Advancing Digital Health Equity: A Policy Paper of the Infectious Diseases Society of America and the HIV Medicine Association

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The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic has revolutionized the practice of ambulatory medicine, triggering rapid dissemination of digital healthcare modalities, including synchronous video visits. However, social determinants of health, such as age, race, income, and others, predict readiness for telemedicine and individuals who are not able to connect virtually may become lost to care. This is particularly relevant to the practice of infectious diseases (ID) and human immunodeficiency virus (HIV) medicine, as we care for high proportions of individuals whose health outcomes are affected by such factors. Furthermore, delivering high-quality clinical care in ID and HIV practice necessitates discussion of sensitive topics, which is challenging over video without proper preparation. We describe the “digital divide,” emphasize the relevance to ID and HIV practice, underscore the need to study the issue and develop interventions to mitigate its impact, and provide suggestions for optimizing telemedicine in ID and HIV clinics.

Keywords. HIV; communicable diseases; telemedicine; policy.

Almost overnight, the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic fundamentally changed the practice of ambulatory medicine in the United States. In response to the public health emergency, clinics swiftly launched or expanded options for healthcare delivery through synchronous telemedicine (real-time video conferencing) and other telehealth modalities (“telehealth” refers broadly to all remote electronic healthcare services, including video interactions, telephone communication, asynchronous messaging, and others). A report from the Department of Health and Human Services (HHS) highlights the unprecedented change, noting that 43.5% of Medicare visits in April 2020 (~1.3 million visits per week) were conducted electronically—the report includes interactions by voice, voice and video, chat, or e-mail—compared with 0.1% in February 2020 (~2000 per week) [1].

The immediate expansion of remote healthcare service delivery was facilitated by Congressional House Bill 6074, which allowed HHS to waive certain telemedicine restrictions, coupled with emergency declaration waivers from the Centers for Medicare and Medicaid Services [2–4]. These directives suspended regulatory obstacles to video visits; previously, patients had to live in designated rural or medically underserved areas and could not connect to visits from home. The declarations also expanded provider types who could bill for telehealth services and allowed use of remote communication applications that may not meet Health Insurance Portability and Accountability Act (HIPAA) requirements. These new mandates, coupled with improved coverage from private payors, enabled the rapid and dramatic expansion of virtual healthcare. However, many of these regulatory decrees are temporary. Moreover, the accelerated adoption of remote healthcare has exposed critical gaps in access. Socioeconomic disparities prevent many vulnerable persons from benefiting from telehealth innovations; such disparities create a “digital divide” [5–7].

This digital divide, defined as unequal access to or ability to engage in care using technological means, is not new, but has become more apparent with the recent proliferation of video visits. As an example, researchers analyzed data from cardiology clinic visits since onset of the SARS-CoV-2 pandemic and results reveal that social determinants of health significantly impact a person’s ability to engage via telehealth [8]. In general, video visits are preferred over telephone visits [9], as they allow for better communication, a limited physical assessment, and enhanced reimbursement. However, female, older, lower-income (<$50 000/year), and non–English-speaking patients were more likely to complete a telephone visit instead of a video visit [8]. Another troubling finding: non–English proficiency was associated with a more than 50% decrease in the use
of either video or phone visits. Similarly, investigators examined
data from gastroenterology clinic visits during the pandemic
and found that Black race and age above 60 were independent
predictors of completing a phone visit instead of video and of
lower usage of online portals [10].

Practitioners in the fields of infectious diseases (ID) and
human immunodeficiency virus (HIV) medicine care for a dis-
proportionately large number of individuals whose health out-
comes are affected by social determinants of health, including
race, ethnicity, gender, income, housing stability, mental health,
substance use, education, language, incarceration history, and
others [11, 12]. The degree to which social determinants of
health predict digital health readiness is striking. They influ-
ence a person’s likelihood of being able to participate in video
visits, communicate by electronic health record (EHR) portals,
and request appointments or prescription refills electronically
[13, 14]. In addition, most mobile health applications are not
designed to engage individuals with limited English profi-
ciency [13]. Efforts to eliminate health inequities based on the
intersectionality of various socioeconomic factors must also ad-
dress the influence of such factors on digital health access.

For an individual to benefit from digital healthcare, experts
describe 3 requirements: (1) technology, (2) technical literacy,
and (3) broadband internet connectivity [15]. We would add
a fourth related, yet independent, need: personal privacy. For
individuals with conditions that sadly remain stigmatizing
(HIV, viral hepatitis, sexually transmitted infections, tubercu-
losis, and others) or when discussing personal matters (sexual
health, gender-affirming care, intimate partner violence, mental
health, substance use), personal privacy becomes a crucial, yet
sometimes scarce, commodity outside of the clinic. These sen-
sitive discussions are critical to delivery of high-quality care in
ID and HIV medicine; raising such conversations by video or
phone can create ethical dilemmas for the patient and provider
if proper planning and preparations are not completed.

Here, we aim to examine how critical digital health access
points—technology, technical literacy, broadband connectivity,
and personal privacy—impact care. We seek to highlight unique
considerations for ID and HIV practitioners, acknowledge eth-
ical dilemmas that may arise in the practice of telemedicine as
well as risks of exacerbating implicit biases, and recommend
that, as a community of practitioners, we work towards inter-
ventions to relieve these pressure points. We emphasize the
importance of collecting data, tracking, and researching dispari-
ties in telehealth access in order to devise interventions and
promote digital health equity.

SOCIAL DETERMINANTS OF HEALTH PREDICT
READINESS FOR TELEMEDICINE

The most obvious requisite for telemedicine is a device with
audio and video capability, such as a desktop, laptop, smart-
phone, or tablet. However, one must also have consistent
broadband internet connectivity. Access to any internet service
is not the same as access to reliable broadband; patients may
have some internet access at home or on their device but lack
stable broadband or sufficient data speeds and quantities for
video interactions. Additionally, to access virtual visits, a person
must feel comfortable using and interacting with their device
and understand how to connect to EHR portals and video inter-
faces. Participation in telemedicine becomes more difficult if a
person requires care through multiple healthcare centers that
use different EHR portals and video apps.

As an illustration of disparities in device ownership and
broadband internet access, 2016 data from the US Census
Bureau showed that 80.9% of white households had a desktop
or laptop computer, compared with 63.9% of Black and 67.5%
of Hispanic households, with similar discrepancies in broad-
band subscriptions [16]. Analyses from the Pew Internet and
American Life Project demonstrate stark differences in smart-
phone ownership and home broadband use by age, race, income,
and educational level [17] (Figure 1). Individuals from ethnic
minority or lower income groups are more likely to be “smart-
phone dependent” (rely on a phone for internet service), which
may be less dependable than an established device with stable
broadband connectivity in the home [18, 19]. Additionally,
urban versus rural discrepancies in telemedicine access remain
stark. Many rural areas in the United States still lack high-speed
broadband connectivity and individuals living outside of met-
apolitan and urban areas are less likely have the capacity to
complete video visits from home [13, 16, 17]. Telehealth visit
increases in recent months have been more modest in rural
compared with urban areas, at least partly due to differences in
broadband availability [1].

Age and social isolation are also critical factors that reduce
the likelihood of engaging in virtual healthcare. Studies using
2018 data estimated that, of older adults in the United States,
38% were not ready for home-based video visits; technical inex-
erience emerged as a predominant barrier [20]. Additionally,
20% of older adults were unready for phone visits due to limited
hearing, vision, or cognition. Lack of telemedicine readiness
was more likely for individuals who were older, male, unmar-
rried, Black or Hispanic, resided in nonmetropolitan areas, had
less education, lower income, and poorer self-reported health.
A similar analysis identified significant barriers to telemedicine
for many Medicare beneficiaries: 41.4% lacked a desktop or
laptop computer with high-speed internet connection at home,
40.9% lacked a smartphone with wireless data, and 26.3% lacked
both (even higher for Black or Hispanic individuals or persons
with lower income, high school education or less, Medicaid, or
a disability) [21].

In ID and HIV clinics, practitioners may care for large pro-
portions of individuals who experience an intersection of fac-
tors that make them especially vulnerable to these disparities
in digital health access. For example, a study that surveyed
persons with HIV (PWH) and hepatitis C as well as a history of substance use found that, while 86% owned a mobile phone, there were high rates of phone turnover and only 52% had daily internet service [22]. Researchers in a metropolitan area surveyed 103 cis-gender women with HIV (median age, 50 years; majority Black, half with less than a high school education, and half unstably housed) and determined that 61% were active internet users, but most relied on a mobile phone for access. Those who were older, had lower income, or less social support were less likely to use the internet [23]. Given sizeable numbers of individuals with HIV, hepatitis C, and other infectious diseases in rural regions, as well as recent outbreaks associated with the opioid epidemic, geographic disparities in digital healthcare access are also highly relevant [24, 25]. Furthermore, large proportions of patients in ID and HIV clinics may be older and rates of social isolation are dramatically high, so the digital divide is germane to ID and HIV practice [26–28].

Undoubtedly, some individuals benefit greatly from telemedicine. Individuals who live far from the clinic or have barriers to transportation or mobility, for example, may better engage in care by video as opposed to in-person, and indeed, many individuals were ready and eager for telemedicine prior to the SARS-CoV-2 pandemic [1]. Remote visits reduce other burdens created by in-person appointments (lost time from work, childcare needs, or stigma that some feel when attending visits at an ID or HIV clinic), and video visits may add insights for the provider into the patient’s living situation, thus augmenting quality of care (reminiscent of a home visit). Moreover, the ability to offer remote visits is critical during the current public health crisis and gives an opportunity to help keep individuals who are vulnerable to severe SARS-CoV-2 infection at home and safe. We assert that recent regulatory changes should be extended so that after the pandemic we can continue to utilize telemedicine to increase care access. However, we also believe it is important to recognize that social determinants of health predict the ability to engage by telemedicine so that disparities can be quantified and addressed.

Concerns have been raised that telemedicine may contribute to “depersonalization of medicine” (less personal connection with patients when relying on distance visits) and data suggest that satisfaction with tele-visits may vary by age, gender, race/ethnicity, and other factors [10, 29–31]. Video visits may also perpetuate or exacerbate provider implicit biases due to visualizing a patient’s living environment or less personal interactions [32]. We must acknowledge and remain aware of these risks.

Figure 1. Smartphone and broadband subscriptions in the United States assessed by various social determinants of health. Recreated with permission from the Pew Research Center.
disparities so that all may benefit from digital innovations. We recommend developing plans to assess each individual’s readiness for telemedicine and focusing on ways to prevent disparities in care from widening.

**IMPORTANCE OF PERSONAL PRIVACY**

As a real-life case scenario that raises important considerations around preparing for and conducting telemedicine visits, a provider logs into a video visit and the patient, a young Black man who has sex with men, joins from the corner of the shelter where he stays, using a personal phone but without headphones. The patient, who has HIV, struggles with medication adherence due to drug use and mental health issues. Should the provider conduct this video visit? If so, how can it be done safely and sensitively, protecting privacy and confidentiality? What preparations could have enhanced the likelihood of a successful visit?

This scenario illustrates an ethical dilemma that providers face more often in the era of frequent video visits. Patients may log into visits from a public space (park, parking lot, city street, public transportation, work site, etc) out of necessity, or from various places in the buildings where they reside (including bathrooms) in an effort to keep discussions with their healthcare providers private. Although headphones may seem like a trivial accessory, they add an essential amount of privacy. Importantly, when a provider logs into a video visit, consent for conducting the visit by video should come first and should acknowledge risks to privacy, particularly if the patient joins from a public setting or does not have headphones. In some instances, the video visit should be rescheduled if privacy is a concern.

Clinicians must exercise judgment in deciding when to encourage in-person versus remote visits and certain medical issues necessitate an in-person visit, especially those that require a hands-on physical examination. Currently, the decision for in-person versus telemedicine visits also requires judgment about risk of SARS-CoV-2 infection in the local jurisdiction, patient risk factors for serious SARS-CoV-2 infection, availability of personal protective equipment, and risks of travel to the clinic, particularly if physical distancing is difficult. Unfortunately, this risk is greater for many individuals from lower income or minority ethnic groups, who are more likely to rely on public transportation and face a disproportionally elevated risk of SARS-CoV-2 infection [33].

**POTENTIAL INTERVENTIONS TO MITIGATE EFFECTS OF DIGITAL HEALTH DISPARITIES**

Research is needed to quantify and characterize the digital divide in ID and HIV, with the goal of understanding and alleviating virtual healthcare barriers. Rodriguez and colleagues [13] recently outlined broad-scale interventions from various stakeholders that would help move towards digital health equity in all fields and we support these recommendations. Steps must be taken at the national, state, and local levels. In addition to campaigns for expansion of broadband internet, advocacy is needed so that recent legislative, regulatory, and reimbursement changes persist and continue to support telehealth services and ensure payment parity after the emergency declarations end (payment parity for video and phone visits, as individuals who are unable to engage in care by video may rely on phone appointments to stay connected).

As an example of a state-level response to the public health crisis, the Washington State Health Care Authority distributed licenses for a telemedicine application to clinics serving vulnerable persons and supplied donated phones to Native American tribes, Medicaid clients, persons enrolled in housing and employment support programs, and other vulnerable individuals [34]. These and similar interventions by other states should be replicated and their impact assessed. As an example of interventions at a healthcare institution, medical students at the University of Washington created a Telehealth Navigation Project in which student volunteers contact individuals prior to scheduled telemedicine visits to help them prepare and connect, plus they are creating a kiosk at the medical center where a volunteer teaches patients how to join video visits.

Other interventions that have been implemented or are in development to support telemedicine should be expanded. These interventions could be adopted by healthcare institutions, clinics, public health departments, community-based organizations, and others, and should be supported with funding at the state and national level:

- Develop protocols to assess patient technical readiness and needs at clinical intake and update at each subsequent visit.
- Ahead of every telemedicine visit, provide instructions (in the patient’s language) for connecting and recommendations for maintaining privacy, such as use of headphones.
- Conduct a test visit to confirm capability, review the process, and ensure a plan for a safe space to conduct the visit (Figure 2 provides a sample checklist).
- Develop programs that offer smartphones, tablets, or laptops to patients, and that provide headphones if a person does not have access to them; offering hardware devices is not a panacea because it does not address other barriers, like broadband access or other hurdles we have outlined, plus devices can be lost or stolen, but for some individuals it can make a major difference.
- Implement classes or other trainings to teach technical literacy, especially for individuals with the most need, such as those with limited English proficiency or hearing or vision impairment.
- Ensure an option for language interpretation services (simultaneous video preferred over audio only) as well as options for hearing impairment (American Sign Language interpreters or closed captioning) and assess if individuals
need assistance due to vision impairment or cognitive impairments; follow telehealth principles outlined by the Consortium for Citizens with Disabilities [35].
- Design virtual user interfaces, mobile health applications, websites, and other online health support tools to engage users of various language and cultural backgrounds and users with visual or hearing impairment.
- Provide a way that patients can access video visits besides the EHR portal; for example, secure HIPAA-compliant texting platforms can be used to message patients with instructions and links to their telemedicine visit.
- Train clinical staff, peer support teams, volunteers, and/or healthcare navigation specialists to help patients manage EHR portals and telemedicine tools.

Figure 2. Sample telemedicine preparation checklist. Abbreviations: EHR, electronic health records; MRN, Medical Research Network.
Design locations where individuals can join teledicine visits that offer reliable connectivity, privacy, and careful cleaning and precautions to prevent SARS-CoV-2 infection (accessible stations in a parking lot or library, for example, or available devices and assistance at central community-based organization sites) [36].

Offer tablets with headphones and a private space to connect at group living sites, such as shelters (with careful cleaning and precautions to prevent SARS-CoV-2).

For clinics and healthcare systems, carefully track which individuals appear to be absent from care, missing video visits, or relying on phone visits instead of video and develop outreach programs.

Include health disparities as a key performance indicator on teledicine dashboards and quality improvement interventions.

Add teledicine best practices to medical education and training curricula.

CONCLUSIONS

Teledicine offers a powerful tool to ensure access to healthcare and some patients are benefiting dramatically from recent expansions. However, we need intentional interventions to ensure that this era of virtual healthcare does not exclude vulnerable persons from care. Local, state, and national approaches to address digital health equity and mitigate the impact of the digital divide on health outcomes for all patients are critical and should be a priority in ID and HIV medicine.

Notes

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