



# Mobilization of Telepsychiatry in Response to COVID-19—Moving Toward 21<sup>st</sup> Century Access to Care

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## Abstract

The COVID-19 pandemic threatens to disrupt the provision of mental health services. In response, policymakers, administrators, and providers have taken bold steps toward enabling telepsychiatry to bridge this sudden gap in care for our most vulnerable populations. With rapid deregulation and adoption of this modality of care, careful consideration of issues related to policy and implementation is essential to maximize its effectiveness and mitigate unintended consequences. Though the crisis places the healthcare system under strain, it sets the stage for a lasting shift in not only how care is delivered, but also our beliefs around the system's capacity for rapid, innovative change.

**Keywords** Telepsychiatry · Policy · Pandemic · Disaster

The current COVID-19 pandemic has created unexpected challenges in providing quality care for mental health patients. Along with rapid efforts to contain the spread of the virus through social distancing, systems and providers must adapt just as rapidly to ensure continuity of care for populations who are at higher risk of decompensation because of their mental illness. Fortunately, existing telepsychiatry technology shows great promise to bridge this sudden gap in care—even more so than telemedicine, as psychiatric assessments are more largely dependent on the interview, and less so on physical examination. Impeding this promise, however, are barriers to widespread adoption, which we aim to illustrate here, related to longstanding policies concerning reimbursement, access, and the practical issues faced by hospitals, clinics, and providers still unprepared to deliver care through this modality. Despite the difficulties and uncertainty, this crisis presents an opportunity to not only improve our healthcare system's response to future local and national emergencies, but also transform its approach to increasing access to care for years to come.

Recent growth of telepsychiatry, though outpacing telemedicine, has been modest partly due to difficulty in

achieving comprehensive parity—insurance coverage and reimbursement equal to that of in-person care. The finding that state mandates for parity have supported growth of telepsychiatry but not telemedicine underscores the unique relevance parity has to our field. However, continued low overall utilization of telepsychiatry despite growing reimbursement suggests other factors are also to blame (Barnett et al. 2018; Douglas et al. 2017). In light of the social distancing employed to contain the growing pandemic, limiting the ability of patients to connect with healthcare, policymakers have taken bold steps toward both promoting parity and lifting restrictions around licensing and encounters.

On March 17, 2020, the U.S. Centers for Medicaid and Medicare Services removed the requirement for patients to travel to an “originating site” to receive care remotely (Medicare Telemedicine Health Care Provider Fact Sheet 2020). In parallel, the Drug Enforcement Agency authorized the prescribing of controlled substances without an initial face-to-face encounter (*DEA's response to COVID-19 2020*) and the Department of Health and Human Services waived penalties for the use of non-HIPAA compliant communication tools (Medicare Telemedicine Health Care Provider Fact Sheet 2020), including popular applications like FaceTime or Zoom. Some governors have issued orders easing licensing requirements to permit remote encounters across state lines as well as mandating parity. State Medicaid programs and private insurers also are starting to join this concerted effort to quickly dismantle some of the traditional

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obstacles telemedicine and telepsychiatry have faced (*The Efficacy and Expansion of Telemedicine to Meet the Growing COVID-19 Pandemic* 2020).

We believe these are steps in the right direction, and recommend going even further by granting more liberal coverage and reimbursement for telephone encounters, since many patients may not have access to a smartphone or computer with video capacity. Additionally, developing a national licensing program would allow providers to reach patients beyond their home state and meet the increasing demand for services. In expanding the availability of telepsychiatry, however, a level of caution in safeguarding patient information must be exercised. Of further concern is the potential for an inadvertent exacerbation of mental health disparities, as certain groups, including the poor, the less-educated, and minorities, in particular African American and Hispanic communities, have historically been left behind in being able to use digital services for their benefit (Lorence and Park 2008). At this point, it remains unclear whether we are witnessing the beginning of a lasting policy shift toward deregulation of telepsychiatry, but further debate is necessary.

These measures, though much-needed, do not address how ready healthcare systems and providers are to deploy telepsychiatry on short notice, particularly in places without a framework in place. In rapidly enabling care with telepsychiatry, the most important practical considerations are ensuring availability of telepsychiatry-enabled devices, adequacy of training, and workflow efficiency. As equipment acquisition is initially the most cost-prohibitive component of telepsychiatry services, we recommend hospitals and clinics explore repurposing existing workstations or having clinicians offer their personal devices for these encounters. For providers with limited technological literacy or experience with telepsychiatry, the American Psychiatric Association's resources (*Telepsychiatry Toolkit Home* 2020) should be referenced and sufficient guidance extended by administrators and IT personnel. In team-based settings, defining protocols for how hospital and clinic staff are to work with providers using telepsychiatry would prevent deficiencies in care delivery.

The context of a pandemic, with the imperative to minimize exposure risk, applies additional constraints to implementing telepsychiatry in inpatient and emergency settings, where even its complete integration is likely to involve significant levels of in-person care—consider behavioral interventions for patients with psychosis or management of acute medical issues. Nonetheless, because exposure risk in these settings is magnified compared to medical units—by factors like communal design and increased likelihood of patient interaction (Miller 2020)—integrating telepsychiatry to its safest possible extent is important. For example, inpatient interdisciplinary treatment team meetings, which typically

include physicians, nurses, and social workers, can be reformatted to videoconference. In contrast, use of telepsychiatry is more well-suited for outpatient encounters, with outcomes being comparable to in-person care (Hubley et al. 2016), though there may be some circumstances where an in-person visit, despite the risk of exposure, may be warranted—as in worsening mental illness requiring a higher level of care.

This context also brings system-level consequences with changes in patient volume flow—for example, increased ED visits for pandemic-related anxiety or fewer disposition options due to facility closures. Given enhanced spread of pathogens in clinical settings, we recommend healthcare systems modify processes to reduce direct patient contact through measures such as converting written consents to verbal—in coordination with the legal system—or decreasing inpatient unit capacity. Managing patients in lower levels of care whenever possible minimizes unnecessary exposure to healthcare providers and patients alike. With more patients receiving care from home, ensuring they are connected to mail-order pharmacies reduces exacerbations due to lapses in medications.

Equal now in importance to building a framework for delivering care through telepsychiatry is a pandemic-informed shift in our approach to patient interactions and treatment recommendations. Those with severe mental illness are at increased risk of decompensating given the isolation inherent in social distancing and self-quarantine as well as the potential stress of acquiring the illness. For some individuals suffering from depression or schizophrenia, a lack of social interaction may trigger an acute exacerbation of their illness. Encouraging these patients to engage in virtual communication with family and friends and increasing frequency of telepsychiatry follow-up is crucial. While exercise is both a preventive and therapeutic factor for many forms of mental illness, the ability to perform these routines has undoubtedly been interrupted, and it is important to discuss creative, housebound strategies such as use of mobile fitness applications and home workout equipment. For patients who cannot meet their therapist, online therapy options and automated mental health conversational agents, both of which have proven benefit (Kumar et al. 2017; Vaidyam et al. 2019), should be explored. Meditation and yoga applications may also provide much-needed relief in these stressful times.

With widespread shelter-in-place orders and an impending economic recession, many of our patients are put at risk of negative mental effects from a worsening life situation. A remote interdisciplinary approach, involving social workers, working to resolve resulting unemployment and homelessness, and psychologists, helping to prevent undesirable outcomes like suicide, is likely to be effective (Mishna et al. 2012; Varker et al. 2019) and critical for those finding themselves in distress. Thus, we recommend healthcare systems and policymakers jointly work to set up and promote

programs based on existing remote collaborative care models (Appleman et al. 2020) to target not only our patients' increasing mental health needs but also their evolving medical and social circumstances.

At our institution, where many of these changes have already been implemented, outpatient attendance has increased dramatically through use of telepsychiatry. This observation, which we expect to be seen at other institutions undergoing this transition, points to the possibility of a seismic, positive impact on mental healthcare delivery. The COVID-19 pandemic has compelled policymakers, administrators, and providers to challenge both the boundaries of our healthcare system at large and the limiting beliefs around its capacity for rapid, innovative change. We call on others to study telemedicine and telepsychiatry outcomes, with regard to measures of quality, access, and fairness, to determine which policy and implementation adaptations provide the most lasting benefit to patients. Even beyond this time of crisis, healthcare leaders must continue to rethink the conventions that have kept us from advancing the vision of a hospital without walls (Sharfstein 2001).

## Compliance with Ethical Standards

**Conflict of interest** The authors have no conflicts of interest or financial interests to disclose.

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