


COMMENTARY

Flattening the Curve by Getting Ahead of It: How the VA Healthcare System Is Leveraging Telehealth to Provide Continued Access to Care for Rural Veterans

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SARS-CoV-2, the virus that causes coronavirus disease (COVID-19), has caused unprecedented global disruption. As of March 28, 2020, the United States surpassed China, Iran, and Italy to become the country with the most COVID-19 infections worldwide.¹ The virus has caused economic volatility, cancellation, and/or suspension of a wide variety of health care services, disruptions in transportation and other non-medical services, and widespread isolation due to recommended social distancing guidelines. COVID-19 has profoundly impacted the health and health care of millions of Americans, especially rural citizens who are generally older and often more medically vulnerable than the overall US population. In addition to the direct effects on people infected with COVID-19, the pandemic will very likely adversely impact access to care and outcomes for individuals with chronic medical and mental health disorders. In the realm of mental health alone, patients surviving the disease and their loved ones may experience an exacer-

bation of a preexisting mental health disorder at the very time their ability to initiate or complete a recommended treatment program is curtailed. In particular, high-risk patients such as those with alcohol and substance use disorders will be in self-isolation at home without the benefit of needed support by way of group therapy, individual psychotherapy, and/or drug treatment programs.²

As the United States scrambles to deliver health care during the COVID-19 pandemic, expanding telehealth services has become the most prominently employed access strategy across the majority of health care systems. Current projections estimate there could be 1 billion telehealth appointments conducted in 2020, compared to the original pre-COVID projection of 36 million virtual visits for 2020.³ Further, a number of important policies and federal regulations have been quickly changed or relaxed to allow systems to meet an unanticipated and unprecedented demand. Fortunately, in its commitment to

providing veterans access to specialized medical and mental health care, the Veterans Health Administration (VHA) has been an early adopter of telehealth. Starting in 2003, it pioneered the testing and implementation of telehealth on a national scale⁴ with several offices within VHA contributing to this effort. The Office of Rural Health, authorized by Congress in 2006 to promote and disseminate research and programs to benefit America's nearly 5 million rural veterans, currently funds 20 virtual care programs and champions expansion of broadband services through public-private partnerships.⁵ The VA Office of Connected Care further promotes access to health care for veterans by offering a web-based patient record system (MyHealth eVet) and over 3 dozen mobile apps addressing a wide variety of medical conditions (VA Mobile).⁶ Further, these 2 offices collaborate to maintain a national network of telehealth resource hubs that provide care and training to provide in-home access to mental health, specialty, and primary care services.

As a result of these and other telehealth initiatives, the VHA is currently the largest telehealth provider in the United States. Collectively, VAs nationwide conducted over a million telehealth visits in 2018. More than half of these visits were for veterans located in rural areas, and 10% of these visits used VA Video Connect (VVC), a secure video-teleconferencing platform, which allows providers to treat veterans on their mobile devices or personal computers at a location of the veteran's choice.⁷ Simultaneously in 2018, the US Congress passed the "Maintaining Internal Systems and Strengthening Integrated Outside Networks" ("MISSION") Act, which included mandates for VHA to establish an "Anywhere to Anywhere" telehealth network.⁸ This law seeks to ensure that by 2021, 100% of VHA providers in outpatient Mental Health and Primary Care service lines nationwide will be both capable and experienced with providing VVC to non-VA locations. COVID-19 has necessitated this 2021 timeline to be rapidly accelerated. Fortunately, because of its prior investments and infrastructure, VHA is primed to minimize disruptions to health care as a result of COVID-19 and the social distancing required to flatten the curve of this virus.

In order to meet the enormous health care challenge COVID-19 has created, the VHA is rapidly increasing the number of outpatient appointments conducted via VVC so veterans can remain connected and engaged in their care while limiting travel and maintaining social distancing to support efforts of flattening the curve. For example, the Ralph H. Johnson VA Medical Center in Charleston, South Carolina, conducted 2,034 mental health appointments via VVC in March 2020 as compared to 1,429 appointments in January 2020, representing

a 42% increase in VVC sessions. Nationally, the VHA has rapidly and significantly expanded the capability for VVC. In addition, given concerns about exceeding even the VHA's comparatively large capacity during this time, VHA is temporarily allowing providers to use remote audio or video communication technology to augment clinical activities including: Apple FaceTime, Google Hangouts video, Google Duo, or CISCO WebEx.⁹ While these changes are likely to be beneficial, their implementation raises a number of important questions such as: To what degree can the VHA and other health care systems emergently respond to the access needs resulting from situations such as COVID-19?; What systems-specific lessons can be learned to better apply VVC in the post-COVID-19 era?; How will veteran and provider perceptions regarding use of consumer products like FaceTime facilitate or impede the use of these products for health care delivery?; and What are the unanticipated consequences of these technologies (eg, loss of privacy and confidentiality) that may result as they are deployed?

Additional challenges resulting from COVID-19 include federal guideline restrictions related to patient safety. For example, on January 31, 2020, Alex Azar, the US Secretary of Health and Human Services, declared COVID-19 a Public Health Emergency, and in response to this, the Diversion Control Division of the US Drug Enforcement Agency temporarily waived the Ryan Haight Act of 2008. This act was initially proposed and passed in a targeted effort to curb the inappropriate distribution of opioids such as Oxycontin by "pill mills" during the peak of the opioid epidemic by requiring the first visit with a provider to prescribe schedule II-IV controlled substances take place in person. Now, and in response to COVID-19, in-person visits are not required to provide prescriptions issued for a legitimate medical purpose in accordance with federal and state law. Instead, in-person visits can now be substituted with an audio-visual, real-time, 2-way interactive communication system.¹⁰ Although necessary, this more relaxed policy change raises the question of if and to what degree there will be an increase in instances of drug diversion. Additionally, will disruptions in prescriptions for controlled substances, particularly drugs such as buprenorphine-naloxone (Suboxone[®]) used to treat opioid addiction, be associated with increased rates of illicit drug use, overdose, or death, particularly among those unable to access the needed technology to obtain prescriptions using a virtual visit?

It remains to be seen what the impact of COVID-19 will be on the health of Americans, including the consequences of potential gaps and delays in care and the rapid expansion of telehealth policy. This will undoubtedly be an important area of future study for health services

researchers given the wide-scale implications for health care access, policy, technology, implementation science, and medication safety. It is likely that the VHA's early adoption and dissemination of telehealth along with swift deployment of creative solutions to expand services in response to COVID-19, can mitigate the impact of this virus on the health of veterans. Additionally, however, the VHA can serve as a unique laboratory in which to measure the impact of COVID-19 on access to care and outcomes, given its national presence and the availability of a vast network of integrated health record and data systems.

Many of the lessons learned from COVID-19 can be used by VHA in preparation for potential future pandemics or a similar national emergency restricting or impacting travel. Additionally, the VHA can serve as an instructive model for the rest of the nation and other health care systems regarding telehealth implementation. Finally, the rapid expansion of telehealth in response to COVID-19 within VHA and subsequent refinements to the system can be used to more immediately improve the health and well-being of veterans facing ongoing access to care barriers, such as those residing in rural areas.

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