

Telehealth Use in 2022 Among US Adults by Sexual Orientation

Elise Atkinson, BS; Prathyusha Galinkala, BS; and Celeste Campos-Castillo, PhD

Despite the swell of studies documenting telehealth use since the start of the COVID-19 pandemic, relatively little research has examined use among sexual minority individuals.^{1,2} Like other minoritized groups, sexual minority individuals (including lesbian, gay, and bisexual individuals) experience barriers in access to care, including discrimination, financial burden, and lack of transportation.³ With the appropriate infrastructure and policy environment in place, telehealth has been touted as a promising avenue to achieve equity by facilitating minoritized groups' access to health care.⁴ Compared with in-person visits, telehealth provides several advantages to minoritized individuals, including increased feelings of anonymity, physical and emotional distance, and convenience in access to health care providers, all of which may address barriers to care among sexual minority individuals.

The sparse literature suggests a strong demand among sexual minority individuals for telehealth, particularly before the technology rose in prominence during the pandemic. Data from a nationally representative sample of US adults who were surveyed in 2013-2014 indicated that gay and bisexual men were using telehealth at higher rates than heterosexual men.⁵ Several reviews on the benefits of telehealth across a range of studies conducted before the pandemic highlighted its potential for improving access to care among sexual minority individuals, particularly for care that may carry stigma, such as for sexually transmitted infections.⁶⁻⁸

More recent snapshots are absent, however, and lack consistency in their findings. Findings from studies conducted during the first year of the pandemic showed mixed results regarding whether sexual minority individuals reported greater or lower rates of telehealth use than their counterparts, but this may be due to differences in the health services studied and in the sampled respondents in terms of their age, health status, and geographic region.⁹⁻¹² Similar inconsistencies appear in findings from studies assessing telehealth usage among other minoritized groups, also for comparable reasons.¹³ National snapshots are necessary for tracking trends in health and health care disparities and identifying potential means for achieving equity, such as supporting telehealth access. This is particularly important as the United States phases into the postpandemic landscape, where

ABSTRACT

OBJECTIVES: To address a lack of research documenting telehealth use and experiences among sexual minority individuals during the COVID-19 pandemic and inform health care policies beyond the pandemic.

STUDY DESIGN: Secondary analysis of the 2022 Health Information National Trends Survey (HINTS), a cross-sectional survey representative of US adults.

METHODS: We estimated multivariable probit regressions to understand how sexual orientation was associated with reporting telehealth use, modality (video only, telephone only, both), and experiences, including the reason for, subject of most recent, and quality of the telehealth visit. We adjusted estimates based on respondents' self-reported demographics and health status. Analyses were weighted to represent the US adult population and used full information maximum likelihood to account for missing data.

RESULTS: Among all HINTS respondents, having a telehealth visit within the past year was more common among sexual minority respondents than heterosexual respondents. Among telehealth users, sexual minority respondents were more likely than heterosexual respondents to say that they used telehealth because it was convenient and minimized their exposure to illnesses and that the subject of the most recent telehealth visit was mental health. They were less likely to say the subject was minor/acute care. Modality use and quality were comparable between sexual minority respondents and heterosexual respondents.

CONCLUSIONS: The findings show greater demand for telehealth, especially for mental health care, among sexual minority adults. Knowledge of factors driving patterns in health care utilization within minoritized communities and the implications for both telehealth access and quality are necessary to create policies that have a broad positive impact.

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TAKEAWAY POINTS

This study provides guidance on how to leverage investments in telehealth to improve health care access among sexual minority adults and facilitate health equity in the postpandemic world.

- ▶ Despite the preponderance of research on telehealth demand since the COVID-19 pandemic started, few studies examine sexual minority adults.
- ▶ In 2022, sexual minority adults reported greater rates of telehealth usage, especially for mental health visits, than heterosexual adults.
- ▶ An understanding of demand for telehealth is key to supporting policies, such as parity laws, that facilitate accessing health care among minoritized communities.

policy makers and practitioners must decide which of the health and social safety nets to support, such as telehealth.¹⁴

What remains unknown, in addition to a recent national snapshot of telehealth use, is how sexual orientation may be associated with telehealth modalities and experiences, such as reasons for use and subject of visit. Such information enables understanding what may drive demand for telehealth and how to leverage it for achieving health equity. For example, previous research indicates greater patient satisfaction as well as better patient outcomes with video telehealth visits compared with other telehealth modalities.¹⁵ In contrast to this, study findings show that minoritized groups, such as racial minority individuals and individuals of low socioeconomic status, exhibit increased use of audio-only telehealth and are less likely to report willingness to use video-based telehealth.^{16,17} Such differences in modality demand suggest the need to understand whether they translate into differences in quality or serve to equalize. Other study findings show patterns suggesting distinct reasons for telehealth use among other minoritized populations, which may indicate how telehealth may facilitate access to care. For example, individuals in rural areas have been found to have a greater portion of their health care delivered through telehealth, implying that convenience may play a role in individuals choosing to use telehealth.¹⁸ Regarding subject of visit, individuals with chronic diseases or mental health issues have reported greater levels of satisfaction and convenience with telehealth use,^{19,20} suggesting how telehealth may be targeted for specific visits to meet demand. Studies such as these that examine demand for telehealth modalities and experiences with the technology among sexual minority individuals are missing.

To address these gaps in the literature, we analyzed national survey data collected in 2022 from US adults and compared sexual minority respondents and heterosexual respondents. We examined self-reported rates of telehealth use overall and by modality as well as respondents' experiences with telehealth.

METHODS

Data Source

Data analyzed in this study were sourced from the 2022 Health Information National Trends Survey (HINTS), a cross-sectional

survey by the National Cancer Institute. This survey documents how US noninstitutionalized adult residents (aged ≥ 18 years) access and understand health information. The 2022 HINTS survey consists of 2 sampling stages. The first stage consists of a stratified sample of US residential addresses. With this 2022 iteration of HINTS, additional consideration was paid to rural addresses—compared with previous iterations of the survey—to create a stratified sample that included data for minority populations in both urban and rural locations.

The second stage of the survey consisted of randomly sampling a single adult from each sampled household. Both stages were fielded over several mailing periods from March 7, 2022, to November 8, 2022. The total number of respondents was 6252, with a final weighted response rate of 28.1%. Additional survey design details are available within the *HINTS 6 Methodology Report*.²¹

Telehealth Measures

Respondents who used telehealth were determined by the following question: "A telehealth visit is a telephone or video appointment with a doctor or health professional. In the past 12 months, did you receive care from a doctor or health professional using telehealth?" Those who replied yes were designated telehealth users and asked whether their visit was conducted via the following modalities: video, phone call (voice only with no video), or both video and phone call.

Reason for choosing to use telehealth was measured with the following question: "Why did you choose a telehealth visit(s) for yourself?" The 6 options provided by HINTS were "The health care provider recommended or required the visit use telehealth," "I wanted advice about whether I needed in-person medical care," "I wanted to avoid possible infection at the doctor's office or hospital (for example, COVID-19 or flu)," "It was more convenient than going to the doctor (for example, less travel or wait times)," "I could include family or other caregivers in my appointment," and "Other." Respondents could select multiple reasons.

Subject of the most recent telehealth visit was identified by the following question: "What was the primary reason for your most recent telehealth visit?" The 6 options provided by HINTS were "annual visit," "minor illness/acute care (for example, fever, sinus infection)," "managing my chronic health condition/disease (for example, high blood pressure, diabetes, heart disease, obesity, cancer)," "medical emergency," "mental health, behavioral, or substance abuse issues (for example, depression, anxiety, drug or alcohol abuse)," and "other." Respondents were instructed to select only 1 option.

Respondents' ratings of experiences with telehealth's technical, care, and privacy quality were measured using three 4-point Likert items (strongly disagree to strongly agree). Values were recoded so that higher values indicated better quality. Respondents were asked, "In general, how much do you agree or disagree with the following statements regarding your telehealth visit(s)?"

- “I had technical problems with my telehealth visit(s) (for example, difficulty using the technology, trouble seeing or hearing my health care provider).”
- “The care I received through telehealth was as good as a regular in-person visit.”
- “I was concerned about the privacy of my telehealth visit(s).”

Sexual Orientation

Respondents' sexual orientation was determined by the following question: “Do you think of yourself as...” Those who selected “homosexual or gay or lesbian,” “bisexual,” or the open response “something else (specify)” were designated a sexual minority, and those who selected “heterosexual or straight” were designated as heterosexual. Respondents were instructed to select only 1 option.

Covariates

Items for respondents' sociodemographics and health were included in the analysis. Sociodemographic items included measures of respondents' race/ethnicity (White, Black, Latino, other), sex (male, female), age in years (18-34, 35-49, 50-64, 65-74, ≥ 75), education level (high school or less, some college, college graduate, postgraduate), and marital status (single, divorced/widowed/separated, married/cohabitating). Health items included measures of respondents' self-rated health (excellent, very good, good, fair, poor) and their score on the 4-item Patient Health Questionnaire.²²

Analyses

All analyses used the jackknife replicate weights provided with the HINTS data set, which account for nonresponse and attempt to match known population benchmarks. After describing the sample characteristics, we estimated a series of probit regressions using the weighted least squares mean and variance adjusted estimator (WLSMV) and full information maximum likelihood (FIML) in Mplus version 8.8 (Muthén & Muthén). Mplus uses the WLSMV to estimate probit regressions within complex survey data that use jackknife replicate weights. FIML is the technique to handle missing data. Rather than dropping respondents from the analysis who are missing values on any single measure, FIML uses all information available to derive estimates. Compared with other methods of handling missing values (listwise deletion, pairwise deletion, multiple imputation) when estimating regressions, FIML produces more efficient estimates (ie, better represents the true values).²³

We use the full sample for estimates of telehealth use ($N = 6252$), whereas the rest of the analysis uses all information available from only those who responded yes to the telehealth use question ($n = 2517$). Estimates of telehealth use, modality, and subject of visit were produced using single equation binary probit regressions. For the quality ratings, we estimated 3 ordinal probit regressions simultaneously, which account for the possibility that responses to any single item are likely to be correlated with responses on the other two. For similar reasons, we estimated responses to the items measuring reasons for the most recent telehealth visit simultaneously. Here, we estimated

TABLE 1. Sample Characteristics

Variable	Statistic ^a
Minoritized sexual identity (n = 5693)	448 (8.6)
Age in years (n = 6154)	
18-34	939 (25.9)
35-49	1240 (25.3)
50-64	1772 (27.3)
65-74	1356 (13.0)
≥ 75	847 (8.6)
Race and ethnicity (n = 5595)	
White	3203 (61.2)
Black	889 (11.0)
Latino	1001 (17.0)
Other	472 (10.8)
Female (n = 5842)	3535 (50.8)
Education (n = 5848)	
High school or less	1455 (28.5)
Some college	1672 (39.0)
College graduate	1613 (19.0)
Postgraduate	1108 (13.7)
Self-rated health is poor or fair (n = 6018)	4930 (82.9)
Relationship status (n = 5837)	
Single	1119 (31.2)
Divorced, widowed, or separated	1721 (12.9)
Married or cohabitating	2997 (55.9)
Patient Health Questionnaire score ^b (n = 6252)	1.76 (3.54)
Used telehealth (n = 6046)	2517 (39.3)
Used video telehealth only (n = 2517)	1110 (47.1)
Used telephone telehealth only (n = 2517)	876 (30.7)
Used both video and telephone telehealth (n = 2517)	531 (22.2)
Reason for choosing telehealth ^c	
Doctor recommended (n = 2413)	1716 (72.7)
Get advice (n = 2399)	680 (30.8)
Minimize exposure (n = 2415)	1158 (50.2)
Convenience (n = 2407)	1516 (65.6)
To include others in visit (n = 2403)	484 (22.7)

(continued)

6 binary probit regressions simultaneously. Statistical significance was defined as an α value of less than .05, 2-tailed.

RESULTS

Sample Characteristics

Sample characteristics are summarized in **Table 1**. Of the full sample, almost 9% were sexual minority individuals and approximately 40% reported using telehealth. Among telehealth users, almost half reported using video only. The most common reasons for using telehealth were because it was doctor recommended and convenient. The most common subject of the most recent telehealth

TABLE 1. (Continued) Sample Characteristics

Variable	Statistic ^a
Subject of most recent telehealth visit (n=2397)	
Annual visit	485 (17.8)
Acute/minor care	600 (29.7)
Managing chronic condition	583 (21.4)
Medical emergency	46 (1.6)
Mental or behavioral health	337 (15.7)
Other	346 (13.8)
Quality: technology problems (n=2335)	
Strongly agree	146 (5.5)
Agree	360 (14.0)
Disagree	348 (17.8)
Strongly disagree	1481 (62.7)
Quality: care (n=2384)	
Strongly agree	227 (8.2)
Agree	378 (16.7)
Disagree	906 (37.8)
Strongly disagree	873 (37.2)
Quality: concerned about privacy (n=2324)	
Strongly agree	98 (3.2)
Agree	268 (13.1)
Disagree	407 (17.0)
Strongly disagree	1551 (66.6)

^aFrequencies and weighted percentages are shown unless noted otherwise.

^bMean and SD shown.

^cNot mutually exclusive.

visit was minor/acute care. Regarding quality, most respondents strongly disagreed that they had privacy concerns and technology problems. Approximately three-quarters of respondents leaned toward indicating that in-person and telehealth care were comparable.

Characteristics of Telehealth Users and of Modality Users

Results from the binary probit regressions estimating characteristics of telehealth users appear in **Table 2**, along with characteristics by modality. Sexual minority respondents had a significantly greater likelihood of reporting telehealth use than heterosexual respondents. Sexual orientation was unrelated to modality.

Telehealth Experiences

The binary probit regressions estimating reasons for telehealth use appear in **Table 3**. Sexual minority respondents were significantly more likely than heterosexual respondents to state that they used telehealth because it was convenient and minimized their exposure to illnesses.

Table 4 shows the binary probit regressions estimating the subject of the most recent telehealth visit. Minor/acute care was significantly less common among sexual minority respondents than heterosexual respondents, whereas mental and behavioral health care was significantly more common.

Table 5 shows the ordinal probit regressions estimating quality of the most recent telehealth visit. Results show no significant differences in reports of quality by the sexual orientation of respondents.

DISCUSSION

Although research documenting telehealth use and experiences since the start of the COVID-19 pandemic is voluminous, few studies examine how individuals' sexual orientation is associated with these patterns. Of the studies that do, the sample tends to not be nationally representative or to focus narrowly on specific health care utilization. Given the disparate designs, results were mixed regarding whether and how sexual orientation may be associated with telehealth use and experiences. To clarify what is known, we analyzed data from a 2022 survey that was representative of US adults.

We found that sexual minority respondents were significantly more likely to report telehealth use than heterosexual respondents. One possible explanation may be differences in need for health care utilization because the health of sexual minority adults has fared worse than that of their heterosexual counterparts since the start of the pandemic.²⁴ The models, however, did adjust for self-reported health status, suggesting that this possibility is partly accounted for and that other reasons may be operant.

The remaining models, which were estimated among telehealth users, provide some additional insight into what may underlie the heightened tendency to use telehealth among sexual minority individuals. Compared with heterosexual adults, sexual minority adults were more likely to say the subject of their most recent telehealth visit was mental and behavioral health. The difference may be due to differences in mental health, but this was accounted for in the model. Other research shows that minoritized groups prefer to use telehealth for stigmatizing health contexts such as these.^{25,26} The combined stigma of being a sexual minority individual and seeking care for mental and behavioral concerns may underlie demand for telehealth. We also found that sexual minority adults were more likely to say they chose telehealth because of convenience and wanting to minimize exposure to illnesses, similar to other groups seeking convenience.¹⁹ Demand for convenience may once again be associated with wanting to reduce the stigma of seeking care for specific conditions, but it may also be related to overcoming transportation and financial barriers as well as pervasive homophobic attitudes among health care institutions.³

Notably, we found that respondents' sexual orientation was unrelated to modality used and the quality of their telehealth experiences. This departs from the findings of other studies showing that minoritized groups prefer telehealth modalities that do not transmit video, but these studies were conducted closer to the start of the COVID-19 pandemic.^{24,25} The differences may therefore be due to changes with the passage of time. Sexual minority individuals reported feeling socially isolated toward the beginning of the pandemic and in response may have begun turning to forms

TABLE 2. Probit Regression Model Predicting Telehealth Use and Modality

Variable	Used telehealth	Video	Telephone	Both video and telephone
	β (SE)	β (SE)	β (SE)	β (SE)
Minoritized sexual identity	0.144*** (0.034)	0.204 (0.190)	-0.206 (0.202)	-0.072 (0.212)
Age in years (vs 18-34)				
35-49	0.025 (0.020)	0.069 (0.453)	0.162 (0.141)	-0.235 (0.159)
50-64	-0.115** (0.043)	0.123 (0.663)	0.089 (0.151)	-0.162 (0.157)
65-74	-0.350*** (0.034)	-0.059 (0.876)	0.509* (0.234)	-0.350 (0.195)
≥75	-0.464*** (0.033)	-0.502 (0.654)	0.789*** (0.191)	-0.233 (0.285)
Race and ethnicity (vs White)				
Black	-0.183** (0.066)	-0.375 (1.315)	0.026 (0.136)	0.068 (0.190)
Latino	-0.064 (0.041)	-0.235 (0.152)	0.199 (0.108)	0.049 (0.160)
Other	-0.082 (0.068)	-0.330 (1.304)	-0.046 (0.217)	0.003 (0.189)
Female (vs male)	0.272*** (0.025)	-0.110 (0.111)	0.074 (0.107)	0.069 (0.131)
Education (vs high school or less)				
Some college	0.143*** (0.042)	0.018 (0.169)	-0.251 (0.141)	0.223 (0.181)
College graduate	0.272*** (0.037)	-0.046 (0.239)	-0.190 (0.143)	0.194 (0.210)
Postgraduate	0.403*** (0.043)	0.172 (0.292)	-0.447** (0.160)	0.177 (0.207)
Self-rated health is poor or fair	-0.382*** (0.013)	0.218 (0.168)	-0.080 (0.129)	-0.165 (0.131)
Patient Health Questionnaire score	0.002 (0.003)	0.010 (0.014)	-0.018 (0.014)	0.009 (0.017)

* $P < .05$; ** $P < .01$; *** $P < .001$.**TABLE 3.** Probit Regression Model Predicting Reason for Telehealth Use

Variable	Doctor suggested	Advice	Minimize exposure	Convenience	Others can join
	β (SE)	β (SE)	β (SE)	β (SE)	β (SE)
Minoritized sexual identity	0.047 (0.178)	0.315 (0.248)	0.530*** (0.162)	0.399* (0.197)	-0.374 (0.229)
Age in years (vs 18-34)					
35-49	0.041 (0.151)	0.013 (0.151)	-0.182 (0.128)	0.182 (0.144)	-0.075 (0.215)
50-64	0.045 (0.157)	-0.092 (0.167)	-0.117 (0.117)	-0.059 (0.129)	-0.041 (0.197)
65-74	0.106 (0.164)	-0.161 (0.161)	-0.113 (0.130)	-0.356** (0.131)	-0.062 (0.195)
≥75	-0.187 (0.214)	-0.045 (0.202)	-0.206 (0.173)	-0.505*** (0.137)	-0.034 (0.213)
Race and ethnicity (vs White)					
Black	-0.377 (0.248)	-0.283 (0.175)	-0.092 (0.183)	0.223 (0.234)	0.150 (0.235)
Latino	-0.269 (0.164)	0.116 (0.162)	0.176 (0.140)	-0.067 (0.130)	-0.035 (0.146)
Other	0.350 (0.272)	0.452 (0.242)	0.395* (0.177)	-0.242 (0.241)	0.017 (0.222)
Female (vs male)	-0.192 (0.110)	0.062 (0.113)	-0.107 (0.090)	-0.016 (0.095)	-0.218* (0.106)
Education (vs high school or less)					
Some college	0.129 (0.121)	0.228 (0.130)	-0.128 (0.148)	-0.052 (0.128)	-0.283 (0.185)
College graduate	-0.059 (0.146)	0.053 (0.142)	-0.286 (0.155)	0.055 (0.149)	-0.466 (0.242)
Postgraduate	-0.175 (0.156)	0.170 (0.140)	-0.077 (0.167)	0.175 (0.145)	-0.533* (0.224)
Self-rated health is poor or fair	0.191 (0.130)	0.090 (0.151)	-0.137 (0.121)	0.036 (0.128)	-0.221 (0.140)
Patient Health Questionnaire score	0.026 (0.016)	-0.019 (0.014)	-0.023 (0.012)	0.016 (0.012)	0.011 (0.017)

* $P < .05$; ** $P < .01$; *** $P < .001$.

of computer-mediated communication that transmit more cues beyond only voice.²⁴ Health care providers may have also revised their approaches to telehealth visits to improve the quality of the experiences.²⁷

Limitations

Study limitations include a lack of details regarding respondents' overall willingness to choose telehealth, whether the modalities asked about were options that were available for the respondents,

TABLE 4. Probit Regression Model Predicting Subject of Most Recent Telehealth Visit

Variable	Annual visit	Minor/ acute care	Chronic condition	Medical emergency	Mental/ behavioral health	Other
	β (SE)	β (SE)	β (SE)	β (SE)	β (SE)	β (SE)
Minoritized sexual identity	0.346 [0.499]	-0.557* [0.217]	-0.283 [0.183]	-0.230 [0.605]	0.533** [0.189]	-0.091 [0.234]
Age in years (vs 18-34)						
35-49	-0.010 [0.414]	-0.496 [0.423]	0.264 [0.150]	-0.518 [1.113]	-0.059 [0.178]	0.030 [0.408]
50-64	-0.028 [0.405]	-0.691 [0.390]	0.654*** [0.155]	-1.267 [1.256]	-0.312 [0.161]	0.010 [0.489]
65-74	0.347 [0.555]	-1.153 [0.595]	0.738*** [0.199]	-0.760 [1.379]	-0.668** [0.216]	0.270 [0.648]
≥75	0.439 [0.569]	-1.387* [0.663]	0.864*** [0.247]	-0.367 [1.692]	-1.564*** [0.262]	0.183 [0.666]
Race and ethnicity (vs White)						
Black	0.70 [0.663]	-0.298 [0.300]	0.112 [0.198]	-0.162 [1.262]	-0.494** [0.160]	0.498 [0.714]
Latino	-0.138 [0.310]	-0.231* [0.117]	0.241 [0.138]	0.386 [0.313]	-0.370* [0.166]	0.282 [0.282]
Other	0.679 [0.565]	-0.376* [0.145]	0.200 [0.154]	-0.502 [0.680]	-0.057 [0.177]	-0.552 [0.523]
Female (vs male)	-0.272* [0.129]	-0.024 [0.103]	0.013 [0.110]	-0.052 [0.307]	0.261 [0.173]	0.062 [0.099]
Education (vs high school or less)						
Some college	-0.042 [0.168]	-0.058 [0.171]	0.140 [0.138]	0.062 [0.320]	-0.033 [0.223]	0.068 [0.145]
College graduate	0.000 [0.154]	-0.213 [0.188]	0.031 [0.106]	0.112 [0.317]	0.130 [0.228]	0.164 [0.195]
Postgraduate	-0.060 [0.161]	-0.029 [0.195]	0.172 [0.143]	-0.235 [0.439]	-0.076 [0.281]	0.143 [0.190]
Self-rated health is poor or fair	-0.057 [0.225]	0.506** [0.183]	-0.432*** [0.117]	0.086 [0.351]	-0.036 [0.195]	-0.097 [0.179]
Patient Health Questionnaire score	-0.059** [0.019]	-0.067*** [0.016]	0.040** [0.014]	0.003 [0.041]	0.080*** [0.019]	0.003 [0.015]

*P < .05; **P < .01; ***P < .001.

TABLE 5. Probit Regression Model Predicting Quality of Telehealth Visit

Variable	Technology problems	Comparable to in-person visit	Privacy concerns
	β (SE)	β (SE)	β (SE)
Minoritized sexual identity	0.213 [0.114]	0.166 [0.175]	0.277 [0.256]
Age in years (vs 18-34)			
35-49	-0.128 [0.155]	0.401** [0.148]	-0.217 [0.160]
50-64	-0.162 [0.157]	0.244 [0.170]	-0.174 [0.144]
65-74	0.130 [0.150]	0.205 [0.186]	-0.073 [0.155]
≥75	0.093 [0.220]	0.171 [0.202]	-0.288 [0.173]
Race and ethnicity (vs White)			
Black	-0.238 [0.148]	-0.011 [0.115]	0.051 [0.190]
Latino	0.090 [0.182]	-0.010 [0.141]	0.182 [0.230]
Other	0.303 [0.208]	-0.051 [0.170]	0.645* [0.297]
Female (vs male)	0.023 [0.101]	0.160 [0.104]	-0.149 [0.114]
Education (vs high school or less)			
Some college	-0.151 [0.110]	-0.149 [0.114]	-0.142 [0.154]
College graduate	-0.171 [0.120]	-0.176 [0.123]	-0.340* [0.145]
Postgraduate	-0.261 [0.150]	-0.284* [0.143]	-0.336* [0.158]
Telehealth modality (vs video)			
Telephone	-0.054 [0.111]	-0.169 [0.970]	0.276* [0.118]
Video and telephone	0.388*** [0.103]	-0.095 [0.117]	0.009 [0.113]
Self-rated health is poor or fair	-0.130 [0.114]	-0.177 [0.122]	-0.077 [0.135]
Patient Health Questionnaire score	0.014 [0.015]	-0.006 [0.012]	0.023 [0.014]

*P < .05; **P < .01; ***P < .001.

ideal modality, reasons behind any modality preferences, and actual clinical outcomes. These factors are important to provide a clear understanding of the underlying reasons why respondents from minoritized sexual identity groups were using telehealth. For example, we cannot tell whether the lack of differences in modality use by sexual orientation is because preferences were comparable, availability was comparable, or some other factors were at play. Future studies should measure access to different telehealth modalities as well as respondents' preferred modality and reasoning. In addition, conclusions reached based on these survey data may not apply to countries other than the United States, especially countries that have more negative public sentiment toward sexual minority individuals or countries with different health care delivery systems. Future research should examine the extent to which these issues underlie the patterns of telehealth use and determine whether cross-national differences exist. Because HINTS is sent only to US households, this survey also may be lacking responses from individuals in uncertain living situations as well as unhoused

individuals, among whom sexual minority individuals are over-represented.²⁸ It is possible, then, that the associations shown here are an underestimation.

CONCLUSIONS

Despite these limitations, findings from the present study provide guidance on how to leverage investments in telehealth to provide care to vulnerable populations and facilitate equity in the postpandemic world. Firstly, telehealth must be offered at a similar price to in-person visits, and options for multiple modality types should be made accessible to patients by providers. One way to facilitate this would be to enact laws to guarantee payment parity, ensuring reimbursement for telehealth visits at the same rate as in-person visits, including in mental health benefits.²⁹ Although modality was unrelated to sexual orientation, audio-only telehealth continues to be common among other minoritized groups. Steps should still be taken to ensure that audio-only telehealth is of comparable quality to video telehealth, perhaps with options for avatars in place of camera use. In addition, given other findings showing that sexual minority groups feel safer to disclose health care information in practices with visible allyship, providers should make clear their allyship with sexual minority individuals to address what may underlie the findings regarding convenience.³⁰ This may include using sexual minority-coded visuals in the physical office space, affirming their commitment to patient privacy, and promoting attitudes of acceptance within their practices. An understanding of involved communities' usage patterns and their implications will be key to developing effective policies that accurately target these underserved communities and prevent substandard care. ■

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Address Correspondence to: Elise Atkinson, BS, Michigan State University, 404 Wilson Rd, Room 287, East Lansing, MI 48824. Email: atkin181@msu.edu.

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