Equity in the Age of Telehealth: Considerations for California Policymakers

Telehealth has proliferated due to the stay home mandates associated with COVID-19 and the desire to keep health care facilities clear for an anticipated influx of critically ill COVID-19 patients. Data from the Centers for Medicare and Medicaid Services (CMS) showed the number of telehealth visits in the early weeks of the pandemic skyrocketed to 1.7 million beneficiaries accessing telehealth in a single week as compared to 13,000 prior to COVID-19. A survey of 29 health care safety-net organizations in California found a significant rise in telehealth visits from .5% of all visits in January to nearly 55% of visits in May. Behavioral health visits were also up roughly 25% during that same time. [1] At least one health plan in Covered California reported an increase from 16% to 30% in the number of telehealth visits since the pandemic began.[2]

California was one of the first states to pass a telehealth law. The Telemedicine Development Act of 1996 (SB 1665), updated in 2011 (AB 415) and most recently in 2019 (AB 714), provided California with a strong foundation to expand access to telehealth services during the current pandemic.[3] In response to COVID-19, California now requires Medi-Cal and commercial plans to reimburse for services provided by telephone, while Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) have been allowed to receive the same Medi-Cal payment for services provided in-person, by video and by phone. Additionally, the Governor relaxed consent and privacy requirements making it easier for providers and consumers to communicate across multiple platforms. Many providers are pushing hard to make these temporary changes permanent and DHCS is currently in the process of evaluating its global telehealth policy to determine which flexibilities should be extended beyond the COVID-19 pandemic.

Telehealth has a tremendous potential to improve health outcomes for those who have historically lacked access to medical care. With more widespread use and adoption in Medi-Cal, low-income communities, including those living in rural and medically underserved areas, can connect to specialists and manage their chronic conditions from home.[4] Research has shown that virtual visits are comparable to in-person visits for certain services and can ease patient burden in terms of transportation costs or lost wages due to time away from work.[5]

But this rapid deployment of technology for health care has not fully accounted for the needs of Black, indigenous, and people of color, including low-income, seniors, limited English proficient, persons with disabilities and those living in rural areas who experience digital barriers at higher rates. A recent evaluation of telemedicine implementation at UCSF Medical Center and Zuckerberg San Francisco General Hospital, found that while video visits increased from 3% to 80% and telephone visits from 0% to 16% of total weekly visits in a 2-week period before and after COVID-19, the proportion of visits with populations at risk for limited digital literacy have decreased significantly, including among patients 65 years of age or older, non-English language patients and those on Medicare or Medicaid.[6]

While the quick pivot to a telehealth world demonstrates that health care can adapt, and adapt quickly, when external factors make the status quo untenable, health care innovation must not leave behind our diverse communities.

Since before Covid-19, we've known that structural racism in health care, creates and perpetuates deep inequities. In California, people of color are most likely to be uninsured, to lack access to health providers, to lack a trusted regular provider, to report negative experiences in health care, and to experience poor health outcomes. Moreover, people of color are underrepresented in health professions, resulting in frequent cultural and linguistic incongruence between consumers and providers.

So how can health care adapt to address the deeply entrenched racial inequities? And is broader adoption and utilization of telehealth part of that puzzle?

While telehealth has existed for many years, research on its impact on communities of color and evaluation of its ability to reduce health disparities is limited. Some of what does exist points to problematic uses that further marginalized communities of color. For example, in the 1970s NASA and the Indian Health Service embarked on a telehealth experiment to bring greater access to care to rural communities, specifically the O'odahm Nation in South Central Arizona. However, the program did not integrate the tribal leadership and was experienced by the community as exploitative and was ultimately canceled. More recent studies of telehealth utilization by Latino patients have shown greater success with the adoption of mobile behavioral health treatments, and remote blood pressure measurements, among others.[7] These findings demonstrate that more attention must be paid to assessing consumer satisfaction across populations to identify and implement best practices now in order to prevent more widespread disparities later.
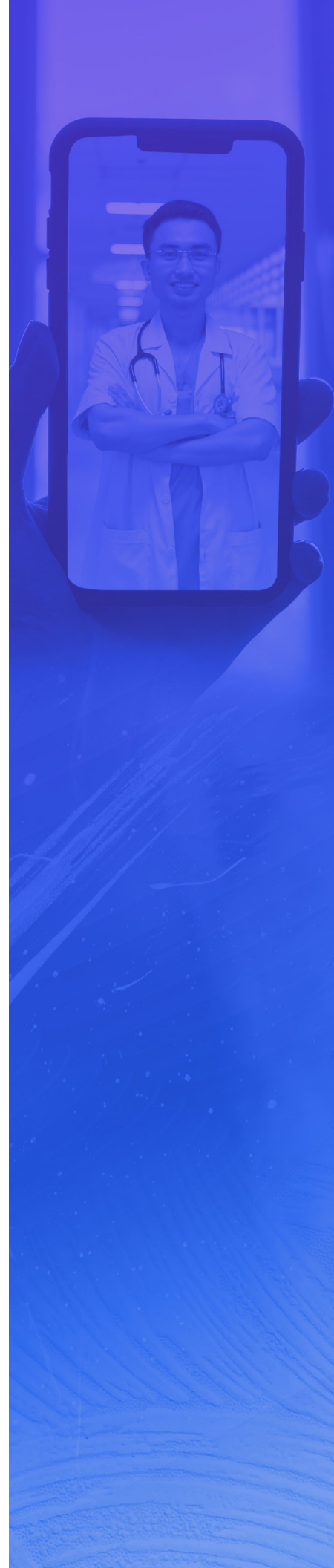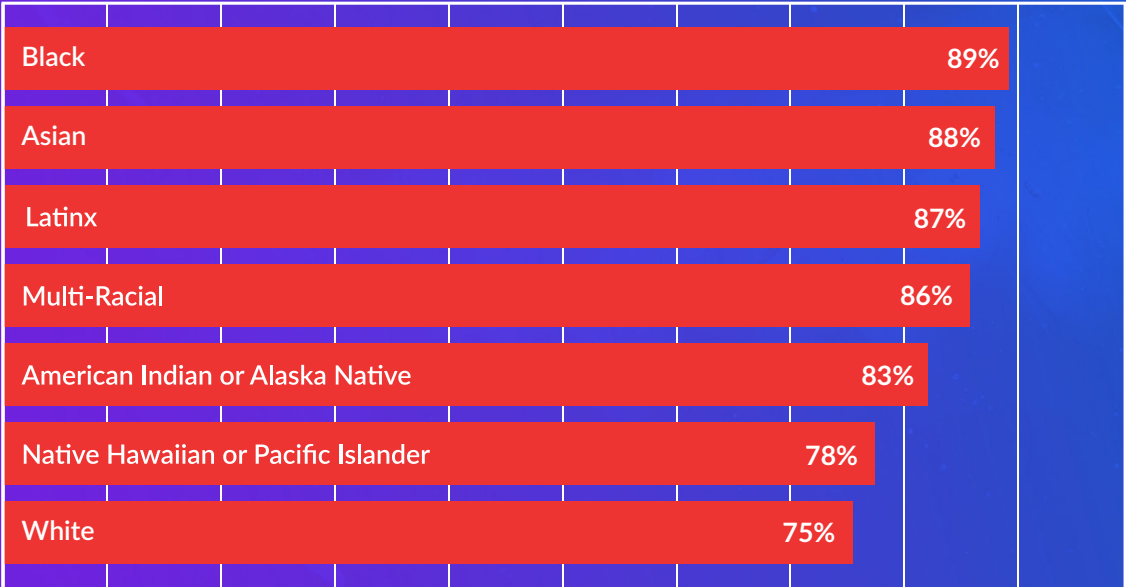
Consumer Survey Findings

To address this gap in our understanding of how consumers of color experience telehealth, the California Pan-Ethnic Health Network (CPEHN) fielded a consumer experience survey in September 2020. The survey targeted people of color and those with limited English proficiency through an online platform and was conducted in English, Spanish, Chinese, and Korean. While the survey findings are limited by being conducted as a convenience sample, this survey also represents one of the most robust samples of people of color reporting on experiences with telehealth to date.

1,662 consumers with a recent telehealth experience completed the survey. Of these, 36% were Black, 12% Latinx, 9% Asian, 5% American Indian or Alaska Native, 4% Native Hawaiian and Pacific Islander, 6% Multi-Racial, and 19% White. Over a quarter of respondents reported a primary language other than English, predominantly Spanish and followed by Chinese and Korean. Approximately a third of respondents identified as a person with a disability and a third identified as LGBTQ+. 68% of respondents had accessed primary care via telemedicine, 20% had accessed specialty care, and 11% had accessed mental health or substance use treatment.

The survey results demonstrate that telehealth holds significant promise for increasing access to care in communities of color, and for shifting health care to truly place the consumer at the center.

Survey respondents overwhelmingly reported satisfaction with telehealth. Nearly 90% of Black respondents reported satisfaction with their telehealth visit overall, and equal or greater satisfaction with telehealth than with in-person medical care. Interestingly, all populations of color reported satisfaction with telehealth at a greater rate than the White sample, with 75% reporting satisfaction.

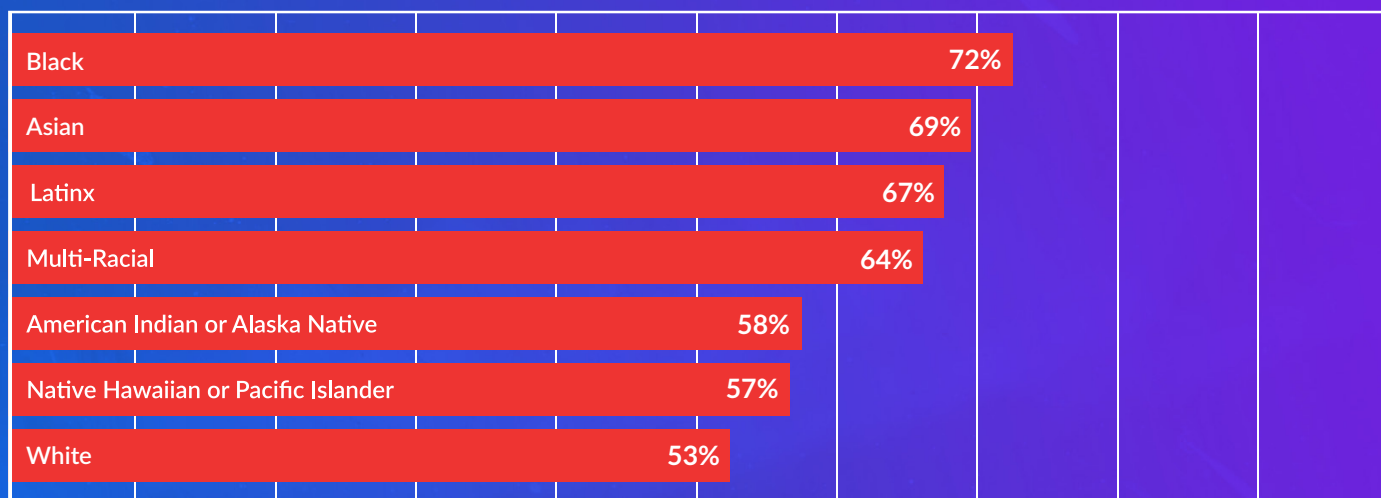**Majority of respondents were at least "somewhat satisfied" with their telehealth visit.**

Race/Ethnicity	Percentage
Black	89%
Asian	88%
Latinx	87%
Multi-Racial	86%
American Indian or Alaska Native	83%
Native Hawaiian or Pacific Islander	78%
White	75%

Percentage of respondents who were at least "Somewhat Satisfied"

Over 70% of Black and Asian consumers reported that their telehealth appointment was easier to keep than an in-person appointment would have been. This dovetails with provider reports that no-show rates have been significantly reduced.

A majority of people of color stated they prefer telehealth, although by smaller margins and with wider variation between populations. Over 60% of Native Hawaiians and Pacific Islanders, Blacks, and Asians stated a preference for telehealth, but only a slight majority of Latinx and American Indians had the same preference.

Majority of respondents prefer telehealth over an in-person visit.

| Group	Percentage
Black	72%
Asian	69%
Latinx	67%
Multi-Racial	64%
American Indian or Alaska Native	58%
Native Hawaiian or Pacific Islander	57%
White	53%

Percentage of respondents who prefer telehealth over an in-person visit

These findings are similar to the results of a recent California Health Care Foundation survey of low-income consumers, which reported that people of color and those with low-incomes were most likely to use telehealth and were satisfied with their experience, by large margins.[8]

This data points to the importance of expanding the availability of telehealth and strengthening the integration of virtual care within our delivery system. However, there are some important considerations in order to ensure that a longer-term shift to telehealth as a health care modality lessens disparate access and improves health equity. **Although these survey findings show a high rate of overall utilization and satisfaction across all populations, the disaggregated data reveal barriers for BIPOC populations that may be masked by just looking at that topline data.**

- **Privacy:** When asked whether they have a private place to be during a telehealth appointment, 36% of Asian respondents indicated that they do not, followed by 32% of American Indian or Alaska Native respondents, and 30% of Native Hawaiian and Pacific Islander respondents. Black and Latinx respondents were less likely to report lack of a private space, with only 17% of each population indicating that this is a concern.

- **Language Access:** Language access is a major concern. 60% of limited English proficient individuals who responded to the survey reported that the telehealth services they received were not in their preferred language. This appears to be less of a concern for Spanish speakers, with 75% reporting that they did receive services in their preferred language.

- **Technology:** Latinx respondents were most likely to report access to technology as a barrier. 62% responded that they did not have a strong enough internet connection or bandwidth and 57% stated that they did not have enough cell phone minutes to effectively utilize telehealth.

- **Consumer Education and Assistance:** 40% of consumers reported that they did not receive any instruction from their provider on how to prepare for or access their telehealth appointment.

Most limited English proficient respondents could not access an in-language telehealth provider.

Telehealth visit in-language

Telehealth visit not in-language

60%

40%
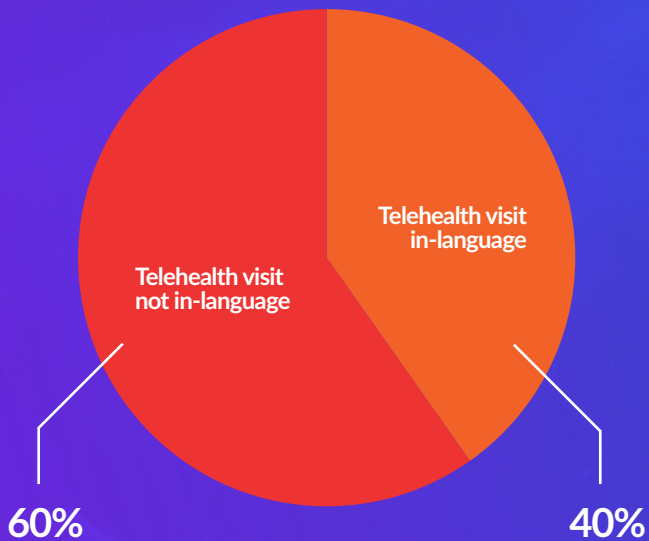
Many consumers did not receive instruction on how to prepare for or access their telehealth appointment.

2%
Did not answer

Did not receive instruction

Received instruction

58%

40%
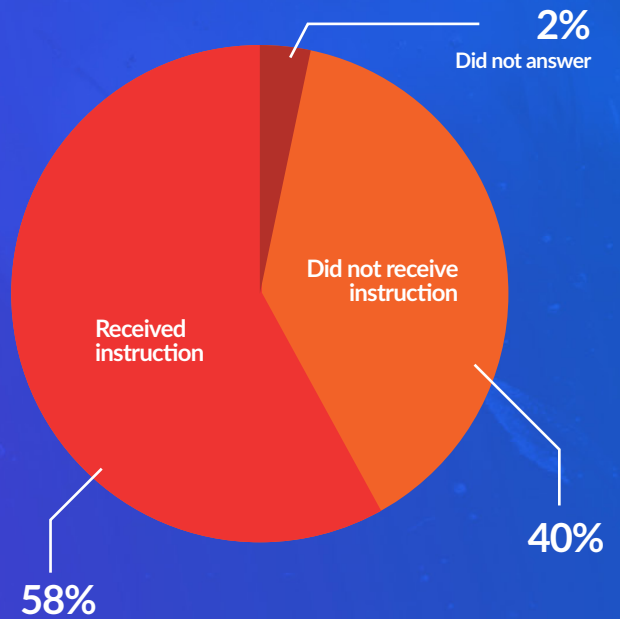
Policy Recommendations

As the health care delivery system continues to adapt and federal and state policymakers consider the merits of making permanent the temporary expansion of telehealth, we must center health equity and the needs of diverse consumers in future decisions related to telehealth policy. This will require state policymakers to:

1. Study and evaluate diverse consumer experiences and needs,

2. Ensure adequate investment in consumer education, care coordination and appropriate patient tools and supports

3. Ensure access to culturally and linguistically appropriate care,

4. Support expanded and universal access to technology, and

5. Ensure adequate consumer protections

1. Study and Evaluate Diverse Consumer Experiences and Needs:

The rapid adoption of telehealth borne out of necessity due to COVID-19 presents a grand experiment with which to study diverse consumer experiences specifically focused on Black, indigenous, and people of color, people with limited English proficiency, and people with disabilities. We must evaluate how intersections of geography, income, care type, and coverage type impact the consumer experience in order to target policy changes effectively. Evaluations should focus on access, care coordination (which can be particularly challenging when providers are also working from home) and outcomes for diverse populations for physical, behavioral and oral health across the continuum of care. Continued widespread expansion of telehealth must be predicated on the adoption of Broadband and other appropriate tools and supports to ensure all patients can access this new technology. Reimbursement after COVID-19 should not be based on a fee-for-service transactional model but integrated into broader system transformation and payment reform that expands access, improves quality, reduces disparities, and provides more options for all health care consumers.

Policy Recommendations:

- **Collect and publicly report disaggregated data on patient, family and caregiver experience:** The Department of Health Care Services (DHCS), Covered California and other major purchasers should collect and publicly report data from health plans, health systems and providers on utilization of telehealth services for physical, oral and behavioral health, and track and trend diverse consumer experience and patient reported outcomes over time in order to understand and be responsive to gaps in access, services and supports.

- **Contribute to rigorous research and evaluations of telehealth:** DHCS, Covered California and CalPERS have a wealth of claims, encounter and patient data that is a valuable resource to researchers in California and nationally seeking to understand the impact of telehealth and inform public policy and health care delivery. The state should make this data more readily available to support sound research in this important and emerging policy area.

2. Ensure Adequate Investment in Consumer Education, Care Coordination and Appropriate Patient Tools and Supports:

As more and more services are provided through telehealth, California purchasers and health plans must provide the consumer education and preparation needed to ensure familiarity with and optimal use of telehealth modalities. Particularly for consumers with less experience and skills with technology, such as seniors or Limited English Proficient (LEP), it is imperative that providers conduct robust outreach, preparation, and assistance.[9] Some providers utilize medical support staff to conduct pre-appointment orientations to the technology and some health systems are engaged in broad consumer education about the specific telehealth modalities available to consumers.

Additionally, we must equip both consumers and providers with adequate technology, tools and supports to conduct quality, culturally and linguistically appropriate telehealth visits. This can include training as well as equipment and devices to monitor one's health at home (e.g., smart tablets, blood pressure monitors, weight scales, glucose monitors etc.) that are expensive to purchase and not universally covered by one's plan.

Policy Recommendations:

- **Require Medi-Cal managed care plans and/or providers to train and utilize direct support professionals such as medical assistants, care coordinators, social workers, peer advocates, and community health workers to teach patients eHealth skills and digital literacy:** Pacific Asian Counseling Services in Los Angeles for example, dedicated a full-time staff at the start of the pandemic to train both other staff and clients in accessing Zoom videoconferencing technology. Similarly, CHCF's Tipping Point for Telehealth Initiative, is funding safety-net providers to ensure Medi-Cal enrollees statewide have access to care via telehealth, including those who currently face digital and other barriers to using the technology.[10]

- **Expand billing codes to allow direct support professionals such as medical assistants and patient care coordinators, social workers, peer advocates, and community health workers to bill Medi-Cal for services provided by telehealth:** Unfortunately while many providers readily acknowledge the continued need for administrative and supportive patient services, services provided by support staff are not currently billable under telehealth. The Center for Medicare and Medicaid Innovation for example, has signaled support for integrating these types of support services by including reimbursement for care coordination through the Next Generation Accountable Care Organization (ACO) Model Telehealth Expansion Waiver.[11] However more is needed to ensure consumers can continue to access support services.

- **Ensure access to tools (e.g. computers and tablets) to assist patients in managing conditions at home by leveraging federal flexibility and requiring health plans to waive co-payments:** California state purchasers and health plans should provide adequate coverage for equipment that enables consumers and providers to monitor health conditions remotely such as scales, blood pressure cuffs, continuous glucose monitors, and smart tablets. As a cautionary note, adoption of remote monitoring techniques must carefully consider and protect consumer privacy.

- **Continue to leverage federal flexibility to provide adequate coverage for tools (e.g. computers and tablets) to assist patients in managing conditions at home:** California's DHCS should continue to leverage federal flexibility through Appendix K authority, a stand-alone waiver under the existing 1915(c) home-and community-based services (HCBS) to provide access to technology tools and supports including computer monitors, cell phones, tablets and other similar handheld devices. The waiver, which DHCS applied for and received in September, will allow for an evaluation of the technology needs of the participant, family members or service providers to support the provision of remote services. This can include training and instruction about accessing remote services and utilizing assistive technology.[12] Additionally, the state could opt to stop charging copayments for particular items or services in the Children's Health Insurance Program (CHIP) through a CHIP disaster relief State Plan Amendment.[13]

3. Ensure Access to Culturally and Linguistically Appropriate Care:

Telehealth should increase, rather than stymie, access to culturally and linguistically appropriate care. California has strong state laws to ensure beneficiaries are able to access language assistance services including oral interpretation in any language. However telehealth technology has not evolved to meet those challenges. Health plans, systems and providers should better integrate remote video and telephonic interpreters (who can themselves be physically located almost anywhere) and auxiliary aids and services. In-person interpretation should continue to be used, especially for sensitive clinical encounters such as sharing a diagnosis and discussing end-of-life directives.

Policy Recommendations:

- **Allow Federally Qualified Health Centers and Rural Health Centers to provide virtual care to their patients:** Community health centers, at the forefront of efforts to provide culturally and linguistically appropriate care, should be allowed to bill as others providers can for new and established patients using telehealth.

- **Authorize reimbursement for telehealth services for team-based care:** Services should include those provided by nurses, home visits, encounters with community health workers and promotoras, and other alternative visits such as virtual dental homes using telehealth technology to link specially trained dental hygienists in the community with dentists in dental offices and clinics. DHCS should encourage patients to optimize contacts or "touches" with the entire health care team, including through authorization of shorter, more frequent telehealth check-ins to address different parts of one's individualized treatment/health improvement plan rather than trying to address all issues through rushed in-person visits with one's physician/primary care provider. For example, New York's Medicaid program, reimburses non-traditional providers for appropriate telephonic services through health homes, including peer specialists.[14]

- **Allow reimbursement for individuals who have multiple or complex conditions to access health care asynchronously,** e.g., going in for a blood draw or imaging at their convenience, including beyond "business hours."

- **Allow for direct reimbursement for language access and auxiliary aides and supports:** Minnesota's Medicaid program reimburses providers for language interpreter services for sign language services administered telephonically or through telemedicine.[15]

- **Review alternative access standards to strengthen access to bilingual providers:** In California, there is unmet demand for bilingual providers, particularly in behavioral health but across all health care. Moving forward, telehealth offers an important opportunity to expand access to culturally and linguistically competent care by allowing organizations to contract with bilingual providers from other parts of the state. Additional flexibilities for example, could allow a Korean-speaking consumer in Sacramento to see a Korean-speaking therapist in Los Angeles via telehealth if one cannot be found locally.

4. Support Expanded and Universal Access to Technology:

Telehealth has the potential to enhance patient-centered care, but only if consumers have equitable access. People with low incomes, those living in rural areas, and Black and Latino households are most likely to lack a broadband subscription. In our survey, approximately half of respondents used video for their visit, while a quarter used phone applications, 15% used a cell phone, and nearly 6% used a landline phone. Digital divide issues for limited English proficient individuals, individuals with disabilities, residents of rural communities, and low-income households who cannot access or afford high speed internet will need to be addressed through free or subsidized equipment such as tablets or smartphones, and expansion of universal broadband, free WiFi, and subsidized/discounted Lifeline assistance programs.

Policy Recommendations:

- **Invest in broadband/fiber optics, and digital cellular technology:** Future policymaking must view access to technology, including broadband but also phone minutes, as a health equity issue. AB 570 (Aguiar-Curry) and SB 1130 (Gonzalez) are two important state bills that will increase access to broadband services for California consumers.

- **Expand California's Lifeline program:** California's Lifeline program provides discount home phone and cell phone services to eligible households in California. However this assistance is capped after individuals reach their allowable minutes and is generally limited to one member of a household. State policymakers should consider expanding the number of cell phone minutes and allowing for additional household members to receive this discount.

5. Ensure Adequate Consumer Protections:

As the use of telehealth expands, it is important to ensure consumers continue to be informed of their right to informed consent and to request an in-person visit as well as language assistance and other accommodations for persons with disabilities.

Policy Recommendations:

- **Strengthen informed consent law:** In California, providers must inform patients about the use of telehealth and obtain verbal or written consent from patients before utilizing telehealth. If a healthcare provider at the originating or distant site maintains a general consent agreement that addresses the use of telehealth that is sufficient for documentation of patient consent and must be kept in the patient's medical file. If telehealth flexibilities become permanent, providers should be required to notify patients before each visit of their rights, including the right to request an in-person visit, if one is preferred.

- **Improve oversight and enforcement of consumer protections:** With the expanded use of telehealth, DHCS must ensure that contracted Medi-Cal health plans are still providing consumers with access to care that is culturally and linguistically responsive. Health plans that are unable to meet the access standards in law today or that fail to meet benchmarks for quality of care across multiple measures and populations should no longer be eligible to contract with Medi-Cal. DHCS should work more proactively with the Department of Managed Health Care (DMHC) to monitor health plan compliance with language access laws and ADA requirements to ensure health plans are meeting minimum quality performance standards and requirements.

Conclusion:

California has an enormous opportunity with the accelerated utilization of telehealth, to reduce disparities by permanently expanding access to telehealth for everyone, including Medi-Cal beneficiaries. Decisions regarding which policies should be made permanent however, must be centered in health equity and the needs of California's diverse consumers. California's purchasers have a critical role to play during this unprecedented moment, in contributing to rigorous research and evaluations of telehealth, including gaps and barriers for vulnerable communities to accessing these services so policy makers can act now to address them. Equitable implementation of telehealth will require adequate investment in consumer education in digital literacy and e-Health technology, care coordination, appropriate patient tools and supports, strengthened access to technology, and adherence to basic consumer protections to ensure all Californians can experience the full benefits of this technology.

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