Telepsychiatry and the Coronavirus Disease 2019 Pandemic— Current and Future Outcomes of the Rapid Virtualization of Psychiatric Care

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Viewpoint

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The coronavirus disease 2019 (COVID-19) pandemic is a seminal event that is precipitating radical transformative change to our society and health care systems. Social distancing, isolation, and deployment of suppression and mitigation strategies are directly influencing the morbidity and mortality rates of the pandemic.[1] Remote communication technologies are being broadly deployed in all spheres of medicine to support these strategies while still delivering effective health care. Telepsychiatry, in the form of videoconferencing and other technologies, was uniquely positioned to push the field of psychiatry to the forefront of these efforts. Prior to the pandemic, telepsychiatry had built a strong scientific foundation and real-world evidence base, demonstrating its effectiveness across a range of psychiatric treatments, populations, and settings.[2-5] Although previously leveraged temporarily in disaster response,[6] telepsychiatry's use in the COVID-19 pandemic has been distinctive and will have long-lasting and wide-ranging effects on the field of psychiatry, including mental health care delivery and configuration and patient experience and expectations.

Globally, health care systems, psychiatric organizations, and individual clinicians have been rapidly virtualizing their operations. These activities have included the extensive use of videoconferencing, either expanding or initiating direct clinician-home to patient-home services, and partially or fully virtualizing administrative operations. Implementation has occurred at a pace never experienced in telemedicine, with many large organizations fully virtualizing in a matter of days. Historically, full implementation of telepsychiatry, especially in large organizations, could take months to years. Rapid virtualization has shown that clinicians, patients, and systems can quickly adapt to telepsychiatry, although not without challenges and lessons learned. Previous barriers including regulatory constraints, system inertia, and general resistance to telepsychiatry have disappeared, at least temporarily; technical innovations abound as clinicians and organizations work to best configure telepsychiatry to current clinical needs and environments.

Historically, telepsychiatry has experienced a substantial evolutionary period with the expansion of the internet and the use of other technologies and peripheral devices that are ubiquitous to consumers and based largely on commercial uses and applications. Currently, in response to the COVID-19 emergency, there has been an unprecedented revolution in the telehealth landscape with the lifting of federal and state regulatory barriers to telemedicine and telepsychiatry. Such changes include the suspension of the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, which placed restrictions on controlled substance prescription via videoconferencing, previously inadequately addressed despite years of advocacy for change by the telemedicine community. Rules around Medicare and Medicaid reimbursement, such as Medicare location requirements, have loosened to support and encourage videoconferencing and telephone-based services. Many states are creating COVID-19–specific exceptions no longer requiring psychiatrists and other mental health clinicians' licensure in the state where a patient is physically located during a video session. These actions have been incredibly favorable and enabling for telepsychiatry and have been requested for years by the field.

The development of telepsychiatry will likely be viewed in the future in terms of the eras before, during, and after COVID-19. The current system and regulatory changes raise the questions "What happens next?" and "What happens when the COVID-19 pandemic ends?" The immediate future depends on the course of the pandemic. The longer the pandemic and associated quarantines continue, the more likely current changes become solidified and routinized into the practice of psychiatry. Less certain are what changes will remain in effect when the pandemic is controlled, as well as what changes that will occur if the pandemic becomes episodic, resulting in a series of sporadic and regional quarantines. Will the current regulatory and structural changes stay in place, or will they also change in a parallel, sporadic, and episodic manner?

Psychiatric organizations and clinicians should begin to strategically plan for these scenarios, identifying how, when, and to what extent they would transition back to more in-person care. Additionally, there are short-term and long-term financial consequences of the conversion to virtual services that include patient volume and reimbursement scenarios. It is not clear how the current billing environment will affect the long-term resources and sustainability of psychiatric organizations and clinicians. To the extent that information is available, financial forecasting and planning with assumptions of both current and traditional billing environments is warranted.

When the pandemic eventually ends, psychiatry and telepsychiatry will be transformed. What the psychiatric care environment will look like is currently unpredictable. Psychiatry is well-positioned to prepare for the transition to a post–COVID-19 health care world. Pre–COVID-19, many in psychiatry and other mental health disciplines were already working with digital technologies and leading efforts to advocate for more widespread use and deployment of telehealth to support broader access to quality psychiatric treatment. Psy-

chiatry has historically been a leader across medical disciplines in the use of technologies to deliver services, and for now, telepsychiatry is the dominant form of psychiatric treatment.

Over the past decade, psychiatry has been working to understand and master the art of holding the clinician-patient relationship across a range of technology platforms and settings blending with in-person interactions, which are termed *hybrid physician-patient relationships*.[7] Moving forward, psychiatry must determine the balance between in-person and technology interactions or risk losing advances brought about in the current environment. What will the lessons of the COVID-19 pandemic be, in terms of what can vs should be done in person or through telepsychiatry or other technologies? How much virtual care is too much? Is there a virtual saturation point, at which the benefits of a virtual relationship decrease or patients request more in-person interactions? What data need to be captured now to better understand this and identify current lessons learned? We also need to catalog patient, clinician, and administrator experiences and expertise gained about rapid virtualization to be better prepared for similar future situations. Rapid virtualization should now be part of every psychiatric organization's and clinician's emergency plan.

The changes in telemedicine regulations in response to COVID-19 have been groundbreaking, but it is unclear whether the recent prescription, licensure, and reimbursement changes will revert to their pre–COVID-19 rules when federal and state COVID-19 emergency declarations end. Will the authorities do this abruptly, or will there be a transition period? Will legislatures use a process to consider whether to make these permanent going forward? The field of psychiatry, working with our colleagues in the wider field of medicine, has an opportunity now to proactively look at the current telemedicine regulations and begin advocating for their longer-term maintenance. If we fail to do so, we run the risk of state and federal legislatures reinstituting barriers to telepsychiatry that are ultimately harmful to patient care.

Our priority now is to support our patients, systems, and colleagues as we weather the current storm. The regulatory and system changes wrought by the COVID-19 crisis present the opportunity for the field to gather lessons learned to strategically shape the post–COVID-19 world of psychiatry and telepsychiatry. This work could usher in a golden era for technology in psychiatry in which we are able to harmonize the benefits of telepsychiatry and virtual care while maintaining the core of our treatment: that of human connectedness.

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