The expansion of telehealth in primary care has been rapidly accelerated by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic.\(^1\) Alexander and colleagues\(^2\) analyzed a cross-sectional audit of ambulatory care to estimate national trends during the second quarter of 2020 compared with the prior 2 years. They found a substantial decrease in total primary care encounters, accompanied by a dramatic increase in the proportion of those encounters conducted via telehealth rather than in person. The authors found an overall decline in assessments of blood pressure and cholesterol during this period and concluded that this decrease was associated with fewer assessments during telemedicine encounters compared with office-based encounters. Notably, the authors did not find a difference in telehealth uptake between Black and White patients, and they reported a smaller than expected association with payer type. This led to the tentatively optimistic suggestion that telehealth is accessible to many patients systematically susceptible to health disparities.

There is substantial room for an optimistic reading of this analysis by Alexander et al.\(^2\) The decrease in blood pressure or cholesterol assessments during telemedicine encounters could be mitigated by focusing on reliable ways of capturing objective information at home. For example, if patients with hypertension had home blood pressure monitors, much as diabetic patients are equipped with tools for measuring glycemic control, hypertension would become more straightforward and practical to manage virtually. However, access to care such as telemedicine and/or home monitoring tools are simply not available to all patients, leading to disparities in care and health care inequity.

Our experience in the Pacific Northwest, where Alexander et al\(^2\) found the sharpest increase in telehealth adoption, leads us to predict far more consequences for health equity than were revealed in their analysis. While we were glad to see similar rates of telehealth care provided to White and Black patients in their sample, our local patterns suggest a story of differential access to virtual care. During the second quarter of 2020, we saw low rates of telemedicine (ie, audiovisual visits) adoption in clinics primarily dedicated to the care of patients who are unhoused (11 of 2632 visits [0.4%]), patients with limited English proficiency (69 of 2617 visits [2.6%]), and a racially diverse safety-net population (329 of 4477 visits [7.3%]). These clinics had the same rapid expansion of access to telemedicine support and technology as general medicine clinics within our system, where 1775 of 5828 visits (30.5%) were conducted by telemedicine during the same period. Despite implementing real-time technical support for audiovisual visits at 2 safety-net clinics, we still have very low rates of successful visits via an audiovisual platform. The most common barrier we encounter is lack of access to the necessary technology. Our observations are not unique; Nouri et al\(^3\) recently found that patients with socioeconomic disadvantage were significantly underserved by telemedicine visits in March 2020. Citing poor access to technology as a major factor, they described lower rates of telemedicine uptake among patients who were non-White individuals, were older, had low English proficiency, and lacked commercial insurance.\(^3\)

Alexander et al\(^2\) considered both telephone and video visits in their analysis, and they did not distinguish between these 2 methods of care delivery. While telehealth is often used as an umbrella term for all patient care conducted by phone or audiovisual technology, it is important to note that these 2 methods have very different implications. For example, the Centers for Medicare & Medicaid Services specifies that “the provider must use an interactive audio and video telecommunications system”\(^4\) to conduct a virtual visit. We do not have to look far for an example of the inequity encoded in this definition. As telehealth has rapidly expanded, the skills required to support video and audiovisual visits have become increasingly difficult to access. This has had the effect of expanding telehealth to patients with greater access to technology, but it has also narrowed the pool of providers who can conduct telemedicine visits. While telehealth is accessible to many patients, it remains a luxury for those without the right technology.
by this strict definition. Recently, a patient under our care was denied home health services because his telephone visit with his primary physician did not qualify as a face-to-face encounter. Unable to leave his house easily—or safely, as rates of coronavirus disease 2019 (COVID-19) are still not suppressed in our area—and unequipped with the technology for a telemedicine visit as defined by his insurer, he was prevented from accessing the same care available to his neighbor with an internet connection. Beyond implications related to reimbursement, there may be qualitative differences between care provided over the telephone and that conducted via audiovisual technology. For example, patients with limited English proficiency have been shown to have worse understanding of diagnoses when interpretation was facilitated by audio alone compared with using video technology. More research comparing the content and quality of audiovisual to telephone-only visits is needed. Although we acknowledge the potential of telemedicine for many patients, we are concerned by the systematic introduction of a new mechanism of health inequity.

Regarding which patient visits are best conducted in person rather than virtually, it is difficult to rely on a common algorithm. Our approach as primary care physicians is to share that decision-making with patients. There are some patients we would strongly prefer to examine in person, but many of those are most susceptible to COVID-19 or live far away or have out-of-pocket expenses that make an in-person visit prohibitive. Ultimately, we weigh the risks and benefits of virtual care with our patients, falling back on the imperative to provide patient-centered primary care. Pivoting toward a hybrid model, wherein more patient visits are conducted at a distance, would preserve a safer physical space for those with conditions or barriers that preclude telehealth. However, we must mitigate the hidden costs of in-person visits via meaningful policy change.

Access to digital services is important not just for health care but also for education, housing, other social services, job applications, and food delivery in communities with COVID-19 outbreaks. Cross-sector collaboration among health care systems, local governments, telecommunication companies, schools, community-based organizations, and philanthropic organizations is needed to address inequitable access to critical resources and provide assistance for the members of our communities with the most risk. We must advocate for broadband infrastructure and internet-capable devices for underserved patients. Prospective systematic studies of the effects of policies and access to telehealth on health inequities will be needed. The expansion of telehealth has great potential, both for good and for harm. It is imperative that physicians engage in the stewardship of this change.

ARTICLE INFORMATION


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REFERENCES


