



IssueBrief

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Telehealth for at-risk populations: It's so much more than the technology

No matter how snazzy the interface or how novel the platform, telehealth must always be about the client first with technology coming second. Keeping that top of mind is crucial when thinking about telehealth for vulnerable populations, says Vivian Campagna, DNP, RN-BC, CCM, chief industry relations officer, Commission for Case Manager Certification.

Many clients, including older adults, those with low incomes, people with low health or computer literacy and those not proficient in English already struggle with access to care. Telehealth—which we generally think enhances access—in fact creates new hurdles for these clients. This is especially true for those with limited or no internet access and those in crowded living conditions with no privacy.

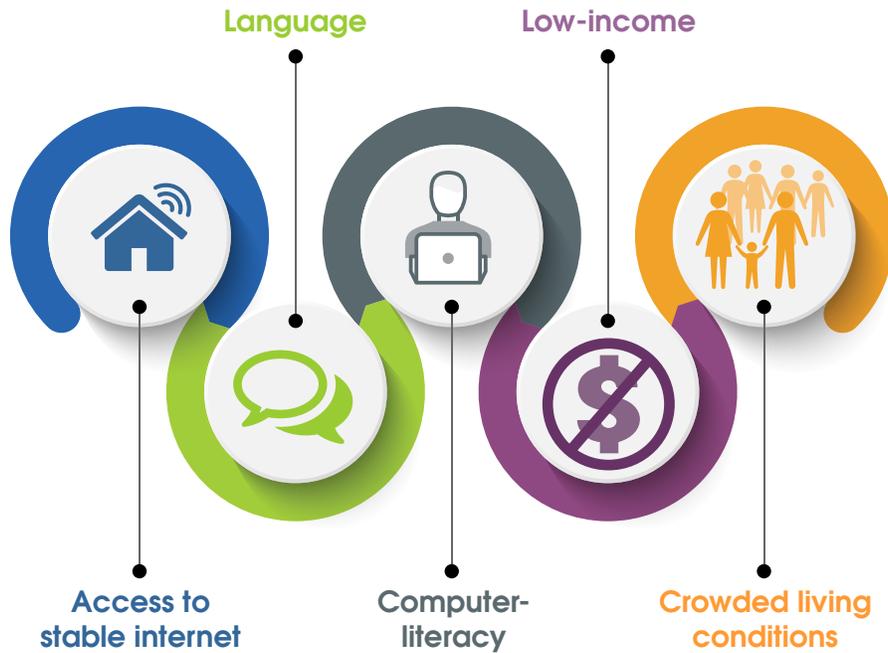
As a result, the move to telehealth during the pandemic both improved *and* restricted health care access, Campagna explains. “Some people who couldn’t comprehend these new modalities went without needed health care.” Despite the pandemic-driven uptake in the use of telehealth platforms and applications, or “apps,” many patients still struggle.

Yet those who struggle the most with telehealth may be the ones with the most to gain. Think about an elderly woman who doesn’t drive—being

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Barriers for at-risk populations



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able to connect with her doctor and case manager from her home could keep her healthier longer. So how can case managers help these clients overcome the barriers to virtual care? By doing what they do best: Advocating for and supporting clients.

Casey Pierce, PhD, assistant professor at the University of Michigan School of Information, has

developed a simple framework that can help case managers best meet clients' needs: people, place and technology—in that order.

Consider Clients First

Technology designers build in features that might be useful to most users, but not to the technology neophyte. Pierce points to the drop-down option menu on web browsers or certain apps. It might be second nature to most of us to click on the three horizontal lines to see more options, but it's certainly not intuitive or obvious to the first-time user. Case managers need to remember that what's familiar to them may be totally foreign to clients who are not tech savvy.

A client's attitude toward technology plays a significant role, too. We

all have different mental models and technology frames that influence how we think about the devices that we use, Dr. Pierce explains. "How we come to understand technology is shaped by our understanding of the world." For example, if your client believes technology is always surveilling them, they might be skeptical of

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using telehealth at all. On the other hand, those who enjoy using technology to be more socially connected might be very receptive.

Another consideration is the digital divide. Does your client even have adequate broadband access—either at home or at a safe nearby location?

The digital divide isn't merely determined by access to the internet: Age, educational background, socioeconomic status, etc., all make a difference. Research consistently reveals that people who are older, of lower socioeconomic status and have less education use technology less frequently. Consider some 2021 findings from the [Pew Research Center](#):

- **A quarter of adults ages 65 and older report never going online, compared with much fewer numbers of adults under the age of 65.**
- **Adults living in households earning less than \$30,000 a year are far more likely than those whose annual household income is \$75,000 or more to report not using the internet (14% vs. 1%).**

This is not to say these people cannot learn a new technology, Pierce says. "The point is that it's important to consider the learning curve to become proficient using a technology."

When working with less tech-savvy clients, find out what their preferences are for a telehealth visit.

Do they want to connect from the desktop? From their mobile phone? Maybe they want to use a landline phone.

Next, how will they access the visit? For most clients, sending a link to click for a virtual visit won't be a problem. But for others, it can be a heavy lift. If this is the first time that they've ever received an invitation to sign up for a telehealth consult, it might take extra time for them just to log on, set up the account, complete the two-factor verification, etc.—all before they even see the provider.

Even the most experienced online denizen sometimes gets locked out because of password issues. Consider how much more frustrating that would be for someone who doesn't spend much time online.

When they are ready for the remote visit, do they have someone in their care network to help them setup and troubleshoot before or during the appointment? "Understanding care networks is important for technology access. And caregivers can have an important influence on how at-risk populations access telehealth," Pierce says.

Many caregivers can help the client connect, but not all are equipped to do so. "Not everyone has what I call an 'IT help desk member' in their family or in their circle of friends," Pierce says. Even if caregivers do have the skills, they aren't necessarily available on demand. When advising clients on scheduling a telehealth appointment, consider when they

will have someone nearby to help with the setup.

Place: Location matters

Telehealth changes the physical boundaries of where one can access care. This proved incredibly useful during the pandemic, but as Campagna noted earlier, it ended up being a barrier to care for many.

Key considerations are infrastructure and resources. And again, lack of adequate, equitable broadband access can make connection difficult. Even if your client does have a broadband connection, will they feel safe discussing health information openly? Even if the living situation is safe, it may not be private. Who will be within earshot? And keep in mind that your client may be sharing devices and computers.

Many community centers and libraries can help people access telehealth, and some of these social interactions can also be beneficial in other ways. (See sidebar on next page for an example of a senior center.) But these venues can raise privacy concerns as well.

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Meeting elders where they are: Pre-pandemic telehealth implementation at a community senior center

Pierce's research team at the University of Michigan collaborated with a senior community center in rural southeast Michigan to provide access to telehealth. The center had roughly 1,000 members, some as young as 50.

The center offers social support, classes, clubs, on-site meals and various other activities and services for older adults, notably, broadband access. Since most members had limited or no broadband access at home, the community center became a place where the members could connect to broadband—even if it meant accessing Wi-Fi from the parking lot.

Through a partnership with Meals on Wheels, the center provided meals to those who couldn't make it to the center. Pierce and her research team suggested that this connection could be helpful in supporting a future telehealth implementation at the center, especially for homebound seniors.

In terms of proficiency and familiarity with technology and their willingness to try telehealth, the membership varied widely. However, the center offered an array of different computer tech classes, and members always had someone to turn to when they struggled with their phones, computers, etc. The fact the center's staff was equipped to help members access telehealth services made implementation much easier. And there was another advantage: Because this center was in a former elementary school, it could provide dedicated rooms for the encounters.

Again, people and place dictated technology. And Pierce and her team recognized that the community center setting allowed

for both a high-tech and high-touch approach; the telehealth implementation aligned with the social supports already in place.

As part of the high-tech/high-touch focus, she and her team proposed using voice-based technologies such as Google, Alexa or Siri for those who had difficulty using screens. These wouldn't be used for remote visits, but it could help those who were homebound to have "something that they could connect with and could communicate with." However, voice assistants respond by pulling information from reputable health websites—not by answering an individual's specific health questions. As a result, she points out, users should be made aware that the device's information may be inaccurate or incomplete in terms of their own personal situation.

Through a partnership with Meals on Wheels, the center provided meals to those who couldn't make it to the center. Pierce and her research team suggested that this connection could be helpful in supporting a future telehealth implementation at the center, especially for homebound seniors. For example, Meals on Wheels volunteers who delivered meals to seniors' homes could also do social check-ins—not only for a senior's wellness status, but also for technology troubleshooting issues. This could include helping someone log into a telehealth appointment, letting the center know what devices or resources someone needs to access telehealth, or providing assistance arranging travel to the center for their telehealth appointments.

Supporting older adults as they age in place requires moving sites of care beyond the clinic walls. However, merely offering telehealth isn't enough. This example illustrates how community centers provide the opportunity to bring together high-tech and high-touch services that make telehealth a viable option. Moreover, telehealth services may be less daunting when they are part of a senior's larger social environment—whether in the center itself or through a trusted Meals on Wheels volunteer. ■

If your client needs to leave home for a telehealth visit, will they need to access via public Wi-Fi? If so, do they *fully* understand how to keep their information safe? That can include looking for “https” at the beginning of the web address on every page of a website and logging out from each account. If they are using a public computer, can they protect their information? Do they know how to fully log out—and delete all cookies and trackers—when they’ve finished the visit? The same applies if they are sharing devices with family members or friends.

Taking everything into consideration, you and your client might decide that the best option is an in-person visit. Technology isn’t always the solution.

Technology should never be the driver

Pierce is adamant on this point: Align the technology with the social factors (people and place), not the other way around. “We cannot fully leverage the benefits of any technology, let alone telehealth, without aligning it with these social factors.”

Too often, she says, we fall into this technology-solution mindset, thinking that if we only had a particular technology, it would make us more efficient, it would fix our problems, etc. “We think that if we have access to X technology, it will lead to Y outcome. So, with telehealth we think, ‘oh, if everyone has access to telehealth, everyone then will have access to equitable care.’” But that’s not the case.

Moreover, not all clients benefit from the same approach. For example, we know that some older adults have visual impairments or dexterity issues that might rule out using a mouse or keyboard. It might be easier to tap on a tablet screen. In fact, tablets have been shown to be quite useful for accessing technology services for older adults.

Mobile smartphones might seem like a good default option, but the screen size can be limiting. For many people, a larger computer screen would be most appropriate. For other clients, the most basic telehealth offering—a phone call—may be the best option. Start with the simplest option first—not the one with all the bells and whistles.

A final consideration is the continuum of care. Does the telehealth option support coordinated care across different providers? This relates to the platform, not the

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device. Direct-to-consumer options are far less likely to provide continuity of care than are hospital- and practice-based telehealth services.

Meeting clients where they are

The beauty of telehealth is that it can meet people where they are—typically, in their home. But “where your clients are” encompasses so much more than location.

Telehealth can increase access to care for your most vulnerable clients, helping them achieve optimal health, says Campagna. It’s an increasingly essential tool, but not everyone is able to use it well. “It is incumbent upon us as case managers to help our clients overcome the barriers to telehealth, ensuring they have equitable access to care wherever they are.” ■

About the Experts



Casey Pierce, PhD
Assistant Professor
University of Michigan, School of Information

Dr. Casey Pierce is an assistant professor at the University of Michigan School of Information (UMSI). Her research focuses on the changing nature of work as it relates to technology, policy and knowledge sharing in organizations.

Currently, Dr. Pierce is studying how telehealth platforms and policies impact clinicians' work practices and professional identities. This research addresses implications concerning how digital platforms shape new models of patient care and the rise of contingent work arrangements in the health care industry.

Dr. Pierce earned her Ph.D. in media, technology, and society program at Northwestern University School of Communication. She also received her B.A. and M.A. from the University of Southern California.



Vivian Campagna, DNP, RN-BC, CCM
Chief Industry Relations Officer
Commission for Case Manager Certification

Vivian Campagna works with individuals and organizations interested in certification (CCM®/CDMS®), related products and services through the Commission's broader marketing and promotions efforts. She fosters strategic partnerships and alliances and provides insight and guidance related to industry trends and developments. Campagna has been involved in case management for more than twenty-five years. She has held staff and administrative positions on both the independent and acute care side of the industry. She has published articles on case management topics and is a frequent presenter and educator. She was a founding member of the Long Island chapter of CMSA and served on the board and the conference committee of the NYC chapter of CMSA. Campagna was a member of the inaugural class of certified case managers and worked with CCMC as a volunteer for more than 10 years. She is a former Commissioner and past chair for the Commission. Campagna earned her nursing diploma from St. Clare's Hospital and Health Center School of Nursing, her bachelor's degree from CW Post Center of Long Island University, her master's degree in nursing from Seton Hall University and her DNP from American Sentinel University. She is certified in case management by both the Commission for Case Manager Certification and the American Nurses Credentialing Corporation.



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