

## Achieving Equity in Telehealth

Andrea Westby, MD FAAFP, Assistant Professor, North Memorial Family Medicine Residency/Broadway Family Medicine, Department of Family Medicine and Community Health, University of Minnesota Medical School

Tanner Nissly, DO, Assistant Professor, North Memorial Family Medicine Residency/Broadway Family Medicine, Department of Family Medicine and Community Health, University of Minnesota Medical School

Rebecca Giesecker, MD, PGY-1, North Memorial Family Medicine Residency/Broadway Family Medicine, Department of Family Medicine and Community Health, University of Minnesota Medical School

Kaleigh Timmins, MD, PGY-1, North Memorial Family Medicine Residency/Broadway Family Medicine, Department of Family Medicine and Community Health, University of Minnesota Medical School

Kathryn Justesen, MD, Assistant Professor, North Memorial Family Medicine Residency/Broadway Family Medicine, Department of Family Medicine and Community Health, University of Minnesota Medical School

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Abstract:

The SARS-CoV2 epidemic has led to rapid transformation of healthcare delivery and access with increased provision of telehealth services despite previously identified barriers and limitations to this care. While telehealth was initially envisioned to increase equitable access to care for under-resourced populations, the way in which telehealth provision is designed and implemented may result in worsening disparities if not thoughtfully done. This commentary seeks to demonstrate the opportunities for telehealth equity based on past research, recent developments, and a recent patient experience case example highlighting benefits of telehealth care in underserved patient populations. Recommendations to improve equity in telehealth provision include improved virtual visit technology with a focus on patient ease of use, strategies to increase access to video visit equipment, universal broadband wireless, and inclusion of telephone visits in CMS reimbursement criteria for telehealth.

Telehealth, defined by the World Health Organization (WHO) as the provision of healthcare services where patients and providers are separated by distance<sup>1</sup>, has held the promise of equity in access to care since its implementation in the United States in the 1970s.

Opportunities to reach communities and populations that lacked access to high quality healthcare seemed limitless. However, in the following decades, increasing insurance and governmental regulations led to telehealth being designed, marketed, and implemented for communities and populations already well-resourced. This then led to enhancing the health of the majority and already healthier populations through the offering of telemedicine concierge services, private partnerships, and “expanded access for those who can pay for expanded access”<sup>2</sup>. Additionally, the Center for Medicare and Medicaid Services (CMS) defines telehealth more narrowly than WHO<sup>3</sup>, only including visits with real time face-to-face interaction, i.e. video, and excluding telephone visits, potentially limiting the reimbursement of certain types of visits and disproportionately impacting under-resourced populations.

In response to the SARS-CoV-2 epidemic, ambulatory medicine practices have rapidly implemented telehealth options to continue caring for populations while limiting risk of exposure to the virus for healthcare providers and patients. Preexisting telehealth guidelines and reimbursements which had previously limited the breadth of impact in many settings have rapidly shifted in response. However, policymakers currently state that these changes are temporary to provide relief for the duration of the pandemic<sup>4</sup>. Based on our clinical experiences to date, we feel telehealth offers ongoing opportunity to improve equity in healthcare access beyond the pandemic provided a few key improvements are made.

When the public health crisis of SARS-CoV-2 became an immediate threat to the health and safety of providers, staff, and patients, University of Minnesota Broadway Family Medicine Clinic

in Minneapolis promptly transitioned the majority of our in-person office visits to telephone or video visits, regardless of the potential for reimbursement. Within the first eight weeks of offering phone and video visits, providers at our clinic performed 2,766 patient visits. Of these visits, 1,692 were by phone, 498 were by video, and 576 were in-person. Medical students, family medicine residents, and our community health worker identified patients over the age of 60 with high risk health conditions such as diabetes, COPD, and heart disease and conducted outreach by telephone to discuss the virus and services currently being offered at Broadway. This outreach led to a sense of safety and community among patients and providers, and as a result, many patients who had not been seen in the clinic in over a year scheduled and completed telephone visits. Here is one case example of a patient served by telehealth:

*DM is a 61-year-old male with type 2 diabetes and cardiovascular disease with a history of limited clinic follow up. He was last seen in clinic in January of 2019 after a hospitalization for acute pancreatitis and uncontrolled diabetes. DM has limited access to transportation, making traveling to the clinic a challenge. As part of our outreach to high risk patients during the SARS-COV2 epidemic, our clinic's community health worker contacted him and scheduled him for a telephone visit, as he had concerns about not being able to use the technology for a video visit. DM also did not read well, a barrier to care that he had not disclosed to anyone in the clinic previously and was not documented in his chart. Because he was in his own home and speaking to a provider on the phone, DM felt comfortable disclosing his challenges with reading and was able to spell the medication names directly from his medication bottles to the provider. He was not aware that some of his medications were supposed to be taken twice a day (including short-acting metformin and carvedilol) because he could not read the instructions on the bottle. Because he had his medication bottles in front of him while at home, DM was able to directly mark the twice-a-day medications, which increases the likelihood that he will adhere to*

*the prescribed treatment regimen. He was also able to come in for a lab visit at his convenience and was glad to schedule a follow up telephone visit in 2 weeks to review his medication changes.*

As seen in the case of DM, telephone communication is accessible, efficient, and well-accepted by patients in our underserved clinic setting. Additionally, providing telephone visits has increased access to primary care that was limited in our patient population by barriers such as those faced by DM. Studies on telehealth barriers have assumed that certain “individual” level factors are barriers that cannot be overcome by clinical or systemic innovation. However, in 2019 Antonio et al discussed the importance of not misinterpreting demographic factors as individual, unavoidable predictors of health outcomes. Instead, they recommend viewing these demographic factors as “social determinants of health inequities”, in order to emphasize that they are socially-mediated rather than personal or individual<sup>5</sup>.

Underserved populations often have known barriers to face-to-face telehealth visits: lack of access to video equipment, lack of reliable internet, concern about cost of copays, concern about cost of wireless data consumption, unfamiliarity with virtual platforms, confidentiality and trust concerns, and language barriers<sup>6</sup>. Despite these obstacles, we have seen the implementation of telehealth at our clinic as an opportunity to increase provision of high-quality primary care to underserved and under-resourced communities. Transportation issues, insufficient childcare, and limited ability to take time off work to attend an in-office visit have been mitigated by telehealth options. Other barriers, including transit time, time spent in clinic, and mental health barriers such as agoraphobia or depression have been significantly decreased if not completely eliminated by telehealth. As our clinic has limited visitors attending

in-person office visits, telehealth provides the opportunity for family members and caregivers to contribute to the history and decision-making if the patient desires this additional support.

In order to provide true equity of care, we must center at the margins: we must make the system work for the people and communities who experience inequities, both prior to and now exacerbated by the pandemic. “Centering at the margins”, a central tenet of critical race theory, refers to “making the perspectives of socially marginalized groups, rather than those of people belonging to dominant race or culture, the central axis around which discourse on a topic revolves”.<sup>7</sup>

If telehealth is accessible for those who are presumed the least able to use it, it will also work for those who do not have similar limitations. We need to ask our patients and communities what limits their access to telehealth primary care, both video and telephone, and address the limitations through systemic changes to progress toward equitable access to health care.

From our evaluation of the literature and the information gained during the rapid implementation of telemedicine during the SARS-CoV-2 pandemic in early 2020, we propose the following considerations to increase the likelihood of equitable telehealth care:

1. Healthcare providers need to utilize telehealth platforms that are easy to use even for the most technology-challenged patients and do not incur additional costs or barriers to use.
2. Payers should reimburse telephone visits at the same rate as face-to-face video and in-person visits in order to ensure equity of care provision. People who cannot access video visits should not be relegated to in-person office visits as their only option at this time, as this could be a barrier to quality primary care. Additionally, to remain financially

solvent, health care systems need assurance that adequate reimbursements for telehealth will persist beyond the pandemic and include higher reimbursement for initial video visits to account for time spent orienting the patient to the technology being used.

3. Video visits must be an accessible option for all patients who desire them. Many significant structural barriers must be overcome for this to be a reality, including access to high-speed broadband internet, video capable devices, and an appropriate environment from which to have a visit. Potential options for providing the necessary resources for video visits include:
  - a. Dispensing of video-capable devices or webcams by insurance companies, clinics/healthcare providers, or governmental agencies with whom patients come into contact.
  - b. Addition of video hubs staffed by community health workers (CHWs) in high rises, homeless shelters, or community centers. From 1972-1975, Mt. Sinai Hospital established and operated an experimental telemedicine-enabled community health site in a public assistance housing project in East Harlem, which was ultimately terminated due to lack of funding.<sup>2</sup>
  - c. Provision of high-speed broadband internet access for all people. Consider free wireless internet options in parking lots of grocery stores, post offices, big box stores, etc. One example already in place is in Washington state, where the state encouraged grocery stores and Wal-Marts to expand their free wireless internet access and make it more user-friendly<sup>8</sup>. Additionally, companies such as Comcast have adjusted their business plans to ensure internet access through the current pandemic<sup>9</sup>.

- d. Remember that some of the barriers to video visits are individual level and not easily overcome by healthcare system action, policy change or systemic procedures, and thus telephone visits must be an option for these patients.

Currently, there is no documented research showing a difference in quality between in-person, telephone, and video visits in primary care. Further studies will need to be done to examine outcomes in more detail, as until the SARS-CoV-2 pandemic, telehealth primary care, particularly telephone primary care, was not provided widely. This investigation must include how the lack of physical exam affects quality of care, and if we can trust provider knowledge and expertise to guide which conditions warrant a physical exam to provide appropriate care. We would argue that if done thoughtfully, telephone visits will increase access to primary care without compromising quality. Minimizing barriers to telehealth for all communities and populations will provide increased access to health care, thereby leading us closer to health equity for all.

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