April 7, 2020

Representative Tina Liebling
Chair, House Health Finance and Policy Committee
477 State Office Building
St. Paul, MN 55155

Delivered electronically

RE: Comments on HF 2128- Article 7- Telehealth

Dear Chair Liebling and Members of the Committee:

My name is Jewelean Jackson. I am writing today to submit comments on HF 2128 Article 7 on Telehealth. I just concluded my term as board chair of Community-University Health Care Center after 9 years, and continue as a patient. As you know, Community Health Centers are committed to providing access to primary care for uninsured patients and those who are enrolled in public health care programs. Community Health Centers, work with communities who disproportionately face health disparities, and social determinates of health to improve outcomes, and provide wrap around services that meets patients where they are. I am here today to talk about my experience with audio- only telehealth, and the important role it can play in patient engagement.

I know, as a patient myself. I am a person on medical assistance with a $300 monthly spend down. My monthly finances are already behind the 8 ball. The cost associated with accessing technology is great, not only for the cost of the phone, but for the data packages as well.

Like many individuals, I have a number of health concerns that require ongoing care. I have used audio-only to communicate with my provider to manage conditions like asthma, high blood pressure and depression.

I believe equity in healthcare is the allowed use of the totality of my options for in person and telehealth which includes an audio-only option. This is even more important for those of us who are unsheltered, and only have access to a flip phone or have hearing aids. No one wants to call their healthcare provider on a video call in a public library, where there is limited privacy to discuss serious concerns. If they an individual is able to access and understand the technology once they have it.

Additionally, the use audio-only allows patients access to providers with flexibility in scheduling. For example, if a patient has an hourly job, they can connect with a provider on a break from work without the technology required for a video conference, and without requiring them to lose income. This can also assist individuals without transportation access care.

This is not just an issue in the city, but in rural areas where broadband access is often a significant barrier to video conferencing. Additionally, as you know technology can fail, and it can become a frustrating barrier for individuals with limited internet connectivity, or knowledge of the platforms required.

If audio-only goes away, BIPOC and low-income communities face limitations to care that could further contribute to health inequity. It takes away an avenue for them to connect with their providers. An example of this is in mental health where there can be cultural stigma in seeking services. Currently about 50% of mental health visits at Health Centers, access to mental health care is a critical need, and increased access is essential. There is real concern if audio-only is not continued there may be individuals who elect to no-longer seek care. We know that continuity and relationship with a provider through in person or by phone, is critical to receiving good care. This is not about mandating all low-income receive audio-only care, but allowing individuals the choice to access care when how meets their needs.

We appreciate that there is a study that will continue looking into how audio-only may be used in a post-pandemic world, but urge you to consider not sun-setting this important provision while the study is conducted. So that all individuals have equal access to care.

Thank you for your consideration, and I appreciate the opportunity to express my concerns.

Sincerely,

Jewelean Jackson