Access, Equity, and Neutral Space: Telehealth Beyond the Pandemic

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ABSTRACT

As I begin my 4th year of medical school amidst the coronavirus disease 2019 (COVID-19) pandemic, telehealth has allowed me to connect with many patients who previously struggled to access consistent primary care. In this essay, I describe 2 of my most formative experiences with telehealth: participating in my medical school's new "tele-hotspotting" elective, and providing virtual gender-affirming care through our student-run free clinic. These experiences demonstrate not only telehealth's utility during a viral pandemic, but also its potential as a powerful tool for expanding access to care and promoting health equity over the coming years. With this said, telehealth is not without limitations. Patients and clinicians alike have expressed concerns regarding the challenge of performing a physical exam and maintaining emotional connection across physical distance. A sustained expansion of telehealth is further challenged by inconsistent availability of broadband Internet, as well as a lack of standardized reimbursement procedures for telehealth visits. Strategies are available to help meet these challenges while maximizing health equity.

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The coronavirus disease 2019 (COVID-19) pandemic offers a glimpse into a world where telehealth is the norm. Like many other rising 4th-year medical students, my medical education has shifted almost overnight from early-morning pre-rounding and on-the-job learning to Zoom lectures and volunteer efforts to help mitigate the pandemic's impact on my community. During this time, telehealth has provided me some of my most valuable and career-affirming experiences. Two of these experiences in particular—participating in my medical school's new "tele-hotspotting" elective, and providing virtual gender-affirming care through our student-run free clinic—illustrate not only the utility of telehealth in a viral pandemic, but also its potential as a powerful tool for expanding access to care and promoting health equity.

In early May, I enrolled in STRIVE (Student Tele-hotspotting to Reduce Isolation and VulnErability), one of several new "virtual" electives created by the University of North Carolina (UNC) School of Medicine in light of the COVID-19 pandemic. As part of this elective, I provided weekly "wellness calls" for a panel of 10 patients who are at elevated risk of social isolation and increased socioeconomic stress during the pandemic. Inspired by the Camden Coalition's interdisciplinary "hot spotting" model,[1] I worked with a physician, a case manager, and often a behavioral health specialist to ensure that each patient received the care they need, including financial relief, food, and housing support. For some of these patients, the greatest service I can provide is a nonjudgmental presence, listening as they share their experiences with me. I can't fix everything, but I can show up for them in a time of widespread isolation.

I have also used telehealth to continue seeing patients through UNC's free, student-run Gender Affirming Care Clinic during the COVID-19

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pandemic. As one of our clinic's volunteer student members, I work under the supervision of an attending physician to provide primary care, including hormone therapy, for a small panel of local transgender and gender-nonconforming folks. Now that we conduct our visits over video, we are unable to perform physical exams or track laboratory values as we would at our in-person free clinic. These are not the conditions under which I imagined I would be providing care, but I am still providing care. And it is helping. I can't follow my patient's hematocrit, but I can carefully ask about symptoms concerning side effects of testosterone therapy, and continue this crucial treatment in their absence. I can watch my patient's shoulders relax as we talk about the emotional changes they have experienced after several months indoors.

In both of these examples, telehealth serves as a bridge between our health care system and some of its most marginalized patients, many of whom struggled to access care long before the COVID-19 pandemic began.[2] Consistency of preventive care is lower among those experiencing social and geographic isolation,[3,4] unstable housing,[5] food insecurity,[5] and other forms of socioeconomic stress, all of which are encoded within a system of structural racism that limits access and worsens outcomes for people of color.[6] For transgender individuals, particularly transgender and gender-nonconforming people of color, these barriers are often compounded by experiences of discrimination and trauma in clinical spaces.[7-9] Before the pandemic, many of my current telehealth patients missed multiple clinic appointments due to limited transportation and other logistical barriers. Others hadn't left their houses in months due to limited mobility, or had repeatedly deferred care due to anxiety around entering a clinical space. Even after resolution of our current public health emergency, they will still face these barriers to in-person care. While by no means a definitive solution, continuing to expand the availability of telephone and video visits beyond the COVID-19 pandemic will help mitigate our nation's vast racial, economic, and geographic disparities in consistent access to medical care.

In the interest of health equity, it is important to address the limitations of telephone- and video-based clinical interactions, particularly if these services are to be extended more frequently to patients experiencing higher degrees of socioeconomic marginalization.[10] To that end, patients and clinicians alike have expressed concerns over limited capacity to perform a physical exam and measure vital signs over telehealth.[11] While I share these concerns, I feel that the necessity of in-person evaluation varies by clinical encounter. Evaluation of dyspnea, for example, has been found to benefit significantly from a physical exam.[12] Home blood pressure monitoring, on the other hand, has repeatedly demonstrated greater accuracy and prognostic value than in-clinic readings, especially when a medical professional observes and provides feedback on patients' self-measurement technique over video.[13] With this variation in mind, "hybrid practices," which provide a combination of in-person and telehealth visits, offer a promising compromise.[10]

Other recent articles have discussed the challenge of establishing emotional connection with patients over telehealth, in the absence of shared physical space.[14,15] To borrow a phrase from Dhruv Khullar, my medical education has taught me to deeply appreciate the honor and responsibility of sitting with my patients.[16] Some of our most meaningful interpersonal exchanges are silent navigations of shared space: shaking hands to solidify a new lifestyle goal, passing a box of tissues during a tearful conversation, sharing silence after I deliver a life-changing diagnosis. I worry about the implications of losing these interactions, particularly with those of my patients who are already most marginalized from our health care system.

However, removing this spatial dimension from my clinical practice has also challenged me to become more aware of how my words invite or discourage dialog. I pause more during my telehealth visits, leaving space for patients to ask questions and share thoughts. I use the teach-back method[17] to confirm their understanding, and check in more frequently regarding their comfort and concerns. Sometimes, it feels as if seeing my patients over video helps to level the inherent power dynamic between us.[18] In an in-person visit, the patient enters a physical space which is clearly demarcated as mine, not theirs: a "doctor's office." My command over this space is compounded by other aspects of my identity: whiteness, maleness, cisgenderedness, able-bodiedness.[19] While telehealth certainly does not eliminate all of these complex dynamics, it presents an opportunity to connect with each patient in a new context. As we sit behind our computer screens, in our own rooms, we create a shared space that belongs to neither and yet to both of us.

In developing best practices for sharing this new "virtual space" with our patients, it is important that we utilize focus groups, community advisory boards, and other strategies to solicit input and feedback from communities lacking access to consistent primary care. With this said, many of these communities—including those in remote rural and inner-city counties—also disproportionately lack access to secure Internet or video-compatible devices.[20] Internet use and digital literacy (ie, comfort with using web-based technology) are particularly low among Americans aged 65 years

and older, and lower still with decreasing health literacy.[21] In order to ensure that telehealth reaches those who need it most, it is therefore important to address Internet access and digital literacy as social determinants of health.[22] This may be accomplished through large-scale expansion of broadband Internet access (including fiber, wireless, or satellite technology),[23] as well as through distribution of secure mobile WiFi hotspots and video-compatible devices to those who lack these resources. Additionally, community-based telehealth educators could provide individual or group instruction for those with low digital literacy.

Long-term expansion of telehealth is further challenged by a lack of standardized reimbursement procedures for telehealth visits. Insurance coverage of telehealth varies by state and plan, and may change rapidly in response to new regulations. As a result, clinicians and patients alike are often left with unpredictable price tags.[24] The American Academy of Family Physicians[25] and many other professional societies have publicly endorsed "telehealth parity," ie, comparable reimbursement for telephone, video, and in-person visits. The Centers for Medicare and Medicaid Services,[26] as well as several private insurers,[27] have responded with mostly temporary policy waivers to increase reimbursement for telehealth services during the COVID-19 pandemic. While temporary waivers are an important start, permanent adoption of telehealth parity across insurance providers will help to sustain these crucial services.

As much as I look forward to resuming in-person clinical interaction, I worry about returning to a world in which so many of my patients are unable to access routine clinical care. Telehealth is not a one-stop solution to our nation's vast structural inequities, and its limitations with respect to in-person care merit serious consideration. If my brief experience is any indication, however, telehealth may continue to be a crucial resource for some of our most marginalized patients long after this national state of emergency has resolved. Sustaining a widespread expansion of telehealth beyond the COVID-19 pandemic will require flexibility, collaboration, resilience, and openness to change, but I'm confident that we can rise to the challenge. Our health care community's collective response to the COVID-19 pandemic has demonstrated that we are capable of bending without breaking—especially when our patients' lives hang in the balance. If we are intentional about centering equity, telehealth may be an important tool for constructing a new normal: a health care system that is more accessible, adaptable, and equitable than its predecessor.

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