Telebehavioral Health Workforce Opportunities During the COVID-19 Pandemic

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NATIONAL COUNCIL *for* Mental Wellbeing

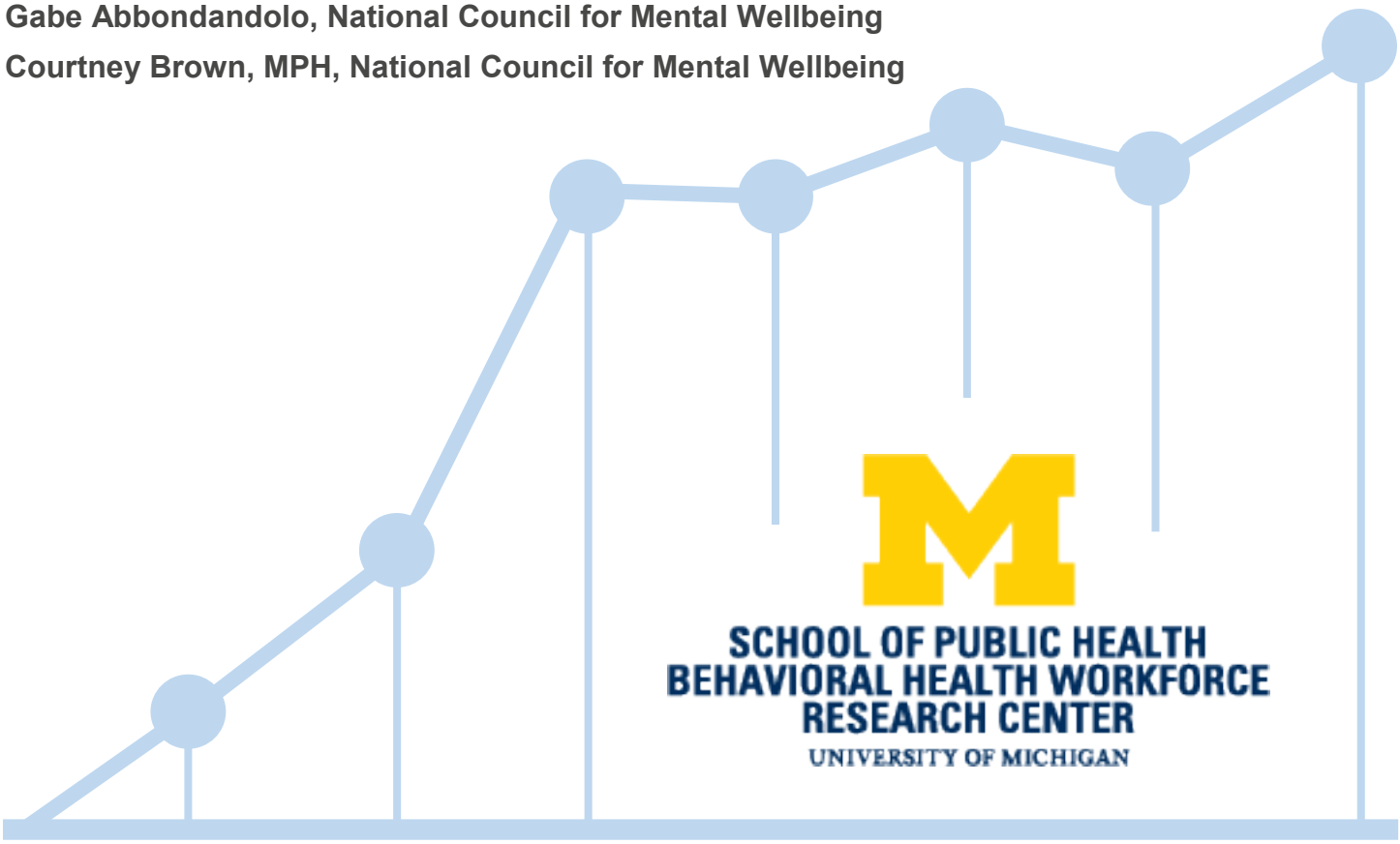
Project Team

Shannon Mace, JD, MPH, National Council for Mental Wellbeing

Nicole Cadovius, MBA, MSM, National Council for Mental Wellbeing

Gabe Abbondandolo, National Council for Mental Wellbeing

Courtney Brown, MPH, National Council for Mental Wellbeing



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Background

Behavioral health providers have increasingly adopted and implemented telebehavioral health services to improve access to behavioral health care by overcoming geographic, workforce capacity, and other barriers. The coronavirus disease 2019 (COVID-19) pandemic, which resulted in a declaration of national emergency in the U.S. in March 2020, caused a rapid transition to virtual healthcare services, including telebehavioral health. To better understand behavioral health workforce development opportunities for telebehavioral health, including training, and the impact of COVID-19, the National Council for Mental Wellbeing (National Council), in partnership with the University of Michigan Behavioral Health Workforce Center, conducted a mixed methods study between April and September 2020. This report provides a summary of the findings related to telebehavioral health workforce development opportunities and the impact of the COVID-19 pandemic.

Overview

In 2019, 51.5 million adults had any mental illness and 26% (13.3 million people) had a perceived unmet need for mental health care in the past year.[1] Among adults with a perceived unmet need for services, 43% of people did not receive mental health services in the past year.[1] Additionally, 48% of individuals with a serious mental illness had a perceived unmet need for mental health services in the last year.[1] Of the estimated 20.4 million people aged ≥12 years that had a past-year substance use disorder, only 2.1 million (10%) received any substance use treatment in the past year.[1] Additionally, among the 1.6 million people aged ≥12 years with an opioid use disorder, only 18% received evidence-based medication assisted treatment for opioid use disorder.[1] Barriers to accessing behavioral health services exist across the country, including overcoming stigma and having to travel long distances for treatment and services, among others.[2] These issues, coupled with other challenges, including inadequate funding, workforce maldistribution issues, and lack of specialty services, create a demand for innovative service delivery, including telebehavioral health services.

The Role of Telebehavioral Health Services in Behavioral Health Care

The Health Resources and Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration."[3] Telehealth refers to the use of information and communication technology, including the use of electronic health records, streaming media, and video conferencing, to exchange health information and provide health services.[4] Telehealth can be used across the continuum of care to deliver and enhance behavioral health services. For purposes of this report, "telebehavioral health" is used to describe behavioral health services delivered via telehealth.

Telebehavioral Workforce Development and Training

Various types of telehealth training are currently available to healthcare providers, including in-person training, virtual training, and peer-to-peer support programs. Many of the providers of these resources and tools also offer information on upcoming training and education opportunities through established web-based mailing services, listservs, and on their webpages. Several national public health, nonprofit, and government agencies offer free training and technical assistance support for healthcare and behavioral health providers to increase adoption of telehealth. Although numerous training, technical assistance, and resource centers exist, fewer organizations offer trainings specifically tailored for behavioral health providers.

A non-exhaustive list of trainings, technical assistance, and resources currently available to healthcare and behavioral healthcare providers includes the following:

- Project Extension for Community Healthcare Outcomes (ECHO), initially established in 2003, is an

evidence-based telehealth program that offers training and education to providers across the U.S.[5] Project ECHO was identified as a primary telehealth training resource for behavioral health providers in a previous National Council and Behavioral Health Workforce Research Center study.[6]

- The Southwest Telehealth Resource Center provides an online video library of educational trainings on a variety of topics, including telepsychiatry, facility design (steps required to set up a telehealth facility), video and data communication, information services, and culture, etiquette, and technology.[7]
- The HRSA Substance Abuse Treatment Telehealth Network Grant Program provides training to providers, among other services. The purpose of this grant is to demonstrate how telehealth programs and networks can improve access to healthcare services, specifically substance abuse treatment services, in rural, frontier, and underserved communities.[8]
- The HRSA-funded National Consortium of Telehealth Resource Centers provide free education, assistance, and information to organizations and individuals seeking to adopt or improve telehealth use through a network of 14 regional centers.[9]
- The Association of State and Territorial Health Officials Clinical to Community Connections resources provides written guides, recorded webinars, and case examples.[10]
- The Rural Health Information Hub, funded by HRSA, provides links to numerous resources, including case examples of telehealth programs in behavioral health, best practices for videoconferencing-based telemental health, practice guidelines, and evidence-based telemental health practice guidelines.[11]
- The Center for Connected Health Policy, though not specifically focused on training resources, provides current policy updates, implementation resources, research, and news articles, and consultation services to organizations.[12]
- The Addiction Technology Transfer Center Network, funded by SAMHSA, provides a host of training and technical assistance resources for substance use disorder treatment providers on a wide variety of topics, including telehealth.[13]

Types of Training Packages Needed by Behavioral Health Professionals

Although a wide variety of training and technical resources exist, a lack of knowledge related to education and training needs for telebehavioral health persists. A survey study of 329 behavioral health providers in 2018 found that 75% (n=247) reported they were unaware of any programs to support telebehavioral health uptake and education.6 These data could indicate that while training is available, it is not being marketed to or tailored for behavioral health providers.

Impact of the COVID-19 Pandemic on Behavioral Health Services

In March 2020, a national emergency was declared in the U.S. due to the spread of COVID-19 across the country. In response to the pandemic, municipalities, states, and the federal government implemented an unprecedented number of policy and regulatory changes to reduce the spread of the disease, address economic and housing instability, and address disruptions in health care, including behavioral health services. Policy changes were implemented to increase access to healthcare services, especially telehealth services, while shelter-in-place and social distancing policies are enacted.

Some examples of policy and regulatory changes that were enacted during the pandemic that affect the use of telebehavioral health services include:

- Changes to Medicare fee-for-service telehealth coverage, including
  - ◊ Eliminating geographic restrictions,
  - ◊ Allowing patients to be in their homes during telehealth interactions,

    - ◊ Allowing providers to provide services when at home, and
    - ◊ Expanding reimbursement for telephonic only services.[14]
- Changes to Medicaid reimbursement policies.[14]
    - ◊ Waiving licensure requirements for Medicaid (but state requirements still apply).
- Changes to the Ryan Haight Act requirements enforced by the Drug Enforcement Administration.[14]
    - ◊ Allowing Drug Enforcement Administration–registered practitioners to issue prescriptions for controlled substances to patients without having conducted an in-person medical evaluation if specific conditions are met.
- Changes to the Health Insurance Portability and Accountability Act (HIPAA).[14]
    - ◊ The Department of Health and Human Services Office of Civil Rights can exercise enforcement discretion and waive penalties for HIPAA violations against healthcare providers acting in good faith.
- Changes to some private insurance plans to make telehealth more widely available, including expanding reimbursement for some services.[14]
- Changes to state licensure requirements for providing telehealth.[15]
    - ◊ As of October 16, 2020, a total of 42 states had implemented some type of waiver related to requirements for providing telehealth services during the COVID-19 pandemic.[16]

These policy changes have made telehealth a more accessible service for patients and providers. In August 2020, the National Council and Qualifacts conducted a survey with >1,000 behavioral health providers to better understand the impact of the COVID-19 pandemic on virtual care, including telebehavioral health services. Survey results showed that the COVID-19 pandemic prompted a rapid transition from in-person to telebehavioral health services. Ninety-three percent of respondents reported that only 0%–20% of their services were virtual prior to the pandemic. After the onset of the pandemic, however, 60% of respondents reported that >81% of their services were being provided virtually.[17] Survey respondents were asked to rate which recent federal and state policy changes were most impactful to facilitate the transition to virtual care. The top 3 ranked changes included:

- Expansion of services that may be delivered via telehealth,
- Expansion of allowable patient locations for telehealth, and
- Expansion of telehealth services that may be delivered via audio-only communication.[17]

The National Council and Qualifacts survey also asked respondents to identify the types of tools needed by care providers to improve virtual care. The top 5 important technological capabilities to support virtual care identified by providers and staff included:

- Comprehensive telehealth platform,
- Patient engagement solutions to enhance care between sessions,
- Staff engagement solutions to enhance communication with staff members,
- Patient portals, and
- Telephones/audio-only technologies.[17]

Survey respondents were also asked about their concerns and preferences related to providing services in a virtual environment. Thirty-two percent of respondents agreed that they are “concerned about maintaining my connections with peers and supervisors in a virtual care environment”; 15% strongly agreed with the statement and 30% strongly disagreed or disagreed with the statement. Regarding preferences for virtual care delivery, 26% of respondents reported that they agree or strongly agree with the statement, “I

prefer providing care virtually versus traditional care models"; 38% of respondents neither agreed nor disagreed with the statement and 35% disagreed or strongly disagreed with the statement.

Methods

To better understand the workforce development and training opportunities to advance telebehavioral health and the impact of the COVID-19 pandemic on telebehavioral health services, National Council research staff collected quantitative and qualitative data from behavioral health provider organizations nationwide. Two phases of the study were conducted: (1) an electronic survey in August 2020, and (2) key informant interviews that took place in August and September 2020.

The purpose of study was to gain insights to the following questions:

1. How has the COVID-19 pandemic impacted the utilization of telebehavioral health services?
2. What types of training are currently available to behavioral health providers?
3. What types of training packages and resources are needed by behavioral health professionals to deliver telebehavioral health services?

Phase 1 Methods

To collect quantitative data from a convenience sample of behavioral health providers from the National Council, an electronic survey tool was designed and administered. Prior to dissemination, the online survey was reviewed by Behavioral Health Workforce Center experts and pilot tested by several National Council team members and external behavioral health providers not involved in the research project. SurveyMonkey, an electronic research platform, was used to securely collect data. The survey was designed to be completed within approximately 15 minutes.

In July 2020, the survey tool was distributed via e-mail through the National Council's communications list, via general newsletter and email blast to more than 50,000 behavioral health stakeholders representing all 50 states via newsletter transmission and email blast. A response rate was not calculated due to the survey recruitment methods used. Participation in the survey was voluntary and a $25 electronic gift card was provided as an incentive to the first 350 participants to complete the survey. The survey was available online for 3 weeks. Quantitative data generated from the survey were analyzed with Microsoft Excel software.

Phase 2 Methods

To gain a deeper understanding of the impact of the COVID-19 pandemic on telebehavioral health and workforce training needs, qualitative data were collected through key informant interviews in August and September 2020. A semi-structured interview guide was developed to facilitate the interviews. Interviews were recorded and transcribed and Microsoft Excel was used for data analysis. A thematic analysis was performed to identify common themes shared across respondents. Interviewees included behavioral healthcare providers and staff whose organizations offer telebehavioral health services. Participation in the key informant interviews was voluntary and key informants were offered a $25 gift card incentive.

Results

Overview of Survey Respondents

There was an initial total of 832 individuals that responded to the survey, but 62 respondents were not providing behavioral health services and were therefore excluded from consideration. Among the remaining 770 participants, 89% (686/770) reported that their organizations were currently providing telebehavioral health services, 8% (64/770) reported that they were not, and 3% (20/770) reported that they did not know.

However, 116 respondents elected not to participate in the rest of the survey and were therefore excluded from the remaining analyses. This leaves a final analytic sample of 654 providers from 48 states, the District of Columbia, Puerto Rico, and the Virgin Islands that responded to the survey. The 2 states not represented in the survey are Hawaii and Wyoming.

Table 1 displays the breakdown of the different types of providers who responded to the survey. The majority of respondents indicated they were a medical, clinical, or staff director (21%, 130/626), social worker (17%, 106/626), or a chief executive officer, executive director, president (15%, 95/626).

Table 1: Survey Respondent's Provider Type

Provider Type	Count n (%)
Medical, clinical, or staff director	130 (21%)
Social worker	106 (17%)
CEO, executive director, or president	95 (15%)
Mental health counselor	60 (10%)
Other chief, coordinator, vice president, or director	59 (9%)
Peer support specialist, peer specialist, or recovery coach	19 (3%)
Psychologist	19 (3%)
Substance use counselor	18 (3%)
Licensed professional counselor	16 (2%)
Marriage and family therapist	12 (2%)
Advanced practice registered nurse	8 (1%)
Psychiatrist	7 (1%)
Community health worker	4 (1%)
Other provider (i.e. care manager, quality assurance, nurse)	73 (12%)

A wide range of organizations are represented by survey respondents. The most common types of organizations represented include mental health clinics (38%, or 292/770), substance use disorder treatment organizations (23%, or 179/770), and social services agencies (12%, or 91/770). It should be noted that some organizations identified themselves as more than one type of organization, i.e. an organization could select mental health and substance use disorder treatment organization.

Seventeen percent of respondents' organizations were identified as "other," which includes:

- Accountable Care Organizations
- Military Organizations
- Senior Centers
- Tribal Organizations
- Research Organizations
- Jails or Prisons
- State Government
- Community Mental Health
- Outpatient Dialysis Clinic
- Hospital-based Specialty Clinics
- Veterans Administration
- Care Management Organizations
- Private Provider Organizations
- Child Welfare Agencies
- Human Service Agencies
- Public Health
- Assertive Community Treatment
- Residential Treatment Facilities
- Private Nonprofit Agencies
- Recovery Organizations
- Homeless Outreach and Shelter

More than half of the respondents (53%, 328/619) are from urban areas with populations >50,000 people. Approximately one quarter of respondents (27%, 169/619) are from areas with populations of between 2,500 and 49,999 people. Nine percent (55/619) of respondents are from rural areas with <2,500 people. Eight percent (51/619) of respondents reported they are from medically underserved areas and 2% (10/619) from Frontier Health Professional Shortage Areas. Approximately 1% (6/619) of respondents are from tribal areas.

Half (314/622) of the respondents work at organizations that serve <5,000 individuals annually. Seven percent (41/622) work at organizations that serve >50,000 people annually.

Overview of Key Informants

Selected survey respondents were invited to participate in a 60-minute key informant interview to better understand the ways in which the COVID-19 pandemic has impacted the utilization of telebehavioral health services, workforce, and training needs related to telebehavioral health. Survey respondents invited to participate in the interview were selected based on representation related to geographic areas served, experience using telebehavioral health, and type of organization. A total of 9 key informants participated in interviews representing 7 different states (Table 2). Five of the respondents' organizations did not use telebehavioral health prior to the onset of the COVID-19 pandemic and 4 did offer telebehavioral health for some, but not all, services. Several of the represented organizations provided services at >1 location and to >1 type of geographic setting (e.g., rural and urban locations). The types of organizations represented by key informants included a Federally Qualified Health Center, a Certified Community Behavioral Health Clinic, a county department of human services, a private independent provider, a large medical center, and community behavioral health organizations.

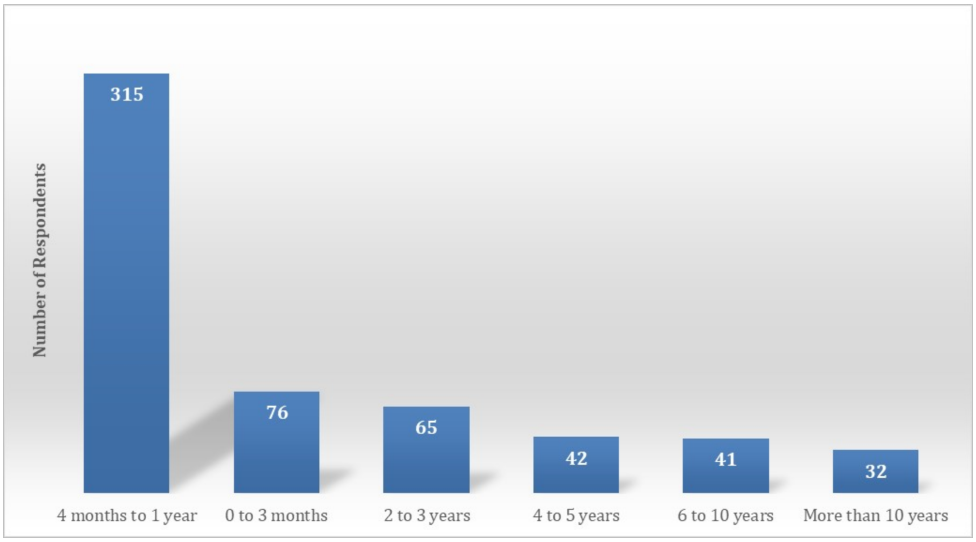
Table 2: Key Informant Participants

State	Role of Key Informant	Type of Organization	Primary Geographic Service Areas	Organization Provided Telebehavioral Health Prior to COVID-19?
CO	Therapist/Special programs supervisor	County department of human services	Rural	No
GA	Marriage and family therapist	Private independent provider	Urban, Suburban, Rural	No
GA	Dual diagnosis and outpatient mental health clinician	Community behavioral health organization	Rural	Yes, for very limited services
MI	Behavioral health consultant	Community behavioral health organization	Rural, Urban	No
NY	Psychiatrist	Large medical center serving several regions in	Urban, Suburban, Rural	Yes, for specific care sites and services
NY	Project Director	Certified Community Behavioral Health Clinic	Urban, Suburban	Yes, for limited services
NC	Chief information officer	Large community behavioral health provider serving 22 counties	Urban, Suburban, Rural	Yes, for a large number of services
OR	Behavioral health supervisor / Pediatric behavioral health consultant	Federally Qualified Health Center	Urban, Suburban, Rural	No, but had started a pilot program
WA	Behavioral health data and technology specialist	Community behavioral health organization	Rural	No

Delivery of Telebehavioral Health Services

Survey respondents were asked whether their organizations were currently providing telebehavioral health services. Among 654 participants, 89% (580/654) reported that their organizations were currently providing telebehavioral health services, 9% (57/654) reported that they were not, and 2% (17/654) reported that they

Figure 1. Length of Time Providing Telebehavioral Health Services



did not know. Respondents were asked to identify how long their organizations have provided telebehavioral health services (Figure 1). The majority of respondents (55%, 315/571) indicated that they began providing telebehavioral health services 4 months to 1 year ago. Thirteen percent (76/571) of respondent organizations began providing telebehavioral health services 0–3 months ago and 11% (65/571) began 2–3 years ago. Approximately 6% (32/571) began providing telebehavioral health services >10 years ago. Additionally, all 9 organizations represented by key informants were providing telebehavioral health services to the majority of their clients at the time of the interviews.

Benefits of Providing Telebehavioral Health Services

To better understand the perceived benefits of providing telebehavioral health services, survey respondents were asked, "What about using telebehavioral health services to clients was most beneficial?". The most commonly identified benefit was an increase in clients attending their appointments (46%, 249/537), followed by decreased wait times (38%, 204/537), and improved organizational communication (25%, 132/537). Additionally, 23% (125/537 respondents identified "other" benefits of providing telebehavioral health services, which included:

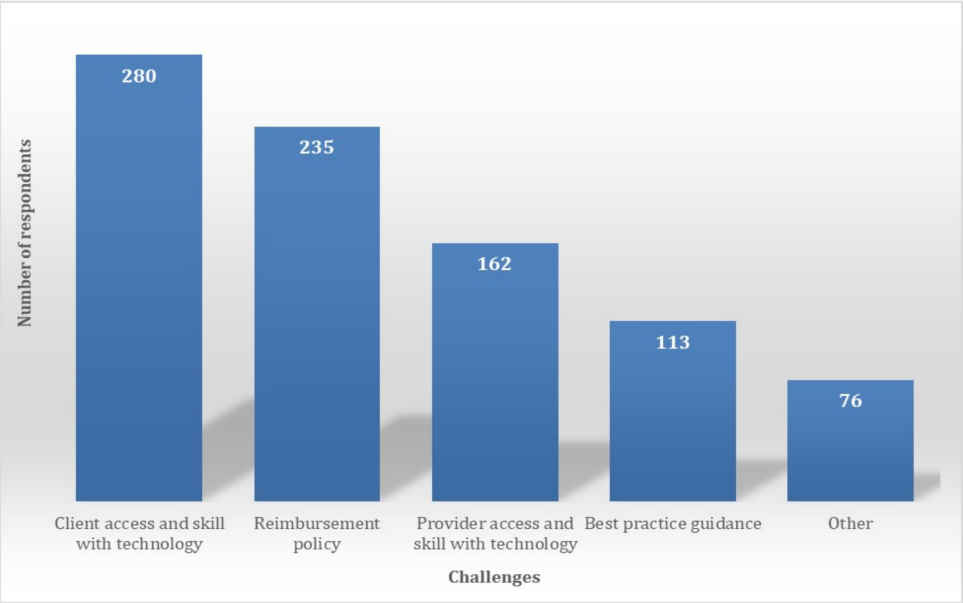
- Increased access to care,
- Decreased transportation barriers,
- Decreased no-show rates,
- Decreased provider travel time,
- Increased ability to provide psychiatric services and recruit psychiatric providers,
- Patient preference and convenience,
- Improved care coordination and coordination with community partners,
- Increased access to prescribers and physicians, and
- Improved engagement of specific populations (e.g., adolescents, veterans, individuals living in rural areas).

Challenges Related to Providing Telebehavioral Health Services Prior to the COVID-19 Pandemic

To better understand challenges associated with providing telebehavioral health services encountered by organizations prior to the pandemic, survey respondents were asked to identify what "was not working" about providing telebehavioral health services to clients. Client access and skill with technology was identified as the most common challenge encountered, followed by reimbursement policy, and provider access and skill with technology (Figure 2). Seventy-six respondents identified "other" factors that were not working well prior to pandemic, which included:

- Client acceptance and preference,
- State-based regulations related to telehealth,
- Difficulty with connectivity and Internet availability,
- Equipment,
- Limitations on provider type allowed to offer telehealth services,
- Client cancelations, and
- Issues with technology not working.

Figure 2. Challenges Providing Telebehavioral Health Services Prior to the COVID-19 Pandemic



Impact of the COVID-19 Pandemic on Telebehavioral Health Services

To better understand the impact of the COVID-19 pandemic on telebehavioral health services, survey participants and key informants were asked a series of questions related to telebehavioral health utilization, facilitators for using telebehavioral health, and client-related challenges to using telebehavioral health.

Telebehavioral Health Utilization Since the COVID-19 Pandemic

Since the onset of the COVID-19 pandemic, there has been an immense increase in the utilization of telebehavioral health services. Almost all survey respondents (95%, 543/573) reported that the percentage of patients using telebehavioral health services increased since the beginning of the pandemic. Survey participants were asked to estimate what percentage of their patients were using telebehavioral health services at the time of the survey. More than half (56%, 320/571) reported that 76%–100% percent of patients are currently using telebehavioral health services. Less than one percent (0.4%, 2/571) reported that none of their patients were using telebehavioral health services.

Respondents were also asked whether they introduced new or expanded existing telebehavioral health services in response to the COVID-19 pandemic. Ninety-nine percent of the respondents to this question reported that they introduced new services (59%, 340/575) or expanded telebehavioral health services (40%, 229/575) in response to the pandemic. Only 1% (6/575) of respondents reported that their organizations did not introduce or expand telebehavioral health services in response to the pandemic.

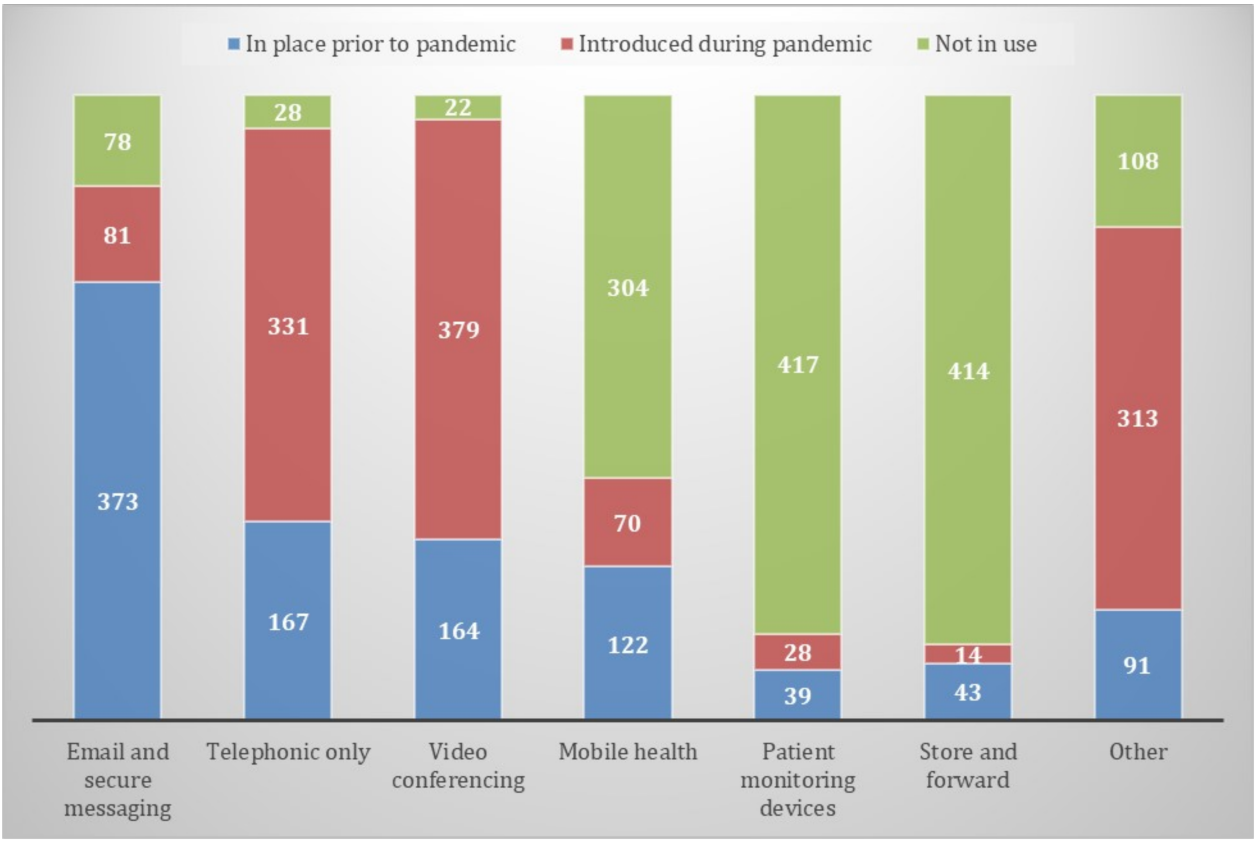
In addition to introducing new or expanding existing telebehavioral health services, respondents were asked whether their organization was able to provide or acquire the adequate technology needed to offer telebehavioral health services during the pandemic. Ninety percent (515/574) of respondents reported that their organizations were able to acquire the necessary technology and 10% (59/574) were not.

Types of Telebehavioral Health Services Used

Survey respondents were asked to identify the types of telebehavioral health services they currently provide and whether they used those services before the COVID-19 pandemic. The most common types of telebehavioral health services in use prior to the pandemic included e-mail or secure messaging (70%, 373/532), followed by telephonic only (32%, 167/526), and then video conferencing (29%, 164/565).

Following the onset of the pandemic, the most common types of telebehavioral health services used included video conferencing (96%, 543/565), telephonic only (95%, 498/526), and e-mail and secure messaging (85%, 454/532). The least common types of services used before and after the onset of the pandemic were store and forward (12%, 57/471) and patient monitoring devices (14%, 67/484) (Figure 3). During the pandemic, video conferencing, telephonic only, and "other" types of telebehavioral health services were the most commonly types of new services introduced.

Figure 3. Types of Telebehavioral Health Services Delivered



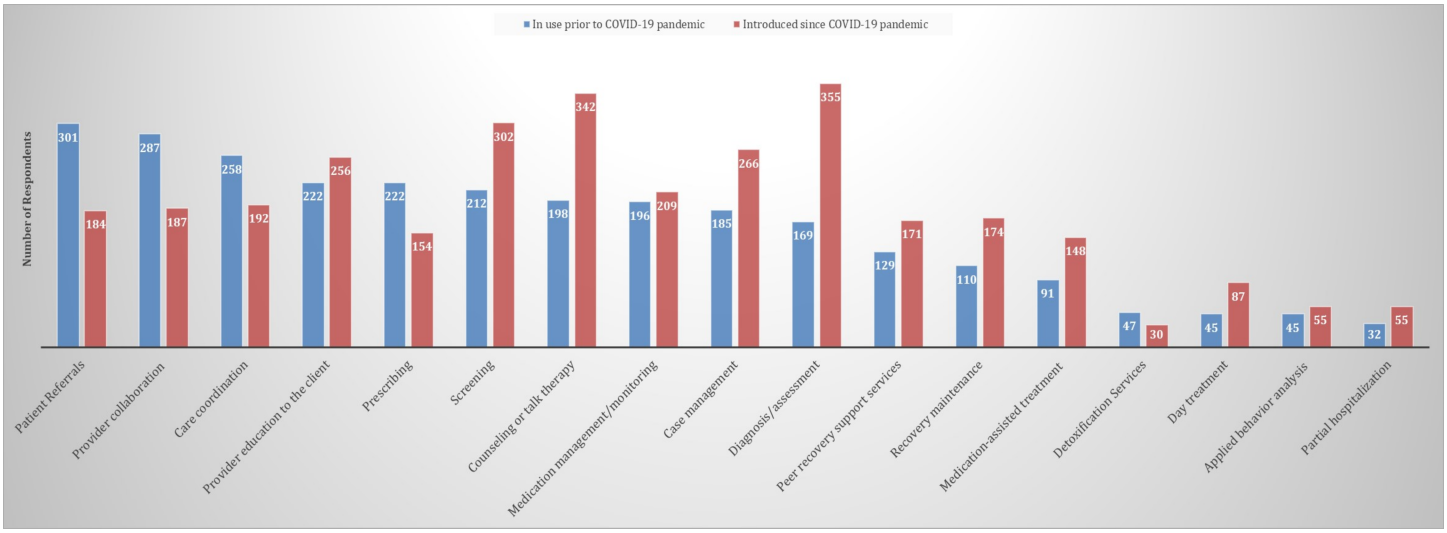
Types of Care Delivered via Telebehavioral Health Services Before and Since the COVID-19 Pandemic

In addition to asking respondents to identify the types of telebehavioral health services they have used prior to and since the COVID-19 pandemic, survey respondents were asked to identify the types of care provided by telebehavioral health services (Figure 4). Respondents were asked to indicate whether particular types of care are provided using telebehavioral health and when those services were introduced (prior to or since the COVID-19 pandemic). Respondents were also asked to identify if any telebehavioral health services were discontinued owing to the COVID-19 pandemic.

The most common types of care provided via telebehavioral health in use prior to the COVID-19 pandemic included patient referrals (56%, 301/537), provider collaboration (54%, 287/536), and care coordination (48%, 258/543). The least common types of care components offered via telebehavioral health prior to the pandemic included partial hospitalization (6%, 32/526), applied behavior analysis (9%, 45/520), day treatment (9%, 45/527), and detoxification services (9%, 47/519).

The most common types of care components offered via telebehavioral health introduced since the COVID-19 pandemic included diagnosis/assessment (64%, 355/557), counseling or talk therapy (61%,

Figure 4. Types of Care Components Delivered via Telebehavioral Health



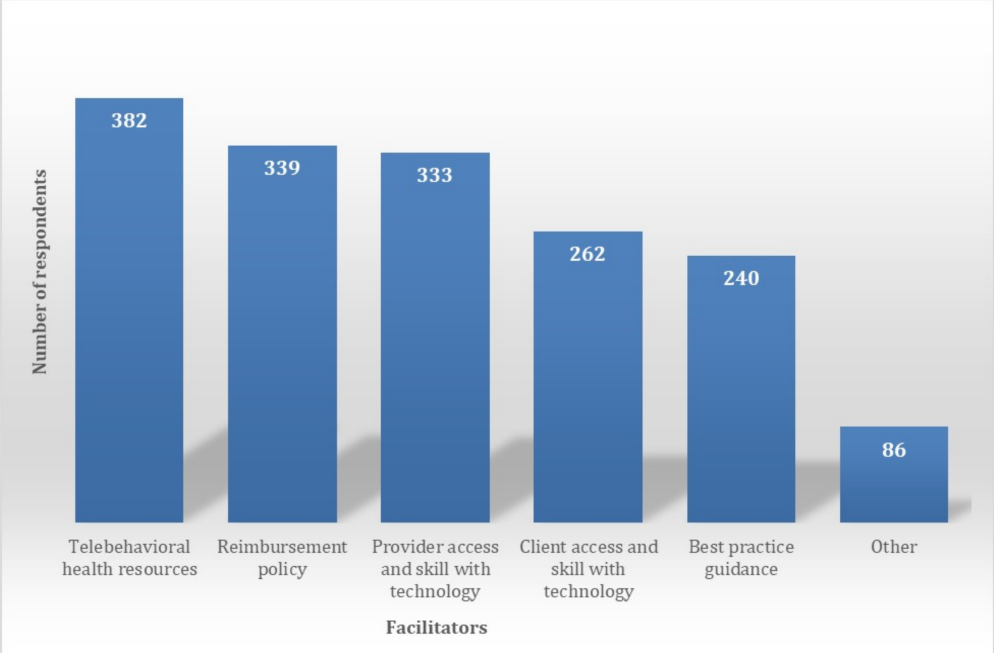
342/565), and screening (54%, 302/559). The least common types of care components offered via telebehavioral health introduced since the COVID-19 pandemic were detoxification services (6%, 30/519), partial hospitalization (10%, 55/526), and applied behavior analysis (11%, 55/520).

Respondents indicated that few services were ended owing to the COVID-19 pandemic. The most common services that were ended included day treatment (5%, 27/527) and peer recovery support services (3%, 14/533). Fewer than 10 respondents reported that they ended partial hospitalization (n=8), recovery maintenance (n=7), care coordination (n=5), screening (n=4), prescribing (n=4), Applied Behavior Analysis (n=3), diagnosis/assessment (n=2), provider collaboration (n=2), medication management/monitoring (n=1), and case management (n=1).

Facilitators for Telebehavioral Health Adoption or Expansion During the COVID-19 Pandemic

Survey participants were asked to choose which factors facilitated or challenged the introduction or expansion of telebehavioral health services in response to the COVID-19 pandemic (Figure 5). The most commonly cited facilitators of telebehavioral health services in response to the pandemic included telebehavioral health resources (68%, 382/562), reimbursement policy (60%, 339/562), and provider access and skill with technology (59%, 333/562). In addition, 86 of 562 respondents (15%) chose "other" factors that helped facilitate the introduction or

Figure 5. Facilitators for the Introduction or expansion of Telebehavioral Health Services in Response to the COVID-19 Pandemic



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expansion of telebehavioral health services, which included:

- Relaxed federal and state regulations related to providing telehealth,
- Expansion of funding to support services (e.g., Medicare, grants, and Medicaid waivers),
- The ability to receive reimbursement for telephonic-only services,
- Staff willingness and flexibility to try a new way to deliver services,
- Client willingness to try telebehavioral health services,
- Information technology staff support,
- Training, and
- Peer support.

In addition to the survey responses, key informants also identified facilitators for the introduction or expansion of telebehavioral health services during the pandemic. Common facilitators identified by key informants included government agency support, reimbursement for telebehavioral health services, privacy and confidentiality regulation flexibilities, free trainings and support, and provider willingness and flexibility.

One common theme among key informants was having the support of local and state government agencies to quickly transition to virtual services. One respondent reported that their county provided free Zoom licenses for providers, which facilitated a quick transition and established consistency across providers. Another key informant reported that the county prioritized services for clients above anything else, which meant providers were given more flexibility related to reporting and compliance requirements. Another key informant echoed this stating:

"The county was very supportive of provider organizations and trusted them."

Another common theme related to facilitators was the availability of free trainings and webinars offered by national organizations. Several key informants reported that they participated in in online trainings and information sessions to adapt more easily to providing telebehavioral health services.

Key informants also commonly reported that provider willingness to transition to virtual services and their flexibility during the pandemic was incredibly important for successful implementation or expansion of telebehavioral health services. Several key informants commented on the need for providers to be creative, adaptive, and flexible, particularly to engage clients during virtual sessions and to overcome challenges. One respondent used an example of how providers were creatively employing strategies to overcome patient challenges and increase engagement in services and treatment modalities:

"Staff are using creative techniques to help patients engage. For example, suggesting someone take a walk together while being on the phone with a provider."

By suggesting a client take a walk (in compliance with the local social distancing requirements) the provider was able to overcome a challenge of privacy at home, was able to connect with the client in that they were walking together, and encourage the client to engage in physical exercise.

Several other facilitators were identified by key informants, including:

- Receiving funding, including a technology grant, to support the purchase of equipment for providers to deliver services from their homes.
- Having pre-existing relationships with clients made the transition to virtual services easier for some providers.
- Using real-time data to quickly troubleshoot issues and identify trends (for example, types of client populations who were not engaging in services).
- Having clients who faced connectivity challenges go to places that offered free Wi-Fi (e.g., parking

lots of restaurants).

- Conducting weekly team meetings to discuss challenges and solutions.
- Establishing provider protocols for engaging patients virtually. For example, asking clients if they are alone and if they can stay where they are for the duration of the session.

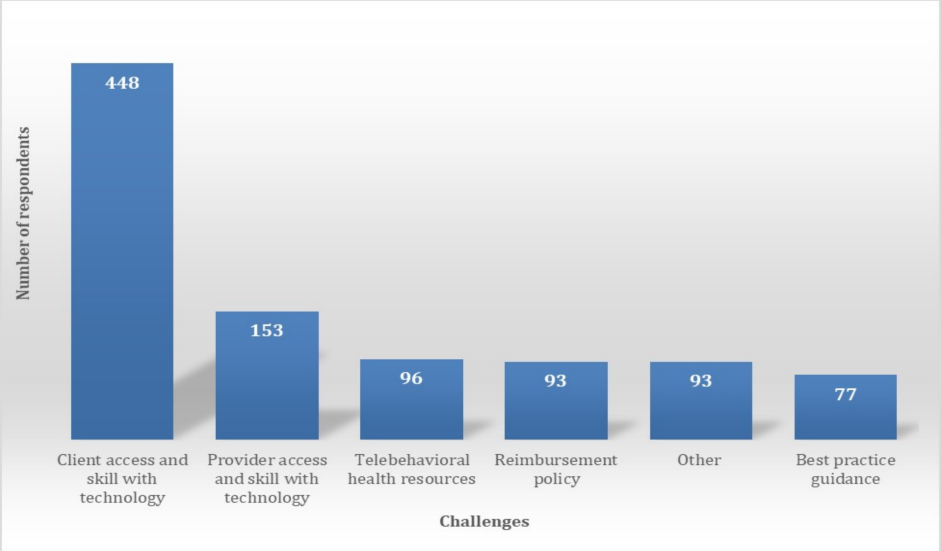
Challenges to Adopt or Expand Telebehavioral Health During the COVID-19 Pandemic

Respondents were also asked to identify factors that were their greatest challenges related to introducing or expanding telebehavioral health services in response to the COVID-19 pandemic (Figure 6). The most commonly identified challenge was client access and skill with technology (80%, 448/560), followed by provider access and skill with technology (27%, 153/560), and telebehavioral health resources (17%, 96/560). Ninety-three of 560 (17%) respondents also identified "other" factors that were challenges.

The most commonly identified challenges included:

- Equipment,
- Broadband access and quality,
- Client privacy and confidentiality,
- Client willingness,
- Initial buy in from staff and clients,
- Choosing high-quality technology platforms,
- Frequently changing reimbursement policies, and
- Technology glitches.

Figure 6. Challenges Related to Introducing or Expanding Telebehavioral Health Services in Response to the COVID-19 Pandemic



Challenges Faced by Clients

Information collected through key informant interviews support survey findings. The most commonly cited major challenges experienced by key informants were related to patient access to technology. Examples of challenges related to client access to technology include a lack of Internet connectivity and coverage, an inability among clients to purchase new technology, and a lack of privacy while at home.

"Here in our community, the number one barrier was connectivity because a lot of the clients live in areas where Internet services wasn't great."

A common theme among key informants was the ways in which social determinants of health impact individuals' ability to meaningfully engage in telebehavioral health services, especially during the pandemic when many families faced economic and housing crises. One informant commented on the fact that poverty impacts clients' ability to engage in telebehavioral health by prohibiting the purchase of necessary technology, but also by impacting technological literacy and the knowledge of how to use the technology. One provider serving a rural area in Georgia reported that their organization quickly introduced Zoom to provide video-based telebehavioral health services to clients; however, approximately 5% of clients did not have access to Zoom. To overcome this challenge, the organization put measures in place to allow clients to access the same services by telephone.

In addition to social and economic challenges faced by clients, clients are also at risk of and fearful of getting COVID-19. One informant commented:

"Recently, one of my clients actually tested positive, so on top of everything else these extra fears are escalating everything. I really have to focus on the escalation and calming of the brain before I can engage in the planned sessions. Trying to uncover those layers has been challenging."

Challenges Faced by Providers

In addition to client-related challenges, key informants identified challenges impacting providers' ability to meaningfully engage in telebehavioral health services during the pandemic. One challenge echoed by several key informants was providers' struggle with trying to deliver telebehavioral health services from their own homes while having to manage their personal responsibilities, including having children at home, finding private physical spaces to deliver services, and experiencing connectivity challenges while working from home.

Another key challenge identified by providers was the inability to conduct thorough assessments of clients using telebehavioral health (video and audio-only services). One provider commented:

> *"I work a lot with teenagers and I'm struggling to get an adequate assessment of the words I'm hearing being accurate. Whereas, when I'm in person, I can read their body language to see that."*

A related challenge expressed by several key informants was related to being able to adequately assess for safety issues, including domestic and child abuse, using telebehavioral health services. The concern about not being able to conduct adequate safety assessments was exacerbated by the fact that clients are not being seen by other providers who would otherwise also be able to identify safety issues. Providers stated that it was very difficult to assess for safety issues owing to clients' lack of privacy at home, especially children. One provider stated:

> *"Feeling a burden of it being all on us to evaluate versus before there used to be teachers or daycare providers or other people who might be able to put eyes on the child. A lot of the time, they can't say anything because the parent or potential abuser is sitting right next to them."*

When asked about engagement in and preferences for telebehavioral health services among clients, key informants' responses varied. Some key informants reported that no-show rates declined when their organization transitioned to telebehavioral health; however, other key informants reported that no-show rates increased and clients were generally less engaged in services. One key informant reported that they felt the no-show rates dropped to virtually 0 after the transition to telebehavioral health because clients had fewer barriers to accessing services, such as transportation or childcare. On the other hand, some key informants reported that their clients are not showing up for telebehavioral health appointments or are disengaged when they do log in for virtual appointments. Several key informants also identified engaging children and adolescents during virtual visits was especially challenging. One key informant stated:

> *"Providers have experienced some frustration with patients not understanding that the patient was scheduled with the doctor. Patients have also been found to be preoccupied during appointments. For example, working as a mechanic, driving, and in one case, chasing chickens."*

Provider burnout and fatigue was also identified as a challenge among several key informants. The need for self-care and self-compassion were echoed by key informants as well as the need to identify how challenging it is for providers to manage the trauma, grief, and stress experienced during the pandemic.

Another challenge identified by key informants was related to delivering telebehavioral health services in a manner that is culturally relevant and appropriate. Several key informants reported a need for additional training related to culturally specific telebehavioral health services. One provider explained that they work with

a population where women are often with their husbands during sessions and it has been a challenge to be able to get clients in space where they are alone to talk to the provider without their husband present. Other key informants also commented on challenges related to using translation and interpretation services during telebehavioral health services.

Technology-Related Challenges

Key informants were asked to comment on challenges related to specific types of technologies used (e.g., video, audio only). One challenge identified by several key informants was related to facilitating group sessions and group therapy through virtual formats. One respondent reported that they found Zoom worked well for their organization for group work; however, it was a process of trial and error before choosing the best technology and format for the work. Another technology-related challenge identified by several key informants was difficulty obtaining equipment, specifically cameras, owing to short supplies during the pandemic.

Other technology-related challenges identified by key informants included:

- Experiencing "glitches" when trying to mask personal cell phone numbers by routing them through the office line.
- Connectivity in provider homes, client homes, and office locations.
- For small and solo providers, investing in technology is a considerable expense to bear and it can be difficult to discern the types of technology needed.
- Challenges related to having clients e-sign documents.
- Meaningfully engaging translation and interpretation services with many of the types of technology currently being used to conduct telebehavioral health services.

Continued Use of Telebehavioral Health Services Beyond the COVID-19 Pandemic

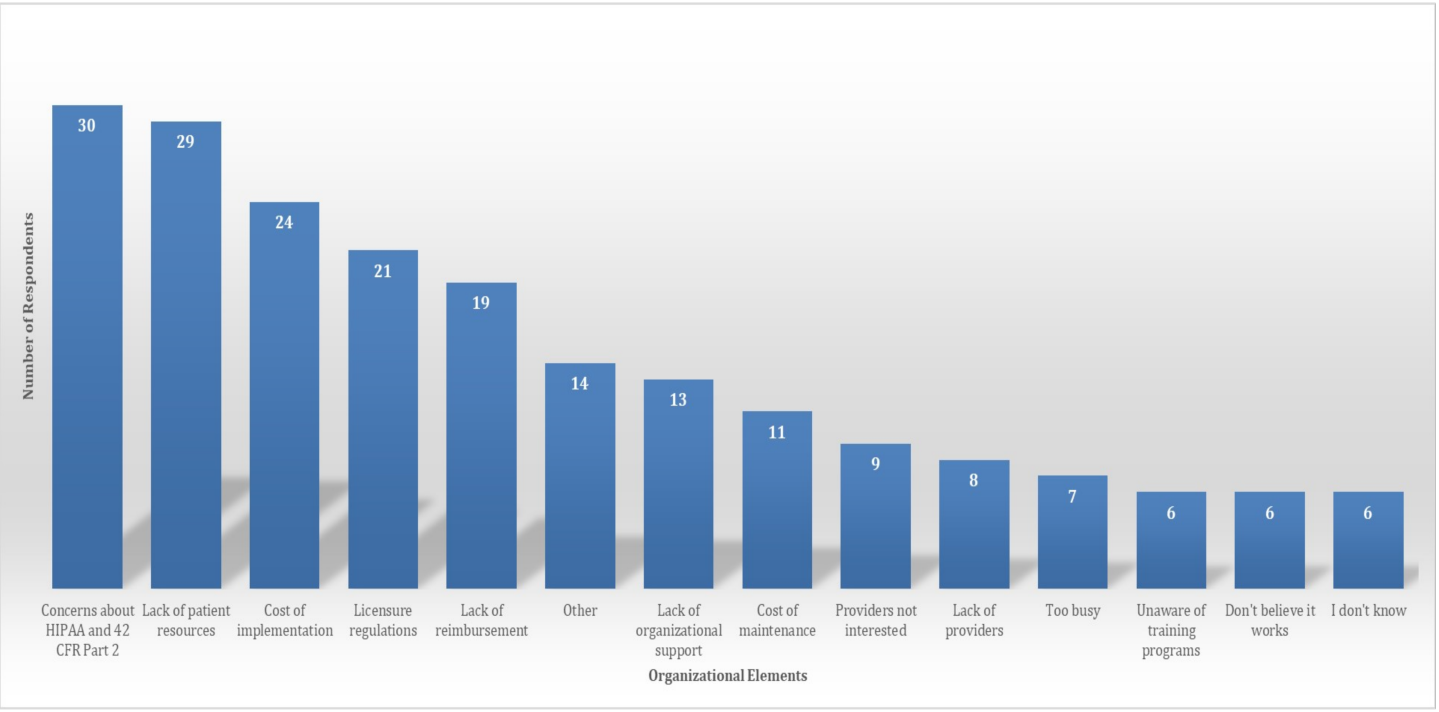
Survey respondents were asked whether their organizations plan on using telebehavioral health services beyond the period of the COVID-19 pandemic and related social distancing restrictions. The majority of respondents (79%, 452/573) reported that their organization did plan on using telebehavioral health services after the pandemic, 20% (117/573) reported that their organization was undetermined, and 1% (4/573) reported that their organization was not planning on using telebehavioral health services after the COVID-19 pandemic.

Key informants were also asked whether their organizations had planned on using telebehavioral health services beyond the COVID-19 pandemic. All but 1 informant reported that their organization does plan to provide some type telebehavioral health beyond the period of the pandemic. One informant was not sure as their organization did not use telebehavioral health prior to the pandemic. Many key informants stated that the decision about offering telebehavioral health services is largely being driven by reimbursement and funding for services. For example, currently there are several policies in place allowing for reimbursement for telephonic-only services; however, if those reimbursement mechanisms cease, then organizations may stop offering the services. Most of the key informants stated that they hope the current policy and reimbursement flexibilities remain in place beyond the period of the pandemic.

Organizations Not Currently Using Telebehavioral Health Services

Survey respondents who indicated their organizations are not using telebehavioral health services were asked to identify the factors that influenced the decision not to use telebehavioral health services (Figure 7). Sixty-five respondents answered this question. The most commonly identified factors for not using telebehavioral services included concerns about HIPAA and 42 CFR Part compliance (46%, 30/65), patients lack resources to engage in telebehavioral health (45%, 29/65), and cost of implementation (37%, 24/65). The least commonly cited factors included not believing it works (9%, 6/65), being unaware of training programs (9%, 6/65), and being too busy (11%, 7/65).

Figure 7. Organizational Factors for Not Using Telebehavioral Health Services



Additionally, 14 respondents identified "other" factors, including:

- A preference for in person counseling,
- Insurance restrictions,
- Funding, and
- Lack of patient interest.

Resources to Support Telebehavioral Health Implementation

Survey respondents whose organizations are not currently providing telebehavioral health services were asked to identify resources that would be most helpful to their organizations as they consider using telebehavioral health services. The most commonly identified helpful resources included best practices and strategies on how to effectively deliver telebehavioral health (78%, 57/73), how to engage patients (71%, 52/73), and understanding compliance and licensure regulations for telebehavioral health (55%, 40/73).

Telebehavioral Health Training

In addition to understanding the ways in which the COVID-19 pandemic has impacted telebehavioral health use, the goals of this study included better understanding training needs related to telebehavioral health. Among 650 survey respondents, 57% (373/650) reported that they had been trained in the delivery of telebehavioral health and 43% (277/650) reported that they did not receive training. Among 366 respondents who did receive telebehavioral health training, most individuals received training after they were employed at their current place of employment (77%, 283/366). Only 23% (83/366) of individuals received training prior to their current place of employment.

Respondents who received telebehavioral health training were also asked to identify the source of the training and whether they received training before or since the COVID-19 pandemic. A greater number of trainings took place following the onset of the pandemic (60%, 535/887) compared with prior to pandemic (36%, 320/887). The most common sources of training included nonprofit agencies (21%, 182/887), employer -provided sources (20%, 181/887), and private company providing continuing education credits (12%,

109/887). The least common sources of training included residency (0.8%, 7/887), field practicum or internship (2%, 17/887), and graduate school course work (4%, 32/887).

Key informants were also asked to describe the types of telebehavioral health trainings they engaged in and would benefit from. Many key informants reported that they participated in free webinars and online trainings offered by national organizations to better assist with the transition to telebehavioral health services. Examples of organizations offering such trainings cited by key informants included the Addiction Technology Transfer Center, the SAMHSA, the National Association for Alcoholism and Drug Abuse Counselors, and the National Council.

Few key informants participated in trainings on providing telebehavioral health services prior to the onset of the pandemic. Many key informants reported topics related to telebehavioral health were often missing from offered continuing education events and trainings. Key informants that did receive training on telebehavioral health since the pandemic mostly reported that they did so through national organizations offering live webinar events. One organization that has been providing telebehavioral health services for >10 years did offer their own organizational trainings for staff. The key informant from that organization reported:

"Training was always important, but the nature and topics of trainings have changed as they related to telehealth."

Several key informants reported that they were learnings as they went and constantly adapting to new changes and lessons learned. The need for flexibility and adaption was echoed throughout key informant interviews related to a range of topics. One respondent commented:

"We're building the plane as we fly it."

Many key informants also reported that they are engaging in learning opportunities through collaboration with state agencies and other organizations. One key informant reported that community organizations were collaborating to share policies, for example. One organization partnered early with their state agencies to identify the types of technology that would be supported by state longer term and used that information to help train staff. Another key informant reported:

"We collaborated with other organizations in the community who were implementing services, so no program had to reinvent the wheel."

Training Needs

Key informants identified a range of training needs throughout the interviews, including adapting evidence-based and best practices to virtual environments, engaging clients, implementing culturally relevant and specific strategies within telebehavioral health, and self-care during the pandemic.

Many key informants commented that they did not face major challenges with using the technology itself, but do face challenges in trying to adapt evidence-based and best practice techniques and services to a virtual environment. Some key informants described providing behavioral health services virtually as being fundamentally different than providing them in person. Major challenges related to engaging clients, conducting assessments, and conducting group therapy were identified by informants. Adapting evidence-based techniques generally conducted in person to a virtual environment was also echoed by several informants. Key informants stated:

"We need more training around evidence-based practices specific to telehealth. How do you take CBT [Cognitive Behavioral Therapy] and shift it to online?"

"In the training that I took, there wasn't a lot around best practices for virtual engagement, for example, what types of backgrounds to use or not use, whether to use music during wait times, how to set a calming virtual environment."

Another challenge identified by clients was related to delivering services in a culturally specific and relevant manner virtually. These issues included how to best incorporate translation and interpretation

services within the technology used to provide telebehavioral health. One key informant commented:

> *"Cultural intelligence, competence, diversity, equity, and engagement should be included no matter what. Those are the principles that we should be operating from. Additionally, there are other considerations and recommendations related to telebehavioral health services that might require a level of coaching, mentoring, education, and support for recognizing how and why certain groups of individuals may engage differently in virtual services."*

Conclusions and Policy Considerations

The telebehavioral health landscape was fundamentally changed by the COVID-19 pandemic and subsequent policy and regulatory reforms. The rapid adoption of telebehavioral health services by providers has helped to engage and maintain clients in behavioral health services, which are especially critical during times of national crisis, such as a pandemic. Telebehavioral health providers' experiences since the onset of the pandemic provide valuable information related to the workforce challenges and opportunities related to adopting, implementing, and sustaining telebehavioral health.

Nearly all survey respondents (99%, 569/575) reported that their organizations introduced new or expanding existing telebehavioral health services in response to the COVID-19 pandemic and a majority (79%, 452/573) of the organizations plan to continue to offer telebehavioral health beyond the pandemic period. Most interviewed key informants expressed that the policy and regulatory exceptions and reforms currently in place because of the pandemic should be extended beyond the period of the pandemic to further support and facilitate increased access to telebehavioral health.

The greatest challenges identified here related to providing telebehavioral health services were client access and skill with technology. These challenges were rooted in the harmful social determinants faced by many clients that are exacerbated by COVID-19 pandemic. Lack of resources to purchase technology, low technology literacy, lack of Internet connectivity, and lack of privacy were major challenges faced by patients identified by key informants.

Providers faced new and unique challenges related to delivering telebehavioral health services during the pandemic, including having to balance personal responsibilities such as childcare while providing services from their homes. Providers also faced stress and trauma due to the pandemic and identified the need for increased self-care and self-compassion while transitioning to and employing telebehavioral health services to clients.

Training was identified as a major need and facilitator for the successful transition to telebehavioral health; however, identified training topics focused less on the technical aspects of employing technology and more so on how to adapt and integrate evidence-based, trauma-informed, and culturally relevant strategies within virtual settings. Related training needs related to successfully engaging clients in telebehavioral health services and conducting thorough assessments were identified.

This study has multiple limitations that should be considered when interpreting the results. First, the response rate for this survey was unable to be calculated due to the method of survey transmission. Additionally, a non-probability convenience sample was used to recruit behavioral health providers. These methodological limitations make it unclear whether the study sample is representative of behavioral health providers and caution should be taken when generalizing these results. Lastly, this is a descriptive study so significant differences and causality cannot be implied.

There are meaningful opportunities for more research in this area as the experiences, effects, and impacts of the rapid transition to telebehavioral health services and the pandemic and related policy changes are continuing to evolve.

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