



# Key Findings from RAND Health Care Research on Telehealth Policy



Although virtual health care has been on the horizon for years, telehealth use exploded in the early days of the coronavirus disease 2019 (COVID-19) pandemic: It increased by more than 4,000 percent in the first months of the pandemic, relative to the same period in 2019 (FAIR Health, 2020). Yet increased use of telehealth offset only about half of the decline in in-person visits, suggesting that a significant amount of services were deferred (Cantor et al., 2022).

RAND Health Care researchers have been studying telehealth's effects on care quality, access, and equity to gain insights on the uses of and preferences regarding telehealth before and during the pandemic. Prepandemic policies regarding telehealth service reimbursement, which had been in place to limit overspending and potential fraud, were temporarily waived to ease access to care during the public health emergency (PHE) (Centers for Medicare & Medicaid Services, 2021; Public Law 116-136, 2020). The Consolidated Appropriations Act of 2022 (Public Law 117-103, 2022) preserves the effects of those waivers for 151 days after the PHE ends, but policymakers and payers will eventually need to make long-term decisions regarding telehealth.

The key findings from recent RAND research on telehealth synthesized in this brief will help policymakers and payers make informed decisions about telehealth policies as the PHE ends.

## Adapting to Emergencies

- About 30 percent of patients used video telehealth services in the first months of the pandemic, a RAND American Life Panel survey

found. This was a marked increase from the 4 percent of patients surveyed in 2019 who used video telehealth services. Much of the increase was due to patients seeing their own doctors through telehealth (Fischer et al., 2021).

Increased use of telehealth offset only about half of the decline of in-person visits, suggesting that a significant amount of services were deferred.

- Survey data collected later in the pandemic showed that willingness to try telehealth among respondents—particularly Black respondents—significantly increased, relative to February 2019 (Fischer, Predmore, et al., 2022). Willingness to use telehealth may also depend on whether virtual visits can occur with their usual providers (Fischer and Breslau, 2021). However, if virtual visits cost more, most respondents preferred in-person visits for non-emergency care (Predmore et al., 2021).
- Rapid-response interviews conducted early in the pandemic revealed that providers pivoted to telehealth out of necessity, not only to protect themselves and their patients from viral spread, but also to offset losses from reduced in-person visit volume (Uscher-Pines, 2020).
- Most psychiatrists interviewed in April 2020 regarding the sudden incorporation of telehealth into their practices were positive about the transition overall, although some had concerns about the amount of clinical data

available, patient privacy, and home distractions (Uscher-Pines, Sousa, Raja, et al., 2020a).

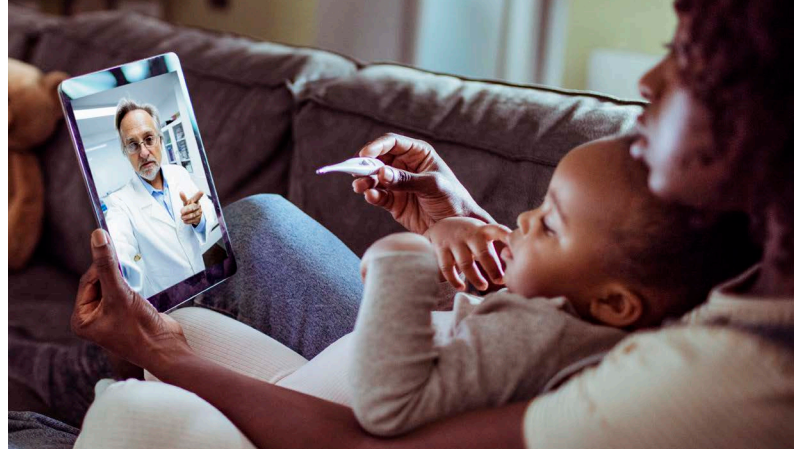
- Psychiatrists interviewed in the summer of 2021 felt that almost all their patients would be good candidates for receiving care through televisits as part of hybrid care, given some essentials, such as access to private space (Uscher-Pines, Parks, et al., 2022).

## Enabling Treatment for Substance Use Disorders

- Many providers who treat patients with opioid use disorder (OUD) made dramatic changes to care patterns in response to the COVID-19 pandemic, including using telemedicine with the majority of their patients, waiving urine toxicology screening, sending patients home with a larger supply of OUD medications, and requiring fewer visits (Hunter et al., 2021).
- Most providers associated remote treatment with improved access and better patient interactions, though some reported challenges with having enough clinical data for decisionmaking and technological issues (Uscher-Pines, Sousa, Raja, et al., 2020b).
- Before the pandemic, less than 18 percent of substance use disorder treatment facilities nationwide offered telehealth-based treatment, and adoption varied by state policy laws, among other local factors (Uscher-Pines, Cantor, et al., 2020).
- Although various states instituted some policies expanding access to and initiation of remote OUD treatment, no state implemented policies to comprehensively expand access to OUD treatment (Pessar et al., 2021).

## Lowering Barriers to Care

- Military Health System (MHS) facilities could use strategies—including tele-psychotherapy—to improve access to care for remote service members (i.e., those living at least 40 miles from an MHS facility) and to reduce their risk for worse outcomes for such conditions as posttraumatic stress disorder, depression, and substance use



disorder (Hepner, Brown, et al., 2021). As of October 2020, most MHS virtual behavioral health care was being conducted by phone, though interviewed providers were open to conducting video visits, if clear guidance on and orientation to using the technology were provided (Hepner, Sousa, et al., 2021).

- Telehealth can be used to deliver professional breastfeeding support. Almost 45 percent of mothers in rural Pennsylvania in a randomized controlled trial of remote lactation services used app-based video services to help answer their breastfeeding questions and concerns (Uscher-Pines, Kapinos, et al., 2019). Users were more likely to be new to breastfeeding and working at 12 weeks postpartum, and calls typically occurred outside normal business hours (Kapinos et al., 2019).
- Telehealth's ability to relieve issues of workforce distribution or shortage is limited by underlying issues regarding reimbursement. A study of mental health availability and accessibility in New York City found neighborhoods in which no providers accepted Medicaid or other insurance payment. PHE-related reimbursement waivers helped increase the number of patients seen, but this increase was mainly among providers accepting insurance payments and serving English-speaking patients (Breslau et al., 2022).

## Addressing Health Care Inequities

- A study of visits to more than 40 federally qualified health centers serving 2 million patients in California found that audio-only calls made up about half of all visits in April 2020 (Uscher-Pines, Sousa, Jones, et al., 2021). This high proportion of audio-only visits might reflect

barriers to video call access experienced by low-income patients.

- Initially, some thought that audio-only visits could be essential to overcoming access barriers (Uscher-Pines, Jones, et al., 2021). However, the continued high prevalence in 2021 of audio-only visits raised questions about whether patients were receiving enough preventive care (Uscher-Pines, Arora, et al., 2022). Future policies regarding telehealth should try to address the underlying reasons for lower access to in-person visits among some populations (Uscher-Pines and Schulson, 2021).
- A study of about 6.5 million commercial insurance claims found that the 20-fold increase in the use of telehealth early in the pandemic occurred mostly among adults in higher-income counties (Cantor et al., 2021). Patients in lower-income zip codes were less likely to defer office visits—but also less likely to access telehealth services (Whaley et al., 2020).



- An estimated 6 million children and adolescents live in low-income and rural counties with access to neither child psychiatric services nor sufficient broadband to support telepsychiatry (McBain et al., 2021).

## Forging Ahead

Using telehealth to help patients and providers maintain access to care has rightly been a top priority during the pandemic. But some newer uses of telehealth, such as audio-only visits, have raised concerns about care quality. Telehealth access appears to be uneven, with individu-



als in low-income or rural areas having low access to broadband internet that enables video calls. These issues will need continued research, and studies will need to continue investigating telehealth's effects on costs, health outcomes, and health equity (Mehrotra and Uscher-Pines, 2022). Policymakers might also want to begin thinking of telehealth less as an either-or proposition (i.e., either telehealth or office visits) and more in terms of how the two modalities can be used in a hybrid format.

## This research highlight summarizes RAND Health Care research reported in the following publications:

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