

The Impact of Operational Partnership on Telemental Health Before, During, and After COVID-19

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The coronavirus disease (COVID-19) pandemic significantly accelerated the growth of telehealth services within the Veterans Health Administration (VHA), as the use of video conferencing to meet with Veterans in their homes increased tenfold in a 3-month period. A substantial portion of telehealth in VHA has traditionally comprised mental health services, and both the scope and volume of such services were significantly broadened in response to COVID-19 to allow for social distancing. The current article is a review of this mobilization from the framework of the People, Process, Technology, and Information model, with a particular highlight on the critical operational partnership between individual facilities providing care and the governing VHA program offices. Lessons learned and future goals for the sustainment and integration of telemental health services are also discussed.

Impact Statement

COVID-19 significantly accelerated the growth of telehealth services within the Veterans Health Administration (VHA). This article reviews the rapid mobilization of telemental health within VHA as a tool to provide socially-distanced mental health services throughout the COVID-19 pandemic.

Keywords: telehealth, telemental health, organizational change, COVID-19, Veterans

Although telemental health (TMH) in the Veterans Health Administration (VHA) had been steadily increasing over the past several years, the coronavirus disease (COVID-19) pandemic

significantly accelerated its growth and effectively changed the face of mental healthcare delivery. TMH includes the provision of mental health (MH) services via clinical video telehealth to clinic and clinical video telehealth to home/preferred location (CVT-H). Given the greater convenience for Veterans, VHA's focus had been on expanding CVT-H adoption and usage. The onset of the COVID-19 pandemic in March 2020 and resulting distancing restrictions on in-clinic appointments led to CVT-H being fast-tracked from being an additional option for care to an essential treatment modality. VHA rapidly converted to and expanded TMH in an unexpected shift for patients and providers alike, with the goal of minimizing any disruption in mental services due to the pandemic.

The importance of the success of this transition was underscored by the increased need for MH services to support amplifications in stress, anxiety, loneliness, and other psychological sequelae of

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enduring a global pandemic. As a discipline, MH had already been at the forefront of telehealth in VHA, and to date MH continues to be the primary service delivered via CVT-H. As such, well-established infrastructure existed that facilitated the quick spread of practices and adoption of TMH by providers and Veterans once the pandemic hit (Connolly et al., 2021). The most vital component of this infrastructure was the established partnership between VHA national program offices and local facilities (colloquially referred to as “the field”).

The current article describes the conversion to TMH during the pandemic in VHA using the framework of the People, Process, Technology, and Information model (cite). Throughout our review, we highlight the partnership between the field and OMHSP and the ways in which this collaboration was integral to the success of TMH during the pandemic. Though the current article focuses on processes within VHA, the relational dynamics, dissemination of information, and lessons learned are applicable to a wide variety of healthcare organizations and practices. Future goals for the sustainment and integration of TMH services in VHA and healthcare more broadly are also discussed.

History of TMH in the VA

The vital role VHA has played in pioneering TMH provided a solid foundation from which to significantly and rapidly expand in the midst of COVID-19. The first use of telehealth within VA occurred in the 1960s (internal VA Communication). Particularly since the early 2000s, Telehealth services have grown with respect to the types of services, location of services, and number of patients served. Within VHA, the steady evolution of technology alongside a culture shift toward virtual health care led to Veterans’ ability to access their healthcare provider from the comfort of their own home with the debut of CVT-H in 2013. In 2017, VHA refined its CVT-H platform with the advent of VA Video Connect (VVC), which remains the VHA’s current platform for clinical video teleconferencing to non-VA locations. A key development occurred in 2018 when the “Anywhere to Anywhere” initiative was introduced (Department of Veterans Affairs, 2018), enabling VHA providers

to deliver services throughout the United States and its territories and provide a continuum of services nationally—regardless of Veteran or provider location within the U.S.

The spread of TMH has been supported by empirical findings collectively demonstrating that psychotherapies delivered via video-based appointments are equally as effective with respect to working alliance, satisfaction, and clinical improvement as in-person modalities (e.g., Acierno et al., 2017; Fletcher et al., 2018; Morland et al., 2014), and result in fewer missed appointments (e.g., Hommel et al., 2013). Further, video telehealth offers important clinical advantages over telephone appointments, including the ability to see facial expressions, observe the home environment, and replicate in-person care (Chen et al., 2021; Lindsay et al., 2020). Bolstered by the robust body of supporting literature, TMH had steadily increased over the past several years (VHA Support Service Center, unpublished data, 2020) before reaching a critical mass with the onset of the COVID-19 pandemic (see Figure 1).

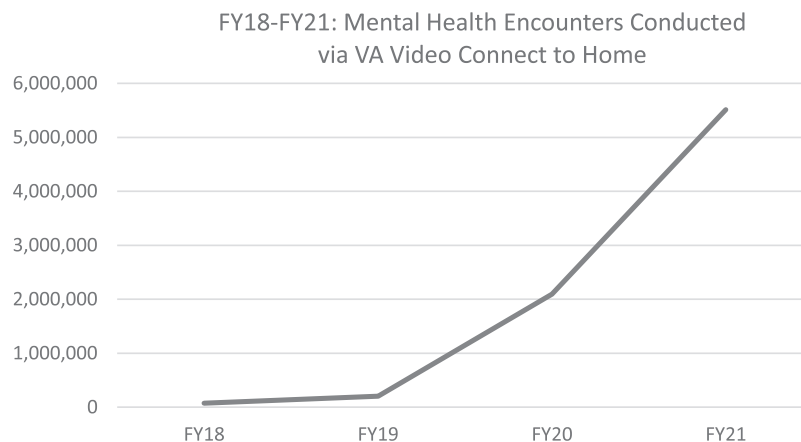
By early March 2020, national and local guidance was issued to prepare for the possibility that many more patients would be seen at home by providers working from home. This rapid and massive shift in the location of providers and patients required national and local guidance in a range of areas including: administrative logistics, deployment of technology, and work processes and workload expectations.

People, Process, Technology, and Information Framework

The history of People, Process, Technology, and Information (PPTI) model originates from Leavitt’s Diamond Model of organizational change where the focus was on bidirectional relationships within and among four factors: People, Tasks, Structure, and Technology (Leavitt, 1965). Over time “structure” and “tasks” were combined to create “processes,” resulting in the People, Process, and Technology model that focuses equally on these three areas to inform the change process in organizations and businesses. It is often referred to as the Triangle model or three-legged stool approach where each area balances the others for optimal performance. Some refinements of the model have added “Information” to

Figure 1

Mental Health Encounters Conducted via Videoconferencing to Home in VHA



Note. FY = fiscal year (October 1 to September 30). VHA = Veterans Health Administration. Encounters refer to the number of mental health visits in that fiscal year. Data for FY 18 to FY 21.

help establish a feedback loop, allowing for a more overall holistic approach to change strategy and systems. The use of this PPTI model when implementing organization change affords a streamlined approach in targeting areas for improvement.

Most often, the recommended initial focal area is *People*—the individuals within the organization, their current abilities and performance, and those impacted by organizational change (e.g., patients). In particular, ensuring that the organization has buy-in from all parties is vital. Next, the focus shifts to the review and modification of *Processes* to achieve the desired goal. This area underscores the importance of defining critical steps in the process and ensuring all players are aware of their roles. *Technology* is an integral component of any organizational change and is a particularly salient consideration in changes involving a rapid shift to virtual tools. Ensuring that the technology needed to facilitate the change is right-sized and aligned with the defined process and needs of the people is vital to a successful transformation. Finally, a focus on *Information* allows for specific consideration of the tools that are disseminated and bidirectional data and other forms of feedback that are shared.

People

VHA Providers

While many large organizations often struggle with identifying and engaging talent where it is needed, large-scale cooperation and collaboration across all levels of VHA was essential to ensure all providers were CVT-H capable. The partnerships between providers, facilities, and national program offices that had been established prior to the pandemic became crucial throughout the pandemic, particularly in the early stages. There were several partnerships and practices that were important for the successful transition to virtual care. One of the most critical aspects of this was the prepandemic identification of local (facility based) and regional (Veterans Integrated Service Network [VISN] based) TMH champions across VHA. While all VISNs had identified champions prior to the pandemic, a more formal and robust partnership between VHA national program offices and the field focused on identifying champions at every VA hospital across the country. As part of this effort, existing and new communities of practice were streamlined and formed with more explicit purpose, structure, and streams of communication. These communities of practice included regular meetings where information could be disseminated from program offices to the field, input from the field was elicited, and drop-in “office-hours” that allowed for a less formal venue for questions and answers as well as sharing strong practices. Additionally, instant message groups were established that consisted of representatives from VHA national program offices and field direct care providers that helped to disseminate information from national program offices to the field and provide on-the-spot consultation regarding virtual care with leaders as well as colleagues. For example, especially early in the pandemic, there were many technical questions about VVC, navigating remote systems for telework, and adapting in-person practices to virtual care. These various meetings and communities of practice allowed for a feedback loop whereby questions and comments within the less formal calls would drive agenda items in the more formal meetings so that questions could be addressed fully.

Importantly, these venues also provided opportunities for the field to provide input and feedback to the national program offices. For example, the local champions provided feedback to VHA national

program offices regarding the functionality of technology, proposed updates, and general ideas for improvement. One specific area that was identified early was the need for more streamlined training for VVC. As an important first step in making virtual care available to Veterans, leadership acted quickly to condense the initial 3-part training series into one course. As a result, clinicians were able to complete the training more efficiently, and champions were able to track training completion much more easily. Again, this bidirectional flow of information between stakeholders has been instrumental in successfully providing and improving CVT-H services throughout the pandemic. Additionally, this infrastructure has provided opportunities for collaboration on specific topics whereby program office leadership can easily identify champions to form field-based workgroups for input into policies, procedures, and documents prior to release. For example, field-based workgroups in partnership with program offices have formed to develop guidance around emergency procedures, behavioral guidelines, and virtual training among others. Bringing together the national and administrative perspectives of leadership with the applied and practical knowledge and expertise of front-line champions has provided a depth and breadth to decision-making that sets VHA apart as a leader in virtual care.

An additional benefit of identifying local champions is that facilities could then leverage the knowledge, experience, and expertise of those champions and others seasoned in CVT-H to lead orientations and provide didactics. Potential areas to cover in these didactics are outlined in Table 1. Those new to CVT-H could also be paired with an experienced provider serving as a point of contact to address concerns, answer questions, and provide support in navigating the logistics. Often these consultations have been useful in addressing questions regarding adaptation of interventions to a virtual modality and have helped providers navigate concerns regarding the appropriateness of CVT-H for navigating complex clinical issues. Additionally, as in any healthcare system, a significant change in practice can sometimes be perceived as a top-down policy initiative. Flattening the organizational hierarchy to listen to and support the field as well as fostering efforts to connect experienced CVT-H providers with those newer to the modality can help shift this perception to a more bottom-up, clinician-driven effort to provide care to those who need it and ultimately improve commitment to CVT-H across providers.

Veterans

Along with provider readiness, engaging Veterans at various levels of VHA is also critical. Nationally, there was urgency to schedule Veterans for CVT-H appointments to avoid potential health risks in coming to a medical setting during a highly contagious pandemic and to educate Veterans about VVC. Through

Table 1
Sample Topic Areas for Provider Orientation CVT-H

Converting MH in-person appointments to virtual care
Ethical and Legal Considerations
Safety Planning, Risk, and Emergency Protocols
Informed Consent for CVT-H
Screening/Determining Appropriateness for CVT-H
Getting Started in Treatment: Frame and Building Rapport

Note. CVT-H = video conferencing to home.

multiple communication strategies, numerous stakeholder groups such as Veterans Service Organizations and other state and national organizations were leveraged to help inform Veterans about VVC and virtual options. Much emphasis was placed on direct-to-consumer marketing for virtual care in VHA, to include webinars, blogs, and live social media streams. VHA websites, including the main VHA landing page's COVID FAQs, now included links to multiple virtual tools: education regarding VVC, Secure Messaging (a method of sending secured communications to care teams from within the Veteran patient portal known as My HealtheVet), and VA Mobile applications. In particular, the COVID Coach mobile application was rapidly developed to link Veterans with education, tools, and resources for coping with stress related to the pandemic.

Processes

Over the course of the pandemic, VHA both developed new policies and procedures to navigate the unprecedented and rapid change from in-person to remote services, and rapidly and broadly disseminated procedures that it had presciently established over the course of developing its TMH infrastructure. Throughout the course of the pandemic, outcomes were monitored, and goals shifted from a focus on implementation to sustainability.

Among the newly developed policies and procedures were those designed to facilitate the notable administrative changes associated with the shift from processes designed for in-person care to telehealth. Policies communicated VHA's prioritization of activities and services, which included a shift away from nonessential academic, research, and nonclinical activities, as well as communication of which clinical services to prioritize and which to postpone to ensure the clinical needs of Veterans, were met; preserve staff, personal protective equipment, and patient care supplies; and expand hospital capacity. These policies were vetted with the field in a continuous feedback loop to ensure relevance and feasibility. For example, a collaborative workgroup was assembled to perform ongoing reviews and collations of extant TMH-related literature, the findings of which have been used to support VHA guidance and influence providers to adopt TMH. Further, VHA set up a process of recurring review and updates to these summaries, which collectively support the effectiveness and patient satisfaction with TMH (e.g., Egede et al., 2015; Frueh et al., 2005; Germain et al., 2009; Holmqvist et al., 2014; Luxton et al., 2016; Mitchell et al., 2008), VHA-wide to ensure providers in the field are familiar with the current literature.

Guidance and training were also provided around a range of administrative logistics including procedures for scheduling CVT-H appointments, workload, billing, documentation and procedural coding. For existing in-person appointments, administrative staff were provided with protocols for making the necessary shifts to shift from in-person visits and to virtual appointments. VHA also issued specific guidance to assist providers in identifying and communicating with high-risk Veterans and ensuring their safety and care. These efforts incorporated the dissemination of a range of existing tools, such as the Safety Plan within the PTSD Coach Mobile App from the National Center for PTSD, which could facilitate clinical service delivery for specific vulnerable populations. Existing resources were also leveraged, such as Suicide Prevention Population Risk Identification and Tracking for Exigencies (SPRITE), a dashboard used to assist in the identification of high-risk Veterans

for additional clinical follow-up. VHA also issued new guidance around the delivery of services for special populations such as sharing national public health emergency guidance on controlled substance prescribing through telehealth during COVID-19.

Throughout the pandemic, national guidance was issued on a broad range of critical technical issues including: appropriate telehealth platforms and methods for communicating with patients and delivering services, troubleshooting technical difficulties, and strategies for conserving bandwidth to ensure stable communication between providers and patients. VHA also simultaneously worked to expand available technological resources for both providers and patients, as described further in the next section. Multiple levels of leadership within VHA (including national VHA program office leadership, field subject matter experts, and local TMH Champions) developed and disseminated clinical guidance on a range of TMH-specific clinical processes and issues to orient providers to TMH (see Table 1).

Technology

While the number of providers who delivered MH via telehealth in the VHA greatly increased in FY19, the COVID pandemic required a rapid and effective deployment of technology for all patients and providers to become "telehealth ready." Through national VHA interoffice and field collaboration, access to equipment and infrastructure expanded; this provided VHA staff and patients the physical devices and technological capacity to attend appointments from their homes.

At the onset of the pandemic, VHA mobilized to ensure that providers either had government-furnished equipment, such as smartphones or laptops, to facilitate remote connection, or had access to the VA network from their personally owned devices. Simultaneously, growing capacity demands on the VVC platform were met with flexible expansion of infrastructure using cloud-based technology.

While increasing bandwidth capacity to VVC became an urgent priority during the COVID pandemic, improvements to the VVC platform and its accompanying scheduling platform Virtual Care Manager (VCM) have been ongoing for much longer to continue improving the user experience (e.g., on demand appointments, ability to change layouts for groups, ability to text VVC appointment links). Since the VVC platform was created in 2017, VHA has continuously added improvements to the software platform, based on feedback from providers and Veterans.

In addition to increased bandwidth and improvements for remote work and CVT-H, the necessity to provide widespread, flexible access to care was evident across the U.S. healthcare system. In order to empower providers to deliver healthcare during the pandemic, the Department of Health and Human Services issued guidance allowing providers to "in good faith, provide telehealth services to patients using remote communication technologies . . . even if the application does not fully comply with HIPAA rules." (Telehealth: Delivering Care Safely During COVID-19|HHS.gov). In summer 2020, VHA provided national guidance and clarification to MH staff through multiple communication methods that when Veteran acceptability, bandwidth, and technology permit, video is the preferred virtual modality over the telephone, and that while VVC is the preferred technology for video visits, alternate technologies may be used as a back-up.

While increasing bandwidth and provider adoption of telehealth has been a priority and improving before the COVID pandemic, the

need to overcome barriers on the patient side has also been evident for a long time. According to the Pew Research Center, low-income Americans have lower levels of technology adoption and rely on smartphones to stay connected. In 2016, the VA began to distribute tablets to Veterans without video-capable devices or connectivity (Zulman et al., 2019), leading to an increase in Veterans reporting convenient care and fewer missed appointments and no shows for MH appointments. In the fall of 2020, nationally, the Digital Divide Consult was introduced to increase resources available to Veterans (e.g., tablets and peripheral medical devices and support for internet connectivity). Additionally, smartphones are an option for Veterans in the VA Homeless Program, and Veterans who receive a VA loaned device are offered specialized support to assist them in operating their device.

As with other areas of this shift to TMH, the need for and nature of these technological improvements was driven by the communication between the field and VHA, and this bidirectional feedback loop was critical in quickly and efficiently assessing technological issues and creating and deploying remedies.

Information

In large health care systems, disseminating consistent information to clinicians is no simple task. During a novel time in history, with constantly changing guidance, it became critical to organize information so it could be easily metabolized by clinicians and site leadership. VHA responded to this need by expanding existing tools while creating new ones for both providing guidance to clinicians, and updates to site leadership on telehealth usage at their specific facilities. The partnership between program offices and the field has been crucial, with experiences from the field helping to shape national guidance and policies.

VHA created and updated national SharePoint sites to house TMH guidance during the pandemic. This comprehensive guidance includes information on providing controlled substances via telehealth during the pandemic, scripting for clinicians and support staff to use when scheduling virtual care appointments, educational materials supporting VVC for providers and Veterans, technology troubleshooting/basic connection tips and guides, and steps on scheduling and coding telehealth visits. A national workgroup consisting of members from program offices and the field also developed a VVC Fundamentals SharePoint page that detailed some of the nuances related to healthcare service delivery via VVC—to be used as an ongoing resource for new and existing front-line clinicians.

In addition to the online repositories of tools that clinicians and support staff can access on a comprehensive list of telehealth topics, dashboards to provide a pulse of telehealth usage were expanded or created during this time. These dashboards captured data on the modality of care provided to Veterans on a clinician, clinic, and site level. This was important to recognize gaps in access to telehealth and empowered champions to address these gaps within their sites. Additionally, a national patient satisfaction survey was utilized to gather feedback regarding Veterans' perceptions about video care. These data are then used in strategic planning and process improvement at the national and local levels. For example, data regarding older Veterans' preferences for receiving MH care via video has been used to dispel myths regarding older adults' openness to technology.

Future Directions

There are a number of lessons we have learned during this rapid scale-up, and as a result we will focus on three major areas as we continue our collaborative partnerships to improve telemental healthcare: technology integration, service expansion, and clinical research. With respect to technology, better integrating the multitude of technological tools (e.g., mobile applications, teleconferencing platforms, scheduling software) is critical to streamline processes and ensure fidelity to evidence-based clinical models and workflows. Additionally, ensuring that emergency resources are integrated within the technology is critical to ensure providers have access to support functions. For example, VHA has integrated an e911 feature into the VVC platform, and this enables quick connection with emergency services located near the patient.

Another area for growth is continuing to improve and expand our TMH services to ensure equitable access for all individuals in need of MH care. The “digital divide” is a term that has been used to describe the gap between those with and without adequate access to technology and related services. Factors such as socioeconomic status, geographical location, physical ability, and digital literacy can all impact the extent to which patients can access care virtually. VHA has begun to address these issues in a multitude of ways, to include a loaned devices program for those without telecapable devices, use of the Federal Communications Commission's Lifeline program which provides discounted communications services, establishing secure telehealth access stations in select rural communities with suboptimal internet service, and offering education and testing for video calls prior to the appointment with the provider. VHA has also been working to promote solutions that would foster increased capability for those who may need more assistance with telehealth (e.g., those with hearing difficulties).

Ensuring that more research is done on different aspects of providing evidence-based care via telehealth is also a high priority. While there is a robust literature supporting the use of CVT-H for evidence-based psychotherapy, particularly for PTSD, more work is still needed to examine its use in specific group formats and for subpopulations such as patients with severe mental illnesses. The pandemic created a situation where healthcare providers and organizations have been able to widely extend the use of CVT-H to new populations. Going forward, more work will be needed to understand what modifications are and are not required to deliver treatments successfully, particularly after social distancing recommendations cease and the decision between in-person or CVT-H care is driven primarily by preference. Understanding patient and provider preference for care will be an important next step when it comes to CVT-H research.

In addition, it will be critical to examine the system-level issue of standardizing how CVT-H is offered and how training is provided. VHA has recently developed guidance to facilitate all Veterans being offered telehealth as an option when scheduling an appointment. Scripts and how-to guides for schedulers have been provided to ensure that all Veterans are uniformly offered video as an option for their healthcare. Understanding how many patients are being offered this modality vis-à-vis how many decline, and reasons for declining, will offer important information regarding patient preferences and improvements needed.

Telehealth has made it possible to reduce barriers and create and sustain access to MH care for patients who may have otherwise been

unable or disinclined to physically present for in-person treatment during the COVID-19 pandemic. The resources that VHA has invested in TMH over many years are now paying dividends, and VHA can offer a template for community providers to increase scale and spread of their TMH offerings. The COVID-19 pandemic has effectively changed the healthcare industry, with the projection that this impact will outlast the pandemic; the success of and satisfaction with TMH suggest that, as a society, we are unlikely to revert to a healthcare model in which virtual modalities are the exception. With continued operational partnerships and investment in staff, technology, research, and implementation efforts, virtual MH programs will thrive for the duration of this pandemic and beyond.

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