

Telehealth: New Considerations for Life Care Planners

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Abstract

Telemedicine visits across medical specialties and subspecialties have been expanding steadily alongside burgeoning technology and increasing technological access; however, there has been a dramatic acceleration in recent months due to the need to provide healthcare services while minimizing face-to-face contact and mitigating the spread of the novel coronavirus. This increasingly prominent modality of healthcare service impacts life care planning considerations for evaluatees who may benefit from, or are already be receiving, telehealth services. Specific considerations to the limits and values of telehealth services for evaluatees, including the technology required for implementation, will be discussed.

Evolution of Telehealth

While telemedicine has been brought to the forefront of our collective awareness due to the ongoing COVID-19 pandemic, its history goes back more than a century. An article in the *Lancet* from 1879 discussed the potential of the telephone to reduce the necessity for in-person visits (Nesbitt, 2012), and in 1967, the transmission of electrocardiographic rhythms from fire-rescue units to Jackson Memorial Hospital was reported by physicians at the University of Miami School of Medicine and the City of Miami Fire Department (Field, 2019).

More recently, the 2010s saw a steady expansion of telehealth offerings in many specialties, as providers and patients alike began to embrace new technology. A white paper published by FAIR Health in 2019 examined trends in alternative places of healthcare services, including telehealth, ambulatory surgery centers, retail clinics and more. Their findings indicated that the national utilization of telehealth services increased 53% from 2016 to 2017, the most of any place of service. By contrast, urgent care centers saw the second most increase in utilization, up 14% nationally in the same time frame. Mental health claims, previously the foremost diagnostic category for telehealth visits in 2016, moved down to the fifth most diagnostic category in 2017, while telehealth visits for injuries and for young adult and pediatric patients increased. The national claim lines for telehealth from 2012 to 2017 grew by an astounding 1,202% (FAIR Health, 2019). Even before COVID-19, telehealth was an important and growing sector of the healthcare market.

COVID-19 and Telehealth Expansion

With the advent of COVID-19, telehealth has become a necessity for nearly all specialties, as virtual medicine services have been integrated with, or on occasion entirely replaced, in-person visits, thrusting this service to the forefront of medical offices as providers and staff worked to provide quality care for their patients in a manner that was safe for both patients and staff. Barriers of reimbursement, interstate licensing and data confidentiality were quickly, although sometimes temporarily, removed, allowing telehealth to be available to nearly anyone who needed it. A report from the U.S. Department of Health and Human Services published on July 28, 2020 shows the dramatic increase in the utilization of telehealth primary care visits by Medicare beneficiaries. Initially, in-person visits for primary care “fell precipitously in mid-March at the start of the COVID-19 public health emergency (PHE)” (p. 1). However, “nearly half (43.5%) of Medicare primary care visits were provided via telehealth in April, compared with less than one percent before the PHE in February (0.1%)” (p. 1). As Charles R. Doarn recently wrote in an editorial in *Telemedicine and e-Health*, telehealth “is not going to go away or somehow be put back in the box. It will no longer be stifled. It will continue to grow in utility and applicability” (p. 1).

With adequate resources for both providers and patients, telehealth services can reduce barriers to care and allow for more frequent and cost-effective visits. Rural residents, patients with disabilities, and patients requiring specialty care not offered in a certain area can benefit greatly from access to telehealth services. These services have gone from a convenience in years past to a necessity in the present era and moving forward. However, there are also barriers to access that must be considered. What does this mean for life care planners?

Technological Considerations

First and foremost, consideration needs to be given to the technology requirements. Depending on the services needed, a smart phone with adequate internet service or cellular signal can be enough to connect with a provider. However, in many cases, a tablet or computer and high-speed internet connection will be required. Per the most recent *Computer and Internet Use in the United States* report by the United States Census Bureau (2018), 10.7% of households, or

approximately 35 million Americans, do not have a computer or smartphone in the home. The connectivity of a given household also varies widely depending on various socioeconomic, regional, racial, and age-based demographics. It was found that just over 40% of residents of households whose income was less than \$25,000 per year either did not have broadband or did not have a computer, a percentage which shrank to approximately 5% for households with incomes greater than \$150,000. In Washington, the state with the highest percentage of residents with a broadband internet subscription, 87.4% of residents have broadband internet in the home, while in Mississippi, the state with the lowest percentage of residents with a broadband internet subscription, only 70.7% of residents have broadband internet. With regard to age, a home resident in the age range of 35 to 44 years is most likely to have some type of connectivity, while a resident above the age of 65 is the least likely (Ryan, 2018). Per the Federal Communications Commission (FCC), approximately 18 million Americans lack access to broadband, high-speed internet, a number which “wildly understates the extent of the digital divide in this country. That is because if a broadband provider tells the FCC that it can offer service to a single customer in a census block, the agency assumes that service is available throughout. The result is data that systematically overstates service across the country. Other studies have shown that the true number of people without broadband access ranges from 42 million to as high as 162 million (Federal Communications Commission, 2020). The FCC estimates that approximately one-quarter of rural residents and over one-quarter of the residents in Tribal areas lack access to broadband. These numbers do not include U.S. Territories, which have additional and unique issues to connectivity access. While cellular data and cellular hotspots can potentially bridge some of the gap between those with and without high-speed internet, there are still many Americans who live in areas without reliable cellular signal and without broadband access. For these evaluatees, it may be difficult to achieve the bandwidth necessary for a seamless provider visit or therapy session. Life care planners should therefore consider the necessity for various technological upgrades to an evaluatee’s connectivity-related devices that are needed for telehealth services.

Technology upgrades to be considered include the provision for both hardware and software upgrades and the allowance must be tailored to the evaluatee and what is available to them. Some allowances are more readily apparent, such as a laptop or tablet on which an evaluatee can attend a telehealth visit, or a provision for broadband access for evaluatees who reside in an area where that is available. For an evaluatee who is among the American residents without access to high-speed internet, the options available to them may be less clear. For an evaluatee without access to broadband, but with access to quality cellular signal, a cellular hotspot such as Verizon’s or Sprint’s MiFi, T-

Mobile’s T9 Hotspot, or AT&T’s Nighthawk LTE, in conjunction with a laptop or tablet, may suffice to allow for a telehealth experience of reasonable quality. Many of these hotspots require monthly data fees, and may or may not have data limits, which should be considered by the life care planner when evaluating technological requirements for telehealth visits. For evaluatees who lack both reliable, quality cellular signal as well as broadband access, a signal-boosting device may be added to the home, to be used in conjunction with a hotspot and laptop or tablet. Signal boosters come in a range of boosting capabilities, to include the strength of the boost and the coverage area, so it is imperative to consider the evaluatee’s specific residence when choosing an appropriate booster. It should be noted that typical signal boosters require an external antenna, which may require professional installation, depending on the functional abilities and limitations of a given evaluatee. Special consideration should also be given to evaluatees whose sole broadband access is via a satellite provider, as the quality and reliability of satellite internet connections can fluctuate dramatically based on the weather and cloud cover on a given day.

Other emerging technology to watch closely as it pertains to telehealth are the platforms used to conduct visits. While free and popular services may be preferred and more widely used by patients, there is not currently a gold-standard platform by which providers conduct telehealth visits. Zoom has been one option used for telehealth visits, but it has also been plagued with concerning, albeit rare, hacks. Other platforms advertising themselves as HIPAA-compliant are VSee, Doxy.me, Klara, thera-LINK, and Microsoft Teams, just to name a few. Platforms and adaptations also exist for evaluatees who are vision or hearing-impaired, a consideration many providers did not initially consider but are now expanding to include. As new platforms advertising themselves as able to provide HIPAA-compliant telehealth interfaces are constantly emerging and medical offices rush to adapt to new circumstances, it remains to be seen whether there will be an emerging professional consensus on telehealth platform usages. The need to preserve patient privacy and comfort is paramount, and equally important in terms of ensuring patient adherence are ease of use and seamless integration between providers.

It is essential that life care planners stay abreast of emerging technology for evaluatees, be it in the realm of therapies, prosthetics, equipment, and now, telehealth visits. For rural patients, changing technology and expanding broadband will ideally improve accessibility. However, it is impossible to fully anticipate the effects of emerging technologies, such as the fifth-generation cellular network (5G), new platforms and apps, and whether such emergence will further widen the gap between residents of areas with higher-quality network access, and those of areas without. However, life care planners should begin to find out, whenever possible, the specific connectivity access of

evaluatees to accommodate for telehealth services, and the telehealth platforms used by treating providers.

Telehealth Services: Physical and Mental Health Visits

In addition to the technology required to allow for the possibility of telehealth visits, allowances for telehealth visits themselves should also be included in life care plans. While not all visits can be, or even necessarily should be, conducted via telehealth, it is often well-suited for follow-up care to reevaluate a medical or physical intervention or for routine monitoring of chronic conditions. Remote patient monitoring can be used to transmit data on weight, blood pressure, blood sugar, pulse oximetry, activity levels, and more. An allowance for at least some of a client's rehabilitation needs to be performed via telehealth can allow for more frequent and sooner interventions for patients, as visits would no longer need to be cancelled or postponed due to a disruption in transportation, and as the time requirements for the visits are shortened due to lack of commute time for the patient. With the proper technological supports, there will be evaluatees who would benefit from these services throughout their lifetime.

Telehealth services for mental health, better known as telemental health services, have been in use for many years. This type of care, which generally involves more discussion than physical contact, lends itself well to remote care models. The stresses added to daily life from the COVID-19 pandemic including (but not limited to) fear of illness, stress of caregiving, existing professional and personal demands, loss of employment, financial instability, childcare and associated education needs, and social isolation, have amplified the mental health needs of some evaluatees. Those who have existing provider relationships with counselors and psychiatrists can often access these services through telehealth with the appropriate technology resources relatively easily. While many local providers are accepting new patients for telemental health visits, there are also larger platforms such as BetterHelp.com that provide individual and couples counseling services via messaging, chat, phone and video.

Virtual physical, occupational and speech therapy sessions, generally known as telerehabilitation, are now in widespread use as well. Research performed in recent years regarding the efficacy of musculoskeletal physical therapy performed via telerehabilitation in areas such as postsurgical outcomes and chronic pain has been promising. Benefits such as the reduction of hospitalization rate, prevention of readmissions, and early discharge from rehabilitation units are especially important as we work to limit potential exposure to the novel coronavirus by vulnerable populations and reduce the burden on our hospitals and healthcare system (Turolla et al., 2020).

Often, the charges for telehealth visits are similar to in-person visits and allowing for a choice of visit type, in-person or remote, may be prudent. Life care planners are always

cognizant of costs and changes in pricing over time, and this awareness will, and should, extend to the inclusion of telehealth services in a life care plan. In anecdotal experience, these authors can report that research obtained since the start of the pandemic indicates that the cost for telehealth visits are approximately the same as in-person visits. Julie Sommer, MSOT, OTRL, reported that “[m]ost insurance companies are paying for our OT/SLP codes for telehealth at the same rate as they do for in-person” (personal communication, August 3, 2020), and she noted that her clinic has expanded financial aid for their clients as well. Looking at the potential costs of telehealth visits more broadly, the Centers for Medicare and Medicaid Services published an article in March of 2020 stating that telehealth visits “are considered the same as in-person visits and are paid at the same rate as regular, in-person visits” (Centers for Medicare & Medicaid Services, 2020). According to the most recent data available from the National Association of Insurance Commissioners, the top five largest private insurers in the accident and health insurance industry are UnitedHealth, Kaiser, Anthem, Humana, and CVS (National Association of Insurance Commissioners, 2019). All five insurers have updated their policies to temporarily reimburse, or waive cost-sharing, telehealth visits at the contracted rate for in-person visits (AOTA, 2020; CVS Health, 2020; Humana, 2020; Kaiser, 2020; UnitedHealthcare, 2020). All five also specified that the changes were temporary, therefore future telehealth reimbursement, which may affect clinic pricing, should be closely monitored by life care planners. While the reimbursements for telehealth visits are currently aligned with those of in-person visits, the self-pay prices for telehealth visits by providers remain to be seen and may vary widely. Restrictions on services, reimbursement, and modalities have been changing quickly and it is unknown what these will be in the next few months and years. On March 6, 2020, Medicare lifted many of their prior barriers to accessing care from home due to the public health emergency. Other insurers followed suit, although some are now returning to prior restrictions. There are also state regulations on telehealth and typically, a provider may only provide telehealth services to a client who is physically in a state where the provider holds a license. This may provide issue for evaluatees residing near state borders who regularly get care in multiple states.

In an interview conducted with Ryan Stephenson, D.O., a physical medicine and rehabilitation physician currently practicing in Denver, Colorado, Dr. Stephenson indicated that while he had provided telehealth services prior to the pandemic, most often for amputees living remotely, the COVID-19 crisis allowed for its dramatic expansion (R. Stephenson, personal communication, August 10, 2020). He highlighted some positives and pitfalls of conducting patient visits via telehealth, noting the following:

[i]n some ways care has been more efficient by using telehealth, as communication is often more focused and

problem directed. However, while somewhat more concise, these visits are a bit less personable. Some aspects of care are not as well-suited for telehealth—physical exam is limited to what can be observed over video, and obviously procedural interventions cannot be performed. However, telehealth is an excellent way to obtain a detailed and focused history, and provide medical, lifestyle, and some therapeutic recommendations.

Patients with pain, he noted, may have borne additional suffering due to the telehealth medium. Because in-person alternative modalities for pain management have been minimized or delayed, and due to increased scrutiny on the use of prescription pain medications, he speculated that “some patients likely suffered more than they would have otherwise” due to the exclusive or near-exclusive use of telehealth. Looking toward the future, he stated the following:

Most patients have elected to be seen in person as opposed to via telehealth. We will continue to offer telehealth services, and I expect those who live more remotely will benefit from being seen through telehealth. However, given the hands on and often interventional procedural nature of PM&R, I suspect that most patients will continue to prefer being seen in person.

The interview with Dr. Stephenson highlights some important aspects of consideration for life care planners regarding the inclusion of telehealth visits, including the suitability of a given specialty to telehealth visits, evaluatee proximity to the provider, and evaluatee complaints. For evaluatees with pain, but who might prefer or otherwise utilize telehealth visits with providers who provided pain management interventions, life care planners might allow for additional at-home pain interventions, like TENS units, personal massagers, heating and cooling packs, over-the-counter topical analgesic preparations, meditation or visualization courses, and other therapeutic items and interventions than they would for evaluatees expected to solely use provider-based in-person pain management interventions.

The Impact of Telehealth on Delayed Interventions due to COVID-19

Additional consideration needs to be given to the impact of delayed interventions for all clients, but especially those from birth to age five. These children usually receive intensive services that are likely not available currently at the level they would normally be provided. In March 2020, the U.S. Department of Education published a Supplemental Fact Sheet regarding serving children with disabilities while addressing the risk of COVID-19 which recognized the “inevitable delay in providing services – or even making decisions about how to provide services”, stating that Individualized Education Plan (IEP) teams “must make an individualized determination whether and to what extent

compensatory services may be needed when schools resume normal operations”. As we face continued disruptions in education, waiting until schools resume normal operations is not an option for many children or families. Lawsuits are growing around the country as parents sue schools and state education departments over breaches in their students’ IEPs (Kamenetz, 2020).

Interviews were also conducted with a speech therapist and an occupational therapist, both of whom provide services to young children, who are now providing online services. Both providers felt that virtual sessions have been valuable for the families who had participated. Allison Januszewicz, CCC-SLP reported that almost all of her clients had been receptive to teletherapy sessions and that without them “*clients absolutely would have regressed, and parents would have not had the support they really needed during this time*” (personal communication, July 31, 2020). Teletherapy also provided her the opportunity to “*build better, stronger relationships with my families since I am in their homes every week instead of them coming into my office*”. Julie Sommer, MSOT, OTR/L reported having many patients who were not receiving their needed level of care and stated,

we should be continuing to make every effort to safely provide in-person services and continue providing parent education/training on ways to effectively minimize regression and negative behavioral outcomes that are resulting from decreased services and also the COVID climate in general.

Some evaluatees may be better suited to telehealth visits than others. Evaluatees who may particularly benefit from telehealth services are those with chronic conditions, those who are immunocompromised or susceptible to known complications of COVID-19, those in rural areas or who live longer distances from their preferred providers, those with difficulties surrounding transportation, and evaluatees with numerous annual provider visits and/or who struggle with adherence to follow-up recommendations. Clinicians Januszewicz and Sommer both reported barriers to telehealth visits which included evaluatees who did not feel that remote services were the right fit for them; difficulty utilizing the technology; lack of a high-speed internet connection; the added stress of online therapy sessions to providing home education; having multiple children at home requiring care and attention; and physical and communication deficits that can make it harder for some children to engage in teletherapy.

The impact of these changes to, or lack of, therapy will vary from child to child and will likely not be fully understood for many years. We do not yet know the efficacy of an intervention that is delayed and what impact this will have on future function. While we can hope to gather data that better allows for continuous therapy options for all families during times of future crisis, there are families now who are slipping through the cracks. As life care planners, we need to provide as many avenues to accessible care as

possible and consider allowing for intensive services or a longer duration of therapy in the future if the currently available therapies are not fully meeting a child's needs.

Conclusion

It is possible that telehealth services may be utilized often in the immediate future due to COVID-19 but less in the years to come, depending on the circumstance and the current successes and failures with the rapid implementation of telehealth services. With COVID-19 as a catalyst for remote healthcare service implementation, healthcare may forever be changed by this recent rapid shift in care as providers and patients who would likely never have tried telehealth services have now found such visits to be easier and more convenient than they had imagined. A blended care model will likely emerge for many evaluatees, as the best of in-person and remote care is utilized. It is therefore anticipated that life care planners will need to give consideration to technology, including access to internet and cellular service, identify when evaluatees may benefit from telehealth services, allow for the option of telehealth visits when appropriate, and monitor the continually changing regulations, platforms, and services. Life Care Planners themselves must stay personally familiar with popular and accessible telehealth-related and secure platforms as they have been increasingly called upon to remotely conduct independent and compulsory medical evaluations, as well as depositions. As the services being provided to children with disabilities continue to be impacted, creative solutions will need to continue to be explored to ensure that this vulnerable population is not left with lasting disparities as a result of lost or delayed interventions. The current healthcare environment is fluid, dynamic, and in flux, and life care planners must stay abreast of emerging literature in the coming months and years regarding the impacts of telehealth on services, both during and after the global Covid-19 pandemic.

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