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Telepsychiatry Current Practice and Implications for Future Trends: A 2023 American Psychiatric Association Member Survey

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Abstract

Introduction: Although telehealth was a viable means of delivering psychiatric care even before the COVID-19 public health emergency, flexibilities at the federal and state levels during the pandemic prompted mass adoption in a short timeframe. Little is known about how psychiatrists plan to offer care going forward and to what degree services will be offered virtually, in-person, or in a hybrid format.

Methods: We conducted a survey of American Psychiatric Association (APA) members regarding telepsychiatry practice and potential barriers.

Results: The survey was completed by 1,660 APA members. Most survey respondents (94%) conduct at least some telepsychiatry. Most respondents indicate operating in a hybrid environment in which they maintain a physical practice location, while 16% indicate that they do not have a physical practice and only see patients remotely. Across all setting types, 82% of respondents deliver telehealth via all or mostly video; 11% report conducting telehealth visits via mostly audio-only modalities; and 7% report equal usage of both modalities. Barriers to telepsychiatry noted by respondents include limited reimbursement, state medical licensure,

federal and state regulations regarding controlled substance prescribing via telehealth, and technical challenges.

Conclusion: Results of this survey of APA members show that the majority conduct at least some telepsychiatry; operate in a hybrid environment; and deliver telehealth via all or mostly video. Reported barriers to telepsychiatry practice include legal, regulatory, reimbursement, and technical issues. The future of telepsychiatry may largely be determined by which legal, regulatory, and reimbursement flexibilities are ended, extended temporarily, or made permanent.

Keywords: telepsychiatry, telehealth, policy, psychiatry, mental health, telemedicine

Introduction

While telehealth was a viable means of delivering psychiatric care for decades leading up to the COVID-19 public health emergency (PHE), the pandemic prompted mass adoption in a short timeframe along with novel and pressing physical and mental health needs. Numerous studies highlighted entire departments and clinical practices transforming from in-person to virtual care in a matter of days or weeks, with telehealth visits increasing from 0.3% of all encounters in March to June of 2019 and 23.6% of all interactions during the same three-month period a year later.¹⁻³ This was possible in part due to increased reimbursement by payers and emergency federal and state policy efforts that created flexibilities to facilitate access to care through telehealth.⁴ Patient and clinician patterns and preferences changed to accommodate this new virtual-first reality. During this rapid transition, many psychiatrists had little or no prior telepsychiatry experience.⁵ Now, almost four years after the Spring 2020 mass migration

to telehealth, psychiatrists and their patients once again have options about how to meet.

Little is known about how psychiatrists plan to offer care going forward and to what degree services will be offered virtually, in-person, or in a hybrid format. Earlier studies have been published with conflicting results. Some reports suggest that psychiatrists prefer telehealth and that online visits will be the new norm, some report that they prefer to offer in-person care, and some report that psychiatrists plan to offer a combination of modalities.⁶ Often, the relatively small sample size or homogeneity of the sample (e.g., representing one region or one type of practice) in these studies makes results difficult to generalize.

Despite the end of federal and state-level COVID-19 PHEs and the number of COVID-19 infections and deaths falling, the United States (U.S.) continues to experience an access to care crisis and telehealth remains a tool to mitigate this challenge. Fifty-five percent of U.S. counties have no psychiatrists, and 130 million people live in areas with a shortage of mental health providers.^{7,8} The COVID-19 PHE has acutely exacerbated these challenges, especially in children and adolescents, which has prompted many national organizations to declare a national emergency in child mental health in addition to the ongoing active opioid PHE.⁹

Federal and state agencies have recognized the potential for telehealth to address health needs given a stretched-thin clinician workforce and high rates of patient satisfaction with telehealth services.¹⁰ However, policymakers and health care industry decision-makers have reasonable questions about the quality and cost-effectiveness of telehealth services including: Is telehealth driving patients to access unnecessary care? Why should payers reimburse clinicians for the cost of an office if they are working from home?

Fundamentally, payers and regulatory agencies wonder if patient and practitioner expectations and habits really changed that much since the pre-pandemic period to now require and justify new reimbursement and regulatory approaches. Telehealth care and coverage also come with risks for health care institutions, including challenges to quality of care or patient retention due to virtual therapeutic relationships and potential for increased costs due to increased utilization. Clinician behavior is a significant determinant of these outcomes, with ideal telehealth delivery mimicking the standard of care of in-person care while increasing accessibility. Policy must balance the benefits and risks to payers and regulators by meeting the imperative to increase access with standard expectations of quality and cost.

Structurally, practice expenses are reflected in the relative value units assigned to procedure codes. Relative value units

are designated by the Centers for Medicare and Medicaid (CMS) for use in public insurance programs and are often used as the basis for fee schedules in commercial insurance plans. Accordingly, the real cost to clinicians of administering a service, including infrastructure and overhead like office space and software licenses—plays a role in determining reimbursement rates.¹¹ Thus, the cost calculus for payers can go in multiple directions, recognizing that payers have a vested interest in matching their rates to true costs. If the cost of administering a practice remains the same with telepsychiatry as a component of practice, then there is an argument for reimbursement rates to remain the same. If psychiatrists on an industry-wide basis are giving up their practice spaces or otherwise downsizing their infrastructure, then perhaps practice expenses should be reduced for those practices.

Therefore, there is a pressing need to understand, on a profession-wide basis, how psychiatrists plan to and can practice in the aftermath of the COVID-19 PHE as this information has consequences for access to care, health equity, regulation, training, payment parity, and advocacy. Health care policies, including those permitting the use of telehealth for the prescription of controlled substances and those permitting audio-only telehealth services, may have a profound influence on access to and quality of care. Likewise, the cost of running a practice and overhead associated with all-virtual, all-in-person, or hybrid care models will demand different solutions to payment parity and ensuring access to care. Targeted educational efforts to help psychiatrists thrive in telehealth environments while meeting the needs of individual patients are also dependent on community needs.

While many federal PHE-era flexibilities allowing ongoing telehealth delivery have been extended, the permanent status of these policies is uncertain. Flexibilities that have enabled telehealth delivery include those related to Medicare beneficiaries (e.g., removal of geographic restrictions, removal of originating site restrictions, expansion of types of practitioners and services); prescription of controlled medications without a prior in-person examination; and increased reimbursement of telehealth services, in some cases, at rates equivalent to in-person services.¹²⁻¹⁴ Some PHE-era telehealth policies will remain indefinitely, including expanded services eligible for Medicare telehealth delivery. Some flexibility expired with the end of the COVID-19 PHE, including those related to state medical licensure, which was often tied to state-level emergency declarations and executive orders.

The American Psychiatric Association (APA) is the national medical specialty society representing over 38,000 psychiatrists.¹⁵ We conducted a survey of APA members to assess patterns of telepsychiatry and hybrid practice; modalities used;

awareness of changes to telepsychiatry practice with the end of the COVID-19 PHE; and key hurdles to telepsychiatry practice.

Methods

A 7-item, anonymous survey was distributed via email to 17,842 APA members in March 2023. The survey questions, designed by the Policy, Programs, and Partnerships Division of the APA with several rounds of iterative feedback from the APA Committees on Mental Health Information Technology and Telepsychiatry, focused on telehealth issues relevant to practicing psychiatrists and federal and state regulators and policymakers. The full survey is included in the appendix.

There were 1,660 responses received (response rate = 9.3%) and 1,211 of these included qualitative responses to an open-ended question (“What is your greatest barrier to providing telepsychiatry? Is there any other feedback you would like to provide?”). Responses were stratified by the reported settings of services (“Office practice,” “Outpatient clinic,” and “Inpatient unit”) for additional contextualization.

Our survey used open-ended questions to collect qualitative information. Using Dedoose, a qualitative coding software, a set of thematic codes based on key insights that came up frequently was developed. We identified major trends within our findings related to the barriers to telehealth delivery and access reported by the clinicians surveyed.

Participants gave informed consent before taking part. The APA Institutional Review Board (IRB) determined exempt status for this project.

Results

Most respondents—about 71%—practice in either solo or group office practices, while about 25% practice in outpatient clinics in either private hospitals (1%) or not-for-profit, public, VA, or academic hospitals (24%).

Overall, most survey respondents—94%—are conducting at least some telepsychiatry (*Fig. 1*) across inpatient and outpatient settings.

Despite this significant increase in the implementation of virtual care, most respondents operate in a hybrid environment (*Fig. 2*), and many respondents note that they maintain a physical practice location where they can see patients as required for clinical or regulatory reasons. While telehealth can operate as a triage mechanism, most encounters are stand-alone and the majority of respondents note that most of their patients do not require a follow-up in-person visit after a telepsychiatry visit (*Fig. 3*). Respondents report some key barriers to providing clinical appropriate telehealth to include regulations, particularly around telemedicine prescribing

of controlled substances; reimbursement rates; licensure; and patient access to and comfort with technology.

PHYSICAL PRACTICE LOCATIONS AND HYBRID CARE

Most respondents practice in hybrid environments with both telehealth and in-person care offered. About 85% of respondents, across all practice settings, reported maintaining at least one physical practice location. Across practice settings, about 25% of respondents have a physical location in only one state but not in another state in which they treat patients, leaving those patients at risk of losing access to care based on specific state licensure or in-person treatment circumstances. A small minority of respondents—about 3% in office practices and outpatient clinics—note that they see patients in more than one state and have a practice location and licensure in each state in which they practice.

REQUIRED FOLLOW-UP IN-PERSON VISIT AFTER A TELEPSYCHIATRY VISIT

To assess whether telehealth is additive or substitutive, we asked respondents whether their patients typically require in-person care after a telehealth visit. Follow-up in-person visits are needed rarely or never (25% of the time or less) after a telehealth visit, indicating that telehealth visits are primarily replacing rather than adding visits. These rates differ by practice setting: in about 90% of office-based and inpatient settings, follow-up in-person visits are needed rarely or never (25% or less), and in about 80% of outpatient clinic settings, follow-up in-person visits are needed rarely or never. In about 6% of situations across all settings, follow-up in-person visits are almost always needed.

MODALITIES FOR TELEPSYCHIATRY

Regulators and payers often distinguish telehealth delivery by the technical modality used (video vs. audio-only care). Across all settings, most respondents (82%) deliver telehealth via all or mostly video. In inpatient settings, about 85% of telehealth is delivered via all or mostly video. About 11% of respondents report conducting telehealth visits via mostly audio-only modalities, and about 7% report equal usage of both modalities. Most telepsychiatry is delivered using video technology although clinicians are prepared to offer audio-only services as clinically and situationally appropriate or because videoconference is not possible.

MAJOR BARRIERS

Respondents report regulatory and technical barriers to delivering telehealth services. Barriers were identified from the free response text provided by some respondents (*Table 1*).

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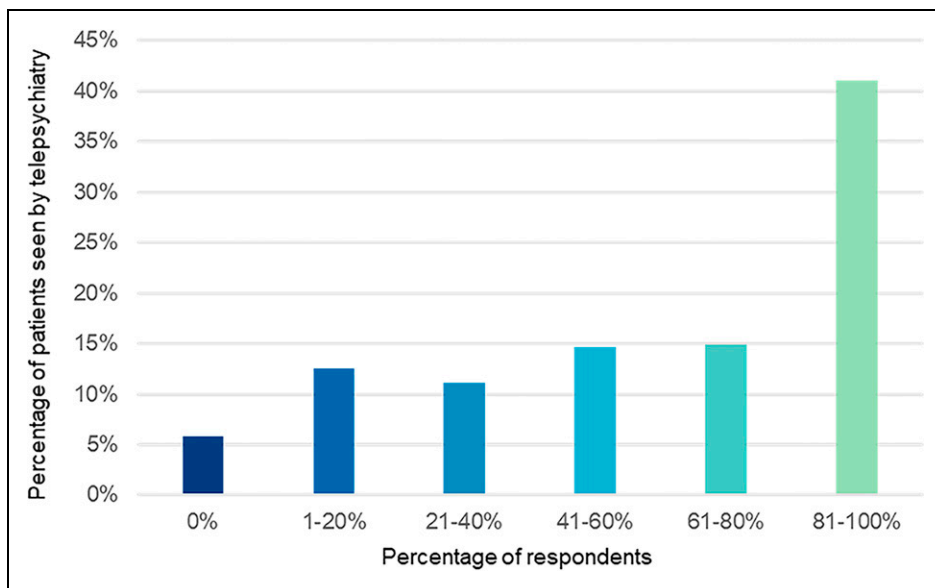


Fig. 1. Percentage of patients seen via telepsychiatry.

Discussion

Results of this large survey show that many psychiatrists continue to use telehealth to augment in-person care. While payer rules and clinical considerations affect individual

modality decisions, including the patient’s condition and whether or not the patient is established with the clinician, most psychiatrists offer virtual care options. This is broadly consistent with trends across health care. While this survey may overrepresent telepsychiatry as a modality due to survey respondent self-selection, a majority of physicians across specialties have reported the adoption of telehealth in their practice.¹⁶ Mental health services are uniquely well-suited to virtual delivery modalities, and mental health services delivered via telehealth have remained significantly elevated post-pandemic relative to other outpatient use.^{17,18}

Respondents report barriers that may limit the potential for telehealth to expand access to care including reimbursement difficulties, restrictions related to prescribing controlled substances, licensure, and technical challenges. The future of telepsychiatry may largely be determined by which legal, regulatory, and reimbursement flexibilities are maintained at the federal and state levels.

The main finding that psychiatrists offer hybrid care with both in-person and virtual options raises important policy implications. Federal legislation and rulemaking have been active in this area during and after the COVID-19 PHE with key policy issues including reimbursement rates for telehealth, authority to prescribe controlled substances via telemedicine, and licensure across state lines. Results of this survey indicate that most clinicians are using telehealth as a clinical modality based on the needs of patients and that regulatory flexibilities can support continuity of care, equitable access to care, and improved outcomes.

COVERAGE AND REIMBURSEMENT
Physical locations are a key proxy for regulators and payers to account for patient safety, licensure, and cost of care considerations. From a reimbursement perspective, practice expenses include physical items (e.g.,

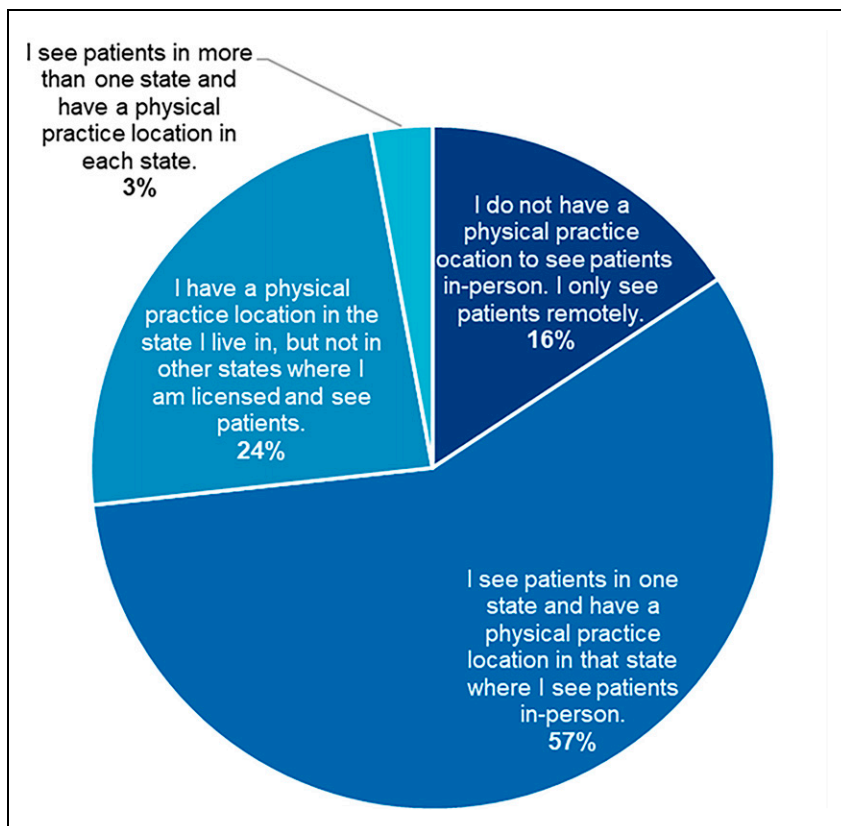


Fig. 2. Maintenance of a physical practice location to see patients in person.

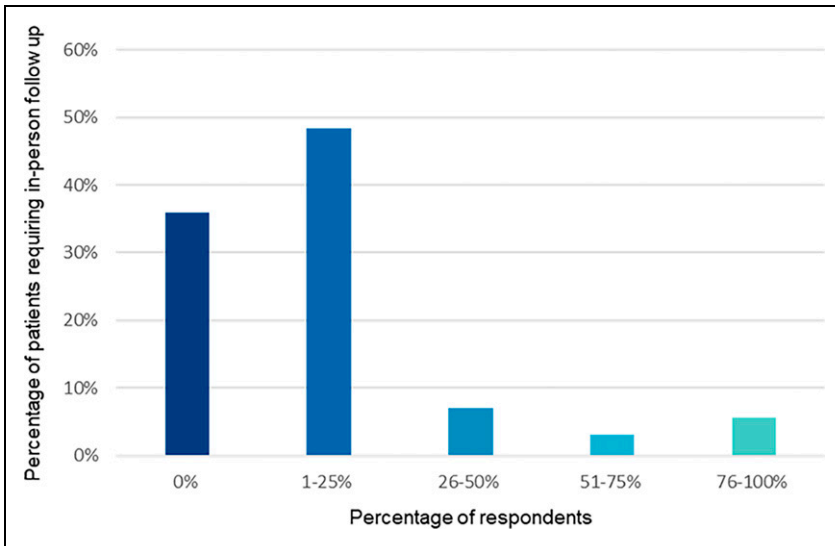


Fig. 3. Percentage of patients requiring an in-person follow-up visit after a telepsychiatry visit for clinically indicated reason.

blood pressure apparatus, office space), staff (e.g., front desk staff, nurses), and infrastructure (e.g., electronic health records, billing software). In theory, an all-virtual practice would not incur some major costs like rent or medical supplies but would have ongoing costs for telehealth software, staff, and other infrastructure. In a hybrid practice, clinicians maintain both physical and virtual capabilities, including office space, software licenses, and staff. Reimbursement reductions for telehealth may not reflect hybrid practice patterns and costs.

are not purely additive to in-person care, care modalities should be well matched to the patient: patient modality preference should be accommodated and clinicians should be aware of what conditions and concerns they are best equipped to manage virtually.²⁰

Payers are contemplating coverage for audio-only care, which current research largely suggests to be as effective as in-person and hybrid care models in the management of chronic conditions.²¹ Although the majority of survey respondents conduct video visits, maintaining the ability to

Additional payer concerns center on whether telehealth care generates duplicative or unnecessary services. Although we do not have data comparing the rate of in-person follow-up visits needed after in-person visits, these data suggest that clinicians do not believe that telehealth encounters generate additional visits that would not have been otherwise necessary. Other studies have found that practices with high percentages of telehealth visits may deliver more services, indicating the need for further research on potential precursors and mediators of telehealth utilization in comparison to in-person care.¹⁹ Of note, increases in telehealth utilization may indicate *appropriate* utilization, as patients who are able to access telehealth may have been unable to access in-person care. In order to ensure that telehealth visits

Table 1. Major Barriers Reported to Providing Clinically Appropriate Telehealth Services

BARRIER	DESCRIPTION	EXAMPLES	N	%
General regulation	Federal or state health care oversight	"Confusing federal restrictions." "Complicated requirements."	185	15.3%
Reimbursement difficulties	Lack of coverage or low payment rates	"Changes to CPT reimbursement." "Reimbursement issues."	54	4.5%
Telemedicine prescribing of controlled substances	Restrictions on abilities to prescribe controlled medications	"Restrictive DEA rules." "Patients across the entire state, can't come for in-person."	141	11.6%
Medical licensure	Interstate practice restrictions	"Patients are no longer in state where psychiatrist is licensed."	146	12.1%
Technical challenges	Lack of access to technology or equipment or software failure	"Patients don't have [Z]oom access." "Patient's audio cuts out."	56	4.6%

deliver audio-only visits enables patients and clinicians to choose the modality best suited to the patient in the moment (e.g., in case of platform outages, lack of access to the necessary technology and network connectivity, dropped video calls, or lack of consent for video). Increasing numbers of older adults, rural residents, and people with lower literacy are using smartphones, but there remain significant gaps in smartphone usage, bandwidth, digital literacy, and other factors affecting access to video visits.²²

PRESCRIBING CONTROLLED SUBSTANCES VIA TELEMEDICINE

At the time of publication, a federal law requiring an in-person visit before prescribing controlled medications via telemedicine is still in place but is temporarily waived by the Drug Enforcement Administration (DEA), with the future of these rules uncertain. Going forward, regulators like the DEA want to ensure that physicians are conducting appropriate clinical due diligence around medications with the potential for addiction and diversion, although psychiatrists note that physical examinations are not always clinically necessary for psychiatric treatment and that collateral data may serve as proxies for necessary physiological observations.²³

LICENSURE AND CROSS-STATE CARE

With both patients and clinicians relocating and technology-enabled clinical practice evolving as a result of the COVID-19 PHE, physical practice in the same state as a patient(s) has become increasingly complex. Medical licensure is state specific, and most state waivers around license to practice have expired with the end of the federal PHE.²⁴ These rules largely remain in place with states exploring policy options including licensure compacts, telehealth-specific licensure or registration, and continuity of care flexibilities.²⁵ Regulators and payers like the CMS, state Medicaid agencies, and state medical boards will likely continue policy efforts to ensure that clinicians are practicing where they are licensed, are incurring typical practice expenses, and are following published clinical guidelines. Clinician decisions around location and in-person practice, as well as a variety of state and federal regulatory frameworks, risk reduction in access to care by telehealth providers.

REMAINING RESEARCH

Additional research should be conducted to identify the effectiveness of telehealth in different patient populations, diseases or conditions, and telehealth modalities (e.g., video visits vs. audio-only). This inquiry should include cases in which telehealth generates improved patient outcomes

relative to in-person care and how different populations may require additional support (e.g., digital literacy and internet connections).

In addition, telehealth services are not limited to live care that offers the same services that would have been delivered in-person. Additional studies should investigate the costs and benefits of asynchronous technology-enabled care, including amending clinical care with data obtained from wearable technology; offering texting-based care; and adding nonclinician-mediated health-related apps into clinical care and recommendations, while identifying cost-effective methods of reimbursing these asynchronous care.

Limitations

Although the survey allowed responses that indicated that the respondent conducted no telepsychiatry, respondents likely self-selected for telepsychiatry use based on the survey title ("2023 APA Telepsychiatry Survey"). Accordingly, those who deliver telepsychiatry may be overrepresented in these results. Further, there are practicing psychiatrists in the United States who are not APA members who did not receive this survey.

Although our survey response rate of 9.3% is lower than we hoped, it is reasonable for a quantitative study. Moreover, it is the largest survey of its kind and results may be used to help design additional qualitative and quantitative studies aimed at learning more about how busy psychiatrists use new technologies to enhance their practice, especially during a PHE or other crises.

Conclusions

Results of this survey of APA members show that the majority conduct at least some telepsychiatry; operate in a hybrid environment; and deliver telehealth via all or mostly video. Reported barriers to telepsychiatry practice include legal, regulatory, reimbursement, and technical issues. The future of telepsychiatry may largely be determined by which legal, regulatory, and reimbursement flexibilities are ended, extended temporarily, or made permanent.

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Authors' Contributions

A.W.: Data curation, formal analysis, investigation, methodology, project administration, software, visualization, and

writing—original draft. J.T.: Formal analysis, methodology, resources, and writing—original draft. S.K. Methodology, resources, and writing—review and editing. N.H.: Formal analysis. T.R.: Conceptualization, supervision, and writing—review and editing.

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Supplementary Material

Supplementary Data S1

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