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Telepsychiatry in Academic Medical Centers: Opportunities, Challenges, and the Regulatory Landscape of a Hybrid Ecosystem

Amir A. Afkhami

The COVID-19 pandemic era was a seminal moment in the evolution of workplace culture and educational practices in psychiatry. The rapid developments in telecommunications infrastructure and secure HIPAA compliant conferencing platforms, and its obligatory adoption to reduce the global contagion, acculturated the behavioral health workforce in the United States to distance medical consultation and learning paradigms. This ensured that synchronous and asynchronous remote care and education will persist in the ensuing post-pandemic period, despite the historically heavy emphasis on in-person encounters between patients and clinicians as a cornerstone of psychiatric treatment. In this increasingly "hybrid" workplace environment, the authors of this piece reflect on challenges and opportunities faced by their academic medical center, which are mirrored across the country.

The rise in telepsychiatry followed on the heels of a steadily increasing espousal of Electronic Medical Records (EMR) in medical practices across the U.S. over the past two decades. This trend played an important role in enhancing data management and improving clinical efficiency. With the transition to a hybrid model of psychiatric care in the post-pandemic period, practitioners have witnessed further improvements in the efficiency of psychiatric care, particularly in the ambulatory setting, through better time management and the seamless incorporation of digital rating scales and other measures to enhance real-time diagnosis and management of patients. The use of telepsychiatry also allows providers to have glimpses into their patient's living and working environments, something that had been historically restricted to assertive community treatment teams, giving additional data points to formulate assessments and wholistic treatments for patients. And in this hybrid model of care, providers still perform more comprehensive physical and mental status exams during in-person visits, if necessary. From the patients' perspective, the option to see their providers remotely has increased access and convenience for the psychiatrically ill. This has been particularly beneficial for those in rural or underserved areas, where access to traditional in-person mental healthcare is

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Commentary on "Navigating Hybrid Work: Reflecting on Experiences ofMental Health Providers in an Academic Medical Center" by Elizabeth Greene and Rachel Shor.

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often limited by distances to care facilities and medical workforce shortages. Even in the urban milieu where psychiatric care is less affected by geographical access and specialists, telemedicine helps reduce barriers to regular and sustained psychotherapy among busy professionals who, in the past, might have found it difficult to physically leave their workplace on a regular basis to attend their treatment sessions (DiCarlo et al., 2021; Newby et al., 2024; Person et al., 2023). Finally, remote treatment has opened new avenues of care, such as maritime psychiatry, which had been the traditional purview of internists and emergency room physicians due to the slow adoption of telehealth platforms and other distance treatment technology before the COVID pandemic by the professionals in the mental health arena.

From a learner's perspective, the growing espousal of remote teaching in psychiatric education has made the learning environment more accessible to medical students and residents who have often had to negotiate the twin demands of clinical obligations and didactic learning. Similarly, it has allowed course directors and other educational leaders to tap into a larger pool of experts across the nation and the world, an advantage to which the authors of this piece have alluded. Further, in addition to the "diversity of instructors and learners," the adoption of hybrid learning models has had unforeseen favorable budgetary impacts on medical education as well. This is most clearly manifested in the reduction of the cost burden associated with transport and lodging of experts engaged in grand rounds and other continuing medical educational efforts and conferences. The use of conferencing video platforms and other forms of distance and virtual learning, both synchronous and asynchronous, also facilitates a more seamless incorporation of multimedia resources, case discussions, and digital simulations; allowing for a more inclusive approach to teaching that takes into account the varying learning styles and needs of students (Cheng et al., 2023; Kaplan et al.,

2023; Khoo et al., 2021; Koraym et al., 2021; Stancic et al., 2003).

Despite these advantages, hybrid clinical care and education have not been without difficulties. The authors have underlined the challenges around boundary setting, privacy, and treatment limitations faced by providers who engage patients in a virtual setting. More fundamentally however, providers often attest to the difficulty of building a therapeutic alliance with their patients in a virtual environment. Subtle non-verbal and physical cues can be missed in remote sessions, all of which can impact outcomes in care. And, as the authors have pointed out, both providers and patients are more likely to be distracted when engaging remotely. Moreover, most providers will attest to the persistence of technical barriers, even in higher resourced institutions and states, such as poor video/audio quality, dropped calls, or software glitches that can disrupt sessions and cause frustration for both patients and clinicians. The adoption of remote doctor-patient engagement has also led to migration away from formal clinical sites of service, resulting in a decline of collaborative engagement with peers and professional isolation which have been some of the major downsides of telemedicine practices. The growing shift toward offsite work has made it increasingly difficult to balance work and personal life. While this challenge has often been underreported, the rising number of providers working remotely from home blurs the boundaries between personal and professional life, with clear negative impacts on the quality of patient care (Brunt & Gale-Grant, 2023; Shore et al., 2020; Uscher-Pines et al., 2020).

Similarly, on the educational front, virtual educational platforms have not replicated the interactive nature of in-person events. Medical students and residents often struggle with maintaining meaningful engagement and interaction with their instructors. This erosion of the real-time relationship between teacher and learner has reinforced a transactional model of medical

education, one focused primarily on the most efficient means of conveying and acquiring knowledge, at the expense of the less tangible yet essential function of mentorship, inspiration, and professional role modeling in the learning environment (Riley et al., 2024; Tuma et al., 2021).

The challenges faced in the virtual classroom are also experienced on a broader scale with the growing shift to hybrid attendance at professional meetings and conferences. As professional educational events have increasingly embraced a "remote" attendance model, incorporating both synchronous and asynchronous formats, technical challenges have risen, while attendee engagement has waned. And, much like the classroom, the hybrid conference attendance has become increasingly transactional and focused on earning continuing medical education credits at the expense of valuable networking opportunities, such as informal conversations, unanticipated encounters, networking events, and social gatherings that often occur during in-person gatherings. This has cost professional organizations a decline in revenue from exhibitors, sponsors, and ticket sales at their annual conferences, driven by declining in-person attendance and sponsors' reluctance to offer the same level of funding for convenings with limited exposure and fewer opportunities for interaction with stakeholders (Guetter et al., 2022; Ram et al., 2024).

While opportunities and challenges are plentiful in the academic hybrid work environment, the regulatory and legal issues that will ultimately determine how the hybrid model of teaching and practice evolves in the coming years. These challenges arise from state-level variations in telehealth laws, disparities in insurance reimbursements across plans and states, state-specific licensure and practice regulations, and jurisdictional restrictions on the types of telehealth services psychiatrists and other behavioral health providers are allowed to provide.

During the height of the COVID-19 pandemic, Congress implemented emergency measures that temporarily relaxed regulations surrounding telepsychiatry, including equalizing payment rates for telehealth and in-person care under Medicare. However, these provisions were intended as short-term solutions, and as the pandemic subsided, many of these measures began to expire. As a result, telehealth reimbursement rates remain inconsistent across state lines. As of 2024, 10 states and Washington, D.C. still lack laws that address payment and reimbursement rates for telehealth services. And while mental healthcare has benefited from expanded telehealth coverage and payment parity, only 11 states have enacted laws that mandate payment parity between in-person and remote behavioral health services (American Medical Association, 2023; Vaidya, 2024).

As the COVID-19 emergency measures have wound down, many states have also implemented restrictive regulations governing the practice of telepsychiatry, including rules on patient consent, restrictions on the use of telepsychiatry for initial consultations, and site-of-service requirements for clinical encounters. These regulations often mandate that providers be physically present at a healthcare facility and licensed in the state where the patient is located to deliver remote treatment. Additionally, regulations around the prescribing of medications, especially controlled substances like stimulants, vary widely by state. Some states restrict the prescription of these medications during telehealth encounters unless the prescribing provider has conducted an in-person evaluation of the patient or has established an ongoing patient-provider relationship. In contrast, other states have more flexible regulations. These restrictions have been mirrored in post-pandemic federal regulations that have rolled back several COVID-19-era flexibilities around remote healthcare in a bid to address ongoing government concerns about fraud, quality of care, and nationwide drug shortages linked to the overprescription of certain medications. These federal and state-specific mandates are often adopted by regional

insurance plans and incorporated into malpractice coverage agreements for physicians and institutions, further entrenching jurisdictional differences in the way telemedicine and in-person care is implemented in hybrid practices within academic medical centers. The more restrictive regulations around remote clinical care also exacerbated the challenges faced by academic medical centers in lower resourced and more rural states as they work to address geographic and provider-level disparities in underserved regions (American Psychiatric Association, 2022; Kleinpell et al., 2023).

Regulatory restrictions on telehealth also affect clinical education in the ambulatory settings, particularly in smaller psychiatric departments. States and insurance plans have imposed varying requirements for the supervision of psychiatric residents and midlevel providers, forcing residency program directors and other educational leaders to navigate state and insurance mandates for real-time supervision with the often-occurring need for asynchronous clinical supervision, especially in specialized areas of psychotherapy where academic departments regularly depend on offsite voluntary faculty for the mentorship of trainees.

One of the key factors driving these regulatory inconsistencies and restrictions is the absence of universally accepted, clear, and consistent quality measures to assess the effectiveness of telepsychiatry in clinical practice and remote supervision, which can inform policymakers and advocates alike. Although some studies suggest that telepsychiatry and remote therapy are effective in treating conditions like depression and anxiety, larger and more robust research is needed to establish consistent quality indicators (Bashshur et al., 2016; Kelber et al., 2024; Krzyzaniak et al., 2024). As a result, practice guidelines developed by professional organizations such as the American Psychiatric Association (APA) and the American Telemedicine Association (ATA) are primarily concentrated on navigating regulatory requirements related to service delivery and billing, rather than emphasizing evidence-based clinical

best practices in telepsychiatry (Mishkind et al., 2024).

The Centers for Medicare and Medicaid Services (CMS), which oversees the Medicare, Medicaid, and CHIP programs in collaboration with states and payers, will be crucial in shaping the future of remote care within the hybrid model increasingly adopted by academic medical centers, including the one highlighted by the authors of this article. Currently, Congress and the federal government are addressing several key issues, including the requirement for in-person exams for Medicare patients, whether homes can serve as originating sites for treatment, the flexibility of state licensure for Medicaid Part B providers, reimbursement parity between virtual and in-person visits, and the role of mid-level practitioners in providing mental health services under general supervision in virtual settings.

A promising solution to many of these challenges has emerged through the U.S. House Ways and Means Committee's introduction of the *Preserving Telehealth, Hospital, and Ambulance Access Act* (H.R. 8261). This bipartisan bill, which passed both the Ways and Means and Energy and Commerce Committees in August, seeks to eliminate geographic restrictions and expand the list of eligible originating sites for telehealth services. If enacted, this change would enable rural health centers and federally qualified health centers to provide telehealth services and access Medicare coverage for behavioral health services (Henry, 2024; Preserving Telehealth, Hospital, and Ambulance Access Act, 2024). The legislation is expected to encourage commercial insurers to adopt similar policies, supporting the long-term sustainability of telepsychiatry and the hybrid care model in academic medical centers. Ultimately, this would expand access to vital mental health services across the United States.

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