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HEALTH POLICY CENTER




TELEHEALTH LANDSCAPE ANALYSIS: TELEBEHAVIORAL HEALTH

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Georgia Health Policy Center

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INTRODUCTION

The COVID-19 pandemic changed the way people live and work across the United States. California issued the first statewide stay-at-home order on March 16, 2020, and many states soon followed California's lead.[1] States adopted stay-at-home orders, social distancing guidelines, and mask mandates to flatten the COVID-19 curve. While evidence suggests these policies slowed the spread of the virus, there were numerous downstream impacts on people and communities from their implementation and the resulting economic recession.[2]

The pandemic exacerbated the mental health crisis that already existed prior to its onset. In 2019, one in 10 Americans reported symptoms of anxiety or depression. In 2020, four in 10 Americans reported symptoms of anxiety or depression, with 56% of young adults reporting such symptoms. In addition, 13% of adults reported substance abuse because of stress from the pandemic.[3] In 2020, 91,799 people died from drug-involved overdoses, an increase of over 20,000 from 2019.[4] While the number of suicides in 2020 dropped by 3% from the 2019 figures, 11% of adults say that they have seriously considered committing suicide in the past 30 days.[4,5] Among those with "repeated past experiences of trauma," COVID-19 is a source of trauma associated with symptoms of post-traumatic stress disorder (PTSD).[6] COVID-19 isolation was also linked to an increase in domestic violence.[7] This mental health crisis has put behavioral health services in high demand.

As the American economy shifted to virtual platforms to cope with the pandemic, the health care industry followed suit. The industry made a significant pivot to providing services via telecommunications technologies, referred to as telehealth or telemedicine. Both the federal and state governments responded to the pandemic by issuing new policies and guidance to support the uptake of telehealth by providers and patients. These developments helped expand telehealth use in rural and other underserved areas; however, some inequities persist and have increased due to the pandemic. This report explores the issues surrounding behavioral health and telehealth before and during the COVID-19 pandemic and strategies for addressing behavioral health via telehealth with examples of initiatives and resources.

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[7] Nikos-Rose, K. (2021). COVID-19 Isolation Linked to Increased Domestic Violence, Researchers Suggest. UC Davis. https://www.ucdavis.edu/curiosity/news/covid-19-isolation-linked-increased-domestic-violence-researchers-suggest.

OVERVIEW OF BEHAVIORAL HEALTH LANDSCAPE

Rural and Urban Disparities

The COVID-19 pandemic created new and amplified existing health adversities in both rural and urban communities, widening the disparity in behavioral health outcomes between urban and rural populations over the past decade. Access to care has continued to worsen in rural areas, with 138 rural hospitals closing since 2010.[8] Rural communities see higher mortality rates from heart disease, cancer, unintentional injury, lower respiratory disease, and stroke than urban residents.[9] While the prevalence of mental illness is similar in urban and rural areas, behavioral health outcomes are worse in rural areas because of reduced access to behavioral health service providers. Over 60% of rural Americans live in areas designated as "mental health provider shortage areas."[10] Those behavioral health service providers who do work in rural areas are less likely to have specialized training, which furthers the disparity between urban and rural mental health. The mental health crisis and the prevalence of opioid and substance misuse have devastated rural communities, with three out of four farmers or farm workers reporting that their lives have been directly impacted by opioid abuse.[11]

It is also important to note that rural health disparities are exacerbated for racial and ethnic minorities living in rural areas, leading to further health inequities.[12] Rural Black populations tend to be older and have higher rates of underlying health conditions and are less likely to have a regular health care provider than white rural residents.[13] Rural Latino populations, which are comprised of people from many different countries, races, and other cultural traits that can significantly impact health, are less likely to receive adequate care because of a large diversity of health risks that rural hospitals are ill-equipped to handle.[14] Furthermore, mental health professionals from minority groups compose only 17% of America's psychologists.[15] The lack of diversity among mental health care providers combined with a low number of culturally competent providers further restricts minority populations' access to care.[16]

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Workforce

The COVID-19 pandemic put immense pressure on rural and urban behavioral health providers. With four out of 10 Americans now reporting they struggle with either anxiety or depression, demand for behavioral health treatment has skyrocketed. Rural communities are facing a workforce shortage in behavioral health. Over 60% percent of rural residents live in an area with a shortage of behavioral health providers. In total, only 9% of the nation's physicians practice in rural communities.[17] This disparity becomes worse when looking at specialty providers. An alarming 81% of rural areas do not have any psychiatric nurse practitioners, and 65% of rural areas do not have any psychiatrists to go to for treatment. Even for non-psychiatric needs, 47% of rural areas do not even have a psychologist. This problem is so severe that two out of three primary care physicians struggle with referring rural patients for behavioral health care.[15]

Several government programs have attempted to remedy this worker shortage. For example, some state governments have offered financial incentives for behavioral health providers in the form of student loan forgiveness for them to open their offices in rural areas.[18] However, after the providers cease receiving the benefits provided to them through the incentive program, 50% leave rural areas to open their offices elsewhere.[19] In addition, low reimbursement rates make providing mental health services not profitable for some Rural Health Clinics.[20] Understaffing at rural mental health practices among providers who do stay has led to increased workloads and longer shifts, which further restricts access to care for patients.[21] Moreover, most primary care physicians are not fully trained in behavioral health, particularly in how to recognize and assess for suicidality, something that is needed in rural areas where behavioral health providers are not readily available.[22] Nevertheless, the Mental Health First Aid program has provided some relief. The Mental Health First Aid program is an early intervention education program that teaches individuals how to assist those experiencing a behavioral health crisis. The program has been rolled out in rural areas across the United States.[23] Over 167,850 people in rural areas completed this program, and research shows that program participants gained improved knowledge of mental illnesses and appropriate treatment strategies.[24]

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[22] University of Michigan Behavioral Health Workforce Research Center. (2019). Behavioral Health Service Provision by Primary Care Physicians. Ann Arbor, MI: UMSPH. https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/12/Y4-P10-BH-Capacityof-PC-Phys_Full.pdf

[23] Rural Health Information Hub. (2021). Mental Health First Aid. Retrieved https://www.ruralhealthinfo.org/project-examples/725.

[24] Rural Health Information Hub. (2021). Mental Health First Aid. Retrieved from https://www.ruralhealthinfo.org/project-examples/725.

Increasing Disparities

As industries transitioned from in-person work to virtual work, some rural communities were left behind in the transition. 28% of rural households still do not have broadband internet.[25] Rural households are also less likely to own multiple internet devices, putting families with more than one child in a bind to ensure that their children can attend virtual classes.[26] The pandemic emphasized this digital divide and the need for infrastructure improvements. Infrastructure challenges prevent dependable high-speed internet from becoming a reality in some rural communities. Connecting all rural households to broadband internet could cost $150 billion depending on the materials used.[27] The roughness of the terrain and the remoteness of some of the rural regions contribute to this high price tag.[28] $92.6 billion has been allocated since 2020 to build this national broadband network through the Infrastructure Investment and Jobs Act, the Consolidated Appropriations Act of 2021, and the American Rescue Plan Act.[28, 29]

Poor infrastructure also inhibits transportation in rural communities. Approximately 40% of roads in rural areas are "inadequate for current travel," and 50% of bridges over 20 feet are "structurally deficient." Because of rural hospital closures and an absence of specialized care, rural residents need to travel farther to receive the care they need. Public transportation often does not reach rural areas, so residents often must take their own motor vehicles.[30] Smaller populations come with smaller tax pools, so funding for infrastructure is limited compared to urban areas. An estimated $211 billion is needed to repair and improve rural transportation systems.[31] The Infrastructure Investment and Jobs Act of 2021 will provide $110 billion for highway, bridge, and road repair.[32]

Rural residents are also more likely to be uninsured. In 2018, 9.1% of rural residents did not have health insurance. From 2011 to 2015, 19.9% of infants living in rural households did not have health insurance compared to 16.8% in urban households. Among uninsured rural residents, 43.4% did not have a "usual source of care." The high cost of healthcare serves as a disincentive for some uninsured residents to seek the care they need. Rural residents are also more likely to be underinsured and face higher deductibles, which those with lower incomes struggle to meet.[33]

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[25] Vogels, E. (2021). Some Digital Divides Persist Between Rural, Urban and Suburban America. Pew Research Center. https://www.pewresearch.org/fact-tank/2021/08/19/some-digital-divides-persist-between-rural-urban-and-suburban-america/.

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[30] Rural health Information Hub. (2019). Barriers to Transportation in Rural Areas. Retrieved https://www.ruralhealthinfo.org/toolkits/transportation/1/barriers.

[31] Farm Bureau. (2020). U.S. Rural Roads and Bridges

[32] Jalonick, M.C.. (2021). Roads, Transit, Internet: What's in the Infrastructure Bill. *Associated Press*. Retrieved from https://apnews.com/article/joe-biden-technology-business-broadband-internet-congress-d89d6bb1b39cd9c67ae9fc91f5eb4c0d

[33] Hawryluk, M. (2020). High-Deductible Plans Jeopardize Financial Health of Patients and Rural Hospitals. *Kaiser Family Foundation*. Retrieved https://khn.org/news/high-deductible-plans-jeopardize-financial-health-of-patients-and-rural-hospitals/.

Rural residents pay 29% of their health care costs out-of-pocket, 6% more than urban residents, yet tend to have lower incomes.[28, 34] These disparities make it even harder for rural residents to access behavioral health services.

Recent Trends

There have been several worrying trends tangentially related to COVID-19 that are widening the disparity between rural and urban populations. The isolation policies of the last two years have been linked to an increase in domestic violence.[35] Police departments across America have reported an increase in calls pertaining to domestic violence.[36] Women in small, rural areas are 7% more likely to be victims of domestic violence than urban women.[37] At a rural South Carolina hospital, the number of emergency department (ED) patients whose admission was related to domestic violence increased by approximately 0.6%.[38] This increase in domestic violence is concerning because approximately one out of three female homicides in the United States is linked to domestic violence, and survivors of domestic violence are "twice as likely to attempt to commit suicide multiple times."[39, 40] Misinformation and lower levels of trust in public health institutions have also been seen. In a 2021 survey, only 52% of Americans reported having a great deal of trust in the Centers for Disease Control and Prevention (CDC), and a mere 37% said they have a great deal of trust in the National Institutes of Health.[41] Eighty-six percent of rural residents trust their own doctor or health care provider, but only 66% say they trust CDC.[42]

Telehealth's Potential

In the face of an increasing disparity between rural and urban areas and the infrastructure obstacles present, telehealth services can alleviate some of the challenges faced by rural and urban residents. Telehealth has the potential to connect people to specialized behavioral health providers regardless of their geographic location. If a rural resident does not have a psychiatrist in their county, they can make a virtual appointment with one to get the treatment they need. If a rural resident is afraid of stigmas related to seeking behavioral health treatment, telehealth can provide a level of comfort by seeking and receiving care from the privacy of their own home. Of

[34] Georgetown Health Policy Institute. Rural and Urban Health. Retrieved https://hpi.georgetown.edu/rural/#:~:text=Median%20total%20health%20care%20expenditures,percent%20(see%20Figure%206).

[35] Nikos-Rose, K. (2021). COVID-19 Isolation Linked to Increased Domestic Violence, Researchers Suggest. UC Davis. https://www.ucdavis.edu/curiosity/news/covid-19-isolation-linked-increased-domestic-violence-researchers-suggest.

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[37] Injury Prevention Research Center. (2020) Rural Injuries and Violence at Home During COVID-19. https://iprc.public-health.uiowa.edu/2020/04/07/rural-injuries-violence-at-home-during-covid-19/.

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[41] Simmons-Duffin, S. (2021). Poll Finds Public Health has a Trust Problem. NPR. Retrieved from https://www.npr.org/2021/05/13/996331692/poll-finds-public-health-has-a-trust-problem.

[42] Brodie, M, Kirzinger, A, Munana, C. (2021). Vaccine Hesitancy in Rural America. Kaiser Family Foundation. Retrieved https://www.kff.org/coronavirus-covid-19/poll-finding/vaccine-hesitancy-in-rural-america/.

the rural residents who have received telehealth services, 14% say they would "not have sought care at all" if telehealth had not been made available to them. Moreover, 5% of telehealth appointments in 2021 were for the purpose of mental health or substance use treatment.[43] Encouraging the implementation of telehealth and ensuring rural areas have the appropriate infrastructure to provide adequate internet connection for virtual appointments will enable better access to care for those in need of behavioral health care.

[43] Panzirer, W. (2021). Survey Confirms Effectiveness of Telehealth in Rural America and Beyond. *Health Affairs*. https://www.healthaffairs.org/do/10.1377/forefront.20211019.985495/full/.

TELEBEHAVIORAL HEALTH

The Health Resources and Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration, and public health."[44] Telehealth modalities can be used to deliver behavioral health services to patients at remote locations. This type of telehealth is known as telebehavioral or telemental health and is defined as "any telehealth services delivered by behavioral health professionals, such as psychiatrists, psychologists, and social workers."[45] Telebehavioral health can be used to provide a variety of mental health services to patients, including psychotherapy, evaluations, interventions, and medication management. Its use has grown over the past two years of the COVID pandemic as isolation and fear of disease and death have caused an increase in depression and anxiety, resulting in a greater demand for behavioral health services that can be provided safely without fear of COVID-19 transmission.[46]

Current Policy Trends

Prior to COVID-19, Medicaid programs in 49 states covered at least one type of telehealth service for their members.[45] Since the COVID-19 emergency began at the beginning of 2020, Medicare, as well as Medicaid programs in all 50 states and the District of Columbia, provide coverage of some type of live video telehealth services.[47] These policy flexibilities have led to a dramatic increase in the use of telehealth since the beginning of the pandemic. For example, in late March 2020, telehealth use was 154% higher than a year prior. Although initial rapid increases in telehealth use have flattened somewhat, telehealth is still being used more often by more people than it was prior to the COVID-19 pandemic. As of July 2021, telehealth use had stabilized to a level of use 38 times greater than pre-pandemic levels.[48] The telehealth policy flexibilities introduced by Medicare and state Medicaid programs at the beginning of the pandemic, such as Medicare allowing telebehavioral use beyond rural areas, have also led to an increase in the use of telehealth to address mental and behavioral health concerns. In the first three months after the emergency declaration, 146,000 Medicare beneficiaries received telehealth services via a psychologist or psychiatrist, compared to 87,120 telebehavioral health visits for Medicare rural beneficiaries in all of 2014 (prior to the pandemic when Medicare only reimbursed for telehealth in rural areas).[49]

As outlined in a previous landscape analysis, Medicare, state Medicaid programs, and private insurance providers made several policy changes during the pandemic to make telehealth services

[44] Health Resources and Services Administration. (2021). What is Telehealth? https://www.hrsa.gov/rural-health/telehealth/what-is-telehealth
[45] Lazur, B., Sobolik, L., & King. V. (2021). Telebehavioral Health: An Effective Alternative to In-Person Care. Milbank Memorial Fund Issue Brief. Retrieved from https://www.milbank.org/publications/telebehavioral-health-an-effective-alternative-to-in-person-care/
[46] National Institute of Mental Health. (n.d.). What is Telemental Health? https://www.nimh.nih.gov/health/publications/what-is-telemental-health
[47] Center for Connected Health Policy. (2021). Policy Trend Maps. https://www.cchpca.org/policy-trends/
[48] Marley, R. (2021). 8 key trends driving the future of telehealth. Healthcare Transformers. https://healthcaretransformers.com/digital-health/future-of-telehealth/
[49] IMPAQ. (2020). Defining the Role of Telemental Health During & After the COVID-19 Pandemic. https://impaqint.com/media-center/blog/defining-role-telemental-health-during-after-covid-19-pandemic

more widely available to more people. Although most of these changes are only good for the duration of the public health emergency, the federal government and some states have already made some of these changes permanent. For example, the Centers for Medicare and Medicaid Services (CMS) has already finalized a new rule that would allow Medicare coverage of at home telebehavioral health visits to continue after the pandemic so long as the patient had an in-person exam at least six months prior to their first telehealth visit with a provider. The rule also requires at least one in-person visit each year that the patient is receiving telebehavioral health services.[50] In addition, the recently passed Consolidated Appropriations Act of 2022 provides that all Medicare telehealth flexibilities will continue for 151 days after the end of the public health emergency, allowing providers and patients more time to prepare for and adjust to Medicare's traditional telehealth restrictions.[51] Similarly, several state Medicaid programs have made permanent changes to their telehealth policies. For example, Arkansas Medicaid now allows telehealth to be used for a variety of mental health and substance use services, including individual and group therapy, crisis intervention, and substance use assessments. In addition, Arizona, Iowa, Massachusetts, and New Hampshire are already planning to require reimbursement parity for telehealth services once the pandemic ends.[52]

Barriers

Despite the uptake of telehealth because of the pandemic and despite the efforts made by CMS and several states to continue policy flexibilities after the pandemic, several barriers to telebehavioral health services remain and will need to be addressed. Although telehealth has dramatically increased access to behavioral health services, especially in rural areas, disparities in broadband availability and patient literacy persist and create barriers to accessing care (the September 2021 Telehealth Landscape Analysis provides more information about telehealth disparities).[52] Workforce shortages in behavioral health also reduce the availability of telebehavioral health services in all areas. In a 2017 report (more than two years prior to the COVID-19 pandemic), HRSA found that *even with no increase in the number of people needing mental health services*, the number of psychiatrists and addiction counselors would be insufficient to meet demand by 2030.[53] Given the increased number of people needing mental health services due to the COVID-19 pandemic, this shortage is already occurring in many areas. As of September 2021, there were 5,930 mental health care Health Professional Shortage Areas (HPSA) in the United States, representing nearly 130 million people. In these areas, only 28% of mental health care needs are being met. It is predicted that 6,559 additional providers are needed to meet those

[50] Centers for Medicare and Medicaid Services. (2021). CY 2022 Physician Fee Schedule Final Rule. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1751-f

[51] Consolidated Appropriations Act, 2022, H.R. 2471, 117th Congress. (2022). https://www.congress.gov/bill/117th-congress/house-bill/2471

[52] Ollove, M. (2021). Telehealth May Be Here to Stay. Stateline. Pew Charitable Trusts. https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/12/01/telehealth-may-be-here-to-stay

[53] HRSA Health Workforce. (2017). Behavioral Health Workforce Projections, 2017-2030. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf

needs.[54] Despite telehealth's ability to increase health care access in rural areas, without enough behavioral health care providers available to work at originating sites, telehealth alone cannot fully mitigate rural access issues.

Uses of Telebehavioral Health

Telebehavioral health interventions usually fall into one of four categories:

- **Hospital Care**—rural hospitals can use telehealth to connect patients to behavioral health specialists. For example, a psychiatrist could be connected with an emergency room patient to evaluate them for mental illness.
- **Integrated Primary Care**—patients can receive behavioral health services at their primary provider's office via a telehealth connection with a behavioral health professional located offsite. For example, a patient at a rural clinic could use telehealth to receive psychological counseling.
- **Mobile Health Applications**—these can be used to support long-term behavioral health interventions. For example, a substance use disorder (SUD) patient could use an application on their phone to track medication adherence.
- **Direct to Consumer Services**—these allow patients to connect with behavioral health providers in real time, often from their homes. For example, a patient could use a mobile phone app to access mental health counseling when needed.[55]

Any of these interventions can be used for the treatment of mental health issues and disorders, including SUD. Of the four main telehealth modalities—live video, store and forward, remote patient monitoring, and mobile health—live video is most used with telebehavioral health, especially for patient visits, group therapy, provider to provider consultations, and integrated care. An important use of telehealth for SUD is for medication-assisted treatment (MAT). MAT involves the use of medications, such as methadone or buprenorphine, to help patients recover from opioid dependence. MAT services provided via telehealth can include assessment, psychotherapy, prescribing, and medication management. For these services, a patient is usually located at an originating site and communicates with a MAT provider located at a distant site, connected via live video. The patient is often accompanied at the originating site by another health care professional. Both the patient and provider may have a telehealth coordinator assisting them. In addition, remote patient monitoring can be used to track adherence to medication and to prevent abuse.[56]

[54] Kaiser Family Foundation. (2021). Mental Health Care Health Professional Shortage Areas. State Health Facts. https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[55] RHIhub. (2022). Telehealth Models for Increasing Access to Behavioral and Mental Health Treatment. Rural Telehealth Toolkit. https://www.ruralhealthinfo.org/toolkits/telehealth/2/specific-populations/behavioral-health

[56] U.S. Department of Health and Human Services. (2017). Using Telehealth to Identify and Manage Mental Health and Substance Use Disorder Conditions in Rural Areas. https://aspe.hhs.gov/sites/default/files/private/pdf/260286/RuralTele.pdf

Integrated Health Systems

Integrated health systems can also create and use their own telehealth networks to connect providers and patients in multiple communities. Patients can access health services at their local clinic and, if behavioral health services are needed, be connected via live video with a behavioral health provider located at another clinic within the telehealth network. Similar services can be provided to the emergency room and hospital patients via live video. Providers within the network can also communicate with one another via telehealth and use the network to educate patients and staff. Telebehavioral health can also be used to deliver outpatient services, such as group therapy. Sessions can be scheduled at multiple clinical sites where patients are connected with a provider located at a distant site within the network. A therapy aide can be located at each originating site to assist patients if needed.[57]

Crisis Response

Telehealth can also be used for crisis response. In rural areas where there is a shortage of behavioral health providers and disproportionately high suicide and attempted suicide rates, telebehavioral health has been shown effective at reducing suicide, even before the COVID-19 pandemic. For example, a patient experiencing suicidal ideation can access a behavioral health provider remotely through video or audio modalities, which can help calm the patient while the provider arranges appropriate emergency care. However, studies of telebehavioral health's effectiveness in suicide prevention are limited, though promising. In a systematic review of the use of telehealth versus in-person delivery of suicide interventions, 21 studies were identified, and all of them found telehealth to be effective at assessing suicide risk, managing suicidal ideation, and preventing suicide. There were no suicides found in the studies reviewed.[57] Despite the lack of studies regarding suicide, numerous other studies have demonstrated that telebehavioral health is just as effective in the treatment of various mental health problems, including PTSD, depression, and anger, as in-person behavioral health care.[58, 59]

Telebehavioral Health During the Pandemic

Successes

The use of telebehavioral health has risen dramatically during the COVID-19 pandemic and has become an important component of crisis response plans. During the pandemic, the demand for behavioral health care has increased dramatically, especially for those suffering from depression, anxiety, and substance use. For example, according to Pierce and colleagues, the use of telepsychology has risen substantially during the pandemic: prior to COVID-19, about 7% of psychologists reported using telehealth with their patients, as compared to 85% of psychologists during the pandemic. Furthermore, roughly 67% of psychologists report using telehealth

[57] Rojas, S.M., Carter, S.P., McGinn, M.M., & Reger, M.A. (2020). A Review of Telemental Health as a Modality to Deliver Suicide-Specific Interventions for Rural Populations. *Telemedicine and e-Health,* 26(6): 700-709.

[58] Hilty, D.M., Ferrer, D.C., Parish, M.B., Johnston, B., Callahan, E.J., & Yellowlees, P.M. (2013). The effectiveness of telemental health: A 2013 review. *Telemed J E Health*, 19:444–454.

[59] Hubley, S., Lynch, S.B., Schneck, C., Thomas, M., Shore, J. (2016). Review of key telepsychiatry outcomes. *World J Psychiatry*, 6:269–282.

exclusively during the pandemic.[60] In a qualitative study of behavioral health providers, Schoebel and colleagues found that providers were generally pleased with the experience of using telebehavioral health with their clients during the COVID pandemic. Specifically, providers felt that telebehavioral health increased patient access to service while maintaining quality of care. In addition, providers reported no privacy concerns. Nevertheless, access to care was still a challenge for older patients, low-income patients, and patients without access to necessary technology.[61]

Studies regarding clinical outcomes and patient satisfaction with telebehavioral health during the COVID-19 pandemic in the United States are scarce. However, a systematic review by Appleton and colleagues (with most studies reviewed happening in the United States) found general satisfaction from both providers and patients of telebehavioral health services during the pandemic. Some mental health patients even preferred telehealth to in-person encounters. The authors also found that, in most cases, telebehavioral health services were just as effective as those delivered in person.[62]

Limitations

Despite these successes, Appleton and colleagues also identified several limitations to telebehavioral health services. Providers felt that sometimes video interactions limited their ability to pick up on non-verbal cues, such as body language, and therefore required more concentration; telehealth also limited providers' ability to assess physical indicators of mental health status. Another limitation was that staff needed to be quickly trained on telehealth modalities as many of them had no experience with it prior to the COVID-19 pandemic. Patients reported several limitations as well, such as the unreliability of internet connections, lack of experience with technology, and concerns about privacy.[62] Similar limitations were found by Chaudhry and colleagues in their study of the Early Psychosis Intervention Clinic in New Orleans, LA (EPIC-NOLA) and its rapid expansion of offerings of telebehavioral health services during the pandemic. The clinic found that the initial transition to telebehavioral health was easier than the maintenance of what had become an online clinic. As a result, EPIC-NOLA had to create new policies and procedures for virtual care. Clinic staff also had difficulty obtaining signed consent forms from patients for telehealth services. Obtaining paperwork for new patients also created challenges. Most of these problems were caused by patients not having access to a printer or understanding how to electronically sign documents. EPIC-NOLA is considering requiring new patients to have an initial in-person appointment to complete paperwork. Clinic staff also reported difficulties contacting patients, receiving timely payment of co-pays, and scheduling follow-up appointments, all issues that were not a problem when patients were primarily seen in the clinic in person.[63]

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[60] Pierce, B. S., Perrin, P. B., Tyler, C. M., McKee, G. B., & Watson, J. D. (2021). The COVID-19 telepsychology revolution: A national study of pandemic-based changes in U.S. mental health care delivery. *American Psychologist, 76*(1), 14-25.

[61] Schoebel, V., Wayment, C., Gaiser. M., Page C., Buche, J., & Beck, A. J. (2021). Telebehavioral Health During the COVID-19 Pandemic: A Qualitative Analysis of Provider Experiences and Perspectives. *Telemedicine and e-Health*, 27(8): 947-954.

[62] Appleton R, Williams J, Vera San Juan N, Needle J, Schlief M, Jordan H, Sheridan Rains L, Goulding L, Badhan M, Roxburgh E, Barnett P, Spyridonidis S, Tomaskova M, Mo J, Harju-Seppänen J, Haime Z, Casetta C, Papamichail A, Lloyd-Evans B, Simpson A, Sevdalis N, Gaughran F, & Johnson S. (2021). Implementation, Adoption, and Perceptions of Telemental Health During the COVID-19 Pandemic: Systematic Review. *J Med Internet Res*, 23(12):e31746.

[63] Chaudhry, S., Weiss, A., Dillon, G., O'Shea, A., & Hansel, T. (2021). Psychosis, Telehealth, and COVID-19: Successes and Lessons Learned From the First Wave of the Pandemic. *Disaster Medicine and Public Health Preparedness,* 1-4. doi:10.1017/dmp.2021.42

The Future of Telebehavioral Health

Although the rapid uptake of telebehavioral health during the COVID pandemic has increased access for many patients in rural and other underserved areas, it is not a panacea. As mentioned previously, telehealth services are not appropriate for all behavioral health patients. Although most providers support telehealth for patients with depression, anxiety, and PTSD, there is disagreement on its usefulness with more severe behavioral health issues, such as psychotic disorders and SUD, where in-person interaction between patient and provider is necessary to obtain a complete picture of a patient's condition. In addition, certain population groups are less suitable for telebehavioral health, such as the elderly, who may not be as comfortable with technology or those without the necessary equipment or access to high-speed broadband connections.[64]

Emerging evidence is also showing that the availability of behavioral health services during the pandemic, even those provided via telehealth, has not kept up with the demand for behavioral health care. In 2019, prior to the COVID pandemic, the reported need for services was only 4.4%, but in November 2020, almost a year into the pandemic, the need for services was 11.2%. As mentioned previously, shortages of behavioral health providers already existed prior to the pandemic and have only been exacerbated by it. This fact, combined with the scarcity of evidence as to the effectiveness of telebehavioral health, indicates that more research is needed on behavioral health outcomes from telehealth services provided during the pandemic, what services worked best for whom, and where provider shortages are most acute.[65] Although there will most likely be a sustained increase in the use of telebehavioral health services post-pandemic as compared to pre-pandemic, it is not yet clear how great that increase will be.

It is also important to note that without additional action or guidance from the state or federal governments, upon termination of the public health emergency declaration (or 151 days thereafter in the case of Medicare), the telehealth policy changes that have facilitated the expansion of the availability and use of telebehavioral health services will revert to those in effect prior to the COVID-19 pandemic. Fortunately, some of these have already been made permanent. For example, CMS now allows Medicare coverage for the telehealth diagnosis, treatment, and evaluation of mental health disorders regardless of geographic location.[66] In addition, the telehealth flexibilities that state Medicaid programs received through 1135 emergency waivers will end with the COVID-19 emergency. However, many of these changes can be made permanent through Medicaid state plan amendments (allow states to make changes to their Medicaid programs within the parameters of federal law), 1115 demonstration waivers (allow states to

[64] Zagorski, N. (2021, June 15). Telemental Health Use Remains Robust, But What Does Future Hold? *Psychiatric News*. https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.7.15

[65] Institute for Health Policy and Leadership. (2020). The Good, the Bad and the Future of Telemental Health. Loma Linda University Health blog post. https://ihpl.llu.edu/blog/good-bad-and-future-telemental-health

[66] Health Resources and Services Administration. (2021). Consolidated Appropriations and American Rescue Plan Acts of 2021 telehealth updates. https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/consolidated-appropriations-and-american-rescue-plan-acts-2021/.

make changes to their Medicaid programs that would not normally be allowed under federal law), and changes to state laws. State Plan amendments can be used to expand the types of services that state programs cover via telehealth to the extent that they are already an option under current federal Medicaid regulations. Other changes, such as covering out-of-state providers, may require an 1115 waiver because they would normally not be allowed under current Medicaid law and regulations. Finally, because every state Medicaid program is different and every state's telehealth laws are different, permanent changes to a state's Medicaid program may require changes to state law. CMS has already put together guidance for states for transitioning back to pre-COVID Medicaid policy, which can be found here. Note that this guidance is for Medicaid policy in general and not limited to telehealth.

TELEBEHAVIORAL HEALTH GRANTEE SPOTLIGHTS

Cornerstone Whole Healthcare Organization, Inc.

The Cornerstone Whole Healthcare Organization of Idaho has begun an initiative known as the Greater Rural Idaho Telehealth Team Expansion (GRITTE) Project. The GRITTE Project expands the use of behavioral health services delivered through telehealth in rural Idaho communities. The project seeks to link integrated and specialty behavioral health providers to primary care patients through the Telehealth Idaho Independent Provider Integration Network (TIIPIN). This network assists rural communities in reducing barriers to integrated and specialty behavioral health care such as geographic isolation, low provider density, and long wait times. Participating clinics receive telehealth equipment and supplies to facilitate secure and Health Insurance Portability and Accountability Act–compliant telehealth services for any on-site encounters, as well as extensive technical assistance related to encounter management, workflows, billing, and data support. In addition, clinic sites can reduce total wait times for patients referred for outpatient behavioral health treatment. All participating TIIPIN providers are managed via a robust care compact to ensure timely and appropriate communication with primary care providers and to promote collaborative care.[67] More information about Cornerstone Whole Healthcare can be found here.

University of Kansas Medical Center

The Telehealth ROCKS Communities (THRC) project is an extension of ongoing outreach and telehealth by the University of Kansas Medical Center (KUMC) with partners in southeast Kansas who focus on unmet behavioral health needs in the pediatric populations in Kansas' most underserved region, with long-standing pediatric developmental and behavioral health needs exacerbated by the pandemic. To meet these needs, THRC empowers patient and family-directed care, including direct-to-consumer (DTC) tele–behavioral health and community health workers, across multitiered evidence-based services. All three distant-site partners—KUMC, Community Health Center of Southeast Kansas, and Coffeyville USD 445—provide direct therapeutic and specialty behavioral health services through DTC telehealth to students in three school districts—Chanute, Pittsburg, and Coffeyville—along with two stand-alone integrated early learning centers, the Hamm Early Learning Center in Coffeyville, and the Family Resource Center in Pittsburg. Through community health worker care coordination before, during, and after telehealth encounters, the parent or guardian drives DTC encounters at the location that best fits their needs and trust.[67] More information about the University of Kansas Medical Center can be found here.

East Carolina University Brody School of Medicine

The East Carolina University Brody School of Medicine is partnering with North Carolina Statewide Tele-Psychiatry (NC-STeP) to expand its statewide psychiatry network that originally consisted of

[67] HRSA Office for the Advancement of Telehealth. (2022). Grantee Directory 2021.

58 EDs and eight community clinic sites. The present project further expands the NC-STeP program by bringing telehealth-enabled behavioral health counseling and care management (i.e., wrap-around services) directly into rural EDs in underserved regions of North Carolina, creating a unique opportunity to improve access to care and care coordination for an underserved and impoverished population. The primary goal is to identify patients at risk for coming to or returning to the emergency room and to implement specific telehealth-enabled counseling and care management strategies to improve outcomes and limit expensive ED admissions. The project is also pilot testing the use of wireless technology in a mobile van or other pre-hospital settings to reach acutely ill/crisis behavioral patients and deliver behavioral counseling even prior to traditional ED evaluation. The project is being implemented in five hospital sites, affiliated clinic sites, and in a mobile van program run by a partnering Federally Qualified Health Center, all located in rural HPSA designated counties in North Carolina.[67] More information about the Brody School of Medicine can be found here.

Intermountain Healthcare, Inc.

Intermountain Healthcare of Utah is partnering with the Healthy Granite County Network (HGCN), an existing community coalition and behavioral health network, to create Healthy Southwest Montana. This project seeks to enhance HGCN by delivering 24-hour ED crises and consultation services via telehealth to rural providers without emergency care specialists and expand the network membership to include two additional counties, Powell and Ravalli. HGCN includes critical access hospitals, community health centers, primary care and behavioral health care providers, local school districts, and first responder agencies. This project focuses on telebehavioral or tele-crisis as a form of tele-emergency services. All three hospitals in the network are critical access hospitals serving very rural, high needs, and underserved areas. Intermountain provides 24-hour ED consultation services, training, and support to network members. Intermountain also serves as the tele-emergency hub, providing access to telebehavioral health care, including psychiatric care, to EDs and first responders when the ED does not have capacity for a person in crisis. Healthy Southwest Montana plans to expand services beyond the three original project counties into additional surrounding counties in rural western Montana.[67] More information on Intermountain Healthcare can be found here.

TELEBEHAVIORAL HEALTH RESOURCES

Telebehavioral Health Codes and Services - https://telehealthresourcecenter.org/resources/fact-sheets/telebehavioral-health-codes-and-services/

SAMHSA Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders - https://store.samhsa.gov/product/telehealth-for-treatment-serious-mental-illness-substance-use-disorders/PEP21-06-02-001

HHS Best practice guide Telehealth for behavioral health care - https://telehealth.hhs.gov/providers/telehealth-for-behavioral-health/

IHS Telebehavioral Health Center of Excellence Toolkit - https://www.ihs.gov/sites/telebehavioral/themes/responsive2017/display_objects/documents/TBHCEtoolkit2019.pdf

APA Guidance on psychological tele-assessment during the COVID-19 crisis - https://www.apaservices.org/practice/reimbursement/health-codes/testing/tele-assessment-covid-19

APA Telepsychiatry Toolkit - https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit

Telehealth Clinical and Technical Considerations for Mental Health Providers - https://cars-rp.org/_MHTTC/docs/Telehealth%20Clinical%20Considerations.pdf

RHI Hub Telehealth Models for Increasing Access to Behavioral and Mental Health Treatment - https://www.ruralhealthinfo.org/toolkits/telehealth/2/specific-populations/behavioral-health

Behavioral Telehealth Session Checklist - https://mhttcnetwork.org/sites/default/files/2020-03/PAR_checklist.pdf

Telehealth Instructions for Behavioral Health Patients - https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/behavioral-health-partners/documents/bhp-telehealth-instructions.pdf

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Andrew Young School of Policy Studies
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