

# **Assessing Patient Satisfaction with Telehealth at Community Health Centers:**

## **A Policy Brief**

**National Association of Community Health Centers**

## **Acknowledgements and Additional Information**

This report was written on behalf of the National Association of Community Health Centers (NACHC) by JSI Research & Training Institute, Inc. (JSI) staff, Erin Shigekawa, Anupam Sharma, and Alec McKinney. Quantitative design and analysis was provided by JSI staff, Marianne Mabida and Jide Bamishigbin Jr. Graphic design was provided by JSI staff, Faith Bouchard. Technical review was provided by NACHC staff, Amy Flowers and Gracy Trinoskey-Rice.

For additional resources from NACHC related to telehealth, please visit

<https://www.nachc.org/focus-areas/policy-matters/telehealth/>. Please contact Amy Flowers (Director, Policy Research) or Gracy Trinoskey-Rice, (Policy Research and Data Analyst) at NACHC with questions ([research@nachc.org](mailto:research@nachc.org)).

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## TABLE OF CONTENTS

<b>Executive Summary</b>	<b>2</b>
<b>Introduction</b>	<b>5</b>
<b>Telehealth Patient Experience Assessment</b>	<b>7</b>
<b>Methods And Data Limitations</b>	<b>7</b>
<b>Results</b>	<b>8</b>
<b>Policy And Practice Implications</b>	<b>18</b>
<b>Appendix: Methods</b>	<b>19</b>
<b>Appendix: Demographics Of The Sample</b>	<b>22</b>
<b>Appendix: Tables Describing The Assessment Sample And Results By Demographic Characteristics</b>	<b>24</b>

## EXECUTIVE SUMMARY

Community Health Centers provide quality, affordable primary and preventive health care to over 30 million patients in underserved communities. Health centers are the backbone of the primary care safety net, expanding access to care for millions of patients who face barriers to accessing care from private practices.

The essential role of health centers became even more clear during the COVID-19 pandemic, when health centers rapidly innovated to expand access to COVID-19 interventions while maintaining primary care services and minimizing the risk of COVID-19 infection among patients and staff.

During the COVID-19 pandemic, health centers quickly adopted telehealth modalities to ensure continuation of care for existing patients and to meet the growing demand for COVID-19 interventions and behavioral health services. Telehealth utilization among health centers increased from 43% in 2019 to 99.3% in 2021, and health centers provided 26 million visits via telehealth in 2021 alone.

State and federal policy makers eased telehealth restrictions to support access to care during the COVID-19 public health emergency (PHE). As the nation recovers from the pandemic and navigates the end of the PHE, policy makers are taking steps to extend some COVID-era flexibilities, for example, with regards to audio-only telehealth and reimbursement methods.

As lawmakers consider the future of telehealth policy, there is a growing need to understand the value and efficacy of telehealth as a tool to deliver quality care and expand access to patients who face barriers to accessing in-person services. Research on clinical quality,

effectiveness, and patient satisfaction regarding telehealth is evolving, but remains limited.

This brief describes findings from a national assessment of health center patients' experiences with telehealth and the policy implications of these findings. The national assessment, conducted by John Snow, Inc. (JSI) and the National Association of Community Health Centers (NACHC), focused on three key aspects of telehealth services:

### The assessment focused on three aspects of telehealth experience:

- Ease of use (e.g., saved travel time, supports access to needed health care)
- Interaction with clinician (e.g., communication with their provider), and
- Overall comfort/satisfaction.

Assessment results include responses from 1,764 community health center patients who received telehealth services within the last 6 months prior to the assessment period. Respondents include patients of varying demographic characteristics, languages spoken, and health insurance status.

## Key Findings:

**9 of 10 health center patients are satisfied with telehealth care overall, especially related to ease of use and interactions with their providers.**

- **Ease of use:** 92% of respondents agree that telehealth helps them get access to needed services, and 93% of respondents agree that telehealth saves them time traveling to a hospital or clinic.
- **Clinician interaction:** 90% of respondents agree that they can easily and effectively communicate with their provider during telehealth visits, and 75% agree that the care received via telehealth is as good as in-person care.
- **Overall satisfaction:** 90% of patients agree that they are comfortable and satisfied with telehealth and would use telehealth to get care again.

**Audio-only visits accounted for the greatest portion of telehealth visits** during the study period. **Half** of respondents had at least one audio/telephone appointment, **one-third** had at least one video appointment, and **13.5%** had both video and audio appointments.

Most telehealth visits were for primary care (56.6%), followed by behavioral health (26.0%), then medical specialty (5.9%) and ‘other’ services (7.0%).

**Patient satisfaction varied by demographic characteristics** in some cases.

- **Age:** In general, older adults reported positive experiences with telehealth. However, older adults reported lower ratings of telehealth overall compared to younger respondents across all major categories. Adults 70 years or older had

more audio-only visits (82.7%) compared to the overall sample (50.1%). Audio-only telehealth may reduce some barriers for older adults as it does not require a smart device, webcam, or internet connection.

- **Race and ethnicity:** Black/African American respondents reported significantly higher levels of satisfaction with all three aspects of telehealth encounters relative to white, Hispanic, Asian, and multiracial respondents. No significant differences were observed for Asian and Hispanic patients relative to white patients.
- **Language:** Respondents who spoke primarily English at home reported slightly higher levels of satisfaction in the domains of clinician interaction and overall comfort with telehealth. When asked to reflect on the statement “I can easily talk to the doctor during my telehealth visit(s)”, 90.5% of English-only respondents agreed or strongly agreed compared to 77.1% for all respondents who spoke languages other than English.
- **Gender identity:** Women rated telehealth more favorably than men across every question in all three domains of telehealth, including ease of use, interaction with clinician, and overall comfort/satisfaction. In some cases, transgender individuals reported significantly higher telehealth satisfaction than cisgender respondents.
- **Self-reported disability status:** When asked to consider whether telehealth saved time traveling to and from hospitals and clinics, 94.7% of respondents who identified as having a disability agreed or strongly agreed that telehealth saved travel time, compared to 93.1% of the overall sample.

## Conclusions and Recommendations:

**Health center patients report high satisfaction with audio and video telehealth** across categories including ease of use, interaction with clinician, and overall comfort/satisfaction. Patients utilized audio-only telehealth at high rates, underscoring that maintaining access to audio-only telehealth should be a priority. Additionally, 75% of patients agree that care received via telehealth is as good as in-person care, which complements growing evidence that providers believe telehealth allows them to provide quality care in most cases. This finding should be considered when determining reimbursement parity for telehealth services including audio-only telehealth.

**Respondents overwhelmingly agree that telehealth improves access**, though some populations may need additional support when accessing telehealth. User support may include strategies such as: making materials accessible in multiple languages, using images and words in online communications, providing digital navigators, using assistive devices, training providers on cultural competency, and using speech recognition technologies designed with equity in mind.

**Telehealth could be a tool to narrow disparities in access to care** if implemented with an equity lens and an understanding that one size does not fit all. Women, transgender, and Black Americans all reported high satisfaction with telehealth compared to their peers. Some barriers to accessing care faced by these populations may be alleviated by access to telehealth.

9 out of 10 respondents utilizing telehealth for a behavioral health visit reported high satisfaction, supporting existing evidence that **telehealth is a promising tool for meeting the growing demand for behavioral health care**.

**Telehealth has become a vital part of serving health center patients.** As the policy, reimbursement, and care delivery landscapes continue to evolve post-PHE, this assessment raises important considerations for telehealth policy and its impact on health center patients.

## INTRODUCTION

Federally-qualified health centers (FQHCs), also called Community Health Centers, provide quality, affordable primary and preventive health care to over 30 million patients in underserved communities. Health centers care for all patients regardless of income or insurance status and rely on federal grant funding to provide services to uninsured and low-income patients on a sliding-fee scale. Community Health Centers are the backbone of the primary care safety net, expanding access for millions of patients who face barriers to accessing care from private practices due to location, insurance status, income, or other circumstances.

During the COVID-19 pandemic, health centers rapidly adopted and dramatically increased their use of telehealth to maintain access and meet the needs of their patients. With limited resources and myriad challenges, health centers adeptly innovated to make telehealth services accessible.<sup>1,2</sup>

State and federal policy makers enacted telehealth flexibilities to support access to care during the public health emergency (for example, relaxing requirements for establishing a new patient via telehealth and “originating site” requirements).<sup>3,4</sup> Many of these flexibilities made telehealth a more feasible option for health centers; prior to the pandemic, 43% of health centers used telehealth and after the pandemic began, 99.3% of health centers were using telehealth.<sup>5</sup> From 2019 to 2021, telehealth visits jumped from less than 1% of total health center visits to 21% of total visits (26 million visits).<sup>6</sup>

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<sup>1</sup> Uscher-Pines, L., Arora, N., Jones, M., Lee, A., Sousa, J.L., McCullough, C.M., Lee, S.D., Martineau, M., Predmore, Z., Whaley, C.M., and Ober, A.J., (2022). Experiences of Health Centers in Implementing Telehealth Visits for Underserved Patients During the COVID-19 Pandemic: Results from the Connected Care Accelerator Initiative. Santa Monica, CA: RAND Corporation. [https://www.rand.org/pubs/research\\_reports/RRA1840-1.html](https://www.rand.org/pubs/research_reports/RRA1840-1.html).

<sup>2</sup> Cooper, A. Virtual Care Innovation Across Community Health Centers, *Community Health Center Network*, <https://chcnetwork.org/stories/virtual-care-innovation-across-community-health-centers/>

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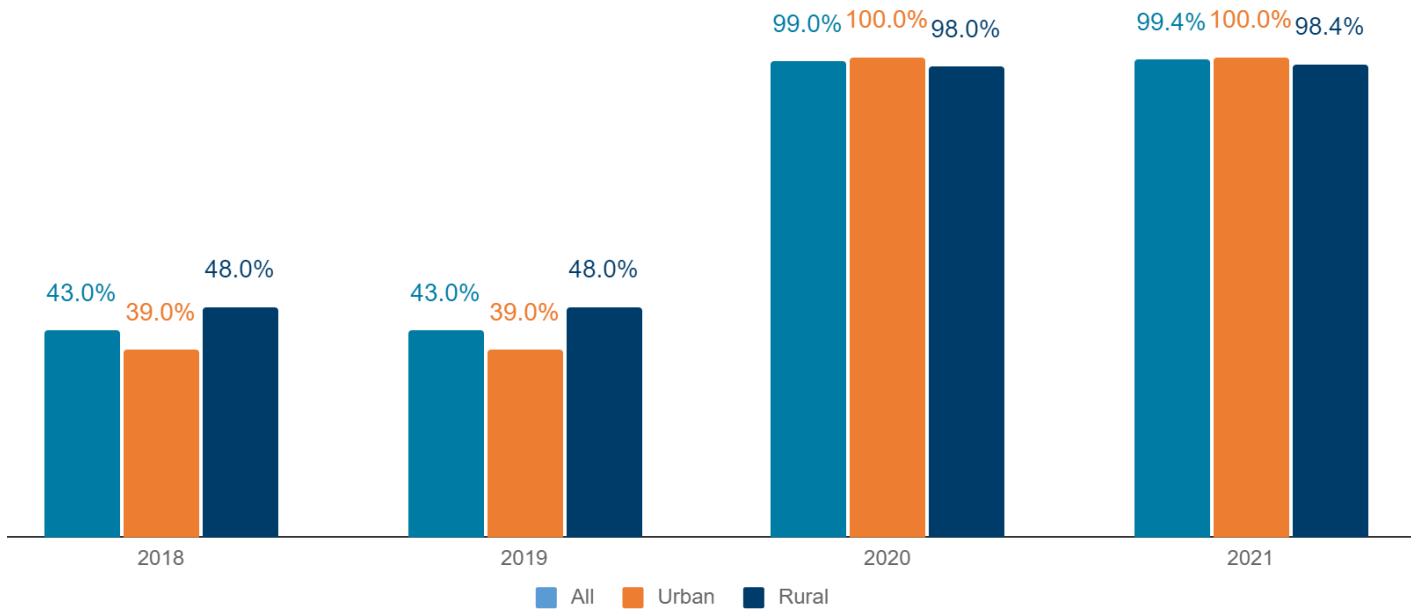
<sup>3</sup> Telehealth policy changes after the COVID-19 public health emergency. *HRSA*. <https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/policy-changes-after-the-covid-19-public-health-emergency/>

<sup>4</sup> Updates to Originating Site, (2023), *Center for Connected Health Policy*. <https://www.cchpca.org/topic/originating-site/#:~:text=Originating%20site%20refers%20to%20the,the%20home%20and%20other%20locations.>

<sup>5</sup> Telehealth During COVID-19 Ensured Patients Were Not Left Behind. *NACHC*. <https://www.nachc.org/wp-content/uploads/2021/07/Audio-Only-Report-Final.pdf>

<sup>6</sup> Sharac, J., Corallo, B., Tolbert, J., and Rosenbaum, S. (2022). Changes in Community Health Center Patients and Services During the COVID-19 Pandemic, *KFF*. <https://www.kff.org/medicaid/issue-brief/changes-in-community-health-center-patients-and-services-during-the-covid-19-pandemic/>

Figure 1: Percent of Health Centers Offering Telehealth Services by Location, 2018-2021.



Source: Community Health Center Chartbook, 2023. National Association of Community Health Centers.

Most states have now ended their public health emergency declarations. Many telehealth visits have transitioned back to in-person care, with the exception that some studies have found that audio-only visits have persisted, particularly for primary care medical services.<sup>7 8</sup> Despite this shift, research shows high levels of patient satisfaction with telehealth, which offers a vital option for health care practices and patients.

<sup>7</sup> Shah, S.D., Alkureishi, L., Lee, W.W., (2021). Seizing The Moment For Telehealth Policy And Equity, *Health Affairs*, DOI:10.1377/hblog20210909.961330

<sup>8</sup>Uscher-Pines, L., Arora, N., Jones, M., Lee, A., Sousa, J.L., McCullough, C.M., Lee, S.D.,Martineau, M., Predmore, Z., Whaley, C.M., and Ober, A.J.,(2022). Experiences of Health Centers in Implementing Telehealth Visits for Underserved Patients During the COVID-19 Pandemic: Results from the Connected Care Accelerator Initiative. Santa Monica, CA: RAND Corporation. [https://www.rand.org/pubs/research\\_reports/RRA1840-1.html](https://www.rand.org/pubs/research_reports/RRA1840-1.html).

Multiple reports, including this assessment, show that telehealth can reduce many common barriers to care for patients and can also address workforce challenges for providers.

Many states are taking steps to make some COVID-era telehealth policy and reimbursement flexibilities permanent (e.g., permanently easing restrictions on audio-only telehealth). Telehealth will never completely replace in-person care, but it is an important part of health centers’ ability to meet patients’ needs and ensure timely, accessible, high quality, patient-centered, and equitable care.

Research regarding the provision of telehealth is continuously evolving, including research related to clinical quality, effectiveness, patient access and satisfaction, health equity, and provider



experience. In health center settings specifically, there is limited information on patient satisfaction and how patients view telehealth compared to in-person care. Research considering disparities in access to telehealth services is also limited. There is some evidence indicating that marginalized populations can face barriers to telehealth access due to factors such as limited internet access, lack of video-enabled technology, and unstable housing or lack of a private space to participate in virtual visits. These barriers must be addressed to maximize the benefit of telehealth for all populations.<sup>9</sup>

This brief describes a national assessment of health center patients' recent telehealth experiences. JSI Research & Training Institute, Inc. (JSI), in partnership with the National Association of Community Health Centers (NACHC), fielded this assessment from September 2022 to January 2023.

This brief describes assessment results and recommends policy and operational actions to promote equity in access to care and improved patient experience.

## **TELEHEALTH PATIENT EXPERIENCE ASSESSMENT**

The telehealth patient experience assessment was developed based on existing telehealth research and surveys, reviewed by telehealth content experts, and administered as an online assessment for US health center patients. Participants were health center patients in the US (states, District of Columbia, and territories) who received telehealth services within the last six

months. The assessment included a section on recent telehealth history (i.e., whether the individual had a video or audio telehealth appointment in the last six months) and the type of care received via telehealth (e.g., primary care, behavioral health, etc.). The assessment focused on telehealth experience, split into three subsections: ease of use, interaction with clinician, and overall comfort/satisfaction. Respondents were then asked to share information about themselves, such as age, race, ethnicity, language, gender identity, sexual orientation, and insurance status. All demographic questions were optional. Ultimately, 1,764 individuals responded to the assessment. For more information about the methods of this assessment, see the Appendix.

## **METHODS AND DATA LIMITATIONS**

The fielding of the survey took place from September 2022 through January 2023. NACHC and JSI pursued multiple avenues of dissemination, including email blasts to all FQHCs, survey promotion at stranding technical assistance webinars hosted by NACHC, periodic information sessions for health centers interested in participating, and pre-written dissemination tools that were made available to health centers willing to survey their patients. JSI developed a website for this project and directed health centers interested in participating to the website for further information and guidance on how to administer the survey. To support accessibility, the assessment tool and the dissemination materials were made available to patients in English and seven additional languages, including Arabic, Chinese (simplified characters), Haitian-Creole, Korean, Russian,

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<sup>9</sup>Health equity in telehealth, HRSA, <https://telehealth.hhs.gov/providers/health-equity-in-telehealth>

Spanish, and Vietnamese. Once data collection was complete, the dataset was cleaned and weighted using an iterative proportional fitting (raking) technique to ensure that the data were representative of health center patients nationally.

This assessment has various limitations. First, the sample is heavily concentrated in certain states where there were more respondents (like California). Secondly, the sample is limited in various characteristics, such as rural status or languages other than English or Spanish. The weighting methodology referenced above was designed to address these sampling biases and make the sample mirror national populations. Lastly, this was an online assessment; an online assessment may not reach individuals who generally have difficulties with technology; individuals in this group are also likely to have more difficulty accessing telehealth.

For more information about the methods of this assessment, see the Appendix.

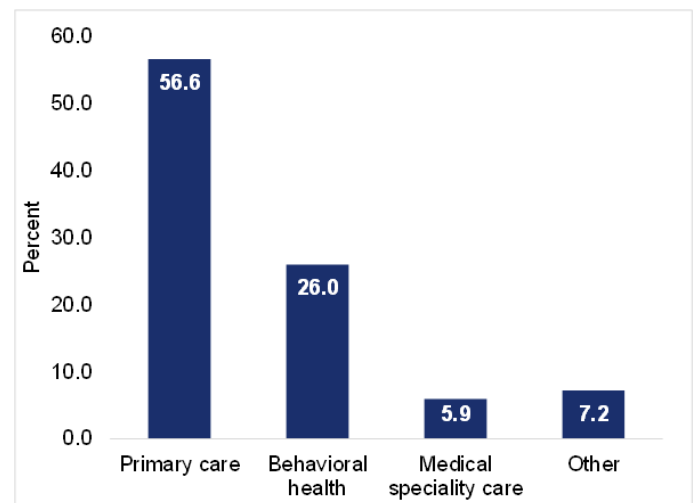
## RESULTS

### Telehealth Utilization

About half of respondents (50.1%) had one or more audio/telephone appointments in the six months prior to the assessment, over one-third (36.4%) had one or more video appointments, and 13.5% had both video and audio appointments. This distribution by appointment type is aligned with other research on telehealth visits among health center patients during the pandemic; one California study conducted during the pandemic found that audio-only visits

accounted for the greatest volume of telehealth visits for both primary care and behavioral health.<sup>10</sup> Respondents used telehealth services to address a broad array of health and wellbeing needs, illustrated in Figure 2. Among the 1,764 assessment respondents, 56.6% used telehealth for primary care and 26.0% used telehealth for behavioral health. The remainder used telehealth for medical specialty care (5.9%), and “other” services (7.0%).

Figure 2. Types of telehealth appointments among respondents.



Of respondents who reported a recent telehealth visit for primary care, 45.7% of those visits were via video and 67.0% via audio/phone.<sup>11</sup> One-quarter of respondents reported having had a telehealth appointment for behavioral health, with 65.7% via video and 52.5% via audio/phone. For medical specialty care, 5.9% of respondents reported having had an appointment, with

<sup>10</sup>Uscher-Pines, L., Arora, N., Jones, M., Lee, A., Sousa, J.L., McCullough, C.M., Lee, S.D., Martineau, M., Predmore, Z., Whaley, C.M., and Ober, A.J., (2022), Experiences of Health Centers in Implementing Telehealth Visits for Underserved Patients During the COVID-19 Pandemic: Results from the Connected Care Accelerator Initiative. Santa Monica, CA: RAND Corporation. [https://www.rand.org/pubs/research\\_reports/RRA1840-1.html](https://www.rand.org/pubs/research_reports/RRA1840-1.html).

<sup>11</sup> The total is greater than 100% because some patients had both video and audio appointments.

44.7% via video and 68.5% over audio/phone. These findings suggest that for primary care and medical specialty care, respondents were more likely to have audio/phone appointments compared to video appointments, and for behavioral health, respondents were more likely to have a video appointment than an audio/phone appointment.

### **Telehealth Satisfaction**

Overall, respondents shared a positive view of telehealth. Almost 9 of 10 respondents agreed or strongly agreed that telehealth addressed their needs, was suitable for interaction with their clinician, and that they were generally comfortable and satisfied with care via telehealth.

Respondents rated telehealth most highly in the 'ease of use' category, especially related to saved time traveling to a hospital or clinic (93.1% agreed or strongly agreed) and getting access to needed services (92.0% agreed or strongly agreed) (see Table 1).

In the lowest rated statement, 8.8% of respondents disagreed or strongly disagreed that the care they receive via telehealth is as good as the care they receive in-person (see Table 1). Still, 75.9% agreed or strongly agreed that the care received over telehealth is as good as care received at in-person visits.

Table 1. Telehealth experience in three categories: ease of use, interaction with clinician, and overall comfort / satisfaction.

Telehealth Experience	Agree & strongly agree (Weighted %)	Neither agree nor disagree (Weighted %)	Disagree & strongly disagree (Weighted %)
<b>Telehealth Domain: Ease of Use</b>			
Telehealth helps me get access to healthcare services I need	92.0	4.7	3.4
Telehealth saves me time traveling to a hospital or clinic	93.1	4.4	2.4
Telehealth addresses my healthcare needs	89.4	6.2	4.3
<b>Telehealth Domain: Interaction with Clinician</b>			
I can easily talk to the doctor during my telehealth visit(s)	89.4	5.7	4.9
I can express myself effectively during my telehealth visit(s)	89.9	4.8	5.2
My doctor is able to understand my health condition during my telehealth visits	88.5	6.5	5.0
The care I get over telehealth is as good as the care I get at in-person visits	75.9	15.3	8.8
<b>Telehealth Domain: Overall Comfort / Satisfaction</b>			
I feel comfortable communicating with the doctor using telehealth	88.6	7.3	4.1
I would use telehealth to get care again	87.5	7.5	5.0
Overall, I am satisfied with telehealth	87.7	7.7	4.6

Note: The data in the table above and cited throughout this policy brief reflects the assessment's weighted results, which helps to refine the analysis, and ensure that the analytic findings are representative of health center patients nationally.

## Age and Telehealth Experience

In general, older adults in this assessment report a positive experience with telehealth. However, consistent with the peer reviewed literature, older adult respondents reported lower overall ratings of telehealth experience compared to younger respondents. Respondents 70 years old or older were more likely to signal some dissatisfaction with their telehealth experience in all categories (ease of use, interaction with clinician, overall comfort/satisfaction) compared to younger age groups. For example, 82.2% of respondents 70 years old or older agreed or strongly agreed that they are satisfied with telehealth overall, compared to 87.7% of the general sample.

When asked to respond to the statement, “The care I get over telehealth is as good as the care I get at in-person visits,” 71.3% of respondents 70 or older agreed or strongly agreed; slightly lower than the 75.8% of the overall sample. Similarly, 83.1% of respondents 70 years or older agreed or strongly agreed that they would use telehealth to get care again compared to 87.5% of the overall sample.

That older individuals would rate telehealth less favorably is not surprising given the ample literature about barriers, challenges, and needed support among older populations when using telehealth. Existing research suggests that, in comparison to younger adults, older adults are less satisfied with telehealth services,<sup>12</sup> less likely

<sup>12</sup> Phenicie, R., Acosta Wright, R., & Holzberg, J. (2021). Patient satisfaction with telehealth during COVID-19: experience in a rural county on the United States–Mexico border. *Telemedicine and e-Health*, 27(8), 859-865.

to use telehealth,<sup>13,14,15</sup> and have more challenges with telehealth.<sup>16</sup>

Research shows that there is a difference in satisfaction between video visits and phone visits with older adults finding phone visits to be more accessible.

Assessment results showed that older respondents were significantly more likely to have had an audio appointment compared to a video appointment:

Table 2. Type of telehealth appointment by age.

	% of participants who had...	
	At least one audio appt.	At least one video appt.
Ages 40-54	69.6	44.4
Ages 55-69	65.8	42.7
Ages 70+	82.7	45.5

This pattern could be due to the relative ease of phone (or audio-only) visits compared to video visits, as phone is a more accessible modality compared to video, which requires an internet connection, a smart device or computer, and the ability to navigate video visit platforms.

<sup>13</sup> Jewett, P. I., Vogel, R. I., Ghebre, R., Hui, J. Y., Parsons, H. M., Rao, A., ... & Blaes, A. H. (2022). Telehealth in cancer care during COVID-19: disparities by age, race/ethnicity, and residential status. *Journal of Cancer Survivorship*, 16(1), 44-51.

<sup>14</sup> Kochar, B., Ufere, N. N., Nipp, R., Gustafson, J. L., Carolan, P., & Ritchie, C. S. (2021). Video-based telehealth visits decrease with increasing age. *The American Journal of Gastroenterology*.

<sup>15</sup> Wegermann, K., Wilder, J. M., Parish, A., Niedzwiecki, D., Gellad, Z. F., Muir, A. J., & Patel, Y. A. (2021). Racial and socioeconomic disparities in utilization of telehealth in patients with liver disease during COVID-19. *Digestive diseases and sciences*, 1-7.

<sup>16</sup> Magnus, M., Sikka, N., Cherian, T., & Lew, S. Q. (2017). Satisfaction and improvements in peritoneal dialysis outcomes associated with telehealth. *Applied Clinical Informatics*, 26(01), 214-225.

## Race And Ethnicity

Black/African American respondents reported significantly higher levels of satisfaction with all aspects of telehealth encounters (ease of use, interaction with clinician, and overall comfort/satisfaction) relative to white, Hispanic, Asian, and multiracial respondents. When asked about telehealth's ease of use, for example, 93.0% of Black/African American respondents reported agreeing or strongly agreeing with the statement "telehealth addresses my healthcare needs" compared to 89.4% of all respondents.

This finding complements existing literature suggesting that Black/African American patients are more likely to use telehealth than their white counterparts.<sup>17</sup>

For Asian and Hispanic patients, no meaningful differences in satisfaction and likelihood of use were observed relative to white patients. Literature on the subject offers unclear and sometimes conflicting results. Some studies suggest that Hispanic and Asian patients are also more likely to use telehealth than white patients. Other studies, meanwhile, report the opposite trend for Asian, Native Hawaiian, and Pacific Islander individuals.<sup>18,19</sup>

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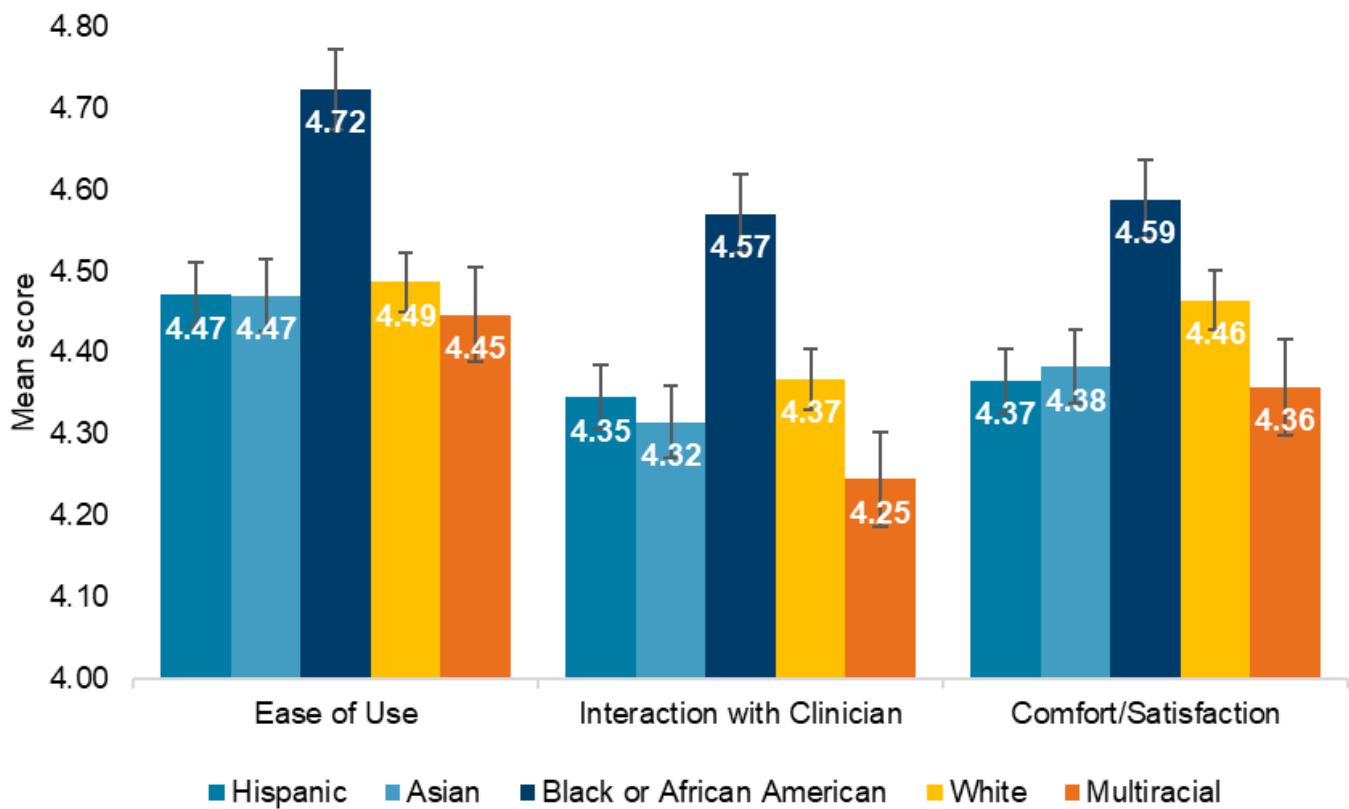
<sup>17</sup> Chen, K., Lodaria, K., & Jackson, H. B. (2022). Patient satisfaction with telehealth versus in-person visits during COVID-19 at a large, public healthcare system. *Journal of Evaluation in Clinical Practice*, 28(6), 986-990.

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<sup>18</sup> Campos-Castillo C, Anthony D. (2021). Racial and ethnic differences in self-reported telehealth use during the COVID-19 pandemic: a secondary analysis of a US survey of internet users from late March. *Journal of the Medical Informatics Association*, 28(1), 119-125.

<sup>19</sup> Meno, M., Abe, J., Fukui, J., Braun-Inglis, C., Pagano, I., & Acoba, J. (2021). Telehealth amid the COVID-19 pandemic: perception among Asian, Native Hawaiian and Pacific Islander cancer patients. *Future Oncology*, 17(23), 3077-3085.

Figure 3: Overall telehealth domain scores by race and ethnicity.



Note: Mean scores represent responses to a Likert Scale question where 5 indicates strongly agree, 4 agree, 3 neither agree nor disagree, 2 disagree, and 1 strongly disagree with a positive statement about telehealth. Higher scores indicate a higher rating of telehealth.

### Language

Individuals who completed the assessment were asked to report what primary language they spoke at home. Options included English, Arabic, Cantonese, Mandarin, French, Haitian Creole, Japanese, Portuguese, Spanish, Tagalog, Vietnamese, other, and prefer not to answer.

While over ten languages were represented in our sample, many of the non-English languages were not well represented; 6 of the 11 languages had 3 or fewer respondents. Accordingly, the analysis grouped respondents into English and non-English respondent categories.

Respondents who spoke primarily English at home reported slightly higher levels of satisfaction in the domains of clinician interaction and overall comfort with telehealth compared to respondents who primarily spoke a language other than English. No significant differences were observed in response to questions considering ease of use for telehealth appointments.

When asked to reflect on the statement “I can easily talk to the doctor during my telehealth visit(s)”, 90.5% of English-only respondents agreed or strongly agreed compared to an average of 77.1% for all respondents who spoke languages other than English. Similar differences were observed between these groups in the statements “I feel comfortable communicating with the doctor using telehealth” and “I would use telehealth to get care again.” These differences align with previous studies that suggest that individuals who primarily speak languages other than English were less satisfied with

telehealth.<sup>20,21</sup> It is worth noting that the literature on clinical visit satisfaction among patients with limited English proficiency (LEP) is mixed, irrespective of visit type (in-person or virtual). Some studies have identified relatively high patient satisfaction in spaces with little to no access to interpretation services. Other studies have found LEP patients to have a lower satisfaction rate compared to patients who speak English only.<sup>22,23</sup>

The observed differences between English-only and other language speakers in this assessment and in prior research suggest a possible lack of resources to adequately support telehealth use by LEP patients and individuals who primarily speak languages other than English. Patients who primarily speak a language other than English may benefit from resources to support communication during their visit, including interpreters, translators, and multilingual patient information guides.

Research on the effectiveness of telehealth visits that accommodate LEP patients in FQHCs through multilingual clinical care staff and audio-only visits have demonstrated a positive impact on accessibility and patient experience.

Accessibility is improved when patients receive guidance in their primary language to navigate technological hurdles when setting up telehealth appointments, and the clinical care experience is improved because patients receive both language-specific and culturally appropriate care.<sup>24</sup> These interventions have the potential to increase both video and audio-only telehealth visit satisfaction and close the satisfaction/comfort gap observed in this assessment.

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<sup>20</sup> Rodriguez, J. A., Saadi, A., Schwamm, L. H., Bates, D. W., & Samal, L. (2021). Disparities In Telehealth Use Among California Patients With Limited English Proficiency: Study examines disparities in telehealth use among California patients with limited English proficiency. *Health Affairs*, 40(3), 487-495.

<sup>21</sup> Cockrell, H., Wayne, D., Wandell, G., Wang, X., Greenberg, S. L., Kieran, K., Bonilla-Velez, J. (2022). Understanding hispanic patient satisfaction with telehealth during COVID-19. *Journal of Pediatric Surgery*.

<sup>22</sup> Soh, H., Rohlfing, M.L., Keefe, K.R., Valentine, A.D., Noordzij, P.J., Brook, C.D., Levi, J. (2022). Interpreter Use and Patient Satisfaction in the Otolaryngology Outpatient Clinic. *Cureus*. May 9;14(5).

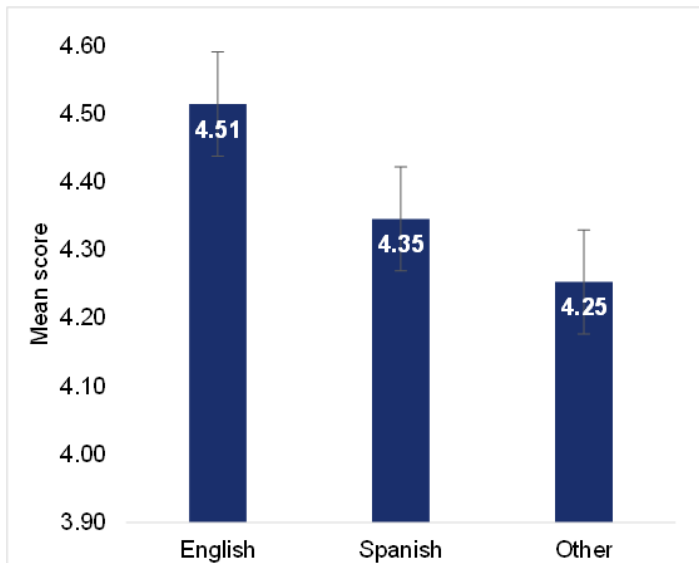
<sup>23</sup> Sanserino, K. A., Papatla, K., Aioub, M., Gee, T., Datwani, H. (2022). Quality of Care and Communication With Limited English Proficiency (LEP) Obstetric Patients. *Obstetrics & Gynecology* 135.

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<sup>24</sup> Payán, D. D., Frehn, J. L., Garcia, L., Tierney, A.A., Rodriguez, H.P. (2022). Telemedicine implementation and use in community health centers during COVID-19: Clinic personnel and patient perspectives. *SSM - Qualitative Research in Health*, 2(1).



Figure 4. Responses to the statement: “I feel comfortable communicating with the doctor using telehealth.”



Note: Mean scores represent responses to a Likert Scale question where 5 indicates strongly agree, 4 agree, 3 neither agree nor disagree, 2 disagree, and 1 strongly disagree with a positive statement about telehealth. Higher scores indicate a higher rating of telehealth.

## Sexual Orientation

Respondents were asked to select their sexual orientation from the options of asexual, bisexual or pansexual, gay or lesbian, straight or heterosexual, queer, questioning/unsure, a sexual orientation not listed or prefer not to answer. In most categories, straight and asexual respondents rated telehealth significantly more favorably than respondents who were bisexual, pansexual, gay, lesbian, queer, or questioning.

Gay and lesbian respondents responded less favorably across the domains of telehealth experience (ease of use, interaction with clinician, and overall comfort/satisfaction) compared to the overall sample and to straight or heterosexual respondents. For example, compared to straight or heterosexual respondents, gay or lesbian respondents were less likely to agree or strongly agree that telehealth saves them time traveling to a hospital or clinic (79.1% vs. 95.6%), less likely to agree that they can easily communicate to their doctor during their telehealth visits (78.4% vs. 90.0%), and less likely to agree that they are satisfied with telehealth overall (79.7% vs. 88.4%).

Research on lesbian, gay, and bisexual patient experiences with clinical care suggests that satisfaction rates are generally lower when compared to straight and heterosexual patients, irrespective of visit modality (telehealth or in-person). This study cannot conclude, then, that telehealth is necessarily a cause for lower visit satisfaction for LGB patients. Rather, dissatisfaction among lesbian, gay, and bisexual patients may be related to experiencing a lack of courtesy by healthcare staff and a tendency to be blamed for their health problems or otherwise have them dismissed.<sup>25,26 27</sup>

<sup>25</sup> Dawson, L., Frederiksen, B., Long, M., Ranji, U., & Kates, J. (2021). LGBT+ People's health and experiences accessing care. *KFF*. Retrieved March 15, 2023, from <https://www.kff.org/womens-health-policy/report/lgbt-peoples-health-and-experiences-accessing-care/>

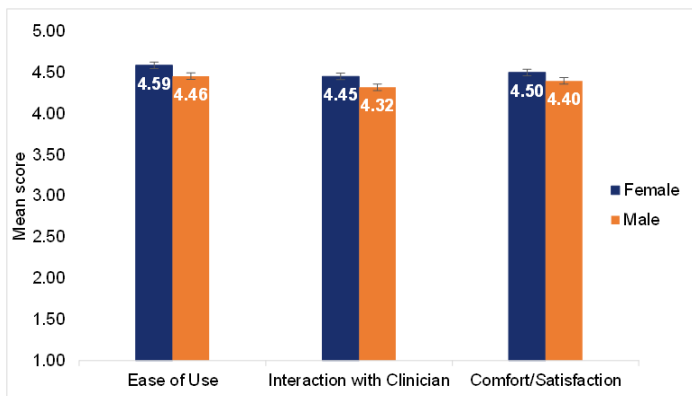
<sup>26</sup> Klotzbaugh, R., & Spencer, G. (2020). Lesbian, gay, bisexual, and Transgender Inpatient Satisfaction Survey: Results and implications. *Journal of patient experience*.

<sup>27</sup> For significance testing, certain sexual orientations were grouped together because of small sample sizes. Significance tests compared 1) asexual respondents with 2) bisexual, pansexual, gay or lesbian, queer, and questioning respondents, and 3) straight or heterosexual respondents.

## Gender Identity

Women rated telehealth more favorably than men across every question in all three domains of telehealth, including ease of use, interaction with clinician, and overall comfort/satisfaction (Figure 5). The differences were statistically significant across the board. This is aligned with other research which has found that women tend to be more satisfied by telehealth services than men.<sup>28,29</sup> Women may be juggling a disproportionate share of competing responsibilities, including work, child care, and other caregiving responsibilities which make in-person health care less convenient to access.<sup>30</sup>

Figure 5. Overall domain scores by male or female gender identity.

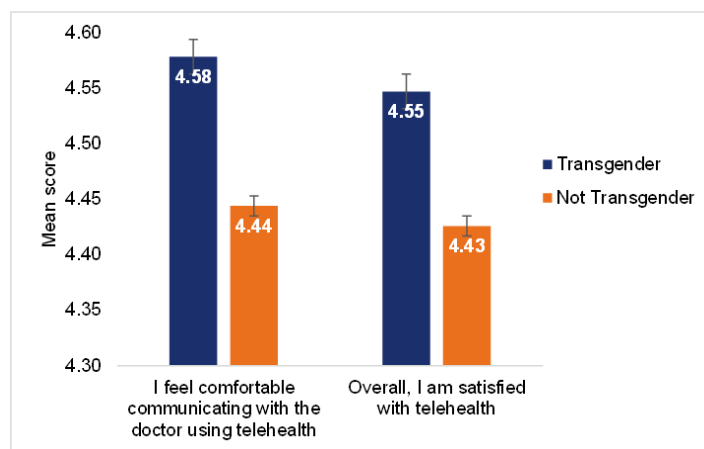


Note: Mean scores represent responses to a Likert Scale question where 5 indicates strongly agree, 4 agree, 3 neither agree nor disagree, 2 disagree,

and 1 strongly disagree with a positive statement about telehealth. Higher scores indicate a higher rating of telehealth.

Participants were asked whether they identify as transgender (meaning their gender identity is different from their gender assigned at birth). There were statistically significant differences between transgender and cisgender respondents in some cases (Figure 6). For example, 96.0% of transgender respondents agreed or strongly agreed that they feel comfortable communicating with their doctor using telehealth compared to 88.7% of cisgender respondents. Additionally, 94.2% of transgender respondents agreed or strongly agreed that they are satisfied with telehealth overall compared to 87.8% of cisgender respondents.

Figure 6. Telehealth mean scores by transgender identity.



Note: Mean scores represent responses to a Likert Scale question where 5 indicates strongly agree, 4 agree, 3 neither agree nor disagree, 2 disagree, and 1 strongly disagree with a positive statement about telehealth. Thus, higher scores indicate a higher rating of telehealth.

<sup>28</sup> Polinski, J. M., Barker, T., Gagliano, N., Sussman, A., Brennan, T. A., & Shrank, W. H. (2016). Patients' satisfaction with and preference for telehealth visits. *Journal of general internal medicine*, 31, 269-275.

<sup>29</sup> Cho, D., Khalil, S., Kamath, M., Wilhalme, H., Lewis, A., Moore, M., & Nsair, A. (2021). Evaluating factors of greater patient satisfaction with outpatient cardiology telehealth visits during the COVID-19 pandemic. *Cardiovascular digital health journal*, 2(6), 312-322.

<sup>30</sup> Polinski, J. M., Barker, T., Gagliano, N., Sussman, A., Brennan, T. A., & Shrank, W. H. (2016). Patients' satisfaction with and preference for telehealth visits. *Journal of general internal medicine*, 31, 269-275.

Limited research has examined telehealth satisfaction among transgender individuals. One study of 21 transgender and gender diverse youth and 38 caregivers found that 87% of youth and 95% of caregivers were satisfied with medical gender affirming care delivered via telehealth; 94% and 93%, respectively, were satisfied with behavioral gender affirming care delivered via telehealth.<sup>31</sup>

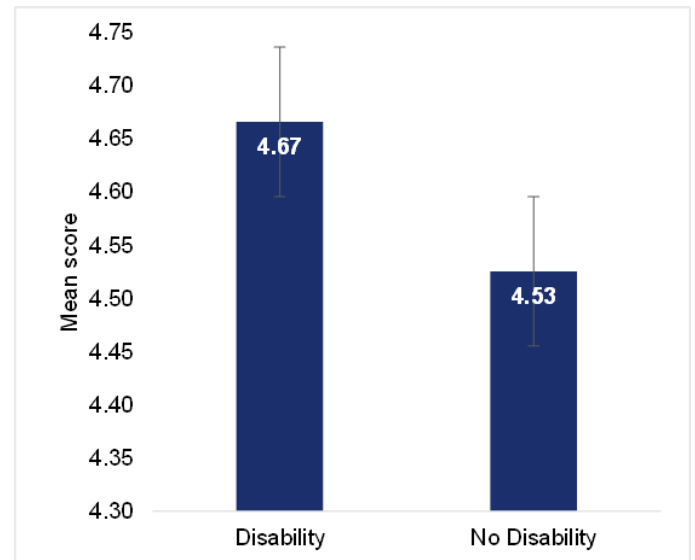
Considering a wave of anti-transgender legislation across the country, telehealth could play an important role in connecting transgender individuals to affirming clinical providers that they may not be able to see in-person due to distance, cost, or other barriers. Moreover, this assessment indicates that transgender health center respondents had positive experiences with telehealth.

## Disability Status

Respondents were asked to indicate whether they had a disability. There was just one statistically significant difference in telehealth experiences between respondents who disclosed having a disability and those who did not. When asked to consider whether telehealth has saved patients time traveling to and from hospitals and clinics, 94.7% of respondents who identified as having a disability agreed or strongly agreed that telehealth saved travel time as compared to 93.1% of the overall sample. Previous studies conducted prior to the onset of the COVID-19 pandemic corroborate the idea that individuals

who disclose having a disability are generally satisfied with their telehealth experiences.<sup>32</sup>

Figure 7. Responses to the statement: “Telehealth saves me time traveling to a hospital or clinic.”



Note: Mean scores represent responses to a Likert Scale question where 5 indicates strongly agree, 4 agree, 3 neither agree nor disagree, 2 disagree, and 1 strongly disagree with a positive statement about telehealth. Thus, higher scores indicate a higher rating of telehealth.

<sup>31</sup> Apple, D. E., Lett, E., Wood, S., Freeman Baber, K., Chuo, J., Schwartz, L. A., ... & Dowshen, N. (2022). Acceptability of telehealth for gender-affirming care in transgender and gender diverse youth and their caregivers. *Transgender Health, 7*(2), 159-164.

<sup>32</sup> Christensen, K. M., & Bezyak, J. (2020). Telehealth use among rural individuals with disabilities. From <https://rockymountainada.org/sites/default/files/2020-02/Rural%20Telehealth%20Rapid%20Response%20Report.pdf>

## POLICY AND PRACTICE IMPLICATIONS

First, the assessment's results show that health center patients have had very positive experiences with telehealth and believe that it is an effective way to access care and communicate with their clinical providers. More than four in five respondents agreed or strongly agreed with nearly all items addressed in the assessment related to ease of use, interaction with clinician, and overall comfort/satisfaction with telehealth.

Second, there is a clear priority to maintain access to tele-audio or telehealth visits via phone. This is an important way for health center patients to access telehealth and is more accessible than video telehealth; individuals do not need a smart device, laptop, or broadband internet access to access tele-audio services. Additionally, they may be a more accessible option for special populations such as older adults who may experience barriers with other types of telehealth, like live video.

Third, while the research is clear that telehealth can reduce barriers to care and promote health equity, it is important to acknowledge that some populations may need additional support when accessing telehealth. For example, people who prefer to speak a language other than English, or have limited English proficiency, have a disability, are older, or who have historically been marginalized have been shown to benefit from telehealth but may require additional supports to maximize the impact of telehealth and address their specific needs. Support may include strategies such as: making materials accessible in different formats and multiple languages, using images and words in online communications, providing digital navigators, using assistive devices, training providers on cultural

competency, and using speech recognition technologies designed with equity in mind.<sup>33</sup>

Fourth, telehealth has the potential to alleviate inequities and disparities in care access and care experience. Based on demographic trends observed in this assessment, there is evidence for expanded use of telehealth to better serve the needs of people who may face barriers to accessing care, including those who face systemic discrimination because of their race, ethnicity, sexual orientation, and/or gender identity. For example, this assessment found that Black patients had notably positive experiences with telehealth, that women rated telehealth very highly compared to men, and that people who are transgender rated telehealth highly across categories. If implemented with an equity lens and an understanding that one size does not fit all, telehealth can help address the health care needs of groups who face barriers to equitable care.

Fifth, respondents with a recent behavioral health visit rated telehealth highly, with approximately 9 of 10 respondents agreeing or strongly agreeing with positive statements about telehealth. This supports the already robust evidence that telehealth is a promising tool for addressing behavioral health needs, which grew significantly from the COVID-19 pandemic and associated stressors. As many states grapple with behavioral health provider shortages, telehealth could provide an accessible option for patients who don't have access to a behavioral health provider in their local community. Additionally, tele-behavioral health could be a lower-barrier option for individuals who are less likely to seek needed behavioral health care due to stigma or fear.

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<sup>33</sup> Health Equity in Telehealth, (2023), *Health Resources & Services Administration*.  
<https://telehealth.hhs.gov/providers/health-equity-in-telehealth>

Sixth, telehealth is an important tool for patients and providers, however, it is not a one-size fits all approach to health care. Telehealth is a popular option among health center patients as evidenced by the very positive ratings from respondents. However, it is only an *option*; patient choice and provider discretion are paramount. Telehealth does not purport to be a replacement for in-person care, which may be the most appropriate option in many circumstances (e.g., for some specialized medical care).

Finally, this assessment clearly demonstrates that telehealth is a vital component of the health center mission to meet the health and wellbeing needs of their patients by minimizing barriers to accessing services. Preserving telehealth access and supporting improved, equity-focused implementation is a crucial imperative for health center leaders and for policymakers moving forward.

## APPENDIX: METHODS

A cross-sectional study was conducted to gain a comprehensive understanding of diverse patient experiences with telehealth and to recommend policy and operational changes that promote equity in access to care and improve patient experience. The assessment authors researched existing telehealth patient-facing surveys and found a number of telehealth questionnaires developed mostly in the early 2000s, including the Telehealth Usability Questionnaire (TUQ) and Telemedicine Satisfaction Questionnaire (TSQ). Various aspects of these two existing questionnaires were combined and adjusted as needed to develop an assessment tool specific to this inquiry. NACHC and telehealth content experts worked with the research team to ensure clarity and completeness of the final telehealth assessment tool.

The assessment was administered using Alchemer, an online platform. Inclusion criteria required that participants had a telehealth appointment in the past 6 months at a Federally Qualified Health Center (FQHC). Fielding took place from September 2022 through January 2023. NACHC and JSI pursued multiple avenues of dissemination, including email blasts, information sessions for health center staff, and pre-written materials (such as pre-written portal or text messages to patients and stock language to send to health center staff). Health centers were crucial partners in disseminating the assessment to their patients.

To support accessibility, the assessment tool and the dissemination materials were made available to patients in English and seven additional

languages, including Arabic, Chinese-simplified characters, Haitian-Creole, Korean, Russian, Spanish, and Vietnamese.

The research team cleaned the data for consistency and accuracy. Initially, the assessment's raw dataset included 2,537 responses. By applying exclusion criteria, 773 responses were dropped. Responses were excluded if respondents did not have any telehealth appointment of any kind in the past 6 months (435), if they did not respond to any telehealth experience questions (177), or if they provided duplicate responses (161). The final analytic dataset consisted of 1,764 responses.

The cleaned dataset was then weighted to ensure that the data were representative of health center patients nationally. A key component of the research team's weighting methodology was a weight adjustment technique, iterative proportional fitting (raking). Raking adjusts the preliminary weights (pre-raking weights) to create final weights whereby the final weighted distributions of selected variables match known distributions. The known distributions were selected from 2021 HRSA Uniform Data System (UDS) data. The researchers used the following raking dimensions: urban/rural location, insurance status, HRSA region, race/ethnicity, age, and gender identity.

Data were analyzed using IBM SPSS Statistics Version 28. Frequencies and descriptive statistics (mean, standard deviation, standard errors) were conducted to highlight the characteristics of

respondents and the prevalence of telehealth experiences. Differences in telehealth experiences among demographic groups (e.g. age, race/ethnicity, language) were ascertained using independent t-tests (disability, gender, transgender identity) or analysis of variance (ANOVA) tests (age, race/ethnicity, sexual orientation, type of insurance, language). Statistical significance was considered at p-values < 0.05 and a confidence interval of 95% CI.

This assessment has various limitations. First, the sample is heavily concentrated in certain states where there were more respondents (like California). To address this sampling bias, the analytic team designed a weighting methodology to make the sample mirror national populations. Secondly, the sample is limited in various characteristics, such as rural status or languages other than English or Spanish. Again, weighting was applied to address this issue. Lastly, this was an online assessment; an online assessment may not reach individuals who generally have difficulties with technology; individuals in this group are also likely to have more difficulty accessing telehealth.



## APPENDIX: DEMOGRAPHICS OF THE SAMPLE

### Demographics of the Sample

In total, 1,764 community health center patients completed the assessment. The following sections highlight the various demographics represented by the sample:

**Age:** Age was collected in set intervals, with patients between 25 and 39 years of age being the largest percentage, constituting 25.9% of the sample.

Age	N	Weighted %
18-24	109	11.50
25-39	351	29.50
40-54	441	24.30
55-69	582	21.70
70+	93	10.70
Prefer not to answer	31	2.20

**Gender Identity and Transgender Experience:** 469 respondents (58.2%) identified as men, while 1089 (40.0%) identified as women. 17 individuals (0.8%) identified as nonbinary and 31 respondents (1.1%) either associated with a gender identity not listed in the assessment or preferred not to answer the question.

Gender Identity	N	Weighted %
Male	469	58.20
Female	1089	40.00
Non-Binary	17	0.80
Not Listed here	9	0.50
Prefer not to answer	22	0.60
<b>Transgender</b>		
Yes	82	6.20
No	1452	91.40
Prefer not to answer	66	2.30

**Sexual Identity:** 1,057 respondents (68.7%) identified as straight or heterosexual while 299 individuals (20.7%) were either Asexual, Bisexual or Pansexual, Gay or Lesbian, or Queer. The remaining 231 respondents (10.5%) were unable or unwilling to disclose their sexual identity.

Sexual Orientation	N	Weighted %
Asexual	102	6.80
Bisexual or Pansexual	80	5.20
Gay or lesbian	104	8.40
Straight or heterosexual	1057	68.70
Queer	13	0.30
I am questioning/not sure of my sexuality	5	0.20
A sexual orientation not listed here	13	0.30
Prefer not to answer	213	10.00

**Race/Ethnic Identity:** White, Hispanic, and Black respondents comprised nearly 80% (79.8%) of the sample. Multiracial and Asian respondents constituted roughly 11% (10.5%) of the assessment's sample collectively. American Native/Alaskan Native and Native Hawaiian/Pacific Islander categories were not well represented, constituting 2.5% of the total sample, collectively.

Race	N	Weighted %
Hispanic	642	37.40
American Native or Alaska Native	2	2.00
Asian	61	4.10
Black or African American	123	10.80
Native Hawaiian or Other Pacific Islander	14	0.50
White	577	31.60
Multiracial	89	6.40
Unknown, Unreported, or Prefer not to answer	256	13.60

**Language Spoken at home:** Although more than ten languages were represented in the sample, 66.6% of respondents spoke only English at home. 27.8% of respondents spoke Spanish, the next most common language.



Language	N	Weighted %
English	965	66.60
Arabic	24	0.40
Chinese-Cantonese	1	0.10
Chinese-Mandarin	2	0.00
French	3	0.10
Haitian Creole	2	0.10
Japanese	3	0.10
Portuguese	11	0.70
Spanish	446	27.80
Tagalog	11	0.50
Vietnamese	3	0.10
Other, please specify	40	2.40
Prefer not to answer	31	1.20

**Disability:** 560 respondents (37.2%) reported having a disability. 82 individuals (5.9%) reported being deaf or having difficulty hearing whereas 125 people (9.0%) are blind or have difficulty seeing, even when wearing glasses.

Disability Status	N	Weighted %
No	1046	62.80
Yes	560	37.20

**Health Insurance Status:** Respondents were also asked to indicate what health insurance type they had at the time, if any. Medicaid and Medicare respondents were the most highly represented, with 514 and 497 respondents (29.5% and 22.2%) respectively. 240 individuals had private insurance (18.1%) and 7 respondents (0.7%) had coverage from Veterans Affairs or TRICARE/military coverage. 99 people (19.2%) reported having no insurance coverage while 106 individuals (10.4%) had an undetermined coverage status or chose not to disclose this information.

Insurance Status	N	Weighted %
Medicaid	514	29.50
Medicare	497	22.20
Private or group health insurance	240	18.10
Veteran Affairs, TRICARE/military	7	0.70
No insurance or Self-pay	99	19.20
Unknown or Prefer not to answer	106	10.40