



telehealth
& COVID-19

POLICY CONSIDERATIONS TO IMPROVE ACCESS TO CARE

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EXECUTIVE SUMMARY

The first U.S. case of COVID-19 was identified on January 20, 2020 [1]. In just 4 months, over 1.6 million cases have been confirmed across the U.S., with 94,558 of cases in California [2, 3]. Strategic public health measures, including social/physical distancing and home confinement, have been the key method of mitigating the risk of SARS-CoV-2 spread, the novel coronavirus that causes COVID-19. As a result of the novel coronavirus, patients were suddenly no longer able to pursue clinical care in healthcare settings as they once did. To minimize potential exposure and transmission to others, patients are foregoing needed care and essential monitoring of chronic diseases. Providers are scrambling, doing their best to shift to caring for patients at a distance, switching to telehealth-based triaging, scheduling the majority of their visits as video or phone visits, and encouraging the use of mail-order pharmacy services. Healthcare systems are confronted with the need to effectively continue to provide high-quality patient care and ensure adequate access while safeguarding the health of patients and healthcare workers during this pandemic.

Telehealth offers a multitude of technologies to deliver virtual care through medical, health, and education services. It increases access to care by expanding options for patients to connect with providers. Telehealth offers a rapid response way of achieving continued primary care, while concurrently minimizing non-urgent patient flow into emergency departments, hospitals, and clinics; a necessary precaution to safeguard the safety and well-being of our essential medical workers. Telehealth services, which have enabled the continued provision of care for patients in rural and underserved communities and patients pre-pandemic, have expanded to become the primary method to screen for and manage COVID-19 related illness in the outpatient setting. The sudden and unexpected demand for telehealth has faced the dated nature of current regulations, and staggering absence of critical infrastructure and reimbursement to allow broad and sustained expansion. Short and long-term solutions are needed to improve public health and health access. This brief examines the effects of the COVID-19 pandemic on access to care for vulnerable populations and offers policy recommendations to ensure continued access to high-quality care for all patients through telehealth. By building a foundation for widespread and inclusive telehealth implementation, policymakers can ensure our healthcare workforce is able to meet the needs of all patients, especially those residing in linguistically and medically underserved communities.



INTRODUCTION

On January 31, 2020, the U.S. Department of Health and Human Services Secretary declared a public health emergency nationwide as the result of the 2019 novel coronavirus (SARS-CoV-2) [4]. Community transmission of COVID-19 was first identified in the U.S. in February 2020 [5]. As of May 24, 2020, the California Department of Public Health has confirmed 94,558 positive cases [2]. SARS-CoV-2, the virus that causes COVID-19, is thought to spread mainly between people who are in close contact [6]. To lessen COVID-19's impact on the health care system, governments mandated "social or physical distancing" and stay at home orders. Patients with chronic conditions necessitating routine care visits were suddenly unable to physically visit their provider in person. While about 10% of cases in California required hospitalization [2, 7], the remaining 90% of cases required home-based care and monitoring. Keeping stable COVID-19 patients and non-COVID-19 patients away from healthcare settings to mitigate the spread of the virus has challenged primary care providers. Telehealth has become more important than ever, enabling access to medically necessary health care while preventing entry to health care facilities when patient needs can be met remotely. However, the technological infrastructure and necessary financing structure to support sustained and broad implementation are lacking. Vulnerable populations^a need access to care amidst the COVID-19 pandemic and beyond. Disparities in health care access and quality of care for minorities, and between Latinos and non-Latino whites have been extensively documented in the literature^b [8]. There are 7 million Californians, mainly Hispanic/Latino, African American, and Native American, living in an area experiencing a healthcare provider shortage^c [9, 10]. When compared with non-Latino Whites, Latinos are less likely to have a regular source of health care and have fewer physician visits [11]. Yet these same already vulnerable patients are the ones that have been unable to "wall themselves off" from infection because of their jobs in agriculture, sanitation, and front-line retail, and because many rely on public transportation, and they are already dying in disproportionate numbers [10, 12]. This brief highlights the need to leverage telehealth to expand capacity in a health system marked by significant and persistent physician shortages and geographic disparities [13], only made worse during this global pandemic.

IMPACT OF THE NOVEL CORONAVIRUS PANDEMIC ON HEALTHCARE ACCESS

Disruptions in Patient Access and Usual Care During the Novel Coronavirus Pandemic

The efforts to prevent the exposure of vulnerable individuals to the novel coronavirus have led to disruptions in patient's access to primary and specialty care, diagnostics, and therapeutic procedures^d [14]. Prioritization and triaging of care needs have impacted care, particularly affecting services deemed routine and non-urgent. Healthcare maintenance such as routine vaccinations and cancer screenings are being postponed in hopes of minimizing potential exposure to COVID-19 in transit or at a healthcare facility. Yet "routine" care is vital to keeping vulnerable populations healthy not only amidst a pandemic but particularly in the long run, as poorly controlled chronic diseases will further exacerbate healthcare disparities in morbidity and mortality. Postponing mammograms and colorectal cancer screening compromises the quality of care for our most vulnerable patients. Disruptions in primary care continuity also limit access to language concordant care for linguistically underserved populations^e. Those in the safety-net already experience delays in access to specialty care [15], and now with few face-to-face visits and absent infrastructure to support telehealth, vulnerable populations have little access to specialty care. Health care delays and postponement of chronic care management can rapidly impact patient outcomes and health in the long-term. As stay-at-home orders are scaled back and patients

develop comfort in returning to healthcare settings, there will be a considerable surge in demand for care as patients seek months' worth of postponed services. Specifically for populations typically affected by delays in care, systematic outreach may need to be placed into effect to contact patients lost to follow-up, further increasing pressures on primary care clinics. Further disruptions in access to care will inevitably arise as COVID-19 job loss leaves millions uninsured [16]. The Kaiser Family Foundation estimates that 12.7 million of the newly uninsured are eligible for Medicaid [17], which will bring a surge of new patients to the safety-net.

Use of Telehealth for Patients with Limited Access to Care

The COVID-19 pandemic has shown the potential of telehealth to protect patients and healthcare providers. The Health Resources & Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration" [18]. Telehealth includes virtual doctor's visits, telephone visits, health monitoring apps, mobile messaging platforms, and online patient portals, among other technologies that provide access to care and a streamlined form of communication between patients and healthcare providers regardless of patient/provider location. According to the California Future Health Workforce Commission, 7 million, mainly Latino, African American, and Native American Californians currently live in Health Professional Shortage Areas (HPSAs) [9]. Telehealth is used to address the shortage of healthcare providers in rural and underserved communities, by allowing specialists and subspecialists to evaluate these patients virtually and while integrating care with primary care physicians (PCPs), decreasing wait times between a referral and a subsequent visit, thus helping patients get the care they need when they need it.

Telehealth offers advantages in terms of accessibility and practicality to patients and providers. Research has shown that virtual visits are comparable to in-person office visits in terms of appropriate and timely diagnosis, treatment, and communication [19]. Telehealth has been shown to reduce health care costs and allows patients to save on transportation and limits lost income due to time away from work [20-22]. Through virtual visits, patients can be evaluated from home or work [19, 23]. Pilot studies in the Latino community have been largely successful in implementing telehealth interventions like mobile behavioral health treatments, and remote blood pressure measurements, among others [24-26]. While virtual care cannot and should not entirely replace in-person care, research has shown that telehealth is useful to expedite access to care, and in the long-term, will allow physicians to augment continuity of care for medically underserved populations.

IMPROVING HEALTHCARE ACCESS FOR VULNERABLE POPULATIONS AMIDST THE PANDEMIC AND THROUGH THE AFTERMATH

Employing Telehealth In The Time Of COVID-19

Telemedicine can be used in diverse healthcare settings to ensure patients receive the care they need during and despite the COVID-19 pandemic and future peaks that may lie ahead.

Specifically, for COVID-19 related care, telemedicine can be employed in the acute urgent care/emergency care setting, the inpatient setting, and also the outpatient setting. Upon presentation to urgent care or the emergency department, a symptomatic patient can be initially screened via a

telehealth visit with minimal staff exposure by utilizing a mobile device with video capacity [27]. In the emergency department, tele-emergency network programs allow for specialty and subspecialty consultation by remote physicians. Hospitalized patients could similarly access consults by remotely-located specialists. In addition, electronic-ICU monitoring programs enable nurses and physicians to monitor the status of patients in ICUs remotely, sometimes simultaneously at multiple hospitals [27]. Additionally, telemedicine could be employed to provide access to end-of-life care and home hospice care, by allowing remote monitoring by Hospice and Palliative care providers and ensuring critical conversations with family can occur with remotely-located physicians.

The great majority of COVID-19 cases will not require hospitalization and instead require outpatient management by primary care physicians [28]. Ancillary staff can assist primary care offices by fielding COVID-19 related queries and triaging symptomatic patients. Queries reach provider offices via incoming calls and online patient portals, where patients can email their primary care offices and providers directly. As infections rise, a continuous flow in patients needing care and follow up is expected in the outpatient setting. The non-hospitalized patient majority will require frequent outpatient monitoring for complications as they self-isolate and manage symptoms from home.

In addition to care delivered to patients affected by COVID-19, telemedicine offers the possibility that chronic care management continues while social or physical distancing precautions and stay-at-home orders are necessary. Even as primary care offices begin to increase the volume of patients seen in clinic as orders are lifted, this will likely take place in a measured and incremental fashion, requiring ongoing use of telehealth visits. Patients with underlying chronic conditions face a higher risk of severe complications related to COVID-19 [28]. Patients with chronic conditions should limit their travel and potential exposure at healthcare facilities given their inherent vulnerability; telehealth can ensure continuity of care. Proactive team-based outreach will be necessary over the coming weeks and at different potential waves of the pandemic to ensure those most vulnerable and less likely to seek care do not fall through the cracks.

Challenges in Use of Telehealth with Vulnerable Populations

The COVID-19 pandemic has brought to light the inadequacy of existing telehealth infrastructure and the inefficiencies in existing reimbursement rules. Especially hard hit have been safety-net clinics serving medically underserved and rural areas, many facing alarming drops in Medicaid and Medicare reimbursements as a result of the drop in face-to-face consultations [12, 29]. Some are at the brink of bankruptcy as a result of outdated regulations and payment rules, and the absent infrastructure necessary to carry out care of patients who are unable to be seen in the clinic [29]. Not only have patients been affected by their lack of internet or devices to support virtual visits, but also by their providers' lack of broadband connectivity, equipment, and electronic medical record (EMR) and electronic health record (EHR) system capacity limitations. For instances where a patient has no access to internet/broadband or video-capable devices, or in clinics lacking similar devices, physicians have been furnishing evaluations through telephone calls. However, lower rates for telephone visits have created financial hardships for practices and disproportionately affected physicians who care for Medicare beneficiaries and underserved patients, highlighting the importance of sufficient payment for telephone consultations in the short-term, and the need to address equitable access to internet and video-capable devices for underserved communities in the long-term [30].

The potential to help improve healthcare access using telehealth is particularly great in Medi-Cal, California's Medicaid program; however, telehealth data reporting is not yet routine nor standardized across Managed Care Plans (MCPs) [15]. MCPs are currently investing financial resources to expand the availability and use of telehealth to improve access to care, quality of care, and member and provider satisfaction [15]. Ensuring the provision of quality care for linguistically and medically underserved populations may require standardized reporting across MCPs on access, utilization, and MCP measurement of outcomes for enrollees. However, care will need to be taken to prevent increased administrative burden on already overwhelmed primary care physicians.

When designing and implementing health technology, culture, needs, and population demographics must be taken into account [26]. As California's Latino community continues to grow and make up the largest racial/ethnic population, it must be the central focus during the development of these technological interventions. In California, nearly 44% of the population speaks a language other than English at home, and Spanish-speaking physicians are the most under-represented in the physician workforce [31]. Medical interpreter use will need to be systematically incorporated into telehealth technology to ensure language-concordance is addressed. According to the Pew Research Center, 84% of Latino adults report internet use, yet only 59% of Latino adults subscribe to home internet services [32]. Additional research shows that 79% of Latino adults own a smartphone [32]. Although an overall high percentage of Latino adults have access to the internet, whether at home or through a smartphone, there are still disparities in technology use that must be taken into account when implementing telehealth services. In rural communities, many patients do not have video-capable devices and/or adequate internet or cellular coverage to conduct an encounter by any means other than on their landlines. Elderly Latino individuals with lower educational levels are less likely to own digital devices, utilize the internet, and are less likely to use telehealth technology willingly [33]. Guidance and technological troubleshooting are imperative in ensuring access to telehealth services for those with limited technological literacy [34]. Familial intergenerational support might also be leveraged for this. Lastly, research has shown that when community members are involved in the enrollment of patients, telemedicine interventions are more likely to be successful; community buy-in is critical for implementation [35]. As we delve into the virtual future of healthcare spearheaded by the COVID-19 pandemic, vulnerable populations must be the central focus during the development and implementation of these services such that we design a system that enables our most vulnerable patients to seek and receive remote care with any and every modality available to them.

Initial Responses to Facilitate Broad Telehealth Expansion

Some critical updates and expansions have been made in reimbursement and credentialing requirements by the Centers for Medicare and Medicaid Services (CMS) and some local commercial payers in response to COVID-19 [27]. In California, Governor Newsom, the Department of Insurance (CDI), and the Department of Managed Health Care issued notices to facilitate patient access to telehealth, including the directive that insurers immediately implement reimbursement rates that mirror payment rates for in-office care, which have allowed increased uptake of telehealth in the state of California [36, 37]. These are crucial initial responses, but the crisis demands a broader strategy that targets access for vulnerable populations who still face the technological divide. Worth noting is that despite these policy changes, providers are reporting that otherwise properly submitted claims for telehealth services are being rejected [38]. Clearer guidance on billing and reimbursement policies across payers is much needed. Additionally lacking is payer consistency in "evaluation and management" (E/M) service

reimbursement for telephonic encounters, which are fundamental to providing care to patients in the safety-net through the expected length of this pandemic. Despite community health clinics being called upon to do more, they are experiencing a decline in revenue/funding and being compensated at a small fraction of the rate of in-person visits, on average \$12 to \$13, according to the National Association of Community Health Centers [12]. Ironically, a number of health insurers are seeing excess revenue as a result of the steep drop-off in claims for elective procedures, in-person visits, and non-urgent services [39]. As we deploy policy and infrastructure to support physician response to the pandemic, we must consider how we can promote telehealth service use such that we help address and carefully avoid further contributing to inequities within our new era of healthcare delivery.

CONCLUSION

Telehealth can be leveraged by healthcare providers during and after the COVID-19 pandemic to improve access to care in a multitude of patient care settings, but key investments in technological infrastructure and investment financing are necessary. Its potential to facilitate patient access to needed care when and where they need it is particularly great in medically and linguistically underserved communities [40]. It is essential that these technologies become an integral part of daily health care practice now and after the pandemic. More research and studies are needed to determine which Medi-Cal Managed Care Plans are using telehealth to improve access to care for their members and to examine patient experience in accessing care. The development of evaluation measures for telehealth programs is needed to assess telehealth services' ability to effectively provide quality clinical services, and to evaluate its safety, availability, and accommodation of care for limited-English proficient populations [41]. As policymakers pare down social-distancing measures, it will be ever-important to support the continuation of scaled-back in-clinic patient flow to minimize risk for all, but especially for our vulnerable and underserved patients who are already experiencing disproportionate rates of infection and death. Dealing with the immediate impact of COVID-19 is sending safety net clinics into budget crises whilst the extended public-health crisis and socioeconomic crisis from job and health-insurance loss only begin to mount.

Although some of the technologies used for telemedicine have existed for decades, poor penetration into the market is due to heavy regulation and lack of reimbursement from public and private insurers [42]. The current public health emergency and the resulting accelerated growth potential in telehealth services is an opportunity for providers to enhance their care practices and for insurers and policymakers to recognize the value of telemedicine. Physician services and time provided via digital technologies needs to be valued equally as in-person services. The telehealth model has been proven to improve access and reduce costs and will likely prove to be transformative post-COVID-19 [22, 26, 43]. It will also help accelerate the pace of the nation's response to future pandemics. The implementation of telehealth has the potential to reduce barriers for patients and providers, and can recognize the value of physician time and work by offering parity in payment for parity in services.

POLICY RECOMMENDATIONS

Our findings show that telehealth presents an opportunity to expand access to care and save lives during COVID-19. As we formulate the long-term response to COVID-19, we must consider how to capitalize on the progress we have made such that the gains we have achieved can be continued post-COVID-19. Healthcare systems must be supported to incorporate telehealth as a routine part of patient care in both the acute and chronic care setting.

- 1.** Support the expansion of telehealth services for primary care providers.
 - a.** Fund technology access, equipment, and technical support for outpatient clinics and health care systems, prioritizing those serving medically underserved patients.
 - b.** Fund support for equitable access to the equipment and technology necessary to provide telehealth to vulnerable populations and through the safety network.
 - c.** Pursue partnerships with telemedicine-capable platforms for use in safety network clinics with EMR/EHR systems that do not currently support audio-visual patient encounters
 - d.** Consolidate and expand current interim and temporary changes in policy to provide permanent solutions that enable the use of telehealth beyond the COVID-19 pandemic.

- 2.** Ensure access for patients facing limitations in access to the internet and technology necessary to participate in telehealth.
 - a.** Pursue partnerships with internet and smart-device providers to improve acquisition of critical technology for patients without the necessary components to engage in telemedicine.
 - b.** Immediately subsidize broadband internet access for patients that reside in medically and linguistically underserved communities.
 - c.** Allow the use of telephone encounters in place of video encounters and ensure payment parity for these services across payers.
 - d.** Allow patients to communicate with their providers in any and every modality available to them by improving reimbursement structure.

- 3.** Provide primary care doctors the tools necessary to care for patients at a distance.
 - a.** Ensure coverage and access to essential remote-monitoring devices such as blood pressure cuffs and glucometers.
 - b.** Expand access to mail-order pharmacy services to support care rendered remotely for patients needing to obtain medications and refills during this public health emergency [44].

- 4.** Ensure appropriate payment for telehealth services for the long-term.
 - a.** Continue patient protections to minimize out-of-pocket costs for telehealth services such that these services remain accessible for all patients.
 - b.** Payment structure should be standardized across states and payers. Insurers must not have the option to opt-out of coverage or reimbursement for telemedicine services.
 - c.** Payment parity: Payers should be expected to reimburse the same amount for telemedicine services as they would if the service were furnished in person.
 - d.** Minimize administrative barriers for payment and standardize billing procedures and codes for telehealth.

- 5.** Expand telehealth services in specialty care, including hospice care, behavioral health specialists, and chronic care management.
- 6.** Support the expansion of telehealth use in the acute care setting.
 - a.** Expand and support tele-emergency programs. Explore augmentation of first-responder triaging and care through the use of physician consultations in real-time.
- 7.** Ensure coverage and access to medical interpreters.
 - a.** Consideration should be given to expedited training and certification for health care interpreters during this public health emergency.
 - b.** Identify opportunities in state law and regulations to increase the supply of language professionals and multilingual services in healthcare settings [45, 46].

ENDNOTES

- a Vulnerability in the era of COVID-19: Vulnerable groups of people are those that are disproportionately exposed to risk, but who is included in these groups can change dynamically. Amid the COVID-19 pandemic, vulnerable groups are not only elderly people, those with ill health and comorbidities, or homeless or underhoused people, but also people from a gradient of socioeconomic groups that might struggle to cope financially, mentally, or physically with the crisis [47].
- b On average, Latinos and African Americans have worse health and worse access to effective health care than do non-Hispanic Whites [48]. Prior research has shown that Latinos of Mexican ancestry are the most disadvantaged group, compared with any other adult Latino ethnic/racial subgroup for multiple health care access and utilization outcomes [11]. Latinos of Mexican ancestry are less likely to have health insurance, and less likely to have a regular source of health care or usual place to go when sick [11]. Among Latinos in California, undocumented immigrants have the worst access and utilization patterns [49]. In addition, physicians treating Latinos, particularly those who work in primary care, are more likely than physicians treating primarily non-Hispanic White patients to perceive barriers to their ability to provide high-quality care [8]. Physicians with 50 percent or more Latino patients are more likely to report inadequate time with patients, the lack of qualified specialists in their areas, not getting timely reports from other physicians, and difficulties communicating with patients [8].
- c Residents living in rural areas who already have limited resources to critical care may become increasingly vulnerable during the pandemic [50]. The multiple intersections of age, health status, accessibility to health care facilities, medical insurance status, and the shortage of physicians can negatively impact the health of people living in rural communities [10].
- d Guidance for healthcare settings includes CDC recommendations for cancellation of elective procedures, postponement of non-urgent outpatient visits, the use of telemedicine when possible, and optimal infection control measures when caring for suspected and confirmed COVID-19 patients [14].
- e Language concordance between patient and provider is vital for improved interpersonal processes, satisfaction, and improved health outcomes [51, 52]. Limited availability of multilingual providers is creating barriers to care for patients with Limited-English Proficiency (LEP) and families affected by COVID-19 [53]. As healthcare providers are surged to more pressing inpatient needs or are quarantined or infected themselves, the disruptions in primary care provider continuity will rise, further straining access to language concordant care when the existing pool of bilingual providers is already limited.

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