Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Letter to the Editor

Ageism, Mentalism, and Ableism Shape Telehealth Policy

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Dear Editor,

During the first 12 months of the coronavirus disease 2019 (COVID-19) pandemic, over 28 million Medicare beneficiaries (40%) utilized telehealth, representing an 88-fold increase over the previous year. Telehealth accounted for 12% of all Medicare services, 13% of all office visits, and 43% of behavioral health visits.[1] Although implicit systemic biases against older adults predate COVID-19, the pandemic brought into focus the combined effects of prejudice and discrimination based on age (ageism), mental symptoms (mentalism), and differences in physical ability (ableism).[2]

The assumption that older adults can or should utilize information technology for access to healthcare with the same facility as younger age cohorts represents a trifecta of ageism, mentalism and ableism.[2–4] Research indicates that 93% of adults over the age of 70, and 98% of adults over the age of 80 do not use information technology, including video conferencing, to communicate with healthcare providers.[3] An average of 95.5% of Medicare beneficiaries over age 70 rely solely on telephonic (audio-only) contact for telehealth with healthcare providers.[3]

As-yet unaddressed factors that might significantly contribute to older adults' preference for telephonic behavioral telehealth include cognitive and physical conditions interfering with comprehension, vision, hearing, and/or manual dexterity.[4,5] Manual dexterity is significantly compromised by hand osteoarthritis, affecting up to 81% of older adults[6] and characterized by pain, functional limitations, and frustration engaging in routine daily activities,[7] including typing on a keyboard.

Medicare beneficiaries might choose telephonic behavioral telehealth at least in part because other telehealth formats, including video conferencing, require the use of a keyboard.[7] The role of hand osteoarthritis and other physical or mental challenges in determining Medicare beneficiaries' choice of telehealth format has not been addressed by the Center for Medicare Advocacy or other research monitoring potential access to care issues.[3]

Since April of 2020, CMS has authorized reimbursement for telephonic (audio-only) telehealth care during the public health emergency.[8] However, telephonic contact remains under special scrutiny by Medicare and private insurers.[8] The Consolidated Appropriations Act (2022) requires that 151 days (5 months) after the COVID-19 public health emergency has been allowed to expire, Medicare reimbursement for mental health telehealth services will again require an in-person visit within 6 months of initial assessment and every 12 months following.[9]

The assumption that all older adults can or should utilize in-person services might reflect the implicit biases of ageism, mentalism and ableism, which have been described as violations of human rights.[2] Although alternative healthcare delivery models including house calls by behavioral health specialists have demonstrated effectiveness,[10] Medicare legislation like the Consolidated Appropriations Act continues to trend back toward default policies requiring in-office visits.[9] This default position is based on implicit ageism, mentalism and ableism.[2–5]

In the context of health justice to protect access to behavioral healthcare for Medicare beneficiaries, research is recommended exploring the role of physical and mental conditions interfering with vision, hearing, mental ability, and manual dexterity in limiting the range of viable behavioral telehealth options for older adults. It is recommended that currently available valid and reliable instruments are employed by clinicians and healthcare systems to assess the most effective means through which older adults can access behavioral healthcare.[3] In addition, greater utilization of mental health specialists for house calls could significantly expand access to behavioral healthcare for older adults, enhance the flexibility of care delivery, and increase diversity of the behavioral workforce.[10] It is also recommended that Congress and CMS make permanent policy changes allowing reimbursement for telephonic behavioral telehealth services with full parity to video conferencing and in-person visits.

AUTHOR CONTRIBUTIONS

The author warrants that he has reviewed and approved the manuscript prior to its submission, and assumes responsibility for the contents of the entire manuscript.

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The data have not been previously presented orally or by poster at scientific meetings.

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