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Covid-Induced Changes in Health Care Delivery — Can They Last?

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Covid-19 shook the U.S. health care system. The immediate-term fallout was predictable: in-person utilization plummeted and many adults deferred routine care. Health care professionals, hospitals, and patients had to — and did — adapt rapidly to this unprecedented crisis, quickly flexing to increase the use of delivery modes such as telemedicine and home-based care.

Today, widespread vaccination is beginning to bring the pandemic under control. But will the pandemic-induced changes to health care delivery last as the pandemic itself fades? They may, given that they reflect trends that began before the virus emerged. But the rapid pace of change during the pandemic revealed the limitations of these new delivery modes and raises questions about whether our current health care system, and its financing, can support these changes and ensure that they improve quality and equity.

Telehealth is not new — Medicare has paid for rural beneficiaries' telehealth visits since 1996. But regulations made its use cumbersome, with restrictions on where patients could receive these services and which providers could be paid to deliver them; even when telehealth was available, payment rules made its coverage limited and far less lucrative than in-person care. As a result, overall rates of use remained low. With Covid-19, telehealth utilization increased dramatically,[1] and its use has persisted in some specialties that seem particularly amenable to remote care, such as behavioral health and primary care.[2] In primary care, for example, telehealth facilitates monitoring of symptoms of chronic conditions, medication adjustments, and treatment modifications, without requiring patients to return to the office.

Telehealth has other clear benefits. For working adults with limited access to paid sick leave or affordable transportation, the convenience of virtual visits has dramatically lowered barriers to care. Indeed, early data from some health systems have revealed a substantial drop in no-show rates, particularly among patients and in specialties that have historically

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had high no-show rates. Telehealth also makes it easier for clinicians to follow up with patients, particularly for light-touch but important interactions.

But this mode of care may also generate new problems that need to be addressed in financing and policy. Early data suggest that telehealth visits are less likely to include routine screening tests, lab tests, or even blood-pressure checks. More reliance on telehealth may reduce the likelihood that patients receive these important preventive services, which are often provided when a patient seeks in-person care for acute symptoms. And while telehealth reduces some access barriers, it increases others: there is a well-described digital divide, with older patients, poorer patients, and those with limited English proficiency less likely to have access to the technologies that enable telehealth or to have the skills to use them.

Telehealth growth during the pandemic was facilitated by temporary rules whereby payers reimbursed providers at parity with in-person visits under fee-for-service systems. Many practices, especially financially stressed independent practices and safety-net providers, had to pivot to telehealth just to stay afloat during the pandemic.

Supporting the ongoing use of telehealth will require restructuring the traditional payment mechanism that much of U.S. health care continues to rely on. Telehealth may be more sustainable under a global payment system such as capitation or other forms of risk-based contracting. Under these systems, it may be particularly useful in managing both care of high-risk patients and routine visits even if payment parity is rolled back. Such payment may also help to ensure that necessary preventive services are delivered alongside telehealth. But risk-based contracting is still in limited use, and other barriers to adopting telehealth among both providers and patients, including limited access to broadband in some areas, will need to be addressed to ensure equitable access to and use of digital and virtual technologies.

Telehealth, along with the growing use of digital health solutions and apps, also enabled the expansion of in-home care. Spurred in part by payment reforms that hold providers accountable for the total costs of care, health care institutions have increasingly substituted in-home care for inpatient care. The rates of both hospitalization and post-hospital rehabilitation stays in nursing homes have declined, and home-based care was becoming more common even before Covid.

The pandemic hastened these trends. Hospitalization rates plummeted in the early months of the pandemic, and nursing home stays for rehabilitation all but vanished. As Covid-19 continued to devastate nursing homes, patients opted to go home instead. Whereas occupancy rates rebounded in hospitals after the early months of the pandemic, they did not rebound in nursing homes, which remained underused and underoccupied through the end of 2020.

Patients often prefer to recover at home from a hospitalization, and doing so results in lower health care spending.[3] It may also be safer in some instances, particularly for patients who have higher-than-average risk for delirium, infections, and other complications related to inpatient care.

But there are costs to moving care home, many of which we may not be prepared to pay. People often have functional limitations after hospitalization, requiring help with activities of daily living. Home health benefits, such as those provided by Medicare, may cover some of this assistance, but not the frequent care that older adults often need. In these cases, the burden of care is often transferred to unpaid caregivers and family members, at substantial costs to them.[4] These costs are particularly high for the women and low-income people who usually provide such care.

If we are to continue to support the growth of care at home, we will need to expand the availability of and access to paid personal care assistance, which is currently an optional benefit in Medicaid and therefore subject to considerable state variation.

The decline in demand for nursing home care may also lead some homes to close, which will leave fewer options available to patients for whom nursing home care is most appropriate.[5] Solving this problem requires addressing the country's underlying failure to adequately finance and universally provide long-term care.

The Covid pandemic represented one of the largest disruptions to health care in recent memory. But that disruption created an opportunity for innovations — and forced providers and consumers to pivot on a dime to adopt those innovations. The most immediate changes were the scaling up of telehealth and in-home care.

The successful long-term adoption of these modes of care has two prerequisites. First, both patients and health care professionals must change their behavior. Second, the health care system, including delivery systems and payment systems, must adapt to support new ways of doing things.

In normal circumstances, the ordinary rhythm of technological adoption is measured, allowing health care professionals and patients to learn, adapt, and correct course along the way. In this manner, adopters move to new ways of doing things, and they gradually refine the process and do those things better. Financing systems and policies are repeatedly readjusted in parallel with this process so that coverage is expanded and benefits are redefined in an attempt to ensure that the system, and the people in it, can support the new modes of operation over the long term.

During the pandemic, the pace of changes in health care delivery left all those microimprovements and adaptations by the wayside. In the face of Covid-19, all health care professionals, all health care institutions, and all patients simultaneously changed course. A lot of good has come from this rapid innovation, and there is potential for ongoing improvements. But there is also significant uncertainty and concern about possible unintended consequences of the hastening of these trends.

As we move out of the Covid-19 pandemic, will these innovations last? It may depend on whether we can keep the good and fix the bad, and on whether health care leaders and the health care industry can move quickly to ensure that policies and payment support the improvement and development of Covid-accelerated innovations.

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