Moderator: Welcome to the VA HSR&D Investigator Insights podcast series. In this episode Rob Auffrey with the Center for Information Dissemination and Education Resources talks with Lucinda Leung, investigator with the Center for Study of Healthcare Innovation, Implementation and Policy at the Greater Los Angeles VA Healthcare System about her work looking at the widening rural-urban divide in use of telehealth in VA.

Rob Auffrey: Dr. Leung, thank you for taking the time out of the AcademyHealth Annual Research Meeting for this interview.

Lucinda Leung: You're welcome. Pleasure to be here.

Rob Auffrey: Why don't we start with what are your general research interests?

Lucinda Leung: I am a primary care physician at the VA Los Angeles. And I also am a Health Services Researcher with an interest in studying how we can better design our primary care practices to serve Veterans with complex needs, Veterans with mental health needs. How to take care of the whole person in front of me.

Rob Auffrey: What brought you originally to VA?

Lucinda Leung: What brought me to the VA? I feel like you could ask that question to every physician, and it would be hard-pressed for them to say that they've never interacted with the VA in any way. The VA is such a leader in training the next generation of healthcare professionals that I have rotated and worked in VAs across the country.

 By the time I got to the Los Angeles VA I had worked in VA River Junction, VA Providence, VA San Francisco. It's, for me, the VA has been a very important part of my medicine training. It was hard to not be within the VA after I finished residency.

Rob Auffrey: Great. Well, I guess that brings us to what are you presenting here at the AcademyHealth Annual Research Meeting? Can you tell us a little bit about that?

Lucinda Leung: Sure. I have an interest in making mental health care more accessible for Veterans. The VA has been a leader in doing this for so long just because of how high our Veteran population has, in terms of mental health needs. That's not specific to Veterans. It's a problem that we see everywhere with primary care patients. But the VA has specifically prioritized that and really done innovative things to be able to take care of them such as completely reshaping the way primary care practices look. Where it's not just me. As a primary care physician, they are taking care of the patient in front of me. I have a whole team behind me, and that team includes not just nurses, pharmacists, social workers. It also includes mental health specialists. And for your average patient, many of them have to jump through hoops to get to see a mental health specialist.

 At the VA, we have them right next door to me. I can see a patient, identify that they have mental health needs. And well, before COVID, when we were all physically in the same place, we would walk down the hall, and I would introduce them to my colleague who happens to be a psychiatrist or a psychologist. And it would allow my patients to get one-stop shop care; care that is not stigmatizing, that requires them to check into a mental health clinic, declare that they have depression.

 We really want to treat the whole person in front of us in a timely way, in a way that's convenient to them to really get them to engage in care that can be stigmatizing.

Rob Auffrey: Interesting. The abstract that you sent me mentioned telehealth for Veterans, which I know was a priority for VA before COVID-19.

Lucinda Leung: This is what I've been studying for a long time. When the pandemic came, everything changed. And as a practicing physician it felt like overnight I had my practice completely convert to virtual as many of the other healthcare professionals have. And on the patient side, it's the same thing. They are used to coming in to seeing their doctors in-person.

 And then all of a sudden, how do we make this work where we're treating patients over the phone, over video? When I saw this happen it really, it made me want to know the care that we're providing virtually, is it as good as we're providing in-person? Does it make it easier to get people the services that they need? And then the question came up where that change happened everywhere. Is it affecting certain places more so than others?

 What came up was I'm located in Los Angeles, large metropolitan area, and for me I still saw that some of my patients had trouble connecting onto video or saying that they'd agree to doing a remote visit for me when they're just used to talking to their doctors face to face. And I thought, too, "Well, the VA has been doing this for a very long time." It's really a leader in telemedicine.

 Before COVID came along, many places, especially places that were farther from the hospital where I work where patients have to drive hours to get into the main medical center, they've been doing telehealth. And the VA has been really setting up the equipment. They've allowed the providers to take care of patients across state lines, really, the Mission Act propelled that. Did that mean that those places that are farther away, rural areas where people were doing telehealth before COVID came along, were they, did they have a better footing when, really, telehealth took off?

 We looked at all primary care visits from a year before COVID happened to about a year after the vaccine was available. And we studied 63 million primary care visits, almost four million mental health visits that were delivered within primary care to answer this question. We looked at whether those visits were delivered in-person or via Telehealth. And Telehealth we're calling phone visits, video visits, secure messaging.

 And what we found was, yes, like, before the pandemic had arrived, rural sites were delivering much more of telehealth. They were the ones that said, "We have trouble getting a hold of mental specialists. We want to participate in these new initiatives that allow us to get those services virtually." And when the pandemic hit and everybody said, "Okay, well, we'll be accepting of virtually delivered services from primary care physicians, from psychologists," it was really the urban centers that really took off.

 And we were able to see that whatever advantage the rural VA sites had really got lost in that jump in telehealth use. And the way we looked at and classified rural versus VA, we're really looking at the VA, like, healthcare system as a whole. We're talking about a VA hospital and its associated community clinics, and what classified as either rural or urban. We're not even really, necessarily capturing an individual patient who lives in a rural area getting care from an urban VA Medical Center.

 If we were able to do that, I suspect that the effect would be even larger because we know that historically rural sites have had worse off in terms of medical care access. And I think, and they've also had worse off in terms of, like, telehealth use because of many issues. Broadband is one of the big ones, Internet broadband access is one of the big ones that I'm thinking of.

 If we were able to account for all of that, I suspect that what we would see is with lifting all boats with using telehealth more broadly to deliver our VA services, not everybody is coming up in the same way. And our rural sites might be lagging and need more attention.

Rob Auffrey: I'm wondering why the dramatic outpacing of urban Veterans as opposed to rural? Was one group working from home more than the other, or is it, was it something programmatic in the telehealth program at VA?

Lucinda Leung: This study is really just the first step describing that there are these changes that we're seeing over time when comparing before to after the pandemic. We don't get into the reasons, but I think the reasons are very interesting, and need to be explored. Because we don't really see telehealth going away anytime soon.

 If anything, we're trying to figure out how do we make this work together? How do we deliver hybrid care where care is delivered either in-person, either in video? For what patients do we do telehealth visits on? For what conditions do we require that these visits be in-person?

 We don't have answers to any of that. And these were evidence gaps that existed before COVID came along. They're more important to fill now because we've been thrown into the situation where everybody's doing it, and we're trying to patch together, what is the best thing to do without necessarily the evidence space that we would have for most things to guide us in doing it?

 We're playing a lot of catch up with the research and trying to get to a lot of the answers that you asked. I think broadband availability is one of the bigger ones that we do know plays a role. And we hope to eventually add that data to our analysis. But the issue is broadband data, there's some lag in when that data is available for us to include.

Rob Auffrey: Is there anything else that I haven't hit on that you think is important to add?

Lucinda Leung: I think that more broadly speaking, it's really important when studying quality to make sure that we're understanding how it affects certain populations of people. I think that by all metrics, the VA has done a great job at responding to when the pandemic shut us down, and we had to limit people from moving in, and out of the hospital, and coming to see us. We had the equipment there, and the teams there ready to provide that care virtually.

 But in that, we need to make sure that that care is being delivered equitably, so not just, sort of, celebrating, yay, we delivered telemedicine to a large population of people. But really making sure that, okay, is that population preferentially, that's preferentially benefiting my patients in Los Angeles? And we're forgetting about everybody else in rural areas that are maybe, like, four or five hours away from me?

 In my own practice I have patients that live right next door to the VA, West Los Angeles. I have patients traveling all the way from Bakersfield, California. They're making, like, a three, four hour drive to come see me. And I want to make sure that the care I'm delivering them is in a way that is also timely, convenient, effective.

 And I want to make sure that as we're pushing everybody to do telehealth, that we're not forgetting about the folks that telehealth really is not necessarily the best modality for them, and may not be the preferred modality. Or they just don't have the infrastructure or the Internet bandwidth to do a high quality video visit, that they'd prefer to come in-person, that the option is still available.

Rob Auffrey: Well, thank you, Dr. Leung, for your time today, but more importantly, for your work in VA.

Lucinda Leung: Thank you.

Moderator: The views and opinions expressed in the preceding podcast are concerned with the scope of recently concluded or ongoing VA HSR&D funded research and do not necessarily reflect current or to be implemented VA policy. To learn more about this research, visit the VA HSR&D website at www dot hsrd dot research dot VA dot gov.

[END OF TAPE]