Getting Beyond Parity: Telehealth as a Best Practice in Health Equity

Andrew C. Philip, PhD; Mary M. Ford, MS and Jordan Goldberg, JD

Affiliation: Primary Care Development Corporation, New York City.

Corresponding Author: Andrew C. Philip, Email: aphilip@pcdc.org

Keywords: Telehealth, Health Equity, Parity, Telemedicine, Health Disparities, Access to Care

Section: Editorial

The global pandemic spurred a rapid uptake of telehealth for nearly all healthcare providers and has permanently changed how health care is delivered. At present, providers and insurers are grappling with how to balance telehealth and in-person care, focusing discussions around reimbursement models and logistics. In this article, the authors acknowledge barriers to telehealth implementation and utilization as guides to discuss whether telehealth can be considered as a good treatment option as in-person care, if it can be even better, and its potential to address intentional development of equity in health care. Many opportunities exist with telehealth, from expanding the provider pool for patients to reducing stigma associated with presenting for in-person care. These opportunities must be approached strategically if they are to result in meaningful improvements in eliminating health disparities. The authors propose several considerations for ensuring that equity is at the forefront of telehealth implementation discussions and encourage providers, insurers, and advocates to be purposeful in advancing these opportunities.

Rapid telehealth implementation, made necessary by the global pandemic, has significantly changed the delivery of healthcare services in the present and raised questions for its future. At times serving as the primary or even only option for access to health care, the boom in telehealth was borne out of necessity, and not from a carefully executed strategy for controlled expansion and equitable deployment. As a result, while some patients and providers have embraced virtual care as a preferred method of services, low-income populations, rural communities, older adults, and others have struggled to navigate technological and cultural complexities. Now, as systems, health plans, and providers examine the current state and future of telehealth, important questions are emerging from the practical to the ethical.

There is considerable consensus that telehealth will remain as a component of healthcare delivery; however, few are certain of the ultimate balance between in-person and virtually delivered care. The present emphases have been around reimbursement, technology, and ensuring telehealth itself remains a viable platform for various forms of care. An important distinction, however, is that even when the goal of telehealth expansion is to create access to care, history has shown that not all accessible care is inherently equitable. As telehealth is increasingly accepted and expected, providers must take care to avoid an unintentional but insidious two-tier system, where those with the greatest privilege enjoy access to the best quality care and outcomes, and those with less power and means are left with just the opposite.

Telehealth presents an opportunity to enhance access, experience, and quality of care, especially for those we have failed to adequately serve through past models of care.

TOWARD EQUITY OPPORTUNITIES

There are many bona fide opportunities to address parity and equity in health care through telehealth. A shift to center the discourse around these opportunities is essential in the coming years to ensure that meaningful change is realized. The concepts discussed here are primarily positioned from the patient-centered perspective; patient-level social, demographic, and economic characteristics largely drive the gaps in inequitable health outcomes.

Telehealth brings forward the ability to match patient access to a more diverse provider pool than ever before. Evidence demonstrates that matching patient and provider characteristics in areas, such as race, language, gender identity, and cultural background, often leads to higher quality care and better patient outcomes. This works in two ways: first, a greater level of patient trust is often garnered when a provider looks and talks like the patient; second, providers from minority backgrounds have been shown to provide better care to minority patients than white providers. Telehealth can open a larger pool of representative providers to patients across insurers and support technologies, and expand algorithms to maximize matching processes based on patient preferences and data. This larger pool of providers can only be created, however, if educational and healthcare systems do much more to cultivate, attract, and retain diverse professionals available via telehealth.

Beyond the patient's background, telehealth has the potential to address the limited capacity of providers by expanding the patient's network of accessible provider specialties and insurers. Within many specialties, including primary care and behavioral health, providers are at capacity either entirely or within insurance carriers. This can create challenges for patients with Medicaid and Medicare who have some of the most restrictive options for provider access and have frequent reports of the insurance provider "cap" at a health service organization.

Telehealth may also enhance equity through lessening the power of stigma. The basic act of presenting to a physical location can amplify the experience of stigma in accessing certain types of care. Patients visiting brick-and-mortar clinics may fear being seen by colleagues, neighbors, or family where certain and necessary types of providers or health services may be perceived as shameful or damaging (e.g., harm reduction programs, psychiatric centers, and family planning clinics). For some, the physical location of a provider's office may carry stigma, particularly in neighborhoods that remain racially and socially segregated. In addition, some patients find greater comfort in virtual

visits and may be more able to disclose medical history or speak freely about their medical concerns if permitted to access audio-only telehealth services (at present, most telehealth services are assumed to be video).

There are still many important opportunities where telehealth can be used to reduce the practical barriers that telehealth was initially intended to remedy, but the opportunities here have not been fully realized. The ability to overcome distance and transportation barriers through telehealth is meaningful even in non-rural areas and is often overlooked as a consideration in cities, as many metropolitan areas have a poor public transportation infrastructure limiting residents' abilities to travel locally. For disabled and homebound patients, telehealth continues to offer opportunities for care to meet patients where they are. Finally, the costs associated with traveling to medical appointments cannot be understated—these include childcare, taking hours off work, as well as transportation costs. Patients have long reported missing appointments due to childcare or work considerations, and telehealth offers opportunities to move at least a part of health care to a more accessible, convenient format.

APPROACHES TO EQUITY

Telehealth growth and sustainability must focus on incorporating equity and access for all. In the care system, discrimination based on race and ethnicity, stigma around supporting individuals with behavioral health needs, and disregard for older and rural populations have been long documented. What have we learned from increasingly visible injustices in care and communities, where already marginalized individuals remain so? The collective "we"—healthcare practitioners and staff, system leaders, insurers, and federal payers and regulators—must not just "make space" for equity in the discourse on telehealth but also center the discussions around equity at all times.

We offer four practical areas of emphasis to support an equitable approach to telehealth:

1. Accessible care is not the same as quality care. The pandemic-related tide of telehealth implementation brought challenges. Processing complex trauma histories with patients during behavioral health visits or deciphering whether one heard "Inderal" or "Adderall" during a medication reconciliation proved even more complicated while video lagged or connections dropped mid-sentence. Patients struggled too, unable to find privacy in crowded homes or a safe place to request prenatal support.

Equitable telehealth solutions need to consider what typically gets in the way of quality visits, and whether a temporary fix is an ultimate solution. Patients in rural areas or with low income may lack broadband connectivity, and a solution may simply be using a telephone, if available. Patients lacking access to safe spaces for visits may benefit from as basic an intervention as their provider acknowledging that it may be more comfortable for them to engage in visits while outside or in a vehicle. Creativity may yield better access; however, consideration must be given to whether these measures, if ongoing, result in a poorer quality visit.

If racial, geographic, or income disparities bring with them a need for frequent creative solutions, structures may need to be changed to ensure real equity in telehealth. The solutions have taken the form of investments in connectivity and may warrant other changes, like safe, community-based spaces that patients can use to access virtual visits or routinely accessible adaptive technology to ensure patients with visual, speech, and hearing impairments can benefit from telehealth.

Challenges in accessing quality telehealth should not categorically result in opting for only in-person care or rely on constant workarounds faced largely by those with the least privilege.

2. Embrace data and quality improvement strategies in telehealth to proactively test assumptions around fairness and justice. Clinics and hospitals should leverage quality improvement assets to study trends in who is accessing telehealth, what types of services they are accessing, and why. Do the services and outcomes differ by patient demographic? Do black, indigenous, and people of color (BIPoC) patients access virtual care more or less routinely than others? Do outcomes differ based on race when controlling whether services are accessed remotely versus in-person? Are transgender or non-binary patients more or less likely to return for future visits after an initial telehealth appointment compared with cis-gender patients?

Regular, ongoing data review should be targeted to examine not only whether telehealth enables or hinders care overall but also how it differs by groups and particularly among historically marginalized populations. A negative trend need not be met with a reversal of telehealth use, but, instead, instigate a series of rapid interventions to ensure appropriate supports are in place to maximize the value of telehealth for all patients.

3. Consider the implications of reimbursement and incentives to bolster telehealth's ability to expand quality care to broader patient populations. Payers including health plans and Medicare/Medicaid drive a significant amount of focus in nearly all health systems. As telehealth gains greater attention and examination, a key metric, alongside things like appointment availability, health outcomes, and patient satisfaction, should be health equity and eliminating disparities that may be otherwise amplified through inadequately supported telehealth solutions.

The possibility of accessible solutions such as audio-only visits when appropriate should be supported with clear parity. Primary care and other providers in small or solo practices—often a thin lifeline in under-resourced communities—should not face uncertainty when attempting to understand whether an appropriate episode of care that meets a patient's needs and reduces barriers will "count" for reimbursement if conducted virtually. It is essential that parity is enforced to ensure that the right type of telehealth service (be it audio, video, or other technology-enabled solutions) is adequately reimbursed and made available so that all patients can enjoy access to quality telehealth services, especially when access to in-person care is a challenge.

4. Training for staff and patients will ensure long-term acceptability. A minority of healthcare providers practicing today were formally trained in virtual care delivery during graduate and professional education. Patients are still learning to navigate the world of portals, integrated health systems, and now video visits. Small practices and clinics, especially those serving minority or at-risk populations, may need additional support to implement and scale telehealth offerings. Patients with intellectual and developmental disabilities, older adults, and patients who have experienced mistreatment or discrimination in the past may all face obstacles to telehealth acceptance. These barriers can be a sign that in-person care may be preferable, but again, may also be opportunities to enhance equity by providing additional support to engage a successful telehealth encounter.

Providers need training in how to deliver excellent care through both virtual and in-person care. Patients and families need experience in developing healthcare relationships via telehealth services, and a seat at the table in discussions around what care may be most useful for them. Health literacy needs to be a key focus in developing materials and technologies that patients and caretakers understand and feel comfortable interacting with. In telehealth, health literacy may also take the form of helping patients understand potential benefits or trade-offs in selecting telehealth or in-person care. For individuals with barriers to telehealth access and use, the answer cannot be as black-and-white as either not using telehealth at all or experiencing poorer outcomes through telehealth. All patients and providers should be afforded a similar level of access, which may include additional time to develop comfort and dedicated resources to build capacity.

A SUCCESSFUL FUTURE STATE

While providers were focusing on whether telehealth was here to stay a year ago, today the question seems not whether we will continue to utilize telehealth services widely but how, for whom, and to what benefit. Our system of health care has historically failed many of our most deserving Americans, especially BIPoC (Black, Indigenous and People of Color) individuals, LGBTQ + (lesbian, gay, bisexual, transgender, queer [or sometimes questioning], plus others) patients and their families, rural communities, and older and home-bound patients. With telehealth now firmly rooted in the health delivery system, we have an opportunity to center innovation around equitable access and outcomes that are not merely measured as "equal" to past models of care but better. By centering innovation, accountability, and success around a core value of equity and patient-centeredness, telehealth may emerge as an avenue for healing and connection long overdue.

Funding statement: No funding was received from any commercial source for preparing this article for publication.

Conflicts of interest: The authors have no personal financial conflicts or influences to report in this article for publication.

Contributors: A.C.P.: concept development, manuscript preparation, and writing.
M.M.F.: concept development, manuscript preparation, and writing.
J.G.: concept development, collaborative review, and editing.