

KEEP UP: ALIGNING POLICIES AND PRACTICES TO OPTIMIZE TELEMENTAL HEALTH POTENTIAL

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Currently, the United States health care system is undergoing a transformation in health care delivery. Innovative strategies are needed to increase access to evidence-based mental health care and make progress on the goals of the health care “triple aim” of reducing per capita costs, improving health outcomes, and increasing patient satisfaction (Berwick, 2008 p. 760; McWilliams, 2016). Barriers including a shortage of mental health providers, lack of delivery infrastructure, state licensing limitations, and inconsistent insurance coverage must be addressed before telemental health can become viable. By 2025, social workers are anticipated to experience one of the largest shortages of the mental health provider types (Health Resources & Services Administration, 2016). Telehealth services have the potential to improve mental health care access, efficiency, and outcomes by reaching people who don’t seek treatment because of distance, cost of transportation, stigma, or disability, and by sharing clinical expertise and medical documentation to more people in less time. With decreasing costs and increasing acceptability by payers, providers, and patients, telehealth is more viable than ever before. Social workers are particularly well positioned to make use of telehealth opportunities because their training prepares them to work with individuals marginalized by issues such as stigma, disability, and socioeconomic status. To begin to address this gap in mental health care access, states should pass full parity laws for insurance coverage of telemedicine services so that social workers can provide care to clients regardless of where they are located.

BACKGROUND

By 2025, shortages are projected of psychiatrists; clinical, counseling, and school psychologists; and mental health and substance abuse social workers (Health Resources & Services Administration, 2016). Rural areas in particular face persistent shortages in mental health practitioners (Hoeft, 2018). Rural counties comprise two-thirds of all counties and approximately 20% of the United States (U.S.) population but contain fewer than 10% of the mental health workforce

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(Hoeft, 2018). Even when rural location is not a barrier to care, individuals with mental illnesses are not getting the care they need (American Psychological Association [APA], 2018). Among 8.9 million adults with any mental illness and a substance use disorder, 44% received mental health treatment or substance use treatment in the past year, 13.5% received both mental health treatment and substance use treatment, and 37.6% did not receive any treatment (APA, 2018). Evidence suggests that travel time, cost, convenience, and stigma may play a role (Substance Abuse and Mental Health Services Administration, 2014).

According to the American Telemedicine Association's (ATA) guidelines, telemental health consists of using video conferencing for mental health care (Thomas & Capistrant, 2014). Services that can be delivered using telemental health include mental health assessment, counseling, substance abuse treatment, medication management, education/training, monitoring, and collaboration (McWilliams, 2016).

Mental health care is particularly subject to complex sociocultural factors due to challenges in quantifying mental illness, cultural beliefs about mental health, and attribution of mental illness to personal failures or weaknesses. As such, social workers are uniquely poised to address the limited access to mental health services. Telemental health is now making it possible for social workers to provide care to those who encounter barriers such as cost, location, scheduling, language, and other circumstances that perpetuate disparities in access to care. However,

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historically practitioner reimbursement, particularly from private payers, has limited the viability of telehealth (Antoniotti, Kenneth, & Nancy, 2014). Insurance companies are beginning to respond to consumer needs by expanding the services and provider types that they reimburse (AHA, 2016).

Morland et al. (2014) suggest that telemental health is as or more effective than face-to-face (FTF) treatment at monitoring medications and symptoms due to ease of scheduling, reduction of no-show appointments, and communication among other caregivers or family members (Hubley, Lynch, Schneck, Thomas, & Shore, 2016). A number of studies have also shown the same or higher rates of satisfaction among telemedicine patients as compared to traditional FTF services (Morland et al., 2014; O'Reilly et al., 2007). Telemental health makes accessing mental health care more convenient, allows individuals with physical disabilities or who lack of transportation to more easily receive care, prevents patients from

having to take off time from work or other responsibilities, and reduces barriers for those who might not get care because of the stigma associated with visiting a psychiatrist or counselor's office. In addition to delivering services via videoconferencing, social workers can obtain and provide training, supervision, and consultation with specialized mental health providers, such as psychiatrists and clinical psychologists (Hoeft, 2018). Technology is proving to be such an instrumental part of social work that the most recent revision of the National Association of Social Work Code of Ethics was revised to incorporate practice guidelines related to the use of technology (NASW, 2017).

CLINICAL OUTCOMES

There is evidence that telemental health may produce better health outcomes and be more cost-effective than FTF (Moraland, 2014). One study comparing utilization data for telemental health appointments and FTF appointments found that patients kept more telepsychiatry appointments than FTF appointments, were less likely to cancel telemental health appointments, and were significantly less likely to no-show (Leigh, Cruz, & Mallios, 2009). Remote monitoring of patients via telemedicine has also allowed practitioners to check in with patients more regularly, in some cases providing evening and weekend appointments not traditionally possible for FTF service provision (Hublely, Lynch, Schneck, Thomas, & Shore, 2016; Khasanshina, Wolfe, Emerson, & Stachura, 2008; Uscher-Pines & Mehrotra, 2014). Telemental health may be less disruptive to patients' schedules, more cost-effective because of reduced transportation costs, more appealing to those who feel stigmatized for accessing mental health services, and perhaps even the only option for individuals with disabilities or other physical limitations. While more research is needed to fully understand the causes of improved patient compliance with telemental health when compared with FTF, findings suggest that telemental health patients more consistently utilized mental health services than FTF patients (Leigh, Cruz, & Mallios, 2009).

COST

Telemental health has already proven to be more cost-effective for patients, providers, and the health system as a whole. Cost savings include those from reduced travel and lost workdays, appointment cancellations and no-shows, clinical and administrative staff costs, and hospital admissions (Rabinowitz, 2010; Loh, 2013). According to data from the Veterans' Health Administration (VHA) - one of the country's pioneers in telemedicine - the annual cost to fund their telehealth program in 2012 was \$1,600 per patient, per year, compared to over \$13,000 for traditional care

(American Hospital Association [AHA], 2016). Some of these savings come from a reduction in the number of required follow-up visits (see Figure 1). One study of the California Public Employees Retirement System found that patients seen by a telehealth provider were less likely than those who received their initial consult in the emergency department or a physician's office to require a follow-up visit (AHA, 2016). Significantly, data suggest that telemental health increased quality of life adjusted life years (QALYs) when compared to FTF services (Hubley, Lynch, Schneck, Thomas, & Shore, 2016). Telemedicine was also associated with a 25% reduction in the number of bed days of care and a 19% reduction in hospital admissions across all VHA patients utilizing telehealth. The VHA achieved significant reductions in hospitalizations, including over 40% for mental health patients (AHA, 2016). The state of Vermont saved \$63,804 per patient through the use of home-based telehealth and telemonitoring that eliminated expenses related to preventable illnesses and time and travel expenses (AHA, 2016). Overall, the VHA (2016) estimates an average annual savings of \$6,500 for each patient who participated in the telehealth program, which translates to nearly \$1 billion in system-wide savings. The South Carolina Department of Mental Health and the South Carolina Hospital Association established a statewide telepsychiatry network that allows patients, emergency department physicians, and psychiatrists to communicate via video-based and wireless communications. Since its inception, the program has resulted in an estimated cost savings of \$3,320 per inpatient hospital patient (South Carolina Telehealth Alliance, 2016). These are just a few of the encouraging examples of health care providers already embracing the use of telemental health services as part of the care continuum.

PERCENTAGE OF TELEHEALTH, PHYSICIAN OFFICE, AND EMERGENCY DEPARTMENT VISITS WHERE FOLLOW-UP IS REQUIRED FOR SIMILAR CONDITION, APRIL 2012 - FEBRUARY 2013 (USCHER-PINES 2014)

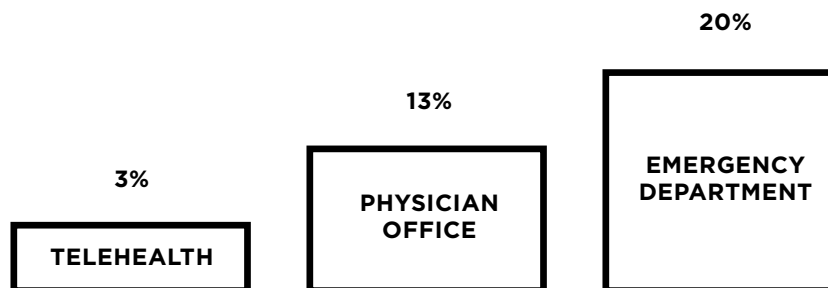


Figure 1: Telehealth decreases utilization in the long run.

CURRENT LEGISLATION

Already, states are seeing the value in using telemedicine to fill provider shortage gaps and ensure access to specialty care. Medicaid, Medicare, and a growing number of third-party payers are beginning to cover telemental health (Deslich, Stec, Tomblin, & Coustasse, 2013). Private insurers such as Aetna, Anthem, and United Healthcare are incorporating telehealth into their Medicare Advantage, commercial, and individual benefit packages (AHA, 2016). Despite progress, however, patients and mental health providers still encounter a patchwork of inconsistent service delivery, legislation, and insurance requirements that make it difficult for both patients and providers to reap the full benefits of telemental health.

State licensing regulations remain a barrier to providing telemental health. Currently, providers must have separate licenses for each state in which they provide services. In some cases, this is not possible due to conflicting regulations from state to state (Thomas & Capistrant, 2014). Providers and patients bear the burden of informing themselves of legal and financial limitations on practicing across multiple jurisdictions. They also have to consider in which jurisdictions laws apply, which professional codes of ethics apply, and whether the practitioner's liability insurance covers services provided when the client, practitioner, or agency are in different jurisdictions (Barsky, 2017). For instance, if an agency is located in New York, the client is in Connecticut, and the social worker is traveling in California, the social worker would have to know regulations and technology policies pertaining to each jurisdiction.

According to an analysis of 13 indicators related to coverage and reimbursement, the ATA found that more than half of U.S. states received a failing score for the quality of their statewide insurance coverage and reimbursement for telemedicine (Thomas & Capistrant, 2014). While availability and coverage of telemental health has gained traction, full legal parity with FTF services—defined as insurance coverage for telemental health that is comparable to that of in-person, FTF services—is still lacking and varies across state borders (Thomas & Capistrant, 2014). Encouragingly, full parity has been achieved in 19 states and the District of Columbia (DC), and nine states and DC have laws mandating statewide coverage and reimbursement for telemedicine-provided services under their Medicaid programs (Weinstein et al., 2014).

TECHNOLOGY

Other concerns with telemental health are technological privacy and costs. Depending on the provider and their setting, initial costs may be several thousand dollars for software, hardware, and other infrastructure. The U.S. Federal Communications Commission's Universal Service Fund subsidizes high bandwidth telecommunications to rural health care

providers, schools, and libraries that require a large network connection and technologies not available for free (McGinty, 2006). If large providers are able to front the technology cost, findings indicate that these expenses can be recovered through long-term telehealth savings. One study found that the threshold at which video conferencing became less costly than FTF was between five and six telemedicine episodes per year (Harley, 2006).

For others, however, audio-visual conferencing systems that are compliant with the Health Insurance Portability and Accountability Act (HIPAA) such as doxy.me, VSee.com, and Polycom can be used at no cost to the provider or patient. Most conferencing systems require the patient and provider to have just a computer with a video camera, microphone, and speakers or a headset, and many systems allow providers to access electronic health records while video conferencing (McGinty, 2006). Confidentiality concerns can be addressed via encryption technology that enable compliance with HIPAA. The use of encrypted codes or the setup of a virtual private network and/or virtual local area networks function to prevent interception of audio, video, and other data during transmission. In the future, FaceTime and similar applications may even be a viable HIPAA-compliant option if WPA2-Enterprise and 128-bit encryption is used over a Wi-Fi connection (Magno, Santos, Tucay, Flores, & Cuyco, 2014).

PATIENT & PROVIDER SATISFACTION

On average, patient satisfaction with telemental health is the same as or better than with comparable FTF care (Khasanshina, Wolfe, Emerson, & Stachura, 2008; Hilty, 2013; Hubley et al., 2016). Satisfaction ratings were higher for both patients and providers in rural versus suburban settings (Hubley et al., 2016). This finding further underscores the viability of telemental health for rural regions where mental health disparities are greatest. Interestingly, patient satisfaction rates tended to be higher than providers perceived them to be, suggesting that provider concerns about quality of telemental health care are largely unfounded. No significant differences were seen in treatment efficacy and telemental health patients report disclosing the same information they would to a FTF provider (Hubley et al., 2016; Khatri, Marziali, Tchernikov, 2014; Stubbings, Rees, & Roberts, 2013).

Diagnosis accuracy also does not decline for telehealth as compared to FTF services (Khasanshina, Wolfe, Emerson, & Stachura, 2008; Hubley et al., 2016). Although telemental health may not be appropriate for someone in imminent risk of self-harm, it has been shown to be effective for assessing and managing suicidal threats (Godleski, Nieves, Darkins, & Lehmann, 2008; Jong, 2004).

RECOMMENDATIONS

To help close gaps in mental health care, state legislatures should pass full parity laws that regulate coverage provided by public and private insurers. Regional and state government officials should also introduce bills to reform existing parity laws. Full parity laws would allow more uniform mental health service provision regardless of parameters such as provider type, health condition, and patient location.

Barriers to practicing across state lines also need to be reduced. Currently, there is no interstate portability agreement surrounding telemental health. Social work licensing agencies should offer licensure mobility solutions or a national license, similar to those seen in Medical and Nurse Licensure Compact legislation (Maheu, Pulier, McMenamin, & Posen, 2012; HHS, 2016). National licensure could coordinate standards, yet allow each state to retain their ability to monitor practice and administer disciplinary actions for clinicians who engage in egregious behavior. National licensure could also require demonstration of competence with telemental health technologies and their best practices. Lastly, professional associations should provide specific guidelines for using telemental health technologies with varying clinical populations, conditions, and circumstances, as well as standards required for competency (Maheu, Pulier, McMenamin, & Posen, 2012).

DISCUSSION/CONCLUSION

Regions with provider shortages, including rural, low-income, minority, elderly, and disabled communities, are important areas to target for mental health care improvement efforts. Travel time, costs, convenience, and stigma associated with seeking many health care services discourage these and other populations from seeking adequate care. A number of states have partial telemental health parity laws. However they limit insurance coverage of telemedicine to certain geographic areas, services, and provider types. While recent efforts signify steps in the right direction, individuals with the highest need will likely not be reached without full parity laws.

Inclusion of telehealth in value-based payment innovations can help with continued efforts to assess the value of telehealth for health systems working to optimize quality improvement, patient satisfaction, and cost savings. While there is a growing body of evidence to support the idea that telemental health results in cost savings, more data are needed to identify what makes these programs successful so that their practices can be generalized to other places in the U.S. Currently, the VHA is one of the only organizations that has used telehealth for long enough to have a sizable body of publicly available data about the costs and benefits of

telehealth. Reflective of a larger challenge in clinical research, studies that examine telehealth treatment outcomes relative to FTF treatments disproportionately sample white individuals (Khasanshina, Wolfe, Emerson, Stachura, 2008). Future research should focus on clarifying best practices for implementing and sustaining telemental health in populations with diverse backgrounds and mental health needs, including provider training specific to the sociodemographic characteristics of the patient and the provider. Sustainable solutions to our nation's mental health care challenges require improved equity in access to care and quality of care. Telemental health represents a highly promising approach to reduce the gap between mental health care demand and access.

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