Telehealth Beyond COVID-19

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Because of the COVID-19 pandemic, many mental health care services have been shifted from face-to-face to virtual interactions. Several health policy changes have influenced telehealth uptake during this time, including changes in technology, Internet connectivity, prescriptions, and reimbursement for services. These changes have been implemented for the duration of the pandemic, and it is unclear if all, some, or none of these new or amended policies will be retained after the pandemic has ended. Accordingly, in the wake of changing policies, mental health care providers will need to make decisions about the future of their telehealth programs. This article briefly reviews telehealth policy changes due to the COVID-19 pandemic and highlights what providers should consider for future delivery and implementation of their telehealth programs.

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The COVID-19 pandemic has changed the landscape of health care delivery. To promote physical distancing during the pandemic, many health care providers have shifted to virtual care delivery. Maintaining continuity of care during this time is particularly important for conditions that require ongoing management, such as behavioral disorders. Telehealth, that is, the electronic exchange of information required for accurate diagnosis, efficient treatment, and ongoing care, can improve treatment access and efficacy. Telehealth uses technology to expand virtual access to the behavioral health workforce and particularly to underresourced rural areas (1). Previous work has shown that telehealth can expand access to care, improve treatment engagement and retention, enhance the clinical efficacy of evidence-based services, and reduce costs while achieving outcomes comparable to those of face-to-face care (2, 3).

Telehealth services include direct care through video communication, remote consultation, telephonic videos, remote monitoring, provider-to-provider communication, apps, and Web-based platforms. Although telehealth had become more prevalent, its uptake was not widespread before the COVID-19 pandemic (4). Telehealth uptake in the United States has been impeded by barriers posed by reimbursement procedures, privacy and security concerns, technology availability and connectivity, and prescription regulations (5). Some of those barriers have been lowered through policy changes that apply for the duration of the pandemic (5–7).

Just as policy changes related to telehealth may not be retained after the pandemic has ended, organizations providing mental health care services may not continue all their current virtual services. Such organizations have several factors to consider when deciding on their postpandemic telehealth strategy. In the following, I discuss the policy changes resulting from the coronavirus pandemic and items for organizations to consider for the future of their telehealth modalities.

Policy Changes Due to COVID-19

Because of COVID-19, some restrictions on reimbursement, security, licensing, and prescribing have been relaxed (5–7) to promote rapid telehealth uptake in order to support physical distancing. For instance, the Centers for Medicare and Medicaid Services (CMS) have expanded reimbursement for telehealth services for the duration of the COVID-19 pandemic, and many private payers have followed suit (5). Support for reimbursement includes removing restrictions on the locations of the provider and the patient, expanding services, and ensuring payment parity. Expansion of services involves inclusion of different providers so that some health care workers, such as occupational and speech therapists, are now

HIGHLIGHTS

- The COVID-19 pandemic has resulted in large shifts in mode of care from face-to-face to virtual interactions.
- Policy changes in response to the pandemic affect reimbursement, technology, connectivity, and prescription rules.
- Organizations must consider several factors for their future telehealth planning.

permitted to be reimbursed for services rendered via a telehealth modality. In addition, patients and providers previously needed to meet for face-to-face consultations in an official health care service facility to be eligible for reimbursement, but now both patient and provider are permitted to meet each other virtually in their homes. Services that are eligible for using telehealth modalities have expanded beyond general medical and behavioral health services and now also include physical, occupational, and speech therapies; home dialysis; and substance use disorder treatments. This expansion also includes nonvideo visits such as remote monitoring and virtual check-ins. Furthermore, telehealth visits via audio-only connection can be reimbursed at the same rate as for in-person face-to-face visits. As with face-to-face consultations, payment for telehealth services depends on the length and complexity of the visit.

Some other private payers and state Medicaid plans have followed suit to support telehealth services. At least 40 states have coverage parity for certain telehealth services, and some have payment parity (6). Many states have expanded telehealth coverage during the pandemic. Some states have participated in the Interstate Medical Licensure Compact to permit telehealth services across state lines (7), and others have expanded Medicaid coverage for substance use disorder treatment. In addition, states have expanded telehealth modalities and payment parity, and some states have allowed for prescriptions via telehealth without a previous in-person exam. Commercial payers vary in telehealth coverage. They have expanded payment and reduced requirements for reimbursement for telehealth consultations during the pandemic, including waiving requirements for previous in-person exams and restrictions on new patients and allowing audio-only telehealth encounters.

Because of COVID-19, the U.S. Drug Enforcement Administration (DEA) has relaxed the enforcement of rules for prescribing controlled substances via telehealth consultations (8). Until recently, the DEA required that controlled substances be issued via telehealth only after a previous in-person visit with the physician, a requirement that has been temporarily relaxed. Moreover, the DEA has indicated that health care providers do not have to register with the DEA in each state as long as they are registered in at least one state.

Telehealth services require a stable technical infrastructure. However, some areas of the United States do not have access to broadband high-speed Internet with stable connectivity (9). This lack of connectivity can result in poor audio and video quality, disconnection, and slowed information exchange. Moreover, some patients and families in such areas may not have access to technology at home to participate in telehealth. To expand reliable access to the Internet during the pandemic, the Federal Communications Commission now has an active grant program that supports health care providers. This program allows providers to expand their technical infrastructure to support core care during the COVID-19 pandemic (10). Funding will be available until the allocated funds are exhausted or the pandemic is over.

Health care providers must establish mechanisms to protect patient privacy when using telehealth services. Patient privacy is protected through HIPAA and through the Code of Federal Regulations (42 CFR Part 2) (11). HIPAA protects patient privacy and security generally, and Part 2 addresses more protections of the privacy of patients with a substance use disorder (12). Neither HIPAA nor 42 CFR Part 2 specifically addresses telehealth, and many organizations rely on telehealth vendors to address technical aspects of compliance. Because of the pandemic, providers needed to establish telehealth services quickly and may not have had the time to identify, select, and implement services with vendors whose technologies were compliant with HIPAA and Part 2. In response to the urgent need to establish services quickly, the Office of Civil Rights (OCR) issued a statement indicating that consumer-facing technologies that do not necessarily meet traditional security requirements, such as FaceTime and Skype, are permissible during the pandemic, as are use of smartphone apps and verbal consent (8).

In their efforts to promote physical distancing during the COVID-19 pandemic, agencies such as the CMS, DEA and OCR have revised rules governing reimbursement procedures, Internet connectivity and security, and prescriptions to enhance telehealth uptake. The agencies have stated that these changes are for the duration of the pandemic. It is not clear if all, some, or none of these changes will be retained after this public health emergency has ended.

Factors to Consider for the Future of Telehealth

Organizations must consider several factors when determining the future of their programs after the pandemic. As health care organizations review the telehealth programs they will provide after the COVID-19 pandemic, they need to consider questions across seven key domains associated with successful telehealth implementation and use. These domains are service selection, operational changes, technical infrastructure, staff engagement, patient outreach, financial considerations, and service evaluation and continuous improvement.

Service selection. During the COVID-19 pandemic, many behavioral health providers moved to an entirely virtual model. After the pandemic, organizations will need to consider which services to offer in person and which to offer virtually. Telehealth services can be selected on the basis of geographic location, whether or not medication is needed, patient needs, or organizational strategy (13, 14). Moreover, organizations may consider the ongoing need for telehealth, identifying virtual services to focus on and the specific benefits and challenges associated with future virtual care.

Identifying operational changes. Moving to a model that includes both face-to-face and virtual care involves several operational aspects (13). For example, the need for physical

space might change if some staff and services move permanently to virtual care. In addition, staff will need direction on when to schedule virtual visits versus in-person visits and how visits will appear on the schedule. This means that differences in workflow between virtual and in-person visits may need to be addressed and coordinated.

Technical infrastructure. During the pandemic, many organizations have used technical solutions that may not be feasible long term. For example, consumer-facing technologies such as Skype and FaceTime were permitted during the pandemic, but it is unknown whether this technology will persist. Organizations may wish to move to a more permanent telehealth solution that can be integrated with other health information technologies such as electronic health records (14). Moreover, providers who were using their own personal equipment during the pandemic may find that this arrangement no longer works for them postpandemic.

Staff engagement. It is important to engage staff at all levels when considering the future of telehealth (15). This includes obtaining their input about service selection and including them in operational changes. Staff must be trained in how to navigate both face-to-face and virtual care in the same practice and understand what care works best in each delivery format. Identifying champions for the future of telehealth and providing time for education and awareness as telehealth becomes a part of the organization on a long-term basis are key operational components to include.

Patient outreach. Some patients may have adjusted to the shift to telehealth during the pandemic more easily than others. Much like staff, patients may have felt that changes to the virtual delivery format were temporary because of the pandemic. The demographic characteristics and needs of the patient population may influence what services will be offered virtually postpandemic and what ongoing training to provide (14, 15). One item to consider is the specific telehealth needs of patients in challenging geographic areas or who may be facing transportation barriers.

Financial and regulatory considerations. Telehealth services can affect infrastructure, workflow, and reimbursement, all of which can have financial implications for health care organizations and patients (14, 15). Not only might there be costs associated with integrating telehealth into ongoing operations, but payer support for telehealth may not be consistent. Organizations will need to accommodate the changing payer landscape. Furthermore, organizations that move to a value-based care model may wish to consider telehealth as part of this model.

Evaluation and continuous improvement. Telehealth implementation occurred quickly during the pandemic. As organizations consider their future telehealth strategies, they should plan how they will assess outcomes and how to use the results of these assessments to steer future directions of their telehealth programs (14, 15).

Conclusions

Policy changes in response to the COVID-19 pandemic have reduced barriers to telehealth uptake by expanding reimbursement, allowing use of additional technologies, providing support for technical infrastructure, and permitting prescribing for medication-assisted treatment via telehealth services. Each government agency has stated that these changes are in place just for the duration of the pandemic. It is unclear whether all, some, or none of the changes will be retained after the pandemic.

When looking to the future, organizations may need to revisit their telehealth strategies. Decision making should include what services to retain or expand and how to measure success, ensure financing, and engage patients and staff when telehealth technologies are used. Organizational leaders and clinical and administrative staff all have roles to play in providing telehealth services, and their input should be sought when determining the future of telehealth.

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Psychiatric Services Announces New Column: Racism & Mental Health Equity

Psychiatric Services welcomes Michael Mensah, M.D., M.P.H., and Lucy Ogbu-Nwobodo, M.D., M.S., as contributing editors, joining Ruth S. Shim, M.D., M.P.H., to review submissions for a new column, Racism & Mental Health Equity.

This column examines the intricate ways that structural racism is embedded in psychiatry and investigates strategies to mitigate the impact of structural racism on mental health service delivery. Contributions to the column will explore antiracism and antioppression frameworks of practice and organizational change in relation to service delivery. Submissions that consider how the intersections of race, ethnicity, class, gender, gender identities, and sexual orientation shape mental health experiences and access to psychiatric services are welcomed. Authors are encouraged to present innovative strategies and solutions to transform and dismantle structures of racism across different dimensions of mental health, including (but not limited to) clinical services, education, training, research, and advocacy.

Submissions (via mc.manuscriptcentral.com/appi-ps) are limited to 2,400 total words, inclusive of a 100-word abstract, two or three one-sentence Highlights, and up to 10 references.