

Telehealth Is Permanent, but Clinicians Can't Measure If It Works: Survey Reveals Outcome Data Gap

75% of mental health providers expect telehealth to remain core to their practice, yet 15% are unsure whether outcomes match those of in-person care.

BALTIMORE, MD, UNITED STATES, July 12, 2026 /EINPresswire.com/ -- More than two years after the pandemic forced behavioral health care online, telehealth has solidified into a permanent practice.

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*ICANotes Chief Clinical Officer,
October Boyles, DNP*

But a critical knowledge gap remains: clinicians are embracing virtual care without rigorous outcome measurement, creating regulatory and reimbursement vulnerabilities as payers and policymakers demand evidence of clinical equivalence.

According to the [ICANotes Clinician Survey 2026](#), which analyzed insights from 416 licensed behavioral health professionals across the United States, 75% of clinicians

are currently delivering telehealth as part of their routine practice—and 75% expect it to remain a significant or core component of their practice long-term.

Yet when asked to compare telehealth patient outcomes to in-person care, clinician confidence in the data is decidedly mixed.

The Outcome Picture: Comparable, But Uncertain.

- 62% report telehealth outcomes are comparable to in-person care
- 17% report outcomes are worse
- 6% report outcomes are better
- 15% say it is too early to say

The "comparable" rating is clinically pragmatic but not enthusiastic. It reflects cautious acceptance rather than evidence-based conviction.

And the "too early to say" response (15%) is telling: it suggests many clinicians remain in a learning phase, still determining which patients and conditions benefit most from virtual delivery.

The data also reveals variation: clinicians delivering 100% telehealth (18% of respondents) report different outcome patterns than those blending virtual and in-person care. Solo practitioners (35%) report different experiences than those in group practices or community health centers (24%).

This heterogeneity suggests telehealth is not a monolithic intervention—its efficacy depends heavily on implementation context.

Measurement Discrepancies:

Unlike robust outcome literature for depression and anxiety treatments, behavioral health practices have not systematized telehealth outcome tracking at the practice level.

Few clinicians use validated outcome measures to compare telehealth vs. in-person patient trajectories.

This represents a significant vulnerability: as payers and regulators increasingly demand outcome documentation to justify reimbursement parity, clinicians may struggle to defend telehealth's clinical standing.

"We've normalized telehealth without fully understanding when it works best," said [ICANotes](#) Chief Clinical Officer, October Boyles, DNP.

"Clinicians are confident in their intuitive sense that telehealth works for many patients and conditions. But that's not the same as having empirical data. If a payer or regulator challenges telehealth reimbursement in two years, clinicians will be asked to produce outcomes evidence, and most practices won't have it."

Regulatory and Economic Risks.

The survey was conducted in May 2026, before any major shifts in telehealth policy.

But the uncertainty among clinicians signals deeper anxiety: reimbursement parity with in-person care remains unsettled. State telehealth licensing reciprocity—critical for national reach—continues to face state-by-state battles. Federal telehealth flexibilities remain subject to renewal.

Several clinicians noted in open responses that telehealth sustainability depends on maintaining current regulatory allowances and insurance coverage. Without those, the permanence clinicians expect becomes fragile.

Telehealth's Role in Capacity.

Interestingly, telehealth adoption correlates with practice capacity decisions.

Clinicians operating 100% telehealth practices (13% of respondents) report different wait times and caseload patterns than those blending modalities. This suggests that telehealth is not just a clinical delivery mode; it's an operational strategy that affects practice volume, staffing, and access.

For clinicians working in rural areas or underserved regions, telehealth has been a lifeline, enabling them to reach patients who would otherwise have no access to care.

For urban practitioners, it has enabled efficiency (no commute between sessions) and flexibility (accommodating patient preferences). Both use cases point to telehealth's structural value, independent of outcome questions.

What Comes Next.

The data suggests three policy and operational priorities:

1. Outcome Standardization. Behavioral health practices need clear guidance on which outcome measures to track for telehealth vs. in-person care—and why.
2. Reimbursement Clarity. Payers and regulators should clarify long-term reimbursement parity expectations. Clinicians cannot invest in telehealth infrastructure if parity is temporary or uncertain.
3. Clinical Guidance. Professional associations should develop evidence-based guidance on which conditions and patient populations are appropriate for telehealth vs. in-person care—removing the guesswork.

Until these gaps are filled, telehealth will remain a pragmatically accepted tool rather than a fully integrated, evidence-supported component of behavioral health care.

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