

# Equity in Telehealth during the COVID-19 Pandemic: Semi-Structured Interviews with Primary Care Workforce



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## I. Introduction

Patient-provider relationships are essential in delivering quality patient care, associated with improved health outcomes in patients.<sup>1-4</sup> Communication between patients and providers is essential in fostering patient satisfaction, with poor communication leading to worse outcomes and patient dissatisfaction<sup>4-8</sup>. However, most literature has focused on in-person communication between patients and providers. Telehealth has been adopted in healthcare service delivery as an important method of patient-provider communication. Telehealth services have been traditionally offered through synchronous (e.g., video or phone appointments) and asynchronous (e.g., email and messaging) methods as well as remote monitoring devices<sup>5</sup>. The COVID-19 pandemic shifted the delivery of primary care, including a rapid uptake of telehealth. While this shift provided critical access to services, not all patients have the capacity to optimally utilize telehealth, raising concerns for health equity during and after the pandemic. Previous studies have found several provider- and patient-level barriers to telehealth service access including digital literacy, broadband access, limited data plans, older age, and provider satisfaction with telehealth<sup>6-10</sup>. This study investigated the challenges of providing primary care services to vulnerable populations (as defined by the CDC)<sup>11</sup> via telehealth during the pandemic and how the patient-provider relationship was impacted by these barriers.

## II. Methods

Semi-structured interviews were conducted between May 2021 to August 2021 with 31 individuals working at 20 primary care practices including medical directors, physicians, and medical assistants. The interviews explored the lived experiences of primary care providers, staff, and administrators in the shift to telehealth services during the COVID-19 pandemic. Interviewees were purposively sampled from primary care practices in Massachusetts, North Carolina, and Texas. The sampling sought variation in healthcare infrastructure and policies (i.e., relevant to the COVID-19 pandemic and telehealth services), rural versus urban location, independent versus health-system affiliated practices, and safety net versus non-safety net practices. Initially, 148 primary care provider organizations were contacted through email and phone and 20 of those agreed to participate. One to three individuals from each organization were interviewed (medical director, clinician, and medical assistant), which resulted in 31 interviews. Most (n=29) interviews were conducted by phone and two were conducted via Zoom. Interviews lasted 45-60 minutes and were audio recorded and coded through NVivo 11 software. The codebook was first developed deductively based on the interview guide and previous literature, then added new codes inductively as themes emerged in the interview data. The final codebook included 15 parent codes and 40 child codes, 12 of which were related to telehealth. The research team used an iterative process to increase inter-rater

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reliability and codebook accuracy through regular meetings, discussion of uncertainties in the coding process, and recognition of each team members' positionality and its impact on the analysis process.

### III. Findings

#### *Barriers to telehealth access*

Respondents expressed challenges in providing telehealth services with video versus telephone-only visits, and three specific populations were commonly identified as ones where telehealth access proved difficult: elderly patients, rural residents, and patients with limited English proficiency. As a result, many of these patients received care via telephone-only visits. Elderly, rural, and limited English proficiency patients faced several critical barriers to telehealth access. Elderly patients either did not have access to laptops and smartphones and, even when they did, often did not know how to use them. The lack of social support from family and friends during the lockdown in the early phases of the pandemic further limited their ability to access services. For rural residents, lack of broadband access and limited cellular plans created barriers to telehealth access. Finally, patients with limited English proficiency faced communication barriers because of the limited availability of linguistically diverse staff and the challenges of integrating interpreters in the workflow of telehealth during the pandemic.

#### *Telehealth impact on patient-provider communication*

Interviewees consistently expressed that telehealth introduced difficulty in communicating and building patient-provider relationships. Three themes emerged from the data. First, telephone-only visits removed dimensions usually present during in-person visits that impacted patient-provider interactions. For example, with telephone-only visits, not being able to see the patient could impact providers' ability to understand the patient completely. Additionally, interviewees mention that patients have expressed doubt about provider's capacity to provide care via telephone-only visits with the patient. Second, telehealth had a particularly negative impact on developing patient-provider relationships for new patients. Interviews indicate that high turnover and staff changes resulted in many patients meeting with a new provider during a telehealth visit, which was more commonly reported by interviewees serving predominantly Spanish and Mandarin-Chinese-speaking patients. Third, telehealth both required and hindered trust-building between patients and providers. In some instances, telehealth placed a greater emphasis on the patients' description of their symptoms or provider visual observations. However, the barriers faced by physicians in treating patients during telehealth appointments were also found to impair patients' long-term view, trust, and engagement with the provider.

### IV. Policy Implications

While the increased availability of telehealth may have enhanced health service access for some patients, this study indicates that telehealth created new barriers to access for elderly, rural, and limited English proficiency patients. These findings provide guidance to policymakers, payers, administrators, and other key stakeholders:

1. *Considering hybrid (both in-person and telehealth) care models:* The COVID-19 pandemic initiated a shift in telehealth reimbursement policies, away from temporary policy waivers to permanent telehealth policy. This shift may provide an opportunity to address critical issues of equity in

healthcare service access.<sup>12-13</sup> Permanent policies that incorporate reimbursement for hybrid care models may allow providers and practices to address essential patient needs, especially for vulnerable populations.

2. *Continued telehealth technical assistance and infrastructure support will be needed:* To optimize its utilization and reduce barriers identified in this study, telehealth services complementary to in-person services should incorporate additional resources and support for providers, including technical assistance, communication training, a recommitment to team-based care, and re-integration of ancillary services.

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## WORKS CITED

1. Levinson W, Lesser CS and Epstein RM. Developing physician communication skills for patient-centered care. *Health Aff* 2017; 29: 1310–1318.
2. Slatore CG, Cecere LM, Reinke LF, et al. Patient-clinician communication: associations with important health outcomes among veterans with COPD. *Chest* 2010; 138: 628–634.
3. Hall MA, Zheng B, Dugan E, et al. Measuring Patients' trust in their primary care providers. *Meas Trust Phys Med Care Res Rev* 2002; 59: 293–318
4. Hojat M, Louis DZ, Markham FW, et al. Physicians' empathy and clinical outcomes for diabetic patients. *Acad Med* 2011; 86: 359–364.
5. 3015-What is telehealth? | HHS.gov, <https://www.hhs.gov/hipaa/for-professionals/faq/3015/what-is-telehealth/index.html> (accessed 1 September 2022).
6. Cao Y, Chen D, Liu Y, et al. Disparities in the use of in-person and telehealth outpatient visits among medicare beneficiaries in an accountable care organization during COVID-19. *Health Serv Res* 2021; 56: 5–5.
7. Lower-income Americans still less likely to have home broadband, smartphone | Pew Research Center, <https://www.pewresearch.org/fact-tank/2021/06/22/digital-divide-persistseven-as-americans-with-lower-incomes-make-gains-in-techadoption/> (accessed 17 October 2022).
8. Payán DD, Frehn JL, Garcia L, et al. Telemedicine implementation and use in community health centers during COVID-19: clinic personnel and patient perspectives. *SSM Qual Res Health* 2022; 2: 100054.
9. Cheshmehzangi A, Zou T, Zhang Y, et al. Commentary: reflecting on the neglected digital divide barriers of telemedicine during COVID-19. *Front Public Health* 2022; 10. DOI:10.3389/FPUBH.2022.915401.
10. Bashshur RL and Bashshur MJ. Telemedicine, history of. In: *The international encyclopedia of health communication*. John Wiley & Sons, Ltd, 2022, pp.1–6.
11. Populations and Vulnerabilities | Tracking | NCEH | CDC, <https://www.cdc.gov/nceh/tracking/topics/PopulationsVulnerabilities.htm> (accessed 9 December 2023).
12. Tang M, Chernew ME and Mehrotra A. How emerging telehealth models challenge policymaking. *Milbank Q* 2022; 100:650–672.
13. Mehrotra A, Bhatia RS and Snoswell CL. Paying for telemedicine after the pandemic. *JAMA* 2021; 325: 431–432.