Telebehavioral Health During the COVID-19 Pandemic: A Qualitative Analysis of Provider Experiences and Perspectives

Victoria Schoebel, MPH,[1,i] Caitlyn Wayment, MPH,[1,2,ii] Maria Gaiser, MPH,[1,iii] Cory Page, MPH, MPP,[1] Jessica Buche, MPH, MA,[1,iv] and Angela J. Beck, PhD, MPH[1,v]

[1]*Behavioral Health Workforce Research Center, University of Michigan School of Public Health, Ann Arbor, Michigan, USA.*
[2]*Department of Community Dentistry and Population Health, University of Colorado School of Dental Medicine, Aurora, Colorado, USA.*
[i]*ORCID ID (https://orcid.org/0000-0001-9211-6120).*
[ii]*ORCID ID (https://orcid.org/0000-0003-0343-8000).*
[iii]*ORCID ID (https://orcid.org/0000-0001-7463-9454).*
[iv]*ORCID ID (https://orcid.org/0000-0002-1726-047X).*
[v]*ORCID ID (https://orcid.org/0000-0002-2877-3422).*

Abstract

Introduction: *Due to the COVID-19 pandemic and prompted by recent federal and state policy shifts impacting behavioral health care delivery, the use of telebehavioral health has rapidly increased. This qualitative study describes behavioral health provider perspectives on the use of telebehavioral health before and during the pandemic and how policy changes impacted access to and utilization of behavioral health services in Michigan.*

Materials and Methods: *A convenience sample of 31 licensed and nonlicensed behavioral health providers operating in Michigan participated in semi-structured interviews between July and August 2020. Interviews were audio-recorded, transcribed, and analyzed by using inductive methods.*

Results: *The thematic analysis resulted in four overarching themes: (1) increased access to care; (2) maintenance of quality of care; (3) minimal privacy concerns; and (4) client and provider satisfaction.*

Discussion: *During and post-pandemic, providers need flexibility to determine whether in-person or telebehavioral health services, including audio-only, best meet client needs. Providers identified several populations for which telebehavioral health was less accessible: clients with serious mental illness and substance use disorder, those with no broadband Internet access, children, and older adults. Additional training in telebehavioral health service provision can positively impact quality of care.*

Conclusion: *Policies that support reimbursement parity and expand provider use of telebehavioral health services should be maintained after the COVID-19 pandemic ends to avoid imposing barriers to accessing behavioral health care barriers post-pandemic.*

Keywords: *telebehavioral health*, *provider perspectives*, *behavioral health*, *mental health*, *workforce*, *telepsychiatry*, *telehealth*, *telemedicine*

Introduction

Telebehavioral health utilization is growing rapidly, a trend anticipated to continue in the wake of the coronavirus disease 2019 (COVID-19) pandemic. Pandemic-induced behavioral health symptoms are on the rise, as housing instability, employment changes, disruption of daily routines, and reduced social activity pose threats to mental health, particularly for underserved, low-income, or otherwise vulnerable communities with preexisting behavioral health conditions.[1,2] Before the pandemic, <20% of people with mental health needs had access to services.[3] Individuals living in rural communities are at an increased disadvantage, as >90% of all psychologists and psychiatrists work exclusively in metropolitan areas.[4] Telebehavioral health not only allows new and established clients to receive much-needed care from inside their homes to minimize risk of exposure to COVID-19, but it also provides opportunities to mitigate accessibility issues beyond the pandemic.[2]

Though telebehavioral health is a promising strategy for improving access to services and reducing provider maldistribution, its adoption by the behavioral health field has lagged behind other sectors. Lack of uniform reimbursement regulations, differing licensure and credentialing requirements, and varying insurance coverage for telehealth across states have limited the availability of cost-effective telehealth services.[5] Earlier studies investigating slow uptake of telehealth indicated reimbursement uncertainty and restrictions were the most prominent barriers to telehealth adoption before the pandemic.[6,7] Slow growth in telebehavioral health utilization can also be attributed to a complex interaction of client–provider barriers that influence telehealth adoption rates, including technical, financial, and behavioral factors.[6,7]

However, pandemic-induced changes in behavioral health care delivery offer solutions for overcoming barriers to telebehavioral health adoption. The federal government advised care delivery shift to a telehealth modality in March 2020,[8] a recommendation accompanied by the passing of emergency orders across states expanding use of telehealth services; 41 states currently permit telehealth service delivery.[9] In Michigan, two executive orders supporting telehealth expansion were issued to provide temporary relief during the COVID-19 emergency from some restrictions and requirements surrounding medical service provision, encourage telehealth services, and broaden some providers' statutory scope of practice.[10,11] Policy changes issued by the Centers for Medicare and Medicaid Services include allowances for providers to practice remote care within and across state lines, deliver telehealth care to new and established clients located in their homes, bill for both audio-only and video telehealth services, and conduct remote services outside of designated rural areas.[12] Although emergency orders greatly expanded telebehavioral health, these policy changes remain temporary; discontinuation of reimbursement for telebehavioral health could reimpose barriers to accessing care for many clients.

Although telebehavioral health has the potential to greatly improve access to care, there is growing concern that it may exacerbate health disparities for individuals with Internet and technology limitations. Lack of broadband Internet, mistrust of technology, poor digital literacy, and economic instability can hinder access for rural and underserved populations, including those most vulnerable to poor health outcomes.[13] In addition, insufficient infrastructure and funding to support telehealth continue to hinder the growth of telebehavioral health service delivery, particularly in rural communities with unstable Internet connectivity.[14] The need for telebehavioral health to bridge communities and mental health care is greater than ever and proper support mechanisms for providers are critical for its diffusion, particularly in underserved communities.[5] Consequently, sufficient infrastructure and policies supporting the behavioral health workforce are needed to optimize the use of telebehavioral health services. This study sought to describe past and current use of telebehavioral health, how policy changes due to the pandemic impacted utilization of telebehavioral health, and methods to sustain these practices beyond the pandemic from the perspective of telebehavioral health providers in Michigan.

Materials and Methods

This qualitative study consisted of semi-structured interviews with behavioral health providers between July 29, 2020 and August 21, 2020. The University of Michigan's Institutional Review Board reviewed this study application and determined it to be exempt from an ongoing review.

PROVIDER RECRUITMENT AND INTERVIEWS

Research collaborators identified a convenience sample of behavioral health providers practicing in Michigan. To encourage a diverse sample of provider types, eligibility was extended to prescribers and both licensed and non-licensed clinicians. Study partner organizations provided recruitment information to behavioral health providers via email. Recruitment efforts continued until researchers found no new emergent themes across provider types in interview responses.

Participating providers completed a preinterview survey to report their occupation, area(s) of practice, primary practice setting location and type, year they began providing direct client care, population(s) served, primary insurance type accepted, and whether they worked in an integrated care setting. Four researchers alternated interviewing study participants via 1-h Zoom sessions. The semi-structured interview guide can be found in the Supplementary Data. A $30 gift card was offered to all participants on completion of their interview.

DATA ANALYSIS

All interview audio was recorded, transcribed verbatim, deidentified, and uploaded to a password-protected computer. The interviewers created a codebook based on the interview guide and augmented it after identifying common themes throughout the interview process. Researchers used Dedoose online software to conduct inductive thematic analyses.[15] With a team of two coders, all interviews were double-coded according to the codebook. Coders met weekly to discuss emerging themes and coding discrepancies until they established 100% reliability across all transcripts.

Results

A total of 31 behavioral health providers participated in this study. The study sample included 11 social workers, 5 peer support specialists, 5 psychologists, 3 licensed professional counselors, 2 board-certified behavioral analysts, 2 registered nurses, and 3 other providers (e.g., nurse practitioner; *Table 1*). These behavioral health providers often work in mental health counseling ($n = 22$), have been practicing for 21 or more years ($n = 9$) or no >5 years ($n = 8$), practice in an urban location ($n = 22$), do not work/unsure whether they work in an integrated care setting ($n = 14$ and 8, respectively), and serve clients with public insurance ($n = 27$). Providers represented a

Table 1. Behavioral Health Provider Professional Characteristics ($n = 31$).

PROVIDER CHARACTERISTICS	*n*
Occupation	
Licensed master or clinical social worker	11
Peer support specialist/recovery coach	5
Psychologist	5
Licensed professional counselor	3
Board-certified behavior analyst	2
Registered nurse	2
Other (e.g., nurse practitioner, psychiatrist)	3
Years practicing	
0–5	8
6–10	5
11–15	4
16–20	4
21+	9
Area(s) of practice	
Mental health counseling	22
Child, adolescent, and family counseling	16
Substance use disorder counseling	9
Clinical counseling	9
Social work	4
Applied behavior analysis	4
Marriage and couples counseling	3
Other (e.g., case management, medication management)	9
Geographic location of primary practice setting	
Urban	22
Rural	8
Unsure	1
Primary practice setting	
Nonprofit organization	7
Certified community behavioral health clinic	5
Mental health clinic	4
Private practice	3
Community mental health clinic	3
Other (e.g., hospital, university setting)	9
Integrated care setting	
Yes	8
No	14
Unsure	8
Payment for services	
Public insurers	27
Commercial insurance	3
Populations served	
Adults	20
Children	18
Individuals with serious mental illness	16
Individuals with developmental disabilities	15
Individuals with low socioeconomic status	15
Individuals with substance use disorders	12
Justice-involved individuals	8
Individuals experiencing homelessness	6
LGBT+ communities	5

variety of settings, such as nonprofit organizations ($n = 7$) and other service locations (e.g., hospitals; $n = 9$).

Twelve behavioral health providers mentioned that their practice provided some form of telehealth services before the COVID-19 pandemic, 8 of which described their use of telebehavioral health as minimal and often restricted for use by psychiatrists and nurse practitioners. Telebehavioral health was typically used solely by prescribers, as behavioral health practitioners were previously not reimbursed for providing telebehavioral health ($n = 17$). As one provider stated, "There was no motivation to do [telebehavioral health] because we couldn't [bill] for it."

Due to social distancing guidelines and telehealth reimbursement policy expansion prompted by the COVID-19 pandemic, all providers in this study began practicing telebehavioral health. No provider reported being paid less than what they were paid for equivalent in-person services. Thematic analyses revealed four themes capturing behavioral health providers' experience using telebehavioral health: (1) improved access to care; (2) maintenance in the quality of care; (3) minimal privacy concerns; and (4) client and provider satisfaction (*Table 2*).

Table 2. Behavioral Health Provider Perspectives on the Influence of Telebehavioral Health in the Access to Care, Quality of Care, Privacy of Care, and Client and Provider Satisfaction ($n = 31$)

THEME	MAIN POINTS	n	RELEVANT QUOTES
Increased access to care	Eliminated transportation as a barrier to care	19	"Like I say, our public transit is very limited, and some people, they don't have a vehicle, or their vehicle is in bad shape, or they don't have money to get gasoline, or somebody else is using the car. And it's just transportations always been terrible for us, so this [telebehavioral health] is really kind of exciting, and we're hoping that it can go past the pandemic because it really helps a lot of people."
	Decreased no-show rates	22	"And we do know statistically our no-show rate for our prescribers has decreased significantly. So some of what we're seeing is transportation and other practical things that get in the way of making appointments have been largely erased, so those appointments that are scheduled are happening at a much higher rate than they were before."
	Increased caseload	15	"I think there's been people that are wanting to engage [in counseling] that maybe wouldn't have come to the office 'cause that's too scary. It's a lot of fear when people come in for the first time. So, I have gotten other people that are new and engaging now."
	Access to care is still an issue for individuals without access to the appropriate technology, older adults, and individuals with lower socioeconomic statuses	25	"So there were a lot of issues dealing with access as far as them being able to get the computer, not having WiFi. Some parents didn't have the WiFi capability. So I have had to do a lot of telephone sessions."
Maintained or improved quality of care	Telebehavioral health is equitable or of better quality than in-person services	18	"For my youth, at least, they love it. They love it. They look at it as… I would think they look at it as a new dynamic where it builds our rapport. I feel like it makes them more comfortable to even call you at any time they're in any type of a crisis."
	Quality improved for teenagers, parents, individuals with anxiety, and individuals with a history of trauma	10	"It was way easier to teach them [parents] something in the moment because there's their child screaming in the background, and we could coach them through what to do right then and there. It was where the things actually take place."
	Quality decreased for young children, older adults, individuals with serious mental illness, individuals with language or speech barriers, individuals with a substance use disorder, and children with autism spectrum disorder	23	"And so with preschoolers, it's really challenging to get them to look at the video or for parents to be, if they're moving all over the place. So for video to be constant, that's really challenging. And to be able to engage by video, it was always like I was super concerned about that."
Privacy concerns	No privacy concerns	17	"We talked about setting expectations for the privacy of meetings, and having that discussion with families at the onset."
	Clients accepting telebehavioral health appointments in public places	13	"I think that you don't have the same level of assurance of confidentiality on the other [client's] end. And if you're seeing pediatric clients like I am, and thinking parents are somewhere in the mix when I really need to talk to them alone."
Satisfaction	Client satisfaction	30	"I've had a couple of people say they really prefer doing it over video, because it feels less intense to them. And so they actually say they're able to talk more deeply about things than they can when they're in a room with somebody. So for some clientele anyway, that little bit of distance feels more protective, I guess."
	Clients with lower technological literacy dissatisfied	18	"One of the things that has been a real challenge is the discomfort of this age [elderly] population with technology itself. And we actually transitioned one of our team members to be almost a full-time tech support person who's made little training video clips, who's actually gone to people's houses and connected it to the router."
	Increased job satisfaction for providers	14	"But I do think it [telehealth] is, it's a great opportunity to engage people more often in the least restrictive environment And it allows us, I think, to provide more care than we would if we were office-based all the time. So I like it, and I'm trying to convince others that…It's not ideal, it may not work for everybody. But if it works for some of them, it's an avenue into care we need to explore and maintain."
	Providers miss in-person interactions	11	"I benefit from the contact that I have with the consumers, being a person in recovery."

IMPROVED ACCESS TO CARE

Twenty-eight providers stated that telebehavioral health reduced barriers restricting access to care, with 19 providers noting reduced transportation barriers for their clients. Telebehavioral health provided opportunities for four urban providers to newly serve rural clients. Most providers ($n = 22$) reported a decrease in no-show rates, and about half ($n = 15$) reported an increased caseload. Conversely, one provider experienced increased no-shows and three providers saw a decrease in their caseload. Improved no-show rates and caseloads were attributed to reduced travel time for clients and providers, the ability to immediately schedule appointments, reimbursements for 15-minute client check-ins, and the availability of audio-only services. Despite an overall perception that telebehavioral health improved access to care, 25 providers voiced concerns that older adults, people with lower socioeconomic statuses, and those in rural areas without access to a stable Internet connection or computer may not have access to telebehavioral health services.

MAINTENANCE IN THE QUALITY OF CARE

Eighteen providers felt that the quality of telebehavioral health is equivalent to, or better than, in-person services. From providers' perspectives, teenagers ($n = 3$), parents ($n = 3$), clients with anxiety ($n = 3$), and individuals with a history of trauma ($n = 2$) experienced a higher quality of care relative to in-person care because telebehavioral health provided a sense of security and immediate support not present during face-to-face appointments. Providers also identified subgroups that experienced a worse quality of care when behavioral health services are delivered via telehealth: young children ($n = 10$), individuals with serious mental illness ($n = 9$), individuals with a substance use disorder ($n = 6$), older adults ($n = 4$), individuals with language or speech barriers ($n = 3$), and children with autism spectrum disorder ($n = 2$). Providers hypothesized that these experiences of lower quality care may stem from clients' difficulties utilizing telehealth platforms, paranoia or trust issues with digital communications, and difficulty focusing on or understanding content. Nonetheless, providers speculated that care quality can be improved if providers adapt their counseling techniques to best fit each individual client. To illustrate this suggestion, two providers reported supplying their younger clients with a toolkit of toys and workbooks to keep them engaged during telebehavioral health appointments.

MINIMAL PRIVACY CONCERNS

More than half of the providers ($n = 17$) expressed no privacy concerns when delivering telebehavioral health. However, 13 providers encountered confidentiality issues when clients accepted an appointment in public spaces (e.g., a grocery store) or around their families. To prevent privacy violations from occurring, providers utilized Health Insurance Portability and Affordability Act (HIPAA)-compliant software, set boundaries with clients at the onset of their first telebehavioral health appointment, and encouraged clients to use headphones during sessions. However, many providers reported using client accessible, noncompliant telecommunications platforms until resources and protocols stabilized. Interviewees confirmed using these noncompliant platforms only after receiving permission from the U.S. Department of Health and Human Services (DHHS),[16] the utilization of which resulted in no accidental breaches of medical privacy.

CLIENT AND PROVIDER SATISFACTION

Every provider described the abrupt transition to telebehavioral health services as challenging for themselves and their clients, with overall satisfaction improving once they had access to, and were familiar with, the necessary technology. Thirty providers reported that clients experienced increased satisfaction over in-person services with continual use of telebehavioral health, driven by not having to arrange childcare or transportation and feeling more comfortable with navigating telehealth platforms. Audio-only services also proved vital to client satisfaction, as they provided immediate support, did not require an Internet connection, and relieved the burden of requiring a face-to-face interaction. However, 18 providers reported their clients with lower technological literacy were less satisfied with telebehavioral health.

Fourteen providers reported increased job satisfaction with using telebehavioral health as compared with only providing in-person services, because telehealth allowed for a better work–life balance and the ability to provide immediate care to clients. Only one provider expressed dissatisfaction with telebehavioral health, potentially due to the circumstances of providing care during a pandemic. In addition, 11 providers expressed missing their coworkers and other in-person interactions. Interviewees ultimately reported satisfaction with telebehavioral health, but they advocated for the flexibility to perform both in-person and telebehavioral health services in the future. One provider highlighted the importance of this flexibility moving forward:

> *If you had told me 10 years ago I'd be saying this, I would have denied it. But I do think [telebehavioral health] is, it's a great opportunity to engage people more often in the least restrictive environment. And it allows us, I think, to provide more care than we would if we were office-based all the time… [if] it works for some of them, it's an avenue into care we need to explore and maintain.*

VISION FOR THE FUTURE

Every provider endorsed offering a hybridized model of both in-person and telebehavioral health services post-pandemic. As one provider said, "If we want to provide ongoing and sustainable treatment, we have to meet those clients where they're at. And one of the places that they're at is in their home, and many don't have other options." This model includes offering audio-only services when in-person video services are not possible, and allowing verbal consent due to the difficulties with obtaining written consent while using telebehavioral health. To emphasize the importance of audio-only reimbursement, one provider stated:

> *I can't say this enough, that we can't assume that free internet is gonna be accessible and viable. Many of our clients live in the county where there's a lot of static or they might not have good reception, so that telephone is imperative. If the Zoom freezes a lot or if that telehealth [video] connection is unstable, it's imperative that we can still bill for those phone conversations.*

To sustain telehealth in the future, providers proposed continued reimbursement for telebehavioral health, ongoing allowance to obtain verbal consent, flexibility in choosing telehealth platforms, and training resources for providers.

Discussion

An overwhelming majority of providers indicated telebehavioral health increases access to behavioral health care in Michigan. This finding is consistent with existing research in support of telehealth's ability to remove barriers to behavioral health care and increase service utilization.[17–20] To ensure that providers continue meeting the behavioral health demands of their clients, post-pandemic, continuation of telebehavioral health reimbursement is imperative. Telebehavioral health may best be incentivized through state-level implementation of service and reimbursement parity legislation to best capitalize on the advantages of remote care. Achieving service parity for telebehavioral health requires in-person services covered by payers to also be covered via telebehavioral health, whereas reimbursement parity requires services provided remotely to be reimbursed at the same rate as those provided in-person.[21] Combined, these forms of parity allow providers the flexibility to choose courses of treatment best suited for clients without undue administrative limitations.

Although there was a near consensus that telebehavioral health increased access to care, not all clients were able to access or navigate telebehavioral health platforms. Notably, people located in rural areas, those with lower socioeconomic status, and older adults may lack the Internet access and technological literacy to navigate telehealth platforms. To address the behavioral health needs of these subgroups, strong consideration should be given to retaining reimbursement for audio-only encounters to ensure providers have flexibility to use the most appropriate treatment modality for their clients' needs. Payers could consider requiring providers to document barriers that their clients face to accessing both in-person services (e.g., great physical distance) and audio–visual telebehavioral health care (e.g., lack of broadband access) if there is a need for this modality to be used sparingly.

Despite the initial negative impact that the abrupt transition to telehealth had on providers and clients, time and experience with using telehealth allowed both parties opportunities to gain familiarity and increase their satisfaction with telebehavioral health services. Since provider and client satisfaction are contingent on seamless transitions to different telebehavioral health modalities, accrediting and professional organizations for behavioral health providers could modify their policies to better facilitate future utilization of telebehavioral health. Accrediting organizations could expand their curriculum standards to include education on telebehavioral health as a therapy modality in both classroom and practicum experiences. Similarly, behavioral health professional organizations could assemble and disseminate toolkits of best practices to organization members, better equipping these members for remote practice. State lawmakers could also consider mandating some proportion of continuing education requirements for licensure renewal to be dedicated to telehealth content.

Study participants reported that the quality of health care was maintained for most, but not all, clients who received telebehavioral health services, some of whom experienced even higher quality care than would have been received through in-person service equivalents. Taken in combination with minimal privacy concerns, these findings are consistent with past research.[22–25] To continue upholding this quality of care without incurring any privacy concerns, providers and their clients alike must be permitted flexibility in the type of telehealth platform they use. Given that unencrypted, non-publicly facing telecommunications platforms (e.g., FaceTime) allowed for easier connections and resulted in no accidental breaches of private medical data, federal legislators could amend HIPAA to codify such leniency for telehealth into the law. Such permission would cement the practice of using safe, yet accessible, telecommunications platforms for telebehavioral health without requiring continued discretionary leniency on the part of DHHS.

LIMITATIONS

Although these findings offer insight into the benefits of telebehavioral health, the following limitations should be considered. Foremost, the study focuses on behavioral health providers in Michigan primarily treating publicly insured individuals and cannot be generalized outside of this setting and population. Further, the use of convenience sampling and the possibility of selection bias and sampling error may have resulted in a nonrepresentative sample. This limitation is potentially exacerbated by the underrepresentation of behavioral health prescribers and a lack of collection of age, race, or sex respondent data. Lastly, researchers were unable to differentiate between the effects of the COVID-19 pandemic and newly implemented telehealth practices on providers' and clients' experiences with telebehavioral health due to both changes occurring simultaneously.

Conclusion

This study is among the first to examine provider experiences with using telebehavioral health services in Michigan during the COVID-19 pandemic. Findings suggest that the use of telebehavioral health vastly increased with the expansion of federal and state policy changes due to the COVID-19 pandemic. Telehealth service and reimbursement parity are essential to ensuring continued service delivery. Despite some persistent barriers for both providers and clients, overall, telebehavioral health increased access to care, offered equivalent or better care than in-person treatment for certain populations, and resulted in minimal privacy concerns. Behavioral health providers voiced support for flexibility to deliver services in the modality that best fits client needs by permitting in-person and telehealth services, including audio-only services, going forward.

Authors' Contributions

A.J.B. and J.B. designed and supervised this project. J.B. recruited interview participants. C.W., M.G., C.P., and J.B. collected data through participant interviews. V.S. performed the thematic analysis with assistance from C.W. V.S. took the lead in writing the article with assistance from C.W., M.G., C.P., J.B., and A.J.B. All authors discussed the results, provided critical feedback, and contributed to the final article.

Acknowledgments

The authors appreciate the support from their partners at Southwest Michigan Behavioral Health and the Community Mental Health Association of Michigan. They thank their partners for their guidance on study design and assistance with provider recruitment. They would also like to acknowledge graduate research assistant, Amanda Mauri, MPH for her federal policy recommendations and data collection contributions to the project.

Disclosure Statement

No competing financial interests exist.

Funding Information

This project was funded by the University of Michigan Institute for Health care Policy and Innovation through the Policy Sprints Program (Grant No. 6-U81-HP-29300-06-06). Additional support was provided by the Health Resources and Services Administration (Grant No. U071062).

Supplementary Material

Supplementary Data

REFERENCES

1. Panchal N, Kamal R, Cox C, Garfield R. The Implications of COVID-19 for Mental Health and Substance Use. **2021**. Available at https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use (last accessed February 18, 2021).
2. Miu AS, Palka JM, Glowacki CR, Robinson RJ. Teletherapy with serious mental illness populations during COVID-19: Telehealth conversion and engagement. Couns Psychol Q **2020**; [Epub ahead of print]; 1–18. DOI:10.1080/09515070.2020.1791800.
3. Pfender E. Mental health and COVID-19: Implications for the future of telehealth. *J Patient Exp* **2020;**7:433–35.
4. Mohatt D. Mental health and rural America: challenges and opportunities. **2018**. Available at https://www.nimh.nih.gov/news/media/2018/mental-health-and-rural- america-challenges-and-opportunities.shtml (last accessed April 22, 2020).
5. Brooks E, Turvey C, Augusterfer EF. Provider barriers to telemental health: Obstacles overcome, obstacles remaining. *Telemed J E Health* **2013;**19:433–437.
6. Gajarawala SN, Pelkowski JN. Telehealth benefits and barriers. *J Nurse Pract* **2020**. [Epub ahead of print]; DOI: 10.1016/j.nurpra.2020.09.013.
7. Lin CC, Dievler A, Robbins C, Sripipatana A, Quinn M, Nair S. Telehealth in health centers: Key adoption factors, barriers, and opportunities. *Health Aff (Millwood)* **2018;**37:1967–974.
8. Department of Health and Human Services. Telehealth: delivering care safely during COVID-19. Updated July 15, 2020. Available at: https://www.hhs.gov/coronavirus/telehealth/index.html (last accessed February 10, 2021).
9. Federation of State Medical Boards. U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19. Updated February 5, 2021. Available at https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf (last accessed February 10, 2021).
10. State of Michigan Office of the Governor. EXECUTIVE ORDER No. 2020-30 Temporary relief from certain restrictions and requirements governing the provision of medical services. **2020**. Available at www.legislature.mi.gov/documents/2019–2020/executiveorder/pdf/2020-EO-30.pdf (last accessed February 19, 2021).
11. State of Michigan Office of the Governor. EXECUTIVE ORDER No. 2020–86 Encouraging the use of telehealth services during the COVID-19 emergency. **2020**. Available at www.legislature.mi.gov/documents/2019–2020/executiveorder/pdf/2020-EO-86.pdf (last accessed February 19, 2021).

12. U.S. Department of Health and Human Services. HHS issues new report highlighting dramatic trends in Medicare beneficiary telehealth utilization amid COVID-19. **2020**. Available at https://www.hhs.gov/about/news/2020/07/28/hhs-issues-new-report-highlighting-dramatic-trends-in-medicare-beneficiary-telehealth-utilization-amid-covid-19.html (last accessed February 10, 2020).

13. Ramsetty A, Adams C. Impact of the digital divide in the age of COVID-19. *J Am Med Inform Assoc* **2020;**27:1147–148.

14. Cortelyou-Ward K, Atkins DN, Noblin A, Rotarius T, White P, Carey C. Navigating the digital divide: Barriers to telehealth in rural areas. *J Health Care Poor Underserved* **2020;**31:1546–556.

15. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. *Am J Eval* **2006;**27:237–246.

16. Department of Health and Human Services. Notification of enforcement discretion for telehealth remote communications during the COVID-19 nationwide public health emergency. Updated January 20, 2021. Available at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html (last accessed February 23, 2021).

17. Jacobs JC, Blonigen DM, Kimerling R, et al. Increasing mental health care access, continuity, and efficiency for veterans through telehealth with video tablets. *Psychiatr Serv* **2019;**70:976–982.

18. Creedon TB, Schrader KE, O'Brien PL, Lin JR, Carroll CD, Mulvaney-Day N. Rural-nonrural differences in telemedicine use for mental and substance use disorders among Medicaid beneficiaries. *Psychiatr Serv* **2020;**71:756–764.

19. Uscher-Pines L, Sousa J, Raja P, Mehrotra A, Barnett M, Huskamp HA. Treatment of opioid use disorder during COVID-19: Experiences of clinicians transitioning to telemedicine. *J Subst Abuse Treat* **2020;**108124.

20. Lau J, Knudsen J, Jackson H, et al. Staying connected in the COVID-19 Pandemic: Telehealth at the largest safety-net system in the United States. *Health Aff (Millwood)* **2020;**39:1437–1442.

21. Weigel G, Ramaswamy A, Sobel L, Salganicoff A, Cubansksi J, Freed M. Opportunities and barriers for telemedicine in the U.S. during the COVID-19 emergency and beyond. **2020**. Available at https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond (last accessed February 24, 2021).

22. Noel K, Messina C, Hou W, Schoenfeld E, Kelly G. Tele-transitions of care (TTOC): A 12-month, randomized controlled trial evaluating the use of Telehealth to achieve triple aim objectives. *BMC Fam Pract* **2020;**21:27.

23. Hilty DM, Maheu MM, Drude KP, et al. Telebehavioral health, telemental health, e-therapy and e-health competencies: The need for an interprofessional framework. *J Technol Behav Sci* **2017;**2:171–89.

24. Luxton DD, Sirotin AP, Mishkin MC. Safety of telemental healthcare delivered to clinically unsupervised settings: A systematic review. *Telemed J E Health* **2010;**16:705–11.

25. Cowan KE, McKean AJ, Gentry MT, Hilty DM. Barriers to use of telepsychiatry: Clinicians as gatekeepers. *Mayo Clin Proc* **2019;**94:2510–523.

Address correspondence to:
Angela J. Beck, PhD, MPH
Behavioral Health Workforce Research Center
University of Michigan School of Public Health
1415 Washington Heights
1706 SPH I
Ann Arbor, MI 48109-2029
USA

E-mail: ajbeck@umich.edu

Received: February 28, 2021
Revised: April 7, 2021
Accepted: April 8, 2021
Online Publication Date: May 20, 2021