

# Health Care Disparities and Access to Video Visits Before and After the COVID-19 Pandemic: Findings from a Patient Survey in Primary Care

Emily C. Webber, MD,<sup>1-3,i</sup> Brock D. McMillen, MD,<sup>4</sup> and Deanna R. Willis, MD, MBA<sup>4</sup>

<sup>1</sup>Riley Children's Health, Indianapolis, Indiana, USA.

<sup>2</sup>Department of Pediatrics, Indiana University School of Medicine, Indianapolis, Indiana, USA.

<sup>3</sup>Indiana University Health, Indianapolis, Indiana, USA.

<sup>4</sup>Department of Family Medicine, Indiana University School of Medicine, Indianapolis, Indiana, USA.

<sup>i</sup>ORCID ID (<https://orcid.org/0000-0001-5877-6707>).

## Abstract

**Background:** In 2020, the Centers for Medicare & Medicaid Services reimbursement structure was relaxed to aid in the rapid adoption nationally of telemedicine during the COVID-19 pandemic. Due to limited access to internet service, cellular phone data, and appropriate devices, many patients may be excluded from telemedicine services.

**Methods:** In this study, we present the findings of a survey of patients at an urban primary care clinic regarding their access to the tools needed for telemedicine before and after the COVID-19 pandemic. Patients provided information about their access to internet services, phone and data plans, and their perceived access to and interest in telemedicine. The survey was conducted in 2019 and then again in September of 2020 after expansion of telemedicine services.

**Results:** In 2019, 168 patients were surveyed; and in 2020, 99 patients participated. In both surveys, 30% of respondents had limited phone data, no data, or no phone at all. In 2019, the patient responses showed a statistically significant difference in phone plan types between patients with different insurance plans ( $p < 0.10$ ), with a higher proportion (39%) of patients with Medicaid or Medicaid waiver having a prepaid phone or no phone at all compared with patients with commercial insurance (26%). The overall awareness rate increased from 17% to 43% in the 2020 survey.

**Conclusions:** This survey illustrated that not all patients had access to devices, cellular data, and internet service, which are all needed to conduct telemedicine. In this survey, patients with Medicaid or Medicaid waiver insurance were less likely

to have these tools than those with a commercial payor. Finally, patients' access to these telemedicine tools correlated with their interest in using telemedicine visits. Providing equitable telemedicine care requires attention to and mitigation strategies for these gaps in access.

**Keywords:** telemedicine, internet, COVID, vulnerable populations

## Introduction

Telemedicine and virtual care expanded rapidly during the COVID-19 pandemic of 2020. Fueled by necessity among health care providers and systems to deliver patient care, adoption was also driven by removal of barriers and expanded Centers for Medicare & Medicaid Services (CMS) reimbursement models. In March 2020, CMS authorized Medicare beneficiaries to receive telehealth at any location, including their homes.<sup>1</sup> Subsequent waivers increased the scope of Medicare telehealth services, including a wider array of practitioners. Finally, the Department of Health and Human Services Office for Civil Rights announced that it would waive penalties for Health Insurance Portability and Accountability Act (HIPAA) violations against health care providers who were using everyday communication technologies to provide telehealth services.<sup>2</sup> These combined changes resulted in millions of additional telehealth visits. CMS data from March and June of 2020 showed an increase from 13,000 beneficiaries using telehealth before the public health emergency to 1.7 million in the last week of April 2020.<sup>3</sup> These CMS expansions were made permanent in January 2021.<sup>4</sup>

Despite these expansions, not all patients are positioned to take advantage of the adoption of telemedicine and virtual care. The digital divide or lack of access to reliable high-speed internet is a well-described gap, made worse in 2020, as many entities turned to virtual solutions to work, study, and conduct business as usual. Nearly 42 million people in the United States may not have the ability to purchase broadband internet as of February 2020,<sup>5</sup> disproportionately impacting communities of color as well as low socioeconomic status.<sup>6</sup>

Finally, according to BroadbandNow, an estimated 1.35 million (20%) residents in Indiana are unserved by broadband internet providers at their home address.<sup>7</sup> At the height of the COVID-19 pandemic, precautions such as stay-at-home orders and business, municipal, and school shutdowns eliminated public options for internet access.

Addressing these gaps is a critical step in preventing worsening inequities in access to care.<sup>8</sup> In this study, we surveyed patients in an urban primary care clinic to determine their access to internet and devices, readiness, and barriers to utilizing telemedicine and virtual health care.

**Methods**

In August 2019, patients from a primary care clinic located in central Indianapolis, Indiana, participated in a 10-question quality improvement survey. The Institutional Review Board reviewed and determined the survey to be exempt. Each patient arriving at the clinic over a 2-day period was given the chance to participate. The paper survey included questions about home internet and device access, phone plan and phone data adequacy, and interest in virtual visits (see Supplementary Data for full survey). The patient’s insurance coverage information was captured on the paper survey form by the staff before handing the form to the patient.

The results were assessed using chi-square tests to determine differences between payor groups. A linear regression model was utilized to analyze the association of phone plan data adequacy with interest in video visits.

Following the results of the first survey, efforts to improve adoption of virtual visits were undertaken, including office signage promoting virtual visits, offering a virtual visit follow-up at checkout, visual cues to prompt providers to schedule virtual follow-ups, and scripting for appointment schedulers to include offering virtual visits at the time of scheduling.

In September 2020, the same quality improvement survey was repeated from the same clinic during an active time period of COVID-19 to see if additional quality improvement efforts were warranted. One additional question was added to the 2020 survey: “How has your ability to do a video visit changed since the onset of COVID-19?” The results were assessed using chi-square tests between payor groups. A linear regression model was utilized to analyze the association of phone plan data

adequacy with interest in video visits. Scheduled appointments were tracked weekly by type and audited for completion throughout the study period. Video visits that could not be completed using video were converted to telephone visits and counted as telephone visits.

**Results**

**RESPONDENTS BY PAYOR TYPE**

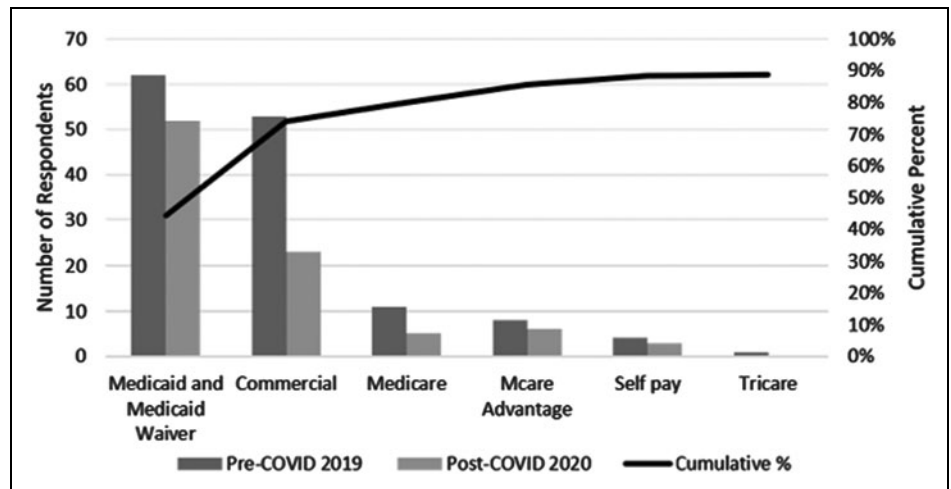
In the 2019 survey obtained pre-COVID, 168 patients participated. In the 2020 survey, 99 patients participated. In both surveys, a range of payors was represented including commercial, Medicaid, and Medicaid waiver (*Fig. 1*).

**ACCESS TO INTERNET, EQUIPMENT, AND DATA—ALL INSURANCE TYPES**

In the pre-COVID-19 2019 survey, 26.8% of respondents had both mobile phones and home computers with video capabilities to support telehealth visits; however, 18.5% of respondents had neither phones nor home computers to support telehealth visits in the pre-COVID-19 cohort and 15.7% in the post-COVID-19 cohort (*Table 1*).

**ACCESS AMONG MEDICAID AND MEDICAID WAIVER INSURANCE BENEFICIARIES COMPARED WITH COMMERCIAL PAYERS**

In the 2019 pre-COVID-19 survey, there was a statistically significant difference in the number of patients with prepaid versus monthly contract phone plan types and between patients with commercial insurance and those with Medicaid/Medicaid waiver plans (*Fig. 2*), with 73.58% of commercially insured patients having a monthly billing contract (the most common). Commercially insured respondents who had a



**Fig. 1.** Respondents by payor.

Downloaded by 47.185.142.8 from www.liebertpub.com at 08/28/21. For personal use only.

**Table 1. Pre-COVID-19 and Post-COVID-19 Respondents' Access to Phones and Home Computers**

	PRE-COVID-19 RESPONDENTS (N= 168), % (n)	POST-COVID-19 RESPONDENTS (N= 89), % (n)
Computer and phone ability to support video	26.8 (45)	32.6% (29)
Computer-only ability to support video	5.4 (9)	7.9 (7)
Phone-only ability to support video	37.5 (63)	36.0 (32)
No computer or phone ability to support video	18.5 (31)	15.7 (14)

**Table 2. Internet, Equipment, and Phone Access Among Patients with Medicaid/Medicare Expansion Insurance**

	PRE-COVID-19 RESPONDENTS (N= 168), % (n)	POST-COVID-19 RESPONDENTS (N= 89), % (n)
High-speed internet at home	55.6 (94)	52.8 (47)
No internet at home	26.8 (45)	19.1 (17)
Internet slow or unreliable at home	14.3 (24)	21.4 (19)
No home computer	56.0 (94)	51.7 (46)
Plenty of phone data	55.4 (93)	57.3 (51)
Limited phone data	25.6 (43)	24.7 (22)
No data on phone	4.8 (13)	2.3 (5)
No phone	3.6 (6)	6.7 (6)
Phone contract billed monthly	64.3 (108)	69.7 (62)
Prepaid phone contract	17.9 (30)	11.2 (10)

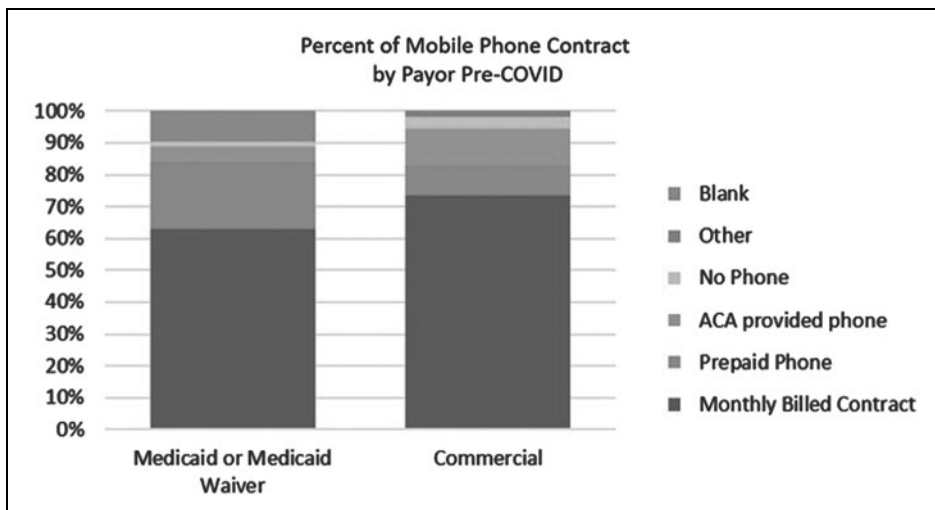
prepaid phone (9.43%) or did not have a phone (3.77%) were less than 10% of all respondents. However, among patients with Medicaid/Medicaid waiver plans, only 62.9% had a monthly billing contract. Twenty one percent of patients with the Medicaid/Medicaid Wavier plan had a prepaid phone compared with respondents with commercial insurance. These availability rates among Medicaid/Medicaid waiver patients were compared with a commercial payor, and results were compared using a two-sample *t*-test ( $p < 0.05$ ).

Among Medicaid and Medicaid waiver patients, only half of the respondents in 2019 and less than half in 2020 had reliable, high-speed internet access at home. Additionally, a slight majority of respondents (65% in 2019 and 62% in 2020) reported that they had plenty of data on their phone plan; however, over 30% of respondents had limited phone data, no

data, or no phone at all. Between the respondents in 2019 and 2020, there was no statistically significant difference in access to internet and equipment (*Table 2*).

**INTEREST IN TELEHEALTH VISITS AND ACCESS—ALL INSURANCE TYPES**

Interest in video visits among survey respondents overall increased post-COVID (*Table 3*). Among respondents to both pre- and post-COVID-19 surveys, technology access was related to interest in video visits. Patients with slow or unreliable internet access or with no internet at all more often responded “not interested” in video visits. Only 12 respondents in the pre-COVID group expressed interest and 9 in the post-COVID group (*Table 4*). Having reliable, high-speed internet access correlated positively in both pre-COVID and post-COVID survey respondents (*Table 4*;  $p = 0.01$  by linear regression relationship). Patients who said they had plenty of data on their phone plan were two times more likely to be interested in virtual visits than those who had to ration their phone data in the pre-COVID-19 survey (*Table 5*;  $p < 0.008$ ). However, in the post-COVID-19 survey group, there was no statistically significant difference noted based on phone data access.



**Fig. 2.** Mobile phone agreements by payor.

**Table 3. Interest in Video Visits Among Pre-COVID and Post-COVID Survey Respondents**

	PRE-COVID SURVEY (N= 168), % (N)	POST-COVID SURVEY (N= 99), % (N)
Interested	30 (50)	37 (36)
Not interested	70 (118)	63 (53)

In the post-COVID-19 2020 survey, there was a significant shift in awareness of the availability of video visits. While 73% of all respondents were unaware in the pre-COVID-19 survey, only 57% were unaware among the post-COVID-19 respondents, reflecting much greater awareness ( $p < 0.0001$ ) (Fig. 3).

Between the survey in 2019 and the survey in 2020, the primary care clinic recorded an increase in the total volume of scheduled virtual visits (Fig. 4) and increased adoption of the telehealth platform system. In the pre-COVID-19 survey in August 2019, virtual visits accounted for 0.2% of all scheduled visits, and in the post-COVID-19 survey in September 2020, virtual visits accounted for 8.1% of all scheduled visits. Scheduled virtual visit appointments were selectively audited and it was found that 50% of video visits during the study period (August 2019–September 2020) had to be converted to audio-only visits at some point. These visits were still counted as video visits since they were scheduled and at least part of the visit included video. The most frequent reason to move to audio only was lack of a clear video connection. Feedback (to clinic staff) for this included inadequate equipment to complete the video portion, inadequate internet or cellular service,

and patient inability to operate the video functionality of their home devices. In preparation for discontinuation of reimbursement for telephone visits after emergency COVID operations, health system leaders asked that telephone visits no longer be scheduled and the focus be on providing in-person care or full video visits in May 2020.

### Discussion

Telehealth and virtual visits increased significantly in the United States during the COVID-19 pandemic; however, not all patients were able to utilize these services. Access to high-speed internet, the equipment needed for virtual care, and phone data plans can all factor into a successful virtual visit for a patient. “WIFI deserts,” similar to food deserts and other social determinants, can worsen health inequities and outcomes as related to access.<sup>5</sup> More recently, following the adoption of telehealth during COVID, studies have been inconsistent about the correlation of equity and access. Some clearly illustrate that the digital divide can be widened, such as the work by Oshima et al., who found that smartphone ownership was associated with the ability to obtain medical care.<sup>8</sup> Others identified a closing of equity gaps to care access during the widespread adoption of telehealth<sup>9</sup> or the patterns of access not falling along traditional lines of equity and access.<sup>10</sup>

Our survey aimed to measure opportunities for improvement and demonstrated the inequities in telemedicine access pre- and post-COVID-19 as correlating with technology access (internet and cellular data) and determining whether these resources influenced the likelihood of telemedicine adoption. In 2019 and 2020, there were a large number of patients who reported a lack of reliable internet, cellular data, and the equipment needed to support virtual care. In the 2020

**Table 4. Interest in Video Visits, Comparing Home Technology Access Among Pre-COVID and Post-COVID Survey Respondents**

	PRE-COVID RESPONDENTS, INTERESTED	PRE-COVID RESPONDENTS, NOT INTERESTED	POST-COVID RESPONDENTS, INTERESTED	POST-COVID RESPONDENTS, NOT INTERESTED
Have high-speed internet	38	56	21	26
Internet access, but slow	2	14	4	11
Internet access, but unreliable	1	3	0	3
Internet access, slow and unreliable	0	4	0	1
No home internet access	9	37	5	11
Did not answer	0	4	6	11
Total (n)	50	118	36	63

**Table 5. Interest in Video Visits, Comparing Data Access on Mobile Phones Among Pre-COVID and Post-COVID Survey Respondents**

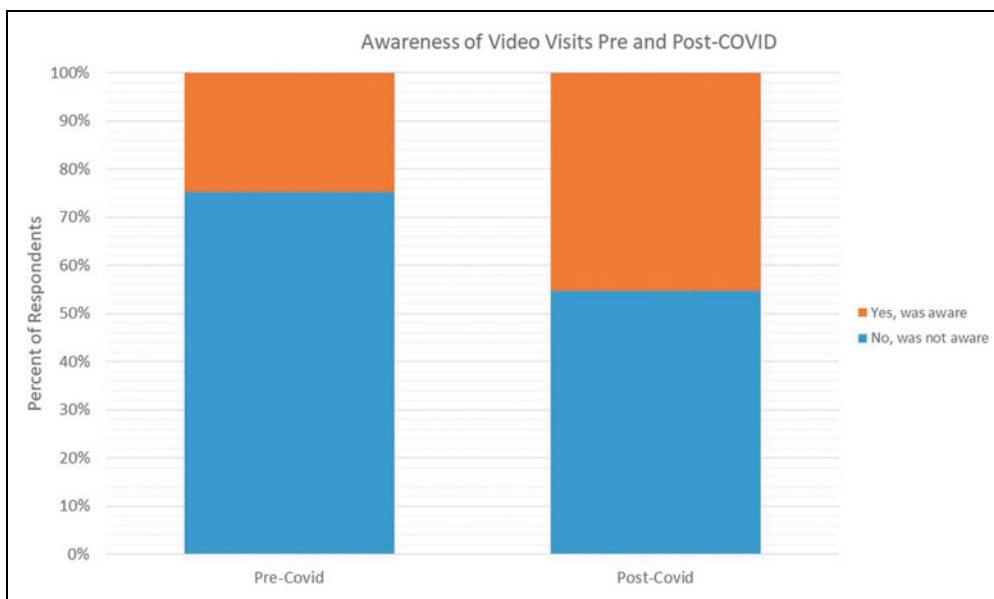
	PRE-COVID RESPONDENTS, INTERESTED	PRE-COVID RESPONDENTS, NOT INTERESTED	POST-COVID RESPONDENTS, INTERESTED	POST-COVID RESPONDENTS, NOT INTERESTED
I have plenty of data	34	59	24	26
I have to watch how much data I use so that I don't go over	9	34	2	20
I don't have data on my mobile phone	0	8	1	4
My mobile phone does not support video calls	0	5	1	0
I don't have a mobile phone	0	1	1	1
Did not answer	7	11	7	12
Total	50	118	36	63

survey during COVID-19, we saw a significant rise in awareness in virtual care; however, our patients continued to face barriers to enable these visits. Our survey responses also indicate that patient perception and interest about telemedicine are closely aligned with their personal resources and access to devices, internet, and cellular phone data at that point in time. In the post-COVID-19 era, in which telemedicine and virtual care can increase access, a patient's access to high-speed internet and their cellular phone data plan were predictors of interest in our survey.

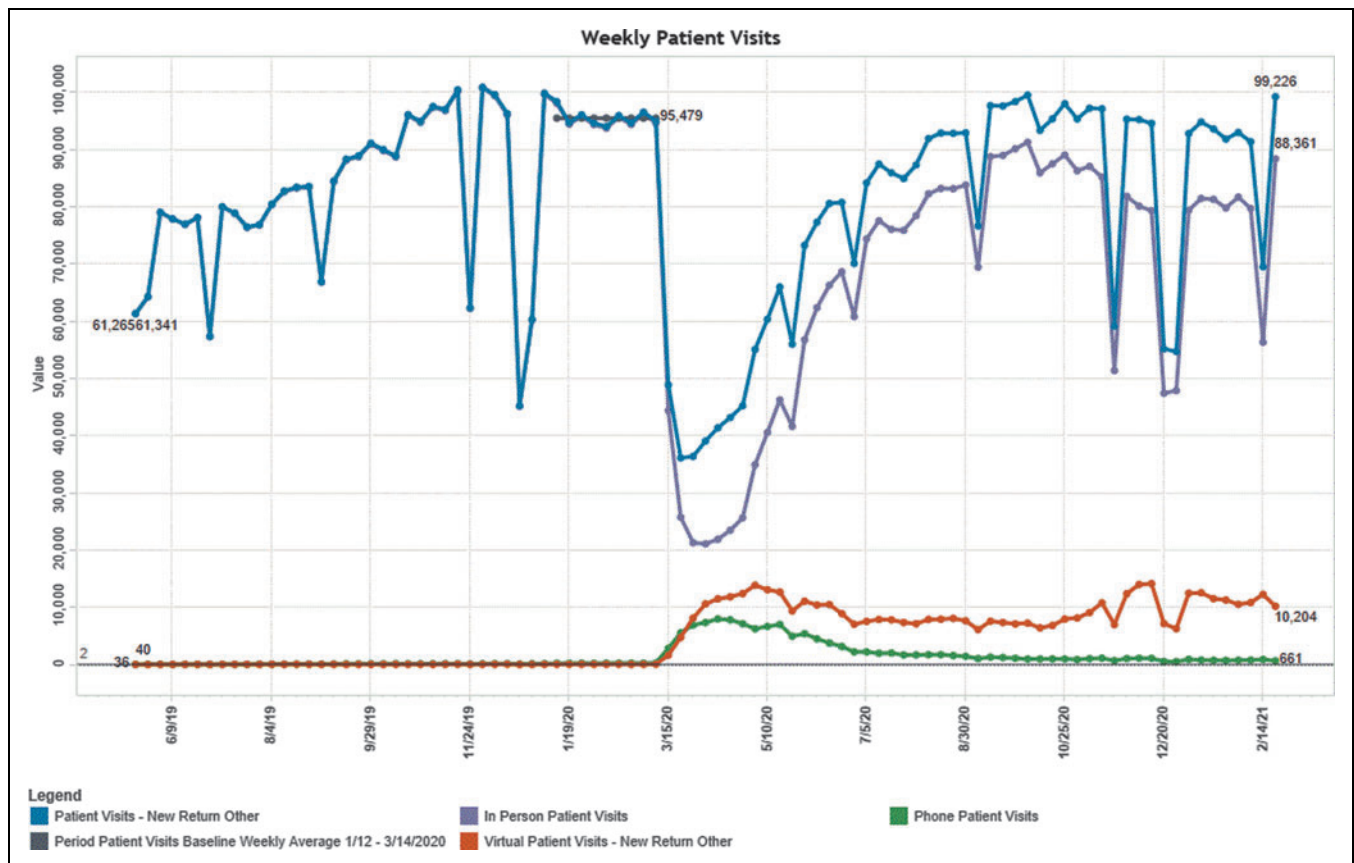
Both before and after the onset of COVID-19, we found that resources are less widely available for Medicare payor groups.

Although not statistically different, our survey noted differences in access to reliable internet either through a home internet service or mobile data plan, which worsened between 2019 to 2020 in this survey of patients. A patient's ability must be considered when determining if telemedicine visits are sustainable for our patient population. If the need to limit in-person visits should arise for a clinic in which the majority of patients do not have cellular or internet access, then telemedicine and virtual care will not be viable alternatives to meet their needs.

These inequities are not unique to our patient population. According to an August 3, 2020, study published in the *Journal of the American Medical Association*, only 6% of adults over age 65 reported being unprepared for telephone visits compared with 38% who were unprepared for video visits. In this study, only 0.3% of telephone visit readiness was attributed to technology, while 10% of video visit readiness was attributed to technology.<sup>11</sup> Additionally, there was a strong association between income and video visit readiness, with 67% of the lowest income quintile being unready for video visits (odds ratio 3.2 [2.2–4.6]). In the area surrounding the clinic involved in our study, 28.2% of the population's income falls below the federal poverty level, nearly triple that of the national average (10.5%) according to 2019 U.S. Census report data.<sup>12</sup>



**Fig. 3.** Awareness of video visits by pre-COVID survey and post-COVID survey.



**Fig. 4.** Increased and sustained volumes of virtual visits (red line) compared with all patient visits (blue) and phone visits (green) from June 2019 to February 2021.

Similarly, Patel et al. also reported variation among the 30 million visits delivered through telehealth to commercially and Medicare Advantage patients.<sup>13</sup> Use of telemedicine in this study was lower in communities with high poverty rates—31.9% in the areas of lowest poverty compared with 27.9% in areas of high poverty.

Poverty is not the only predictor of lower use. Eberly et al. reviewed the charts of 148,402 unique patients receiving care from March to May of 2020 and found that older patients, Asians, and non-English patients had lower rates of telemedicine use. Older patients, females, Blacks, Latinx, and patients of lower socioeconomic status also had lower rates of video use. These inequities are highly concerning for worsening gaps in care.<sup>14</sup>

Our survey had some limitations. This work was completed in a single primary care clinic in a medically underserved area at two points in time: before and after the COVID-19 pandemic. Differentiating phone use by payor type can provide some insight into socioeconomic differences, but other assessments of socioeconomic status, or completing the survey at another location that serves a patient population with dif-

ferent socioeconomic factors, could provide a better understanding of the impact of socioeconomic status on patient ability to complete video visits. In the future, additional questions to assess priorities between cellular and high-speed internet access, as well as the interest and ability to use telemedicine kiosks equipped with the necessary tools, should be addressed. Future work should also evaluate whether these inequities resulted in a lack of access and care—for both virtual visits and in-person care.

Despite limitations, the results of surveys conducted pre- and post-COVID-19 pandemic have been instrumental in identifying specific needs to provide successful virtual care. We have uncovered helpful details to shape the way we prepare to serve a portion of our patients who will need alternatives to both in-person and video visits. This is not a new problem in the United States; despite long-held discussion about the promise of value-based care delivered through telehealth, adoption has been stymied by cumbersome barriers of licensure and service as well as a lack of financial incentive.<sup>3</sup> Interestingly, in the global health literature, mobile phones and digital technology

have been well described as positive interventions<sup>15</sup>; in fact, even simple mobile phones have been shown to have great promise to help close gaps in access, but only if the gaps in phone ownership and access to these digital tools are closed.<sup>16</sup>

The concern we explored in our survey—regarding the equity of telemedicine services—was identified early in the pandemic of 2020. Three main barriers to patients accessing care are commonly identified<sup>17</sup>: absence of technology (i.e., mobile phone or computer), digital literacy, and reliable internet coverage. Indeed, the correlation between reliable internet and the likelihood of telemedicine use was described even before the COVID pandemic.<sup>18</sup> During the first frantic months, many articles were published describing the variable path to successfully identify trends that addressed the gaps in equity. For example, Chang et al. surveyed primary care adoption of telehealth in New York City during 2020 and revealed that the mobile phone was the more common tool among those populations with higher scores on the Centers for Disease Control and Prevention's social vulnerability index.<sup>19</sup> Many additional studies highlighted trends noted in specific services<sup>20</sup> and venues of care.<sup>21</sup>

With these reflections and given this survey's findings as one of many inputs, it is important to recognize that even with the great accessibility and rapid acceleration of care models utilizing virtual care, equity needs to be a constant focus. Key strategies at our institution aiming to mitigate disparities in planning operations for virtual health include assessment of patient access to internet (through home or mobile data plan), advocacy within our communities to provide internet/bandwidth, and identification of "WIFI deserts" to prioritize placement of kiosk-type access to improve compliance. Other similar programs during the COVID pandemic have included distribution of devices to enable remote connections<sup>22</sup>; however, there is additional need to provide or support internet access to power those devices. Immediate strategies have been the use of home care community health workers to facilitate virtual visits for our highest risk patients with chronic illnesses<sup>23</sup> and partnering with community churches and organizations to facilitate virtual visits.<sup>24</sup>

Our ability to meet our most vulnerable patients where they are will require increased awareness and proactive management for patients' tools such as cellular and internet access. The survey findings will inform our strategic and operational planning to enable virtual care as part of our ongoing operations.

### Authors' Contributions

D.R.W. conceived the research idea. D.R.W. and B.D.M. led the survey. E.C.W., D.R.W., and B.D.M. contributed to the analysis of the results and to the writing of the manuscript.

### Acknowledgments

The authors would like to acknowledge the physicians, providers, and clinical staff of the Methodist Primary Care offices as well as the operational leaders and virtual care team for their assistance in these efforts.

### Disclosure Statement

None of the authors have any disclosures.

### Funding Information

This study was not funded.

### Supplementary Material

Supplementary Data

### REFERENCES

1. CMS. Medicare telemedicine health care provider fact sheet. March 17, 2020. Available at <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet> (last accessed June 23, 2021).
2. HHS. Notification of enforcement discretion for telehealth remote communications during the COVID-19 nationwide public health emergency. March 2020, reviewed January 2021. Available at <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html> (last accessed June 23, 2021).
3. Verma S. Early impact of CMS expansion of Medicare telehealth during COVID-19. *Health Affairs* 2020.
4. CMS. Trump administration finalizes permanent expansion of Medicare telehealth services and improved payment for time doctors spend with patients. December 1, 2020. Available at <https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment> (last accessed February 26, 2021).
5. Longley R. Understanding America's digital divide. ThoughtCo. Available at <https://www.thoughtco.com/the-digital-divide-introduction-4151809> (last accessed February 26, 2021).
6. Yoon H, Jang Y, Vaughan PW, Garcia M. Older adults' internet use for health information: Digital divide by race/ethnicity and socioeconomic status. *J Appl Gerontol* 2020;39:105-110.
7. Busby J. FCC reports broadband unavailable to 21.3 million Americans, BroadbandNow study indicates 42 million do not have access. BroadbandNow Research. February 3, 2020. Available at <https://broadbandnow.com/research/fcc-underestimates-unserved-by-50-percent> (last accessed February 26, 2021).
8. Oshima SM, Tait SD, Thomas SM, Fayanju OM, Ingraham K, Barrett NJ, Hwang ES. Association of smartphone ownership and internet use with markers of health literacy and access: Cross-sectional survey study of perspectives from project PLACE (Population Level Approaches to Cancer Elimination). *J Med Internet Res* 2021;23:e24947.
9. Hayrapetian L, Zepp M, Rao S, Hennessey M, Houle M, Atienza M, Belfaqeeh OA, Dharia I, Khan A, Borum ML. Expanding telehealth options during the COVID pandemic eliminated racial and age disparities in electronic communication by inflammatory bowel disease patients. *J Natl Med Assoc* 2021;113:474-477.
10. Stevens JP, Mechanic O, Markson L, O'Donoghue A, Kimball AB. Telehealth use by age and race at a single academic medical center during the COVID-19 pandemic: Retrospective cohort study. *J Med Internet Res* 2021;23:e23905.

11. Lam K, Lu AD, Shi Y, Covinsky KE. Assessing telemedicine unreadiness among older adults in the United States during the COVID-19 pandemic. *JAMA Intern Med* **2020**;180:1389–1391.
12. U.S. Census Bureau. Income and Poverty in the United States: 2019. Available at <https://www.census.gov/library/publications/2020/demo/p60-270.html> (last accessed February 26, 2021).
13. Patel SY, Mehrotra A, Huskamp HA, Uscher-Pines L, Ganguli I, Barnett ML. Variation in telemedicine use and outpatient care during the COVID-19 pandemic in the United States. *Health Aff (Millwood)* **2021**;40:349–358.
14. Eberly LA, et al. Patient characteristics associated with telemedicine access for primary and specialty ambulatory care during the COVID-19 pandemic. *JAMA Netw Open* **2020**;3:e2031640.
15. Mu A, Deng Z, Wu X, Zhou L. Does digital technology reduce health disparity? Investigating difference of depression stemming from socioeconomic status among Chinese older adults. *BMC Geriatr* **2021**;21:264.
16. Maddukuri S, Patel J, Lipoff JB. Tele dermatology addressing disparities in health care access: A review. *Curr Dermatol Rep* **2021**;12:1–8.
17. Ensuring the growth of telehealth during COVID-19 does not exacerbate disparities in care. *Health Affairs* blog, May 8, 2020. Available at <https://www.healthaffairs.org/doi/10.1377/hblog20200505.591306/full> (last accessed August 8, 2021).
18. Wilcock AD, Rose S, Busch AB, et al. Association between broadband internet availability and telemedicine use. *JAMA Intern Med* **2019**;179:1580–1582.
19. Chang JE, Lai AY, Gupta A, Nguyen AM, Berry CA, Shelley DR. Rapid transition to telehealth and the digital divide: Implications for primary care access and equity in a post-COVID era. *Milbank Q* **2021**;99:340–368.
20. Li Z, Harrison SE, Li X, Hung P. Telepsychiatry adoption across hospitals in the United States: A cross-sectional study. *BMC Psychiatry* **2021**;21:182.
21. Jacobs J, Ferguson JM, Van Campen J, Yefimova M, Greene L, Heyworth L, Zulman DM. Organizational and external factors associated with video telehealth use in the veterans health administration before and during the COVID-19 pandemic. *Telemed J E Health* **2021**; [Epub ahead of print]; <https://doi.org/10.1089/tmj.2020.0530>.
22. Kazevman G, Mercado M, Hulme J, Somers A. Prescribing phones to address health equity needs in the COVID-19 era: The PHONE-CONNECT Program. *J Med Internet Res* **2021**;23:e23914.
23. Indiana University Health. IU Health annual virtual visit program. Available at <https://iuhealth.org/find-medical-services/virtual-care-annual-health-visit> (last accessed June 23, 2021).
24. Barnes TJ. Congregations connect with patients for ongoing care. Available at <https://iuhealth.org/thrive/congregations-connect-with-patients-for-ongoing-care> (last accessed June 21, 2021).

Address correspondence to:

Emily C. Webber, MD  
 Riley Children's Health  
 705 Riley Hospital Drive, Suite 2962  
 Indianapolis, IN 46202  
 USA

E-mail: [ewebber@iuhealth.org](mailto:ewebber@iuhealth.org)

Received: March 1, 2021

Revised: June 25, 2021

Accepted: June 28, 2021

Online Publication Date: August 27, 2021