

Telehealth Use and Availability in VHA Outpatient Mental Health Care

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Bottom Line Up Front

The Veterans Health Administration has expanded telehealth services significantly since the start of the COVID-19 pandemic, granting Veterans greater access to care. Despite notable increases in telehealth use and availability, in-person care remains prevalent for mental health services, suggesting that one care modality may not suit all Veteran needs and preferences. Continuing to provide mental health care virtually and in-person will likely be the best Veteran-centered approach to access.

Telehealth Use within VHA

As part of the Veterans Health Administration’s (VHA) Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, the “Anywhere to Anywhere” telehealth initiative was established to provide Veterans greater access to virtual care services by 2021.¹ VHA became the largest provider of telehealth in the United States, offering services to 782,000 unique Veterans in 2018.² Then, in response to the COVID-19 pandemic, VHA expedited expansion of telehealth services, including outpatient mental health care (MH). By June 2020, 58% of VHA care was provided by telehealth, compared to 14% prior to March 2020.³

Telehealth and its Benefits

Telehealth, also known as virtual care, utilizes information and communication technology to provide health care services to patients outside of traditional in-person settings. VHA telehealth services often include video care (like VA Video Connect), phone consultations, and a range of other digital tools to navigate health care (such as the My HealtheVet online portal and VA mobile apps).²

While not always an appropriate alternative to in-person care, telehealth offers increased flexibility for both patients and providers. Patients save travel time,⁴ providers save physical space,⁵ and there’s a reduced risk of spreading disease.⁶ From a clinical management perspective, telehealth appointments are less prone to last-minute cancellations compared to in-person,⁷ allowing providers to complete more visits daily. Telehealth can also help alleviate provider shortages by allowing providers to serve Veterans outside of their typical service areas.⁸

Exploring Telehealth Modalities and Access in Mental Health Care

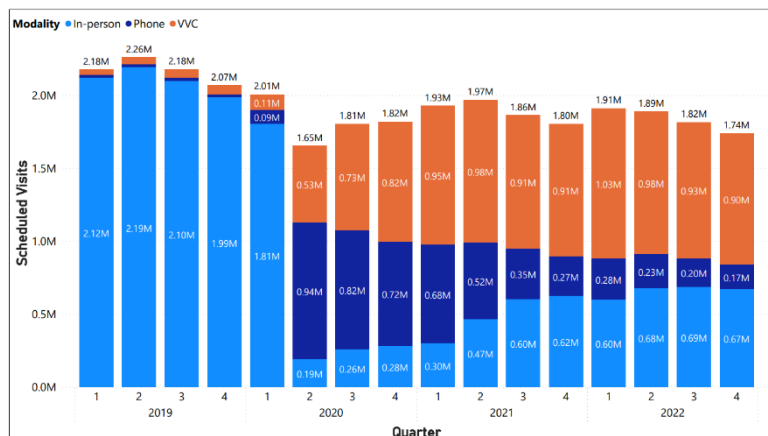
Compared to other specialties, VHA telehealth utilization grew the most in MH during the pandemic. The Partnered Evidence-based Policy Resource Center (PEPREc) explored the extent to which in-person visits may have been substituted with telehealth over time.

Visit Volume by Care Modality

PEPREc examined the volume of three health care modalities: in-person, phone, and video. We investigated the use of each modality across medical centers, providers, and patients.

Figure 1 (right) shows the total scheduled outpatient MH visit volume by modality for three provider types (psychologists, social workers, and psychiatrists) from the Corporate Data Warehouse (CDW). By 2022 Q2, video care (orange) represented 52% of scheduled MH visits. In-person visits (light blue) have increased again since the start of COVID-19 pandemic (11.5% in 2020 Q2 vs. 36% in 2022 Q2). Phone visits are in dark blue.

Figure 1: Total completed scheduled outpatient MH visit volume by modality (visits with psychologists, social workers, psychiatrists).



While in-person care continues to rebound, it remains below pre-pandemic levels.

Prior to the COVID-19 pandemic, telehealth represented 3% of all MH visits (1% video and 2% phone). Since phone visits require less infrastructure⁹ and training than video visits, they represented the majority of visits at the start of the pandemic (about 57% in 2020 Q2) then decreased substantially to about 10% by 2022 Q4. As the number of phone visits decreased, video care increased, representing over half (52%) of MH visits by the end of 2022.

Modality Provision Among Providers

Since 2020, there has been an increase in the share of MH providers offering a mix of care modalities. By 2022, 98% of all VHA MH providers conducted both telehealth and in-person MH visits.¹⁰ Most individual providers (70%) were almost exclusively providing telehealth at the start of the pandemic. However, this share decreased to 30% by 2023 Q1. The largest share of providers offer a mix of modalities, but most patients use only one modality. That may suggest that providers offer a mix of modalities to accommodate their patients' preferences.

Figure 2: Distribution of Providers by Mix of Modalities

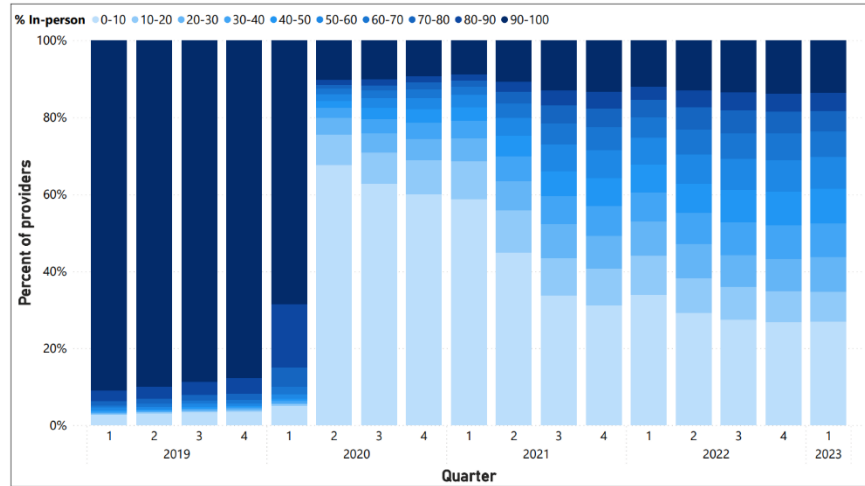
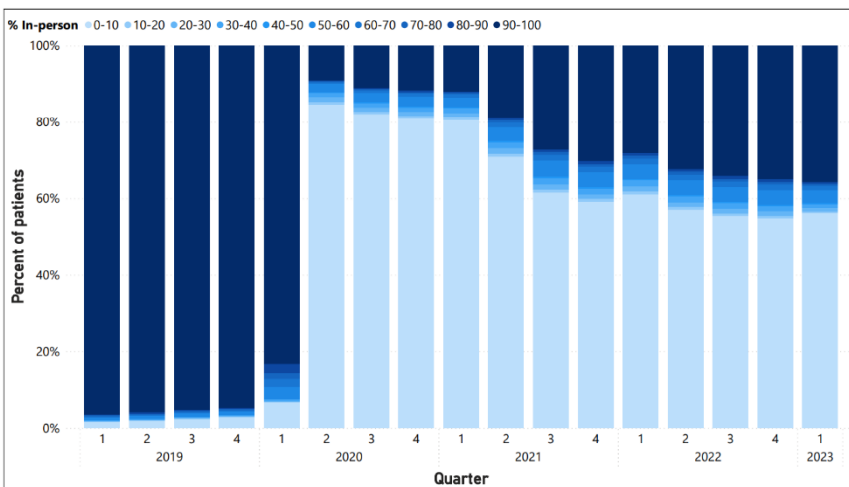


Figure 2 above shows the distribution of the percentage of providers across varying levels of in-person MH visits data from the CDW. Providers using mainly in-person MH visits are in dark blue/navy, while providers offering exclusively telehealth MH visits are shown in light blue.

Modality Usage Among Patients

Figure 3: Distribution of Patients by Mix of Modalities



Prior to the pandemic, most patients were exclusively having in-person MH visits. This switched to almost exclusively telehealth in 2020 Q2. As of early 2023, 36% scheduled exclusively in-person and 56% opted solely for telehealth visits. Only 8% of patients scheduled a mix of in-person and telehealth appointments, suggesting that patients typically choose one modality over another.

Figure 3 above shows the distribution of the percentage of patients across varying levels of in-person MH visits data from CDW. Only 5-14% of patients scheduled a mix of in-person and telehealth visits for April 2020-February 2023 (moderate blue color).

PEPReC observed similar dichotomies within certain subpopulations of patients. In 2022, the majority of Veterans exclusively used telehealth for outpatient MH appointments (66% of ages 18-39, 61% of ages 40-64, and 57% of ages 65+). Also in 2022, patients living in rural areas seemed to choose exclusively in-person care slightly more often than patients in urban areas (30% rural vs. 27% urban). Patients who received MH care exclusively via telehealth represent the largest share of urban (59%) and rural (58%) Veterans.

Policy Implications and Limitations

Telehealth use for outpatient MH care has grown significantly across VHA.¹² Despite the rapid rise in use, not all patients and providers have adopted it to the same extent. This suggests that one care modality may not suit all patient needs in outpatient MH care. Telehealth use depends on availability of providers who offer telehealth and patient preferences for that modality. There may be logistical challenges to using telehealth for certain populations,¹³ such as older adults in rural areas who might struggle with technology or internet access.¹⁴

Telehealth also has the potential to address disparities for marginalized groups (e.g., rural, elderly, people with serious mental illness, people of color) and promote better access to care. Further analysis is needed to determine its impact for other patients, such as Veterans who are of low socioeconomic status or have a PTSD diagnosis, and its use within urgent care services. Policymakers may want to consider taking a patient-centered approach and offer patients a choice in care modality for future MH care services.

Substitutability

Relative to other specialties that are more procedure-based, MH may be more amenable to substitution with telehealth. PEPReC's findings focus on services provided by social workers, psychologists, and psychiatrists, which can include therapy, medication management, care coordination, and peer support groups. There may be other diagnostic services and treatments in MH that still require in-person visits. In addition, these findings focus on scheduled MH visits as it may relate to patients' willingness to wait for one modality over another. As urgent care is an essential part of MH, particularly suicide prevention and crisis interventions, telehealth may provide increased access to walk-in or same-day appointments. Further research is needed to determine the telehealth impact on patient health outcomes and access in urgent MH care.

Wait Times & Patient Satisfaction

New patient wait times in VHA are highly correlated with patient satisfaction in primary and specialty care settings,¹¹ but that relationship has yet to be confirmed in MH. By February 2023, we observed similar new patient wait times for MH video and in-person visits. If the relationship between new patient wait times and patient satisfaction seen in primary and specialty care holds in MH, we could assume that Veterans are choosing to wait for the care modality they prefer. Further, phone care wait times have remained the lowest, suggesting patients are willing to wait for an in-person or video visit rather than take an earlier phone appointment. Additional analysis is needed to further explore the impacts of telehealth on patient outcomes and satisfaction.

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ABOUT PEPRcC POLICY BRIEFS

This evidence-based policy brief is written by Partnered Evidence-based Policy Resource Center (PEPRcC) staff to inform policymakers and Veterans Health Administration (VHA) managers about the evidence regarding important developments in the broader health system and economy. PEPRcC is a Quality Enhancement Research Initiative-funded resource center that collaborates with operational partners to design and execute randomized evaluations of VHA initiatives, develops and refines performance metrics, and writes evidence-based policy briefs. *The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.*

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