

EDITORS' NOTE

The “Telehealth Divide”—Who Are the Underserved, and What Care Is Improved?

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After years of slow progress, the COVID-19 pandemic forced a rapid adoption of telehealth and telemedicine. The transition was not uniform across demographic groups, reflecting social determinants of health. This special issue of *JABFM* highlights many lessons learned and reviews insights gained by patients, clinicians, and health care administrators about telehealth and telemedicine during the pandemic. The focus on research on the COVID-19 pandemic is turning increasingly toward the long-term impact of the pandemic. Reports on Medicare wellness visits, drug safety, medical abortion, and the differences in scope and location of practice by race and ethnicity of family physicians can also be found in this issue. (*J Am Board Fam Med* 2022;35:451–453.)

Telemedicine Visits and the Vulnerable/Underserved

The COVID-19 pandemic forced a dramatic expansion of telehealth and telemedicine. Patients underserved within the traditional in-person care model experience widening disparities in the telemedicine model, even when the patient is served by a Federally Qualified Health Center (FQHC). A report from Texas—which ranks poorly in the number of primary care physicians per capita—finds provider characteristics were not associated with telemedicine visits but patient characteristics were.¹ Similarly, Leung et al² found the most vulnerable patients in their academic inner-city practice were also the least likely to attend video visits, even with documented access to broadband Internet.

Another practice successfully leveraged technology to care for vulnerable patients, sending a nurse to the home to do formal assessments and assist with a clinician video visit.³ This led to many positive outcomes, such as designation of a needed guardian. In another important report, Hall et al⁴ compared the experience of both FQHC clinicians and patients in 2 separate trials comparing mental health professional telephone consultation with the patient’s primary care clinician to mental health clinical care assumed by the mental health provider. The results suggest

positive outcomes yet differences in the merits of these 2 different strategies.

Anaya et al⁵ propose important policy solutions for states and the Centers for Medicare and Medicaid Services to help address structural determinants of telemedicine barriers experienced by historically marginalized, low-income, and limited English-speaking populations.

Telehealth and Telemedicine Insights

Multiple reports provide insights to telehealth and telemedicine implementation. In West Virginia, the use of telemedicine increased visit completion rates by a clinically relevant amount.⁶ In a report from Arizona, the time to a follow-up visit was different for telemedicine versus in-person visits.⁷ Another report compares the number of diagnoses managed through telemedicine and office visits.⁸ A post-televisit survey⁹ provides patient satisfaction data. The least liked feature? No surprise, perhaps—it was a copayment.

Segal et al¹⁰ and Hall et al¹¹ provide a rich variety of perceptions on telehealth through interviews with patients, clinicians, and selected others. Separately, Frazee et al¹² provide the perspectives on telehealth from administrators of health care organizations, bringing other concepts to our understanding of telehealth, including loyalty of patients. Segal and colleagues take the next step, proposing a framework for appropriate virtual care.¹³

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Burdick et al.¹⁴ describe postadmission care (transitional care) that reduced readmissions, providing information on steps taken that created the difference and reminding providers that transitional care can include telemedicine visits. Stewart et al¹⁵ report positive outcomes with telehealth and Fitbit data in an innovative adaptation of the National Diabetes Prevention Program.

Online portals are also potentially powerful channels for telemedicine that are concurrently overused, underused, and undervalued by many. Tuan et al¹⁶ conducted a retrospective study of portal use for patients at 18 family medicine clinics over a 5-year period using an electronic access log.

COVID-19

Canada's eConsult Service proved highly helpful during the COVID-19 pandemic—primary care clinicians could submit a question to a specific specialty physician and get a quick reply.¹⁷

A sense of loneliness during the pandemic would not be unexpected, but what is the depth and breadth? Lonergan-Cullum et al provide suggestions for family physicians caring for the many patients that might be struggling with loneliness.¹⁸

Many family physicians and other providers worry about the long-term outcomes of COVID-19 on the future health of our patients. In a study of college students,¹⁹ many had asymptomatic COVID-19, while a significant minority reported persistent symptoms. Concurrently, Kansas family physicians have strongly positive attitudes toward COVID-19 vaccines, along multiple dimensions.²⁰

This Issue's Potpourri

Family physician practices (n = 145 across 36 states) use a wide variety of tools for the annual Medicare wellness visit, as documented by Loskutova et al,²¹ and their use is quite varied.

After a rigorous systematic literature search, Young et al²² (sadly) found few reports that investigated interventions to improve outpatient drug safety. Less surprisingly, recognized medication lists to warn of harms substantially overestimate *actual* harms. Medication abortion has received much recent attention. In a qualitative study, Razona et al²³ report family physician perspectives on barriers and motivations to medical abortion provision.

In this issue's policy brief, Wang et al²⁴ report on differences in scope and location of practice by race and ethnicity of family physicians. The results may not be what is commonly presumed.

To see this article online, please go to: <http://jabfm.org/content/35/3/451.full>.

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