

Statement of the American Academy of Family Physicians

By

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To

U.S. Senate Committee on Commerce, Science, and Transportation  
Subcommittee on Communications, Media, and Broadband

On

State of Telehealth: Removing Barriers to Access and Improving Patient  
Outcomes

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Chairman Lujan, Ranking Member Thune and members of the Committee: I am Dr. Sterling Ransone, president of the American Academy of Family Physicians (AAFP), and I am honored to be here today representing the 133,500 physician and student members of the AAFP.

In addition to my leadership role at the AAFP, I am the physician practice director at Riverside Fishing Bay Family Practice in Deltaville, Va., and an assistant clinical professor of family medicine and population health at Virginia Commonwealth University.

Having practiced in a rural community for more than 20 years with my wife, who is a pediatrician, I have seen firsthand how telehealth can enhance the patient-physician relationship; increase access to care; improve health outcomes by enabling timely care interventions; and decrease costs when utilized as a component of, and coordinated with, continuous care. Telehealth services during the pandemic have allowed patients and families to maintain access to their usual source of primary care, ensuring care continuity.

Full success of telehealth cannot be achieved without significantly improving our nation's broadband infrastructure. The ongoing pandemic has highlighted the utility and importance of broadband for access to primary care, mental and behavioral health care, education, remote work, applications for support programs, and public health information.

Without broadband, many rural, tribal, and urban areas lack critical resources, and physicians face greater difficulty serving these communities. Recent research found that lack of access to high-speed internet was a primary barrier to equitable telehealth access for patients in rural areas, and stories from family physicians confirm that too many people have been left out as telehealth has grown during the COVID-19 pandemic.<sup>1</sup> We must make sure that, moving forward, we have policies and programs in place that enable equitable telehealth access and utilization.

As Congress considers investments in our nation's broadband infrastructure and policies to expand telehealth access beyond the public health emergency, the AAFP offers the following recommendations.

- **Invest in efforts to ensure universal access to affordable broadband services for individuals and health care providers.**
- **Invest in programs that provide end-user devices and digital literacy training and assistance to patients in need.**
- **Expand and target federal telehealth programs to support small physician practices.**
- **Preserve access to audio-only telehealth.**
- **Adopt coverage and payment policies that support physicians' and clinicians' ability to choose the most appropriate modality of care.**
- **Adopt telehealth policies that enhance the physician-patient relationship rather than disrupt it, and also incentivize coordinated, continuous care provided by the medical home.**
- **Monitor the impact of telehealth and broadband on health care access and equity by ensuring that data collection and evaluation include race, ethnicity, gender, language, and other key factors.**

Broadband access must be recognized as a social determinant of health. The COVID-19 pandemic has underscored the strong link between digital equity and health equity. Having access to broadband, especially in times of pandemic and disaster, is vital for connecting people to the most basic necessities, such as health care, education, and employment. It is estimated that 42 million Americans don't have the ability to purchase broadband internet service.<sup>2</sup> And rural Americans are 10 times more likely to lack broadband access than their urban counterparts.<sup>3</sup> Additionally, rural areas tend to rely on older broadband technologies such as DSL, satellite internet, or cellular-based fixed wireless access. These broadband technologies are useful for limited web-browsing, but typically are not reliable enough to support telehealth services. **In order to realize the potential of telehealth and address health disparities, Congress must invest in efforts to ensure universal access to affordable broadband services for individuals and health care providers.**

The AAFP supports the Federal Communications Commission's (FCC) Rural Health Care (RHC) Program, which has helped bridge the digital divide for many rural health care providers by allowing them to obtain high-speed broadband connections similar to their urban and suburban counterparts. These broadband connections have allowed rural practices like mine to implement telehealth services on-site, which can provide patients with timely access to comprehensive care by connecting them and me to remote specialists. However, to provide virtual care to patients at home, both the clinician and the patient need access to broadband.

Lack of broadband internet is associated with fewer telehealth visits, and rural and low-income urban populations are less likely to have broadband internet.<sup>45</sup> Affordability remains one of main barriers to broadband adoption. The lack of reliable and affordable internet access is especially severe in rural communities, where only two out of every three people say they have broadband access.<sup>6</sup> I have seen many of my patients, particularly those enrolled in Medicaid, who are unable to afford high-speed internet at home, which affects their ability to use telehealth services and limits my engagement with them outside the office.

The FCC's Lifeline Program has been critical in helping low-income Americans access broadband; however, it is used almost exclusively for mobile, rather than in-home, broadband services. Mobile services have significant value, but broadband at home creates additional public benefits — including the ability to connect with your physician via telehealth. Additionally, mobile or wireless broadband connections may not have sufficient bandwidth depending on the telehealth platform. We urge Congress to expand and reform the Lifeline Program so it can also provide broadband access in homes and in turn expand access to telehealth.

Beyond virtual visits, the lack of broadband access is limiting the potential of other digital health tools, such as patient portals and remote patient monitoring. Patients who cannot access the online patient portal cannot view their own or a family member's health data, message securely with their physician, schedule appointments online, or request prescription refills online. Remote monitoring devices can feed real-time patient data, such as vitals, to clinicians and allow them to adjust medications and treatment regimens as needed without bringing the patient back into the office; however, these devices work only with a strong, reliable internet connection. I have a patient with congestive heart issues who drives more than an hour each way to see me and who would benefit tremendously from this technology, but we can't use it because of poor bandwidth.

A 2020 report found that access to broadband for Black and Hispanic Americans is an estimated 10 years behind that of white Americans.<sup>7</sup> As stated in our joint principles for telehealth policy in partnership with the American Academy of Pediatrics and the American Colleges of Physicians, equitable access to broadband is critical to reducing health disparities and addressing many social determinants of health, including education and employment.

The COVID-19 pandemic has reinforced how lack of access to broadband and end-user devices perpetuates digital health inequity, and limited access to virtual health information worsens the digital divide.<sup>8, 9</sup> **It is not enough to simply expand access to broadband. Congress must ensure that patients in need can access end-user devices, such as tablets, to connect to digital health tools and invest in training and assistance so patients can confidently use those tools to ensure we don't further marginalize and disenfranchise them.**

One out of three households headed by someone over the age of 65 does not have a computer, and more than half of people over the age of 65 do not have a smartphone.<sup>10</sup> Children in low-income households are less likely to have access to a computer, and 30% of Black or Hispanic children do not have a computer, compared with 14% of whites.<sup>11</sup> Digital literacy also varies with age, income, and ethnicity. Many of our members have [shared](#) the challenges their patients have faced during the COVID-19 pandemic in accessing telehealth services and their patient portal. In my practice, I have seen that seniors have a significant learning curve when accessing these tools unless they have a younger family member to help them log on or troubleshoot technology issues.

To achieve the full promise of telehealth, Congress must act to address these structural barriers to virtual care. The AAFP has [called for](#) the creation of a pilot program to fund digital health navigators; development of digital health literacy programs; and deployment of digital health tools that provide interpretive services at the point of care, are available in non-English languages, easily and securely integrate with third-party applications, and include assistive technology. Such a pilot should include robust evaluation to demonstrate how the interventions have addressed gaps in care or increased access for underserved populations.

I applaud Congress' and the FCC's efforts and recognition that closing the digital divide, especially during a pandemic, is critical to ensuring that Americans continue to have access to care via telehealth. Programs such as the COVID-19 Telehealth Program and Connected Care Pilot Program have increased telehealth adoption among community health centers and hospitals serving communities most in need. The COVID-19 Telehealth Program has also helped ensure patients have the connected devices they need to benefit from comprehensive telehealth and remote monitoring services. Unfortunately, these have largely excluded primary care practices, for which the startup and ongoing costs of telehealth impede adoption.

For many small physician practices, especially those that serve a disproportionate number of Medicaid and uninsured patients, the costs of telehealth technology can be prohibitive. Many telemedicine vendor solutions charge setup fees ranging from \$400 to \$3,000 dollars, in addition to recurring subscription or transaction fees. **Congress should ensure that small practices are adequately supported, either by making them eligible for funding through existing telehealth programs or by creating a new program.** Supporting telehealth adoption within these practices will improve equitable and timely access health care and promote health care competition by enabling smaller practices to remain independent.

The AAFP supports the Connected Care Pilot Program's focus on improving equitable access to quality telehealth services for low-income patients by addressing the high cost of broadband connectivity, including equipment and information services, and urges the FCC to extend and expand this program.

As this Committee is acutely aware, our nation has a long way to go before all Americans have high-speed broadband and the tools and knowledge to leverage it for virtual video health care visits. Further, there may be times that an old-fashioned phone call is the best way for a clinician to treat a patient. **Therefore, it is critical to preserve access to audio-only telehealth services provided by a patient's usual source of care.**

A survey of AAFP members conducted in May 2020 found that audio-only telephone was the most commonly used tool for conducting virtual visits, and a follow-up survey in September 2020 found that 80% of respondents were still using telephone visits.<sup>12</sup> From my own experience, and talking with other family physicians, I can tell you that the reasons for this are lack of reliable, high-speed internet connection; patients' inability to navigate complex technology required for video visits; and the challenge for physicians of adopting or perfecting a video-visit platform.

A comprehensive review of literature comparing the effectiveness of video conference versus telephone in the delivery of health care found that patient outcomes were generally comparable between video conference and phone, with no consistent differences in patient mortality or satisfaction.<sup>13</sup> These findings underscore that telephone can be an effective and appropriate means of providing telehealth care.

However, face-to-face interactions between a physician and a patient are important components of a patient's care that allow a physician to gather a comprehensive understanding of the patient and their needs and build trust and communication. Unlike video visits, telephone visits do not allow physicians the benefit of being able to visually examine a patient or read body language and facial expressions. AAFP members sharing their experiences with telehealth said they feel much more comfortable evaluating patients they know over the phone. To protect patient safety and reduce potential for fraud, it may be prudent to limit coverage of telephone visits to established patients.

Recent studies of telehealth utilization by patients with limited English proficiency show that non-English speakers have used telehealth far less than English speakers. Many physicians routinely use telephone translation services to provide linguistically appropriate care, and these services can be more seamlessly integrated into telephone visits, whereas integrating translation services into audio-video platforms can be costly and complex. Preserving access to audio-only telehealth services is important for ensuring equitable access to care.

**Coverage and payment policies should support patients' and clinicians' ability to choose the most appropriate modality of care (i.e., audio-video, audio-only or in-person) and ensure appropriate payment for care provided.** Some patients and some cases are better suited to virtual care, and others require in-person care; some issues can be effectively treated through a phone call, whereas others require a visual examination. As a family physician, I am highly trained and adhere to standards of care. I also know my patients and have formed trusted relationships with them over years. No two patients or cases are alike, and I should be able to choose how to care for them based on my clinical judgement, not based on arbitrary insurance rules.

**Telehealth benefit expansions must increase access to care and promote high-quality, comprehensive, continuous care.** Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care and expand access to care for under-resourced communities and vulnerable populations. As outlined in our [Joint Principles for Telehealth Policy](#), in partnership with the American Academy of Pediatrics and the American College of Physicians, the AAFP strongly believes that the permanent expansion of telehealth services should be done in a way that advances care continuity and the patient-physician relationship. Expanding telehealth services in isolation, without regard for previous physician-patient relationship, medical history, or the eventual need for a follow-up hands-on physical examination, can undermine the basic principles of the medical home, increase fragmentation of care, and lead to the patient receiving suboptimal care. In fact, a recent nationwide survey found that most patients prefer to see their usual physician through a telehealth visit, feel it is important to have an established relationship with the clinician providing telehealth services, and believe it is important for the clinician to have access to their full medical record.<sup>14</sup>

**Telehealth cannot fully replace in-person primary care.** Researchers at the Robert Graham Center recently conducted an analysis of National Ambulatory Medical Care Survey (NAMCS) data to estimate what proportion of primary care visits can be provided via telehealth.<sup>15</sup> They found that two-thirds of all primary care visits in 2016 required at least one in-person service. The study also revealed how crucial primary care practices are in providing preventive and chronic care: 95% of immunizations and annual wellness visits, one-third of pap tests, 70% of foot exams and more than half of neurological and retinal exams. Equally important, according to the Graham Center analysis, more than 90% of all rapid strep tests and throat cultures occurred in a primary care office setting, and one in four casts/splints/wraps were performed by primary care physicians. While telehealth can expand the reach of primary care by making it more convenient and accessible to patients in their homes, it is clear that virtual-only providers cannot offer fully comprehensive primary care. This underscores the importance of federal policymakers supporting physician practices like mine in adopting and sustaining telehealth so that we can offer our patients both in-person and virtual care.

While the rapid expansion of telehealth has yielded many benefits for patients and clinicians, not everyone has benefited equally. Without sufficient investment and thoughtful policies, telehealth could actually worsen health disparities. Prior to the COVID-19 pandemic, evidence suggested that telehealth uptake was higher among patients with higher levels of education and those with access to employer-sponsored insurance. Another study found that patients with limited English proficiency utilized telehealth at one-third the rate of proficient English speakers. Anecdotes from family physicians suggest that the same trend may hold true for the past year — that those benefitting most from telehealth are those who already had better access to care. With respect to broadband, more accurate information can help federal agencies direct funds to those households truly in need, and in turn will help address the digital divide. **As Congress seeks additional studies to inform the direction of permanent telehealth policies and additional broadband investments, you should ensure the collection and reporting of data stratified by race, ethnicity, gender, language, and other key factors.**

In closing, the COVID-19 pandemic has illustrated that telehealth can and should be an essential part of health care. But more needs to be done to ensure that everyone in this country has access to high-quality virtual care as part of their medical home. Thank you for the opportunity to discuss our recommendations with the Committee.

*Founded in 1947, the AAFP represents 133,500 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits — that's 192 million visits annually, or 48% more than the next most-visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine, the AAFP's positions on issues and clinical care, and for downloadable multimedia highlighting family medicine, visit [www.aafp.org/media](http://www.aafp.org/media). For information about health care, health conditions, and wellness, please visit the AAFP's award-winning consumer website, [www.familydoctor.org](http://www.familydoctor.org).*

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