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EDITORIAL – GLOBAL HEALTH SERVICES RESEARCH

# Bridging the Disparity Gap in Surgical Oncology Access: Does Telehealth Hold a Key?

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Barriers to access quality cancer care are among the cardinal reasons for poorer oncologic outcomes for Black, Hispanic, rural, uninsured, and underinsured patients compared with wealthier White urban patients with insurance coverage. Barriers may be geographic, i.e. long travel distances, or social such as the lack of a support system to help the patients navigate the complexities of cancer care, the availability of childcare or means of transportation. In rural Western states, patients must travel hundreds of miles to reach quality cancer care; the exorbitant cost of gasoline and difficult weather conditions further contribute to disparities. Economic barriers conspire with the geographic and social barriers, especially for patients of low socioeconomic status.

The coronavirus disease 2019 (COVID-19) pandemic, one of the major catastrophic events of modern history, has not only upended our way of life and routine practice of medicine as we knew it but also laid bare some of the staggering disparities for marginalized, migrant, minoritized patients.[1] Social determinants of health—the circumstances we are born into, grow up and learn, receive care, work, worship, and age in—ultimately determine healthcare processes and outcomes. At the height of the pandemic, providers and/or patients were forced to or chose to cancel or reschedule appointments and procedures to minimize their risk of exposure to COVID. The critical need to continue to provide 'elective' patient care in the face of a devastating COVID-19 pandemic undoubtedly led to the leap in telehealth implementation across many health systems. The benefits of telehealth, such as time, expenses, and efforts saved to receive care, in terms of gasoline, vehicle maintenance, and a decrease in the number of days missing from work, have been described before the pandemic.[2] However, profound barriers such as hospital and physician reimbursement, provider licensing, and robust telehealth information technology (IT) infrastructure that is Health Insurance Portability and Accountability Act (HIPAA)-compliant prevented telehealth from being a standard component of healthcare access.[3] In response to the pandemic, sweeping changes from the Centers for Medicare and Medicaid Services (CMS) regarding reimbursement and temporary changes from state governments dismantled some significant prior obstacles to routine telehealth utilization from the healthcare system standpoint.[4]

Yet many institutions, providers, and patients were not ready. For example, in a cross-sectional study of Medicare beneficiaries, Lam et al. cited lack of familiarity with technology, dementia, and hearing impairment or difficulty with communication.[5] Nearly one-quarter of American households lack broadband internet access (BIA),[6] especially among rural communities (28%), households with low scholastic attainment (41%) or low income (43%), and Hispanic (35%),[6,7] suggesting that the population that might gain most may be too disadvantaged to access telehealth.

In this issue of *Annals of Surgical Oncology*, Paro and colleagues investigate telehealth utilization among 2942 patients seen at The Ohio State James Cancer Hospital from March 2020 to May 2021.[8] They focused on the digital divide index (DDI), a composite score that includes infrastructure/adoption, and the socioeconomic status score

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to predict telehealth utilization.[9] Patients utilizing telemedicine had a median age of 61 years and were predominantly White (87.2%), and 99% were English speaking. Patients with better insurance coverage were overrepresented among telehealth users and nearly half resided in the same or neighboring county as the hospital. Paro and colleagues found that county-level DDI did not impact telehealth utilization, but age, sex, primary site of cancer diagnosis and insurance did.[8] The authors did not describe the details of their telehealth implementation, which are crucial, as ease of use and flexibility in implementation will favor some groups or discourage others, e.g. translation services may have only been available for in-person visits, which could explain why few non-English-speaking patients took advantage of the telehealth offer.

While the work by Paro et al. adds to our understanding of the interplay between DDI and telehealth utilization, several important limitations hinder generalization beyond this cohort, their geography, and institution. The median age at cancer diagnosis in the US is 66 years compared with 61 years in this cohort—the age distribution will impact utilization because nearly one-quarter of Medicare beneficiaries lack digital access at home.[10] The reported rate of home BIA in 2021 among ages 50–64 years was 79% versus 64% for patients $\geq$ 65 years of age.[6] Racial and ethnic minorities with lower home BIA rates represent only 10% of the study cohort. Half of the patients in this study live within the county where the hospital is located or in neighboring counties, yet telehealth should be more beneficial the longer the distance traveled; one wonders how this applies in the Rural Mountain West or the Southern US where patients must travel long distances to seek cancer treatment. Paro et al. describe higher utilization among certain cancer types; is this the result of physician or patient preferences, or unequal implementation across the healthcare system?

Paro and colleagues ask the right questions, when they wonder if "certain groups such as women with breast cancer – may prefer in-person appointments," or why "telemedicine utilization may have a harder time gaining traction among socially vulnerable" populations. Partnering with mixed methods researchers to hear the lived experiences of patients, caregivers, and frontline clinicians would help to learn what hinders or helps equitable telemedicine adoption. Taken together, the data highlight how context drives utilization of telehealth services. Further work examining telehealth utilization among different geographic regions and ethinically/racially diverse cohorts will refine the insights provided by the work by Paro and colleagues. A concerted, multidisciplinary effort will be necessary to extend the benefits and advantages afforded by telehealth services to all our surgical oncology patients.

**DISCLOSURES** Elliot A. Asare, Michael H. Andreae, and John H. Stewart IV declare no conflicts of interest.

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