DEPARTMENT OF HUMAN SERVICES

Assessing Telehealth Utilization and Experiences Among Adult Medical Assistance (MA) Enrollees in Minnesota

Findings from a Mixed Methods Study of Enrollees and Providers

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Acronyms and definitions

BIPOC: Black, Indigenous, and People of Color

Culturally and linguistically appropriate services (CLAS): a set of standards developed by the U.S. Department of Health and Human Services that aim to improve health equity and reduce health disparities.

DHS: Minnesota Department of Human Services

Health Information Portability and Accountability Act (HIPAA): a federal law that includes a set of national standards that aim to protect patients' health information.

Medicaid Management Information System (MMIS): database that holds information about Minnesota Health Care Programs, including MA, and their enrollees.

Medical Assistance (MA): Minnesota's Medicaid program for people with low income. MA is Minnesota's largest health care program and serves children and families, pregnant women, adults without children, seniors and people who are blind or have a disability. For this study, we focused specifically on individuals aged 18-64 accessing MA.

Medical Assistance Participant Expert Panel (PEP): a group of MA enrollees who share their experiences with the MA program and provide feedback on various DHS initiatives, including this study. See Appendix C for additional information.

Minnesota Health Care Programs (MHCP): health care coverage provider housed within DHS. Programs include MA, MinnesotaCare, and the Minnesota Family Planning Program.

MinnesotaCare: Minnesota's Basic Health Program that provides coverage to people who do not have access to affordable employer-sponsored health insurance but whose income exceeds the MA eligibility income limit.

Telehealth:

- Legislative definition: "Delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care."
- Definition used in the survey instrument: "Talking to a health care provider over the phone or through a video call."
- Definition used in the interviews and focus groups: "Telehealth includes video and telephone calls with your doctor, nurse practitioner, therapist, or any other provider, but not nurses, schedulers, or office staff."
- Additionally, there are several types of telehealth as defined below:
    - Audio-only telehealth definitions used in the survey instrument: "phone call" without further description and "phone call (without video)"
    - Video-based telehealth definitions used in the survey instrument: "video call" without further description and "video call (where you could see and hear each other)." Note that this study did not differentiate between video-only (no audio) and audiovisual (both video and audio).

Executive summary

Background

In 2021, the Minnesota Department of Human Services (DHS) contracted with Wilder Research to conduct a study of telehealth utilization among people enrolled in Minnesota Health Care Programs (MHCP), with a specific focus on the Medical Assistance (MA) program. For this study, telehealth is defined as receiving health care by video or telephone. This report captures the findings from this study to inform policy and practice pertaining to telehealth for MHCP enrollees in Minnesota. This report uses the abbreviation "MA" to refer to the population of people enrolled in Medical Assistance (e.g., "MA enrollees").

Wilder Research used a mixed-methods approach to complete this assessment, including a survey of 2,985 randomly selected MA enrollees, 2 focus groups and 28 interviews with MA enrollees, and 26 interviews with behavioral health providers who serve MA enrollees. Throughout the study, DHS and Wilder Research engaged a diverse panel of individuals enrolled in MA to guide the study and ensure a culturally-inclusive and community-informed approach.

Telehealth has become widely used

Almost two-thirds of survey respondents reported receiving telehealth care at some point in their life (62%), and about half reported receiving telehealth care in the past year (51%).

Sixty percent of service recipient interviewees (and some urban focus group participants) thought that telehealth is better for simple health care issues but not for complex issues that might require lab work or examinations. Many service recipients shared that they have used telehealth for their behavioral health needs, namely psychotherapy, and they prefer and plan to continue to do so.

Regarding their future care, 73% of survey respondents said they would be interested in accessing health care via telehealth, including 46% interested in either video or phone, 17% interested in phone only, and 10% interested in video only.

Providers and MA enrollees see a comparable quality of care between telehealth and in-person care

> "I really haven't seen any differences in quality per se, but difference in experiences. I really have top notch providers and they do a good job whether it is telehealth or in person." – service recipient

> "It is better to do something than nothing at all. Let's say we are not allowed to do [telehealth] and only face-to-face, our clients will suffer greatly. Telehealth should be an option for clients, but also the providers. We cannot operate like it was 20 years ago. We need to have more options for clients to choose from." – provider

Overall, the majority of survey respondents agreed that there was no difference in quality between telehealth and in-person care for the services they received. For those who did identify a difference, a higher percentage said that in-person care would be of higher quality (Figure 1).

Figure 1. MA enrollee responses regarding care quality

MA enrollee responses	Via telehealth[a]	In-person	No difference
I would have received better care if we had met… (N=1,421)	5%	35%	61%
My provider would have listened more carefully to me if we had met… (N=1,415)	6%	32%	62%
I would have been more comfortable sharing my thoughts and feelings with my health care provider if we had met… (N=1,436)	10%	34%	56%
I would have had more say over decisions that affect my health if we had met… (N=1,418)	6%	31%	63%
I would have left the appointment feeling more confident that I can manage my health and any necessary treatment if we had met… (N=1,428)	7%	35%	58%

Note. Percentages may not add to 100% due to rounding.
[a] This response option did not differentiate between the various modes of telehealth (e.g., audio-only, video-only, audiovisual).

When asked about future services, reasons respondents reported for preferring in-person care included:

- They and their provider would be able to hear and see each other better (67%)
- They would feel more comfortable talking openly with their provider (54%)
- Their provider can explain things better in person (51%)
- There would be fewer distractions during the appointment (51%)
- Their provider needs to assess their health concern in person (45%)

A third of providers (9 out of 26) and 60% of service recipients interviewed indicated that telehealth (defined in the interviews as video and telephone calls with their doctor, nurse practitioner, therapist, or any other provider, but not nurses, schedulers, or office staff), helps build relationships, and enhances rapport and communication through more consistent and frequent interactions and participation from patients. In addition, the majority of service recipient interviewees and focus group participants said they felt more comfortable and safer (including COVID-related and social- or psychological-related safety reasons) receiving services via telehealth. However,

some providers felt that patients and their family members could easily disengage from telehealth services and it can be more difficult to build new relationships with patients using telehealth.

MA enrollees and providers believe telehealth increases access to care

> "It was a good thing because it guarantees that I can actually attend the meetings/sessions. Prior to not having telehealth services, I would have to drive to the clinics. Most of the services are during the day and will require me taking time off work. With telehealth, it increases my access to the services that I need." – service recipient

Two-thirds of survey respondents who received telehealth services in the past year (65%) said that telehealth made it possible for them to access health care they otherwise would not have received. Telehealth may be particularly helpful in improving access for enrollees of certain racial/ethnic groups, enrollees in rural areas, enrollees who received behavioral health services, and younger enrollees (i.e., age 49 and under compared to enrollees aged 50-64). In addition, almost all providers (25 out of 26) shared that telehealth helped reduce barriers to accessing services for their patients. Because of improved access, providers noticed an increase in utilization of services from patients who usually do not seek care and more consistent and reliable care across their patients.

Specifically, the most common health care services survey respondents received by telehealth that they otherwise wouldn't have received include:

- Mental health treatment (52%)
- A visit with a doctor for an injury or illness (34%)
- A visit with a specialist who focuses on treating certain conditions or parts of the body (28%)
- A preventative visit with a doctor (25%)
- Medication or medical equipment (25%)

With regard to access, around half of respondents felt that there would be no difference between telehealth or in-person care. However, those who said one would be better than the other most often said telehealth would be easier to access (Figure 2).

Figure 2. MA enrollee responses regarding access to care among respondents who received telehealth services in the past year

MA enrollee responses	Via telehealth[a]	In-person	No difference
Transportation would have been easier if we had met… (N=1,408)	36%	16%	48%
The wait time to get an appointment would have been shorter if we had met… (N=1,416)	26%	17%	56%

[a] This response option did not differentiate between the various modes of telehealth (e.g., audio-only, video-only, audiovisual).

When asked about future health care, respondents who said they would prefer telehealth most often said it was because of:

- No travel time (78%)
- No need to pay for gas, parking fees, and other travel costs (71%)
- Easier to schedule (67%)
- Shorter wait times for appointments (56%)
- No need to take time off from work (47%)
- No need to find child care or elder care (34%)

Recommendations for telehealth

There was a broad consensus among all study respondents that telehealth should continue to be offered as an option for care. Study respondents and DHS staff identified a number of important recommendations for improving or enhancing telehealth in the future:

- Continue existing expansions of telehealth, including extending the coverage of audio-only, for Medical Assistance and MinnesotaCare enrollees until more information is collected to inform the development of permanent policies.
- Ensure authentic and equitable choice for providers and MA enrollees to access care via telehealth or in-person.
- Conduct additional research on telehealth cost-benefit analyses and the clinical effectiveness of telehealth.
- Continue support for legislation to allow payment parity in reimbursement for all telehealth formats until further data can inform a final policy recommendation, particularly with regard to audio-only services.
- Future telehealth policies should be tailored by service type and intensity, diagnostic complexities, which may vary significantly between physical health and behavioral health care Provide training and support to providers, including technical assistance, education, and quality assurance.
- Continue efforts to better understand how culture, identity, and demographics, and the social and structural factors associated with these identities (e.g., oppression and marginalization), impact telehealth experiences, including for:
    - Enrollees who access care in a language other than English.
    - Enrollees with disabilities and/or blindness and deaf or hard of hearing enrollees.
    - Black, Indigenous, and People of Color (BIPOC) enrollees and enrollees who identify with specific cultural communities, particularly in greater Minnesota.
    - Young children and older adults.
- Continue to advocate and prioritize funding for telehealth infrastructure to ensure enrollees are able to access telehealth services, including reliable internet and devices.

Background

To fulfill a legislative requirement in 2021, the Minnesota Department of Human Services (DHS) contracted with Wilder Research (Wilder) to conduct a study of telehealth utilization among people enrolled in Minnesota Health Care Programs (MHCP), with a specific focus on Medical Assistance (MA). This report captures the findings from this study to inform policy and practice pertaining to telehealth for MHCP enrollees in Minnesota. This report uses the abbreviation "MA" to refer to the population of people enrolled in Medical Assistance (e.g., "MA enrollees").

Legislation

According to the Minnesota Legislature (Section 1. Minnesota Statutes 2021 Supplement, section 62A.673, subdivision 2), "'Telehealth' means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, 2023, telehealth also includes audio-only communication between a health care provider and a patient. Telehealth does not include communication between health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an e-mail or facsimile transmission. Telehealth does not include telemonitoring services."

In 2021, the Minnesota Legislature passed a requirement that the Department of Human Services, Department of Health, and Department of Commerce collectively conduct a study of the impact of telehealth expansion and payment parity (Minnesota Session Laws, 2021). Specifically, the study was required to assess the impact of telehealth on access to health care services, quality of care, self-reported health outcomes and patient satisfaction, with an emphasis on equitable access to care for underserved communities and the effectiveness of audio-only care. DHS took responsibility for collecting information from public program enrollees and the providers who serve them. Clinical outcomes, including symptom reduction or improvements in functioning, were not assessed in the current study. DHS will also continue to consult with Minnesota's Department of Health (MDH) and Department of Commerce to ensure a collaborative and informed set of legislative recommendations.

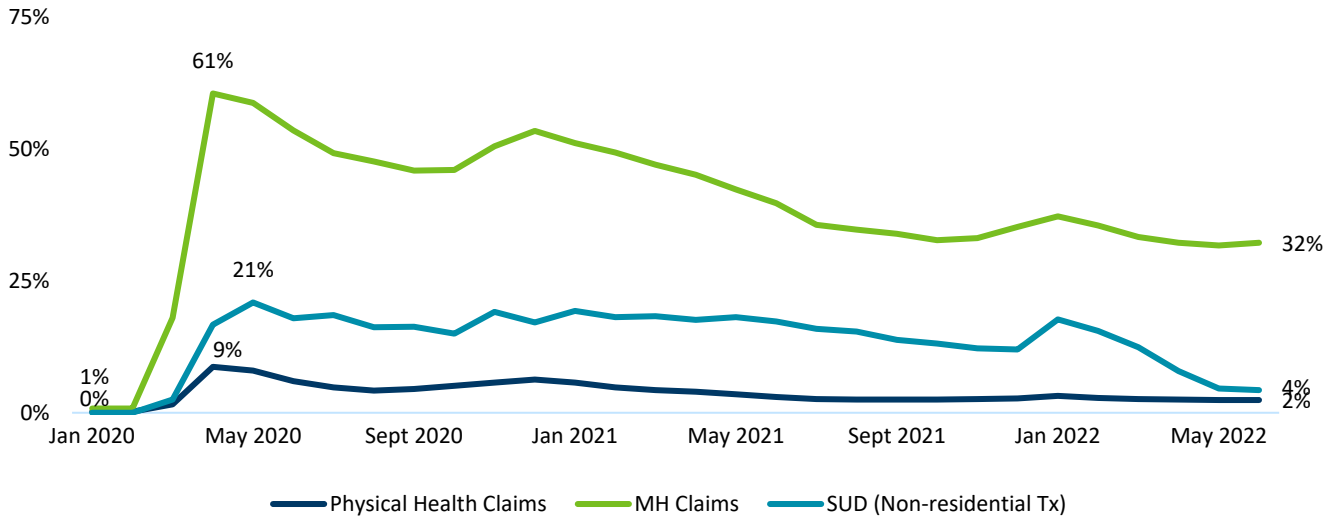
Current law states that Minnesota Health Care Programs (MHCP), which includes MA, will cover telehealth services in the same manner as any other benefits covered through the programs. In addition, as the definition of telehealth states, audio-only care is permissible through June 30, 2025, as long as a) there is a scheduled appointment and this modality is deemed appropriate for the type of care needed and/or b) behavioral health care is needed in a crisis or emergency situation.

Brief review of prior telehealth research

Telehealth use over time

Telehealth utilization increased significantly across the U.S. during the COVID-19 pandemic (Karimi et al., 2022; U.S. Department of Health and Human Services, 2022a), including among Medicaid enrollees (Chu et al., 2021). This pattern can also be found in Minnesota DHS claims data, with claims increasing from 0-1% of all claims in January 2020 to a high of 61% of mental health claims, 21% of substance use disorder (SUD) claims, and 9% of physical health claims in April and May 2020 immediately following the start of the public health emergency. Over time, telehealth use for all three service types declined and appears to have plateaued. Telehealth use still comprises about one-third of mental health claims, but only 4% of SUD claims and 2% of physical health claims. It should be noted that in-person and telehealth services are not mutually exclusive, so the same individuals may have received both modes of care.

Figure 3. Percentage of telehealth Medicaid claims by type of service and month



Delivery format

Previous research has found that using a video-based format (using a device that uses both audio and visual components) and a telephone format (audio-only) are comparable regarding behavioral health client levels of comfort, therapeutic alliance, levels of distraction, client outcomes and client participation (Chen et al., 2022; Day & Schneider, 2002; Hatami et al., 2022; McGrath et al., 2011; Thomas et al., 2021), and that these delivery formats are comparable to in-person services (Bellanti et al., 2022; Chen et al., 2022; Day & Schneider, 2002; Osenbach et al., 2013; Stiles-Shields et al., 2014; Thomas et al., 2021). Regarding general health care, Rush and colleagues (2018) also found comparable levels of patient satisfaction and patient outcomes between video-based and audio-only formats.

Benefits of the video-based format

There is some evidence that the visual component of the video-based format may contribute to client engagement and encourage a sense of connectedness and familiarity between client and provider, and providers may feel more competent and comfortable delivering services via video-based format compared to providing services by telephone (Bouchard et al., 2004; Chang et al., 2021; Nelson & Bui, 2010). Providers have also reported that the video-based format is a more useful delivery format than phone calls to treat adults with mental illness, substance use disorders, and intellectual and/or developmental disabilities (Community Mental Health Association of Michigan, 2021).

Similarly, previous research has found that the video-based format is better suited to provide care that requires visual assessments (Chang et al., 2021). The video-based format allows providers to collect visual information that can yield a better understanding of the patient's health concerns, symptoms, and/or daily life, such as hygiene and medication adherence (Chang et al., 2021; Chen et al., 2022; Thomas et al., 2021). In a review comparing the audio-only and video-based formats to deliver health care generally, Rush and colleagues (2018) found that the video-based format improved diagnostic and decision-making accuracy and yielded fewer medication errors compared to a telephone call.

Lastly, in studies assessing providers' perceptions of the transition to telehealth due to the COVID-19 pandemic, providers generally preferred the video-based format over audio-only (Chang et al., 2021; Molfenter et al., 2021).

Benefits of the audio-only format

There are also several benefits unique to the audio-only format, primarily regarding improving access to care. Specifically, this format often involves only a telephone call, which is generally easier to access than the computer programs often needed for a video-based format, increasing its feasibility (Chang et al., 2021). Access to telephone services is also generally greater compared to internet or mobile data access that is required for the video-based format (Bailey et al., 2021; Chen et al., 2022). Despite providers' general preference for the video-based format, they also maintained support for ensuring access to the audio-only option, as it may be more affordable, more accessible, and easier to use for some patients (Chang et al., 2021; Molfenter et al., 2021).

Research has also found that the audio-only format increases access to care for populations that already experience health care disparities (e.g., older adults, BIPOC communities, people who need access to an interpreter, people with low household incomes, and those who receive health care through Medicaid), and eliminating this delivery option may worsen these disparities (Chen et al., 2022; Karimi et al., 2022; Kleinman & Sanches, 2022). A similar pattern exists among Medicare enrollees, with older enrollees and Hispanic enrollees more likely to utilize the audio-only format, and those who received audio-only services use the audio-only format almost exclusively (U.S. Department of Health and Human Services, 2022b). In addition, Minnesota community providers and partners report positive attitudes toward telehealth generally among ethnic minority groups and rural tribal groups, but noted a preference for the telephone delivery format (Singh & Marquardt, 2020).

Lastly, the audio-only format can further reduce patient concerns about privacy and anonymity, increasing the likelihood of accessing care for some patients (Chang et al., 2021; Watzke et al., 2017).

Benefits related to telehealth

Improved access

Overall, previous research has demonstrated important benefits to telehealth services for patients. Many researchers have identified the critical role telehealth has played to ensure continued access to care during the COVID-19 pandemic and subsequent social distancing recommendations (Andrews et al., 2020; Monaghesh & Hajizadeh, 2020; Wosik et al., 2020).

Beyond ensuring continued access to care during public health emergencies, research has found many other benefits of the telehealth format. These include improving access to health care by increasing convenience (Bashshur et al., 2016; Lal & Adair, 2014; Nelson & Sharp, 2016; U.S. Department of Health and Human Services, 2021), reducing geographic and transportation barriers (AspireMN, 2020; Lal & Adair, 2014; Petersen et al., 2020) and reducing costs to access care, such as transportation costs and time away from work (Bashshur et al., 2016; Lal & Adair, 2014). The convenience of telehealth may provide more opportunities for care for individuals who would otherwise not seek care (Singh & Marquardt, 2020) or who require specialty care that is not geographically accessible (RTI International, 2017; U.S. Department of Health and Human Services, 2021).

In addition, telehealth services can ease the burden for caregivers, family members, and other individuals involved in a client's life (American Telemedicine Association [ATA], 2017; Nelson & Sharp, 2016). This reduction in barriers to accessing care has been shown to improve retention and adherence to treatment plans and medication (Bashshur et al., 2016; Basit et al., 2020; CDC, 2020; Deloitte Center for Government Insights, 2019; Mohr et al., 2012; Nelson & Sharp, 2016; SAMHSA, 2016; SAMHSA, 2021; Tse et al., 2015).

Satisfied clients

Generally, clients tend to be satisfied with telehealth services (Andrews et al., 2020; AspireMN, 2020; Backhaus et al., 2012; Bashshur et al., 2016; Brenes et al., 2011; Deloitte Center for Government Insights, 2019; Jenkins-Guarnieri et al., 2015; Lin et al., 2019; Nelson & Sharp, 2016; Orlando et al., 2019; Reese et al., 2015; Richardson et al., 2009; SAMHSA, 2016; Tse et al., 2015; Tse et al., 2021; Turgoose et al., 2018). Previous studies have found that clients are accepting and willing to receive telehealth services (Andrews et al., 2020; Bashshur et al., 2016; Brooks et al., 2013; Himle et al., 2012; McCall et al., 2019; Nelson & Sharp, 2016; Tse et al., 2021; Yuen et al., 2013) and report feeling engaged and that they benefit from telehealth services (AspireMN, 2020). In some contexts, clients feel greater privacy and less stigma when using telehealth, including when there is a risk of seeing others or being treated by someone they know in a treatment setting (Deloitte Center for Government Insights, 2019; Hilty et al., 2016; Nelson & Sharp, 2016).

High quality of care

Extensive research has demonstrated that telehealth services are effective for treating mental health and substance use disorders (Bashshur et al., 2016; Bellanti et al., 2022; Hatami et al., 2022; Nelson & Sharp, 2016). Behavioral health clients who receive telehealth services experience symptom improvement, positive clinical outcomes and overall quality of life improvement (Backhaus et al., 2012; Bashshur et al., 2016; Bellanti et al., 2022; Berryhill et al., 2019; Chen et al., 2022; Gannon et al., 2022; Giovanetti et al., 2022; Greenwood et al., 2022; Hatami et al.,

2022; Lazur et al., 2020; Nelson & Sharp, 2016; Stubbings et al., 2013; Thomas et al., 2021; Varker et al., 2019; Yuen et al., 2013). This includes improvements in depressive symptoms (Berryhill et al., 2019; Bulkes et al., 2022), anxiety symptoms (O'Bryan et al., 2022), emotional dysregulation (O'Bryan et al., 2022), post-traumatic stress disorder (PTSD) symptoms (Peterson et al., 2022) and psychosis symptoms (Sharp et al., 2011).

Furthermore, telehealth may have unique benefits over in-person care. For instance, telehealth can allow for providers to understand the client's environment (Singh and Marquardt, 2020) and engage clients who are more comfortable at home, including those on the autism spectrum (Hepburn et al., 2016) or those with dementia (Gibson et al., 2007). Research also suggests that effectiveness of telehealth is comparable to in-person care regarding a wide range of physical health concerns (Gutierrez et al., 2022; Snoswell et al., 2021).

SAMHSA (2021) considers the telehealth format effective for a wide range of services, including assessments and screenings, pharmacotherapy, medication management, case management, recovery supports and crisis services.

Challenges related to telehealth

Limited access to resources

Research also suggests the telehealth delivery format poses challenges. Specifically, telehealth requires patients to have access to technological resources and digital literacy, which can pose challenges to accessing telehealth services for some individuals (AspireMN, 2020; Couser et al., 2021; Langarizadeh et al., 2017; Ojha & Syed, 2020; Summers-Gabr, 2020). Technology-related problems can be disruptive (AspireMN, 2020; Traube et al., 2020), and clients may need access to technology support (Singh & Marquardt, 2020). In addition, some clients may have greater privacy concerns with telehealth, including those without access to a private area in which to conduct the appointment (Community Mental Health Association of Michigan, 2021; Singh & Marquardt, 2020).

Negative perceptions of telehealth

Although many clients appreciate having access to telehealth, research suggests many others do not feel comfortable using telehealth services (Petersen et al., 2020; Singh & Marquardt, 2020). In addition, some clients perceive telehealth services as lower quality (Singh & Marquardt, 2020). Some providers also identify quality concerns associated with telehealth, including difficulty perceiving non-verbal cues (Singh and Marquardt, 2020), building therapeutic alliance (Bischoff et al., 2004; Mucic & Hilty, 2020), and addressing safety concerns, such as significant or severe suicidal ideation, externalizing behaviors, and physical aggression or self-harm (American Psychiatric Association, 2018; Racine et al., 2020).

Equity in telehealth

Equity-related challenges of telehealth

In addition to the benefits and challenges associated with telehealth broadly, there are also specific considerations for different demographic groups. Research suggests there are demographic differences in telehealth use and perceptions, such that individuals are more likely to use telehealth services if they have higher levels of English

proficiency, identify as white, are insured, have greater disease burdens, live in an urban area, have higher levels of internet use and internet access, are young or middle-aged adults and have higher incomes (Adepoju et al., 2022; Chu et al., 2021; Drake et al., 2021; Eberly et al., 2020; Hsiao et al., 2021; Mann et al., 2020; Neeman et al., 2020; Rodriguez et al., 2021; Yuan et al., 2021).

One factor that may be associated with these differences is that acceptance and willingness to use technology varies across communities and communities use technology at different levels and in different ways (Brooks et al., 2013; Disney et al., 2021; Yellowlees et al., 2008). Individuals from marginalized communities, such as immigrants and refugees, individuals with disabilities and those with low incomes often have even less access to and/or may be less comfortable with the required technology (Disney et al., 2021; Hames et al., 2020; Noel & Ellison, 2020; Rocky Mountain ADA Center, 2020). The platforms available may also be less appropriate for individuals with disabilities (Annaswamy et al., 2020). In addition, communication styles vary across cultures regarding tone, pace, eye contact, and use of silence, and these differences may pose more of a challenge when conducting sessions via telehealth (Brooks et al., 2013). Providers have also reported that it is more difficult to find interpreters willing to work within the telehealth format, and that the telehealth format often makes it more difficult to communicate when an interpreter is needed (Disney et al., 2021). Communication-related issues are also commonly reported by the deaf community, particularly the lack of access to interpreters who are sufficiently trained in health care interpretation (Mussallem et al., 2022).

Due to historic oppression, discrimination and potential previous experiences receiving culturally insensitive care, many communities may also lack trust in the health care system and avoid seeking care (Brooks et al., 2013; Ekblad, 2020; SAMHSA, 2016; Toombs et al., 2020). Access to behavioral health services in general may be more limited for historically-marginalized groups as they may face additional obstacles such as language barriers, transportation barriers, a lack of culturally-matched providers, a lack of trust in the health care system and providers, previous experiences receiving culturally inappropriate or discriminatory services, and a lack of knowledge of available services (Brooks et al., 2013; Ekblad, 2020; SAMHSA, 2016; Singh & Marquardt, 2020; Stewart et al., 2017; Stewart et al., 2019; Toombs et al., 2020; Whaibeh et al., 2020).

Equity-related benefits of telehealth

Research suggests telehealth can effectively serve a wide range of populations, experiencing various types of health concerns, including providing behavioral health care to BIPOC communities and communities that primarily speak languages other than English (Bailey et al., 2021; Fien et al., 2022; Truong et al., 2022). Researchers have also identified strategies that can be used to address equity-related challenges and ensure access for communities that experience health disparities. Specifically, Jelinek and colleagues (2022) demonstrated an increase in telehealth utilization among racial/ethnic minority populations after several modifications, including prioritizing community engagement and awareness about telehealth, using clear and simple descriptions of telehealth care during the scheduling process, and simplifying and translating the telehealth access portal. Similarly, in a review of research assessing the implementation of telehealth to serve populations that experience health disparities (e.g., racial/ethnic minority communities, limited English proficiency, people with disabilities), Bailey and colleagues (2021) found that telehealth is an effective delivery format for these populations. However, they underscored the need for ensuring patient-centered care, culturally tailoring treatment approaches, and providing services in collaboration

with partners who are trusted in those communities, such as paraprofessional health workers who can guide patients through the process of utilizing telehealth (Bailey et al., 2021).

Telehealth also provides unique opportunities to address disparities compared to in-person care, particularly the potential for connecting culturally or linguistically "matched" provider and client pairs without the barrier of physical distance, which can improve treatment outcomes (Manchanda et al., 2022; Mucic & Hilty, 2020). In their review of existing literature, Singh and Marquardt (2020) found evidence of telehealth's potential to increase access for many populations, including older adults, Veterans, individuals living in rural areas, individuals with disabilities, individuals with mental health needs and individuals with transportation or mobility-related barriers. For the initial telemedicine analyses in the DHS Telemedicine Utilization Report (Singh & Marquardt, 2020), DHS gathered data from community partners and providers. They indicated positive attitudes toward telehealth among individuals from ethnic minority groups and rural tribal groups.

Methods overview

DHS contracted with Wilder Research to collaboratively fulfill the requirements of the legislative mandate to better understand telehealth experiences of MA enrollees and the providers who serve them. Wilder Research used a mixed methods approach to complete this assessment, including the following:

- ***Survey of a random sample of MA enrollees.*** This survey had a broader focus than solely informing this report, but it included a detailed section specifically about telehealth use, preferences and experiences. The survey was conducted in March and April 2022 both online and by mail. A total of 2,985 individuals completed the survey (approximately 18% response rate). The web survey was available in Spanish, Somali, and Hmong. Survey respondents only included MA enrollees and did not include MinnesotaCare enrollees.
- ***Focus groups and interviews with MA enrollees.*** Wilder Research also conducted interviews and focus groups with MA and MinnesotaCare enrollees between January and March 2022 to gather more detailed, nuanced information about their experiences with telehealth. The interviews and focus groups targeted specific populations of interest to DHS and the legislature, including enrollees in urban areas (7 focus group participants), rural areas (5 focus group participants), over age 65 (6 interviewees), and who received audio-only telehealth care (17 interviewees).
- ***Interviews with providers.*** To better understand how providers experience telehealth, Wilder Research conducted virtual interviews between February and March 2022 with a sample of 26 behavioral health providers who serve individuals on MA and MinnesotaCare. The study focused primarily on providers who serve specific cultural communities such as American Indian/Native American, U.S.-born African American, East African, Karen, Hmong, and Hispanic populations.

Data from the survey were weighted to reflect the overall population of MA enrollees, and analyzed to examine aggregate frequencies and crosstabs by different respondent characteristics and health care usage. Data from the interviews and focus groups were analyzed using an open-coding method to identify key themes. Results were shared with a group of individuals enrolled in MA and a group of decision-makers from DHS to assist with the interpretation and development of data-informed recommendations.

See Appendix A for detailed evaluation methods. See Appendix C for detailed data-informed decision-making process and themes.

Community engagement in research process

DHS and Wilder Research prioritized community engagement and cultural responsiveness in this study to ensure that the results were as meaningful and inclusive as possible. The steps DHS and Wilder took to integrate community voice in this study include:

- Engaging a planning committee with subject matter experts in inclusion, equity and accessibility.
- Developing a Medical Assistance Participant Expert Panel (MA PEP) comprised of diverse individuals enrolled in MA to provide guidance on the study. Specifically, this group provided input on the survey and focus group questions and recruitment approach on the front end and data interpretation and recommendations on the back-end. See Appendix C for more detail about this group.
- Attending meetings with the American Indian Mental Health Advisory Council to provide input on interview and survey questions.
- Ensuring survey demographic questions were inclusive of different populations and identities such as interpreter needs, gender identity, and diverse racial/ethnic identity options.
- Translating the survey and recruitment language into Hmong, Somali, and Spanish.
- Stratifying the survey sample to ensure representation from diverse populations.
- Recruiting providers and MA enrollees for interviews and focus groups by partnering with culturally-responsive providers and providers who serve culturally specific communities.

In addition, the project team plans to continue these efforts by translating the executive summary from this report into Hmong, Somali, and Spanish and through community-based dissemination planning, including hosting a town hall meeting and attending community-led meetings to share study findings.

Guiding framework and report overview

The Institute of Healthcare Improvement (Perry, Federico, & Huebner, 2021) published a framework for ensuring safe, equitable, person-centered telehealth care. A panel of experts from around the world convened to identify the data-driven framework components. This framework outlines the necessary components for high quality telehealth. The scope of the current study goes beyond assessing how telehealth is implemented to also include comparisons between telehealth and in-person care, and the benefits and challenges of telehealth for specific populations and conditions. Therefore, we expanded the domain definitions of the framework to better fit the scope of this report. The six core domains of the framework, and the ways we adapted each domain are described in Figure 4. This framework was used to guide the data analysis and reporting for the current study.

Figure 4. Framework for ensuring safe, equitable, person-centered telehealth care

Framework domain	Institute of Healthcare Improvement Definition	Study Adaptation
Access	Patient access to reliable technology devices and internet Patient digital literacy Access to phone-based telehealth Respect for patient preference	Broadened to include benefits and challenges associated with telehealth for overall access to health care
Privacy	Clear informed consent process Data protections and cybersecurity Access to private locations for appointments	Facets separated into system supports, communication, and emotional and physical safety
Diagnostic accuracy	Patients demonstrate health concerns in home environment Patient support people (e.g., caregivers or parents) are engaged in their care Providers trained to make diagnoses virtually Providers identify when telehealth is not appropriate	Reframed as assessing health concerns and telehealth fit
Communication	Accessible/assistive technology Appropriate interpreter access Ability to interpret non-verbal communication Active and empathetic listening	Broadened to include satisfaction with communication and relationship quality
Psychological and emotional safety	Patient and provider safety are mutually reinforcing Honor patient preference Verify all patient concerns addressed Active and empathetic listening	Broadened to include emotional and physical safety and engagement, also reflected in autonomy, choice, and self-efficacy section

Framework domain	Institute of Healthcare Improvement Definition	Study Adaptation
Human factors and system design	Telehealth fully integrated into health care delivery system User-centered co-design process to meet patient and provider needs System supports and monitoring for safety and effectiveness Care coordination and continuity of care Provider training and IT support	Reframed as technological resources, supporting systems, and autonomy, choice and self-efficacy

In addition to the domains of the framework, the current study also focused on telehealth utilization, overall patient and provider satisfaction with telehealth, and equity.

To explore equity, Wilder Research analyzed survey data to include crosstabs for selected items and the following selected enrollee characteristics:

- Race/ethnicity: Asian and Pacific Islander, Black immigrant, US-born Black, Hispanic, Native American, and white (from the MA database)
- Geography: rural, urban, and mixed (based on enrollee's county identified in the MA database)
- Treatment plan: whether an enrollee has a current treatment plan (from the survey)
- Interpreter access: whether an enrollee requires interpreter access during their health care appointments (from the survey)
- Sex: female and male (from the MA database)
- Age: 18-34, 35-49, and 50-64 (from the MA database)
- Disabilities or blindness: enrollees who are eligible for MA due to a disability or blindness (from the MA database) compared to two eligibility types: single adults and parents with children
- Type of care and delivery format (from the survey)
    - Behavioral health audio-only services
    - Behavioral health video-based services
    - Physical health audio-only services
    - Physical health video-based services
    - No telehealth in the past 12 months
    - Behavioral health services
    - Behavioral health services by race/ethnicity (same categories as above)

Wilder generally used a threshold of a 15-percentage point difference between groups to identify notable differences. Selected differences within the above subgroup categories are noted throughout the report and all differences meeting this threshold are noted in the databook that accompanies this report. Additionally, Appendix B includes written descriptions of notable differences. Note that not all items were analyzed by all demographic and care characteristic groups. Additionally, Wilder suppressed data for any group with under 20 enrollees (unweighted), and these are noted in the databook.

Throughout this report, themes from interviews with providers and MA enrollees are described if at least 5 individuals discussed the idea. Counts of the number of individuals who mentioned a theme are listed in this report, but these should be treated as estimates. Due to the nature of interviews, a person may not mention a concept, but that idea may still be relevant to them.

Limitations

There are several limitations of this study that need to be considered. These limitations require caution when generalizing or extrapolating from the study findings. The key limitations include:

- While this study collected some information specific to both audio-only and video-based telehealth formats, many of the findings relate to telehealth generally. Additionally, this study did not collect any information specific to "video-only," in which enrollees and providers visually communicate but do not use audio (e.g., enrollees who use American Sign Language (ASL)).
- The current study was unable to assess clinical outcomes (e.g., symptom reduction) or improvements in functioning.
- This study was specific to enrollees in Medical Assistance in Minnesota. Accordingly, generalizability to other populations may be limited.
- Participation in the survey, interviews, and focus groups may have been biased toward enrollees who have stable housing and/or enrollees who have consistent access to a reliable device and internet.
- The survey received very few responses in languages other than English. Accordingly, the results may be biased toward enrollees who are fluent in English.
- Because of the weighting process (as described in Appendix A), enrollees were categorized into only one racial/ethnic group. Accordingly, the survey findings do not speak to enrollees who are multiracial, and each racial/ethnic group likely includes enrollees who also identify as another racial/ethnic identity in addition to the group they were categorized into.
- Note that both the "entirely rural" and "rural and urban mix" geography categories primarily consist of white enrollees (77-79%) compared to 45% of the "entirely urban" category (see Appendix A for additional detail). Findings by geography may be influenced by their proportions of racial/ethnic groups (e.g., findings among enrollees in rural areas may be partially driven by the fact that this group mostly consists of white enrollees).

Telehealth utilization

Key findings:

• Nearly two-thirds of survey respondents reported receiving telehealth services in their lifetime, and about half reported receiving telehealth services in the previous year. There were similar rates of utilization between care types (i.e., physical health and behavioral health) and delivery formats (i.e., audio-only and video-based).

• Survey respondents with treatment plans and those with disabilities or blindness reported using telehealth at higher rates, while a lower percentage of older adults reported ever using telehealth.

• The percentage of survey respondents who reported receiving behavioral health services was higher among those with treatment plans compared to those without treatment plans.

• The proportion of survey respondents who reported receiving audio-only services was higher among individuals with disabilities or blindness compared to other MA eligibility types.

Almost two-thirds of survey respondents reported receiving telehealth care at some point in their life (62%; Figure 5), and about half reported receiving telehealth care in the past year (51%). Survey respondents were also asked to indicate whether they received physical or behavioral health services in the past 12 months and whether the appointment was by phone or video, and these percentages were similar across all four types of care (18-24%).

The proportion of survey respondents who reported ever receiving telehealth services was higher among individuals with disabilities or blindness compared to other MA eligibility types (72% versus 56-64%). And, the proportion of respondents who reported receiving either behavioral health or physical health audio-only services was higher among individuals with disabilities or blindness compared to other MA eligibility types (31-37% versus 15-20%).

Additionally, the percentage of survey respondents who reported ever receiving telehealth services was lower among older enrollees age 50-64 compared to enrollees age 18-34 and 35-49 (53% versus 62-70%). Respondents with treatment plans reported ever receiving telehealth services at a higher rate (72%) compared to those without treatment plans (48%) and receiving behavioral telehealth services in either format in the past year at a higher rate (26-34% versus 7-11%) than those without treatment plans.

Figure 5. Previous telehealth utilization

Have you ever received health care through a phone call or video?	**% (N=2,827-2,899)**
Yes	62%
No	38%
Which of the following types of health care visits have you had in the past 12 months? (Select all that apply)	
Phone call for a mental health or substance use concern	18%
Video call for a mental health or substance use concern	24%
Phone call for a physical concern	23%
Video call for a physical concern	23%
Have not received health care by phone or video in the past 12 months	49%

Telehealth utilization by type of care

For most of the subsequent telehealth items, survey respondents were asked to specifically think of the visit that comes first in the list above (i.e., if a respondent had a phone call for a mental health or substance use concern and a phone call for a physical concern, they were directed to think specifically of the phone call for the mental health or substance use concern). For the visit respondents were directed to think about, they were asked to identify the specific type of care they received during that visit. They most commonly reported receiving mental health treatment (35%), followed by receiving treatment for an injury or illness (19%) and seeing a specialist that treats certain conditions or parts of the body (15%; Figure 6).

Figure 6. Type of care respondents received during the telehealth visit they were asked to think about

For the visit we asked you to think about, which type of health care did you receive? (Select one)	% (N=1,414)
Mental health treatment	35%
A visit with a doctor for an injury or illness	19%
A visit with a specialist who focuses on treating certain conditions or parts of the body	15%
Preventative visit with a doctor	13%
Medication or medical equipment	8%
Other services[a]	6%
Prenatal care for my pregnancy	4%
Treatment for substance use disorder	2%

Note. Percentages may not add to 100% due to rounding.
[a]This category combines respondents who selected "other services that support my health" and "other, please specify."

Telehealth utilization by respondent and care characteristics

Telehealth utilization was similar across racial/ethnic groups, and half or more of each racial/ethnic group reported ever receiving telehealth services (53-64%; Figure 7). Additionally, the percentages of survey respondents who reported receiving specific types of services in the past year were also similar across racial/ethnic groups, including audio-only behavioral health services (i.e., a phone call for a mental health or substance use concern; 10% to 21%), video-based behavioral health services (i.e., a video call for a mental health or substance use concern; 15-26%), audio-only physical health services (i.e., a phone call for a physical concern; 17-24%), and video-based physical health services (i.e., a video call for a physical concern; 15-25%). The percentage of respondents who said they haven't received any type of telehealth service in the past year ranged from 46% to 60%.

Figure 7. Telehealth utilization by race/ethnicity

Have you ever received health care through a phone call or video call?	Asian or Pacific Islander (N=211-224)	Black immigrants (N=178-193)	US-born Black (N=423-429)	Hispanic (N=208-219)	Native American (N=150-154)	White (N=1,657-1,681)
Yes	53%	58%	62%	59%	58%	64%
No	47%	42%	38%	41%	42%	36%
Which of the following types of health care visits have you had in the past 12 months? (Select all that apply)						
Phone call for a mental health or substance use concern	14%	10%	17%	14%	21%	19%
Video call for a mental health or substance use concern	18%	15%	23%	22%	19%	26%
Phone call for a physical concern	20%	24%	24%	17%	21%	23%
Video call for a physical concern	21%	15%	21%	18%	17%	25%
Have not received health care by phone or video in the past 12 months	60%	56%	47%	54%	54%	46%

Quality of care

Key findings

•Survey respondents were asked about several aspects of care quality and if they felt each aspect would have been better via telehealth or in person, or if there would be no difference. They most often said there would be no difference between telehealth and in-person care. However, for those who rated one higher over the other, a higher percentage said that care quality would have been better in person.

•When asked if they would be interested in receiving telehealth services in the future, almost three-fourths of survey respondents reported they would be interested in receiving care via telehealth through only a phone call, only a video call, or either format. Delivery format preferences generally aligned with the delivery format they used in the past (i.e., enrollees who received audio-only services showed greater interest in audio-only services, while enrollees who received video-based services showed greater interest in video-based services).

•While telehealth services generally provide quality care, findings suggest that in-person services may provide better quality care in certain situations. This may include serving MA enrollees with disabilities or blindness, enrollees who need access to an interpreter, older enrollees, and enrollees of certain racial/ethnic groups (e.g., Black immigrant enrollees).

• Additionally, a higher proportion of enrollees who received audio-only services reported several aspects of care quality would have been better in person compared to those who received video-based services.

• The proportion of enrollees who would prefer in-person care in the future was higher among enrollees who received physical health services compared to those who received behavioral health services. Certain aspects of care quality may be more important depending on the type of care, such that communication- and safety-related factors may have a greater impact on the quality of behavioral health services, while the need for in-person assessment of health concerns may have a greater impact on the quality of physical health services.

• Providers also identified certain situations in which patients may be best served in person (e.g., abuse concerns, suicidal ideation or severe mental health concerns).

• It is important that providers have the ability and flexibility to determine whether telehealth is a good fit for their patients and that it is an ongoing discussion between providers and patients.

Client satisfaction

Key findings

• Most survey respondents reported there would have been no difference between telehealth and in person regarding receiving better care, with about a third of respondents reporting they would have received better care in person.

• The proportion of respondents who reported they would have received better care in person was higher among those who need interpreter access (versus those that do not), Black immigrant and US-born respondents (versus respondents of other racial/ethnic identities), older respondents (versus younger respondents), and respondents who received audio-only services (versus those who received video-based services).

• Among all survey respondents, most were interested in receiving telehealth services in the future, including both audio-only and video-based delivery formats.

• Survey respondents who received audio-only services showed a higher level of interest in receiving audio-only services in the future, and individuals who received video-based services showed a higher level of interest in video-based services in the future.

• Preferences for receiving care in person in the future were higher among Black immigrant respondents

(versus respondents of other racial/ethnic identities), respondents who need interpreter access (versus those that do not), older respondents (versus younger respondents), and respondents who received physical health services (versus those who received behavioral health services).

Receiving quality care

When asked if they would have received better care via telehealth or in person, 61% of survey respondents said there would have been no difference, with 35% saying in person (Figure 8).

The proportion of respondents who reported they would have received better quality care in person was higher among:

- Black immigrant (53%) and Black US-born (50%) respondents, especially compared to Native American (29%) and white (28%) respondents.
- Older individuals age 50-64 (43%), followed by age 18-34 (36%) and age 35-49 (26%).
- Respondents who need interpreter access (64%) compared to those that do not (32%).
- Respondents who received either physical or behavioral health audio-only services (39-40%) compared to those who received either physical or behavioral health video-based services (24-30%).

It should be noted that these are respondent perceptions of the quality of care. This does not assess the clinical outcomes associated with care.

Figure 8. Delivery format: Receiving better care among respondents who received telehealth services in the past year

I would have received better care if we had met…	Via telehealth[a]	In person	No difference
All respondents (N=1,421)	5%	35%	61%
Asian or Pacific Islander (N=88)	5%	47%	47%
Black immigrants (N=85)	9%	**53%**	38%
US-born Black (N=205)	7%	**50%**	43%
Hispanic (N=94)	3%	41%	56%
Native American (N=69)	8%	**29%**	64%
White (N=880)	4%	**28%**	68%

Note. Percentages may not add to 100% due to rounding.
[a] This response option did not differentiate between the various modes of telehealth (e.g., audio-only, video-only, audiovisual).

In addition, many service recipients and providers interviewed agreed that telehealth provides care that is comparable in quality to in-person care. Some MA enrollees said the quality of telehealth is better because they are able to communicate with their providers more effectively.

> "I really haven't seen any differences in quality per se, but difference in experiences. I really have top notch providers and they do a good job whether it is telehealth or in person." – service recipient

> "I feel like using telehealth has given me the opportunity for better care almost. Because on my end, I am more open. It just makes it so much easier. It relieves a lot of anxiety for me being at home and doing it over the phone." – audio-only service recipient

> "When I look at the quality of care, the toughest thing in Minnesota is access in the rural care. We have doctors that will listen and allow you to participate more than they used to. They are opening the line of communication. … You can discuss a treatment plan over the phone or in person." - provider

Delivery format preferences among MA enrollees who have received telehealth services in the past year

Survey respondents who indicated they had received telehealth services in the past year were asked to share which format they would prefer if they needed the same type of care after the COVID-19 pandemic ends. About half said they would prefer in person (52%), followed by video call (30%) and telephone call (18%; Figure 9).

Preferences for a telephone call were higher among respondents who received either physical or behavioral health audio-only services (24-25%) compared to those who received video-based services (7-11%), while respondents who received video-based services more commonly preferred a video appointment (36-46%) compared to those who received either physical or behavioral health audio-only services (13-31%). Additionally, the proportion who preferred in-person care was higher among those who received physical health services in either format (54%-61%) compared to respondents who received behavioral health services (45-48%).

In-person preferences were higher among Black immigrant respondents (67% versus 48-58%) and respondents who need interpreter access (69% versus 51%).

Figure 9. Delivery format preference among respondents who have received telehealth services in the past year

Still thinking about this visit, if you need this kind of care after the COVID-19 pandemic is over, would you prefer a telephone c all, a video call, or an in-person appointment? (Select one)	% (N=1,391)
Telephone call	18%
Video call	30%
Telehealth unspecified[a]	<1%
In person	52%

Note. Percentages may not add to 100% due to rounding.
[a] These respondents either selected both "telephone call" and "video call" or did not indicate a preference, but completed the subsequent question that asked why respondents preferred telehealth.

Delivery format preferences for all respondents regardless of previous telehealth utilization

All survey respondents were asked if they would be interested in receiving telehealth services in the future, regardless of whether they had received them in the past. Most said that they would be interested (72%), with half of respondents saying they would be interested in either phone or video (46%; Figure 10).

No interest in telehealth in either format was more common among Black immigrant respondents (39%) compared to other racial/ethnic identities (22-28%) and among respondents who need interpreter access (42%) compared to those that do not (27%; Figure 10). Preferences also aligned with prior telehealth experience, with respondents showing greater interest in a phone visit if they had received either physical or behavioral health audio-only services (17-20% versus 4-7% among those who received video-based services) and greater interest in a video visit if they had received either physical or behavioral health video-based services (18-21% versus 5-7% among those who received audio-only services).

Figure 10. Delivery format preference among all respondents regardless of previous telehealth utilization

Are you interested in using health care by phone or video in the future? Select the type you would like to use in the future.	Phone call only	Video call only	Either phone or video	Neither video nor phone
All respondents (N=2,921)	17%	10%	46%	28%
By respondent race/ethnicity				
Asian or Pacific Islander (N=229)	20%	13%	45%	22%
Black immigrants (N=186)	14%	6%	41%	39%
US-born Black (N=439)	20%	7%	45%	28%
Hispanic (N=218)	20%	10%	45%	24%
Native American (N=155)	17%	6%	51%	27%
White (N=1,694)	16%	10%	46%	28%
By type of care received and delivery format				
Audio-only behavioral health (N=493)	20%	5%	64%	12%
Video-based behavioral health (N=683)	7%	21%	59%	14%
Audio-only physical health (N=642)	17%	7%	57%	20%
Video-based physical health (N=647)	4%	18%	65%	14%

Note. Percentages may not add to 100% due to rounding.

Assessing health concerns and telehealth fit

Key findings

- About half of survey respondents who indicated a preference for in-person care agreed that their provider needs to assess their concern in person. This was more common among respondents who received physical health services compared to those who received behavioral health services.

- Additionally, while the proportion of survey respondents who reported this as a reason for their preference for in-person care was higher among those who received audio-only behavioral health services compared to those who received video-based behavioral health services, it was lower among those who received audio-only physical health services compared to video-based physical health services.

- Interviewees shared that telehealth is better for some simple health care issues, but not complex ones that might require lab work or examinations. MA enrollees interviewed also seem to be more comfortable with telehealth for behavioral health care compared to physical health care. Respondents thought meeting a doctor for the first time or when they need their providers to physically examine their symptoms are examples of when telehealth would not be a good fit.

- Several providers expressed their concerns of providing telehealth services when working with patients who have a history of domestic abuse, suicidal thoughts or attempts, and severe mental health disorders. These providers expressed their preference to see these patients in person rather than via telehealth.

- It is important that providers have the ability and flexibility to determine whether telehealth is a good fit for their patients, and that it is an ongoing discussion between providers and patients.

About two-thirds of providers (19 out of 26) appreciated the flexibility they have to be able to determine whether telehealth is a good fit for their patients. They expressed similar sentiments about their patients having options to choose between in-person care and telehealth services. The flexibility allows providers to work with individual patients to meet their needs. A few providers emphasized the importance of having providers making the clinical determination or recommendations on the modes of health care services.

> "If there is a clinical recommendation for audio-only for a reason, we should let the licensed providers make that determination. Limiting access is not what we want to do." – provider

Sixty percent of service recipient interviewees (14 out of 23) and some urban focus group participants thought that telehealth is better for simple health care issues, but not for complex issues that might require lab work or examinations. Many service recipients shared that they have used telehealth for their behavioral health needs, namely psychotherapy, and they plan to continue to do so. On the other hand, a few service recipients felt that, when meeting a doctor for the first time or when they need their providers to physically examine their symptoms, telehealth would not be a good fit.

> "[I am] very satisfied with telehealth and I will keep using it for sure for [psycho]therapy. I will continue going in person for my medical appointments. I feel it has just always been that way before telehealth was discovered and used more. It is my health and my body. If something is going on with my body, it makes sense to be there in person, especially if we need to take blood or something like that. It just makes more sense that way." – audio-only service recipient

> "It's a very thorough appointment and most of the telehealth I have been in a therapeutic setting. I have not met my primary care provider on telehealth. I have mainly met them in person. Most of the appointments I have that are medical I have to do in person since I have to have a catheter change or have a test run. Other than that, I don't go to the doctors. It's usually for a specific issue that I would go to the doctor. All of that has been in person. It's hard to say since I am basing everything on mental health and chemical dependency telehealth." – audio-only service recipient

> "I don't feel any different. If you are meeting a doctor for the first time or have things that they need to see or feel in person, telehealth is not going to work at all." – audio-only service recipient

Seven out of 26 providers shared their concerns of providing telehealth services when working with patients who have history of domestic abuse, suicidal thoughts or attempts, and severe mental health disorders. These providers expressed their preference to see these patients in person rather than via telehealth.

> "For our patients that are extremely high risk, I would not use telehealth. The complexity comes into play with collaborating with our partners -- it creates additional burden for the patients and staff. We make sure that our high-risk patients come into in-person visits. We got some pushback from law enforcement that they would not do a welfare check when we cannot get a hold of a patient with high risk via phone or telehealth." – provider

> "I think that if I have somebody who is only on the phone and they express serious suicidal thinking, I would want to do a safety plan and show my professional care for that person. I would like to know who their 911 call is. I have not had that experience yet, but thought about it. I want to try to connect with somebody who is in that area. Telephone-only is the concern of mine, but they are also the people who need help. I would try to integrate that into the community." – provider

> "At the high level of care, if we have any concern about safety, we would not do telehealth. Anyone who has had a suicide attempt, it makes staff very uncomfortable to provide services via telehealth." – provider

Need to assess health concerns in person

Almost half of survey respondents who reported a preference for in-person care after the COVID-19 pandemic ends indicated that their provider needs to assess their health concern in person (45%; Figure 11).

Endorsement was greater among Asian or Pacific Islander enrollees (53%) and US-born Black enrollees (50%) compared to enrollees of other racial/ethnic identities (30-46%) and among enrollees who received physical health services in either delivery format (50-71%) compared to behavioral health services (21-45%).

Regarding delivery format, there was a different pattern between behavioral health services and physical health services. Within behavioral health services, preference for in-person care in the future was higher among survey respondents who received audio-only services (45%) compared to video-based services (21%). Within physical health services, endorsement was higher among respondents who received video-based services (71%) compared to audio-only (50%).

Figure 11. Reason for in-person care preference: Provider needs to assess concern in person

Why would you prefer in person after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported an in person preference (N=719)
My provider needs to assess my health concern in person	45%

Communication

Key findings

• The most frequently identified reason for survey respondents' preference for in-person care is that they would be able to hear and see their providers better.

• Most survey respondents reported that there would have been no difference between telehealth and in-person care regarding the extent to which their provider listened carefully. However, some respondents reported a preference, and a higher percentage of MA enrollees reported their provider would have listened more carefully in person than via telehealth.

• About half of survey respondents who prefer in-person care reported that their provider can explain things better in person.

• Several factors appear to impact communication quality. Communication concerns were more common among older survey respondents (versus younger respondents), respondents who need interpreter access (versus those that do not), respondents with disabilities or blindness (versus respondents with other MA eligibility types), respondents who received audio-only services (versus video-based services) and/or behavioral health services (versus physical health services), and certain

racial/ethnic identities, such as Asian or Pacific Islander and Black immigrant enrollees (versus respondents with other racial/ethnic identities).

• Providers and MA enrollees shared that telehealth helps build relationships and enhances rapport and trust through consistent interactions and participation. However, a few providers mentioned that telehealth could also limit interaction with their patients.

Communication challenges

Among survey respondents who indicated a preference for in-person services after the COVID-19 public health emergency ends, 67% said that they have this preference because they would be able to hear and see their provider better in person (67%; Figure 12). This was the most commonly endorsed reason why respondents prefer in-person care.

Endorsement of this reason for a preference for in-person care was higher among Asian or Pacific Islander and Black immigrant respondents (84-85%) compared to respondents of other racial/ethnic identities (64-69%). Endorsement was also higher among respondents with disabilities or blindness (76%) compared to respondents with other eligibility types (61-69%), respondents who received behavioral health services in either format (69-77%) compared to enrollees who received physical health services in either format (52-64%), and enrollees who received either physical or behavioral health audio-only services (64-77%) compared to respondents who received either physical or behavioral health video-based services (52-69%).

Figure 12. Reason for in-person care preference: Respondents would hear and see provider better

Why would you prefer <u>in person</u> after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported an in person preference (N=719)
My provider and I would be able to hear and see each other better	67%

Communication challenges were also identified in the interviews. Six providers identified gaps in communication when using telehealth, particularly in interpretation of verbal and sign languages. These providers noted miscommunication is common when working with interpreters, but doing so via telehealth makes it more likely. Some providers who have used the LanguageLine shared that connectivity is another challenge they have faced when providing services via telehealth. They shared that having interpreters on site is more convenient.

> "There is always the potential to miscommunicate with interpreters. Doing so on telehealth, it even increases that exponentially." – provider

> "We have interpreters at our sites, so it is a lot easier. When we have to use the LanguageLine, sometimes there are problems with connectivity that makes it more difficult, but that is occasionally." – provider

About half of the providers interviewed (15 out of 26) identified an inability to read body language or facial expressions as a barrier to effective communication, and it can limit the provider's ability to accurately diagnose patients. Providers also added that these limitations are particularly common for audio-only services.

> "There is so much we do that relies beyond only talking on the phone, such as facial expressions or language. In-person service also provides a sense of energy between two people. That energy transfer is something that is lost in telehealth." – provider

> "Telephone-only won't work in cases where someone has severe psychosis. It is best to see them face-to-face. The thing that is missing is we are unable to see their face. So with nonverbal clients, it is not going to work." – provider

> "Being able to pair the conversation with body language raises the level of insight from the interaction. Phone-only can be limited in that respect. With the right amount and good questions, you can assess most things through conversation." – provider

Relationships

Extent to which providers listen carefully

Two-thirds of survey respondents shared that there would have been no difference between telehealth and in person regarding the extent to which their provider listened carefully to them (62%; Figure 13). However, a higher percentage of respondents said their provider would have listened more carefully in person (32%) than via telehealth (6%).

The proportion of respondents who reported their providers would have listened more carefully **in person** was higher among:

- Black immigrant and US-born Black (43-46%) enrollees compared to enrollees of other racial/ethnic identities (27-37%).
- Older respondents age 50-64 (43%), followed by age 18-34 (32%) and age 35-49 (23%).
- Respondents who need interpreter access (69%) compared to those that don't (29%).
- Respondents who received either physical or behavioral health audio-only services (33-36%) compared to respondents who received video-based services (22-28%).

Figure 13. Delivery format: Extent to which provider would have listened carefully among respondents who received telehealth services in the past year

Extent to which provider would have listened carefully	Via telehealth[a]	In person	No difference
My provider would have listened more carefully to me if we had met… (N=1,415)	6%	32%	62%

[a] This response option did not differentiate between the various modes of telehealth (e.g., audio-only, video-only, audiovisual).

Extent to which the provider can explain things better

When asked why they would prefer in-person services after the COVID-19 pandemic ends, about half of survey respondents said that their provider can explain things better in person (51%; Figure 14).

Percentages who said their provider can explain things better in person were higher among Asian or Pacific Islander respondents (72%) compared to respondents of other racial/ethnic identities (40-58%), respondents with disabilities or blindness (60%) compared to other MA eligibility types (45-53%), and respondents who received behavioral health services in either delivery format (53-58%) compared to those who received physical health services in either delivery format (42-46%). Endorsement was also higher among older respondents (62% among age 50-64), followed by age 18-34 (52%) and age 35-49 (44%).

Figure 14. Reason for in-person care preference: Providers are better able to explain things

Why would you prefer <u>in person</u> after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported an in person preference (N=719)
My provider can explain things better to me in person	51%

Consistent communication and rapport-building

When asked what things are most important to them when they see their providers, about half of service recipient interviewees (12 out of 23) and some focus group participants from rural and urban areas highlighted the importance of having providers who listen deeply without making assumptions about their symptoms while collaborating with patients. A few interviewees also mentioned care coordination as being important for them, especially patients who have children.

> "What's important to me when I go to the doctor, whether it's in person or telehealth, is that they are listening to me, treating me with dignity and honoring that I know about my health. That is what is vital to me whether in person or telehealth. I want that care and treatment and I expect it." – audio-only service recipient

> "Whether it's telehealth or in person, the most important thing for me is that the provider treats me like the expert in my child's care. Doing things with him instead of for him." – audio-only service recipient

A third of providers (9 out of 26) indicated that telehealth helps build relationships and enhances rapport and communication through consistent interactions and participation from patients. Because of the consistent interaction over time, these providers are able to build strong therapeutic relationships and work to identify goals together with their patients, just as they did in person. These providers also noticed that their patients are more engaged and comfortable during their telehealth appointments.

> "The clients want to engage. It seems like people are more comfortable in their own space and not having to deal with people on the bus or receptionists at the provider's office." – provider

> "For quantity of care, clients showed up more. So the work continued to go up. So better outcomes for patients. They responded favorably. You are able to develop therapeutic relationships and identify goals with the clients, as in person." – provider

Similarly, about 60% of service recipient interviewees (13 out of 23) and some rural focus group participants shared that telehealth allows them to see their doctors more consistently and that helps build a strong relationship and trust. A few interviewees mentioned that they tend to change providers frequently, but, because of telehealth, they are planning to stick with their current provider longer.

> "I feel very well supported given that I never stayed more than a year with a provider. I have been with my current doctor for 12 months now and will continue to see him for other medical needs and vision tests." – audio-only service recipient

> "Because I couldn't always get to where I needed for my therapy appointments, it is hard to keep going to the same person. A lot of the time, I get kicked off their list or they don't want to see me because I can't always make it. It is nice to have a longer-lasting relationship. I have been able to keep this counselor for a long time since audio-only has been allowed as an option." – audio-only service recipient

Even though telehealth can help build rapport and relationships as stated earlier, some providers (7 out of 26) shared that telehealth can also limit interactions with their patients. They felt that patients and their family members could easily disengage from the services. Additionally, when working with a new client, these providers find it more difficult to build rapport compared to in-person services during the first few appointments.

> "In addition to the benefits, families are able to disengage from the service easily. When they come into the office, they are able to engage with the providers. So sometimes you see parents less available with telehealth compared to in person. The ease of access leads to less engagement from parents." – provider

> "It is also based on relationship as well. For those who I have worked with for a long time, it is easy to work with them." – provider

> "It is an easy way to connect but also the zoom fatigue became a reality for some people. It is as much as connecting as it is also disconnecting in a lot of ways." – provider

Emotional and physical safety

Key findings

Comfort and trust

• Most survey respondents reported that there would have been no difference between telehealth and in person regarding the extent to which they would have felt comfortable sharing their thoughts and feelings with their provider and trust their provider is doing what is best for them, but about a third said they would have been more comfortable and had more trust in person.

• Among survey respondents who reported a preference for in-person care, about half reported they would

feel more comfortable talking openly with their provider. Endorsement was more common among respondents who have disabilities or blindness (versus other MA eligibility types), respondents who received behavioral health services (versus those who received physical health services), older respondents (versus younger respondents), respondents in urban or mixed rural/urban areas (versus those in rural areas), and Asian or Pacific Islander respondents (versus respondents of other racial/ethnic identities).

• Many providers noticed that their patients feel more comfortable and safer receiving services while in their own home. Half of MA enrollees interviewed also mentioned this, especially those who have anxiety when seeing their providers in person. Telehealth has allowed them to be more relaxed and to participate in their session more freely.

Autonomy, choice, and self-efficacy

• Survey respondents frequently reported they were given the choice between telehealth and in-person services, with some differences by race/ethnicity.

• Most survey respondents said there would have been no difference between telehealth and in-person care regarding the extent to which they would have had more say in the decisions that affect their health and feeling confident managing their health.

• However, the proportion of respondents who reported these aspects would have been better in person was higher among MA enrollees of certain racial/ethnic identities (e.g., Black immigrant enrollees), and enrollees who need interpreter access (versus those that do not). Additionally, the proportion who reported they would have felt more confident managing their health and treatment if the visit had been in person was higher among older enrollees (versus younger enrollees) and enrollees who received audio-only services (versus enrollees who received video-based services).

• The majority of MA enrollees interviewed shared that it is important for them that they feel listened to and validated by their providers. They do not want their providers to make any decisions before seeing them or without their input. They believed that this would help create a strong therapeutic relationship.

Engagement

• About half of survey respondents who prefer in-person care reported there would be fewer distractions in person, and this was more common among individuals who received behavioral health services compared to those who received physical health services.

• A majority of providers identified that engagement and interaction are benefits of telehealth. However, half also felt that some patients are less engaged and have some difficulties with staying focused during telehealth appointments. This is particularly true for younger clients and clients who have attention-related disorders.

Comfort and trust

Comfort sharing thoughts and feelings with providers

Half of survey respondents said there was no difference between telehealth and in person when asked if they would have felt more comfortable sharing their thoughts and feelings with their provider (56%), though about a third reported they would have felt more comfortable in person (34%; Figure 15).

The proportion of respondents who reported they would feel more comfortable sharing **in person** was higher among:

- Black immigrants (60%) compared to enrollees of other racial/ethnic identities (28-40%).
- Respondents who need interpreter access (66%) compared to those that do not (31%).

Figure 15. Delivery format: Comfort sharing thoughts and feelings with provider among respondents who received telehealth services in the past year

Comfort sharing thoughts and feelings	Via telehealth[a]	In person	No difference
I would have been more comfortable sharing my thoughts and feelings with my health care provider if we had met… (N=1,436)	10%	34%	56%

[a] This response option did not differentiate between the various modes of telehealth (e.g., audio-only, video-only, audiovisual).

Trust that the provider is doing what's best for the enrollee

Most survey respondents said there was no difference between telehealth and in-person care regarding the extent to which they trust that their provider is doing what is best for them (61%), followed by 32% who said they would have more trust in person (Figure 16).

The proportion of respondents who reported they would have had more trust **in person** was higher among:

- BIPOC respondents (32-45%) compared to white enrollees (26%).
- Respondents who need interpreter access (64%) compared to those that do not (29%).

Figure 16. Delivery format: Trust that provider is doing what is best for respondent among respondents who received telehealth services in the past year

Trust that provider is doing what is best	Via telehealth[a]	In person	No difference
I would have more trust that my provider is doing what is best for me if we had met… (N=1,426)	7%	32%	61%

[a] This response option did not differentiate between the various modes of telehealth (e.g., audio-only, video-only, audiovisual).

Comfort talking openly with the provider

About half of survey respondents who indicated a preference for in-person care after the COVID-19 pandemic ends said that they would feel more comfortable talking openly with their provider in person (54%; Figure 17).

Endorsement of the item in Figure 17 was greater among Asian or Pacific Islander respondents (69%) compared to respondents of other racial/ethnic identities (37-60%), respondents with disabilities or blindness (64%) compared to other MA eligibility types (49-53%), and respondents who received behavioral health services in either delivery format (66% each) compared to respondents who received physical health services in either format (33-42%). Endorsement was also higher among respondents who have treatment plans (60%) compared to those that do not (42%) and among older respondents (65% among age 50-64), followed by age 18-34 (58%) and age 35-49 (41%).

Endorsement was less common among individuals in rural areas (42%) compared to those in urban or mixed rural/urban areas (55-61%).

Figure 17. Reason for in-person care preference: Comfort talking openly with provider

Why would you prefer in person after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported an in person preference (N=719)
I would feel more comfortable talking openly with my provider	54%

Comfort and safety at home

Similar themes were found in the qualitative data. Eleven out of 26 providers noticed their patients feel more comfortable and safer receiving services at their own home. These providers said that their patients are more relaxed and can focus more during appointments. One of the most commonly mentioned reasons was that their patients do not have to drive into the office.

> "With some of the new clients I have, they said that they feel safer, and they have a hard time coming in person in the first place. For them to be able to do it from home makes a huge difference." – provider

> "For example, when you can do a therapy group where they can be comfortable at their home or office, they are more relaxed and can focus more. Some folks might find it difficult

to have to drive to an office. For the most part, it's been as good. What I would say is sometimes it's as good or maybe better." – provider

"Some people just do really well with telehealth. They are in a comfortable situation at home. It is as if we were together in the same room. As a result, we are able to do good work. One thing that I appreciate about telehealth is that if someone comes down with COVID, we can still meet and they do not have to miss the session." – provider

The majority of service recipient interviewees (13 out of 23) and some focus group participants from both urban and rural groups highlighted the feeling of comfort they get from accessing services via telehealth. Many of them shared they have anxiety when seeing their providers in person. Telehealth, including audio-only mode, has allowed them to be more relaxed and to participate in their session more freely.

"My anxiety gets high when I go to see them in person. I just have a lot of anxiety and wanted to make sure that I am clearly presentable. In person, I mumble a lot and what I say doesn't make a lot of sense." – audio-only service recipient

"I do not have to look at her as I am crying. I can tell she is sympathetic throughout. I can feel free to be myself by being in my own home instead of going into the office. I can be at home and process everything at my place." – audio-only service recipient

"The convenience and being able to actually talk to them and not having to see them and make eye contact since I have anxiety. I can spew more words and think when I am not in person and can hide behind the phone. It is set up and makes it easy to use. The convenience is the main thing." – audio-only service recipient

Feeling listened to and validated

Sixty percent of service recipient interviewees (14 out of 23) and both the rural and urban focus group participants shared that it is important for them to feel listened to and validated by their providers. They do not want their providers to make any decisions before seeing them or without their input. They believed that this will help create a therapeutic relationship. Interviewees identified that this value is important to them regardless of whether their care is delivered through telehealth or in person.

"The most important thing for me is that I am being heard. They do not already have decisions made before me going in. So feeling like your need is being heard."
– audio-only service recipient

"Yes. I felt like I was heard and got what I needed. The providers are just as caring through their tone of voice. There is also follow through from them as well."
– audio-only service recipient

Autonomy, choice, and self-efficacy

Delivery format choice

Most survey respondents reported that they were given a choice between telehealth and in person for the telehealth visit they were asked to think about in the survey (69%; Figure 18). Note that respondents were not asked whether they were given a choice of telehealth delivery format (e.g., audio-only versus video).

The proportion of survey respondents who reported that they were given a choice between telehealth and in person was highest among Asian or Pacific Islander enrollees (85%) and lowest among Black immigrant enrollees (61%) and white enrollees (65%) compared to other racial or ethnic identities (72-76%).

Figure 18. Respondents given a choice between in person and telehealth

Thinking about this visit, did the clinic give you the choice of whether the appointment would be in person or via telehealth?	% (N=1,489)
Yes, I was given the choice and I chose telehealth	69%
No, telehealth was the only option I was given	31%

Working with patients to determine the right delivery format

Half of the providers (13 out of 26) mentioned that, before receiving services, their patients are informed about options they have to access services and they can choose the option with which they are most comfortable. However, a few providers said that they didn't offer in-person visits during the peak of COVID-19.

> *"*From an administrative perspective, we let patients know that telehealth is an option because sometimes people don't know that and they don't access them. If they do know that they have the telehealth option, they are more likely to access the services." – provider

> "[In-person care] was not offered at the peak of COVID. Of course now, all type of services are given options for them to choose from." – provider

> "It allows us to set the table. Being able to have the telehealth option, we are able to set the expectation for the patients and meet the expectation. What you may want done when you think it is an emergency situation, it might not be possible to do that. With telehealth, we are able to consult with the patients before coming in, so that helps set the expectation in line and it will not disappoint the clients when they think something needs to be fixed when it is not necessary." – provider

Having say over decisions that affect MA enrollees' health

Most survey respondents said there would have been no difference between telehealth and in-person care regarding the extent to which they would have had say over decisions that affect their health (63%), while about a third reported they would have had more say if the visit had occurred in person (31%; Figure 19).

The proportion of respondents who reported that they would have more of a say over health decisions **in person** was higher among:

- Black immigrant (50%) and US-born Black (48%) respondents, particularly compared to white respondents (23%).
- Respondents who need interpreter access (62%) compared to those that do not (27%).

Figure 19. Delivery format: Say over health decisions among respondents who received telehealth services in the past year

Say over health decisions	Via telehealth[a]	In person	No difference
I would have had more say over decisions that affect my health if we had met… (N=1,418)	6%	31%	63%

[a] This response option did not differentiate between the various modes of telehealth (e.g., audio-only, video-only, audiovisual).

Confidence managing health and treatment

Most survey respondents also reported there would have been no difference between telehealth and in person regarding the extent to which they would feel more confident that they can manage their health and treatment (58%), with about a third saying they would have felt more confident if the appointment had been in person (35%; Figure 20).

The proportion of respondents who reported they would feel more confident managing their health and treatment **in person** was higher among:

- Black immigrants (59%) compared to enrollees of other racial/ethnic identities (29-49%).
- Older respondents age 50-64 (46%), followed by age 18-34 (35%) and age 35-49 (27%).
- Respondents who need interpreter access (63%) compared to those that do not (32%).
- Respondents who received either physical or behavioral health audio-only services (37-40%) compared to respondents who received either physical or behavioral health video-based services (26-31%).

Figure 20. Delivery format: Feeling confident to manage health and treatment among respondents who received telehealth services in the past year

Feeling confident to manage health and treatment	Via telehealth[a]	In person	No difference
I would have left the appointment feeling more confident that I can manage my health and any necessary treatment if we had met… (N=1,428)	7%	35%	58%

[a] This response option did not differentiate between the various modes of telehealth (e.g., audio-only, video-only, audiovisual).

Engagement

Twenty-one providers highlighted an increase in patient and caregiver engagement and interaction as a benefit of telehealth. These providers felt that they have greater access to parents and they communicate more frequently. They are able to get more buy-in from the parents. Another added benefit of telehealth is that it allows divorced/separated parents who are not physically living in the same space to attend their children's appointment together.

> "Sometimes, parents are also able to be more engaged because of busy schedules at work so they are able to join in the quick meeting with us. Telehealth (video) provides a more personable experience with somebody than telephone-only too. It helps to build relationships better. But access to telephone-only is also helpful." – provider

> "Now that we are used to it, I start to like it especially with the family and caregiver piece. For example, parents can record the video of the child and send it to us for us to observe. We then can discuss with the parents and answer any questions parents might have about their child. That increases parents' engagement and creates more buy-in. It makes parents and the child more comfortable too since I don't have to be in the same room with them." – provider

> "It is great -- especially I have several divorced parents that they cannot be in the same room together. I have a lot of dads and moms at different houses where we can have sessions together. I have a family with a child living in MN and dad lives in AZ. It is great that they are able to join in this space together." – provider

However, half of the providers (13 out of 26) felt that some patients are less engaged and have some difficulties with staying focused during telehealth appointments. This is particularly true for younger clients and clients who have attention-related disorders. A few providers highlighted the role parents can play in helping their children engage and stay focused during the session.

> "Working with children, especially the younger kids via telehealth is difficult. It is harder to conduct sessions with children because they are not as engaged." – provider

> "Depending on the needs of the clients, like youth, who are less engaged in services, telehealth provides another way for them to disengage easily like just walking out of the screen. Kids who are very dysregulated are also very difficult with telehealth." – provider

> "[For parents], there is not a separation between work and the session with their kids. But, when they come into the office, they cannot really plan anything from their work that they need to be involved in so they can focus more on the session with their kids. It is really an issue for clients who are impulsive so it is hard to get parents to make sure that they are present and able to step in to help." – provider

Distractions

When asked why they would prefer in person after the COVID-19 pandemic ends, about half of survey respondents that indicated an in-person preference reported that there would be fewer distractions during the appointment (51%; Figure 21).

Endorsement was higher among Asian or Pacific Islander and white respondents (both 55%) compared to respondents of other racial/ethnic identities (40-46%) and among respondents who received behavioral health services in either delivery format (56-67%) compared to those who received physical health services (38-41%).

Endorsement was lower among respondents in urban areas (46%) compared to rural (55%) or mixed rural/urban (63%) areas.

Figure 21. Reason for in-person preference: Fewer distractions

Why would you prefer in person after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported an in person preference (N=719)
There would be fewer distractions during the appointment	51%

Access

Key findings

• Telehealth has allowed survey respondents to access care they otherwise would not have been able to receive.

• Some respondents shared that accessing care may be easier via telehealth, and respondents who indicated a preference to receive services via telehealth often identified access-related reasons for their preference, especially transportation-related reasons.

• Telehealth may be particularly effective in increasing access for certain groups, including enrollees in rural areas, younger enrollees, Asian or Pacific Islander or Hispanic enrollees, enrollees with treatment plans and enrollees who received behavioral health services.

• Additionally, telehealth may help ease barriers related to travel time and travel costs, particularly among younger enrollees, enrollees who received behavioral health services, and Black immigrant enrollees.

• While less common, respondents also identified not having to take time off of work and not having to find child care or elder care as reasons for their preference for telehealth. These factors may be particularly helpful in increasing access for Black immigrant enrollees and younger enrollees.

• About half of survey respondents reported there would have been no difference between telehealth and in person regarding wait time to get an appointment. However, two-thirds of respondents who would prefer telehealth in the future agreed that telehealth appointments are easier to schedule.

• While relatively uncommon among survey respondents, discomfort with using telehealth technology may pose a barrier to accessing telehealth services for some populations, including enrollees with disabilities or blindness and older enrollees.

• Providers and MA enrollees highlighted the need to have reliable internet and technology equipment for patients to access services.

Overall ease of accessing care

Key findings

• Two-thirds of survey respondents reported that telehealth has made it possible for them to receive care they otherwise would not have received. This was more common among younger respondents (versus older respondents), respondents who received behavioral health services (versus those who received physical health services) and Hispanic and Asian or Pacific Islander respondents (versus respondents of other racial/ethnic identities).

• Additionally, about half of survey respondents reported there would have been no difference between telehealth and in-person services regarding the ease of getting care.

• The proportion of survey respondents who reported that getting care would have been easier using telehealth was higher among respondents in rural areas (versus urban or mixed rural/urban areas), younger respondents (versus older respondents) and respondents who received behavioral health services (versus those who received physical health services).

• The proportion who reported getting care would have been easier in person was higher among older respondents (versus younger respondents), respondents who need interpreter access (versus those who do not), respondents who received audio-only services (versus those who received video-based services), and Black immigrant respondents (versus respondents of other racial/ethnic identities).

• Providers and MA enrollees also shared that telehealth has reduced barriers, reduced stressors and increased service utilization.

Opportunities to receive care that enrollees otherwise would not have received

Two-thirds of survey respondents who received telehealth services in the past 12 months reported that telehealth has allowed them to receive care they otherwise would not have received (65%; Figure 22). Note that many respondents also reported they were not sure (see footnote in Figure 22).

Mental health treatment was the most commonly specified type of care that respondents were able to receive (52%), followed by services for an injury or illness (34%) and specialists that treat certain conditions or parts of the body (28%).

Figure 22. Respondents who have been able to access care because of telehealth

Has telehealth made it possible for you to get health care that otherwise you would not have received?[a]	**% of respondents who received telehealth services in the past year (N=1,102)**
Yes	65%
No	35%
What kind of health care did you receive that you otherwise would not have been able to get without telehealth? (Select all that apply)	**% of respondents who reported telehealth made it possible for them to get care they otherwise wouldn't have received (N=684)**
Mental health treatment	52%
A visit with a doctor for an injury or illness	34%
A visit with a specialist who focuses on treating certain conditions or parts of the body	28%
A preventative visit with a doctor	25%
Medication or medical equipment	25%
Other services	22%
Prenatal care	5%
Treatment for substance use disorder	7%

[a] Note that many respondents also reported they didn't know whether telehealth has made it possible to receive care they otherwise wouldn't have received. Including these cases in the overall percentages increases the total N to 1,525, and the percentages change as follows: 47% selected "yes," 25% selected "no," and 28% selected "don't know."

Opportunities to receive care not otherwise received by respondent characteristics

The proportion of survey respondents who reported that telehealth has made it possible for them to receive care they otherwise wouldn't have received was highest among Hispanic (76%) and Asian or Pacific Islander (75%) respondents and lowest among Black immigrant respondents (40%) compared to respondents of other racial/ethnic identities (63-70%; Figure 23). Additionally, this was also more commonly reported among younger respondents (age 18-34; 73%) compared to age 35-49 (63%) and age 50-64 (55%) and among respondents who received behavioral health services in either format (74-78%) compared to respondents who received physical health services in either format (65-67%).

Survey respondents in rural areas also more commonly reported that telehealth has made it possible for them to receive mental health care they otherwise wouldn't have received (75%) compared to urban and mixed rural/urban areas (46-60%). This was also more commonly reported by individuals with a treatment plan (62%) compared to those without a treatment plan (22%).

Figure 23. Ability to access care because of telehealth, by respondent group

Has telehealth made it possible for you to get health care that otherwise you would not have received?	Yes	No
By respondent race/ethnicity		
Asian or Pacific Islander (N=66)	75%	25%
Black immigrants (N=59)	40%	60%
US-born Black (N=159)	63%	38%
Hispanic (N=78)	76%	24%
Native American (N=50)	70%	30%
White (N=690)	65%	35%
By type of care received and delivery format		
Audio-only behavioral telehealth (N=381)	78%	22%
Video-based behavioral telehealth (N=539)	74%	27%
Audio-only physical telehealth (N=438)	65%	35%
Video-based physical telehealth (N=505)	67%	33%

Extent to which it would have been easier to get care

About half of survey respondents reported there was no difference between telehealth and in-person services regarding the extent to which it would have been easier for them to get care (53%), followed by in person (28%) and telehealth (19%; Figure 24).

The proportion of respondents who reported it would have been easier for them to get care **in person** was higher among:

- Black immigrant enrollees (57%) compared to enrollees of other racial/ethnic identities (21-41%).
- Older respondents age 50-64 (39%), compared to 23-25% among respondents age 18-34 and 35-49.
- Respondents who need interpreter access (65%) compared to those that do not (25%).
- Respondents who received either physical or behavioral health audio-only services (32-35%) compared to physical or behavioral health video-based services (17-22%).

However, the proportion of respondents who reported it would have been easier for them to get care **via telehealth** was higher among:

- Rural respondents (29%) compared to enrollees in urban or mixed rural/urban areas (14-18%).
- Younger respondents age 18-34 (24%), compared to 13-16% among respondents age 35-49 and 50-64.
- Respondents who received behavioral health services in either delivery format (23-28%) compared to those who received physical health services (9-14%).

Figure 24. Delivery format: Ease of getting health care among respondents who received telehealth services in the past year

Ease of getting health care	Via telehealth[a]	In person	No difference
It would have been easier for me to get this health care if we had met… (N=1,407)	19%	28%	53%

[a] This response option did not differentiate between the various modes of telehealth (e.g., audio-only, video-only, audiovisual).

Reduced barriers and stressors and increased utilization

Almost all providers (25 out of 26) shared that telehealth helps reduce barriers to accessing services for their patients. Some of the most commonly mentioned barriers included transportation, child care, and time off from work. Some providers mentioned parking and gas costs, as well as time spent on going into the office for a visit. Because of improved access, providers noticed an increase in utilization of services from patients who usually do not seek care because of these barriers.

> "Same with transportation. I grew up in a rural area and I know that it takes a lot of time, and [patients] have to drive far away to find a provider." – provider

> "People can actually get care. It improves access. There are some folks who have just gone without care because of transportation or scheduling. Telephone-only is just a very easy way for people to connect and get the services that they need. So I would say it's all improved." – provider

> "[Telehealth] is convenient. People don't have to take time off from work. When in person, for people who have young children, we asked them if they needed child care." – provider

A third of providers (8 out of 26) mentioned that telehealth provides an opportunity to reduce stressors to accessing services when it is not always possible with in-person care. Patients do not have to worry about transportation, finding child care, or taking time off from work. A few providers also appreciated the flexibility their patients have to receive services via phone. This helps their patients overcome barriers related to internet or bandwidth issues.

> "It improved access from a patient perspective because now they have an option to complete a visit on the phone. So they can do it even during the work day and they don't have to calculate time. It opens up more opportunity for different days in the week that they are able to meet us." – provider

> "The convenience is so helpful for clients. A lot of my clients don't have a car or transportation; they can access services while they are at work or school." – provider

> "That has been nice [to use phone] when we have bandwidth issues. For some of our folks who are not tech-savvy, we are able to still be in contact with them. I know that some folks struggle to use Zoom, so this really helps them." – provider

Similar to providers, all of the service recipients who participated in interviews (n=23) and some focus groups participants noted that telehealth reduced barriers to accessing services for them. Some of the barriers mentioned included transportation, parking, child care, and time taken to go into their doctor's office. Because of easier access to services, some service recipients are able to consistently attend their appointments even when they are busy.

> "It was a good thing because it guarantees that I can actually attend the meetings/sessions. Prior to not having telehealth services, I would have to drive to the clinics. Most of the services are during the day and will require me taking time off work. With telehealth, it increases my access to the services that I need." – audio-only service recipient

> "Timeliness. The ability to access those services in the first place. Ability to get there. Ability to access them without paying extra like parking costs. Distance is another reason - two of my current providers live far away, about 45 minutes one way, so telehealth helps with that." – audio-only service recipient

> "I have been able to utilize more services. A lot more doctors are more open to more of it. One doctor told me that they are allowed to see more patients due to telehealth." – service recipient

Transportation

Key findings

• Telehealth may pose fewer transportation-related barriers to care compared to in-person services for many MA enrollees, including no travel time and no travel costs. However, about half of survey respondents perceive transportation-related barriers as equivalent between the two delivery formats.

• Telehealth may be particularly helpful in addressing certain transportation barriers for some groups. The proportion of survey respondents who reported transportation would have been easier via telehealth was higher among respondents who received behavioral health services (versus physical health services) and among respondents with treatment plans (versus those that do not).

• Some respondents shared that transportation would have been easier with an in-person appointment, and this proportion was higher among BIPOC respondents (versus white respondents), older respondents (versus younger respondents) and respondents who need interpreter access (versus those that do not).

• The proportion of survey respondents who reported that they would prefer telehealth in the future because of no travel time was higher among respondents who received behavioral health services (versus physical health services) and among younger respondents (versus older respondents).

• The proportion of survey respondents who reported a preference for telehealth because of fewer travel costs was higher among younger respondents (versus older respondents) and among Black immigrant respondents (versus respondents of other racial/ethnic identities).

• The utility of telehealth in addressing transportation barriers may be more limited for other groups, including MA enrollees who need access to an interpreter.

Ease of transportation

Almost half of survey respondents reported there was no difference between telehealth and in person regarding the extent to which transportation would have been easier (48%), followed by about a third of respondents reporting that transportation would have been easier for a telehealth appointment (36%; Figure 25).

The proportion of respondents who reported transportation would have been easier for **in person** appointments was higher among:

- BIPOC respondents (16-34%) compared white respondents (11%).
- Older respondents age 50-64 (25%), followed by age 18-34 (16%) and age 35-49 (8%).
- Respondents who need interpreter access (49%) compared to those that do not (12%).

However, the proportion of respondents who reported transportation would have been easier for **telehealth** appointments was higher among:

- White respondents (40%) compared to BIPOC respondents (21-35%).
- Respondents with a treatment plan (41%) compared to those without one (24%).
- Respondents who received behavioral health services in either format (42-46%) compared to respondents who received physical health services in either format (25-27%).

Figure 25. Delivery format: Ease of transportation among respondents who received telehealth services in the past year

Ease of transportation	Via telehealth[a]	In person	No difference
Transportation would have been easier if we had met… (N=1,408)	36%	16%	48%

[a] This response option did not differentiate between the various modes of telehealth (e.g., audio-only, video-only, audiovisual).

Travel time

Many survey respondents who indicated a preference for telehealth in the future agreed that their preference is at least partially due to no travel time (78%; Figure 26). This was the most commonly endorsed reason for preferring telehealth over in-person care.

Agreement that no travel time is a reason for their preference for telehealth was higher among younger respondents age 18-34 and 35-49 (78-85% versus 70% among age 50-64) and among respondents who received behavioral health services in either format (79-90%) compared to physical health services (67-71%). It was lower among respondents who need interpreter access (62%) compared to those that do not need interpreter access (79%).

Figure 26. Reason for telehealth preference: No travel time

Why would you prefer a telephone or video call after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported a preference for telehealth (N=663)
No travel time	78%

Travel costs

Similarly, most survey respondents who prefer telehealth agreed that one of the reasons for their preference is that there is no need to pay for travel costs (71%; Figure 27). Agreement was higher among Black immigrant

respondents (82%) compared to respondents of other racial/ethnic identities (61-75%) and younger respondents age 18-49 (71-77% versus 61% among age 50-64), and it was lower among enrollees who need interpreter access (37%) compared to those that do not (72%).

While endorsement of this reason was similar between respondents who received audio-only behavioral health services (72%) and video-based behavioral health services (77%), there was a much larger difference between respondents who received audio-only physical health services (51%) and those who received video-based physical health services (80%).

Figure 27. Reason for telehealth preference: No need to pay travel costs

Why would you prefer a telephone or video call after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported a preference for telehealth (N=663)
No need to pay for gas, parking fees, and other travel costs	71%

Other barriers to care

Key findings

• While not as common as transportation-related barriers, some survey respondents shared that their preference for telehealth is partially driven by no need to take time off of work and no need to find child care or elder care.

• Reducing these barriers may be particularly helpful for increasing access for certain groups, including Black immigrant MA enrollees and younger enrollees.

Time off work

Almost half of survey respondents who prefer telehealth reported that this preference is at least partially due to not having to take time off of work (47%; Figure 28).

Endorsement was higher among Black immigrant respondents (75%) compared to respondents of other racial/ethnic groups (38-53%), and it was also higher among younger respondents age 18-49 (49-57%) compared to 30% of age 50-64.

Figure 28. Reason for telehealth preference: No need to take time off from work

Why would you prefer a telephone or video call after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported a preference for telehealth (N=663)
No need to take time off from work	47%

Child care and elder care

About a third of survey respondents who prefer telehealth reported that this preference is at least partially due to not having to find child care or elder care (34%; Figure 29). However, this was the least commonly endorsed reason for respondents' telehealth preferences.

Endorsement was highest among Black immigrant respondents (57%) compared to respondents of other racial/ethnic identities (29-41%), as well as younger respondents age 18-49 (37-41%) compared to age 50-64 (20%).

Figure 29. Reason for telehealth preference: No need to find child care or elder care

Why would you prefer a telephone or video call after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported a preference for telehealth (N=663)
No need to find child care or elder care	34%

Wait time and scheduling appointments

Key findings

• About half of survey respondents reported that there would have been no difference between telehealth and in person regarding wait time to get an appointment, and about a quarter of respondents reported it would have been easier via telehealth. About half of respondents who prefer telehealth reported that one of the reasons for their preference is shorter wait times.

• The proportion of survey respondents who reported wait times would be shorter via telehealth was higher among certain groups, including younger respondents (versus older respondents), while others shared they would be shorter in person, including Black immigrants (versus respondents of other racial/ethnic identities), respondents who need access to an interpreter (versus those that do not), and respondents who received audio-only services (versus those who received video-based services).

• Two-thirds of survey respondents who prefer telehealth for future care agree that telehealth appointments are easier to schedule.

Wait time

About half of survey respondents reported there was no difference between telehealth and in person regarding the extent to which the wait time to get an appointment would have been shorter (56%), followed by respondents reporting wait times would have been shorter if the visit were held via telehealth (26%; Figure 30). Among respondents who prefer telehealth for future care, about half reported that shorter appointment wait times was a reason for their preference (56%; Figure 31).

The proportion of respondents who reported that the wait time would have been shorter for **in person** appointments was higher among:

- Black immigrant respondents (47%) compared to respondents of other racial/ethnic identities (11-30%).
- Older respondents age 50-64 (26%), compared to respondents age 18-34 and 35-49 (11-17%).
- Respondents who need interpreter access (54%) compared to those that do not (13%).
- Respondents who received audio-only services (21-22%) compared to those who received video-based care (7-13%).

Among survey respondents who would prefer telehealth in the future, a greater proportion of Asian or Pacific Islander respondents (73%) and Black immigrant respondents (69%) agreed that telehealth offers shorter wait times compared to enrollees of other racial/ethnic identities (52-56%).

Figure 30. Delivery format: Wait time to get an appointment among respondents who received telehealth services in the past year

Wait time	Via telehealth[a]	In person	No difference
The wait time to get an appointment would have been shorter if we had met… (N=1,416)	26%	17%	56%

Note. Percentages may not add to 100% due to rounding.
[a] This response option did not differentiate between the various modes of telehealth (e.g., audio-only, video-only, audiovisual).

Figure 31. Reason for telehealth preference: Shorter wait times for appointments

Why would you prefer a telephone or video call after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported a preference for telehealth (N=663)
Shorter wait times for appointments	56%

Nineteen out of 23 service recipient interviewees and focus group participants in both rural and urban groups noted that, because of telehealth, they are able to have faster and more consistent access to their providers.

Many of them felt that they did not have to wait for an appointment -- they are able to have their appointment scheduled faster compared to in person.

> *"*I felt like I get the same care that I get in the clinic, but without the distractions. I have not had to wait for an appointment via telehealth, but I have to wait in the clinics. The knowledge that it is easy to get a hold of them and get an appointment sooner." – audio-only service recipient

> "With telehealth appointments, you get moved up the line quicker. Instead of waiting for 2 weeks to get them in person, I get to see my doctors in 2 days instead." – service recipient

Scheduling appointments

Among survey respondents who indicated a preference for telehealth after the COVID-19 pandemic ends, most agreed that they prefer telehealth at least partially because telehealth appointments are easier to schedule (67%; Figure 32).

Endorsement of this reason was higher among Asian or Pacific Islanders (84%) and Black immigrants (80%) compared to other racial/ethnic groups (64-66%).

Figure 32. Reason for telehealth preference: Appointments are easier to schedule

Why would you prefer a telephone or video call after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported a preference for telehealth (N=663)
Easier to schedule	67%

Scheduling challenges

While the majority of service recipients felt that it is easier to schedule a telehealth appointment, about one-sixth of interviewees (4 out of 23) and some urban focus group participants shared their frustration with scheduling appointments. Some of the frustrations come from their inability to schedule appointments directly with their doctors and from the miscommunication between scheduling staff and the providers.

> "The frustrating part is that the providers cannot schedule their own telehealth appointment so they rely on other staff like scheduler to help set up the next appointment." – audio-only service recipient

> "Some of the times, at the beginning and recently, there seems to be gaps between the schedulers and physician when it comes to help set up the appointments. Sometimes they are not having all the information to be able to reach out to me." – audio-only service recipient

Technological resources and skills

While some survey respondents reported that one of the reasons they would prefer in-person visits is a lack of comfort with telehealth technology, this was not common.

• Endorsement of this reason was more common among older respondents (versus younger respondents) and respondents with disabilities or blindness (versus other MA eligibility types).

• Providers and MA enrollees highlighted the need to have reliable internet and technology equipment for patients to access services.

Technological skills

Among survey respondents who reported a preference for in-person care once the COVID-19 pandemic is over, 18% said that one of the reasons for their preference is a lack of comfort using the technology needed for telehealth services (Figure 33). However, this was the least commonly selected reason.

Agreement was greater among respondents with disabilities or blindness (37%) compared to respondents with other eligibility types (12-15%) and older respondents (age 50-64; 33%) compared to younger respondents (age 18-34 and 35-49; 14-15%).

Figure 33. Reason for telehealth preference: Lack of comfort using telehealth technology

Why would you prefer in person after the COVID-19 pandemic is over? (Select all that apply)	% of respondents who reported an in person preference (N=719)
I am not comfortable using the technology needed for a telehealth appointment	18%

Technology infrastructure

A third of service recipient interviewees (8 out of 23) and some urban focus group participants said that telehealth infrastructures need to be improved. Those improvements are centered around availability of reliable internet and technology devices that would allow them to access services more easily.

> "There's always the concern of whether or not my technology is up to the standards. This is what has to change for those of us who are on a fixed income. It is not enough to get us a reduced rate on internet. We have to be able to somehow have our devices if we are home bound. We need to check every 2 years or so on whether our device can be upgraded. So a stipend for better technology to continue that care. The technology is always changing and there is improved continuity to have the internet." – audio-only service recipient

> "Sometimes the receiving end of the video is challenging. Sometimes my computer can't see. So there are some improvements that need to be made for connection. We could see each other, but we could not communicate. I appreciate it, but that part needs to be improved. You do not want to drive in the cold and there are accidents. Telehealth provides a lot of opportunities. The system needs to improve." – audio-only service recipient

> "There haven't been too many [challenges]. I would say the most challenging was initial access. Sometimes it wasn't very clear or smooth. I would end up going in a circle to find providers for a COVID-19 test and that stuff related to the pandemic. It was difficult to get there, but, once I got there, it was easy. Navigation could be a challenge at times. It was a little of a learning curve." – audio-only service recipient

Technology access

Similarly, 8 out of 26 providers emphasized the need to have reliable internet connection and technology equipment to access services. These providers are particularly concerned about internet access in rural areas of the state. Some providers mentioned that their organizations were able to provide access to laptops or phones to their patients. However, they stressed the need to have more resources to support these demands.

> "Telehealth plays an important role in MN. Having the ability to do telehealth is amazing and important. In rural MN, it can be hard to access it. Having access to equipment to do it across rural MN is important. I hope that internet access and equipment can be more accessible for the people living in rural MN. At the beginning of the pandemic, I had to work very hard to get internet access and equipment to our patients." – provider

> "We still need to have telehealth as an option. Access is a barrier. I live 15 minutes from another town and I do not have internet and cable TV. I have a landline, but cannot have internet. I have only a hot spot. There are people who do not have access to electronic devices. It is a big deal up here." – provider

> "It would be nice if folks who are on MNcare or MA would also have access to a laptop or smartphone via their health care cost. Many people have challenges with that. We used to have donated laptops or phones." – provider

Specific populations

Telehealth has increased access for some demographic groups (e.g., people living in rural areas and divorced households).

• Providers highlighted an increase in patient and caregiver engagement and interaction as a benefit of telehealth

Nineteen out of 26 providers felt that telehealth increased access for some demographic groups that were traditionally unable to access services. Those demographic groups include traditionally hard-to-reach people, such as people living in rural areas, people who do not have reliable internet or transportation, or people who

generally would not seek care because they have barriers to access. Another demographic group that providers mentioned many times is divorced parents. Because of telehealth, providers are able to reach these pockets of people. A few providers mentioned that patients who are not vaccinated and not comfortable connecting with them face-to-face found telehealth to be valuable.

> "Being able to capture those groups that traditionally cannot make it. It helps with attendance. On the other side, we also lost people because of it. We gained more people than losing them. Overall, it is a good experience." – provider

> "The difference is that it provides access. It provides an avenue to care. For those who only have access to phone, they are appreciative of the opportunity to have the care they have. By the fact that they schedule follow-up appointments, it means that it works. They didn't disappear." – provider

> "Some clients are not comfortable connecting with you face-to-face. Half of my clients are not fully vaccinated. Some of them are not going to get vaccinated. By communicating through the phone to educate them and to do these things with them is convenient for us and the clients." – provider

Consistency

- Telehealth allows patients to receive services more consistently and reliably. It makes it easier for patients to keep their appointments.
- MA enrollees are able to have faster and more consistent access to their providers.

Slightly more than half of providers (17 out of 26) shared that telehealth helps their patients receive services more consistently and reliably. They felt that telehealth makes it easier for their patients to keep their appointment when they would otherwise have missed it in person. Therefore, there is a decrease in no-show rates and rescheduling appointments. Telephone-only seems to play a big role in enabling patients to access services more easily and consistently.

> "It definitely improved. I do not know how much they access services beyond me. I saw a client virtually the other night and I asked her how she feels about it. She said that virtual meeting makes it more likely for her to stick to the appointment." – provider

> "There are a lot of no shows when working with this population. But with telehealth, the clients can use their phone to call me right away. Phone has the ability to narrow the gap and maintains the relationships. It gives us a lot of ability to get connected with the clients and their family."— provider

> "We definitely get comments from people that their providers check in with them. Because of that, there might be more. It seems like people answer their phone more nowadays. There is something there with people willing to connect by phone. People said 'I feel cared for from my provider.'"— provider

Infrastructure supports

- Providers want to see payment parity for telehealth services continue. This will help incentivize providers to continue to provide telehealth services.
- Some MA enrollees shared concerns about insurance coverage and ways to pay for services. This is a barrier for some of them in accessing telehealth care.
- Providers are generally able to collect consent forms prior to providing telehealth services.
- It is important to have a secure system to store confidential information, as well as secure teleconference platforms. Enrollees expressed concerns about the security of their medical information.
- Providers discussed the need for resources and additional trainings to help prepare them to provide telehealth services.
- Providers want more funding or grants to help get their organizations equipped to provide telehealth services. The funding will address both the structural and technological barriers.

Payment for telehealth services

About a third of providers (8 out of 26) mentioned payment parity for telehealth services as important. They hoped that telehealth services would continue to be reimbursed at the same rate as in-person services. They felt that payment parity would incentivize and encourage providers to continue to provide telehealth services.

> "Similar to now, making sure that the incentive structure remains in place that a telehealth visit is equally valued as an in-person visit. Because if it is devalued, the incentive to provide that modality from a structural point of view will lessen. It will make it more difficult to justify or push for phone-only services." – provider

> "I would say that one of the things that would be good is making sure there is adequate funding for services we are providing. Billing for telehealth should be the same for in person. [If not,] that would decrease people's interest and openness in providing the services." – provider

> "We also learned that it works when you pay the same rate for it. Having it available at the same rate is hugely important. We have a few clinics that got paid poorly and they have had to close their clinics." – provider

One-fifth of the service recipient interviewees (5 out of 23) and some focus group participants from urban areas expressed concerns about insurance coverage and ways to pay for services. It is a barrier for many of them accessing care and it has taken a toll on them financially and mentally.

> "I have been lucky since my physical health has been good. I have had regular appointments even through the pandemic. I have kept up with my regular preventive checkups and whatever

tests are needed for my age. I did have a lot of dental issues and that was not covered by insurance. So that put a lot of stress on me financially." – audio-only service recipient

"I don't know what DHS covers when it comes to telehealth and I don't know what my provider would offer. I am hesitant to use something that is not covered." – service recipient

Secure technology

Almost all providers (24 out of 26) shared that they were able to obtain consents before providing telehealth services. Those consents are usually either electronic or verbal and include information about the privacy and security of patient information.

"We have a set up where patients can review the paperwork and sign it electronically. We will make sure to go through the important points such as confidentiality at the beginning of the session. It is all signed before we begin the session." – provider

"It is a verbal consent. Those who are coming into the clinic, they do written consent. With verbal consent, we do that virtually and document it in the paperwork that it is a verbal consent." – provider

Some providers (5 out of 26) raised the importance of having a secure system to store confidential information, including consent forms and sensitive health records. This secure system also includes teleconference platforms patients can access easily and securely.

In addition, 5 out of 23 service recipient interviewees expressed concerns regarding their health and medical information. They were concerned that their medical information was not properly protected and that their electronic medical records are prone to hacking.

"The biggest limitation we found is the accessibility for patients. Not everyone is readily available to use the platform to access it. Thinking about the program that is structurally secure and safe to handle this kind of appointment, it limits the accessibility for certain groups of people."— provider

"I know that the software exists, you can create a client portal to have clients sign the electronic form. We don't have that infrastructure in our program." – provider

"I would talk to them on the phone and I wouldn't do video since it doesn't seem private. I would talk to my doctor on the landline and not a cellphone. It can be hacked and I have many concerns about our medical information. HIPAA means nothing when it can be hacked." – service recipient

"The only thing that one of the doctors said is when they are working from home and with one child around, he is worried about HIPPA and confidentiality concerns." – service recipient

Resources and supports

About half of providers (12 out of 26) discussed the need for additional resources and trainings for providers to provide telehealth services. Some of the resources and trainings that providers mentioned were related to intervention methods, best practices for using telehealth, ways to incorporate telehealth into a regular workflow, and regulations and guidelines on platforms agencies should and should not use.

> "It would be nice to see or learn what best practices people have established whether locally in the city or more broadly in the state or country. And incorporate telehealth into the regular workflow or practice. We have to shift things around without any real experience at all. Being able to learn what others learn and see how we can best optimize our resources but make sure we provide the best experience for our clients while we are still figuring what the best way to do this is." – provider

> "Also, we, as providers, need better directions about finding resources, knowing where to find policy, access to implement those resources, and telehealth best practices, so that they provide good quality of care. For consumers, having those resources about what good quality of care looks like would allow them to see and decide by themselves whether they receive good services." – provider

About a fourth of providers (7 out of 26) mentioned wanting to receive more funding or grants to help get their organizations equipped to provide telehealth services. The additional funding would help address both the structural barriers, such as renovating existing buildings, setting up physical space for patients to use, or creating community telehealth hubs, and some technological challenges by purchasing laptops and electronic tablets for patients.

> "We are in an old building and other organizations too. Our buildings are not doing it. Being able to help organizations get their building up-to-speed for them to do the hybrid formats. Support them so that they can have everything set up in their organization to provide those services." –provider

> "Technologically, it would be nice if clients have more access to be able to do video if they choose to do so. I know that there are some programs from the county to get low-cost computers or internet. They should do more of that. We have a clinic where we help clients get set up with computers and [our patient portal]. We will work with technology equity so we help the seniors there to learn how to access computers, internet or [the portal] to help them get more comfortable with technology." –provider

In addition to having more access to technical equipment, a third of providers (8 out of 26) highlighted the need to have access to reliable internet. This is especially important for patients who live in rural areas.

> "Continuing to get broadband to rural communities is such a huge piece. People look at this issue as metro-centric. When you are in rural MN and stay on your friend's couch - a place that has Wi-Fi might be, like, 25 miles away."– provider

> "If anything, we need faster bandwidth and stronger cellphone coverage. So it helps with the stronger technical connections." – provider

Final Recommendations

Continue existing expansions of telehealth, including extending the coverage of audio-only, for Medical Assistance and MinnesotaCare enrollees until more information is collected to inform the development of permanent policies. Based on current literature and report data sources, telehealth contributes to ensuring continued access to health care services for Minnesotans enrolled in Medical Assistance and MinnesotaCare. According to the MA survey results, 65% of enrollees who received telehealth services in the past year agreed that telehealth has made it possible for them to get the health care they otherwise wouldn't have received and 72% of individuals indicated that they would be interested in utilizing telehealth services in the future. Overall, survey respondents generally reported that there was no difference in quality between telehealth and in-person care, including respondents who received audio-only services. Qualitative data themes described telehealth experiences as offering more consistent access to services and a reduction of stressors often related to travel barriers for MA recipients and providers. Additionally, audio-only telehealth services may be particularly helpful in ensuring access to care for enrollees with disabilities or blindness, as audio-only utilization was more common among this population. Importantly, experiences with telehealth differed across different communities, and there may be additional considerations regarding delivery format, including audio-only, that are specific to certain communities. Further monitoring and analysis is needed to ensure policies do not have unintended consequences that could exacerbate health disparities.

Ensure authentic and equitable choice for providers and MA enrollees to access care via telehealth or in person. MA recipients and providers emphasized the importance of choice with regard to telehealth versus in-person care. Survey respondents frequently reported they were given the choice between telehealth and in-person services (69%). In addition, data on MA recipient preferences also varied by demographic, the type of care received and many other factors (e.g., racial/ethnic identity, age, needing an interpreter, transportation or geographic factors, technological skills, access to technological resources, family or caregiving responsibilities). It will be important to ensure that providers have the flexibility to make informed decisions about the appropriateness of telehealth for the people they serve and for enrollees to make decisions about the type of care they are most comfortable receiving. This includes reducing structural barriers to accessing both telehealth and in-person care to ensure there is an authentic choice available.

Conduct additional research, including telehealth cost-benefit analyses and the clinical effectiveness of telehealth. While the current telehealth data available is extensive and offers valuable information about perceived access and quality of care among MA enrollees and providers, additional information is still needed regarding the impact of telehealth expansion and payment parity related to clinical effectiveness, outcomes of audio-only service delivery, and telehealth addition/duplication costs. Further examination on payment rates on different telehealth formats (video-based, audio-only, etc.) should guide future payer adjustments. Additional research and analyses are warranted and will inform how to improve the effectiveness of telehealth based on specific types of care (i.e., beyond behavioral health vs. physical health), as well as individual circumstances. Consistent with the previous DHS telehealth utilization report (Singh & Marquardt, 2020), DHS should continue to monitor utilization and longitudinal data over time. In addition, continued assessment of telehealth experiences of consumers and providers as technology and comfort with technology changes over time would be beneficial to ensure improved access, quality of care, health outcomes, patient satisfaction, value-based payments and innovation in health care delivery.

Continue support for legislation to allow payment parity in reimbursement for all telehealth formats until further data can inform a final policy recommendation, particularly with regard to audio-only services. Providers and DHS payer/policy staff indicated a range of support for telehealth payment parity for now. In the focus groups and interviews for the current study, several providers expressed hope that telehealth services would continue to be reimbursed at the same rate as in-person services. They felt that payment parity would incentivize and encourage providers to continue to provide telehealth services. In addition, many service recipients expressed confusion or concern about what MA will and will not cover with telehealth, which posed a barrier to them accessing services. Based on current limited data sources, there is no indication audio-only services significantly decrease MA recipient health care satisfaction and quality of experience. Furthermore, based on our survey and qualitative data, telehealth services, including audio-only, appear to increase access at times for individuals who may face barriers to receiving in-person health care services. However, DHS payer and policy staff identified a need to better understand and ensure alignment with the payment structures other payers are implementing.

Future telehealth policies should be tailored by service type and intensity, diagnostic complexities, which may vary significantly between physical health and behavioral health care. Based on a review of all data sources, there is a significant difference regarding telehealth utilization and preference based on type of service (i.e., physical health versus behavioral health). From July 2021 to June 2022, 2-3% of physical health services were provided via telehealth, while 31-34% of mental health services and 7-17% of substance use treatment services were provided via telehealth (Figure 3). Survey respondents and qualitative interviews also evidenced differences in preferences. Based on type of care received (physical telehealth versus behavioral health service), survey respondents indicated that assessing health concerns in person may be more important for physical health concerns (53%) compared to assessing health concerns for behavioral health services (28%). Alternatively, communication concerns were more common among individuals who had previously received audio-only services and/or behavioral health services. Ethical, safe, and person-centered care practices also support the need for tailored policies based on enrollees with certain health concerns (e.g., abuse, suicidal ideation, severe mental health concerns, addiction, concerns that are complex and/or require physical examinations or lab work).

Provide training and support to providers, including technical assistance, education and quality assurance. Approximately 50% of providers in our study discussed the need for additional resources, training and education for providers to offer telehealth services, including best practices for telehealth, ways to incorporate telehealth into a regular workflow and regulations and guidance on platforms agencies should and should not use. This feedback is consistent with the previous DHS telehealth utilization report (Singh & Marquardt, 2020). To support providers and increase community collaborations, DHS should develop and disseminate a set of clinical decision-making guidelines for providers regarding the use of telehealth. On-demand training modules for technical assistance, claims/billing procedures, and quality assurance are also warranted. The guidelines and on-demand trainings are particularly warranted for behavioral health services due to the continued high volume in claims data that demonstrate 1 in 3 behavioral health services are provided via telehealth.

Continue efforts to better understand how culture, identity, and demographics, and the social and structural factors associated with these identities (e.g., oppression and marginalization), impact telehealth experiences. In order to ensure equitable access and quality of telehealth for all enrollees, it is important to gather additional information from populations who may experience telehealth differently. This includes better understanding the

systemic and social factors that influence enrollee experiences with healthcare, generally, and telehealth, specifically. Given the many factors that impact the telehealth experience, it is important to prioritize authentic choice and telehealth fit for each enrollee individually, while also considering the overall cultural context in which individuals are accessing care. Specific populations in which telehealth needs to be explored further include:

- **Enrollees who access care in a language other than English.** In accordance with DHS core values to provide culturally and linguistically appropriate services (CLAS) to all Minnesotans, paired with the current report data, it is essential to improve the quality of telehealth with interpreters. Specifically, the proportion of enrollees who reported that the in-person format would have been better was higher among individuals who require an interpreter (compared to those that do not need an interpreter) across all care quality and access items. In addition, providers discussed concerns about diagnostic accuracy for individuals that require interpreters. CLAS trainings on collaborative strategies between providers and interpreters to provide high quality telehealth care are warranted. DHS should continue to identify innovative technology opportunities related to language and interpretive support. Further study is needed to better understand the experiences of individuals who use interpreters. This should involve learning from the deaf and hard of hearing community, where telehealth with interpreters was happening prior to the increase in telehealth associated with the COVID-19 pandemic.
- **Enrollees with disabilities and/or blindness and deaf or hard of hearing enrollees.** The findings from this study indicate that more information is needed about the telehealth experiences of enrollees who are deaf or hard of hearing and enrollees who have disabilities and/or blindness, particularly because many of these populations require modifications to standard communication modes (e.g., enrollees with blindness likely rely on audio-only services, while deaf and hard of hearing enrollees likely rely on video-only services). Additionally, findings indicate that discomfort with the technology needed to access telehealth is a greater concern among enrollees with disabilities and/or blindness. Accordingly, there is a need to better understand how telehealth can best serve these populations and identify ways the experience can be improved to ensure access to high quality care.
- **Black, Indigenous, and People of Color (BIPOC) enrollees, particularly in greater Minnesota.** There is a need to better understand telehealth experiences among BIPOC enrollees, including whether telehealth increases access to care, particularly in greater Minnesota and regarding culturally-specific or culturally-responsive services, including services provided by tribal health care agencies. While survey results indicate that some populations may perceive more challenges with telehealth (e.g., Black immigrant enrollees), patterns varied by survey item and more information is needed to better understand the contributing factors to these challenges and how to address them. Additionally, it is important to include enrollees of identities not explored in this study, such as multiracial enrollees and more specific racial and ethnic communities (e.g., Hmong, Somali, Karen).
- **Young children and older adults.** There is also a need to better understand how age impacts telehealth experiences. While not a specific focus of the current study, some enrollees and providers shared that telehealth can better facilitate caregiver involvement in a child's health care, but that there are some challenges providing services to young children via telehealth. Additionally, findings indicate that discomfort with the technology needed to access telehealth services was greater among older adults (33% among age 50-64 compared to 14-15% among age 18-34 and 35-49).

Continue to advocate and prioritize funding for telehealth infrastructure and resources to ensure enrollees are able to access telehealth services, including reliable internet and devices. Data from MA enrollees and providers identified a need to support enrollees in accessing telehealth care. Specifically, they suggested providing devices (e.g., laptops) and a physical space for enrollees to use while accessing telehealth services, and ensuring enrollees have consistent access to reliable internet. Similarly, the most commonly reported reason for preferring in-person services over telehealth is that respondents would be able to hear and see their provider better (67%), indicating a need to improve internet or phone connections and/or speed. Data also emphasized that access may be particularly challenging for individuals in MA who do not have disposable income. Provider data suggested they were particularly concerned about internet access in rural areas of the state and requested more funding or grants to help their organizations get equipped to provide telehealth services for patients. Furthermore, 18% of survey respondents that prefer in-person services reported they were not comfortable using the technology needed for a telehealth appointment. This was more common among older enrollees (33%) and enrollees with disabilities or blindness (38%). Qualitative findings also indicate that some enrollees may benefit from additional support to address lack of comfort or skill with necessary technology. Barriers to telehealth access would be reduced with continued investment to support interoperability for stable and consistent internet or cellular signals and availability of devices for both staff and patients, including offering technology set-up and use support.

Appendix

A: Detailed methodology

Survey of MA enrollees

DHS prioritized six topic areas to incorporate into the survey, including:

- MA application process
- Accessing health care
- Health care quality and treatment plans
- Cultural responsivity and discrimination
- Financial well-being
- Telehealth

To develop the survey tool, DHS gathered input from researchers, directors, and managers within DHS's Health Care Administration (HCA) and Community Supports Administration (SCA), as well as other subject matter experts. Additionally, Wilder provided feedback on drafts of the survey tool.

To translate the web survey into Spanish, Somali, and Hmong, Wilder worked with a translation vendor. DHS programmed all versions of the survey into their survey software program, Snap.

The mailed materials, the survey and a proposal outlining the survey methodology were submitted to the DHS Institutional Research Board (IRB). After reviewing the application, the IRB identified several required changes to the project. After these changes were addressed, the project received IRB approval.

To determine the sample for the survey, DHS identified three priority variables from the MA enrollee database:

- Prior telehealth utilization: enrollees who received behavioral health services via telehealth, enrollees who received only physical health services via telehealth (no behavioral health services), and enrollees who had not received any telehealth services
- Eligibility type (i.e., the reason someone is eligible for Medical Assistance): adults, parents and children, and enrollees with disabilities or blindness
- Race/ethnicity: Asian or Pacific Islander, Black immigrant, US-born Black, Hispanic, Native American, and white. DHS had a specific interest in assessing the differences between enrollees who identify as Black and are immigrants and enrollees who identify as Black and were born in the U.S. Note that in order to sample by race/ethnicity, there can only be one race/ethnicity category assigned to each respondent. Accordingly, all enrollees sampled for this study only had one race/ethnicity category assigned to them. While enrollees can select all racial or ethnic groups that they identify with, DHS assigned each enrollee to the racial/ethnic category that is least common in the population.

Using data from these variables, Wilder created a sample of 18,036 individuals, such that there were 334 enrollees in 54 total groups (i.e., one group for each possible combination of the above variables). Enrollees in each group were randomly sampled.

DHS then identified and removed household duplicates and individuals who had no valid address, no forwarding address according to the National Change of Address System, and no email address, resulting in a total of 17,817 individuals in the sample.

Invitations to complete the survey were sent in the following sequence:

- Invitation #1 sent on March 9, 2022: letters with the link to the web survey were mailed to all enrollees in the sample. Email invitations were also sent to enrollees who had an email address listed in the MA database.
- Invitation #2 sent on March 16, 2022: postcards with the link to the web survey were mailed to all enrollees in the sample. Follow-up email invitations were also sent to enrollees with email addresses. These were sent one week after the first invitation.
- Invitation #3 sent on March 30, 2022: a printed paper copy of the survey and letters with the link to the web survey were mailed to all enrollees who had not yet completed the survey and had valid mailing addresses (i.e., prior mailings were deliverable). One final email invitation was also sent to enrollees who hadn't yet completed the survey and had email addresses. These were sent two weeks after the second invitation.

All invitation materials noted that enrollees who completed the survey would receive a $15 Target or Walmart gift card, and that the survey would take about 20-30 minutes to complete. Additionally, the materials stated that survey responses are confidential and won't be shared outside the Wilder Research and DHS teams working on the project, that participation will not affect MA or other program eligibility, and that the survey must be completed by the person the invitation was sent to. Materials also included a survey access code that enrollees had to use to access the web survey, allowing Wilder and DHS to connect their survey responses to data from the MA database.

The web survey was open until Monday, May 2, 2022, and the last day Wilder accepted surveys was May 6, 2022.

As Wilder received completed mailed surveys, Wilder staff entered them into a tracking file, cleaned the responses as needed, and entered the data. Once all the mailed surveys were entered, DHS sent Wilder the web survey responses for the telehealth and demographics questions. Wilder then combined the files and removed duplicate responses, for a total of 2,985 responses.

To calculate the response rate, enrollees were removed from the overall sample denominator if their mailed letter was undeliverable and their email invitation was undeliverable or they did not have an email address. The final denominator used to calculate the response rate was 16,412, and the final response rate was 18%.

Wilder then weighted the dataset to produce reliable estimates of population parameters for each of the sampling areas: prior telehealth utilization, program enrollment and race/ethnicity. For this study, survey weights were calculated using the method of iterative proportional fitting, commonly referred to as "raking." The weights were put through a series of quality control checks to identify extreme outliers (weights were truncated so no single respondent counts too strongly in the analysis) and to avoid any computational or procedural errors. Wilder then generated frequencies and crosstabs to produce the findings included in this report.

Note that most results included in this report relate to a specific appointment that a respondent had, as directed by the survey instrument. Respondents were first asked about telehealth utilization and, if a respondent indicated

they received telehealth services in the past 12 months, they were then asked to choose the category that comes first in a list of care and delivery format types: phone call for a mental health or substance use concern, a video call for a mental health or substance use concern, a phone call for a physical concern, and a video call for a physical concern (this order also matches the order these items are listed in this report and the survey databook). For example, if a respondent had a phone call for a mental health or substance use concern and a phone call for a physical concern, they were asked to choose the phone call for the mental health or substance use concern. Respondents were then asked to think about the most recent visit they had within this category before completing the next set of questions. This allowed the survey analysis to prioritize data pertaining to audio-only services and behavioral health services.

Weighted survey demographics

This section outlines the weighted demographics of survey respondents as well as corresponding information from the MA database (as available). As described above, there were three variables used to create the sample and ultimately weight the survey data (race/ethnicity, prior telehealth utilization, and program eligibility type). Accordingly, the percentages for these variables among survey respondents match the percentages for these variables among the population as a whole.

In addition to the race/ethnicity information already included in the MA database, the survey also asked respondents to self-identify their race/ethnicity. These percentages were similar to the percentages from the MA database, with a difference of only one or two percentage points for most categories (Figure A1). However, the percentage of enrollees who identify as white or Caucasian was higher in the self-identified survey data compared to the MA database (64% versus 58%).

Figure A1. Race and ethnicity of survey respondents and MA enrollee population

Race and ethnicity	Weighted survey respondents % (N=2,832-2,985)	MA enrollee population % (N=658,881)
Race/ethnicity (MA database; only one identity assigned to each enrollee)[a]		
Asian or Pacific Islander	8%	8%
Black immigrant	7%	7%
US-born Black	15%	15%
Hispanic	7%	7%

Race and ethnicity	Weighted survey respondents % (N=2,832-2,985)	MA enrollee population % (N=658,881)
Native American	5%	5%
White	58%	58%
Race/ethnicity (Select all that apply; survey responses)		
American Indian, Native American, or Alaska Native	7%	N/A
Asian, Asian American, or Pacific Islander	8%	N/A
Black or African American	23%	N/A
Latino/a or Hispanic	8%	N/A
White or Caucasian	64%	N/A
Not listed[b]	1%	N/A

[a] This variable was used to create the survey sample and in weighting the survey data; accordingly, the percentages among survey respondents and the overall MA enrollee population match.
[b] Responses included individuals who identify as multiracial and did not specify further and individuals who identify as Middle Eastern or North African.

The percentages of enrollees who live in rural, urban, and mixed rural/urban areas were similar between survey respondents and the overall MA enrollee population (Figure A2).

Figure A2. Geography of survey respondents and MA enrollee population

Geography	Weighted survey respondents % (N=2,985)	MA enrollee population % (N=658,881)
Entirely rural	17%	18%
Entirely urban	62%	62%
Urban/town/rural mix	21%	20%
Not clearly assigned at the time the sample was pulled from the MA database	N/A	<1%

Note. Percentages may not add to 100% due to rounding.

Most enrollees in rural and mixed rural/urban areas are white (77-79%; Figure A3), with other race/ethnicities comprising 1-9%. About half of respondents in urban areas identify as white (45%), followed by US-born Black (22%).

Figure A3. Geography by race/ethnicity among survey respondents

Geography by race and ethnicity	Weighted survey respondents: Entirely rural (N=514)	Weighted survey respondents: Entirely urban (N=1,848)	Weighted survey respondents: Rural and urban mix (N=623)
Asian or Pacific Islander	3%	11%	1%
Black immigrants	1%	10%	3%
US-born Black	2%	22%	4%

Geography by race and ethnicity	Weighted survey respondents: Entirely rural (N=514)	Weighted survey respondents: Entirely urban (N=1,848)	Weighted survey respondents: Rural and urban mix (N=623)
Hispanic	8%	8%	7%
Native American	9%	4%	6%
White	77%	45%	79%

Respondents most often identified as Ojibwe (11%) or Mexican (11%) when asked which cultural, ethnic, or tribal communities they identify with (Figure A4).

Figure A4. Cultural, ethnic, or tribal community identities of survey respondents

Cultural, ethnic, or tribal community identities (Check all that apply)	Weighted survey respondents % (N=1,180)
Somali	8%
Oromo	3%
Ethiopian or Amharic	4%
Ojibwe	11%
Dakota	3%
Mexican	11%
Puerto Rican	2%

Cultural, ethnic, or tribal community identities (Check all that apply)	Weighted survey respondents % (N=1,180)
Hmong	9%
Vietnamese	3%
Karen, Karenni, or other Burmese ancestry	2%
Lao	1%
Another group not listed above[a]	32%

[a] Respondents reported more than 100 distinct identities. The five most common identities were white (N=42); American (unspecified; N=33); Black, Black American or African American (N=25); British, English, Scottish, Welsh, or Northern Irish (N=19), and Scandinavian (unspecified, N=17).

Nearly all respondents completed the survey in English (99%; Figure A5).

Figure A5. Language survey was completed in

Language survey was completed in	Weighted survey respondents % (N=2,985)
English	99%
Somali	<1%
Spanish	<1%
Hmong	0%

Note. Percentages may not add to 100% due to rounding.

Percentages of enrollees of each age group were similar between survey respondents and the overall MA enrollee population, with a slightly greater number of respondents identifying as age 50-64 and fewer as age 18-34 (Figure A6).

Figure A6. Age of survey respondents and MA enrollee population

Age	Weighted survey respondents % (N=2,985)	MA enrollee population % (N=658,881)
18-34	42%	47%
35-49	31%	30%
50-64	28%	23%

Note. Percentages may not add to 100% due to rounding.

A greater number of enrollees identified as female in the MA database completed the survey compared to the overall population (66% versus 56%; Figure A7). Sex and gender identity percentages were similar.

Figure A7. Sex and gender identity of survey respondents and MA enrollee population

Gender identity and sex	Weighted survey respondents % (N=2,844-2,985)	MA enrollee population % (N=658,881)
Sex (MA database)		
Female	66%	56%
Male	34%	44%
Gender identity (Check all that apply; survey response)		
Woman	66%	N/A

Gender identity and sex	Weighted survey respondents % (N=2,844-2,985)	MA enrollee population % (N=658,881)
Man	33%	N/A
Non-binary	1%	N/A
Transgender	1%	N/A
Prefer to self-describe[a]	<1%	N/A

[a] Responses included genderfluid or genderqueer.

Most enrollees identified as heterosexual or straight (90%), followed by bisexual (7%; Figure A8).

Figure A8. Sexual orientation of survey respondents

Sexual orientation (Check all that apply)	Weighted survey respondents % (N=2,561)
Heterosexual or straight	90%
Lesbian or gay	4%
Bisexual	7%
Another group that is not listed above[a]	2%

[a] Responses included pansexual, queer, demisexual, asexual, and panromantic.

About half of enrollees reported they currently have a treatment plan (56%) and 9% reported they need access to an interpreter during their health care appointments (Figure A9).

Figure A9. Treatment plans and need for interpreters among survey respondents

Treatment plan and need for interpreter	Weighted survey respondents % (N=2,925-2,951)
Do you have a mental or physical health condition that a health care provider is helping you manage or giving you treatment?[a]	
Yes	56%
No	44%
Do you need access to an interpreter during your health care appointments?	
Yes	9%
No	92%

Note. Percentages may not add to 100% due to rounding.
[a] This question was used as a proxy for determining whether an individual has a treatment plan.

The most common eligibility type among enrollees is that they are part of a family unit (44%), followed by adults not in family units (41%) and individuals with disabilities or blindness (15%; Figure A10).

Figure A10. Program eligibility type of survey respondents and MA enrollee population

Eligibility type	Weighted survey respondents % (N=2,985)	MA enrollee population (N=658,881)
Adults	41%	41%
Families	44%	44%

Eligibility type	Weighted survey respondents % (N=2,985)	MA enrollee population (N=658,881)
Disability or blindness	15%	15%

Note. This variable was used to create the survey sample and in weighting the survey data; accordingly, the percentages among survey respondents and the overall MA enrollee population match.

According to records in the MA database, most enrollees have not received telehealth services (71%; Figure A11).

Figure A11. Prior telehealth use of survey respondents and MA enrollee population

Prior telehealth use	Weighted survey respondents % (N=2,985)	MA enrollee population (N=658,881)
Behavioral telehealth services	14%	14%
Only physical telehealth services	16%	16%
No telehealth services	71%	71%

Note. Percentages may not add to 100% due to rounding. This variable was used to create the survey sample and in weighting the survey data; accordingly, the percentages among survey respondents and the overall MA enrollee population match.

Focus groups and interviews with Medical Assistance enrollees

Wilder Research also conducted interviews and focus groups with MA enrollees between January and March 2022 to gather more detailed, nuanced information about their experiences with telehealth. The interviews and focus groups asked enrollees to discuss their ability to access health care services through telehealth, the strengths and challenges of their telehealth experiences, their perceptions of the quality of care received through telehealth, their satisfaction with telehealth, and recommendations for improving telehealth.

The interviews and focus groups targeted specific populations of interest to DHS and the legislature. Specifically, we conducted one virtual focus group with MA enrollees in urban areas (N=7) and one with MA enrollees in rural areas (N=5). We also conducted telephone or video interviews (based on interviewee preference) with 6 older adults and 17 individuals who received audio-only telehealth care.

Respondents were recruited through several different approaches. The top approach we used was to pull potential respondents from the recruitment we did for our MA enrollee Participant Expert Panel (see Appendix C for more detail about this panel). We had over 100 applicants for the 12 spots on the panel, so we prioritized reaching out to folks who did not join the panel and offer them an opportunity to participate in a focus group or interview. To supplement this recruitment, we also did outreach through DHS and partner organization newsletters or listservs, especially for the harder-to-access audio-only population. All MA enrollees who participated in an interview or focus group were given a $20 gift card to thank them for their time.

All of the focus groups and interviews were recorded and transcribed for analysis. Researchers created a codebook using an open-coding method and coded the data in ATLAS.ti, qualitative analysis software. This report only reports the most frequently mentioned themes (mentioned by more than 5 interview participants, which is approximately 20% of those interviewed). Participants spoke about a wide variety of topics and, at times, researchers grouped thematically similar responses together for reporting purposes.

Interviews with service providers

To better understand how providers experience telehealth, Wilder Research conducted telehealth interviews with a sample of 26 providers between February and March 2022. Due to this study's focus, Wilder specifically interviewed providers who specialize in mental and/or chemical health treatment and who serve individuals on Medical Assistance. Ten interviews were conducted with providers who worked with specific demographic groups such as individuals with chronic conditions, individuals transitioning out of care, and individuals from specific racial or ethnic groups of interest (e.g., Hmong, Karen, Somali, Hispanic, or African American). In addition, Wilder conducted seven interviews with providers who work with individuals with disabilities, seven interviews with providers serving Native American communities, and one interview each with a provider from a partial hospitalization program and adult day treatment. In addition, Wilder Research ensured representation from both urban and rural providers.

Providers were recruited through multiple approaches, including through existing relationships Wilder Research and DHS have with agencies or individuals, DHS newsletters and listservs, and outreach to organizations who specifically serve priority populations for this study.

All interviews with providers were recorded and transcribed for analysis. Again, all qualitative analysis was conducted using an open-coding method using ATLAS.ti software. This report only reports the most frequently mentioned themes (mentioned by more than 5 interview participants, which is approximately 20% of those interviewed).

B: Demographic and care characteristic differences within the survey data

This section describes notable differences in the survey data within demographic and care characteristic groups. Wilder used a general threshold of 15 percentage point differences to identify these.

Telehealth utilization

Respondents were asked to share **whether they had ever received telehealth services and whether they received specific types of services in the past year,** including audio-only behavioral telehealth services, video-based behavioral telehealth services, audio-only physical telehealth services and/or video-based physical telehealth services.

The proportion of respondents who report ever receiving telehealth services was higher among respondents with treatment plans (72% versus 48%) and respondents with disabilities or blindness (72%) compared to respondents with other eligibility types (56-64%). It was lower among respondents age 50-64 (53%) compared to those age 18-34 (62%) and 35-49 (70%).

Additionally, respondents with treatment plans more commonly reported receiving audio-only behavioral health services (26% versus 7% among those without treatment plans) and video-based behavioral health services (34% versus 11% among those without treatment plans). Video-based physical health services were more commonly reported by respondents from urban areas (26%) compared to respondents in rural areas (11%). Audio-only services were also more commonly reported by respondents with disabilities or blindness compared to respondents with other eligibility types (31% versus 15% for behavioral health services and 37% versus 20% for physical health services).

Among respondents who reported receiving behavioral health services in the past 12 months, audio-only behavioral health services were most common among white respondents (55%) and least common among Hispanic respondents (40%). Video-based behavioral health services were most common among Hispanic respondents (90%) and least common among Black immigrant and Native American respondents (61-62%). Audio-only physical health services were most commonly reported by US-born Black respondents (42%) and least commonly reported by Hispanic respondents (18%), compared to other racial/ethnic groups. Video-based physical health services were most common among Asian or Pacific Islander respondents (55%) and least common among Black immigrant respondents (26%).

Quality of care

Client satisfaction

Receiving quality care

Respondents were asked to indicate whether various aspects of the visit they were asked to think about would have been better via telehealth, in person, or if there would have been no difference, including **the extent to which they would have received better care.**

The proportion of respondents who reported they would have received better care **in person** was higher among:

- Black immigrant (53%) and US-born Black (50%) respondents compared to respondents of other racial/ethnic identities (28-47%). It was lowest among Native American (29%) and white (28%) respondents.
- Black immigrant respondents who received behavioral health services (48%) compared to respondents of other racial/ethnic identities who received behavioral health services (19-43%). This percentage was lowest among Hispanic respondents (19%).
- Respondents who need interpreter access (64%) compared to those that do not need interpreter access (32%).
- Older respondents (age 50-64; 43%) compared to age 18-34 (36%) and age 35-49 (26%).
- Respondents who received either physical or behavioral health audio-only services (39-40%) compared to respondents who received either physical or behavioral health video-based services (24-30%).

There were no group differences that met the 15 percentage point threshold among respondents who reported they would have received better care via telehealth.

The proportion of respondents who reported there would have been **no difference** was higher among:

- Native American (64%) and white respondents (68%) compared to respondents of other racial/ethnic identities (38-56%).
- Hispanic (77%) and white (68%) respondents who received behavioral health services compared to respondents of other racial/ethnic identities who received behavioral health services (41-63%).
- Respondents who have a treatment plan (65%) compared to respondents without a treatment plan (50%).
- Respondents who do not need access to an interpreter (64%) compared to those that do (20%).
- Respondents who received either physical or behavioral health video-based services (67-74%) compared to respondents who received either physical or behavioral health audio-only services (52-57%).

Delivery format preferences among respondents who have received telehealth services in the past year

Respondents who have received telehealth services in the past year were asked **if they would prefer a phone call, a video call, or in person if they need the same type of care in the future.**

In person preferences were highest among Black immigrant respondents (67%) and lowest among Native American respondents (48%) compared to other identities (50-58%). However, among respondents who received behavioral health services, in person preferences were lowest among Black immigrant respondents (32%) and highest among US-born Black respondents (50%) compared to other identities (36-45%). Black immigrant respondents also more commonly indicated a preference for video-based services (51%) and US-born Black respondents least commonly (34%) compared to other identities (38-46%).

In person preferences were higher among respondents who need interpreter access compared to those that do not (69% versus 51%), and they had lower levels of interest in video-based services compared to those who do not need interpreter access (12% versus 31%).

Additionally, preferences for a phone call were higher among respondents who received either physical or behavioral health audio-only services (24-25%) compared to those who received either physical or behavioral health video-based services (7-11%). Additionally, respondents who received either physical or behavioral health video-based

services (36-46%) more often preferred video compared to those who received either physical or behavioral health audio-only services (13-31%). In person preferences were higher among respondents who received physical health services in either format (54-61%) than those who received behavioral health services (45-48%).

Delivery format preferences for all respondents regardless of previous telehealth utilization

All respondents regardless of previous telehealth utilization were also asked to indicate **whether they would be interested in receiving health care by phone call only, a video call only, either phone or video, or neither video nor phone.**

Interest in audio-only, only video-based, or either audio-only or video-based was similar across racial/ethnic groups. However, the percentage of Black immigrant respondents that reported they would not be interested in either telehealth delivery format was higher (39%) than other racial/ethnic identities (22-28%). Among respondents who received behavioral health services, the percentage of Black immigrants that reported they would be interested in audio-only (38%) was higher than respondents of other racial/ethnic identities (9-15%) and the percentage of Black immigrants that reported interest in either phone or video was lower (38%) than respondents of other identities (53-63%).

Additionally, the percentage of respondents who said they would not be interested in either format was higher among respondents who require interpreter access than those who don't (42% versus 27%) and the percentage who said they would be interested in either format was lower among those who require interpreter access than those who don't (27% versus 48%).

Interest in only a phone call was highest among respondents who had not received telehealth services in the past 12 months (21%) and respondents who have received either physical or behavioral health audio-only services (17-20%) compared to video-based services (4-7%). Interest in only video was higher among respondents who received either physical or behavioral health video-based services (18-21%) compared to physical or behavioral health audio-only services (5-7%). Interest in either video or phone was lower among respondents who have not received telehealth services in the past year (36%) compared to those who received either physical or behavioral health services in either format (57-65%).

No interest in either format was more common among respondents who hadn't received telehealth services in the past year (39%), compared to those who received either physical or behavioral health services in either format (12-20%).

Assessing health concerns and telehealth fit

If a respondent indicated they would prefer in person after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including **whether their provider would need to assess their concern in person.**

Agreement that their provider needs to assess respondents' health concerns in person was more common among some groups, including Asian or Pacific Islander (53%) and US-born Black (50%) respondents compared to respondents of other racial/ethnic identities (30-46%). Agreement was also higher among respondents who received

physical health services in either delivery format (50-71%) compared to respondents who received behavioral health services in either format (21-45%). Agreement was less common among respondents who need interpreter access (28%) compared to those that do not need interpreter access (46%).

Among respondents who received behavioral health care, agreement among different racial and ethnic groups ranged widely, from 17% of Hispanic respondents to 63% of Asian or Pacific Islanders.

Communication

Communication challenges

If a respondent indicated they would prefer in person after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including **whether they would be able to hear and see their provider better.**

Endorsement of this reason was more common among Asian or Pacific Islander respondents (84%) and Black immigrant respondents (85%) compared to respondents of other racial and ethnic backgrounds (64-69%).

However, there was a different pattern between racial and ethnic groups among respondents who received behavioral health services, with US-born Black respondents most commonly reporting that they would be able to hear and see their provider better (89%) and Hispanic respondents least commonly (59%).

Additionally, this was more frequently endorsed among respondents who have disabilities or blindness (76%) compared to respondents with other eligibility types (61-69%). It was also more common among respondents who received either physical or behavioral health audio-only services (64-77%) compared to either physical or behavioral health video-based services (52-69%) and among respondents who received behavioral health services in either format (69-77%) compared to physical health services in either format (52-64%).

Extent to which providers listen carefully

Respondents were asked to indicate whether various aspects of the visit they were asked to think about would have been better via telehealth, in person, or if there would have been no difference, including **the extent to which their provider would have listened carefully.**

The proportion of respondents who reported their providers would have listened more carefully **in person** was higher among:

- Black immigrant (46%) and US-born Black (43%) enrollees compared to enrollees of other racial or ethnic identities (27-37%).
- Black immigrant (43%) enrollees who received behavioral health services compared to other enrollees of other racial or ethnic identities who received behavioral health services (18-32%).
- Enrollees who need interpreter access (69%) compared to those that don't (29%).
- Older enrollees (43% of those age 50-64) compared to younger enrollees (32% of age 18-34 and 23% of age 35-49).

Enrollees who received either physical or behavioral health audio-only services (33-36%) compared to video-based services (22-28%).

There were no group differences that met the 15 percentage point threshold among respondents who reported their provider would have listened more carefully via telehealth.

The proportion who reported that there would have been **no difference** was higher among:

- White respondents (69%) compared to respondents of other racial/ethnic identities (45-63%).
- Hispanic (78%) and white enrollees (70%) who received behavioral health services compared to other respondents of other racial or ethnic identities who received behavioral health services (41-67%).
- Respondents age 35-49 (72%), followed by age 50-64 (53%) and age 18-34 (61%).
- Respondents who do not need access to an interpreter (66%) compared to those that do (22%).
- Respondents who received video-based physical health services (75%) and video-based behavioral health services (66%), compared to audio-only physical health services (62%), and audio-only behavioral health services (57%).

Extent to which provider can explain things better

If a respondent indicated they would prefer in person after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including **whether their provider can explain things better in person.**

The proportion of respondents who agreed that their preference for in person is at least partially because their provider can explain things better in person was highest among respondents who identify as Asian or Pacific Islander (72%) and lowest among Black immigrants (40%) compared to respondents of other races and ethnicities (48-58%). Among respondents who received behavioral health services, endorsement was highest among US-born Black respondents (67%) and lowest among Hispanic respondents (28%) compared to respondents of other races and ethnicities (52-55%).

Agreement was also higher among respondents with disabilities or blindness (60%) compared to respondents with other eligibility types (45-53%) and respondents age 50-64 (62%) compared to age 18-34 and 35-49 (44-52%).

Additionally, agreement was higher among respondents who received audio-only (58%) or video-based (53%) behavioral health services compared to those who received physical health services in either format (42-46%).

Emotional and physical safety

Comfort sharing thoughts and feelings with providers

Respondents were asked to indicate whether various aspects of the visit they were asked to think about would have been better via telehealth, in person, or if there would have been no difference, including **the extent to which respondents would have felt comfortable sharing their thoughts and feelings with their provider.**

The proportion of respondents who reported they would have felt more comfortable sharing their thoughts and feelings **in person** was higher among:

- Black immigrant respondents (60%) compared to respondents of other racial/ethnic backgrounds (28-40%).
- Black immigrant respondents who received behavioral health services (50%) compared to respondents of other racial/ethnic backgrounds who received behavioral health services (22-33%).
- Respondents who need interpreter access (66%) compared to those who do not need interpreter access (31%).

The proportion of respondents who reported they would have felt more comfortable sharing their thoughts and feelings **via telehealth** was higher among:

- Native American respondents (22%) compared to respondents of other racial/ethnic backgrounds (5-15%).
- Native American respondents who received behavioral health services (27%) compared to respondents of other racial/ethnic backgrounds who received behavioral health services (11-20%).

The proportion of respondents who reported that there would have been **no difference** was higher among:

- White respondents (62%) compared to respondents of other racial/ethnic identities (34%-52%). This percentage was lowest among Black immigrant respondents (34%).
- Asian or Pacific Islander respondents who received behavioral health services (62%) compared to respondents of other racial/ethnic identities who received behavioral health services (32-57%). This percentage was lowest among Black immigrants who received behavioral health services (32%).
- Respondents who do not need interpreter access (59%) compared to those that do (25%).
- Respondents who received video-based physical health services (68%), followed by audio-only physical health services (57%) compared to audio-only or video-based behavioral health services (50-55%).

Trust that the provider is doing what's best for the respondent

Respondents were asked to indicate whether various aspects of the visit they were asked to think about would have been better via telehealth, in person, or if there would have been no difference, including **the amount of trust respondents have that their provider is doing what's best for them.**

The proportion of respondents who reported that they would have had more trust **in person** was higher among:

- BIPOC respondents (32-45%) compared to white respondents (26%).
- Black immigrant respondents who received behavioral health services (43%) compared to respondents of other racial/ethnic identities who received behavioral health services (18-34%). This percentage was lowest among Hispanic respondents (18%).
- Respondents who need interpreter access (64%) compared to those that do not need interpreter access (29%).

There were no group differences that met the 15 percentage point threshold among respondents who reported they would have had more trust via telehealth.

The proportion of respondents who reported there would have been **no difference** was higher among:

- White respondents (68%) compared to BIPOC respondents (46-58%).
- Hispanic respondents who received behavioral health services (77%) compared to respondents of other racial/ethnic identities who received behavioral health services (40-66%). This percentage was lowest among Black immigrants (40%).

- Respondents who do not need access to an interpreter (65%) compared to those that do (24%).
- Respondents who received video-based physical health services (74%) followed by video-based behavioral health services (64%), audio-only physical health services (60%), and audio-only behavioral health services (55%).

Comfort talking openly with the provider

If a respondent indicated they would prefer in person after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including **whether they would feel more comfortable talking openly with their provider.**

Endorsement was highest among Asian and Pacific Islander respondents (69%) and US-born Black respondents (60%), while it was lowest among Black immigrant respondents (37%) compared to other racial/ethnic identities (52-60%).

A smaller proportion of respondents who need interpreter access agreed with this statement (39%) compared to respondents who do not need interpreter access (55%). Similarly, fewer respondents in rural areas (42%) agreed compared to respondents in urban (55%) and mixed rural/urban (61%) areas. Agreement was more common among respondents with treatment plans (60%) compared to those without treatment plans (42%); respondents with disabilities or blindness (64%) compared to respondents of other eligibility types (49-53%); and older adults age 50-64 (65%) compared to younger respondents (58% of age 18-34 and 41% of age 35-49).

Agreement was more common among individuals who received either audio-only or video-based behavioral health services (66% each) compared to audio-only (42%) and video-based (33%) physical health services.

Autonomy, choice, and self-efficacy

Delivery format choice

Respondents were asked **whether the clinic gave the respondent a choice between in person and telehealth.**

Asian or Pacific Islander respondents most commonly reported that they were given the choice between telehealth and in person (85%), while Black immigrant respondents (61%) and white respondents (65%) least commonly reported this compared to other racial or ethnic identities (72-76%).

Among respondents who received behavioral health services, Asian or Pacific Islander and Native American respondents most frequently reported they were given a choice of delivery format (80% each) and Black immigrants and white respondents least frequently (61% each) compared to other identities (69-76%).

Having say over decisions that affect respondents' health

Respondents were asked to indicate whether various aspects of the visit they were asked to think about would have been better via telehealth, in person, or if there would have been no difference, including **how much say respondents would have had over decisions that affect their health.**

The proportion of respondents who reported they would have had more say during an **in-person** appointment was higher among:

- Black immigrant (50%) and US-born Black (48%) respondents compared to respondents of other racial/ethnic identities (23-42%). This percentage was lowest among white (23%) and Native American (28%) respondents.
- Black immigrant respondents who received behavioral health services (44%) compared to respondents of other racial/ethnic identities (22-33%). This percentage was lowest among white (22%), Hispanic (23%), and Native American (23%) respondents.
- Respondents who do not have a treatment plan (41%) compared to respondents who have a treatment plan (26%).
- Respondents who need interpreter access (62%) compared to respondents who do not need interpreter access (27%).
- Respondents who received video-based physical health services (22%) compared to audio-only physical health services and behavioral health services in either delivery format (30-34%).

There were no group differences that met the 15 percentage point threshold among respondents who reported they would have had more say via telehealth.

The proportion of respondents who reported there would have been **no difference** was higher among:

- White (72%) and Native American (63%) respondents compared to respondents of other racial/ethnic identities (43-55%).
- Asian or Pacific Islander, Hispanic, and white respondents who received behavioral health services (all 71%) compared to respondents of other racial/ethnic identities who received behavioral health services (39-60%).
- Respondents who have a treatment plan (68%) compared to those that do not have a treatment plan (51%).
- Respondents who do not need access to an interpreter (67%) compared to those that do (26%).
- Respondents who received video-based physical health services (75%) compared to audio-only physical health services and behavioral health services in either delivery format (59-66%).

Confidence managing health and treatment

Respondents were asked to indicate whether various aspects of the visit they were asked to think about would have been better via telehealth, in person, or if there would have been no difference, including **the extent to which respondents would have left the appointment feeling confident that they can manage their health and any necessary treatment.**

The proportion of respondents who reported they would have felt more confident managing their health and treatment with **in-person** care was higher among:

- Black immigrant respondents (59%) compared to respondents of other racial/ethnic identities (29%-49%). This percentage was lowest among Native American and white respondents (29% each).
- Black immigrant respondents who received behavioral health services (46%) compared to respondents of other racial/ethnic identities who received behavioral health services (20-32%).

- Respondents who need access to an interpreter (63%) compared to those that do not need access to an interpreter (32%).
- Older respondents (46% among age 50-64) compared to 35% among age 18-34 and 27% among age 35-49.
- Respondents who received either physical or behavioral health audio-only services (37-40%) compared to respondents who received either physical or behavioral health video-based services (26-31%).

There were no group differences that met the 15 percentage point threshold among respondents who reported they would have felt more confident managing their health and treatment via telehealth.

The proportion of respondents who reported there would have been **no difference** was higher among:

- Native American and white respondents (60-66%) compared to respondents of other racial/ethnic identities (31-52%). This percentage was lowest among Black immigrant respondents (31%).
- Hispanic respondents who received behavioral health care (74%) compared to respondents of other racial/ethnic identities who received behavioral health care (36%-66%). This percentage was lowest among Black immigrant respondents who received behavioral health care (36%).
- Respondents age 35-49 (66%), followed by age 18-34 (57%) and age 50-64 (50%).
- Respondents who do not need access to an interpreter (62%) compared to those that do (20%).
- Respondents who received either physical or behavioral health video based services (65-70%) compared to respondents who received either physical or behavioral health audio-only services (53-54%).

Engagement

Distractions

If a respondent indicated they would prefer in person after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including **the extent to which there would have been fewer distractions.**

Endorsement of this reason was higher among Asian or Pacific Islander and white respondents (55% each) compared to other racial/ethnic identities (40-46%). A similar pattern exists across racial and ethnic groups among respondents who received behavioral health services, with endorsement highest among white and Asian or Pacific Islander respondents (73-77%) and lowest among US-born Black respondents (43%).

Endorsement was less common among respondents who need interpreter access (35%) than those who don't (52%) and less common among respondents identified as male in the MA database (39%) than those identified as female (55%). There were also geographic differences, with endorsement most common among respondents living in mixed rural/urban areas (63%), followed by rural (55%) and urban (46%) areas.

Endorsement was also more common among respondents who received video-based (67%) and audio-only (56%) behavioral health services and less common among those who received video-based (41%) or audio-only (38%) physical health services.

Access

Overall ease of accessing care

Opportunity to receive care respondents otherwise wouldn't have received

Respondents who have received telehealth services in the past year were asked **whether telehealth made it possible for them to receive care they otherwise wouldn't have been able to receive.**

The percentage of respondents who reported that telehealth has made it possible for them to get care they otherwise wouldn't have received was highest among Hispanic (76%) and Asian or Pacific Islander respondents (75%) and lowest among Black immigrant respondents (40%) compared to other identities (63-70%). There were also differences by race/ethnicity regarding the type of care respondents were able to receive because of telehealth, including mental health treatment (15-59%), preventative visits (23-40%), visits for injuries or illnesses (14-47%), and medication or medical equipment (11-28%). See the accompanying databook for additional details.

Among respondents who received behavioral health services, the percentage of respondents who reported that telehealth has allowed them to access care they otherwise wouldn't have received was highest among Native American respondents (90%) and lowest among US-born Black respondents (67%) compared to other identities (73-81%).

Additionally, this percentage was higher among younger respondents (73% among age 18-34) compared to respondents age 35-49 (63%) and age 50-64 (55%) and among respondents who received audio-only behavioral health services (78%), followed by video-based behavioral health services (74%), with physical health services ranging between 65-67%.

Respondents who reported that telehealth made it possible to receive care they otherwise wouldn't have received were also asked what type of care they were able to access because of telehealth. These differences included:

- A greater proportion of older respondents (age 50-64; 38%) reported that telehealth services have made it possible to receive medication and medical equipment-related services compared to other ages (20-23% among age 18-34 and 35-49).
- A greater proportion of respondents in rural areas reported that telehealth has made it possible for them to receive mental health care they otherwise wouldn't have received (75%) compared to respondents in urban or mixed rural/urban areas (46-60%).
- The proportion who reported that they were able to access mental health care was also higher among respondents with a treatment plan (62%) compared to those that do not have a treatment plan (22%).
- The proportion who reported that they were able to access preventative care was higher among respondents who need interpreter access (42%) compared to those that don't (25%), and the proportion who reported they were able to receive medication or medical equipment was lower among respondents who need interpreter access (12%) compared to those that don't (27%).
- The proportion who reported they were able to access mental health treatment was higher among enrollees who reported receiving behavioral health services in either delivery format (74% each versus 43-44%). The proportion who reported they were able to access several different physical health services was higher

among enrollees who reported receiving physical health services in either delivery format compared to those who received behavioral health services, including:
    - Preventative visit with a doctor (27-37% versus 20-22%)
    - Visit with a doctor for an injury or illness (27-35% versus 42-44%)
    - Visit with a specialist who focused on treating certain conditions or parts of the body (24-26% versus 35-42%)

Extent to which it would have been easier to get care

Respondents were asked to indicate whether various aspects of the visit they were asked to think about would have been better via telehealth, in person, or if there would have been no difference, including **the extent to which it would have been easier to get care.**

The proportion of respondents who reported it would have been easier to get care **in person** was higher among:

- Black immigrant respondents (57%) compared to respondents of other racial/ethnic identities (21-41%). This percentage was lowest among Native American (24%) and white (21%) respondents.
- Respondents who require interpreter access (65%) compared to those that do not need interpreter access (25%).
- Older respondents (age 50-64; 39%) compared to age 35-49 (23%) and 18-34 (25%).
- Respondents in urban areas (31%) compared to respondents in mixed rural/urban areas (26%) and respondents in rural areas (17%).
- Respondents who received either physical or behavioral health audio-only services (32-35%) compared to physical or behavioral health video-based services (17-22%).

The proportion of respondents who reported it would have been easier to get care **via telehealth** was higher among:

- White respondents who received behavioral health services (34%) compared to respondents of other racial/ethnic identities who received behavioral health services (16-28%).
- Respondents in rural areas (29%) compared to respondents in urban areas (18%) or mixed rural/urban areas (14%).
- Respondents who received behavioral health services in either format (23-28%) compared to physical health services (9-14%).

The proportion of respondents who said there would have been **no difference** was higher among:

- Native American (64%) and white respondents (57%) compared to respondents of other racial/ethnic identities (31-47%).
- US-born Black (60%), Asian or Pacific Islander (57%), Hispanic (55%), and Native American (53%) respondents who received behavioral health services compared to white (49%) and Black immigrant (45%) respondents who received behavioral health services.
- Respondents who do not need interpreter access (56%) compared to those that do (28%).
- Respondents who received video-based physical health services (69%), followed by audio-only physical health services (56%), video-based behavioral health services (50%), and audio-only behavioral health services (45%).

Transportation

Ease of transportation

Respondents were asked to indicate whether various aspects of the visit they were asked to think about would have been better via telehealth, in person, or if there would have been no difference, including **the extent to which transportation would have been easier.**

The proportion of respondents who reported that transportation would have been easier **in person** was higher among:

- Black immigrant respondents (34%) compared to respondents of other racial/ethnic identities (11-28%).
- Black immigrant respondents who received behavioral health services (25%) compared to respondents of other racial/ethnic identities who received behavioral health services (7-17%).
- Respondents who need interpreter access (49%) compared to those that do not need interpreter access (12%).
- Older respondents (age 50-64; 25%) compared to other ages (age 18-34 and 35-49; 8-16%).
- Respondents who received either physical or behavioral health audio-only services (20% each) compared to physical or behavioral health video-based services (6-12%).

The proportion of respondents who reported that transportation would have been easier **via telehealth** was higher among:

- White respondents (40%) compared to respondents of other racial/ethnic identities (21-35%). The proportion was lowest among Black immigrant respondents (21%).
- Respondents with a treatment plan (41%) compared to those without a treatment plan (24%).
- Respondents who don't need interpreter access (38%) compared to those that do need interpreter access (16%).
- Respondents who received behavioral health services in either format (42-46%) compared to those who received physical health services (25-27%).

The proportion of respondents who reported there would have been **no difference** was higher among:

- Hispanic respondents who received behavioral health services (51%) compared to respondents of other racial/ethnic identities who received behavioral health services (23-43%).
- Respondents with other eligibility types (44-56%) compared to respondents with disabilities of blindness (39%).
- Respondents who do not need interpreter access (50%) compared to respondents that do need interpreter access (35%).
- Respondents who received video-based physical health services (70%), followed by audio-only physical health services (54%), video-based behavioral health services (41%), and audio-only behavioral health services (38%).

Travel time

If a respondent indicated they would prefer telehealth after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including no travel time.

Among respondents who received behavioral health services, endorsement was most common among Hispanic (89%) and white (88%) respondents and least common among Black immigrant respondents (66%) compared to other identities (74-81%).

Endorsement was more common among respondents age 35-49 (85%) compared to age 18-34 and 50-64 (70-78%), and endorsement was lower among respondents who need interpreter access (62%) compared to those that do not (79%).

Endorsement was also higher among respondents who received audio-only (79%) and video-based (90%) behavioral health services compared to those who received audio-only (67%) and video-based (71%) physical health services.

Travel costs

If a respondent indicated they would prefer telehealth after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including no need to pay for gas, parking fees, and other travel costs.

Endorsement of this reason was most common among Black immigrant respondents (82%) and least common among US-born Black (61%) and Hispanic (62%) respondents compared to other identities (67-75%). However, among respondents who received behavioral health services, endorsement was most common among Hispanic respondents (87%) and least common among US-born Black respondents (58%) compared to other identities (64-82%).

Respondents who need access to an interpreter had lower levels of endorsement compared to those who do not need interpreter access (37% versus 72%). Endorsement was also higher among respondents age 35-49 (77%), followed by age 18-34 (71%) and age 50-64 (61%).

Endorsement was also lower among those who received audio-only physical health services compared to other types of services (51% versus 72-80%).

Other barriers to care

Time off work

If a respondent indicated they would prefer telehealth after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including no need to take time off work.

Endorsement was highest among Black immigrant respondents (75%) and lowest among Native American respondents (38%) compared to respondents of other racial/ethnic backgrounds (41-53%). Among respondents who received behavioral health services, endorsement was most common among Hispanic respondents (67%) and least common among Native American respondents (34%) relative to other identities (40-58%).

This reason was less common among respondents with treatment plans (43%) compared to those without treatment plans (60%), respondents with disabilities or blindness (26%) compared to respondents with other eligibility types (43-60%), respondents who need access to an interpreter (31%) compared to those that do not (48%), and older respondents (age 50-64; 30%) compared to younger respondents (age 18-34 and 35-49; 49-57%).

Child care and elder care

If a respondent indicated they would prefer telehealth after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including no need to find child care or elder care.

The proportion of Black immigrants who reported that their preference is at least partially due to no need to find child care or elder care was higher (57%) compared to other racial/ethnic groups (29-41%). However, among respondents who received behavioral health services, the proportion of Black immigrants who reported this was lower (12%) compared to other racial/ethnic groups (28-35%).

Additionally, endorsement was lower among older respondents (20% among age 50-64 versus 37-41% among age 18-49).

Endorsement was also higher among respondents who received video-based physical health services (45%) compared to other types of care (30-34%).

Wait time and scheduling appointments

Wait time

Respondents were asked to indicate whether various aspects of the visit they were asked to think about would have been better via telehealth, in person, or if there would have been no difference, including whether the wait time would have been shorter.

The proportion of respondents who reported the wait time would have been shorter **in person** was higher among:

- Black immigrant respondents (47%) compared to respondents of other racial/ethnic identities (11-30%).
- Black immigrant respondents who received behavioral health services (45%) compared to respondents of other racial/ethnic identities who received behavioral health services (7-17%).
- Respondents who need interpreter access (54%) compared to those that don't (13%).
- Older respondents (age 50-64; 26%) compared to younger respondents (11-17% among age 18-34 and 35-49).
- Respondents who received either physical or behavioral health audio-only services (21-22%) compared to video-based services (7-13%).

The proportion of respondents who reported the wait time would have been shorter **via telehealth** was higher among:

- US-born Black respondents who received behavioral health services (39%) compared to respondents of other racial/ethnic identities who received behavioral health services (21-33%). This percentage was lowest among Hispanic (21%) and Black immigrant (22%) respondents.
- Respondents who do not need interpreter access (28%) compared to those that do (13%).
- Younger respondents (age 18-34; 36%) compared to older respondents (17-22% among age 35-49 and 50-64).

The proportion of respondents who reported there would have been no difference was higher among:

- White respondents (63%) compared to respondents of other racial/ethnic identities (32-56%). This percentage was lowest among Black immigrants (32%).
- Hispanic and white respondents who received behavioral health services (62-70%) compared to respondents of other racial/ethnic identities who received behavioral health services (33-54%).
- Respondents in rural areas (71%) compared to urban (52%) or mixed rural/urban areas (61%).
- Respondents who do not need interpreter access (59%) compared to those that do (33%).
- Respondents age 35-49 (67%) compared to respondents age 18-34 and age 50-64 (47-58%).
- Respondents who received video-based physical health services (63%), followed by audio-only physical health services and video-based behavioral health services (59% each), with audio-only behavioral health services last (48%).

If a respondent indicated they would prefer telehealth after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including shorter wait times for appointments. Endorsement of this reason was most common among Asian or Pacific Islander and Black immigrant respondents (69-73%) compared to respondents of other racial/ethnic identities (52-56%). Among respondents who received behavioral health services, agreement was also highest among Asian or Pacific Islanders (66%), while it was lowest among Black immigrant respondents (42%) compared to other identities (46-61%).

Scheduling appointments

If a respondent indicated they would prefer telehealth after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including telehealth appointments being easier to schedule.

Agreement was highest among respondents who identify as Asian or Pacific Islander (84%) or Black immigrants (80%) compared to respondents of other races and ethnicities (64-66%). Similarly, among respondents who received behavioral health services, agreement was most common among Asian or Pacific Islanders (86%) and Black immigrants (78%) compared to other racial or ethnic groups (67-74%).

Agreement was less common among respondents who received audio-only physical health services (56%) than respondents who received other types of services (69-71%).

Technological resources and skills

Technological skills

If a respondent indicated they would prefer in person after the COVID-19 pandemic ends, they were asked to identify the reasons for their preference, including a lack of comfort using the technology needed for a telehealth appointment.

Among respondents who received behavioral health services, endorsement was most common among Asian or Pacific Islander respondents (30%) and least common among US-born Black respondents (3%) compared to other identities (19-24%).

Agreement was higher among older respondents age 50-64 (33%) compared to younger respondents (14-15% among age 18-34 and 35-49) and among respondents with disabilities or blindness compared to other eligibility types (37% versus 12-15%).

C: Data-informed decision-making approach

In order to ensure the results of this study are as meaningful and impactful as possible, DHS and Wilder Research prioritized getting input on the interpretations and recommendations associated with the study results from two key groups. The first is MA enrollees and the second is DHS leadership. Their input was integral in framing and prioritizing data and recommendations for this report.

Medical Assistance Participant Expert Panel

The Medical Assistance Participant Expert Panel (PEP) was first convened in December 2021 for members to provide feedback on this study and share their experiences of being in the program with leaders from DHS. Staff from Wilder Research and DHS recruited members for the panel in October and November 2021 primarily through social media and outreach to partner organizations that serve MA enrollees. These recruitment efforts resulted in over 100 applicants. In order to be eligible, individuals had to be enrolled in MA for at least one year, be age 18 years or older, and be able to communicate in group conversations in English. Eighty-five applicants met these eligibility criteria. Wilder and DHS staff selected a group of applicants that had diverse representation across racial and ethnic groups, geography, age, ability and experiences with telehealth and behavioral health care. Selected applicants were asked to participate in a brief individual interview to determine their interest in and willingness to commit to participating in the PEP on an ongoing basis. Members get a stipend of $40 per meeting in which they participate.

The PEP meets online monthly, and meeting topics focused on the current study included: informing the study data collection tools and recruitment approaches and helping to interpret the results from the study. In addition, DHS leaders joined the PEP meetings to gather input on approaches for promoting new services supported by MA, behavioral health services and supports, choosing health plans, approaches for notifying enrollees about renewal processes, and payment denial materials.

The PEP has made many meaningful recommendations and contributions to this study and broader DHS planning. In particular, some of the key recommendations regarding the interpretation of study data include:

- Telehealth has been beneficial to many MA enrollees and should continue to be offered as an option.
- Patient choice in accessing telehealth is essential. In order to allow patients to have choice, barriers to accessing both telehealth (e.g., access to equipment and internet) and in-person care (e.g., transportation and adequate staffing) need to be addressed.
- MA enrollees may not be aware of the availability and potential benefits of telehealth. To raise awareness, it will be essential to go to where community members are and share information in various modes (e.g., video, radio, bus ads, and trusted community liaisons).
- Behavioral and physical health require different types of engagement, and the criteria for determining when telehealth is appropriate should be tailored accordingly.

Department of Human Services Leadership

In late September 2022, DHS and Wilder staff convened a group of nine leaders from the Department of Human Services. The individuals invited were selected because of their positions as decision-makers and their interest and investment in telehealth and/or optimal care for MA enrollees. These leaders met for two one-hour sessions scheduled on consecutive days. The first session focused on sharing study results and identifying key considerations from the data. The second session focused on identifying and prioritizing policy and practice recommendations based on the key considerations identified the day before.

Key recommendations from these sessions include:

- The results from the study validated that telehealth is an important tool for MA enrollees to access health care, but in-person care should also continue to be available.
- The study clearly demonstrated that enrollees and providers perceive that telehealth can provide high-quality care, but additional data about clinical outcomes is needed to get a more complete picture of the quality of care provided by telehealth, including audio-only care.
- The impact of telehealth policies will likely disproportionately impact behavioral health care because telehealth has continued to be a larger proportion of care for behavioral health as opposed to physical health care.

D: References

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