Policy Spotlight

Telehealth and the Role of the Aging Network

Developed in partnership with the National Council on Aging, this Policy Spotlight provides an overview of telehealth, important changes that occurred during the COVID-19 pandemic to ensure continued access to care for older adults, current challenges related to access, opportunities for the Aging Network and legislative activities to expand telehealth.

I. Introduction

The pandemic created unprecedented challenges for how patients, particularly older adults, access health care. Since people were advised to stay at home to reduce risk of exposure to COVID-19, there was an urgency to increase access to telehealth services to help those who needed routine care while allowing them to remain safely in their homes. In response, the federal government took extraordinary action to expand telehealth for Medicare beneficiaries. Telehealth was shown to be an effective way for people to access health care safely during the pandemic, including getting prescriptions refilled, managing chronic conditions or obtaining mental health counseling.[1] The Aging Network has played and will continue to play an important role in ensuring that older adults have access to telehealth in a timely and effective manner.

II. Impact of the Pandemic on Use of Telehealth

In 2020, the Coronavirus Preparedness and Response Supplemental Appropriations Act was passed. The law allowed the Centers for Medicare & Medicaid Services (CMS) to take several actions to waive some existing regulations and temporarily expand access to telehealth. For example, CMS allowed Medicare beneficiaries to use telehealth for a wide range of services and in different locations, including in urban areas and at home. Prior to the pandemic, beneficiaries were allowed to use telehealth only from medical facilities located in rural areas, with a few exceptions. CMS also waived certain HIPAA regulations that forbid physicians from using the commonly available virtual platforms, such as Facetime and Skype. In addition, CMS allowed physicians to be reimbursed for telehealth visits at the same rate as office visits.

During the pandemic, CMS increased the number of services that beneficiaries could use via telehealth, to 264 from 118 services. The services that can be provided via telehealth include office visits (evaluation and management), behavioral health counseling, preventive health screenings (e.g., Annual Wellness Visit), nursing home visits and home visits, among

Definitions

Telehealth: A broad term to describe health services that are provided remotely via telecommunication technology. Telehealth can include an appointment with a health care professional over the phone or video chat, messages sent through an online health portal or by using a device that gathers vital signs and sends them back to the healthcare provider.[2]

Telemedicine: More commonly associated with direct clinical services provided by health care provider to a patient, such as an appointment with a health care provider over the phone or video chat. Telemedicine refers specifically to remote clinical services, while telehealth can refer to remote non-clinical services.[2]

1 Verma S. Early Impact of CMS Expansion of Medicare Telehealth During COVID-19. *Health Affairs* Blog. https://www.healthaffairs.org/do/10.1377/forefront.20200715.454789/full.

2 Sources: Centers for Medicare & Medicaid Services, *Medicare Telemedicine Health Care Provider Fact Sheet*, https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet. Medicare.gov, *Telehealth*, https://www.medicare.gov/coverage/telehealth. Centers for Medicare & Medicaid Services, Medicare Telemedicine Snapshot, https://www.cms.gov/medicare-telemedicine-snapshot.

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Telehealth Modalities[2]

Telehealth visit: Services include office visits, psychotherapy, consultations and certain other medical services that are provided by a health care provider who is elsewhere and uses audio and video communication technology such as a telephone or computer. Telehealth can be delivered in the following ways:

- **Live video:** Also referred to as "real-time"; a two-way, face-to-face interaction between a patient and a provider using audiovisual communications technology.
- **Audio-only visits:** Use of telephone for visits without video.
- **E-visits:** A non-face-to-face communication between a patient and their provider through an online patient portal.

Remote patient monitoring: Use of digital technologies to collect health data from patients in one location and electronically transmit that information securely to providers in a different location (health data can include temperature, weight, blood pressure, blood sugar, pacemaker information, etc.).

Virtual check-in: A brief five-to-10-minute patient-initiated communication with a health care provider via telephone or other telecommunications device to determine whether an office visit is needed (or next available appointment).

Store-and-forward: Remote evaluation of recorded video and/or images submitted by an established patient.

Mobile health (mHealth): Allows patients to review their personal health data via mobile devices, such as cell phones and tablets, which can be done from their home and assists in communicating their health status and any changes; often includes use of dedicated software applications, which are downloaded onto devices such as mobile phones or tablets.

Case-based teleconferencing: Method of providing holistic, coordinated and integrated services across providers; usually interdisciplinary, with one or multiple internal and external providers and, if possible and appropriate, the client and family members/close supports.

others. CMS also expanded the use of audio-only visits for certain types of telehealth services, such as office visits and behavioral health services. Prior to the pandemic, only audio-video was allowed for the delivery of telehealth services, with a few exceptions.[3]

Telehealth use skyrocketed during the early months of the pandemic. While its use has since decreased somewhat from that high, it still represents a much more substantial share of health care than before the pandemic. From March through August 2021, eight percent of all outpatient visits were conducted via telehealth—down from 13 percent in the first six months of the pandemic, but well above pre-pandemic levels, when telehealth accounted for a negligible share of outpatient visits.[4]

More than 28 million, or two in five, Medicare beneficiaries used telehealth during the first year of the pandemic. Beneficiaries' use of telehealth peaked in April 2020 and remained high through early 2021. Overall, Medicare beneficiaries used telehealth to receive 13 percent of their services during the first year of the pandemic. Beneficiaries most commonly used telehealth for office visits, which accounted for just under half of all telehealth services used during the first year of the pandemic. However, beneficiaries' use of telehealth for behavioral health services stands out—beneficiaries used telehealth for a larger share of their behavioral health services compared to their use of telehealth for other services. Specifically, beneficiaries used telehealth for 43 percent of behavioral health services, compared to 13 percent of routine office visits.[5]

3 Office of the Inspector General, Department of Health and Human Services. *Data Brief: Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*.

4 Lo J, Rae M, Amin K, Cox C. *Outpatient telehealth use soared early in the COVID-19 pandemic but has since receded. Report by the Kaiser Family Foundation*.

5 Office of the Inspector General, Department of Health and Human Services. *Data Brief: Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*.

III. Disparities in Telehealth Access and Other Barriers to Telehealth

While many Medicare beneficiaries participated in telehealth, nearly one-third of all telemedicine visits were completed by audio-only telehealth.[6] There are still many barriers to telehealth for older adults, including access to technology and broadband internet, lack of experience with technology, or physical limitations.

A 2021 Pew Research study found that 61 percent of those 65 and older own a smartphone, and 44 percent in the same age group own a tablet.[7] Owning technology is just one part of the equation as many older adults live in communities that do not have broadband access. A study conducted by the Older Adults Technology Services from AARP (OATS) found that nearly 22 million older Americans, or 42 percent, do not have broadband internet access at home.[8] Access to technology and broadband is not equal. There is a deep digital divide among older adults. Individuals who are older, have less education, have low incomes, and/or who are members of historically marginalized populations were up to five times less likely to have access to digital health information.[9] The OATS report also found that Black and Latino older adults were 2.5 and 3.3 times more likely, respectively, to be offline.

Further, many telehealth platforms do not account for specific needs of older adults that may relate to age-related changes in vision, hearing, touch and perception. Accessible technology can help close this gap. Engaging caregivers or a support person may also help facilitate a conversation between the patient and health care provider.

Psychological barriers, such as security concerns and readiness, are also common and prevent older adults from participating in telehealth. One literature review found that the most common barriers for older adults engaging in telehealth included technical literacy, lack of desire and cost.[10]

NCOA's Mapping Tool

To help the Aging Network and others understand what is happening in local communities, NCOA created a data visualization tool[11] that maps low-income older adults by race/ethnicity, access to technology, and limited English proficiency. Access to technology includes both access to the broadband internet as well as smartphones and other devices. This data visualization tool can identify needs among the low-income adults in an area, and educate public officials, funders and others about these needs.

IV. Opportunities for the Aging Network

Because of their deep connections to the communities they serve, Area Agencies on Aging and other community-based organizations (CBOs) in the Aging Network have an opportunity to engage with older adults left behind by telehealth's growth and advances. There may also be opportunities for CBOs to contract with health care entities such as health plans and physician practices to assist their older members or patients with accessing needed technology for telehealth visits or services.

To avoid digital exclusion and resulting inequalities, applying an equity lens to any discussions around telehealth access must address the root causes of these existing disparities, including:

- Technical skills or lack of digital literacy
- Infrastructure
- Disability
- Language

6 Verma S. Early Impact of CMS Expansion of Medicare Telehealth During COVID-19. *Health Affairs* Blog. https://www.healthaffairs.org/do/10.1377/forefront.20200715.454789/full.

7 Pew Research Center, *Share of those 65 and older who are tech users has grown in the past decade*, https://www.pewresearch.org/fact-tank/2022/01/13/share-of-those-65-and-older-who-are-tech-users-has-grown-in-the-past-decade.

8 Older Adults Technology Services from AARP, *Aging Connected: Exposing the Hidden Connectivity Crisis for Older Adults*, https://agingconnected.org/wp-content/uploads/2021/05/Aging-Connected_Exposing-the-Hidden-Connectivity-Crisis-for-Older-Adults.pdf.

9 Tappen RM, Cooley ME, Luckmann R, Panday S. Digital Health Information Disparities in Older Adults: a Mixed Methods Study. *J Racial Ethn Health Disparities.* 2022 Feb;9(1):82-92.

10 Kruse C, Fohn J, Wilson N, Nunez Patlan E, Zipp S, Mileski M. Utilization Barriers and Medical Outcomes Commensurate With the Use of Telehealth Among Older Adults: Systematic Review. *JMIR Med Inform* 2020;8(8):e20359. https://medinform.jmir.org/2020/8/e20359.

11 NCOA, *Mapping Low-Income Older Adults by Race, Language, and Technology Access*, https://ncoa.org/article/mapping-low-income-older-adults-by-race-language-and-technology-access.

- Psychological barriers, and
- Preference for or need to use audio-only telemedicine.

When in-person visits are not an option due to geography, the existence of a pandemic, or an individual's immunocompromised status, options must be available to ensure that vulnerable patients who are experiencing disparities in access to telemedicine do not forgo needed clinical or social services. CBOs have unique opportunities to leverage relationships with clients to bring telehealth innovations to older adults who are impeded by barriers that CBOs can help patients overcome.

Technical skills or lack of digital literacy: Many older patients lack the technological skills to fully take advantage of all telehealth has to offer. To address this issue, CBOs could screen older adults for existing digital literacy barriers and provide resource guides or telephonic instruction, for instance, for using a digital patient portal. In-person demonstrations in the community along with peers may be more effective for those unaccustomed to certain technologies. To assist geographically disparate or at-risk patients, CBOs might want to offer the option for telephonic instruction. Care coordinators and others who provide instruction will need a high level of technical proficiency to assist with mobile device management. Partnerships with individuals who can capably provide mobile device instruction may also be needed. If appropriate legally and clinically and desired by the patient, CBOs may wish to provide recordings of instructional sessions to clients to ensure that they are able to review instruction and replicate the process in the future.

Infrastructure: Another way to address any infrastructure-related disparities is to provide free or low-cost rentable, in-home equipment such as tablets or laptops, including those that connect to the television. Prior to providing the equipment, CBOs may wish to analyze the equipment's user interface to identify any potential obstacles to utilization and make adjustments as needed. Technology lending libraries have been created and used throughout the pandemic by many CBOs.

NCOA has created a FAQ on Technology Resources[12] that provides additional examples of increasing access to broadband internet and/or technology.

CBOs can also help users qualify for the Federal Communication Commission's Affordable Connectivity Program and the USAC Lifeline Support to help clients secure access to long-term, affordable broadband internet (see *Resources to Share with Older Adults* for more information).

Resources to Share with Older Adults

- **Universal Service Administrative Company (USAC) Lifeline Support**
  www.lifelinesupport.org
  - Lifeline is a federal program to help reduce the cost of phone and internet services for low-income households. The benefit provides consumers with a monthly discount of up to $9.25. Consumers living on tribal lands can receive a monthly discount of up to $24.25.
- **Federal Communication Commission (FCC) Affordable Connectivity Program**
  www.fcc.gov/acp
  - The Affordable Connectivity Program provides a discount of up to $30 per month toward internet services for qualifying households and up to $75/month for qualifying households on tribal lands. The Affordable Connectivity Program replaced the Emergency Broadband Benefit on December 31, 2021.

Field Example: MAC, Inc.

The Maryland Living Well Center of Excellence (MAC, Inc.) initially engaged multicultural organizations to help with the state's tablet distribution. Although the Aging Network was their first option, many CBOs did not have a strong connection to individuals who have limited English proficiency. They provided nonprofit multi-cultural organizations with tablets to reach Asian, Chinese, Hindu and Spanish-speaking individuals. They have also worked with churches to reach underserved populations and use Facebook to connect with hard-to-reach individuals.

12 NCOA, *Frequently Asked Questions: COVID-19 and Technology Resources*, https://www.ncoa.org/article/frequently-asked-questions-covid-19-and-technology-resources.

Field Example: AgeOptions

AgeOptions has facilitated Chronic Disease Self-Management Program (CDSMP) workshops on Uniper, a "virtual senior center" platform. Through funds made available via the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), AgeOptions launched the platform targeting low-income, minority populations at high risk for social isolation. Through this platform, they were able to reach new communities of older adults who may not live close enough to join a workshop, may not be able to leave home for long periods of time due to caregiver responsibilities, or may be homebound due to physical needs or a lack of access to transportation.

Disability: People with disabilities, such as those with vision or hearing impairments, may encounter unique barriers to care when using telemedicine. CBOs can provide telephonic or in-person assistance to people with disabilities who desire assistance. An example of this would be providing access to screen reading technology that would supplement telehealth equipment to older adults whose vision is impaired. Centers for Independent Living are important partners for the Aging Network in responding to the needs of older adults with disabilities. State Assistive Technology Act Projects are another critical resource for CBOs in the Aging Network.

Assistive Technology Act Projects

The Improving Access to Assistive Technology for Individuals with Disabilities Act of 2004 is a major source of funding for assistive technology. The goal of the act is to provide assistive technology to people with disabilities to help ensure they can more fully participate in education, employment, and daily activities on a level playing field with other members of their communities. Under the law, each state and territory receive a grant to fund an Assistive Technology Act Project. These projects provide services to people with disabilities for their entire life span, as well as to their families or guardians, service providers, and agencies and other entities that are involved in providing services such as education and employment to people with disabilities.

Language: CBOs may also want to ensure that any provided technology is switched to a display language matching that which the older adult is most comfortable. Many telehealth companies offer interfaces in multiple languages. If this is not possible, CBOs may also provide translation services to clients who are using English-language-programmed technology. CBOs will want to find a culturally competent and linguistically appropriate remote translator if the patient's linguistic needs cannot be met in the community.

Psychological: CBOs may encounter psychological barriers to telehealth use when interacting with their clients. Establishing emotional safety can facilitate the delivery of care when CBOs become aware of clients' concerns about in-person care rooted in issues such as previous clinical fears or existing comorbidities. Care coordinators may be able to help clients overcome psychological barriers by offering access to Zoom, email, book readers and other tools. Case managers may also ask friends and family for assistance overcoming any anxiety around using new technology. Furthermore, trusted individuals with necessary telemedicine technical skills may be willing to provide public statements through presentations or videos on the benefits of having a device that can be used to access telehealth clinical care, emails and other information. Any intervening efforts to overcome psychological barriers should also be culturally and linguistically appropriate.

Preference for or need to use audio-only telemedicine: If clients prefer or only have the option to use audio-only telemedicine, if this technology is clinically appropriate, CBOs can ensure that clients can begin and continue to have access to phone-based care. Many patients without access to Wi-Fi, computers or other needed technology may be comfortable with using phone-only telemedicine from their own home. Those who experience anxiety leaving familiar surroundings or those who are immunocompromised may also express a preference for audio-only telehealth.

Other Opportunities

Community Health Workers and Care Managers: All over the country, but especially in Medicare Health Professional Shortage Areas (HPSA), Community Health Workers (CHWs) and care managers within the Aging Network can play an important role in filling gaps in connecting older adults with telehealth visits. CHWs and care managers can assist patients with scheduling and participating in virtual visits. Some CHWs may also be trained for medical interpretation services for

telehealth visits. CHWs may also be able to provide some wrap-around care for patients such as helping patients complete assessments, person-centered care plans, and conducting follow-up calls.[13]

Allowable Services: Due to the COVID-19 Public Health Emergency, new services were allowable under Medicare to be delivered via telehealth. Several of these services can be delivered by CBOs that are Medicare providers or as part of a contract with a health care provider. Allowable services under telehealth[14] include the:

- Annual Wellness Visit, screenings (e.g., alcohol use and depression) and health risk assessments, including the brief emotional behavioral assessment,
- Health behavioral assessment and intervention,
- Advance care planning,
- Chronic care management,
- Medical nutritional therapy, and
- Diabetes self-management training.

Field Example: Rush University Medical Center

Rush University Medical Center developed a training program to shift how its interprofessional education students worked with older adults in the community due to the pandemic. Staff recognized that older adults needed help accessing broadband internet and feeling more comfortable during their telehealth appointments. The team worked with a pilot group of older adults to learn what would be helpful to include in a short training program. From the first cohort, they saw improvements in the confidence level of older adults using telehealth and an improvement in the Adult Wellbeing Assessment.[15] To ensure ease of access, all materials are ADA compliant and older adults can watch the videos and download tip sheets without logging in to the system. The training program is open to the public, and Rush University Medical Center is currently conducting outreach about the program.

V. What's on the Horizon for Telehealth?

In the wake of the rapid growth in the use of telehealth during the pandemic, many federal policymakers are considering permanent implementation of expanded telehealth services. Legislation has focused on provider reimbursement of telehealth but has not included important patient protections around issues such as telehealth consumer privacy and protection. Furthermore, legislation has so far missed a key opportunity to ensure that telehealth does not further exacerbate health disparities or the socio-economic conditions underlying them. Many of the bills introduced take similar approaches to making permanent certain telehealth services:

- Allowing Medicare to cover more hospice and home-dialysis telehealth services;
- Reimbursing telehealth services provided at federally qualified health centers and rural health clinics; and
- Removing the geographic and originating site requirement for reimbursement.

Several bills push the Center for Medicare and Medicaid Innovation (CMMI) to test telehealth models and others reimburse certain audio-only services or permanently extend exemptions for telehealth in high-deductible health plans. Various bills also address but differ on which specialties or which telehealth services should be permanently covered under Medicare.

Opportunities are available through federal and state, legislative and executive branch-led efforts to facilitate the provision of telehealth services to those left behind by the aforementioned access gaps. Policymakers should both provide additional resources to community advocates and facilitate provider and patient connections by making permanent some of the pandemic's telemedicine flexibilities. Congressional legislation addresses some of the latter but ignores the need to provide Wi-Fi, for instance, in public housing. Furthermore, the Biden Administration should make

13 Commonwealth of Massachusetts, Department of Public Health. *Effective ways to engage community health workers in the COVID-19 period: Examples of CHW programs in Massachusetts*. https://machw.org/wp-content/uploads/2020/05/CHWs-and-COVID-Resource-for-CHW-Employers.pdf.

14 Center for Medicare & Medicaid Services,. *List of Telehealth Services*. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

15 NCOA, *100 Million Healthier Lives*, https://ncoa.org/article/100-million-healthier-lives.

sure that the Infrastructure Investment and Jobs Act of 2021 is implemented in an equitable way, thereby ensuring that the most vulnerable older adults benefit from the broadband internet expansion included in the law.

The Older Americans Act allows flexibility around how State Units on Aging and Area Agencies on Aging spend their allocated dollars. If Aging Network providers and other CBOs want to take on these additional responsibilities, Congress should allocate additional funds to ensure that any telehealth community services enhance existing capabilities. Recent funding increases are likely not sufficient to account for the realities and increased need of the past two years, and additional flexible supportive services funding may be a suitable vehicle for addressing continuing gaps in care through the provision of telehealth services.

Guidance could be provided regarding how additional funding should be spent in communities to specifically support:

1. Necessary technical training facilitating consumers' access to telehealth services and their providers;
2. Necessary infrastructure such as tablets, cables connecting to TVs, telehealth kiosks located in schools or in other community spaces;
3. Infrastructure maintenance over time;
4. Assistance for people with disabilities in the form of such tools as screen magnifiers and readers and speech synthesizers;
5. Assistance for those whose primary language is not displayed on telehealth technology;
6. Testimonials from users of telemedicine given to the wider community; and
7. Assistance finding the appropriate clinicians according to patient preferences as well as national, state and local law.

CMS should also incorporate telehealth into existing and future CMMI models. Demonstration projects could provide CMS with needed data on how these trial Medicare and Medicaid programs impact the at-risk, aging population and also gather information about the clinical appropriateness of audio-only and audio-visual telemedicine.

At the state level, policymakers should allow certain providers to easily practice telehealth across state lines. States could allow these same providers to join interstate-licensing compacts. Because more than half of states recognize such compacts, the Interstate Medical Licensure Compact and the National Council and State Boards of Nursing's Nurse Licensure Compact offer an expedited pathway for physicians and nurses, respectively, to apply for and receive licenses from other states. In September 2021, CMS began to allow Medicare Administrative Contractors (MACs) the ability to reimburse remote clinicians, once verified by the MAC, belonging to such interstate compacts.

VI. Conclusion

As telehealth continues to evolve within the health care system, the Aging Network can play an important role in ensuring equitable access for all older adults. Aging Network professionals should stay abreast of federal and state level regulatory and legislative changes that impact how telehealth is delivered. The American Telemedicine Association (ATA) is a leading voice for ensuring that everyone has access to safe, affordable and appropriate care when and where they need it. ATA is a useful resource to stay up-to-date on changes at the federal and state levels. The organization's nine policy principles align with those of the Aging Network, including supporting seniors and expanding "aging in place," ensuring access to non-physician providers, and expanding access to at-risk and underserved populations. ATA's website houses information about state legislation that impacts the expansion of telehealth and virtual care and how to support these proposals.

Digital inequities do not always perfectly align with social and health inequities. Aging Network professionals should understand what disparities and barriers may exist in their own communities, and be part of the solution in partnership with the health care providers and other stakeholders. Aging Network involvement in bridging any one or any combination of these inequities necessitates creative approaches. Opportunities may continue to grow for CBOs to contract with health care providers to assist with

technology access and improve the technology literacy of older adults, especially in underserved communities. When working with providers, the Aging Network could also simultaneously ensure that clinician assumptions around patients' technical skills or preferences do not impede a patient's access to care. Other important roles include scheduling, connecting to and participating with older adults in telehealth visits, as well as providing wrap-around services to the telehealth visit, such as assessments, and help with follow-up care, such as connecting with needed referrals in the Aging Network and elsewhere. When partnering with health care providers, it's important to understand what their pain points are relative to telehealth and discuss how your organization can help them address their challenges to ensure that older adults receive accessible, appropriate and affordable care that will result in optimal health outcomes.

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The National Council on Aging (NCOA) is the national voice for every person's right to age well. We believe that how we age should not be determined by gender, color, sexuality, income, or zip code. Working with thousands of national and local partners, we provide resources, tools, best practices, and advocacy to ensure every person can age with health and financial security. Founded in 1950, we are the oldest national organization focused on older adults. Learn more at www.ncoa.org and @NCOAging.