COVID-19 Pandemic Health Disparities and Pediatric Health Care—The Promise of Telehealth

By mid-July 2020, more than 138,000 US citizens died of novel coronavirus disease 2019 (COVID-19). While an estimated 0.03% of the deaths were children, aged birth through 14 years, many more children were affected directly by the deaths of their parents, grandparents, and caregivers. Given the human loss and public health efforts to mitigate the incidence of COVID-19, access to pediatric physical and mental health care was significantly impacted.

The COVID-19 pandemic revealed glaring health disparities in the US. Health disparities are preventable differences in health outcomes due to racial, ethnic, ability, immigration status, or other marginalizing characteristics. Of 42 states and cities reporting mortality data to the Centers for Disease Control and Prevention, 34 (81.0%) reported higher (>20%) mortality rates among Black individuals in the US than would be predicted based on Black population distribution. Among people of color in the US, the overall state mortality disparities, measured by distribution of COVID-19 deaths, were up to 360% higher for Black individuals in the US than what would be predicted based on their state population percentage. Reported COVID-19 mortality rates were up to 1100% higher in 1 state for the American Indian population, up to 167% higher for Asian populations, and up to 219% higher for Hispanic/Latinx populations.

The statewide mortality rates, however, may not be the whole story. Some cities have even higher COVID-19 mortality disparities. Health disparities in the US may be primarily caused by structural racism and institutional policies that support residential segregation, underfunded schools, unequal pay and benefits, and lack of universal health care. All states without COVID-19 mortality percentage disparities among the Black population enacted the Affordable Care Act (ACA), compared with the ACA enactment in only 50% of the 10 states with the highest disparity percentages of COVID-19 mortality among Black individuals. Tragically, children who live in families with the least resources—those who are poor, disabled, and from marginalized populations—are experiencing the most hardship from the novel coronavirus pandemic due to food scarcity, housing insecurity, and lack of access to health care.

What can we do to bridge the physical and mental health care gaps exacerbated during mitigation strategies to reduce COVID-19? Telehealth may provide part of the answer. The ubiquity of cell phones across the US, with approximately 96% of US citizens owning cell phones, supports the expansion of telehealth. The Pew Research Center found an equal distribution of cell phone ownership across White, Black, and Hispanic/Latinx populations and urban, suburban, and rural environments. Telehealth, therefore, because of its flexible platforms and broad accessibility, may help to reduce pediatric health disparities.

Federal Code 42 CFR §410.78 describes telehealth as a set of services available to patients in specific geographic locations where the health care professional uses interactive audio and video telecommunication systems that permit asynchronous or real-time 2-way communication between the patient and distant-site clinician. Telehealth is considered and reimbursed the same as in-person visits. The national emergency that resulted from the COVID-19 pandemic led to the passage of Public Law 116-123 with a Section 1135 waiver. The Section 1135 waiver allowed the secretary of Health and Human Services to temporarily waive certain Medicare requirements, resulting in the expansion of telehealth services.

Before the COVID-19 pandemic, restrictions on telehealth access existed. A patient living in a rural area had to travel to a medical facility to receive telehealth services from a health care professional. A patient could receive telehealth in their home only under certain conditions, such as home dialysis or treatment of substance use disorder or a co-occurring mental health disorder. During the COVID-19 pandemic, the Section 1135 waiver allowed all patients to receive telehealth in their homes. Permission to provide health care within the home of the patient is a privilege and a benefit for the clinician. For physicians, nurse practitioners, psychologists, and other professionals providing pediatric health care, telehealth virtual home visits may inform therapeutic recommendations through visual understanding of the home environment and resources.

Before the COVID-19 pandemic, regulations for telehealth credentialing varied by state and insurer. Health care professionals usually needed a license in the state where the patient received care. During the COVID-19 pandemic, Centers for Medicare and Medicaid Services regulations allowed out-of-state physicians in all states and territories to obtain emergency medical licenses, with locale-specific easing of telehealth credentialing regulations.

Changes in Medicare and Medicaid guidance allowed by the Section 1135 waiver increased a wide range of previously unavailable telehealth services. Before COVID-19, telehealth professionals were limited to physicians, physician assistants, nurse practitioners, nurse-midwives, mental health professionals, and dietitians. The Section 1135 waiver increased the clinical disciplines eligible to provide and bill for telehealth services. Medicare, Medicaid, and private insurance now reimburse for telehealth services delivered by speech therapists, physical therapists, and occupational therapists. The Section 1135 waiver expanded mental health services by authorizing clinical psychologists and clinical social workers to bill for evaluation and manage-
ment of mental health conditions. New Medicare guidelines allow virtual check-in (5- to 10-minute check-in) and patient-initiated e-visits through an online patient portal for established patients. Expansion of insurance coverage enables children with disabilities and special health care needs to receive allied health services in the home while children are home with parents and schools are working to implement virtual education and therapy services.

Before the COVID-19 pandemic, all states required an in-person visit before prescribing medication via telehealth; however, following the COVID-19-related emergency declaration, initial in-person visit restrictions were waived. Allowing prescribing without an initial in-person visit expedited treatment and reduced the immediate need for in-person visits during mitigation strategies. The in-person visit could then be scheduled when the COVID-19 curve flattened, also allowing time for clinics to implement physical distancing and COVID-19 prevention strategies.

Before the COVID-19 pandemic, federal regulations only allowed telehealth services via the Health Insurance Portability and Accountability Act–compliant telecommunication platforms. Audio, fax, and email health information transfer were not considered telehealth. With the Section 1135 waiver, states relaxed the Health Insurance Portability and Accountability Act regulations and allowed audio, Skype, Facetime, and other social media platforms for telehealth. The expansion of telehealth modalities was essential to promote children’s health and to allow flexible access for parents who are essential employees or work at home.

The COVID-19 crisis created a challenge and an opportunity to provide continuity of health care for children. Sustained pediatric health care resulted from broadening telehealth disciplines, reduced geographic barriers, and increased scheduling flexibility and type of services covered. There remain, however, challenges. There may be differences geographically and by disability status in smartphone ownership. Individuals with disabilities have lower access (70% vs 87%) to cell phones compared with their nondisabled peers.8 People living in rural areas have lower smartphone ownership (71% vs 83%) compared with urban environments.9 To reduce the likelihood of telehealth-related disparities, current policies improving access to telehealth should continue, and universal high-speed internet service should be accessible for all US citizens.

Telehealth may allow closer monitoring and communication with parents of children with complex medical conditions. These services may benefit children, youth, and families living in both rural and urban areas, children who are poor or have disabilities or behavioral health needs. Telehealth may reduce parent burden, decreasing time off from work and distances traveled for health care. Of note, many modifications in telehealth regulations are the result of the Section 1135 waiver. Review of health care practice guidelines is highly recommended. Evaluating COVID-19 pandemic-related telehealth policy modifications that support child health and well-being and safe health care practices are paramount. Telehealth is a vital strategy to bridge pediatric physical and mental health care gaps, potentially reducing health care disparities.

ARTICLE INFORMATION
Conflict of Interest Disclosures: None reported.

REFERENCES