Provider & Client Perspectives on Telebehavioral Health Satisfaction and Quality of Care

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Project Team

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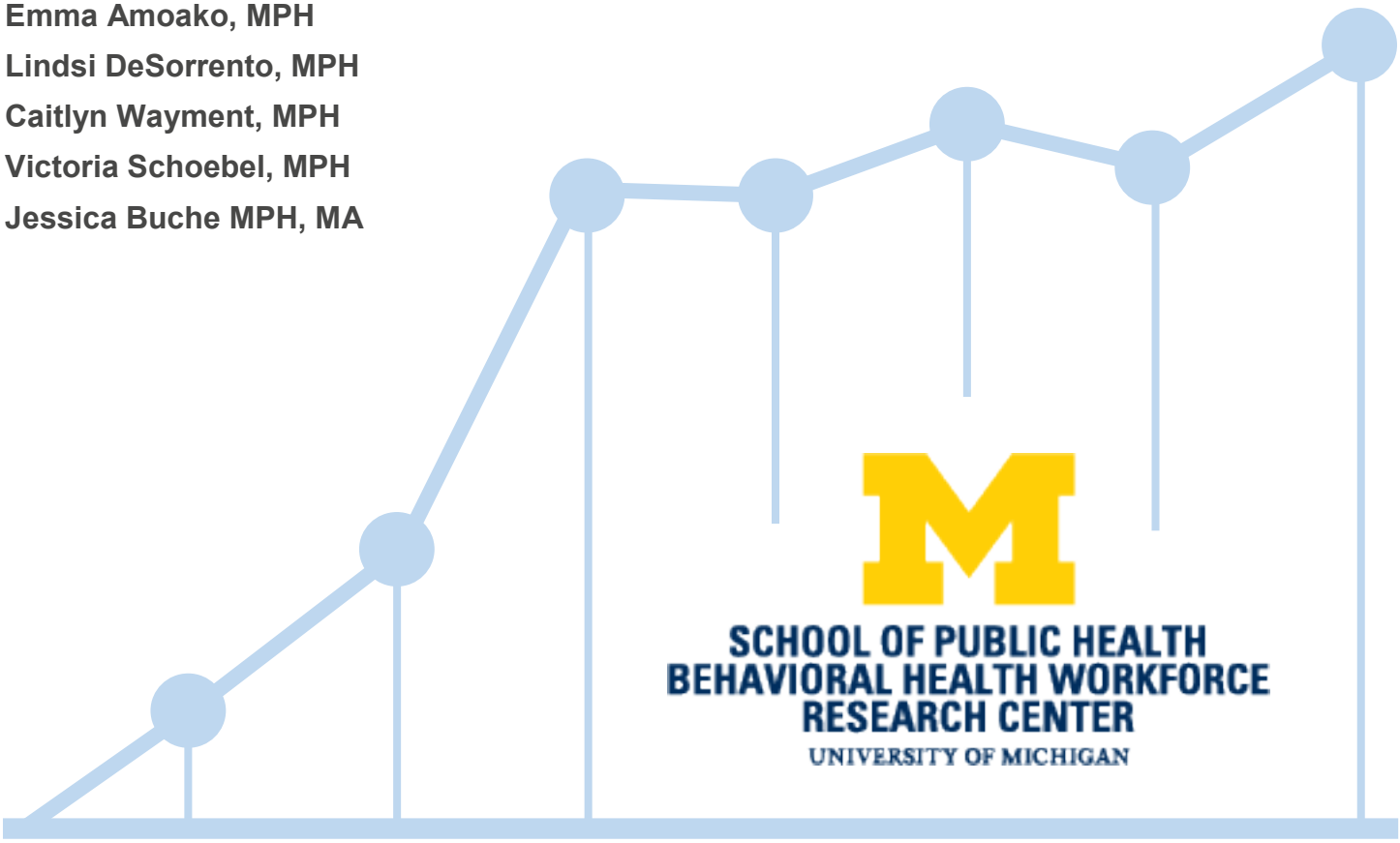

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Background

The coronavirus pandemic (COVID-19) has caused a rapid and dramatic transition to distanced health care services, including telebehavioral health.[1] As part of this transition, state and federal agencies made regulatory and policy changes to allow greater provider flexibility in billing and remote service delivery.[2,3] This initial shift from in-person behavioral health services to telebehavioral health services has persisted throughout the COVID-19 pandemic and may lead to sustained changes in the ways providers and clients use behavioral health services.

The current literature shows that even though providers have identified several barriers and concerns related to telebehavioral health, the benefits generally outweigh the concerns, often leading to positive attitudes toward telebehavioral health.[4] A comprehensive review of peer-reviewed literature on providers' attitudes toward providing telebehavioral health via videoconferencing published between 2000 and 2019 found that providers have largely positive attitudes despite identifying many drawbacks.[5] Even more telling, these positive opinions were generally observed across service type, location of care, and client populations.

A systematic review of peer-reviewed literature published from 2004 to 2014 that examined measures of client satisfaction found generally comparable satisfaction between audiovisual, audio-only, and in-person treatment modalities.[6] According to a study conducted by Guinart and colleagues,[7] the majority of clients who used audiovisual telebehavioral health services during the COVID-19 pandemic rated their overall experience as either good or excellent; similarly, those using audio-only telebehavioral health services reported their experience as good or excellent.[7] The survey results also showed that the majority of clients either agreed or strongly agreed that telebehavioral health sessions were as helpful as in-person treatment.

However, despite overall client and provider satisfaction with telebehavioral health, a review by Connolly and colleagues[5] highlights studies comparing provider and client attitudes toward telebehavioral health that found, on average, clients were more satisfied than providers. One reason for this dissonance is that the provider's Working Alliance Inventory score, which measures tasks, goals, and client–provider relationships, is lower for telebehavioral health compared to in-person care, but there were no significant differences in client-rated scores.[8] Another source of this variation was that providers reported technical difficulties to be more problematic and burdensome than clients reported.[9]

This study seeks to gain a deeper understanding of the overall experiences of those receiving (i.e., clients), directly providing (i.e., providers), and directly supporting (i.e., administrative staff) the provision of telebehavioral health services. This includes the identification of specific barriers and facilitators affecting overall satisfaction and quality of telebehavioral health services during the COVID-19 pandemic. Secondly, this study aims to investigate the overall attitudes about telebehavioral health services held by groups providing and receiving services. Results of this study will help inform future policy changes to best support the delivery of high-quality telebehavioral health services and increase both provider and client satisfaction.

Methods

The National Council for Mental Wellbeing (hereafter referred to as the National Council, formerly known as the National Council for Behavioral Health), in partnership with the Behavioral Health Workforce Research Center at the University of Michigan School of Public Health (BHWRC), collected primary data from mental health and substance use treatment organizations nationwide to address the following research questions:

1. How do providers, clients, and administrative staff describe their overall experiences with telebehavioral health services?
2. What are the specific barriers identified that affect overall satisfaction and quality outcomes of telebehavioral health services for providers, clients, and administrative staff?

3. What facilitators affect overall satisfaction and quality of outcomes with telebehavioral health services for providers, clients, and administrative staff?

Researchers collected data in two phases: (1) a literature review conducted in February 2021 and (2) an electronic survey deployed in summer 2021. The research team collected quantitative data from a convenience sample of behavioral health providers, direct support administrative staff, and clients who had experience with telebehavioral health services in the last year. Researchers distributed a Qualtrics survey via email invitation in May 2021 to more than 50,000 behavioral health stakeholders selected from the National Council's mass communications list. Due to the method of survey distribution, a response rate was not calculated, and this is not a nationally representative sample. The University of Michigan's Institutional Review Board (IRB) approved the survey questions, and no personal identifying information was collected. The survey required approximately 15 minutes for completion, and participation was voluntary with no incentives provided for completing or participating in the survey. The survey was available online for 7 weeks, after which qualitative and quantitative results data were analyzed using Qualtrics and Microsoft Excel software. The survey initially received 2059 responses, with 1489 being dropped during data cleaning due to not completing the survey, being ineligible to take the survey, not identifying which of the three category groups they belonged to, or an initial error involving survey logic and form termination that was quickly rectified. All affected responses before this error was addressed were dropped to preserve the integrity of the data. The final data cleaning resulted in a final analyzed sample of 570 participants.

Findings

Survey Results

Overview of Survey Respondents and Organizations

Providers, clients, and administrative staff who had experience with telebehavioral health services in the last 12 months completed the survey (n=570). Respondents were represented across 43 states, Puerto Rico, and the District of Columbia. Delaware, Utah, South Carolina, Nevada, North Dakota, Wyoming, and South Dakota were not represented in survey responses. Eighty-six respondents identified as administrative staff, 262 identified as providers, and 222 identified as clients.

Table 1 provides a breakdown of respondent demographics and the practice locations of the providers and administrators. The most common types of organizations represented in the provider and administrative groups were community behavioral health clinics (46.5% administrators and 37.5% providers) and Certified Community Behavioral Health Clinics (CCBHCs) (15.1% administrators and 16.9% providers). Services provided included individual therapy, couples therapy, group therapy, medication management, medication-assisted treatment (MAT), serious mental health treatment, neuropsychology, and psychological testing.

The majority of administrators (n=74, 87.1%), providers (n=194, 89.0%), and clients (n=175, 81.4%) identified as female. Further, the majority of administrators, providers, and clients were non-Hispanic (n=79, 91.9%; n=202, 91.8%; n=201, 93.5%, respectively) and white (n=71, 85.5%; n=169, 80.1%; n=176, 85.0%, respectively). The majority of administrators (n=61, 71.8%), providers (n=208, 80.3%), and clients (n=184, 88.5%) were also from urban areas with populations of 2500 or more people.

Prior to the COVID-19 pandemic, 83.6% (n=178) of clients reported not having any audiovisual telebehavioral health appointments; in contrast, during COVID-19, only 7.9% (n=17) of clients reported not receiving any audiovisual telebehavioral health appointments. Similar to audiovisual telebehavioral health services, the onset of the COVID-19 pandemic led to rapid shifts in audio-only telebehavioral health services. The overwhelming majority of client respondents reported no audio-only telebehavioral health appointments

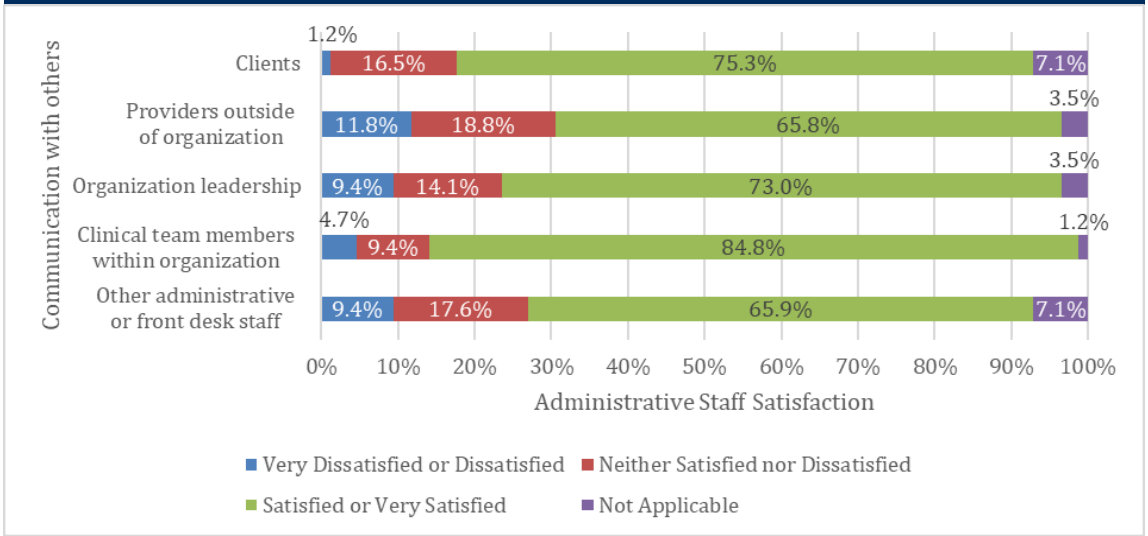
Table 1: Survey Respondents' Demographics and Service Location			
	Administrative	Providers	Clients
Total	86	262	222
Age, *M* (*SD*)	51.86 (10.71)	47.79 (13.27)	47.32 (14.18)
Gender, *n* (%)			
Female	74 (87.1)	194 (89.0)	175 (81.4)
Male	10 (11.8)	22 (10.1)	34 (15.8)
Other	1 (1.2)	2 (0.9)	6 (2.8)
Ethnicity, *n* (%)			
White	71 (85.5)	169 (80.1)	176 (85.0)
Black	6 (7.2)	29 (13.7)	12 (5.8)
Other	6 (7.2)	13 (6.2)	19 (9.2)
Hispanic Descent, *n* (%)			
Yes	7 (8.1)	18 (8.2)	14 (6.5)
No	79 (91.9)	202 (91.8)	201 (93.5)
Location, *n* (%)			
Urban	61 (71.8)	208 (80.3)	184 (88.5)
Rural	24 (28.2)	51 (19.7)	24 (11.5)
Type of Org, *n* (%)			
Community behavioral health	40 (46.5)	98 (37.5)	-
Certified Community Behavioral Health Clinic (CCBHCs)	13 (15.1)	44 (16.9)	-
Federally Qualified Health Centers (FQHCs)	9 (10.5)	19 (7.3)	-
Private practice	4 (4.7)	67 (25.7)	-
Hospital	2 (2.3)	7 (2.7)	-
Other	18 (20.9)	28 (10.0)	-

prepandemic (n=187, 89.0%), but only 44.9% (n=96) reported no audio-only telebehavioral health appointments during the pandemic. Yet, another dramatic shift due to the increased use of telebehavioral health is that no-show rates dropped, with 52.7% (n=134) of staff reporting that these rates either decreased or largely decreased since the start of the pandemic while 26% (n=66) reported that no-show rates stayed the same.

Administrative Staff Findings

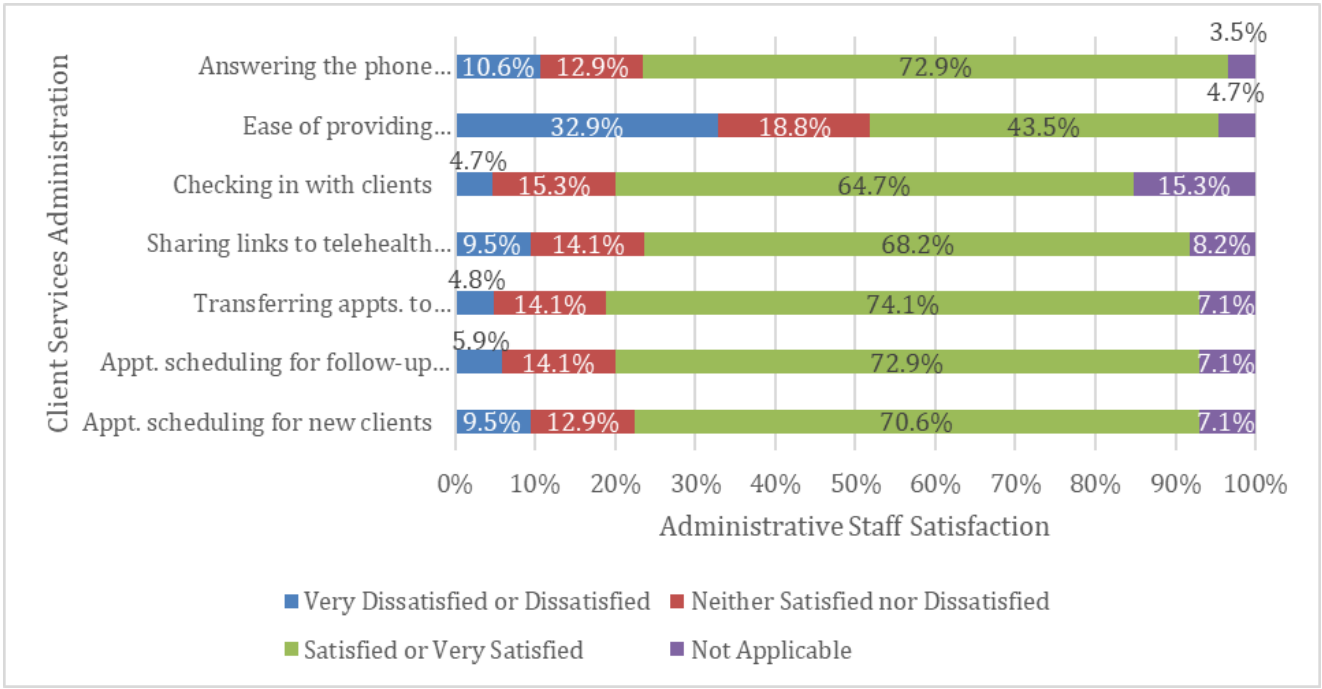
Overall, administrative staff generally describe positive experiences, with 89.4% (n=76) of this group reporting mostly positive or all positive experiences with telebehavioral health and supporting providers to use these services. Relevant domains included

Figure 1



communication, checking in with clients, transferring appointments to telebehavioral health, appointment scheduling for new and existing clients, and many other job role functions (Figure 1, Figure 2). Administrative staff especially reported high satisfaction with phone interactions with clients, providers outside the organization, and clinical team members within their organization (Figure 1). Further, administrative staff reported high levels of satisfaction with answering phones, setting up appointments for new and existing clients, checking in with clients, and transferring appointments to telebehavioral health (Figure 2).

Figure 2



Key themes across qualitative analysis determined that administrators found increased accessibility, increased flexibility, better time management, and more clients completing programs or adhering to court-ordered treatment as facilitators. Barriers included fears of overwork and burnout from increasing caseloads, the need for assistance in getting clients better technology, concerns that telebehavioral health may not be as effective (although this appears to be a minority in the group when compared to quantitative data), especially for some populations such as children and people with severe mental illness (SMI).

Provider Findings

The provider group also reported high overall satisfaction with telebehavioral health services, with over 85% (n=218) of participating clinicians rating the experience of providing telebehavioral heath care as "mostly positive" or "all positive" in the last month. This held true across many specific domains related to administrative tasks and clinical care activities (Figure 3, Figure 4). Especially noteworthy findings include that 79.6% (n=186) of provider respondents reported they were satisfied or very satisfied with their ability to maintain an existing relationship with clients, 77.8% (n=177) responded that they were satisfied or very satisfied with the ability to create a new relationship with clients, and 86.2% (n=206) felt satisfied or very satisfied that they were able to deliver quality clinical services via telebehavioral health. Similar satisfaction ratings were also given for schedule flexibility, appointment attendance (78.8%, n=178), and schedule efficiency (78.8%, n=178). Perhaps most notable of all, though, is that 73.2% (n=175) reported that they were satisfied or very satisfied with the ability to deliver services that are just as effective as in person.

Figure 3

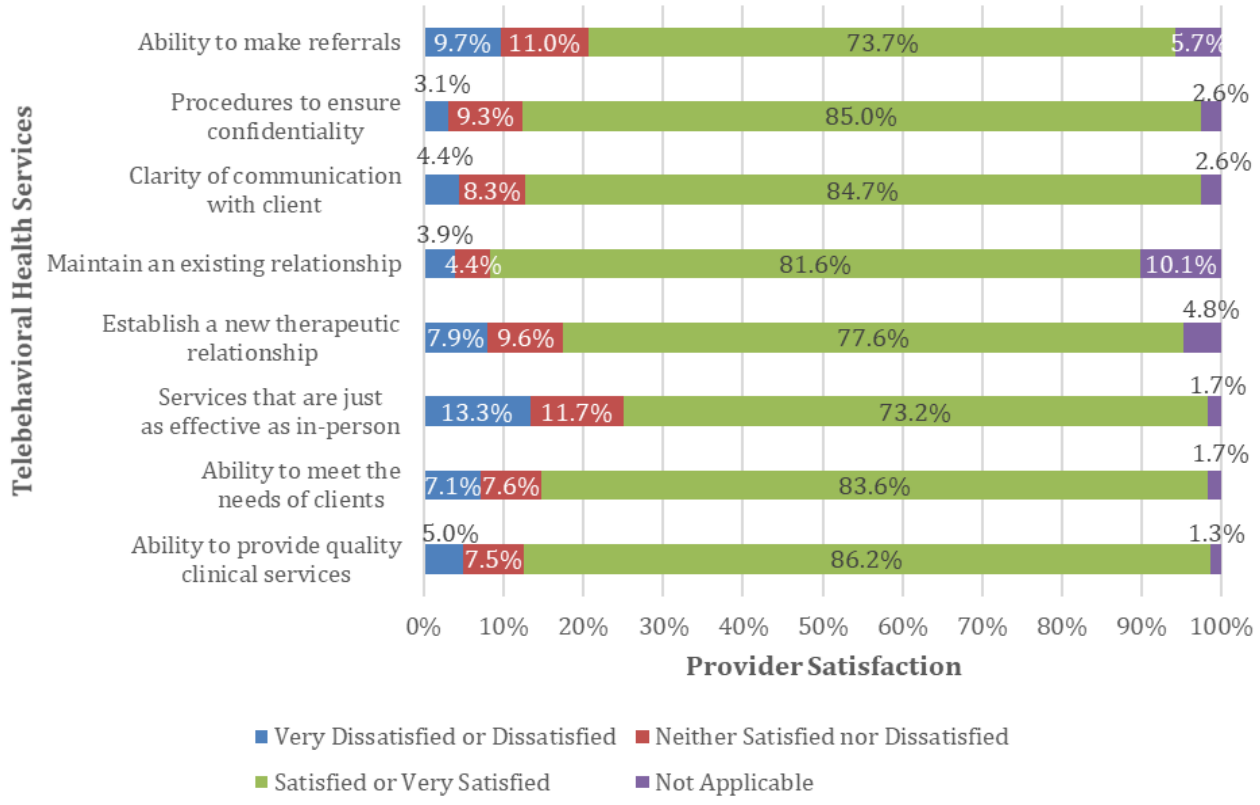


Figure 4

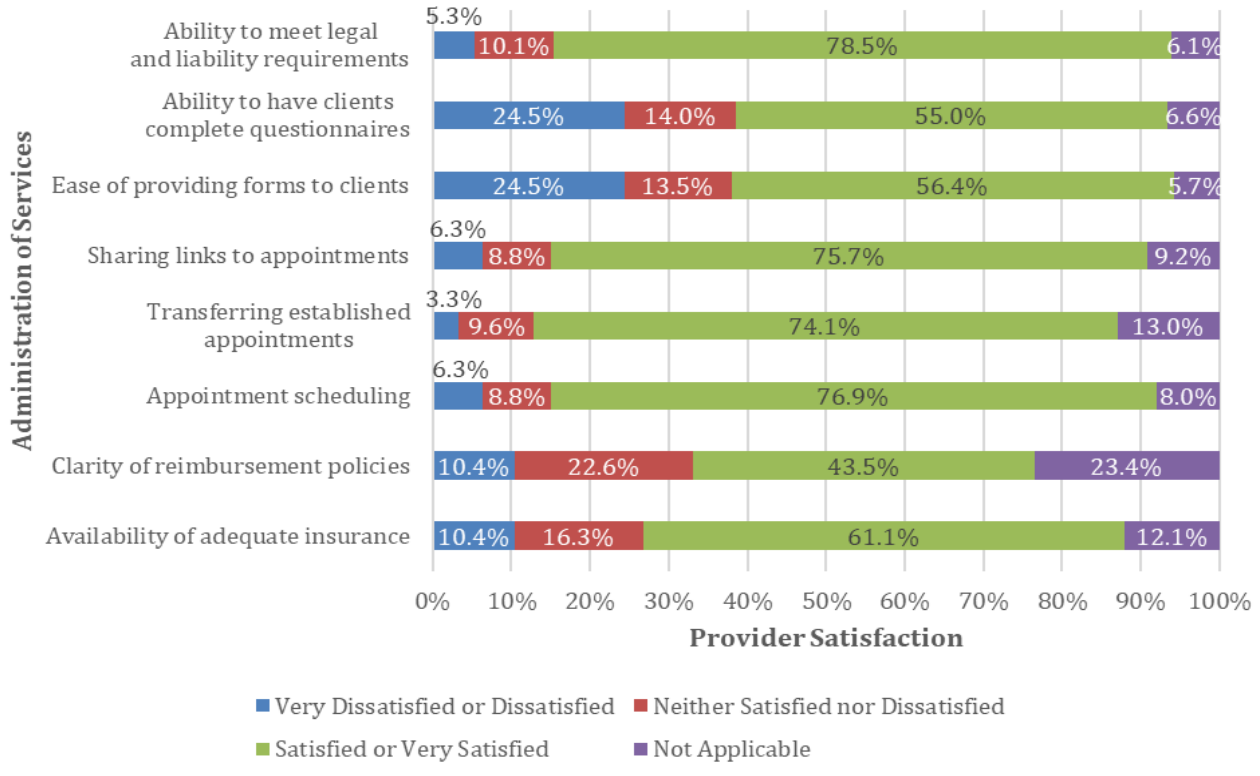
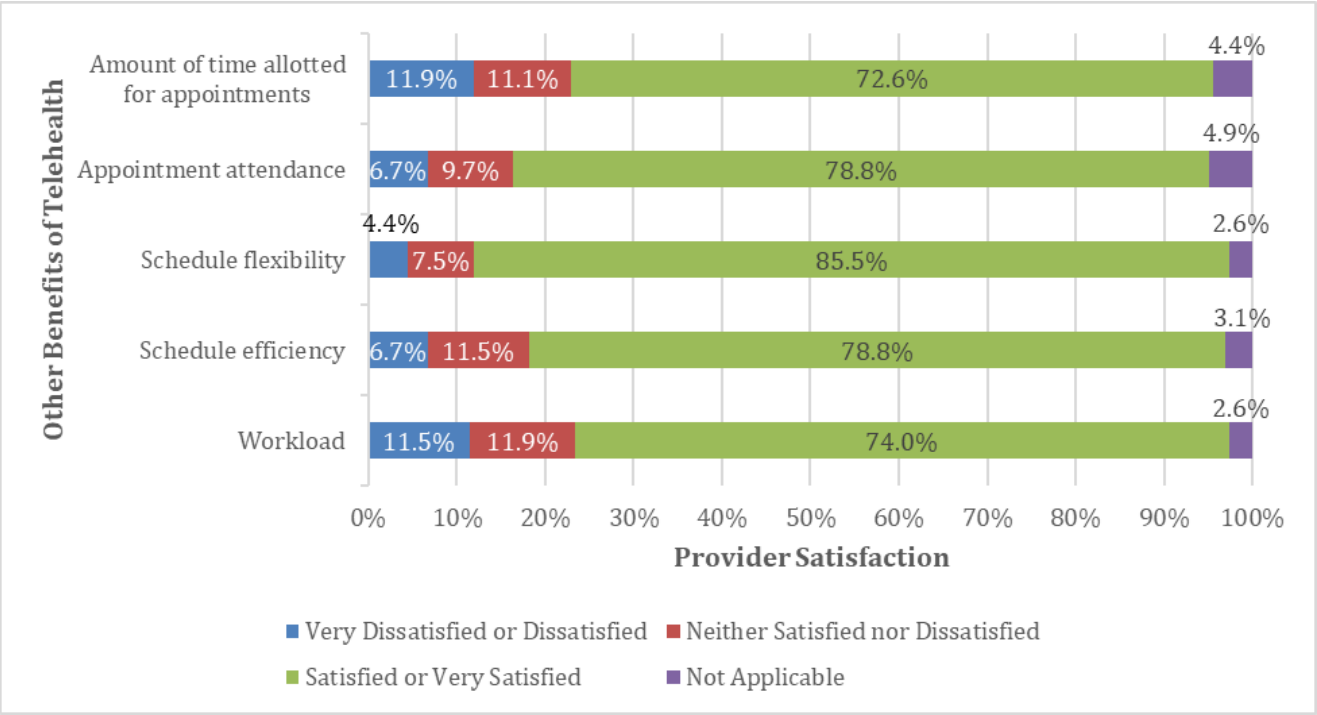


Figure 5



Thematic analysis of qualitative data provided in open-ended response questions identified insufficient technological equipment or connectivity on either the provider or client side, lack of private space for clients, increased burnout of clinicians due to a drop in no-show rates and increasing caseload numbers, difficulties with reimbursement through insurance, and uncertainty if reimbursement will continue past the pandemic as the biggest barriers for providers providing telebehavioral health. Other themes noted were the lack of connection to their organization's culture or colleagues and difficulties reading spontaneous body language or facial expressions via telebehavioral health. The most often cited facilitators of telebehavioral health for providers were the increased access and engagement of clients, reduced waitlists, less travel and commute time, increased flexibility in meeting client needs, and the enjoyment of working from home at least some of the time. Those working with children also noted increased opportunities to engage parents in treatment.

Client Findings

Similar to the administrative staff and provider groups, clients also described high satisfaction and positive experiences with telebehavioral health services, with over 82% (n=178) of this group reporting mostly positive or all positive experiences during the pandemic.

Figure 6 illustrates client satisfaction with services received through telebehavioral health; the majority of client respondents (n=164, 76.3%) reported feeling satisfied or very satisfied with the ability to maintain connections with existing providers and, where applicable, that they were able to establish a connection with a new provider (n=91, 42.3%).

Especially noteworthy was the finding that a majority of clients reported being either satisfied or very satisfied with the convenience of appointments (n=203, 94.4%), ability to attend appointments (n=198, 92.1%), and removal of transportation challenges (n=180, 83.7%). Figure 7 highlights additional benefits of telebehavioral health services and reported client satisfaction.

The most commonly reported barriers for telebehavioral health outcomes were insufficient technological equipment or connectivity, lack of a private space, difficulties with getting appointments due to increased demand for providers, and insurance reimbursement concerns or the cost related to receiving

Figure 6

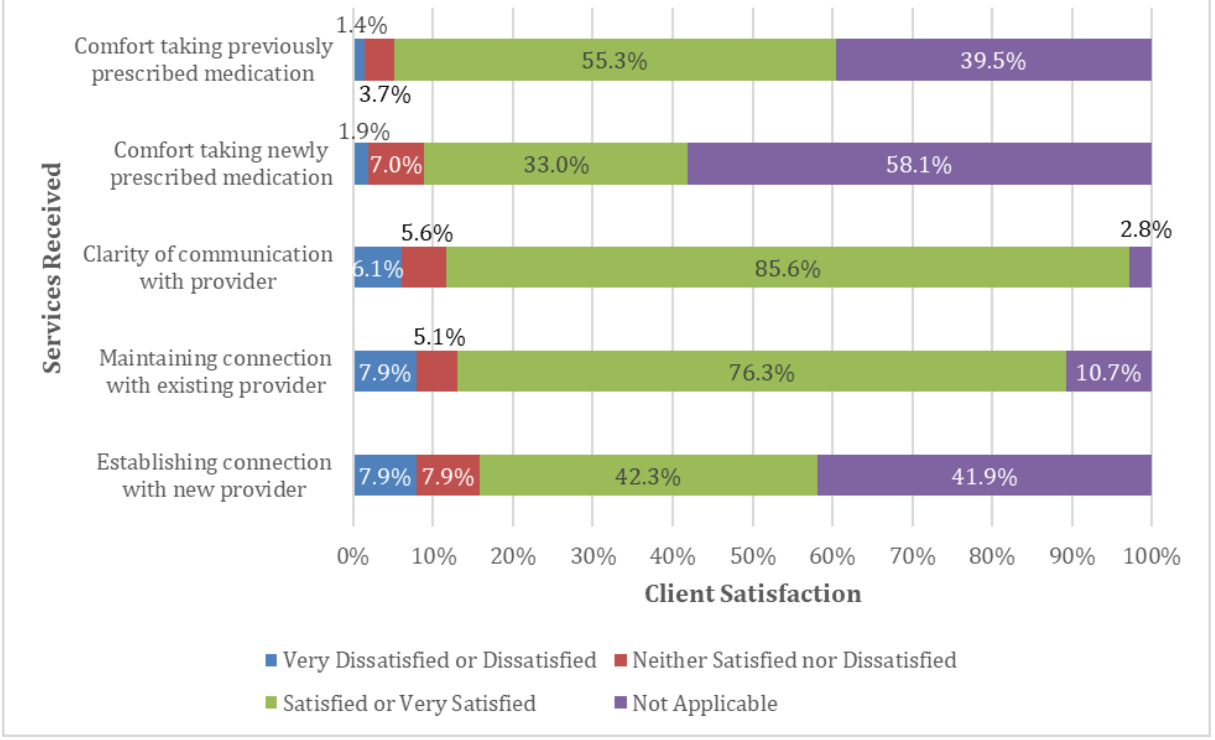
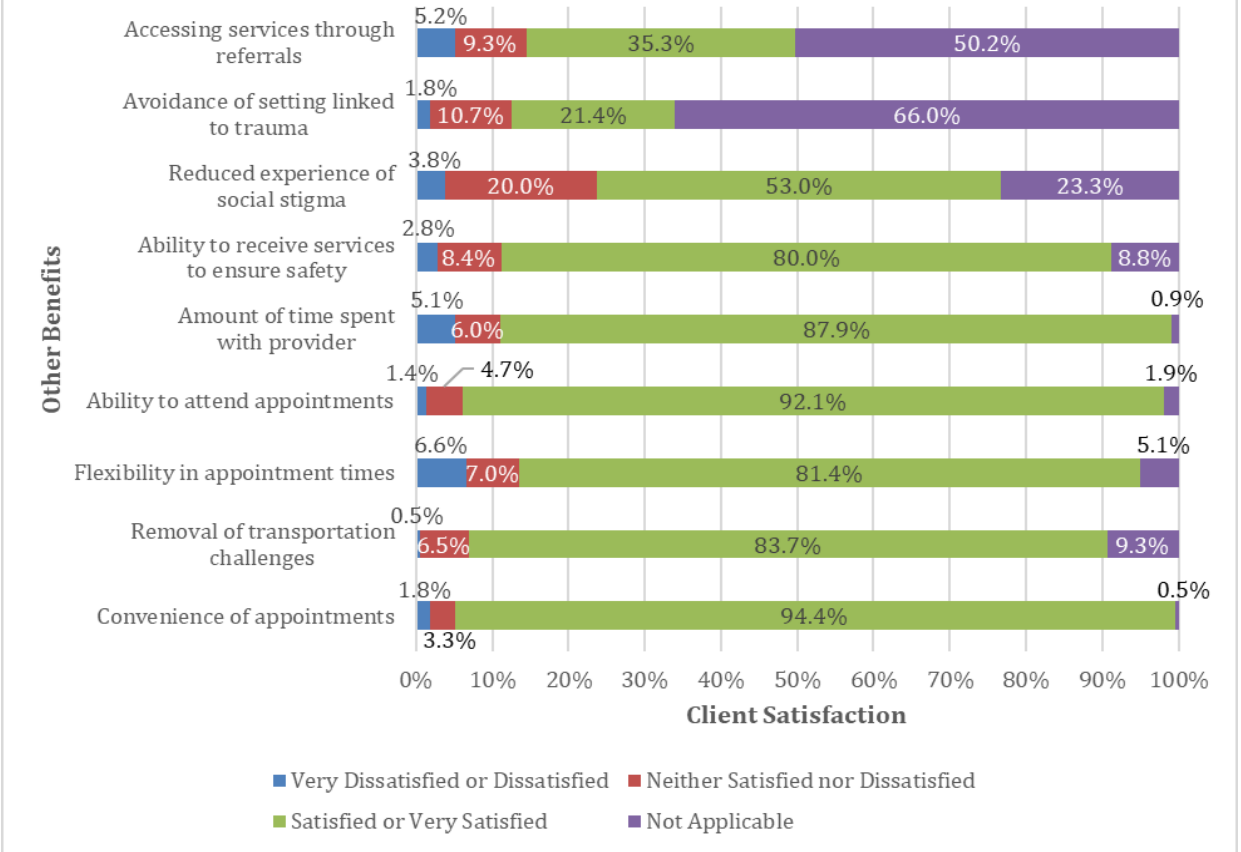


Figure 7



treatment if insurance would not reimburse, reimburse partially or reimburse fully for telehealth. The most often cited single facilitator by far for clients was the lack of travel and related time and expense costs, with other themes being convenience, increased accessibility (either due to symptom interference or external conflicting demands on time), being able to keep providers even if they or the provider move, and being more comfortable in their own homes.

Conclusions

Survey results contribute further to the wealth of existing literature detailing the dramatic shift to telebehavioral health services since the start of the COVID-19 pandemic. Given this disruption to the status quo of clinical service delivery, it is promising that existing literature and this survey show high overall satisfaction rates of experiences with telebehavioral health among clients, providers, and administrative staff. Providers and clients in this study both cited the flexibility and accessibility of using telebehavioral health services and appreciate the reduction in expenses and stress related to travel for appointments (for clients) and the work commute or travel to visits (for providers and administrative staff) as facilitators to satisfaction and outcomes, which is also largely supported by literature. Respondents noted these contributed to decreased no-show rates and increased participation with treatment programming as well as increased rates of completion for some curriculum-based programs (e.g., parenting classes).

The three groups also shared common barriers. Most often, respondents expressed concerns regarding the uncertainty of long-term telebehavioral health, whether through policy, the continuation of less restrictive practice guidelines (HIPAA, agreements between states, etc.), regulations remaining favorable for telebehavioral health practice, and/or if insurance would continue to reimburse or, for some, reimburse at parity with in-person services. Other common barriers shared between providers, clients, and administrative staff were the lack of consistent connectivity on either the provider or client side and lack of sufficient technological equipment. Creating greater access to internet connectivity and low-cost technological equipment would greatly contribute to the resolution of some major barriers and potentially further expand telebehavioral health capabilities and access to new and underserved populations.

Although there was shared overlap between groups, providers, clients, and administrative staff also cited unique barriers and facilitators relevant to their roles in the telebehavioral health delivery spectrum. Unique facilitators that clients reported positively affected outcomes for them that were not seen in other groups included convenience and the fact that they would not have to terminate services if they or their provider moved, which had been a barrier in the past. Administrative staff reported that they were satisfied with much of their unique job duties such as care coordination, referrals, transfers, and liaising with other providers. One barrier that was cited in some qualitative themes analysis was the concern that some treatment may not be as effective when provided via telebehavioral health, although when comparing the quantitative data for the group, overall this appears to be a small minority. A potential direction for future research could be to explore the discrepancy between the provider group and the administrative staff group as administrative staff are not often incorporated into research of this kind.

Finally, the provider group also reported unique barriers and facilitators. Facilitators included reduced waitlists and increased flexibility to meet client needs, while barriers noted included that it could be more difficult to read spontaneous body language or facial expressions via telebehavioral health. Some providers also cited a feeling of lack of connection to greater workplace culture or colleagues. It should be noted that a confounding aspect to this is that with the pandemic many people have been reporting an increase in feeling isolated and lonely in general, so this could be related to or also exacerbated by the general unique situations related to COVID-19 that the greater society is experiencing.

While much of the survey evidence does largely reflect the current literature regarding barriers and facilitators between groups and the fact that clients prefer telebehavioral health slightly more than providers, there were some discrepancies. Therapeutic alliance appeared to be not as much of a concern in this group

as in the established literature, with providers rating that they were satisfied or very satisfied with the assertion that telebehavioral health was as effective as in-person services in quality, which is in contrast to the concerns cited by Connolly and colleagues.[5] Safety concerns and inability to physically coordinate care did not arise as concerns the same way as noted in the literature. However, it is possible that safety concerns do exist but that this sample may not have had a big enough representation of providers who deliver telebehavioral health to individuals with SMI or those on psychiatric medications. Populations cited in qualitative analysis (children, SMI, SUD) of the survey data did reflect the findings of the Richards et al. study[10] from the literature review, which reported that telebehavioral health outcomes may be lower for these populations.

Of particular note is the interplay with some barriers between groups. This was evident in multiple barriers such as how the increase in stressors during the COVID-19 pandemic and other factors led to an increased demand for providers and more people seeking treatment. However, this, coupled with the drop of no-show rates, in part led to a greater burden on providers, ultimately leading to increasing caseloads and greater provider burnout. A related trend can also be seen regarding the acceptance of insurance where, due to the increased demand and uncertainty around insurance reimbursement regarding telebehavioral health, some providers are not taking insurance or are less likely to accept insurance, thereby further contributing to the scarcity of providers, leading to potentially greater costs and restricted access for some clients or greater complications around getting reimbursed for expenses related to these services. This, in turn, can lead to increased demand and greater burnout on providers accepting insurance.[11]

With the evidence from the current study and in the existing literature that telebehavioral health is well received, effective, and lowers barriers to receiving care, action needs to be taken to ensure adequate access to care continues to expand and exists for all those in need, with telebehavioral health a promising fixture of that overall strategy. Future policy action could explore regulatory guidance (especially around ongoing rules for utilization and establishing best practices for telebehavioral health) and create long-term assurances that telebehavioral health will continue to be endorsed and reimbursed fairly as an ongoing form of service delivery after the pandemic. This would then help provider organizations plan long term to expand their telehealth offerings if they chose to do so. Initiatives at federal, state, and/or local levels as well as potential public/private partnerships to expand technology and internet access could also further reduce barriers to accessing treatment for underrepresented and rural populations.

Alongside the needs related to increasing access, another related area requiring action is the decades-old workforce shortages that have now been exacerbated by the increased demand resulting from the pandemic. The decrease in no-show rates as well as increased demand of more and more persons seeking care, coupled with more clinicians and providers leaving the health care workforce, are all obstacles to ensuring adequate care exists for all. While this is a complex issue and raising wages across the field will most likely be a slow process (low wages are commonly cited as a reason workers do not explore or do not stay in the field), policy changes that helped create direct investment into the behavioral health workforce, loan repayment programs, partnerships, and efforts to expand diversity within the workforce could all have a large impact on addressing these shortages and ensuring that quality behavioral health care exist for everyone and that there is enough capacity to make this ideal a reality.

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