unless such licensure is required by the specific contract of Federal law."

Future Policy Considerations

8. Telemedicine will continue to be an area of promise for those interested in improving rural health care opportunities and the sustainability of rural communities in general. Unfortunately, licensure regulations continue to be a barrier to enhancing the breadth and the quality of care available in our rural communities. Encouraging not only a uniformity of licensure requirements among state regulatory bodies, but also an understanding of the importance of collaboration among these same bodies, will improve the environment in which telemedicine services are provided.

9. The National Rural Health Association must aggressively monitor not only established and proposed legislation that could impact this issue, but also identify the organizations (i.e. Federation of State Medical Boards, American Dental Association, American Telemedicine Association,) which are active participants in this issue. It will be important to work with organizations such as the above, for example, to identify solutions agreeable to most (i.e., bipartisan) and to educate these key stakeholders regarding the concerns and issues surrounding our rural providers and the patients they serve.

10. Should the political and regulatory climate be such that a comprehensive uniform telemedicine licensure proposal runs against substantial resistance due to the current political and regulatory climate, the National Rural Health Association must, when and where appropriate, bring forth more modest proposals such as off-site and/or cross state supervision via telemedicine where licensure may currently require on-site supervision (e.g., behavioral health providers). Such cautious policy recommendations, albeit incremental, serve a key purpose. A restrained telemedicine licensure policy approach may be particularly useful at building coalitions in congress and with key community, healthcare and business stake holders and result in a more favorable climate to propose and eventually pass far reaching policy proposals aimed at streamlining telemedicine licensure.

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