Preparing Telemedicine for the Frontlines of Healthcare Equity

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A few weeks ago, which ranked one of the deadliest weeks in New York City with nearly 3000 COVID-19 deaths,¹ I had a chance encounter on the street with a former patient, Mr. K. I had taken care of him in the emergency room five months ago. He is in his mid-fifties, lives in a homeless shelter, and works as a busboy. Not having a primary care doctor, he uses the emergency room (ER) often to manage complications of his diabetes. A few days before we ran into each other on the street, he went back to the ER because he noticed blood in his urine but was turned away because he did not have typical symptoms of COVID-19. Instead, he was offered a virtual care option—that is, asked to speak to a doctor on video. Being uninsured, financially distressed, and having recently lost his job due to restaurant closures, he had no idea where to start.

Thousands of people are in the same plight as Mr. K. In light of the pandemic, many healthcare centers quickly turned to telemedicine—phone or video visits with health providers—as a means to provide non-emergency care. While the infrastructure enabling this capability has been many years in the making, variable state laws and lack of urgency have historically staggered its adoption.² With the sudden advent of COVID-19 and the rapid need to preemptively decongest hospitals, the Federal government lifted many restrictions on telehealth for Medicare. Subsequently, many private insurers followed suit—almost overnight. In doing so, healthcare organizations were able to make non-emergent healthcare accessible to many Americans but challenges remained for those most vulnerable.

Access to technology is still a major barrier to widespread adoption of virtual care.³ Phones and phonelines are not guaranteed for many in low socioeconomic status communities, let alone video-conferencing capabilities that require high-speed broadband connectivity. More fundamentally, digital literacy is lower among poorer and older populations.⁴ Affordability of virtual care may further contribute to this gap:

socioeconomically vulnerable populations may have to think twice about insurance coverage for virtual care and the availability of financial assistance if they are unable to pay.

Social and cultural elements compound these access barriers. African American communities have reported higher levels of mistrust toward the healthcare system, largely as a consequence of historical injustices such as the Tuskegee Syphilis Study and persistent effects of systemic racism.⁵ Immigrant populations may have heightened skepticism around confidentiality, privacy, and data security concerns in the context of telemedicine, particularly in light of current policies such as increased visibility of U.S. Immigration and Customs Enforcement (ICE). Care provisions for undocumented immigrants are also a concern among the Latinx community.⁶ Language barriers and the availability of interpreter services are significant impediments for non-English speakers in low-income communities. Finally, the physical absence of the physician serves as a perceived deterrent to telemedicine use among many cultures.⁶

In reality, telehealth is here to stay—and as patients see its benefits, the adoption will likely see an uptick. Despite its challenges, telemedicine may offer particular benefits to socioeconomically disadvantaged communities by potentially reducing (or eliminating) transportation burdens, unwanted wait times, and having to take time off from work; factors that typically inhibit adequate follow-up.

But as health systems optimize resources for telemedicine, the needs of vulnerable populations need to be paid particular attention to. Phone services may be preferable to videoconferencing, if feasible, as it may not require high-speed internet or complex digital interfaces. People coming from low socioeconomic backgrounds often work long and non-traditional hours to have a stable income: telemedicine offerings can facilitate after-hours availabilities so that it does not compete with income potential.^{5,6}

Reimbursement models may consider offsetting the cost of a phone call for the patient if necessary. Diversifying the provider portfolio can also meet the need for culturally humble care, thereby improving visit satisfaction and, ultimately, healthcare outcomes. The needs of providers caring for lower resourced communities similarly need to be addressed: public and private payers need to negotiate fair reimbursements for healthcare providers and adequately cover costs for the patient on the front end.⁷ Under and/or uninsured patients could be enrolled in social programs that can additionally offset some of these costs.

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Logistics of delivery are important as well. Widespread advertising of service provisions is critical to garnering support among vulnerable populations. The messaging should uphold the service's commitment to not only privacy and security but also superior quality of care. Special consideration must be taken to overcome challenges for those without direct access to telemedicine. Partnerships among local governments, health organizations, and trusted community stakeholders, such as faith-based organizations, barbershops, and local libraries, can mitigate these barriers by organizing lending programs for electronic devices, providing internet-capable private spaces and offering peer-led technical support.

COVID-19 has changed non-emergent healthcare delivery in such a rapid and rampant way—and rightfully so, as curbing the pandemic is of utmost priority. But *truly* curbing a pandemic requires an equitable approach: now, more than ever, we cannot let people like Mr. K. slip through the cracks and spiral into a state where all his robust efforts to gain agency over his own health become futile. As healthcare professionals, it is imperative that we unite not only in the fight against COVID-19, but also against inequity. We must ensure fruitful outcomes for all strata of Americans.

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REFERENCES

1. COVID-19 Data NYC Health. Available at: <https://www1.nyc.gov/site/doh/covid/covid-19-data.page>. Accessed April 17, 2020.
2. State Telehealth Laws and Reimbursement Policies Report. Center for Connected Health Policy. Available at: <https://www.cchpca.org/telehealth-policy/state-telehealth-laws-and-reimbursement-policies-report>. Accessed April 16, 2020.
3. Digital divide persists even as lower-income Americans make gains in tech adoption. Pew Research Center. Available at: <https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/>. Accessed April 15, 2020.
4. Harvard Kennedy School Shorenstein Center on Media, Politics and Public Policy. Computer usage and access in low-income urban communities. Available at: <https://journalistsresource.org/studies/society/internet/computer-usage-access-low-income-urban-communities/>. Accessed April 16, 2020.
5. Corbie-Smith G, Thomas SB, St George DMM. Distrust, Race, and Research. *Arch Intern Med*. 2002; 162:2458-63.
6. George SM, Hamilton A, Baker R. Pre-experience perceptions about telemedicine among African Americans and Latinos in South Central Los Angeles. *Telemed J E Health* 2009;15: 525-530.
7. Milbank Memorial Fund. Telehealth as a tool to address COVID-19: How can states make it easier to use? April 2020. Available at: <https://www.milbank.org/news/telehealth-as-a-tool-to-address-covid-19-how-can-states-make-it-easier-to-use/>. Accessed April 14, 2020.

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