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ARTICLE

COME AS YOU ARE?: DEMOCRATIZING HEALTHCARE THROUGH BLACK CHURCH-TELEHEALTH INITIATIVES

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Drawing from the phrase "come as you are," which is frequently used in Black Churches to encourage and welcome people to church spaces for spiritual restoration and healing irrespective of their various social and economic dispositions, this Article aims to describe how telehealth partnerships with community organizations, such as Black Churches, can help democratize healthcare.

In this project, I develop two models for Black Church-Telehealth Initiatives—a Telehealth Clinic on the Church's campus and a Designated Telehealth Space with the requisite technology to facilitate telehealth encounters—to argue that Black Church-Telehealth Initiatives can help address certain social determinants of health, such as medical mistrust and the digital divide. The Telehealth Clinic would be a licensed medical facility where patients are assisted by medical personnel with seeing a remote physician via the appropriate technology (e.g., computer, video conference software, internet access, and medical devices to obtain certain biometric data). The Designated Telehealth Space, on the other hand, would be a room equipped with non-medical technology that is open to community members without access to the requisite technology for telehealth encounters.

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Black Churches are already important locations for promoting healthcare and can help further democratize healthcare via telehealth, if certain legal hurdles can be resolved. By exploring federal and state law and policy, I examine the legal barriers to telehealth expansion in general, and legal hurdles specific to these initiatives. This Article argues that federalism principles and widespread variation amongst state laws on physician licensure may make it more difficult to democratize healthcare via telehealth. Moreover, depending on the extent of the religious affiliation, Black Church-Telehealth Initiatives may fit into broader trends toward an increased alignment of healthcare institutions with religious organizations and their doctrines. Finally, legal and policy reforms are needed to address certain federal and state limitations on Medicare and Medicaid reimbursement, which may deter healthcare providers from collaborating with Black Churches to establish this Article's initiatives. This makes the need for regulatory reform urgent. Indeed, as healthcare organizations partner with community organizations to expand access to telehealth, creative legal solutions will be required to subject those community organizations to important health laws and policies—including medical privacy and confidentiality laws—without stifling innovation and collaboration.

I. INTRODUCTION

Telehealth is disrupting and transforming the American healthcare system.[1] Scholars suggest that telehealth can reduce health disparities by addressing obstacles to healthcare access, such as a lack of public transportation or shortage of

[1] The term "telehealth" denotes the broad application of telecommunication technologies designed to facilitate the delivery of health and health-related services. *See What is Telehealth?*, NEW ENG. J. MED. CATALYST, https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0268 (last visited July 24, 2023). Telehealth often refers to mobile health apps, remote monitoring devices (e.g., cardiac implantable electronic devices), or communications with a provider via audio and/or video conference software. In previous years, "telemedicine" was frequently used to refer to evaluation and treatment of patients during virtual visits. *Id.* "Telemedicine" is a type of telehealth that is more specific to remote clinical services. *Id.* "Telehealth" includes services that range from traditional diagnostic and patient monitoring activities to health professional and patient education. *Id.*

healthcare professionals.[2] These changes—this democratization of healthcare—are welcome. At the same time, however, this transformation threatens to leave some communities behind. Telehealth is not a one-size-fits-all solution to limited healthcare access. To truly democratize healthcare via telehealth, we must confront the challenges of bringing telehealth to people of diverse races, ethnicities, cultures, and socioeconomic backgrounds.

Telehealth's ability to provide quality care for Black communities effectively requires legal reforms that take account of what public health scholars call the "social determinants of health." These determinants of health include medical mistrust and the digital divide. Medical mistrust is defined as "distrust of health care providers, the health care system, medical treatments, and the government as a steward of public health."[3] Medical mistrust is not only the converse of trust but is "more negative than the absence of trust" as it entails the "belief that the entity that is the object of mistrust is *acting against* one's best interest or well-being."[4] Researchers have found that compared to non-Hispanic white participants, non-Hispanic Black participants were 73% more likely to report mistrust in health professionals.[5] Medical mistrust may impact telehealth accessibility and related health outcomes. Patients who do not trust health professionals may underutilize healthcare services,[6] not adhere to suggested medication regimens,[7] and have a lower quality of life.[8]

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[2] *See* Kelly D. Edmiston & Jordan AlZuBi, *Trends in Telehealth and Its Implications for Health Disparities*, NAT'L ASS'N INS. COMM'RS 3–10, (Mar. 2022), https://content.naic.org/sites/default/files/Telehealth%20and%20Health%20Disparities.pdf [https://perma.cc/DFY3-AN3K]; Mark Melchionna, *Telehealth Reduced Racial Disparities in Primary Care Access in 2020*, MHEALTH INTEL. (May 11, 2022), https://mhealthintelligence.com/news/telehealth-reduced-racial-disparities-in-primary-care-access-in-2020 [https://perma.cc/U8G3-F3U6].

[3] Laura M. Bogart et al., *COVID-19 Related Medical Mistrust, Health Impacts, and Potential Vaccine Hesitancy Among Black Americans Living with HIV*, 86 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 200, 200 (2021) (citing Jessica Jaiswal & Perry N. Halkitis, *Towards a More Inclusive and Dynamic Understanding of Medical Mistrust Informed by Science*, 45 BEHAVIORAL MED. 79 (2019)); *see* Thomas A. LaVeist et al., *Mistrust of Health Care Organizations Is Associated with Underutilization of Health Services*, 44 HEALTH SERVS. RSCH. 2093 (2009).

[4] *See* Jaiswal & Halkitis, *supra* note 3, at 80.

[5] Mohsen Bazargan et al., *Discrimination and Medical Mistrust in a Racially and Ethnically Diverse Sample of California Adults*, 19 ANNALS FAM. MED. 4, 4 (2021).

[6] *See* LaVeist et al., *supra* note 3, at 2100.

[7] *See, e.g.*, Laura M. Bogart et al., *Conspiracy Beliefs About HIV Are Related to Antiretroviral Treatment Nonadherence Among African American Men with HIV*, 53 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 648, 649 (2010) (concluding that a type of medical mistrust, HIV conspiracy beliefs (e.g., "HIV is genocide against African Americans"), was associated with antiretroviral treatment nonadherence among African-American men with HIV); Willie M. Abel & Jimmy T. Efrid, *The Association Between Trust in Health Care Providers and Medication Adherence Among Black Women with Hypertension*, 1 FRONTIERS PUB. HEALTH 1 (2013) (concluding that Black women with hypertension who trusted their healthcare providers were more likely to adhere to their prescribed medications than those who did not trust their providers).

[8] *See, e.g.*, Ballington L. Kinlock et al., *High Levels of Medical Mistrust Are Associated with Low Quality of Life Among Black and White Men with Prostate Cancer*, 24 CANCER CONTROL 72, 72 (2017).

Beyond medical mistrust, the digital divide, which refers to disparate computer and/or internet access across different demographics, is another determinant of health that create challenges to scaling up telehealth in Black communities. A University of Houston College of Medicine study showed that Black and Latinx patients were 35% less likely to use telehealth than white people.[9] These results were attributed to the digital divide. The digital divide presents two obstacles to telehealth democratization: (1) racial minorities, lower-income individuals, and seniors are more likely to lack broadband access or the requisite equipment for a virtual appointment; and (2) low digital literacy generally makes it difficult to navigate online platforms to receive telehealth-care.[10]

Drawing from the concept "come as you are," which is frequently used in Black Churches to encourage and welcome people to church spaces, irrespective of their various social and economic dispositions for spiritual restoration and healing, I focus on Black communities in this Article and introduce two models for Black Church-Telehealth Initiatives as examples of how technology and community partnerships can help address certain determinants of health and democratize healthcare via telehealth. These examples provide a new way forward, building on assets, both cultural and physical, that already exist in the Black community.

Although Black Church-Telehealth Initiatives may take many different forms, this Article offers two models. The first model ("the Telehealth Clinic") would aim to mitigate the impact of medical mistrust and to expand access to primary care and mental healthcare. The Telehealth Clinic would have three unique features: (1) a partnership between a Black Church and a local health system or clinic to establish a community-based telehealth clinic; (2) use of non-medical technology *and* any necessary Food and Drug Administration ("FDA")-cleared or approved telehealth equipment (e.g., tele-stethoscope[11] or other appropriate devices for primary care delivery) to facilitate virtual appointments with a remotely located physician, who is affiliated with the health system or clinic partner; and (3) assistance of medical personnel, qualified under applicable federal or state standards, to help patients

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[9] *See* Bryan Luhn, *Racial and Ethnic Disparities in Telemedicine Usage Persist During Pandemic*, U. HOUSTON (Apr. 13, 2022), https://uh.edu/medicine/news-events/stories/2022/04apr/racial-and-ethnic-disparities-in-telemedicine-usage-persist-during-pandemic.php [https://perma.cc/3YUF-QPH4] (discussing Omolola E. Adepoju et al., *Utilization Gaps During the COVID-19 Pandemic: Racial and Ethnic Disparities in Telemedicine Uptake in Federally Qualified Health Center Clinic*, 37 J. GEN. INTERNAL MED. 1191, 1191–93 (2022)).

[10] *See* Edmiston & AlZuBi, *supra* note 2, at 9 ("About 80 percent of Whites have broadband access at home, which itself meaningfully limits access to telehealth services. But around one-third of Blacks (29 percent) and Hispanics (35 percent) lack broadband at home. The gap for seniors is especially pronounced. In 2021, more than 36 percent of seniors had no broadband at home. The gap in rural areas is 28 percent, which is especially substantial when considering that those in rural areas are perhaps the most in need of telehealth to improve access to care.").

[11] *See, e.g.*, Meg Bryant, *FDA Clears Digital Stethoscope for Telehealth Use*, HEALTHCARE DIVE (Nov. 3, 2016), https://www.healthcaredive.com/news/fda-clears-digital-stethoscope-for-telehealth-use/429633/ [https://perma.cc/REN6-8E7D].

connect to their providers. Moreover, the Telehealth Clinic would likely be in a space on the Church's property and leased to the healthcare provider.[12]

A similar model has been established at a Black Church: in 2021, Atrium Health, a top-ranked health system based in North Carolina, developed a virtual clinic at Mt. Calvary Baptist Church's Community Life Center in Shelby, North Carolina.[13] Mt. Calvary Baptist Church is a predominantly Black religious institution led by a Black pastor.[14] According to Dr. Patty Grinton, medical director for Atrium Health's community-based care initiative, "Community Based Virtual Care allows our community members to access medical care within their rhythm of life. We are breaking down those barriers by meeting people where they are – in their community . . . ."[15] Meeting people where they are—so that they can come to healthcare spaces as they are—is key to democratizing healthcare.

This Article's Telehealth Clinic would go even further than Atrium Health's community-based clinic. First, the Telehealth Clinic would provide mental healthcare in addition to primary and specialized care.[16] As discussed below, this Article advocates for the Church staff's involvement with the Telehealth Clinic's promotion as well as administrative activities, such as front desk responsibilities. The Telehealth Clinic would aim to engender more trust in the quality of care, healthcare professionals, and the health system more broadly by the direct involvement of Church staff with the provision of healthcare.

The second model for Black Church-Telehealth Initiatives ("the Designated Telehealth Space") would be a more modest program designed to address the impact of the digital divide in some Black communities. As demonstrated in Part IV.B, the legal barriers to establishing partnerships between Black Churches and healthcare institutions to form a Telehealth Clinic may be too significant to overcome. If so, Churches may opt to host a Designated Telehealth Space and still leverage the Church's important role in healthcare promotion. Under this model, a Black Church would provide a Designated Telehealth Space for telehealth encounters. At the Designated Telehealth Space, community members may use non-medical technology, such as computers equipped with video-conferencing software and the Church's internet connection. The Church would not be directly involved in the provision of medical care; however, a Church administrator may be staffed to provide technical support to the Designated Telehealth Space's users. Administrative support may further expand access to telehealth by helping those with limited digital literacy connect to remote providers.

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[12] The Church's property would be leased to the healthcare provider at fair market value in compliance with the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b).

[13] *Atrium Health Brings Community Based Virtual Care to Shelby*, ATRIUM HEALTH (Dec. 13, 2021), https://atriumhealth.org/about-us/newsroom/news/2021/12/atrium-health-brings-community-based-virtual-care-to-shelby [https://perma.cc/ZXF3-7YWL] [hereinafter Atrium Health Press Release].

[14] *See Mount Calvary Baptist Church*, https://mtcalvaryshelby.org/ [https://perma.cc/JWV5-VE4S] (last visited Feb. 4, 2023).

[15] *See* Atrium Health Press Release, *supra* note 13.

[16] *See* discussion of mental healthcare shortages in Black communities, *infra* notes 61, 69–72.

But some laws and policies impede these types of novel programs. In this Article, I analyze certain legal barriers to the democratization of healthcare through Black Church-Telehealth Initiatives.

It is important to note that the root cause of medical mistrust is systemic racism and discrimination within the healthcare system.[17] These Black Church-Telehealth Initiatives are not a perfect solution to healthcare access disparities stemming from medical mistrust and the digital divide. Legal reform must primarily target diminishing the barriers to Black Church and healthcare institution partnerships and must address the root causes of medical mistrust in the healthcare system. At the same time, healthcare partnerships with trusted institutions, like Black Churches, should integrate community leaders in telehealth delivery and build trust with the surrounding community.

Focusing on these two models, this Article proceeds in three parts. Part II describes the history of medical mistrust in the Black community as well as its effect on health outcomes. Part III describes the rise in telehealth use and provides a brief historical account of Black Churches and their roles in Black communities. Black Churches may *help* mitigate medical mistrust because Black Churches historically have been the bedrock of many Black communities through the provision of religious services as well as programming related to education, job training, and so much more. Moreover, Black Churches are already important locations for providing healthcare and can help further democratize healthcare via telehealth, if certain legal barriers can be resolved.[18]

Part IV.A briefly evaluates some substantial legal barriers to telehealth in general. Variation in state laws related to physician licensure requirements is a barrier to telehealth expansion. Because physicians generally must be licensed in each state where their patients are located, remote physicians must often complete burdensome application processes to obtain licensure in several states. Moreover, many states are relaxing the legal requirement for an in-person visit before a doctor-patient relationship can be established, allowing such relationships to be established via telehealth.

Part IV.B then evaluates legal hurdles and unresolved questions that are specific to providing telehealth at Black Churches. Because Black Churches are often trusted institutions, telehealth partnerships may be strengthened through integration of the Church's leaders and staff in the daily activities of the Telehealth Clinic. It is the trust in those individuals that may give more credence to the care delivered at the virtual clinic. But that very involvement may open the Church up to tort liability, under the apparent or ostensible agency doctrine, for the negligent acts of remote physicians. Furthermore, depending on the scope of the Church's involvement, health privacy and confidentiality risks may abound under both models. For example, the Church (as a "business associate" for the healthcare provider at the Telehealth Clinic) may fall under the purview of the Health Insurance Portability Accountability Act of 1996 ("HIPAA").[19] This Part also

[17] *See infra* Part II.

[18] *See infra* Part III.

[19] *See infra* Part IV.B.3.

explores legal concerns that may arise when a healthcare partner's or the Church's religious doctrine places limits on the healthcare the Church may provide. Lastly, federal healthcare reimbursement limitations may prevent patients from using Designated Telehealth Spaces to meet with providers or discourage healthcare providers from establishing Telehealth Clinics.

II. RACIAL HEALTH DISPARITIES AND MEDICAL MISTRUST

> "It is far harder to regain trust, once lost, than to squander it in the first place."[20]

The disparities in health outcomes for Black Americans compared to white Americans are astounding. According to the U.S. Department of Health and Human Services (HHS), "[c]hronic disease burden, morbidity, and mortality are all significantly higher among young adult Black Americans than the U.S. population as a whole."[21] Compared to white people, Black people generally have a lower life expectancy and are at a higher risk for stroke, cancer, and heart disease.[22] A 2022 study on racial disparities in maternal and infant health found higher rates of pregnancy-related death in Black women than white women.[23] Even the COVID-19 pandemic (the "pandemic") has led to disproportionate rates of COVID-19 infection, hospitalization, and death in Black communities.[24]

In part, these disparities are caused by gaps in access to healthcare. These gaps, however, have several causes. First, although the Affordable Care Act expanded coverage for nonelderly Black people, the uninsured rate for Black Americans is higher than the rate for white Americans.[25] Second, structural racism impacts

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[20] Sissela Bok, *Shading the Truth in Seeking Informed Consent for Research Purposes*, 5 KENNEDY INST. ETHICS J. 1, 11 (1995).

[21] *Health Insurance Coverage and Access to Care Among Black Americans: Recent Trends and Key Challenges*, U.S. DEP'T HEALTH & HUM. SERVS. 1, 2 (2022).

[22] *See Health Disparities Among African-Americans*, PFIZER (Sept. 9, 2020), https://www.pfizer.com/news/articles/health_disparities_among_african_americans; Andre M. Perry et al., *Why Is Life Expectancy So Low in Black Neighborhoods?*, BROOKINGS INST. (Dec. 20, 2021), https://www.brookings.edu/blog/the-avenue/2021/12/20/why-is-life-expectancy-so-low-in-black-neighborhoods/ [https://perma.cc/9VJC-8MM4].

[23] Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, KFF (Nov. 1, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/ [https://perma.cc/J9QX-WLR6].

[24] Daniel C. DeSimone, *COVID-19 Infections by Race: What's Behind the Health Disparities?, Why Are People of Color More At Risk of Being Affected by Coronavirus Disease 2019 (COVID-19)?*, MAYO CLINIC (Oct. 6, 2022), https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/coronavirus-infection-by-race/faq-20488802 [https://perma.cc/PX94-Z5QK].

[25] *See* DEP'T HEALTH & HUM. SERVS., *supra* note 21, at 1 ("Since the implementation of the Affordable Care Act (ACA)'s coverage provisions, the uninsured rate among Black Americans under age 65 decreased by 8 percentage points, from 20 percent in 2011 to 12 percent in 2019. The uninsured rate for Black Americans, however, is still higher than that for White Americans: 12 percent compared to 9 percent.").

community and individual health through "racialized residential segregation" and "unequal medical treatment."[26]

Medical mistrust is also a cause of the disparities in health outcomes. Regarding medical mistrust, "unequal medical treatment" is a shared experience in many Black communities, and it impacts views of and trust in medical professionals and the healthcare system more broadly. According to a Pew Research Center study, most Black Americans shared they have had to "speak up to get the proper care" or noticed they were being "treated with less respect than other patients."[27] Moreover, Black individuals have varying perspectives on the state of racial disparities in the Black community. Even though 47% of Black individuals believe health outcomes have improved over the last two decades, 31% believe they have not changed and 20% say they have deteriorated.[28] These statistics are staggering given the number of medical advancements over the past few years.

Medical mistrust impacts health outcomes and contributes to health disparities.[29] Due to medical mistrust, individuals may underutilize healthcare services,[30] not adhere to treatment recommendations,[31] and have a lower quality of life.[32] Researchers have found that compared to non-Hispanic white participants, non-Hispanic Black participants were 73% more likely to report mistrust in health professionals.[33] Also, as discussed *infra* at Part IV.A.2, trust is a fundamental component of the doctor-patient relationship. Therefore, medical mistrust is a significant barrier to telehealth expansion because individuals who distrust healthcare professionals may choose to forgo medical care, even in a healthcare system that is otherwise accessible.

As Black people experience and share stories of unequal treatment, communities further develop a mistrust of healthcare professionals. Black Americans may distrust the healthcare system due to a social memory of historic accounts of medical exploitation and also ongoing experiences of discrimination in the healthcare system and American society more broadly. [34] From a historical perspective, public health literature often identifies the notorious Tuskegee Syphilis

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[26] Zinzi Bailey et al., *How Structural Racism Works—Racist Policies as a Root Cause of U.S. Racial Health Inequalities*, 384 NEW ENG. J. MED. 768, 768 (2021).

[27] Cary Funk, *3. Black Americans' Views About Health Disparities, Experiences with Health Care*, PEW RSCH. CTR. (Apr. 7, 2022), https://www.pewresearch.org/science/2022/04/07/black-americans-views-about-health-disparities-experiences-with-health-care/ [https://perma.cc/B68C-LQFU].

[28] *Id*.

[29] *See supra* notes 4–9; UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INST. MED. 175 (Brian D. Smedley et al. eds., 2003).

[30] *See* LaVeist et al., *supra* note 3, at 2100.

[31] *See, e.g.*, Bogart et al., *Conspiracy Beliefs About HIV*, *supra* note 7; Abel & Efrid, *supra* note 7.

[32] *See* Kinlock et al., *supra* note 8, at 72.

[33] Bazargan et al., *supra* note 5, at 4.

[34] Ramona Benkert et al., *Ubiquitous Yet Unclear: A Systematic Review of Medical Mistrust*, 45 BEHAVIORAL MED. 86, 86–88 (2019) (arguing that "a social-ecological perspective is critical in conceptualizing [medical mistrust]" and stating that "health disparities are shaped by historical and contemporary experiences of injustice and discrimination").

Study as the impetus for medical exploitation and medical distrust among racial and ethnic minorities.[35] Yet, the Tuskegee Study was not the start of medical exploitation. During slavery, Black people became skeptical of white physicians because Black people were consistently used in medical experimentation and physician training while simultaneously excluded from receiving meaningful care in the healthcare system.[36]

The Black community's collective memory of hospital segregation and unequal allocation of healthcare resources also contributes to medical mistrust. After the Civil War, hospitals were the predominant site for medical care, and Black people were either placed in segregated facilities or prohibited from receiving care.[37] Indeed, state laws often required segregation in public facilities (including hospitals) and discrimination in treatment.[38] The Jim Crow regime in hospitals had

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[35] *See* Jaiswal & Halkitis, *supra* note 3; V.L. Shavers et al., *Knowledge of the Tuskegee Study and Its Impact on the Willingness to Participate in Medical Research Studies*, 92 J. NAT'L MED. ASS'N 563, 563 (2000) ("Knowledge of the Tuskegee Study resulted in less trust of researchers for 51% of African-Americans and 17% of whites.").

From 1932 to 1972, the United States Public Health Service engaged the Tuskegee Institute in rural Alabama to initiate a medical experiment to evaluate the natural history of syphilis in 600 Black men, 399 with syphilis and the remaining without. *See The U.S. Public Health Service Syphilis Study at Tuskegee*, CTR. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/tuskegee/timeline.htm [https://perma.cc/S83N-KRCG] (last visited July 24, 2023). Not only did the study's investigators fail to provide the participants with informed consent, but the investigators told the participants that they were simply being treated for "bad blood," a term that referred to multiple illnesses, including syphilis, anemia, and fatigue. *Id*. The researchers also withheld penicillin, the treatment for syphilis, from the participants although it was widely available in 1943. *Id*. After a 1972 Associated Press story about the study, an Ad Hoc Advisory panel reviewed the study and concluded that it was "ethically unjustified." *Id*. The study was terminated in November 1973. *Id*. In May 1997, President Bill Clinton issued an official apology for the study. *Id*. However, no apology could erase this study's impact from the hearts and minds of Black people throughout the nation, and it would remain a cautionary tale for future generations about what could happen if Black Americans placed their trust in the healthcare system or willingly participated in medical research.

Henrietta Lacks is another example of involuntary medical experience. *See generally* REBECCA SKLOOT, THE IMMORTAL LIFE OF HENRIETTA LACKS (2010). Lacks' cancer cells were taken without informed consent and are still the basis of many types of clinical research. *See id.*

[36] *See* Kevin Outterson, *Tragedy & Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735, 750 (2005). As the antebellum medical community sought to discover cures and therapeutics for common ailments, slave owners partnered with physicians to exchange enslaved individuals for use in medical experiments. *See* HARRIET A. WASHINGTON, MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT 54 (2007). Occasionally, owners sold captives, who were gravely ill or elderly, to physicians for research purposes. *Id*. For example, in the 1836 *Southern Medical and Surgical Journal*, 50% of the articles described experiments using Black individuals. *Id.* at 57.

[37] *See* Outterson, *supra* note 36, at 757.

[38] For example, an Alabama law often required racial segregation and treatment discrimination. A 1915 law stated,

> No person or corporation shall require any white female nurse to nurse in wards or rooms in hospitals, either public or private, in which negro men are placed for treatment, or to be nursed; and no white female nurse shall nurse in wards or rooms in hospital . . . in which negro men are placed for treatment . . . .

grave consequences for ill Black patients.[39] Countless stories detail the experiences of Black people who were refused service at hospitals designated for white people.[40] Others end tragically as ill Black individuals perished while en route to the nearest medical facility for "colored" people.[41]

In 1946, the federal Hill-Burton Act ("Hill-Burton"), formally known as the Hospital Survey and Construction Act, increased development of public hospitals and long-term care facilities while also codifying racial discrimination in the healthcare system.[42] Hill-Burton was designed as a federal-state partnership, which involved the allocation of federal funds to states for hospital construction.[43] As the Supreme Court's decision in *Plessy v. Ferguson*[44] deemed segregation constitutional, the Hill-Burton Act included a "non-discrimination" provision, which was interpreted to allow "separate but equal" facilities if there was an "equitable provision on the basis of need for facilities and services of comparable quality for each group."[45] Hill-Burton led to the construction of over 100 "separate but equal" facilities.[46]

In addition to hospital discrimination at the patient level, Black physicians were often excluded from staff privileges at hospitals serving white patients.[47] As a result, Black communities created their own health systems in which Black physicians cared for Black patients.[48] But the facilities were anything but equal to the white hospitals due to limited medical resources.[49] Despite the unequal conditions, Black hospitals provided what many white hospitals did not, a place for Black individuals to be cared for by Black physicians who would not use them as "teaching material" in exchange for health services.[50]

PAULI MURRAY, STATE LAWS ON RACE AND COLOR 31 (1997) (citing CODE ALA. tit. 46 § 189 (1915)). This law did not provide an exception for patients in dire need of medical attention. By prohibiting white female nurses from treating Black males, Alabama law mandated racial discrimination in its healthcare system.

[39] MITCHELL F. RICE & WOODROW JONES, JR., PUBLIC POLICY AND THE BLACK HOSPITAL 29 (1994).

[40] *Id*.

[41] *Id*.

[42] *See* Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 J.L. MED. ETHICS 518, 521 (2020).

[43] *Id*.

[44] 163 U.S. 537 (1896).

[45] Emily Largent, *Public Health, Racism, and the Lasting Impact of Hospital Segregation*, 133 PUB. HEALTH REPS. 715, 715 (Nov. 2019) (citing Hospital Survey and Construction Act of 1946, Pub. L. No. 79-725, § 622(f)).

[46] *See* Outterson, *supra* note 36, at 770.

[47] *See* Largent, *supra* note 45, at 716.

[48] *See* Outterson, *supra* note 36.

[49] *Id.* at 767–71.

[50] Steve Sternberg, *Desegregation: The Hidden Legacy of Medicare*, U.S. NEWS & WORLD REP. (July 29, 2015), https://www.usnews.com/news/articles/2015/07/30/desegregation-the-hidden-legacy-of-medicare (interviewing David Barton Smith, Emeritus Professor at Temple

Formal segregation in healthcare would persist after the passage of Title VI in the Civil Rights Act of 1964, which prohibited recipients of federal funding from discriminating on the basis of race, color, or national origin.[51] Many hospitals did not desegregate until the passage of Medicare, which prohibited distribution of federal funds to hospitals with racially segregated facilities: by threatening to withhold Medicare funding from hospitals that practiced racial discrimination, Medicare catalyzed desegregation of many hospitals, including those in southern states that were resistant to integration.[52]

Beyond historical accounts, medical mistrust is linked to Black people's contemporary experiences of racial bias and discrimination within the healthcare system and beyond. Desegregation was ineffective at addressing covert healthcare discrimination, which endures in the absence of segregation even to this day.[53] In response to the pandemic's disproportionate impact on people of color, researchers at the University of Michigan Medical School and School of Public Health surveyed over 2,000 respondents in a study evaluating the lifetime experiences of discrimination within the American healthcare system.[54] The study found that one in five people experienced some form of discrimination during a healthcare encounter, and racial discrimination was the most common type, followed by discrimination based on education, income, weight, sex, and age.[55] An additional

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University and author of *Power to Heal: Civil Rights, Medicare, and the Struggle to Transform America's Health Care System*).

[51] *See* Largent, *supra* note 45, at 718–19. In *Brown v. Board of Education of Topeka*, the Supreme Court ruled that "separate but equal" public schools are unconstitutional under the Fourteenth Amendment's equal protection clause. 347 U.S. 483 (1954). The Fourth Circuit's decision in *Simkins v. Moses H. Cone, Memorial Hospital* successfully addressed hospital segregation a year before the Civil Rights Act of 1964. 323 F.2d 959 (4th Cir. 1963). In *Simkins*, the Court determined that the use of federal funds (through the Hill-Burton Act) in a racially discriminatory manner was unconstitutional. *Id.* Thus, Black physicians should have been granted staff privileges at the defendant hospitals, and Black patients should have received health services as well. *Id.*

[52] *See* Mary Crossley, *Black Health Matters: Disparities, Community Health, and Interest Convergence*, 22 MICH. J. RACE & L. 53, 67 (2016); *see also* Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1047–48 (2005).

[53] *See, e.g.*, D. Mark Anderson et al., *The Federal Effort to Desegregate Southern Hospitals and the Black-White Infant Mortality Gap*, INST. LAB. ECON. 2–3 (Dec. 2020), https://docs.iza.org/dp13920.pdf [https://perma.cc/N7AK-83D3] (discussing a study that "suggest[ed] that correcting overtly discriminatory practices on the part of Southern hospitals was simply not enough to ensure that Black infants experienced the same health outcomes as their White counterparts," as the Government Accounting Office determined in 1972—"the hospital desegregation campaign had virtually eliminated 'overt' racial discrimination, while more 'subtle' forms of racial discrimination persisted"—and as is "consistent with an argument from the anti-discrimination literature that punitive actions against employers are of limited effectiveness because they do not address underlying biases and prejudices").

[54] Paige Nong et al., *Patient-Reported Experiences of Discrimination in the US Health Care Syste*m, J. AM. MED. ASS'N NETWORK OPEN 1 (2020).

[55] *Id.* at 4 ("Our study estimates that, overall, more than 1 in 5 adults in the US have experienced discrimination at least once while receiving health care. Racial discrimination was the most commonly reported type of discrimination.").

study determined that Black patients are consistently undertreated for pain compared to white patients and found evidence of racial bias in pain treatment recommendations.[56] Outside of the health system, injustice within the criminal legal system, such as police brutality and voter suppression efforts, may impact health and trust in medical and public health institutions.[57]

Thus, the history of structural racism and contemporary experiences of discrimination contribute to medical mistrust held in the Black community. But it is important to underscore that Black communities are not at fault for mistrust, which has been described as a "rational coping response" to racism and discrimination within the healthcare system.[58] As we aim to democratize healthcare, the healthcare system must recalibrate to create a more reliable record upon which trust is warranted. At the same time, genuine partnerships between community organizations and health professionals may help strengthen that trust.[59] This is where telehealth and Black Churches come into the fold.

III. BLACK CHURCH-TELEHEALTH INITIATIVES

This Part provides a summary of telehealth's ability to expand access to care and a brief account of Black Churches' roles in Black communities to support the position that these institutions are prime but underutilized locations for digital

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[56] *See* Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCIS. 4296, 4296 (2016); *see also Black Americans Are Systematically Under-Treated for Pain. Why?*, U. VA. FRANK BATTEN SCH. LEADERSHIP & PUB. POL. (June 30, 2020), https://batten.virginia.edu/about/news/black-americans-are-systematically-under-treated-pain-why [https://perma.cc/5BTJ-RBEM].

[57] *See, e.g.*, Sirry Alang et al., *Police Brutality, Medical Mistrust and Unmet Need for Medical Care*, 22 PREVENTATIVE MED. REPS. 1, 1–2 (2021) (describing the impact of perceived police brutality on medical mistrust); Anna K. Hing, *The Right to Vote, The Right to Health: Voter Suppression as a Determinant of Racial Health Disparities*, 12 J. HEALTH DISPARITIES RSCH. & PRAC. 48, 48 (2018) (describing "a framework for how voter suppression may operate to negatively impact health and well-being, especially for people of color"); Alicia L. Best et al., *Institutional Distrust Among African Americans and Building Trustworthiness in the COVID-19 Response: Implications for Ethical Public Health Practice*, 32 J. HEALTH CARE FOR POOR & UNDERSERVED 90, 90 (2021) ("African Americans are disproportionately affected by COVID-19-related disease and mortality due to long-standing social, political, economic, and environmental injustice; and COVID-19 inequities are exacerbated by institutional distrust.") .

[58] *See* Bogart et al., *COVID-19 Related Medical Mistrust*, *supra* note 3, at 203.

[59] Additionally, racial concordance studies suggest that shared racial identities between the physician and patient may improve health outcomes and strengthen the doctor-patient relationship. *See* Michael D. Frakes & Jonathan Gruber, *Racial Concordance and the Quality of Medical Care: Evidence from the Military*, NAT'L BUREAU OF ECON. RSCH. (2022) (finding that racial concordance "leads to improved maintenance of preventive care – and ultimately lower patient mortality"); Lisa A. Cooper et al., *Patient-Centered Communication, Ratings of Care, and Concordance of Patient and Physician Race*, 139 ANNALS INTERNAL MED. 907 (2003) (finding that race-concordant visits are longer); Lisa Cooper-Patrick et al., *Race, Gender, and Partnership in the Patient-Physician Relationship*, 282 J. AM. MED. ASS'N 583 (1999) (finding that visits in which Black patients shared the same race of their physicians had more participatory medical decision making).

health technologies. My objective is not to share a comprehensive narrative of the origin and significance of Black Churches but to include a summary showing the importance, diversity, and historical roles of these institutions in the public sphere.

Black Churches are already important locations for promoting and providing healthcare and can help further democratize healthcare via telehealth. Through this Article's two models of Black Church-Telehealth Initiatives, telehealth can help democratize healthcare by addressing determinants of health like medical mistrust, the digital divide, and geographic barriers to healthcare access.

A. Telehealth and Health Disparities

Legal and policy scholars have argued for expansion of telehealth to increase healthcare and mental healthcare access in a variety of communities.[60]

For example, in rural and remote communities, telehealth would mitigate the impact of certain social determinants of health, such as limited access to public transportation and shortages of primary care physicians and mental health

[60] *See, e.g.*, Allyson E. Gold et al., *Socially Distant Healthcare*, 96 TUL. L. REV. 423, 463 (2022); Tara Sklar & Christopher T. Robertson, *Telehealth for an Aging Population: How Can Law Influence Adoption Among Providers, Payors, and Patients?*, 46 AM. J.L. MED. & ETHICS 311, 311–12 (2020); *see also* Edmiston & AlZuBi, *supra* note 2. Due to the vestiges of housing segregation and chronic divestment from Black communities across the United States, Black people are more likely to reside in impoverished neighborhoods with, among other things, limited access to healthcare services. *See generally* David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404 (2001).

providers.[61] Also, though shortages of healthcare professionals impact both rural[62] and urban areas, legal scholars often overlook physician shortages in urban communities. For example, a 2016 study found that in Philadelphia, an urban city with "sufficient primary care supply overall," predominantly Black or Hispanic neighborhoods had low access to primary care providers.[63] As a result, residents of those neighborhoods may have been required to travel longer distances for healthcare services.[64] These findings suggest that "even in densely populated cities with relatively high levels of primary care provider supply, geographic access can vary dramatically, with stark racial differences."[65]

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[61] Related to their difficulty attracting and retaining medical professionals, approximately 80% of rural counties have shortages of primary care physicians, and 9% do not have any at all. *See* Michael Ollove, *Rural America's Health Crisis Seizes States' Attention*, STATELINE (Jan. 31, 2020), https://stateline.org/2020/01/31/rural-americas-health-crisis-seizes-states-attention/ [https://perma.cc/AJ89-YZ4W].

Additionally, rural hospitals are struggling to keep their doors open. According to the University of North Carolina's "Rural Hospital Closures" tracker, 183 rural hospitals have closed since 2005. *See Rural Hospital Closures*, U.N.C. CECIL G. SHEPS CTR. FOR HEALTH SERVS. RSCH., https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ [https://perma.cc/538H-4K8Y] (last visited Feb. 4, 2023) (noting that of the 186 rural hospital closures, 102 were identified as "complete closures" in which the facilities no longer provide any healthcare services, and the remaining closures were described as "converted closures" in which the facilities only provide some healthcare services (e.g., primary or emergency care)); *see also Social Determinants of Health for Rural People*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/social-determinants-of-health [https://perma.cc/4PZW-QHX5] (last visited Feb. 4, 2023); *Healthcare Access in Rural Communities*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/healthcare-access [https://perma.cc/DQ6V-GG9M] (last visited Feb. 4, 2023).

According to the Association of American Medical Colleges,

> the United States does not have nearly enough mental health professionals to treat everyone who is suffering. Already, more than 150 million people live in federally designated mental health professional shortage areas. Within a few years, the country will be short between 14,280 and 31,109 psychiatrists . . . the gap between need and access is wider among some populations, including those in rural areas.

Stacy Weiner, *A Growing Psychiatrist Shortage and an Enormous Demand for Mental Health Services*, AM. MED. COLL. (Aug. 9, 2022), https://www.aamc.org/news/growing-psychiatrist-shortage-enormous-demand-mental-health-services [https://perma.cc/MG68-2U5L].

[62] Recent 2020 Census data highlighted that as most rural counties experience significant population decline, rural areas are becoming increasingly diverse across America's racial and ethnic minority groups. *See* Kenneth M. Johnson & Daniel T. Lichter, *Growing Racial Diversity in Rural America: Results from the 2020 Census*, U.N.H. CARSEY SCH. PUB. POL. 1–4 (2022). Moreover, the makeup of rural populations of minorities varies by region. For example, Black people are the largest population of color in most of the rural South, where the vestiges of slavery and Jim Crow still largely shape access to healthcare and economic mobility. *See* D.W. Rowlands & Hanna Love, *Mapping Rural America's Diversity and Demographic Change*, BROOKINGS INST. (Sept. 28, 2021), https://www.brookings.edu/blog/the-avenue/2021/09/28/mapping-rural-americas-diversity-and-demographic-change/ [https://perma.cc/BGV9-RXVR].

[63] Elizabeth J. Brown et al., *Racial Disparities in Geographic Access to Primary Care in Philadelphia*, 35 HEALTH AFFS. 1374, 1378 (2016).

[64] *Id.*

[65] *Id.* at 1380.

Access to primary care physicians may prevent patients from seeking care at expensive visits in emergency departments and urgent care facilities for minor conditions.[66] Accordingly, telehealth may offer patients a more convenient option, while also reining in utilization of more expensive healthcare settings.[67] Moreover, telehealth has the capacity to expand access to mental healthcare, chronic care management, and at-home care for aging populations who may face challenges leaving the home due to physical and mental ailments.[68]

In Black communities, accessing mental healthcare services, whether in urban or rural settings, is a complex topic. Insurance coverage disparities, combined with cultural stigma and medical mistrust, create unique and significant barriers to mental healthcare expansion.[69] According to HHS's Office of Minority Health, Black individuals living below the poverty level are more likely to report serious psychological distress than those with more resources.[70] Black adults are more likely than white adults to report signs and symptoms of depression, such as feelings of sadness or that "everything is an effort, all or most of the time."[71] Notwithstanding these statistics, a 2017 study found that "only one-in-three African Americans who needs mental healthcare receives it."[72]

Accordingly, there may be great promise in using telehealth to help expand access to primary and mental healthcare. But, to truly democratize healthcare via telehealth, we must confront the systemic barriers to bringing care to Black communities. Researchers from the Perelman School of Medicine of the University of Pennsylvania, for instance, found that a telehealth program established during

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[66] *See* Melissa Fransco & Erin Trish, *Targeting Affordability in Healthcare: A Review of the Evidence*, U.S. CAL. SCHAEFFER CTR. HEALTH POL. & ECON. 2 (2021); Layla Parast et al., *Racial/Ethnic Differences in Emergency Department Utilization and Experience*, 49 J. GEN. INTERNAL MED. 49, 49–50 (2021) (suggesting that Black and Hispanic people may have a higher emergency department utilization compared to whites, which may be driven by a combination of factors, including lack of access to care); George Rust et al., *Practical Barriers to Timely Primary Care Access: Impact on Adult Use of Emergency Department Services*, 168 J. AM. MED. ASS'N INTERNAL MED. 1705 (2008).

[67] *But see* Fransco & Trish, *supra* note 66, at 3 ("Further research is needed to understand which types of visits are most cost-effective to conduct remotely to optimize a hybrid care model, where telehealth and in-person visits are integrated across the continuum of care.").

[68] *See* Sklar & Robertson, *supra* note 60, at 311–12.

[69] *See Mental Health Disparities: African Americans*, AM. PSYCHIATRIC ASS'N (2017), https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-African-Americans.pdf [https://perma.cc/4UL3-85MV]. Often, there is significant stigma associated with mental health concerns. Some individuals may believe that their mental illnesses are due to personal weakness and subsequently choose to pray the psychological difficulties away instead of seeking mental health care from professionals. *See* Ruth White, *Why Mental Health Care Is Stigmatized in Black Communities* U.S.C. SUZANNE DWORAK-PECK SCH. SOC. WORK (Feb. 12, 2019), https://dworakpeck.usc.edu/news/why-mental-health-care-stigmatized-black-communities [https://perma.cc/QW5S-9Z3W].

[70] *See Mental and Behavioral Health – African Americans,* U.S. DEP'T HEALTH & HUM. SERVS. OFF. MINORITY HEALTH, https://www.minorityhealth.hhs.gov/mental-and-behavioral-health-african-americans [https://perma.cc/Y5ZR-M4MT] (last visited July 24, 2023).

[71] *Id*.

[72] AM. PSYCHIATRIC ASS'N, *supra* note 69, at 2.

the pandemic allowed Black patients to complete primary care visits at a similar rate as non-Black populations.[73] Specifically, primary care visits increased from around 60% among Black participants before the pandemic to over 80% in 2020.[74] Despite these findings, this study acknowledged that "fewer audiovisual appointments among Black patients relative to non-Black patients early in the pandemic, highlighted the potential impact of the digital divide."[75] As described *infra*, another study revealed the prevalence of concerns related to privacy and confidentiality of conversations with mental health professionals via telehealth.[76] Thus, telehealth's effectiveness and capacity to expand access to care is contingent upon deliberate programming and partnerships designed to address institutional and other barriers to care.

B. Black Churches

Black Churches are sites with abundant potential to help expand access to primary care and mental healthcare through telehealth services, particularly by helping to mitigate the effects of medical mistrust, limited access to healthcare, and the digital divide. Healthcare organizations have already partnered with Black Churches to promote other public health initiatives.[77] For example, since 2021,

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[73] Rebecca E. Anastos-Wallen et al., *Primary Care Appointment Completion Rates and Telemedicine Utilization Among Black and Non-Black Patients from 2019 to 2020*, 28 TELEMEDICINE J. ELEC. HEALTH 1786 (2022).

[74] *Id*.

[75] *Id*.; *see* Ellerie Weber et al., *Characteristics of Telehealth Users in NYC for COVID-Related Care During the Coronavirus Pandemic*, 27 J.A. MED. INFORMATICS ASS'N 1949, 1950 (2020) (highlighting pre-pandemic studies showing that racial and ethnic minorities, older populations, and communities with lower socioeconomic status are "disadvantaged by the digital divide"); *but see Medicare Telemedicine Snapshot*, CTR. FOR MEDICARE & MEDICAID SERVS. 7, https://www.cms.gov/files/document/medicare-telemedicine-snapshot.pdf [https://perma.cc/6RH5-M5PP] (last visited Feb. 4, 2022) (showing that, according to Medicare claims and encounter data, from March 1, 2020, to February 28, 2021, 57% of Black Medicare beneficiaries, compared to 53% of total Medicare beneficiaries, used telemedicine).

[76] *See* discussion *infra* Part IV.B.3.

[77] Recent healthcare collaborations include partnerships between Johns Hopkins Medicine, Norton Healthcare, the University of Louisville, and local Black Churches to increase COVID-19 vaccination in their communities through Church-hosted vaccination clinics. *See, e.g.*, *Johns Hopkins Medicine Partners with Black Churches to Bring Covid-19 Vaccines to the Community*, JOHNS HOPKINS MED. (Mar. 26 2021), https://www.hopkinsmedicine.org/news/newsroom/news-releases/johns-hopkins-medicine-partners-with-black-churches-to-bring-covid-19-vaccines-to-the-community [https://perma.cc/GA8Q-3S4F]; *Hospitals Partner with Predominantly Black Churches to Vaccinate People in West and South Louisville*, WDRB.COM (Dec. 30, 2021), https://www.wdrb.com/news/hospitals-partner-with-predominantly-black-churches-to-vaccinate-people-in-west-and-south-louisville/article_b97909c6-6bea-11eb-a1a9-f736f875eb6a.html [https://perma.cc/7962-BLMK].

Through the Fostering African-American Improvement in Total Health ("FAITH!") initiative, the Mayo Clinic worked closely with Black Churches to provide, among other things, "culturally relevant evidence-based materials" to diminish COVID-19 risk in their neighborhoods. *See* LaPrincess C. Brewer et al., *Emergency Preparedness and Risk Communication Among African American Churches: Leveraging a Community-Based Participatory Research Partnership COVID-*

New York City's Mount Sinai Health Center has partnered with First Corinthian Baptist Church's Healing on Purpose and Evolving ("HOPE") Center to dispel stigma around mental health in Black communities and provide licensed mental health providers to those suffering from depression, trauma, and grief.[78] But Black Churches are rarely partners for community-based telehealth clinics or efforts to expand access to digital health technologies in general. Healthcare organizations should optimize this opportunity for partnership.

In describing "the Black Church," James Cone, often called the father of Black Liberation Theology, writes, "The black church is the single most important institution in the black community . . . . [I]t has been the oldest and most independent African-American organization."[79] At the outset, it is important to note "the Black Church" is far from a monolith as the term represents wide variation amongst African-American Christian denominations.[80] "The Black Church" generally includes the following major Black Protestant denominations: the National Baptist Convention, the National Baptist Convention of America, the Progressive National Baptist Convention, the African Methodist Episcopal ("AME") Church, the African Methodist Episcopal Zion Church, the Christian Methodist Episcopal Church, and the Church of God in Christ.[81] While two-thirds of Black Americans are Protestant, 6% of Black Americans are Catholic.[82] Because Black Catholicism has a distinct and complex origin story, this Article focuses on

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19 Initiative, CTR. FOR DISEASE CONTROL & PREVENTION (Dec. 10, 2020), https://www.cdc.gov/pcd/issues/2020/20_0408.htm [https://perma.cc/CV92-UQUK].

[78] Since 2016, the HOPE Center has provided mental health services to the Harlem community. The Center offers ten free psychotherapy sessions to approximately 200 individuals per year, as well as affinity group sessions for certain demographics (e.g., LBGTQIA+ community members and pregnant mothers). *See Breaking Down Barriers in Access to Mental Health Treatment*, MOUNT SINAI, https://reports.mountsinai.org/article/psych2023-06-community [https://perma.cc/ML2D-X52D] (last visited July 24, 2023); *The HOPE Center*, H.O.P.E. CENTER, https://hopecenterharlem.org/about/the-center/ [https://perma.cc/BR5E-2KUR] (last visited July 24, 2023).

[79] JAMES H. CONE, FOR MY PEOPLE: BLACK THEOLOGY AND THE BLACK CHURCH 99 (1984).

[80] HENRY LOUIS GATES JR., THE BLACK CHURCH 10 (2021).

[81] *See id*.

[82] Besheer Mohamed et al., *10. A Brief Overview of Black Religious History in the U.S.*, PEW RSCH. CTR. (Feb. 16, 2021), https://www.pewresearch.org/religion/2021/02/16/a-brief-overview-of-black-religious-history-in-the-u-s/ [https://perma.cc/K7C6-PFJZ]; Jeff Diamant et al., *Black Catholics in America*, PEW RSCH. CTR. (Mar. 15, 2022), https://www.pewresearch.org/religion/2022/03/15/black-catholics-in-america/ [https://perma.cc/X9DN-ZKVM]. Notably, "the Black Church" generally refers to the Protestant denominations articulated above. Like Black Protestants, most Black Catholics believe that "it is essential that churches assist people who need help with bills, housing or food." *Id.* And some Catholic Churches, such as Chicago's the Faith Community of Saint Sabina, play an important role in Black communities and have health ministries like those discussed *infra* at note 93. *See The Faith Community of Saint Sabina*, SAINTSABINA.ORG, https://saintsabina.org/about-us/ministries.html [https://perma.cc/3X3R-8CXP] (last visited Aug. 1, 2023). Even though this Article focuses on Black Protestant Churches, the potential religious limitations on care, discussed *infra* at Part IV.B.1 and the corresponding footnotes, are particularly relevant to telehealth programs at Catholic Churches.

Black Protestant Churches whose religious views may vary significantly even within denominations.

To understand the central role of Black Churches in Black communities, one must first understand the institution's origins. Despite laws regulating (or even prohibiting) religious assembly amongst enslaved people in the antebellum south, enslaved people would "steal away" and engage in religious services in secret.[83] Such restrictions resulted from slaveholders' fear of a slave uprising, especially in states where enslaved people were the majority of the population.[84] These "invisible churches" laid the foundation for what would become the formal institution W.E.B. DuBois coined "the Negro Church."[85] After emancipation, newly freed Black people established their own churches because they desired a place to worship freely and to empower the Black community.[86]

Beyond the religious sphere, social and political partnerships with Black Churches have been grounded in a legacy of improving the experiences of Black Americans through holistic social programming and political activism.[87] Since its inception, the Black Church has provided social services, such as job training and educational programs.[88] For example, because southern white schools prohibited Black students and northern white institutions often admitted few Black students (if any at all), Black Churches, such as the AME Church, partnered with Northern, white benevolent groups (e.g., the American Missionary Association) to establish Black Colleges.[89] Some Historically Black Colleges and Universities ("HBCUs"), such as Spelman College[90] and Morehouse College,[91] were not just founded through partnerships with Black Churches, but were also initially housed on Church

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[83] *See* GATES, *supra* note 80, at 36–39.

[84] Nicholas May, *Holy Rebellion: Religious Assembly Laws in Antebellum South Carolina and Virginia*, 49 AM. J.L. HIST. 237, 237 (2007).

[85] *See* GATES, *supra* note 80, at 22–23, 28–29.

[86] *See* W.E.B. DuBois, *The Negro Church*, ATLANTA U. (May 26, 1903). In 1816, Richard Allen, for instance, purchased his own freedom and founded the AME Church along with other Black Methodists. *See* Mohamed, *supra* note 82. The AME Church was the first Black Protestant denomination. *Id.* In 1787, Allen and others left a predominantly white Church after they were "pulled from their knees in prayer for being in a section of the church where Black worshippers were not allowed." *Id*.

[87] *See generally* GATES, *supra* note 80 (describing the social programs of Black Churches in the 19th and 20th centuries).

[88] *See id.* at 84–85.

[89] *Consecrated Ground: Churches and the Founding of America's Historically Black Colleges and Universities*, NAT'L MUSEUM AFR. AM. HIST. & CULTURE, https://nmaahc.si.edu/explore/stories/consecrated-ground-churches-and-founding-americas-historically-black-colleges-and [https://perma.cc/PAD2-9BCA] (last visited Feb. 5, 2023).

[90] On April 11, 1881, Spelman College was opened in the basement of a predominantly Black Church, called Friendship Baptist Church, in Atlanta, Georgia. *See History in Brief*, SPELMAN COLL., https://www.spelman.edu/about-us/history-in-brief [https://perma.cc/U25K-TWHY] (last visited Feb. 5, 2023).

[91] Augusta Institute, which would become Morehouse College, was founded on February 14, 1867 in Springfield Baptist Church in Augusta, Georgia. *Our History*, MOREHOUSE COLL., https://morehouse.edu/about/our-history_/ [https://perma.cc/ETY2-464F] (last visited Feb. 5, 2023).

grounds. Through the leadership of Black clergy, Black Churches were a primary location for community organizing and political activism during the Civil Rights Movement of the mid-twentieth century.[92]

Today, Black Churches often dedicate discrete "ministries" to target social issues such as health disparities in Black communities.[93] According to a recent Pew Research Center survey, approximately 75% of Black adults believe predominantly Black Churches have done "a great deal" (29%) or "some" (48%) to help advance racial equality in the United States.[94] Moreover, 66% of Black Americans who are not religiously affiliated[95] say that predominantly Black Churches have done at least some to help Black Americans.[96] Significant percentages of Black survey participants also say that houses of worship should offer "housing and food" (55%) and "practical job and life skills" (43%) alongside the more traditional offerings of religious institutions—spiritual comfort (72%) and a "sense of community" (71%).[97] These figures are not surprising considering the historic and ongoing role of Black Churches in Black communities.

Because Black Churches provide a variety of services to address gaps in resources and social services, it makes sense why public health stakeholders would seek Black Church partnerships to help promote health initiatives and expand access to care.

Yet, telehealth partnerships between healthcare organizations and Black Churches are rare. Black Church-telehealth partnerships are nearly nonexistent, and none appear to combine both primary and mental healthcare services.[98]

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[92] See GATES, *supra* note 80, at 109–148.

[93] *See, e.g.*, *Well Being*, ALFRED ST. BAPTIST CHURCH, https://www.alfredstreet.org/ministries/well-being/ [https://perma.cc/F6F2-52CC] (last visited July 24, 2023) (detailing the goals of the Health and Wellness Ministry); *Trinity's Health Ministry Team*, TRINITY UNITED CHURCHES CHRIST (Oct. 9, 2017), https://www.tucc.org/category/tucc-org/page/2 [https://perma.cc/HB39-6676]; *Ministries: Get Involved*, FELLOWSHIP CHI., https://fellowshipchicago.com/ministries/ [https://perma.cc/23YM-RCT5] (last visited July 24, 2023) (describing the Church's Medical Ministry, which "provides healthcare empowerment through educational resources" and "aid and assistance when needed").

[94] Jeff Diamant, *Three-Quarters of Black Americans Say Black Churches Have Helped Promote Racial Equality*, PEW RSCH. CTR. (Feb. 19, 2021), https://www.pewresearch.org/fact-tank/2021/02/19/three-quarters-of-black-americans-say-black-churches-have-helped-promote-racial-equality/ [https://perma.cc/S47W-9LQ4].

[95] *Id.* (explaining that these Black adults describe themselves as atheists, agnostics, or "nothing in particular").

[96] *Id.*

[97] *Id.*

[98] For example, even the University of Chicago Medical Center's Urban Health Initiative, which primarily serves Chicago's South Side community, has not leveraged digital health technologies to establish the Black Church-Telehealth Initiatives described in this Article. *See Urban Health Initiative*, UCHICAGO MED., https://www.uchicagomedicine.org/about-us/community/urban-health-initiative [https://perma.cc/4LHP-JU9B] (last visited Dec. 11, 2023) (describing various programs that focus on expanding access to care in Chicago's South Side community).

One partnership that does exist is between Atrium Health and Mt. Calvary Baptist Church's Community Life Center.[99] The virtual clinic at Mt. Calvary's Community Life Center targets two glaring social determinants of health: healthcare access and the digital divide. This community-based clinic provides healthcare access to community members who do not have a primary care provider and telehealth equipment to those who lack the requisite video-conferencing technology to meet virtually with an Atrium Health provider.[100] At the clinic, remote providers care for patients with non-emergency medical needs.[101] The clinic is available for scheduled appointments and walk-ins.[102]

Mt. Calvary and Atrium Health's partnership also addresses a latent social determinant of health—medical mistrust. By working with Black Churches to develop innovative telehealth initiatives, Atrium Health's providers leverage Mt. Calvary's trusted relationship with its surrounding community to increase access to healthcare.

But, for several reasons, Black Church-telehealth partnerships are not a perfect remedy for health disparities stemming from medical mistrust or geographic access gaps. Public health partnerships will require dual efforts that involve partnerships with trusted organizations *and* legal solutions that sufficiently address systemic racism and discrimination in the healthcare system. Further, regardless of Church involvement, some participants may be reluctant to participate based on historical and ongoing experiences of "being underserved and exploited" in American society more broadly.[103] Moreover, some Churches have been unwelcoming to people from the LBGTQIA+ community, and young Black Americans are "less connected to Black Churches than older generations."[104] Future research efforts must investigate the extent to which members of the LBGTQIA+ community and young people without formal religious affiliations perceive Black Churches as trusted institutions and providers of social programs. All of these potential limitations must be addressed for Black Church-Telehealth Initiatives to reach their full potential of expanding access to care.

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[99] *See* Atrium Health Press Release, *supra* note 13.

[100] *Id*.

[101] *Id.*; *see also Community Life Center*, MOUNT CALVARY BAPTIST CHURCH, https://mtcalvaryshelby.org/community-life-center-robertsdale-campus/ (last visited Dec. 12, 2023) ("The illnesses treated [at the Community Health Clinic] are non-emergency conditions such as Allergies, Asthma, Coughs and colds, Covid-19 testing, Ear pain, Fever, Flu symptoms, Head lice, Headache, Pink eye, Rash, Sore throat, Stomachache, Urinary tract infection.").

[102] *See* Atrium Health Press Release, *supra* note 13.

[103] *See* Susan Markens, *Role of Black Churches in Health Promotion Programs: Lessons from the Los Angeles Mammography Promotion in Churches Program*, 92 AM. J. PUB. HEALTH 805, 805 (2002).

[104] *See* Kelly Brown Douglas, *Black Church Homophobia: What To Do About It?*, YALE DIVINITY SCH. REFLECTIONS (2006), https://reflections.yale.edu/article/sex-and-church/black-church-homophobia-what-do-about-it [https://perma.cc/XGX8-8MGF]; Besheer Mohamed, *10 New Findings About Faith Among Black Americans*, PEW RSCH. CTR. (Feb. 16, 2021), https://www.pewresearch.org/short-reads/2021/02/16/10-new-findings-about-faith-among-black-americans/ [https://perma.cc/36MW-J5YB].

IV. LEGAL BARRIERS AND REFORMS

As Part III makes evident, Black Churches are typically rooted in predominantly Black communities and are often recognized as trusted institutions for public health partnerships. Indeed, at least one health system, Atrium Health, has opened a community-based telehealth clinic on a Black Church's campus.[105] Although this example exists, federal and state laws present barriers to scaling up these partnerships throughout the United States. This Part analyzes the ways in which legal barriers impact the scalability of Black Church-Telehealth Initiatives like the Telehealth Clinics or Designated Telehealth Spaces.[106]

This Part proceeds in two sections. First, I discuss the general legal barriers to telehealth expansion and scalability that are particularly relevant to health equity—state regulation of physician licensure and the legal requirements for establishing a doctor-patient relationship. Then, I analyze specific legal hurdles to this Article's Black Church-Telehealth Initiatives. These legal hurdles concern compelled disclosures of religious limitations on care, medical malpractice liability, privacy and confidentiality risks, and federal reimbursement of telehealth services at Black Churches.

A. General Legal Barriers

1. State Regulation of Physician Licensure

Each state regulates the licensure of medical professionals and the practice of medicine through its "Medical Practice Act."[107] Generally, a healthcare provider must be licensed in the state in which the patient is located.[108] Within each state, the medical licensing board sets its respective rules for physician licensure.[109] Because each state has its own licensing requirements, including definitions of the practice of medicine as well as application fees and process, "the process of obtaining a license in another state is often . . . burdensome, and costly."[110]

The American Association of American Medical Colleges "project[s] that physician demand will grow faster than supply, leading to a projected total

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[105] *See* Atrium Health Press Release, *supra* note 13.

[106] *See* introduction of the two models, *supra* Part I.

[107] *See* Amar Gupta & Deth Sao, *The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of Its Relationship to National and International Health Care Reform*, 21 HEALTH MATRIX 385, 393 (2011); Jacqueline Landess, *State Medical Boards, Licensure, and Discipline in the United States*, 17 FOCUS (AM. PSYCHIATRIC PUBL'N) 337, 338 (2019).

[108] *See* Dent v. West Virginia, 129 U.S. 114, 122–23 (1889).

[109] *Id.* at 122–25.

[110] U.S. DEP'T HEALTH & HUM. SERVS., REFORMING AMERICA'S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION 37 (2018), https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf [https://perma.cc/3NBD-JKDV].

physician shortage of between 37,800 and 124,000 physicians by 2034."[111] Some states currently have shortages or lower numbers of physicians.[112] As a result, those states may have less telehealth expansion. Take Mississippi and Alabama, for example. Mississippi and Alabama have some of the lowest numbers of mental health professionals and primary care physicians per capita.[113] On the other hand, Vermont is ranked within the top ten states for mental health providers and has the most active primary care physicians per 100,000 residents.[114] However, under the current legal regime, a licensed professional in a state with higher numbers of those professionals, such as Vermont, cannot treat a patient in another state, such as Mississippi or Alabama, without first becoming licensed in that state.

Since the pandemic, many states have issued special licenses or temporary waivers for specific telehealth offerings.[115] For example, Minnesota's 2023 statute on the "interstate practice of telehealth" allows physicians licensed in other states to deliver telehealth services to patients in Minnesota if, among other requirements, such physicians have not had their licenses restricted, will not open an office in Minnesota, will not meet with patients within the state in-person, and have registered with the state medical board.[116] Other states temporarily waived their respective licensure requirements, but many of those waivers have expired.[117]

Addressing the patchwork of state licensure laws, some scholars have argued that exclusive state authority over telemedicine regulation is

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[111] *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034*, AM. ASS'N MED. COLL. 58 (June 2021), https://www.aamc.org/media/54681/download [https://perma.cc/SAJ2-PBMV].

[112] Patrick Boyle, *A Data-Based Look at America's Physicians and Medical Students, State-by-State*, AM. ASS'N MED. COLL. (Jan. 13, 2022), https://www.aamc.org/news-insights/data-based-look-america-s-physicians-and-medical-students-state-state [https://perma.cc/K74G-X9H9].

[113] *See* Maddy Reinert et al., *The State of Mental Health in America*, MENTAL HEALTH AM. 29 (2022), https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf [https://perma.cc/YK52-73YA] ("The term 'mental health provider' includes psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care."); *Mississippi Physician Workforce Profile*, AM. ASS'N MED. COLL. (2021), https://www.aamc.org/media/58236/download [https://perma.cc/93WT-8KPW]; *Alabama Physician Workforce Profile*, AM. ASS'N MED. COLL. (2021), https://www.aamc.org/media/58121/download [https://perma.cc/TG6K-HXVX].

[114] *See Vermont Physician Workforce Profile*, AM. ASS'N MED. COLL. (2021), https://www.aamc.org/media/58346/download [https://perma.cc/HE8D-YCWH]; *see also* Reinert, *supra* note 113. Licensure of different types of mental health providers generally varies by state. *See Types of Mental Health Professionals*, NAT'L ALL. MENTAL ILLNESS, https://www.nami.org/About-Mental-Illness/Treatments/Types-of-Mental-Health-Professionals [https://perma.cc/AT58-2E29] (last visited July 24, 2023).

[115] *State Telehealth Laws and Medicaid Program Policies*, CTR. CONNECTED HEALTH POL. (Oct. 2022), https://www.cchpca.org/2022/10/Fall2022_ExecutiveSummary8.pdf [https://perma.cc/M27R-YFLP].

[116] Interstate Practice of Telehealth, MINN. STAT. § 147.032 (2023).

[117] *See, e.g., U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*, FED'N STATE MED. BDS. (Dec. 11, 2023), https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf [https://perma.cc/VHA4-RLDL] (describing various states' waivers of licensure requirements).

unconstitutional under the Dormant Commerce Clause.[118] Moreover, others have emphasized that Congress has authority under the Commerce Clause to establish a general federal medical licensing scheme.[119] However, opponents of federal regulation of medical practice have contended that this would run afoul of the Tenth Amendment's police power provision.[120] Although the Supreme Court has upheld state authority over several aspects of health, there is significant disagreement over whether that authority is exclusive.[121] In cases such as *Gonzales v. Raich*,[122] *Gonzales v. Oregon*,[123] and *National Federation of Independent Business v. Sebelius*,[124] the Court has suggested that the federal government plays an important role in healthcare regulation as well.[125]

Instead of relying on the Commerce Clause, Congress could require state reciprocity of state medical licenses for telehealth practice under the Full Faith and Credit Clause.[126] Congressional reliance on the Full Faith and Credit Clause would avoid federalism concerns under the Tenth Amendment because individual states

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[118] *See* Gupta & Sao, *supra* note 107, at 417.

[119] Michael S. Young & Rachel K. Alexander, *Recognizing the Nature of American Medical Practice: An Argument for Adopting Federal Medical Licensure*, 13 DEPAUL J. HEALTH CARE L. 145, 194 (2010); *cf.* Lindsey T. Goehring, *H.R. 2068: Expansion of Quality or Quantity in Telemedicine in the Rural Trenches of America*, 11 N.C. J.L. & TECH. 99, 112–13 (2009) (focusing on the federal government's establishment of a "national standard of care" because the "expansion of telemedicine will likely take medical practice across state lines," placing telemedicine "under the umbrella of interstate commerce" where "the federal government would have the authority to regulate the practice").

[120] *See, e.g.*, Sarah E. Born, *Telemedicine in Massachusetts: A Better Way to Regulate*, 42 NEW ENG. L. REV. 195, 195 (2008) (arguing that states have control over practice of medicine and that, "in order to maintain control of the welfare of their citizens, it is crucial that states work together to implement licensure schemes that facilitate the practice of telemedicine across state lines, in the alternative to federal regulation").

[121] *See* Bill Marino et al., *A Case for Federal Regulation of Telemedicine in the Wake of the Affordable Care Act*, 16 COLUM. SCI. & TECH. L. REV. 274, 297 (2015).

[122] Gonzales v. Raich, 545 U.S. 1, 2 (2005) (holding that the Controlled Substances Act did not exceed Congress's power under the Commerce Clause to regulate local marijuana cultivation for medical purposes).

[123] Gonzales v. Oregon, 546 U.S. 243, 246–47 (2006) ("The Federal Government can set uniform standards for regulating health and safety.").

[124] National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012) (upholding certain provisions of the Patient Protection and Affordable Care Act of 2010 as constitutional, including the individual mandate which the Court determined to be a constitutional use of Congress's tax power).

[125] *See* Marino, *supra* note 121.

[126] I will further explore this topic in future work. The paper will suggest that states should honor medical licenses for out-of-state telehealth even without a federal law because of the Full Faith and Credit Clause. If the Full Faith and Credit Clause, however, does not require states to honor such licenses for telehealth, Congress may rely on the Full Faith and Credit Clause to pass legislation permanently requiring medical licensure reciprocity for telehealth. For example, in 2021, a bipartisan group of lawmakers unsuccessfully introduced the Temporary Reciprocity to Ensure Access to Treatment Act (the "TREAT Act") to temporarily allow licensing reciprocity for telehealth and interstate healthcare treatment. *See* H.R. 708, 117th Cong. (2021).

would remain responsible for setting their respective requirements for medical practice within their borders.[127]

Current attempts at addressing the patchwork of state medical licensing laws seek to circumvent federalism concerns but are less effective than a federal law mandating license reciprocity. For example, scholars and policymakers have argued for increased state participation in the Interstate Medical Licensure Compact (the "IMLC" or the "Compact"), which aims to increase access to healthcare through telehealth and other novel technologies by "making it easier for physicians to obtain licenses to practice in multiple states."[128] The Compact is an agreement between thirty-seven states, the District of Columbia, and Guam that creates expedited pathways to licensure for physicians in those participating states and territories.[129] Though the IMLC stands to facilitate expansion of telehealth, the Compact does not result in one portable license that allows physicians to practice across state lines. Instead, the IMLC "streamlines" the medical licensing process by allowing a physician to complete the Compact's application process, but the physician must still receive separate licenses from each jurisdiction in which the physician intends to care for patients.[130] Moreover, states must voluntarily agree to participate in the Compact, which results in predictable complications, such as under-participation or potential withdrawal from the Compact.[131]

Reciprocity should not create concerns that physicians will seek licensure in the state with the easiest process, resulting in substandard care provided in telehealth settings. As described above and *infra* at Part IV.A.2, providers remain subject to state laws and regulations on the substantive requirements for medical

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[127] *See supra* note 126.

[128] *A Faster Pathway to Physician Licensure*, INTERSTATE MED. LICENSURE COMPACT, https://www.imlcc.org/a-faster-pathway-to-physician-licensure/ [https://perma.cc/4EXE-DNRG] (last visited Feb. 5, 2023). As another reform, states could redefine licensure to be in the state where the physician is located, rather than the patient. *See* Sklar & Robertson, *supra* note 60, at 319–20. But it is unclear whether this change would mandate that physicians comply with the medical licensure process in their home state *and* the practice of medicine requirements.

[129] *See* INTERSTATE MED. LICENSURE COMPACT, *supra* note 131.

[130] *Id.* ("These licenses are still issued by the individual states – just as they would be using the standard licensing process . . . . Before physicians can participate in the Compact, they must designate an SPL [State of Principal License], complete an application, and then receive a formal Letter of Qualification from that state, verifying that they meet the Compact's strict eligibility requirements. Physicians cannot obtain licenses through the Compact without completing these steps. After verifying a physician's eligibility for the Compact, the SPL shares this information with additional states where the physician wants to practice medicine. By using expedited information-sharing, participating states are able to significantly speed up the licensure process.").

[131] *Id.* In recognition of this fundamental barrier, U.S. Representative Ted Yoho introduced a bill in 2020 to compel state participation in the IMLC. *See* H.R. 8723, 116th Cong. (2020). The bill sought to induce states' participation by prohibiting funding from HHS's Bureau of Health Workforce unless a state has joined the Compact. *Id.* Under the bill, state licensing boards would be ineligible for certain federal grants unless they have "public awareness campaigns to encourage specialty physicians to practice telemedicine." *Id.* The Compact is a small step towards easing the burdensome medical licensure process. But a federal law mandating that states recognize medical licenses of other states for telehealth would better enhance license portability and allow practitioners to provide telehealth-care across state lines.

practice within each patient's state. Along those lines, Part IV.A.2 describes what states require to establish a doctor-patient relationship via telehealth.

2. In-person Requirements to Establish a Doctor-Patient Relationship via Telehealth

The doctor-patient relationship is the heart and foundation of the healthcare system, as it generally establishes to whom the physician has a duty to treat.[132] Once a provider is licensed in a specific state, that state defines the parameters for establishing a doctor-patient relationship, including when telehealth can facilitate the development of that relationship.

Even though states permit a doctor-patient relationship to be established via telehealth, there is wide variation on whether an in-person visit is required prior to the telehealth appointment.[133] Before the pandemic, some states followed the American Medical Association's recommendation that a doctor-patient relationship be established before the telehealth visit either through the patient having an in-person visit with the physician or the new physician consulting with another physician who has an ongoing doctor-patient relationship.[134] Nonetheless, many states loosened these requirements during the pandemic to expand access to care. Delaware, for instance, passed broad legislation allowing any modality as long as the "provider is able to meet the same standard of care as if the health-care services were being provided in-person."[135]

Legal analyses have advanced several types of reform to combat the patchwork of state requirements to establish a patient-provider relationship. State participation in an Interstate Telehealth Compact, for instance, could harmonize telehealth practice standards, including the requirements for establishing a doctor-patient relationship, across the United States.[136]

Regardless of whether states opt to participate in a telehealth compact or to articulate different requirements for establishing a doctor-patient relationship, the foundational question is whether the in-person visit should be required to establish that relationship, making it possible to conduct telehealth appointments without any prior in-person contact.[137]

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[132] *See* Hurley v. Eddingfield, 59 N.E. 1058 (Ind. 1901); Ricks v. Budge, 64 P.2d 208 (Utah 1937).

[133] *See* AM. MED. ASS'N, 50-STATE SURVEY: ESTABLISHMENT OF A PATIENT-PHYSICIAN RELATIONSHIP VIA TELEMEDICINE 1–2 (2018).

[134] *See id.* (listing Hawaii as an example).

[135] 24 DEL. CODE § 6003 (2022).

[136] *See* Allyson E. Gold et al., *Socially Distant Healthcare*, 96 TUL. L. REV. 423, 463–66 (2022) (explaining that a telehealth compact could allow physicians in participating states to obtain one license to practice in any other compact state).

[137] I focus on the in-person requirement in context of this paper's theme of medical mistrust. Other legal scholarship has addressed the importance of allowing diverse modalities when medically appropriate to establish a doctor-patient relationship. *See, e.g.*, *id.* at 457–58.

A flexible rule allowing a telehealth visit (without a prior in-person visit) to establish a doctor-patient relationship recognizes that patients are autonomous individuals who should be empowered to take charge of their own health through convenient, virtual visits with remote physicians.[138] Moreover, in communities with provider shortages, patients may not have access to the requisite physician to meet the in-person requirement. If a state requires an in-person consultation, telehealth expansion will be hindered in those areas.

Yet, the in-person requirement may be crucial for efforts to strengthen trust in the health care professionals. Telehealth services must be rooted in patient trust of providers to improve patient outcomes and patient engagement with their own healthcare.[139] Trust is the foundation of any doctor-patient relationship, and it has historically been developed over the course of in-person appointments. In communities with low trust in health professionals, a sound doctor-patient relationship is even more crucial to establishing care and maintaining a continuity of care. If a physician only virtually communicates with a patient, it may be challenging for the physician to get to know patients and for patients to feel comfortable sharing personal stories related to their health, such as their home conditions and family history of illnesses.

Moreover, critics of telehealth argue that the trend towards virtual care is dehumanizing medical services and further incentivizing physicians to have more and shorter visits with patients to increase profits.[140] This potential downfall is legitimate and may be exacerbated as many private equity corporations invest in telehealth for monetary gain.[141] As described in Part III.B, partnerships with Black Churches may help curb these risks because the Church can supply some of the personal factors that virtual care itself lacks. But it remains to be seen whether racial minorities with a general distrust of healthcare will develop trusting relationships

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[138] *See* Giovanni Rubeis, *Patient Autonomy and Quality of Care in Telehealthcare*, 24 SCI. & ENG'G ETHICS 93, 93 (2018) (concluding that "the technically enhanced encounter between patients and health professionals may mean an empowerment of patient autonomy when it goes along with a personal relationship based on trust, assistance and support" and that, "[w]hen it comes to the quality of care, telehealthcare may lead to an improvement as long it is adopted to the patient's individual needs").

[139] *Cultivating Trust and Building Relationships During a Telehealth Visit*, U.S. DEP'T HEALTH & HUM. SERVS., https://telehealth.hhs.gov/providers/planning-your-telehealth-workflow/cultivating-trust-and-building-relationships-during-a-telehealth-visit [https://perma.cc/PFB3-HUY9] (last visited Feb. 5, 2023).

[140] *See* Casey W. Nelville, *Telehealth: A Balanced Look at Incorporating This Technology into Practice,* 4 SAGE OPEN NURSING 1, 4 (2018) ("The fear of dehumanization or loss of human connection is present with the topic of telehealth . . . . Some fear that providers who communicate with patients solely by way of telehealth lack the empathy and compassion required of a health-care provider. Telehealth may also cause a gap in communication between physician and nurse as well as physician-to-physician and nurse-to-nurse."); Carmel Shachar et al., *Implications for Telehealth in a Postpandemic Future: Regulatory and Privacy Issues*, 3232 J. AM. MED. ASS'N 2375, 2376 (2020) (citing some of the advantages and risks of telehealth, as well as highlighting that telehealth appointments "tend to be shorter and include fewer diagnostic services than in-person visits").

[141] Heather Landi, *Digital Health Dollars Hit $15B High Driven by Telehealth Investment in 2021*, FIERCE HEALTHCARE (July 19, 2021) (noting that funding for digital health companies was $15 billion in the first half of 2021 due in part by telehealth investment).

with physicians through only telehealth encounters and, relatedly, whether they will trust the digital health technologies through which they receive care.[142]

Together, state laws on physician licensure and establishing a doctor-physician relationship deepen our understanding of states' roles in expanding telehealth. Legal and policy reforms targeted at expanding the ways to establish a doctor-patient relationship must consider their impact on communities with deeply held medical mistrust.

B. Legal Barriers and Reforms: Black Church-Telehealth Initiatives

Beyond legal barriers general to telehealth expansion, Black Church-Telehealth Initiatives raise legal obstacles of their own. This section identifies, evaluates, and proposes reforms for those specific legal obstacles to Black Church-Telehealth Initiatives and democratization of healthcare more broadly. This analysis focuses on the creation of the Telehealth Clinic. Should the legal barriers of the Telehealth Clinic be too great to overcome, the Designated Telehealth Space would involve fewer legal and regulatory burdens, while still utilizing the Church as a trusted institution to promote the importance of healthcare.

3. Religious Limitations on Care

Black Church-Telehealth Initiatives may mitigate the impact of medical mistrust and the digital divide. Due to the religious affiliation of the Telehealth Clinic, however, community members may question the Church's involvement with healthcare delivery and be hesitant to "come as they are" to receive care from the Church's Telehealth Clinic. As described in Part III, some individuals have felt unwelcome by Black Churches.[143] Others may have the impression that the Church's religious doctrines proscribe the types of services available through the Telehealth Clinic.

This section lays out the ways in which care may be limited by the religious doctrines of religiously affiliated partners or the Church itself. It also expands upon legal tools found in informed consent literature to compel disclosure of religious limitations on care and analyzes whether reimbursement of healthcare services at these types of initiatives would offend the Establishment Clause.

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[142] A 2022 Mount Sinai study on telehealth users in New York City for COVID-19-related care during the pandemic states,

> [T]he fact that we still find significant racial/ethnic disparities between outpatient office visits and telehealth indicate there may be other issues at play. Disparities in digital access, digital literacy, and telehealth awareness, as well as issues of cost and coverage and *mistrust of digital appointments where physical examinations, labs, and vitals cannot be taken are all potential barriers to telehealth.* Future research should explore these barriers in the context of the new telehealth explosion.

Weber et al., *supra* note 75, at 1952 (emphasis added).

[143] *See* discussion of Black Churches, *supra* Part III.

a. Black Churches and Religiously Affiliated Healthcare Partners

Part III demonstrates that Black Churches possess a wide array of religious beliefs, and there is no single set of general principles governing healthcare services across all Black Churches. However, some Churches may place limitations on the healthcare they provide based on their own religious beliefs or the religious doctrine and moral directives of healthcare partners.

Some medical services via telehealth may raise issues of conscience for some Black Churches and make them hesitant to host provision of those services. For example, primary or family care physicians offer medication-based abortion via telehealth in select states where the service is not prohibited.[144] Other states, however, have enacted laws to proscribe access to medication-based abortions that are often prescribed by primary or family care physicians via telehealth.[145] In states where medication-based abortion is legal, federal and state laws protecting conscientious objections allow entities to refuse to facilitate abortions via telehealth.[146] Entities may even refuse gender-affirming care for LBGTQIA+ patients in states that broadly allow refusals for any medical service or treatment.[147]

In addition to any of a Church's own beliefs, the religious doctrines of the healthcare institution that establishes a satellite clinic at the Church's Telehealth

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[144] *See* Mabel Felix & Laurie Sobel, *A Year After Dobbs: Policies Restricting Access to Abortion in States Even Where It's Not Banned,* KFF (June 22, 2023), https://www.kff.org/policy-watch/year-after-dobbs-policies-restricting-access-to-abortion [https://perma.cc/F4HX-BBEC] (providing a list of states that allow medication abortions and the corresponding state-specific requirements).

[145] Pien Huang & Mara Gordan, *Telehealth Abortion Demand Is Soaring. But Access May Come Down to Where You Live,* NPR (May 20, 2022), https://www.npr.org/sections/health-shots/2022/05/20/1099179361/telehealth-abortions-are-simple-and-private-but-restricted-in-many-states./ [https://perma.cc/5TLJ-UVUM]; *see, e.g.*, ARIZ. REV. STAT. § 36-3604 (2021) (prohibiting a healthcare provider, pre-*Dobbs*, from using telehealth to provide an abortion and providing that, if a provider "knowingly" violates this statute, the provider will be subject to license suspension or revocation).

[146] For example, the federal "Church Amendments" aim to protect such individuals and entities that perform or refuse to perform abortions or sterilization services. 42 U.S.C. § 300a-7. Similarly, the Affordable Care Act provides, "No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions." 42 U.S.C. § 18023(b)(4). Many states have enacted conscientious refusal statutes with wide variation on the types of services that can be refused on moral or religious grounds. *See* Elizabeth Sepper, *Conscientious Refusals of Care*, *in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW 354, 358 (I. Glenn Cohen et al. eds., 2017). These laws in Mississippi, Illinois, and Washington broadly allow conscientious refusals for any medical service or treatment. *See id.* (citing MISS. CODE § 41-107-3 (2009); 745 ILL. COMP. STAT. 70/4–5 (2010); WASH. REV. CODE § 48.43.065(2)(a) (2008)).

[147] *See id.*; *see also Telehealth for LGBTQ+ Patients,* TELEHEALTH.HHS.GOV, https://telehealth.hhs.gov/providers/health-equity-in-telehealth/telehealth-for-lgbtq-patients [https://perma.cc/J6BC-Q3FD] (last visited July 26, 2023) ("Telehealth appointments are a safe, convenient way for LGBTQ+ patients to access healthcare. Telehealth can also be a necessary lifeline for some patients who do not have LGBTQ+-affirming healthcare available nearby.").

Clinic may limit the healthcare the Clinic delivers.[148] Indeed, federal and state laws protect healthcare institutions that refuse to participate in services for moral or religious reasons.[149]

If Black Churches partner with Catholic healthcare institutions to establish Telehealth Clinics, for instance, the U.S. Conference of Catholic Bishops Ethical and Religious Directives for Catholic Health Care Services (the "Directives") may constrain the care provided at the Clinic. The Directives govern the delivery of care and prohibit medical services deemed "intrinsically immoral, such as abortion . . . ."[150] Some Catholic hospitals have also restricted patient access to gender-affirming services.[151]

Catholic healthcare institutions account for one in seven U.S. hospital beds, and their expansion has not shown any sign of slowing down.[152] As these institutions gain market share, they are broadening the impact of their religious doctrine through property leases and other agreements that require their partners to limit the provision of certain healthcare in accordance with the Directives.[153]

Given the expansion of Catholic healthcare institutions, healthcare delivery is growing increasingly more aligned with faith-based institutions.[154] Religious hospitals are dominating the market and imposing religious restrictions on those who seek care at their facilities.[155] A Church's Telehealth Clinic would generally

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[148] If the healthcare partner is a Catholic-affiliated institution, the Ethical Directives for Catholic Healthcare Services likely apply to the partnership. *See* U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTHCARE SERVICES 28 (6th ed. 2018), https://www.usccb.org/resources/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06_0.pdf [https://perma.cc/X2RA-KVSN] (stating that the Directives apply to a variety of institutional settings in which Catholic healthcare is provided, such as "hospitals, clinics, outpatient facilities, urgent care centers, hospices, nursing homes, and parishes") [hereinafter USCCB DIRECTIVES].

[149] See discussion on laws permitting conscientious refusals, *supra* note 146.

[150] *See* USCCB DIRECTIVES, *supra* note 148, at 25.

[151] *See id.*; *see also* Elizabeth Sepper & James D. Nelson, *Disestablishing Hospitals*, 4 J.L. MED. & ETHICS 452, 543 (2021) ("Some hospitals also refuse to provide gender-affirming care for transgender patients, although the ERDs [U.S. Conference of Catholic Bishops Ethical and Religious Directives for Catholic Health Care Services] do not contain any explicit prohibition.").

[152] Frances Stead Sellers & Meena Venkataramaman, *Spread of Catholic Hospitals Limits Reproductive Care Across the U.S.*, WASH. POST (Oct. 10, 2022), https://www.washingtonpost.com/health/2022/10/10/abortion-catholic-hospitals-birth-control/ [https://perma.cc/H39U-9RMX].

[153] At some of these Catholic facilities, providers may be expected to follow the USCCB Directives. *See* USCCB DIRECTIVES, *supra* note 148, at 26 ("In any kind of collaboration, whatever comes under the control of the Catholic institution—whether by acquisition, governance, or management—must be operated in full accord with the moral teaching of the Catholic Church, including these Directives."). Moreover, "[i]t is not permitted to establish another entity that would oversee, manage, or perform immoral procedures. Establishing such an entity includes actions such as drawing up the civil bylaws, policies, or procedures of the entity, establishing the finances of the entity, or legally incorporating the entity." *Id*.

[154] *See generally* Elizabeth Sepper & James David Nelson, *Government's Religious Hospitals*, 109 VA. L. REV. 61 (2023).

[155] *See id*.

further this trend towards more religiously affiliated healthcare, especially where religious limitations on care exist.

Depending on one's point of view, more access to healthcare providers, including those with religious limitations, benefits the members of the communities with care shortages. On the other hand, the Telehealth Clinic's potential imposition of religious doctrine on healthcare conflicts with physician autonomy over healthcare recommendations and their respective medical practices. Moreover, religious limitations on care threaten patients' bodily autonomy. For example, the aforementioned limitations particularly impact women's reproductive health and the healthcare needs of members of the LBGTQIA+ community. A recent survey on how patients view healthcare entities affiliated with religious institutions found that most patients prefer for their preferences to override the religious institution's values.[156]

In response, Black Churches could survey potential partners and opt not to partner with healthcare institutions with religious limitations that conflict with its ministries or beliefs. Given the reach of Catholic-affiliated hospitals and institutions, Black Churches may not have other viable partners to expand access to telehealth via a Telehealth Initiative. Another potential way to avoid these limitations instead focuses on such proscriptions that may be imposed by the Church itself or the applicable denomination. Black Churches could voluntarily join a compact in which each participating Church commits not to impose religious limitations on care at the telehealth facility or other programs within its health ministry. These Churches, however, may risk expulsion from their respective denominations or national organizations for providing care that conflicts with the predominant theology.[157]

b. Sharpening Compelled Disclosure of Religious Limitations to Avoid Establishment Clause Violations

Current informed consent doctrine is a legal tool that may be expanded to require healthcare institutions to disclose religious or moral limitations on care.[158]

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[156] *See* Maryam Guiahi, *Patient Views on Religious Institutional Health Care*, 2 J. AM. MED. ASS'N NETWORK OPEN 1 (2019).

[157] Although the Southern Baptist Convention ("SBC") is not one of the main Protestant dominations for Black Churches, the SBC's recent actions are a prime example of how a denomination's governance rules allow the sanction of churches that break from the denomination's doctrine. In June 2023, the SBC expelled two churches for having female pastors, which the SBC believes is inconsistent with its interpretations of religious scripture. *See* Brendan O'Brien, *Southern Baptists Finalize Expulsion of Two Churches with Female Pastors*, REUTERS (June 14, 2023), https://www.reuters.com/world/us/southern-baptists-finalize-expulsion-two-churches-with-female-pastors-2023-06-14/ [https://perma.cc/B4CT-AWUK].

[158] *See* Nadia N. Sawicki, *Mandating Disclosure of Conscience-Based Limitations on Medical Practice*, 42 AM. J.L. & MED. 85, 111–14 (2016) (explaining that required disclosures of religious limitations on care are consistent with informed consent doctrine). All states have generally articulated that the following essential information should be disclosed to the patient: "the patient's diagnosis and prognosis; the proposed treatment and its risks and benefits; alternative procedures and their risks and benefits; and the risks and benefits of taking no action." *Id.* at 111. *See, e.g.*,

These disclosures aim to arm patients with information on services and alternatives that are limited for religious reasons so that they can choose whether to receive care at that institution.[159]

But compelled disclosures intersect with the constitutional right not to speak. In *National Institute of Family & Life Advocates v. Becerra* ("*NIFLA*"), the Supreme Court held a compelled disclosure related to medical services was unconstitutional because it was an impermissible infringement on free speech, rather than a lawful regulation of medical conduct. In *NIFLA*, pro-life crisis pregnancy centers challenged a California statute requiring licensed clinics to notify women that California provides free or low-cost services, including abortions.[160] The Court struck down the requirement as unconstitutional.[161]

In *NIFLA*, the Court reasoned that the licensed notice involved a content-based restriction on speech that required the clinics to advertise abortions, a topic they opposed.[162] Although the notice regulated professional speech, such speech is not recognized by the Court as a separate category of speech and is not held to less protection unless the statute (1) requires professionals to disclose factual, noncontroversial information or (2) regulates professional conduct that incidentally involves speech.[163] Because neither exception applied, the statute warranted strict scrutiny as it was a content-based speech regulation rather than a regulation of professional conduct.[164]

To the first exception, an analysis of the constitutionality of a compelled disclosure mandate is contingent upon how broad the construction of the exception for factual, noncontroversial information is. In *NIFLA*, the Court determined that the first exception did not apply because the statute required the clinics to disclose information about "abortion, hardly an 'uncontroversial' topic."[165] In the context of conscientious refusals by religiously affiliated institutions, it is hard to imagine a topic that would be deemed "uncontroversial." And the *NIFLA* court did not define "purely factual and uncontroversial."[166] Justice Kennedy's concurrence, however, suggests a law that "compels individuals to contradict their most deeply held beliefs, beliefs grounded in basic philosophical, ethical, or religious precepts, or all of these" raises constitutional concerns.[167] Therefore, a law that mandates speech

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Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir. 1972) ("[T]he physician is under an obligation to communicate specific information to the patient when the exigencies of reasonable care call for it.").

[159] *See* Sawicki, *supra* note 158.

[160] National Institute of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, 2365 (2018).

[161] *Id.* at 2365–67. The Court also held that the statute unconstitutionally required unlicensed clinics to disclose that California had not licensed the clinics to provide medical services. *Id.* This Article only focuses on the licensed notice because the Church's Telehealth Clinic would be a licensed facility.

[162] *Id.*

[163] *Id.*

[164] *Id.*

[165] *Id.* at 2366.

[166] *See id.*

[167] *Id.* at 2379 (Kennedy, J., concurring).

disclosing consciously refused medical services, is likely constitutional because it would provide patients with information about the religiously affiliated facility's limitations on care that align (rather than conflict) with the facility's religious beliefs or values.

On the other hand, the courts may take a broader interpretation and determine that the first exception does not apply to mandated disclosures of any controversial information, regardless of whether it aligns with the facility's religious beliefs or not.[168] In those circumstances, the compelled disclosure mandate would not fall within the first exception and would be subject to strict scrutiny.

Fortunately, *NIFLA*'s second exception signals that disclosure mandates that primarily regulate the practice of medicine and *only incidentally* burden speech are likely constitutional. In *NIFLA*, the Court determined that the licensed notice did more than incidentally burden speech.[169] Distinguishing *Planned Parenthood of Southeastern Pennsylvania v. Casey*, where the Court upheld certain informed consent provisions for abortions in a state statute, the Court reasoned the licensed notice did more than incidentally burden speech.[170] The disclosure mandate was not a requirement of informed consent doctrine or regulation of medical practice because it was "not tied to a [medical] procedure at all."[171] The law "applie[d] to all interactions between a covered facility and its clients, regardless of whether a medical procedure is ever sought, offered, or performed."[172]

Following the Court's reasoning, a state law may constitutionally mandate disclosure of religiously motivated limitations when a loosely related medical procedure is sought or requested by the patient. For example, if a patient is seeking information on the risks and benefits of prenatal care, the facility would then be required to provide information about any of its religious limitations on abortions or contraception. Notably, end-of-life care is another controversial topic about which there are varying religious beliefs, and there are already federal and state laws articulating disclosure requirements on healthcare institutions once care begins.[173] However, this strategy may be less than ideal because it may be more

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[168] *Id.* at 2380 (Breyer, J., dissenting) ("[T]he majority's view, if taken literally, could radically change prior law, perhaps placing much securities law or consumer protection law at constitutional risk, depending on how broadly its exceptions are interpreted.").

[169] *Id.* at 2374–75.

[170] *Id*.

[171] *Id.* at 2373.

[172] *Id.* at 2366.

[173] Sawicki highlights,

> Both the federal Patient Self-Determination Act [PSDA] and Medicare regulations require healthcare facilities to provide patients with written information about their rights to prepare advance directives, of their rights under state law to make decisions about accepting or refusing medical care, and, most importantly, of the facilities' "written policies . . . respecting the implementation of such rights."

Sawicki, *supra* note 158, at 104 (citing Patient Self-Determination Act, 42 U.S.C. § 1395cc(f) (2012); 42 C.F.R. § 489.102(a)(1)(ii) (2015)). The PSDA requires facilities to provide this

useful for information regarding religious limitations on care to be publicly available to patients regardless of whether they have initiated care or are seeking information about a related procedure.[174] That way, patients have the opportunity to evaluate the publicly available information and determine their preferred providers before care is needed or established at an institution.

Finally, compelled disclosure mandates may help mitigate the risk of Establishment Clause violations stemming from government-sponsored programs (i.e., Medicare and Medicaid) providing reimbursements for services at Telehealth Clinics with religious limitations on care.[175] Sectarian healthcare institutions are major recipients of federal funding through Medicare and Medicaid.[176] In the twentieth century, an analysis of whether government funding to religious institutions violated the Establishment Clause predominantly centered on a three-part test known as the *Lemon* test.[177] Based on *Lemon v. Kurtzman*, the Court would measure constitutionality of the government aid by assessing whether the aid (1) had a secular purpose, (2) neither promoted nor inhibited religion, and (3) caused an excessive engagement between the government and religion.[178] Recent Supreme Court precedent, however, has signaled a shift from its inconsistent reliance on the *Lemon* test.[179]

Instead, the Court has focused on the "mechanisms of state funding rather than the character of the recipient institution."[180] In *Zelman v. Simmons-Harris*, for example, the Court emphasized the private choice of aid recipients, who could "choose" to direct state funding to religious or non-religious schools through a publicly funded voucher program, in deciding that the voucher program did not violate the Establishment Clause.[181] In a more recent case, *Carson v. Makin*, the

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information upon patient admission or when provision of care begins. *See* 42 U.S.C. § 1395cc(f) (2012); *see generally* Sawicki, *supra* note 158 (citing various state laws).

[174] For example, the state of Washington passed legislation requiring hospitals to submit their respective policies on reproductive care and other topics for disclosure on Washington's Department of Health website, regardless of whether a medical procedure is sought or performed. *See* REV. CODE WASH. tit. 70, ch. 41, § 520 (2023) ("One form must provide the public with specific information about which reproductive health care services are and are not generally available at each hospital."); *see, e.g.*, *Policy & Procedure: Reproductive Health Care*, ARBOR HEALTH (Oct. 7, 2020), https://doh.wa.gov/sites/default/files/legacy/Documents/2300/HospPolicies/MortonRH.pdf?uid=649c790a79847 [https://perma.cc/Q39Z-4YP3] (disclosing the Washington hospital's policy regarding reproductive healthcare).

[175] U.S. CONST. amend. I.

[176] Note, the healthcare organization, not the Black Church, would receive Medicare and Medicaid reimbursements for the healthcare delivered at the Telehealth Clinic. The Church would only receive the healthcare partner's lease payments for the space. Therefore, federal funds would not flow to the Black Church through the initiatives contemplated in this Article. The partnership may still trigger the Establishment Clause doctrine because federal funds may reimburse services at a religiously affiliated institution with religious limitation on care.

[177] Lemon v. Kurtzman, 403 U.S. 602, 612–13 (1971).

[178] *Id.*

[179] *See* Sepper & Nelson, *supra* note 153, at 101–04.

[180] *Id.* at 102.

[181] Zelman v. Simmons-Harris, 536 U.S. 639, 662–63 (2002).

Court determined that a state tuition assistance program that allows public funds to flow to religious schools did not violate the Establishment Clause because the public funds would reach the religious schools through the "independent private choices of benefit recipients."[182] Thus, the government aid did not violate the Establishment Clause: it was religiously neutral in *Zelman* and *Carson* because it only reimbursed services at religious schools when based on the individual's personal choices.[183]

Legal scholars have employed *Zelman*'s rationale based on the individual's personal choices (the "true private choice theory") in the context of state reimbursement of healthcare services at sectarian healthcare facilities.[184] Because funding is given to Medicare or Medicaid recipients who have "true private choice" in determining where to receive medical services, federal reimbursement likely does not violate the Establishment Clause.[185] But, from a resource scarcity and accessibility perspective, true private choice may not occur if patients reside in locations where religious healthcare institutions are the sole providers of healthcare services in their communities.[186]

This topic begs the following question: can there be true private choice if information asymmetry exists because religious entities have not disclosed restrictions on care such that patients can *truly* decide to seek care at those facilities?

It is plausible that "true private choice" does not occur without disclosures of religious-based restrictions on care. To have "true private choice," an individual must have the requisite medical information to make an informed decision about whether to receive care at a healthcare institution with religious limitations on care. The individual's ability to locate, understand, and analyze the provided medical information is crucial for effectiveness of compelled disclosure mandates.[187] Otherwise, these disclosure requirements are futile procedural requirements that are arguably immaterial to the "true private choice" analysis. Without these disclosures and because individuals may lack "true private choice," reimbursement for services at religiously affiliated healthcare facilities may violate the Establishment Clause due to the impermissible provision of government funds to religious institutions.

As faith-based institutions, like Black Churches, become more entangled with healthcare and become recipients of federal healthcare reimbursements, a

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[182] Carson v. Makin, 142 S. Ct. 1987, 1989 (2022) (citing *Zelman* to explain that "a neutral benefit program in which public funds flow to religious organizations through the independent choices of private benefit recipients does not offend the Establishment Clause").

[183] *Id*.

[184] *See, e.g.*, Emily E. Fountain, *Tracing Blurred Lines: Catholic Hospital Funding and First Amendment Conflicts*, 74 N.Y.U. ANN. SURV. AM. L. 417 (2019); Stacey A. Tovino, *On Health, Law, and Religion*, 74 WASH. & LEE L. REV. 1623, 1644–45 (2017).

[185] *See* Fountain, *supra* note 184.

[186] *Id.* at 431–33.

[187] *See generally* Omri Ben-Shahar & Carl E. Schneider, *The Failure of Mandated Disclosure*, 159 U. PENN. L. REV. 647, 704–29 (2011). This article also provides empirical evidence suggesting that compelled disclosures are ineffective because they do not facilitate a patient's informed consent to medical services. *Id*.

disclosure duty would provide patients with information to facilitate *true* private choice of healthcare and subsequently mitigate the risk of Establishment Clause violations. Nevertheless, the merits of compelled disclosure may be limited because some patients still may not have viable alternatives to faith-based institutions (e.g., patients experiencing medical emergencies or residing in areas without other options). Therefore, future legal scholarship must explore whether healthcare can truly be democratized if institutions impose religious limitations on care.

4. Medical Malpractice Liability

The telehealth industry involves a range of stakeholders and nontraditional organizations involved in healthcare delivery. The Telehealth Clinic contemplates a contractual arrangement in which the healthcare provider outsources selection and retention of front desk staff to the Church, and the Church's leadership team is granted direct involvement in the selection of participating physicians from a cultural competence perspective. The Church's provision of administrative services and involvement with physician selection may give credence to the partnership and strengthen trust in the healthcare delivered at the virtual clinic. On the other hand, it may open Black Churches up to tort liability for medical malpractice. Here, I evaluate the various theories upon which tort liability can be extended to the Church partner in the Telehealth Clinic and the legal tools for overcoming liability.

Beyond the common law, most states have statutes enshrining varying degrees of the corporate practice of medicine doctrine, which broadly prohibits corporations from owning or controlling medical practices.[188] For example, New York has a very rigid prohibition on the corporate practice of medicine, which applies to all licensed healthcare practitioners.[189] The corporate practice of medicine doctrine developed after a push from the American Medical Association in 1847 to protect the medical profession from exploitation and the profit-focused incentives of nonprofessional corporations that could undermine physicians' independent judgment.[190] Thus, because neither non-professional-owned nor non-professional-controlled corporations can practice medicine, some courts have reasoned that these entities cannot be held responsible for a physician's negligence.[191]

Many states, however, have recognized exceptions to their corporate practice of medicine laws to allow certain hospitals, managed care organizations

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[188] *See* Kathrine Marous, *The Corporate Practice of Medicine Doctrine: An Anchor Holding America Back in the Modern and Evolving Healthcare Marketplace*, 70 DEPAUL L. REV. 157, 159–60 (2022); *see, e.g.*, COLO. REV. STAT. § 12-240-138; NEV. REV. STAT. § 89.050.

[189] N.Y. BUS. CORP. L. § 1507; N.Y. EDUC. L. § 6521-29.

[190] *See* Nicole Huberfield, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 244–49 (2004).

[191] *See, e.g.*, Daly v. Aspen Center for Women's Health, 134 P.3d 450 (Colo. App. 2005) (holding, based on the underlying rationale for the corporate practice of medicine doctrine, a health center cannot be responsible for a physician's negligence); *but see* Sloan v. Metropolitan Health Council of Indianapolis, 516 N.E.2d 1104 (Ind. Ct. App. 1987) (explicitly abolishing any reliance on the corporate practice of medicine doctrine and reversing summary judgment in the plaintiff's favor because the HMO could have been vicariously liable for a physician-employee's negligence).

("MCOs") such as health maintenance organizations ("HMOs"), and other entities to employ healthcare professionals.[192] Accordingly, those corporate entities can be liable for a physician's medical malpractice under the traditional theory of respondeat superior.

Nevertheless, even if corporate practice of medicine exceptions cover Black Churches in telehealth partnerships, the healthcare provider, not the Church, would be liable for a physician's negligence. The healthcare provider is the entity that would employ or otherwise control the remote physicians seeing patients at the Telehealth Clinic.[193] Therefore, the Church would not be liable for a physician's negligence under respondeat superior.

Yet, Black Churches may be vicariously liable for a physician's malpractice based on the legal doctrine of ostensible or apparent agency. Apparent agency "holds a principal accountable for the results of third-party beliefs about an actor's authority to act as an agent when the belief is reasonable and is traceable to a manifestation of the principal."[194] Courts have applied the apparent or ostensible agency theories to hospitals resulting in hospital liability for the acts of independent contractors under the hospital's "control."[195] Under these theories, courts have also expanded liability beyond hospitals to MCOs.[196] Certain MCOs, such as HMOs, insure members and provide healthcare access that is limited to their networks of providers.[197]

Even if the MCO does not employ or otherwise control the practice of contracted physicians, courts have relied on the apparent or ostensible agency doctrine to determine whether the MCO created the appearance of a relationship that could have reasonably led the injured patient to believe the physician was

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[192] *See Corporate Practice of Medicine State Law Survey*, LEXIS, https://plus.lexis.com/api/permalink/c612deb5-b3a7-47fc-8109-fd76cf3a2e19/?context=1530671 (last updated Mar. 27, 2023) (including examples of states with these exceptions, such as Alabama, Illinois, and several others).

[193] For example, many states make exceptions from the corporate practice of medicine doctrine for nonprofit hospitals, basing the exception on the belief that nonprofit corporations or charitable organizations do not possess the same profit motives as for-profit corporations. *See, e.g.*, Berlin v. Sara Bush Lincoln Health Ctr., 688 N.E.2d 106, 111–112 (Ill. 1997); Grp. Health Ass'n v. Moor, 24 F. Supp 445, 446–447 (D.D.C. 1938); People ex rel. State Bd. of Med. Exam'rs v. Pac. Health Corp., 82 P.2d 429, 431 (Cal. 1938).

[194] RESTATEMENT (THIRD) OF AGENCY § 2.03 (AM. L. INST. 2006); *see id.* ("Manifestations . . . may take many forms. These include explicit statements that a principal makes directly to a third party, as well as statements made by others concerning an actor's authority that reach the third party and are traceable to the principal. For example, a principal may make a manifestation about an agent's authority by directing that the agent's name and affiliation with the principal be included in a listing of representatives that is provided to a third party.").

[195] *See, e.g.*, Diggs v. Novant Health Inc., 628 S.E.2d 851, 862 (N.C. App. 2006) (determining that a hospital could be liable under the apparent agency doctrine for negligent acts performed by an independent contractor-physician).

[196] *See infra* accompanying text and notes 199–200.

[197] MCOs generally refer to healthcare companies or plans that seek to reduce healthcare costs by influencing patient treatment options. *See* Joseph Heaton & Prasanna Tadi, *Managed Care Organization*, STATPEARLS (Mar. 6, 2023), https://www.ncbi.nlm.nih.gov/books/NBK557797/ [https://perma.cc/MS3L-E84Z].

acting as an agent of the MCO.[198] To determine ostensible agency, courts generally evaluate "(1) whether the patient looks to the institution, rather than the individual physician for care, and (2) whether the HMO 'holds out' the physician as its employee."[199] In *McClellan v. Health Maintenance Organization of Pennsylvania*, for instance, the plaintiff sued an HMO claiming that the negligent physician was an ostensible agent of the HMO.[200] After the trial court granted the HMO's motion to dismiss, the Pennsylvania Superior Court reversed, holding that the plaintiff had sufficiently alleged facts for an ostensible agency claim.[201] Specifically, the plaintiff alleged that the HMO held out the physician as its agent by, among other notable facts, referring the injured patient to the physician and making representations that the physician was qualified and would provide competent medical care.[202]

Likewise, courts may analogize the Black Churches' roles in on-site Telehealth Clinics to the HMO's activities in *McClellan* that amounted to the patient looking to the institution, rather than the physician, for care and the institution "holding out" the physician as its own employee. Like other endeavors that leverage Church leaders to promote healthcare, the Telehealth Clinic would not only be located on Church grounds but would also involve its leaders in promotion of the Clinic to encourage the Church and community members to use it. The Church would likely include information about the virtual clinic on its website, such as its hours of operation and common illnesses treated at the Clinic.[203] Moreover, Church leaders may even hold a sermon series on the importance of mental or primary healthcare followed by a description of the quality of physicians at the Telehealth Clinic or a recommendation that patients make appointments with specific tele-physicians.

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[198] For MCOs that employ physicians, cases proceed under the theory of respondeat superior. *See, e.g.*, Robbins v. HIP of New Jersey, 625 A.2d 45, 47–48 (N.J. Super. 1993) ("Indeed, it seems highly unlikely that the Legislature would immunize HMOs from the ordinary rule of respondeat superior so that only the employees of an HMO and not the HMO itself would be responsible for the negligent provision of health care services and supplies."). HMOs that contract with independent physicians may still be liable for the negligent actions of those physicians. *See, e.g.*, Schleier v. Kaiser Found. Health Plan, 876 F.2d 174, 177 (D.C. Cir. 1989) (finding an HMO vicariously liable for an independent physician's negligence based on the Court's consideration of the following factors: "(1) the selection and engagement of the servant, (2) the payment of wages, (3) the power to discharge, (4) the power to control the servant's conduct, (5) and whether the work is part of the regular business of the employer").

[199] *See generally* Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1234–35 (Pa. Super. Ct. 1988) (reversing the trial court's grant of summary judgment for the HMO because there was an issue of material fact regarding whether the plaintiff reasonably believed that the physician was an agent of the HMO, noting that the HMO provided a list of primary physicians from which members were required to choose a provider and that physicians were required to meet screening requirements to fulfill their contracts with the HMO).

[200] *See* McClellan v. Health Maintenance Organization of Pennsylvania, 604 A.2d 1053, 1056–57 (Pa. Super. Ct. 1992).

[201] *Id.*

[202] *Id.*

[203] *See, e.g.*, MOUNT CALVARY BAPTIST CHURCH, *supra* note 101.

A patient may seek care at the Telehealth Clinic because of the promotion by and integration of Church staff with the Clinic's operations, and, under these facts, a patient may reasonably believe that her tele-physician was one of the Church's agents. To avoid liability for the negligence of the treating physicians, Churches would need to disclaim clearly and expressly that the physicians are not their agents, for example, in patient registration materials or facility signage.[204]

Jurisdictions could consider allowing these types of Church partners to be immune from suit for negligent treatment. In a few states, HMOs are still granted immunity from civil actions seeking to hold them vicariously liable for a physician's negligence.[205] Similarly, the Church partners contemplated in this Article could be immune from negligence suits because these Church partners would not have control over the medical decisions of remote physicians. Beyond Church partner immunity, the Church should clearly and conspicuously disclaim any agency relationship with remote physicians. Churches should also ensure that they have requisite insurance coverage and indemnification provisions to shift liability to the healthcare provider. But these terms do not prevent injured patients from filing complaints against the Church or other tortfeasors in the first place.

5. Privacy & Confidentiality

Maintaining confidentiality is not unique to telehealth settings. Indeed, it is one of the core legal and ethical obligations of healthcare providers. To have a free flow of communication, patients must trust that physicians will safeguard their personal information. Without confidentiality, patients may become less comfortable sharing private health-related information with their physicians, which could hinder the doctor's ability to provide accurate diagnoses.

Studies show that Black people have a heightened awareness of privacy and confidentiality risks associated with telehealth and subsequently are more hesitant to receive telehealth-care. For instance, a study evaluating pre-experience perceptions about telehealth among African American and Latinx communities found that Black Americans expressed more concern about privacy and confidentiality regarding "the use of the Internet for the transmission of personal information."[206] While overall responses to telehealth for mental healthcare were

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[204] *See, e.g.*, Holmes v. Univ. Health Svc., 423 S.E.2d 281, 283 (1992) (finding that the hospital did not hold out the doctor as an agent when the hospital conspicuously posted signs in the emergency room notifying patients that doctors are not employees and patients signed statement acknowledging that the doctors were not hospital employees or agents). Some hospital cases involving claims of ostensible agency have found that a disclaimer in a consent form is insufficient to inform patients of the lack of an agency relationship. *See, e.g.*, Burless v. West Virginia University Hospitals, 601 S.E.2d 85, 96–97 (W. Va. 2004); Sword v. NKC Hospitals, 714 N.E.2d. 142, 152 n.16 (Ind. 1999).

[205] *See, e.g.*, Martin v. PacifiCare of California, 198 Cal. App. 4th 1390, 1393 (2011) (describing a California health and safety statute stating that health plans (or entities contracting with a plan) may not be held vicariously liable for the medical provider's negligence).

[206] *See* Sheba George et al., *How Do Low-Income Urban African Americans and Latinos Feel About Telemedicine? A Diffusion of Innovation Analysis*, INT'L J. TELEMEDICINE & APPLICATIONS 1, 4 (2012); *see also id.* (finding Black participants more concerned about the physician's physical

positive, another survey's Black participants described similar concerns.[207] This section pays close attention to the privacy and confidentiality risks that this Article's Telehealth Clinics and Designated Telehealth Spaces may pose.

a. Black Church-Telehealth Clinics, HIPAA Compliance, and Liability

HIPAA's Privacy Rule and Security Rule protect "patient health information"[208] ("PHI") from unpermitted uses or disclosures but only apply to a narrow group of entities (i.e., "covered entities"[209] and their "business associates"[210]). Whether the Church falls within the narrow group of entities would depend on the scope of the Church's involvement with the Telehealth Clinic. As discussed in Part IV.B.2, patients may have a greater sense of familiarity, comfort, and trust in the care delivered via telehealth visits if the Church's leaders and staff are integrated with the daily activities of the virtual clinic. But that integration and the covered healthcare provider's outsourcing of healthcare administrative or operations activities to Church staff would place the Church squarely within HIPAA's definition of a "business associate," subjecting the Church to certain HIPAA Rules.[211]

To start, the Telehealth Clinic itself would fall under the purview of HIPAA. An example of a qualifying "covered entity" is any "healthcare provider"[212] who

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absence and "the perceived inability to monitor the (distant) specialist's qualifications and level of attention").

[207] *See* Terika McCall, *Acceptability of Telemedicine to Help African American Women Manage Anxiety and Depression*, 264 STUDENT HEALTH TECH. INFO. 699, 702 (2019) ("Most of the concerns centered around privacy, confidentiality, and maintaining the video call connection. Regarding privacy, one respondent stated, 'I would also be concerned about how private the call is, like is the professional alone, how would I know?'").

[208] 45 C.F.R. § 160.103 (2022) (defining "Protected Health Information" as all "individually identifiable health information" maintained or transmitted by a covered entity or its business associate in any form, including information relating to the patient's former, current, or future physician or mental health, delivery of healthcare to the individual, or any payment for the healthcare delivered to the patient). PHI includes common identifiers, such as the patient's name, address, birth date, or Social Security Number. *See Summary of the HIPAA Privacy Rule*, U.S. DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html [https://perma.cc/NV9K-7V7H] (last visited Feb. 6, 2023).

[209] *See* 45 C.F.R. § 160.103 (2022) (definition of "covered entity").

[210] *Id.* (definition of "business associate").

[211] *See Direct Liability of Business Associates*, U.S. DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/factsheet/index.html [https://perma.cc/K6LY-7ZWK] (last visited July 25, 2023).

[212] *Id*. Under HIPAA, "provider" is construed broadly to include all "providers of services" (e.g., hospitals, physicians, dentists, and other practitioners) as defined by Medicare and any other person or entity that bills or is reimbursed for healthcare). *See Summary of HIPAA Privacy Rule*, U.S. DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html [https://perma.cc/66YR-C7YG] (last visited July 25, 2023). These transactions include "claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which HHS has established standards under the HIPAA." *Id*.

electronically transmits health information in connection with specific transactions, such as submission of information regarding medical claims or benefits eligibility.[213] The Telehealth Clinic's healthcare provider would be a covered entity that electronically transmits health information in connection with a qualifying transaction (e.g., billing insurance electronically).[214] By contrast, the Church would not be a covered entity merely because it partners with a healthcare provider, such as a healthcare system or physician's office, to establish the Telehealth Clinic.[215]

Yet, the Telehealth Clinic partnership places Black Churches squarely within HIPAA's definition of "business associate."[216] Generally, "business associates" are persons or organizations that provide certain services involving the use of PHI to, or on behalf of, the covered entity.[217] The Clinic would employ Church members and community leaders as registration and front desk support in order to strengthen trust, drawing from the goals of community health worker programs.[218] Community health workers, who are individuals who "live, eat, play,

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[213] *See* 45 C.F.R. § 160.103 (2022) (definition of "covered entity").

[214] *See id*.

[215] Moreover, the Church does not bill for or receive any federal reimbursements for healthcare services at the Telehealth Clinic.

[216] HIPAA requires a written contract between the covered entity and business associate detailing, among other provisions, (1) the authorized and required uses and disclosures of PHI by the business associate; (2) a prohibition from the business associate using or disclosing PHI beyond the scope of the contract, unless permitted by law; and (3) requirements for the business associate to implement safeguards to prevent unauthorized use or disclosure of PHI, including those in HIPAA's Security Rule. *Business Associate Contracts*, U.S. DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html [https://perma.cc/FF24-D4P9] (last visited July 25, 2023).

[217] 45 C.F.R. § 160.103 (2022) (definition of "business associate").

[218] The Church may decide not to provide front desk services to the covered healthcare provider. In that case, the Church would merely lease a space to a covered healthcare provider. Even so, the Church may be deemed a business associate if, on behalf of the covered provider, it provides services that directly involve the use of PHI. For example, the following activities may implicate the Church: (1) "installation of fixtures that provide or secure patient health information during which the landlord must have access to the PHI;" (2) "administration of or securing PHI, such as by providing medical suites with common support services, receptionists, or data storage;" or (3) "repossession of the leased premises" to appropriately dispose of or store PHI. *See* Gregory G. Gosfield & Daniel F. Shay, *Do's and Don'ts of Medical and Health Care Facility Leasing*, https://www.kfmc.org/wp-content/uploads/2021/01/PBIRealEstateInstitute2011-ChapterAA-medical-and-Health-Care-Facility-Lease.pdf [https://perma.cc/LF38-D2VR] (last visited Feb. 6, 2023); *see also May a Covered Entity Hire a Business Associate to Dispose of Protected Health Information?*, U.S. DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/faq/577/may-a-covered-entity-hire-a-business-associate-to-dispose-of-information/index.html [https://perma.cc/KB35-9E2Z] (last visited Feb. 6, 2023).

Even if the Church is not a business associate, the partnership should ensure that the Clinic is not located near a highly trafficked area on the Church's campus where other community members may hear or see the names of patients waiting to enter a private room for a virtual appointment. HIPAA's Privacy Rule likely allows the covered healthcare provider to use sign-in sheets or have personnel call out patient names, as long as the provider has implemented reasonable safeguards (e.g., not providing the patient's diagnosis unless necessary for the sign-in process). *See May Physician's Offices Use Patient Sign-in Sheets or Call Out the Names of Their Patients in Their Waiting Rooms?*, U.S. DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-

work, and *worship*" in the targeted community and perform various tasks at the local medical facility, have been found to increase access to health services and improve adherence to physician recommendations.[219] Similarly, Church employees would be on the frontlines of welcoming patients to the virtual clinic. Thus, the Church employees would use and be privy to PHI. If a Church employee violates HIPAA by unlawfully disclosing PHI gleaned while registering or checking in a patient, the Church as the business associate would be directly liable.[220]

Despite the potential benefits, the covered healthcare provider may be discouraged from outsourcing these responsibilities to the Church. The provider may be vicariously liable for the Church-business associate's HIPAA's violations if the Church is acting as its agent under the Federal common law of agency.[221] HHS included this requirement "to ensure, where a covered entity or business associate has delegated out an obligation under the HIPAA Rules, that a covered entity or business associate would remain liable for penalties for the failure of its business associate agent to perform the obligation on the covered entity or business associate's behalf."[222]

Contractual "terms, statements, or labels given to parties (e.g., independent contractor) do not control whether an agency relationship exists."[223] Instead, the inquiry of whether the business associate is the covered entity's agent is fact-specific and turns on the covered entity's right or authority to control the business associate's conduct.[224] A covered entity is in control of an agent when a covered entity provides "interim instructions and directions during the course of the relationship."[225] In contrast, a covered entity is not in control and an agency relationship does not exist if the "business associate agreement with a covered entity . . . sets terms and conditions that create contractual obligations" between the parties.[226] As HHS highlighted, "if the only avenue of control is for a covered entity to amend the terms of the agreement or sue for breach of contract, this generally indicates that a business associate is not acting as an agent."[227] Therefore, the agency analysis "depend[s] on the [covered entity's] right or authority to control

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professionals/faq/199/may-health-care-providers-use-sign-in-sheets/index.html [https://perma.cc/H958-V3LH] (last visited Feb. 6, 2023).

[219] *Role of Community Health Workers*, NAT'L HEART, LUNG, & BLOOD INST., https://www.nhlbi.nih.gov/health/educational/healthdisp/role-of-community-health-workers.htm [https://perma.cc/AE49-4KSA] (last visited July 24, 2023) (emphasis added).

[220] *See* 45 C.F.R § 164.502(a)(3) (2023); 78 Fed. Reg. 5566 (Jan. 25, 2013). Additionally, business associates must with comply with technical requirements for securing PHI detailed in the Security Rule. *See* 78 Fed. Reg. 5566 (Jan. 25, 2013).

[221] *See* 45 C.F.R § 160.402(c)(1) (2013).

[222] 78 Fed. Reg. 5566, 5580 (Jan. 25, 2013).

[223] *Id.* at 5581.

[224] *Id.* at 5581–82.

[225] *Id.* at 5581.

[226] *Id.*

[227] *Id.*

the business associate's conduct in the performance of the delegated service based on the right of a covered entity to give interim instructions."[228]

Regarding the Telehealth Clinic, the Church would be an agent of the covered healthcare provider. The provider would be required to give interim instructions and guidance to the Church's staff responsible for services provided by the medical receptionist, because Black Churches would likely be unfamiliar with the complex and tedious requirements of HIPAA's Privacy Rule, much less how to secure PHI in accordance with the Security Rule. Additionally, the agency analysis considers the "type of service and skill level required to perform the service" in determining whether the business associate is an agent.[229] Given the technical expertise and skill required to maintain HIPAA compliance, Church employees will need the established healthcare providers to provide them with training and instructions on how to safeguard private and sensitive health information.

The federal common law of agency would place a heavy burden on the covered healthcare provider to supervise the Church's employees because the covered healthcare provider would be liable for the HIPAA violations of the Church-agent. This may have the unintended consequence of deterring healthcare providers from contracting with Black Churches to select and monitor individuals to serve essentially as the "face" of the practice. Front desk receptionists are often the first individuals to communicate with current and prospective patients and to make them feel welcome in the space.

To avoid the Church's direct liability and the covered healthcare provider's liability for the Church's HIPAA violations, the provider may directly employ members of the Church's staff to provide these services, rather than outsource the front desk services to its Black Church partner, triggering HIPAA's Rules. Although the covered healthcare provider would be experienced in maintaining HIPAA compliance, the Black Church's leadership team would be more proximate to the local community and better able to understand which members of the internal staff and the surrounding community would be best equipped to provide these administrative services. In collaborations with Black Churches, providers would have the obligation to ensure that their Church and community partners are compliant with applicable laws and regulations on privacy and confidentiality, which are vital to healthcare delivery.

b. Designated Telehealth Spaces and the Health Breach Notification Rule

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[228] *Id*. The following factors are "important to consider in any analysis to determine the scope of agency:"

> (1) The time, place, and purpose of a business associate agent's conduct; (2) whether a business associate agent engaged in a course of conduct subject to a covered entity's control; (3) whether a business associate agent's conduct is commonly done by a business associate to accomplish the service performed on behalf of a covered entity; and (4) whether or not the covered entity reasonably expected that a business associate agent would engage in the conduct in question.

Id.

[229] *Id*.

While the Telehealth Clinics would be subject to HIPAA, the Designated Telehealth Space exposes regulatory gaps in federal patient privacy and confidentiality laws and regulations. As previously stated, HIPAA only applies to a subset of organizations that use PHI.[230] To address the gaps in HIPAA's applicability to entities advancing web-based digital health technologies, such as entities offering services through mobile health applications that hold consumers' health information like fitness trackers and do not meet HIPAA's definitions of a "covered entity" or "business associate," the Federal Trade Commission promulgated the Health Breach Notification Rule ("the Rule").[231] The Rule requires "vendors of personal health records [PHRs]," "third party service providers," and "PHR related entities" to notify impacted consumers, the FTC, and sometimes the media of a "breach" of unsecured, electronic PHRs. [232]

Churches with Designated Telehealth Spaces would be neither covered healthcare providers nor business associates providing services on behalf of healthcare providers. Thus, they would not be bound by HIPAA's requirements to maintain certain security measures to prevent breaches. Moreover, Designated Telehealth Spaces would likely not fall under the purview of the Rule.

Yet, without the safeguards of regulation and due to the potential availability of patient health data on computers and servers, Churches with Designated Telehealth Spaces may become more attractive targets for cyberattacks.[233] Health records and other information are incredibly valuable and may even be more valuable to hackers than other personal information, including social security numbers or credit card information.[234] According to HHS records, "[h]ealthcare breaches have exposed 385 million patient records from 2010 to

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[230] *See supra* Part IV.B.3.a.

[231] *See generally* 16 C.F.R. Part 318. The Rule does not apply to HIPAA-covered entities or business associates. *See Health Breach Notification Rule: The Basics for Business*, FED. TRADE COMM'N (Jan. 2022), https://www.ftc.gov/business-guidance/resources/health-breach-notification-rule-basics-business [https://perma.cc/EG7J-MNKD].

[232] 16 C.F.R. § 318.3. A "breach" includes "cybersecurity intrusions or nefarious behavior" as well as the unauthorized access or sharing of covered information. *See* FED. TRADE COMM'N, STATEMENT OF THE COMMISSION ON BREACHES BY HEALTH APPS AND OTHER CONNECTED DEVICES (Sept. 15, 2021), https://www.ftc.gov/system/files/documents/rules/health-breach-notification-rule/statement_of_the_commission_on_breaches_by_health_apps_and_other_connected_devices.pdf [https://perma.cc/34X6-XHPA]; *see generally* 16 C.F.R. § 318.2. PHR related entities include entities that have access to or send information in a personal health record. *See* 16 C.F.R. § 318.2(f)(3); *see also id.* § 318.2(d) (defining a "personal health record" as an electronic record of "identifiable health information on an individual that can be drawn from multiple sources and that is managed, shared, and controlled by or primarily for the individual").

[233] *See Protecting Your Church from Cyber Threats*, HOLLAND & KNIGHT (2018), https://www.hklaw.com/en/news/intheheadlines/2018/09/protecting-your-church-from-cyber-threats [https://perma.cc/N5Y2-BZCR] ("Churches have become a large target for cyber attacks due to low security measures on computer systems.").

[234] *See* Caroline Humer & Jim Finkle, *Your Medical Record Is Worth More to Hackers than Your Credit Card*, REUTERS (Sept. 24, 2014), https://www.reuters.com/article/us-cybersecurity-hospitals/your-medical-record-is-worth-more-to-hackers-than-your-credit-card-idUSKCN0HJ21I20140924 [https://perma.cc/5PLD-ADM9].

2022."[235] A variety of entities have been breached, such as traditional healthcare providers (i.e., clinics and hospitals), health plans, and business associates.[236]

Healthcare is no longer confined to traditional settings. Due to digital health technologies, patients are increasingly opting for virtual care from the comfort of their homes or even community-based locations (e.g., schools).[237] Partnerships focused on targeting the social determinants of health may lead to more innovative methods to expand access to telehealth. At the same time, as more community stakeholders like Black Churches, libraries,[238] and community centers are leveraged, the list of holders of personal health data expands, exposing the gaps in current health privacy law's reach. As a result of the privacy risk, individuals may be reluctant to utilize the Designated Telehealth Clinics to communicate with healthcare providers or receive care at the Clinics.

The FTC's Health Breach Notification Rule is an existing legal tool that should be broadened to account for the health privacy risks inherent in Designated Telehealth Spaces. First, the Rule already applies to entities that are *not* covered by HIPAA. The Rule affects certain entities, including but not limited to "PHR related entities."[239] Second, the FTC's broad definition of "PHR related entities" could subject Churches with Designated Telehealth Spaces to its breach notification requirements, because Churches may have access to PHRs via online patient portals accessed by the Space's users.

Nevertheless, Designated Telehealth Spaces would likely not be covered by the Rule as the FTC interprets it. The FTC's proposed revisions to the Rule clarify that it applies to online services (i.e., "websites, apps, and Internet-connected devices that provide health care services or supplies") and developers of health applications and similar technologies.[240] But the expanded scope does not cover organizations that hold themselves out as locations whereby consumers can access

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[235] Samantha Liss & Jasmine Ye Han, *Hacking Healthcare: With 385M Patient Records Exposed, Cybersecurity Experts Sound Alarm on Breach Surge*, HEALTHCARE DIVE (Mar. 9, 2023), https://www.healthcaredive.com/news/cybersecurity-hacking-healthcare-breaches/643821/ [https://perma.cc/RQE4-RL4Q].

[236] *See Breach Portal: Notice to the Secretary of HHS Breach of Unsecured Protected Health Information*, U.S. DEP'T HEALTH & HUM. SERVS., https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf (last visited July 25, 2023).

[237] *See, e.g.*, *Telehealth for School-Based Services*, TELEHEALTH.HHS.GOV, https://telehealth.hhs.gov/providers/best-practice-guides/school-based-telehealth [https://perma.cc/T5XR-4GBP] (last visited July 25, 2023).

[238] *See* Nick Tanzi, *Telehealth and Libraries; a Perfect Pairing*, ARIZ. TELEMEDICINE PROGRAM (Apr. 28, 2022), https://telemedicine.arizona.edu/blog/telehealth-and-libraries-perfect-pairing [https://perma.cc/Z9RF-VS8N].

[239] *See* 16 C.F.R. § 318.3; *see generally* 16 C.F.R. Part 318. To clarify what may qualify as a PHR related entity, the FTC stated that such entities could include "online applications through which individuals, for example, connect their blood pressure cuffs, blood glucose monitors, or other devices so that the results could be tracked through their personal health records." Health Breach Notification Rule, 74 Fed. Reg. 17914, 17917 (Apr. 20, 2009).

[240] 88 Fed. Reg. 37819, 37819, 37823 (June 9, 2023).

PHRs through those same qualifying technologies.[241] Therefore, Designated Telehealth Spaces would likely not be required to notify consumers of a breach.

To fill this void, the FTC should reconsider the scope of the Rule, given the proliferation of entities like libraries and eventually Black Churches with Designated Telehealth Spaces that facilitate a user's access to PHI through web-based digital health technologies currently covered by the Rule. Congress instructed the FTC to issue the Rule because specific entities that "hold or interact with consumers' personal health records" were not subject to HIPAA's Security and Privacy Rule.[242] The proposed revisions will account for a variety of digital health technologies, but the Commission should take further steps to safeguard unsecured PHRs that are held by entities with Designated Telehealth Spaces to protect users who use an organization's equipment and technology to meet with their physicians.

In sum, Black Church-Telehealth Initiatives should be subject to HIPAA or the Rule so that PHI remains secure and notifications for covered breaches are required. Moreover, even if PHI is not shared with the Church's members through the Church's Telehealth Clinic, participants may have the false impression that Church members have access to their personal information, which could result in increased medical mistrust. Democratization of healthcare requires that community partners, such as Black Churches, take reasonable precautions such as those required by HIPAA and the Rule to limit unconsented access to patient health information, even for well-intentioned reasons, like prayer and other forms of support provided by the Church's respective health ministry.

6. Federal Reimbursement

This Article's final section describes contemporary approaches by Medicare and Medicaid to cover a broad range of originating sites (i.e., the site where the patient is located) and to provide those sites with facility fees for hosting the telehealth encounter. I focus on these government-sponsored programs because both Medicare and Medicaid have helped decrease uninsured rates for lower-income Black individuals and increase access to care.[243]

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[241] *Id.* at 37819.

[242] *Id.* (discussing the Congressional purpose of the American Recovery and Reinvestment Act of 2009, which directed the FTC to promulgate the Rule).

[243] *See* discussion on Medicare's role in forcing hospitals to desegregate, *supra* notes 50–51. In 2021, African Americans were 34.5% of the total Medicaid beneficiaries. *See Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity*, KFF (2021), https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity/ [https://perma.cc/UL5Q-S8XH] (choose "2021" from dropdown under "Timeframe" and "Black" under "Distributions" to "Refine Results"). Moreover, older Black individuals who are Medicare beneficiaries may fill coverage gaps with Medicaid. *See Medicare and Minority Americans*, HENRY J. KAISER FAM. FOUND. (2013), https://www.kff.org/wp-content/uploads/2013/01/medicare-and-minority-americans-fact-sheet.pdf. But several states (e.g., Mississippi, Alabama, Florida, and Georgia) have declined the Affordable Care Act's expansion of Medicaid. *See* Laura Guerra-Cardus & Gideon Lukens, *Last 11 States Should Expand Medicaid to Maximize Coverage and Protect Against Funding Drop as Continuous*

In this section, I present two arguments. First, without flexible definitions of originating sites, Black Churches may not qualify as covered sites for telehealth for Medicare or Medicaid beneficiaries, whether patients are using a Designated Telehealth Space or the Telehealth Clinic. Second, without reimbursement of facility fees, healthcare providers would have to front the bill for the Telehealth Clinic's infrastructure without any hope of receiving federal reimbursement for the administrative costs for hosting the virtual visit (e.g., rent for space on Church's property and requisite equipment). Facility fees are crucial to community partnerships as they reimburse originating sites for the vital administrative staffing and overhead costs that facilitate the telehealth visit. The lack of reimbursement may deter healthcare providers from developing satellite clinics at Black Churches or other community-based sites and limit democratization of healthcare via telehealth.

a. Medicare Reimbursement

Medicare is a federally administered, federally funded healthcare program that provides health insurance for American citizens of age sixty-five or older, younger individuals receiving Social Security benefits, and individuals with End-Stage Renal disease.[244] Medicare reimburses a facility fee to *qualifying* originating sites for facilitating the telehealth encounter.[245]

Prior to the pandemic, a public health emergency, Medicare determined which locations qualified as originating sites based on where the patient was located during the telehealth service (e.g., doctor's office) and the geographic location.[246] Patients were required to see a remote physician at an originating site in clinical settings, such as physician offices, hospitals, or skilled nursing facilities.[247] Moreover, the originating site was generally required to be in rural areas with shortages of healthcare professionals.[248]

Coverage Ends, CTR. BUDGET & POL'Y PRIORITIES (Jan. 24, 2023), https://www.cbpp.org/research/health/last-11-states-should-expand-medicaid-to-maximize-coverage-and-protect-against [https://perma.cc/B5MR-3RFF]. The Center on Budget and Policy Priorities has called for the remaining states to expand Medicaid to decrease the uninsured rate even more. *See id.* ("Expanding Medicaid would be especially important for low-income adults who are in the coverage gap: those whose income is too low to qualify for subsidies in the [Affordable Care Act] marketplace but above the extremely low Medicaid thresholds in non-expansion states. People of color make up 60 percent of people in this gap . . . ."); *see generally* Benjamin D. Sommers, *State Medicaid Expansion and Mortality, Revisited: A Cost-Benefit Analysis*, 3 AM. J. HEALTH ECON. 392 (2017).

[244] *What's Medicare?*, MEDICARE.GOV, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare [https://perma.cc/DS5W-9NBT] (last visited Feb. 5, 2023).

[245] *See* 42 C.F.R. § 410.78(a)(4) (2023) (Medicare definition of originating site); 42 U.S.C. § 1395m(m) (2022); *Medicare Learning Network (MLN) Fact Sheet: Telehealth Services*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 2023), https://www.cms.gov/files/document/mln901705-telehealth-services.pdf [https://perma.cc/U4PF-QDZE].

[246] *See* 42 C.F.R. § 410.78(b).

[247] *See id.* § 410.78(b)(3).

[248] *See id.* § 410.78(b)(4).

Federal laws have quickly evolved to facilitate expansion of telehealth services. Congress recently passed the Consolidated Appropriations Act, 2023, ("the Act"), which extends specific telehealth-related regulatory flexibilities for Medicare beneficiaries through December 31, 2024.[249] The Act temporarily relaxes the aforementioned geographic and originating site restrictions.[250] For example, for the Act's duration, patients may participate in telehealth visits in any geographic location, like urban areas or non-clinical settings, such as their homes.[251] However, the Act prohibits payment of facility fees to newly eligible originating sites.[252]

Moving forward, the Centers for Medicare & Medicaid Services (CMS) should consider permanently maintaining the regulatory flexibilities from the pandemic and reimbursing facility fees to a broader range of originating sites. Medicare's temporarily expanded definition of "originating site" allows patients outside of rural communities to access primary care in a broad range of locations, including Black Churches in rural or urban communities. As discussed in Part III.A, some communities in urban areas have a limited supply of health professionals and would benefit from telehealth services at a broad range of qualifying originating sites. Indeed, when the other flexibilities expire, the Act permanently allows Medicare patients to receive telehealth services for mental healthcare outside of clinical settings (e.g., in their homes) and in any geographic location.[253] To expand access to the Black Church-Telehealth Initiatives described in this Article, HHS could make similar changes for remote primary care visits as well.

b. Medicaid Reimbursement

Similar to the federal Medicare program, state Medicaid programs often limit the types of settings that qualify as originating sites and whether those settings are eligible for facility fee reimbursement.[254] Medicaid is a federal-state assistance

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[249] *See* Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, 136 Stat. 4459, 5898 § 4113.

[250] *See id.* § 4113(a).

[251] *Telehealth*, MEDICARE.GOV, https://www.medicare.gov/coverage/telehealth [https://perma.cc/H6AW-QV6M] (last visited Feb. 13, 2023).

[252] *See* Consolidated Appropriations Act, 2023, § 4113; 42 U.S.C. § 1395m(m)(2)(B)(iii).

[253] *Telehealth Policy Changes After the COVID-19 Public Health Emergency*, TELEHEALTH.HHS.GOV, https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency [https://perma.cc/6MHR-K2SM] (last visited July 25, 2023).

[254] A fall 2023 summary detailing the status of telehealth-related laws and regulations states,

> A total of thirty-five state Medicaid programs reimburse for either a transmission or facility fee, with the facility fee being far more common. These policies typically outline a defined list of eligible facilities that may receive the facility fee, and specify that when the patient's home or other non-medical sites serve as the originating site, the facility fee would not be applicable.

State Telehealth Laws and Medicaid Program Policies (Fall 2023), CTR. FOR CONNECTED HEALTH POL'Y 14 (2023), https://telehealthresourcecenter.org/wp-content/uploads/2023/05/Fall2023_ExecutiveSummaryfinal.pdf [https://perma.cc/7MMM-BKNY].

program in which states administer their Medicaid programs in accordance with federal standards.[255] Nonetheless, because states have flexibility to define and administer their programs, there is significant variation across states regarding reimbursement for telehealth services.[256]

Several states have broad definitions for qualifying originating sites. North Carolina, for instance, deems a qualifying originating site as "the location in which the beneficiary is located, which may be healthcare facilities, schools, community sites, the home, or wherever the beneficiary may be at the time they receive services via telehealth, virtual communications, or remote patient monitoring."[257] In contrast, some states stipulate a list of qualifying originating sites. For instance, New York has identified a list of acceptable originating sites, including physicians' or dental offices, hospitals, and nursing homes as well as non-traditional settings (e.g., schools and patients' homes).[258]

Like the federal Medicare program, some states (e.g., New York) have temporarily relaxed their facility limitations through December 2024.[259] Even though a state may not place any limitations on originating sites, a state's Medicaid program may prohibit reimbursement of a facility fee for any originating site. For example, Louisiana's Medicaid program only reimburses the distant site provider for services provided via telemedicine and telehealth, and it does not reimburse facility fees to the originating site that hosts the virtual visit. [260]

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[255] Per federal law, states are required to cover certain populations. *See Medicaid Eligibility*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/eligibility/index.html [https://perma.cc/FT8H-GP3D] (last visited July 25, 2023) ("Low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services and children in foster care who are not otherwise eligible.").

[256] Robin Rudowitz et al., *10 Things To Know About Medicaid*, KFF (June 30, 2023), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/ [https://perma.cc/T7YV-ET9A].

[257] *Medicaid and Health Choice, Clinical Coverage Policy No: 1H, Telehealth, Virtual Communications and Remote Patient Monitoring*, N.C. MEDICAID DIV. HEALTH BENEFITS 2, (Oct. 1, 2022), https://medicaid.ncdhhs.gov/media/12009/open [https://perma.cc/WF8Y-9PSX].

[258] *Medicaid Update*, N.Y. STATE DEP'T HEALTH 3 (Feb. 2019), https://www.health.ny.gov/health_care/medicaid/program/update/2019/feb19_mu_speced.pdf [https://perma.cc/N3S6-VECJ].

[259] *See Frequently Asked Questions Regarding Use of Telehealth Including Telephonic Services During the COVID-19 State of Emergency*, N.Y. STATE DEP'T HEALTH 6, https://health.ny.gov/health_care/medicaid/covid19/docs/faqs.pdf [https://perma.cc/WD2Z-74DX] (last visited Aug. 5, 2023) (defining "originating site" under the Medicaid guidance during the federal public health emergency as "anywhere the member is located including the member's home," as "[t]here are no limits on originating sites"); *New York State Department of Health Announces Medicaid Telehealth Coverage Extended Beyond COVID-19 Public Health Emergency*, N.Y. STATE DEP'T HEALTH (July 31, 2023), https://www.health.ny.gov/press/releases/2023/2023-07-31_medicaid_telehealth_coverage.htm [https://perma.cc/TU8X-QLKU].

[260] *See Professional Services Provider Manual*, LA. DEP'T HEALTH § 5.1 (June 27, 2022), https://www.lamedicaid.com/provweb1/providermanuals/manuals/ps/ps.pdf [https://perma.cc/7EVR-SR24].

Because the Telehealth Clinic would involve the development of a clinic, reimbursement of originating site fees is imperative to healthcare democratization efforts through these programs. For patients without sufficient broadband access or the requisite technology for a telehealth encounter, Black Churches could be ideal settings for telehealth visits.

Except when telehealth is medically inappropriate in certain non-clinical settings, reversion to pre-pandemic limitations may be primarily driven by medical paternalism. States should aim to empower patients to have control over where they access certain health services. Thus, state Medicaid programs should ensure that their beneficiaries can receive telehealth services in a broad range of locations, including faith-based institutions.[261]

V. CONCLUSION: BEYOND BLACK CHURCH-TELEHEALTH INITIATIVES

Healthcare is quickly evolving, and telehealth is becoming an integral part of how our system delivers care. However, telehealth will not automatically help address health disparities in access to care or improve health outcomes. Therefore, with intentional community partnerships and programming, telehealth must account for the various determinants of health that obstruct access and weaken participation of marginalized and underserved communities.

Community partnerships like Black Church-Telehealth Initiatives have the potential to expand access to care. But, as this Article illustrates, legal barriers stand in the way, making it difficult to democratize healthcare through telehealth. State legal divergence and the impact of complex healthcare federalism principles on certain aspects of telehealth regulation create obstacles for widespread telehealth utilization.

As healthcare organizations partner with community organizations to expand access to telehealth, creative legal solutions will be required to subject those community organizations to important laws and policies including privacy and confidentiality laws without stifling innovation and collaboration. Broader trends towards increasing alignment of healthcare with religious organizations continue to highlight unresolved legal questions on the role of religious doctrine in the healthcare marketplace.

Lastly, underneath it all is the age-old, American debate about whether healthcare should be a privilege or a right. Who is eligible under either view? Moving forward, well-resourced, major health systems should collaborate with community stakeholders, such as Black Churches, and incorporate other measures to remedy historic failures like medical experimentation and contemporary challenges such as the digital divide and medical mistrust. The extent to which the healthcare system must identify and implement effective strategies to address these

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[261] It must be noted, however, that facility fee reimbursements may encourage overutilization of telehealth services and subsequently increase healthcare costs. *See* Antonita Madonna, *U.S. Health Insurers, Wary of Telehealth Overuse, Urge More Planning in Policy Easing*, REUTERS (July 27, 2020), https://www.reuters.com/article/bc-finreg-telehealth-insurance-policies/u-s-health-insurers-wary-of-telehealth-overuse-urge-more-planning-in-policy-easing-idUSKCN24S2EA [https://perma.cc/82WS-5W2X].

factors is based on deeply held ideologies regarding these opposing views of healthcare being a privilege or a right and beliefs about who can be left behind by inadequate programs and legal structures. Telehealth provides us with an opportunity to rebrand and transform the healthcare system's insufficient response to this debate to move towards establishing healthcare as a right for all.