

Response to the influence of teledermatology on health care access and equity



To the Editor: We thank Hadelier and his co-authors for their support of our research and for providing additional context regarding telemedicine's impact on health care access and equity.¹ Although we found that teledermatology services performed during the COVID-19 pandemic benefitted minority and Medicaid patients, Hadelier et al highlight previous survey-based studies from 2011 and 2013 to 2016 that demonstrated these patients were the least likely to utilize telemedicine.² We believe there are 2 key factors that likely contributed to the increased appointment attendance among minority and Medicaid patients found in our study reflecting the rapidly evolving landscape of telemedicine. These factors are also notable, as they have implications for future access to telemedicine.

First, Hadelier et al point out that a frequently cited barrier to telehealth has been a lack of offerings by providers. Our study was conducted in the wake of emergency legislative changes that ensured broad public and private sector coverage and physician reimbursement for telehealth services during the COVID-19 pandemic.³ We demonstrate an increased percentage of Medicaid enrollees seen via telehealth, indicating that this population is, in fact, likely to accept telehealth when offered and covered by insurance. In addition, we observed dramatically reduced no-show rates among minority patients seen via teledermatology when compared with in-person visits, providing further evidence that telemedicine mitigates some of the traditional barriers to care (ie, transportation, approved time off from work) that patients face when accessing in-person visits. The Centers for Medicare and Medicaid Services are currently working toward making telehealth access permanent, and have even developed an online toolkit to facilitate broader adoption of telehealth coverage by states for patients covered by Medicaid.⁴ With the gains achieved during this period of rapid expansion of telehealth and widespread coverage of telehealth services, we are hopeful that additional legislation will address ongoing telehealth coverage at both the state and federal level to enable telemedicine to continue to be accessible to our underserved patients well beyond the pandemic.

Second, Hadelier and colleagues cite internet usage data from 2011 to support the claim of a lack of broadband access in underserved and rural

communities, which is required for interactive tele-visits. It is worth noting that since publication of these data, national smartphone ownership has increased from an estimated 35% in 2011 to 81% in 2019, and the digital divide related to socioeconomic status has markedly narrowed, with more than 70% of people making less than \$30,000 per year owning smartphones in 2019.⁵ The evolution of affordable smartphones over the last decade likely contributed to the increased access to teledermatology services observed in our study.

Given these recent changes, we agree that further population studies are needed to evaluate telemedicine use on a national scale to have a clearer picture of specialty and setting-dependent access. At the same time, we feel strongly that future legislation must preserve broad access to telemedicine to ensure we don't lose the gains observed in our study, in contrast to the previous inequalities highlighted by Hadelier et al.

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Funding sources: None.

IRB approval status: Not applicable.

Reprints not available from the authors.

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Conflicts of interest

None disclosed.

REFERENCES

1. Franciosi EB, Tan AJ, Kassamali B, O'Connor DM, Rashighi M, LaChance A. Understanding the impact of teledermatology on no-show rates and healthcare accessibility: a retrospective chart review. *J Am Acad Dermatol.* 2021;84(3):769-771.
2. Park J, Erikson C, Han X, Iyer P. Are state telehealth policies associated with the use of telehealth services among underserved populations? *Health Aff.* 2018;37(12):2060-2068.
3. Kassamali B, Haddadi NS, Rashighi M, Cavanaugh-Hussey M, LaChance A. Telemedicine and the battle for health equity:

translating temporary regulatory orders into sustained policy change [published online ahead of print, 2020 Aug 8]. *J Am Acad Dermatol*. 2020 S0190-9622(20)32373-2.

4. "Telemedicine." *Medicaid.gov*, 2020. Available at: www.medicaid.gov/medicaid/benefits/telemedicine/index.html.
5. "Demographics of mobile device ownership and adoption in the United States." *Pew Research Center: Internet, Science & Tech*, 2020. Available at: www.pewresearch.org/internet/fact-sheet/mobile/.

<https://doi.org/10.1016/j.jaad.2020.12.037>