

Use of a Research as Intervention Approach to Explore Telebehavioral Health Services During the COVID-19 Pandemic in Southeastern Idaho

Journal of Primary Care & Community Health

Volume 13: 1–11

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DOI: 10.1177/21501319211072998

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Abstract

Introduction: Since the inception of the COVID-19 pandemic, telebehavioral health services have been a key contributor to continuation of care in rural and underserved areas of southeastern Idaho. Providers of telebehavioral health services faced numerous challenges as they navigated rapidly shifting regulations, variable access to internet and their own personal understandings of practice. **Objective:** This study aimed to characterize provider experiences, generate policy- and practice-level recommendations, and raise awareness among community stakeholders regarding telebehavioral health in southeastern Idaho. **Methods:** Using a newly developed conceptual/analytical framework, a research-as-intervention strategy was employed to conduct and analyze semi-structured interviews, short writings, and photographs from 7 primary care and behavioral health providers in the region. **Results:** Providers shared examples from practice that addressed technology and training, access-to-care, safety, changing provider roles, payment for services, treatments that are not well suited to telehealth and the nuances of living and working in newly forged spaces of care. **Conclusions:** Providers found promise in telebehavioral health's utility as a hybrid model of care, but it must be supported by flexible legislation and policy. For example, it would help to make reimbursement expansions permanent and to simplify inter-jurisdictional practice options. Cross-sharing of information between licensing boards could help providers from various disciplines understand the parameters within which their colleagues must work.

Keywords

access to care, behavioral health, primary care, qualitative methods, rural health

Dates received: 28 October 2021; revised: 15 December 2021; accepted: 18 December 2021.

Introduction and Objectives

Behavioral health issues (ie, mental health disorders, substance abuse, and suicide) are a significant concern in southeastern Idaho. The 12-month prevalence rate of any mental illness is over 20% in this region,¹ and Idaho's overall suicide rate is often higher than the U.S. national average.² Bannock County, one of the area's most populous counties, reported 8 suicides within a 30-day period in 2018.³ Rates of substance use are substantial as well, particularly among adolescents and young adults of racial and ethnic minority groups, who reported a higher rate of illegal substance use than their white peers.⁴ Further, the drug overdose mortality rate in Idaho has steadily risen over the last decade.⁵

In spite of the substantial need for behavioral health services, southeastern Idaho's large rural population and lack of behavioral health providers creates barriers to accessing adequate care.⁶ Approximately 96% of the state's total land area is a designated mental health, primary care, or dental health provider shortage area.⁷

During the ongoing COVID-19 pandemic, access to care has been further hampered by new, COVID-19-related

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social factors (eg, stay-at-home orders, social distancing, job insecurity, and masks), which are becoming determinants of health outcomes.⁸⁻¹⁰ These new challenges can make it worse for individuals who were already at risk of going untreated before the pandemic (eg, medically vulnerable or marginalized groups).¹¹

COVID-19 and Telebehavioral Health in Southeastern Idaho

Using technology to deliver behavioral healthcare to patients remotely (ie, telebehavioral health)¹² is one way to potentially address access-to-care challenges in southeastern Idaho. Telebehavioral health refers to the transmission of behavioral healthcare via telephone, video conference, email, or other means of telecommunication to patients who are distant from providers.¹³ While telebehavioral health is new to many healthcare professionals, telebehavioral health, and telehealth networks have existed in a limited fashion since the 1950s.¹⁴ Unprecedented demands for this modality during the COVID-19 pandemic have sparked renewed interest from providers and policy makers.¹⁵ This shift is significant in southeastern Idaho because of its potential to address traditional inequities in access to care in this region.¹⁶

A number of factors have facilitated the present, COVID-era expansion of telebehavioral health utilization in southeastern Idaho, including temporary waivers at the federal level that allow for higher Medicaid reimbursement for audio-only services and for services accessed by patients in their homes.¹⁷ In addition, relevant training has been made freely available by organizations, like the American Psychological Association.¹⁸ Increased attention has also been given to evidence demonstrating the effectiveness and acceptability of telebehavioral health.^{19,20} Taken together, these factors have enhanced providers' abilities to provide evidence-based, telebehavioral health interventions to populations facing substantial access barriers.

In spite of these positive advancements, healthcare providers have faced challenges in implementing telebehavioral health. Many providers worry about negative impacts on patient relationships, efficacy within certain populations,²¹ maintaining protected health information, managing patients in crisis over distance,²² and a general lack of telebehavioral knowledge and training.^{21,23}

While topics like barriers to care and policies that aid in implementing telebehavioral health are well studied, little has been explored on the subject in southeastern Idaho. Further, even less is known about providers' experiences during the rapid shift to telebehavioral health since the onset of the COVID-19 pandemic. Telebehavioral healthcare in this region is in obvious transition. The actions and goals needed to navigate this transition are largely unknown.

As such, a greater understanding of providers' experiences using telebehavioral health in southeastern Idaho during COVID-19 is needed to inform policy and practice recommendations that may impact long-standing barriers faced by disenfranchised populations in this region.

The purpose of this study was to describe experiences of behavioral health and primary care providers as they transitioned to telebehavioral health in southeastern Idaho during the COVID-19 pandemic by: (1) characterizing southeastern Idaho healthcare providers' experiences with telebehavioral health, (2) generating policy- and practice-level recommendations regarding telebehavioral health in this region that will address inequities in access to care, and (3) raising awareness of issues relevant to telebehavioral health among community stakeholders who influence the implementation of this treatment modality in southeastern Idaho.

Method

Procedure

This research was approved by an Institutional Review Board on November 16, 2020. It employed Haalboom et al's²⁴ Research as Intervention (RAI) strategy, which was pioneered in response to the very welcome, but time-consuming and capacity-restricted process of Participatory Action Research. The authors successfully used the strategy to support capacity building and adoption of good practices in five Canadian heart health projects. Much like Participatory Action Research (PAR), RAI holds that the research process, not just its outcomes, should enhance participants' and stakeholders' knowledge and practice through cooperative planning, data collection, and feedback opportunities. RAI uses data collection processes as opportunities to intervene and develop knowledge among stakeholders. Stakeholders should be integrated into decision-making about research design and questions, and they should be given the opportunity to provide feedback about results of data analysis.

In keeping with this approach, a steering committee of 8 stakeholders and 2 researchers guided project activities and development of research questions and data collection processes. They also maintained oversight of final recommendations to policy- and decision-makers. The committee included specialists in suicide prevention, public health, clinical psychology, medical anthropology, primary care and hospital administration, plus 2 health professions students (nursing and clinical psychology). Convening such a group was done with the underlying assumption that its members, who are leaders in the area of interest, could, in real-time, take what they learned from each other in the project back to their respective work environments.

The committee met throughout the project to develop research methods that would help provide insight into behavioral health providers' experiences with telehealth,

and also to raise awareness of telebehavioral health issues among research participants. Further, the committee developed a conceptual/analytical framework along with a methodology that included semi-structured interviews and a “words or pictures” activity.

Seven, semi-structured interviews were conducted between January and early March of 2021. They lasted 30 to 45 min. Informed consents were emailed beforehand and recorded on Zoom. The interviews were then followed by a 15- to 20-min explanation of the “words or pictures” activity. The “words or pictures” activity took place in the clinicians’ workspaces. Using concepts borrowed from photovoice,²⁵ researchers worked with providers as they created visual or written diaries of their experiences and feelings about providing telebehavioral health services during the pandemic over the course of a week. The images provided visual data and insights about day-to-day experiences not otherwise obtainable through interviews. A flyer explaining the “words or pictures” process was given to each participant (Supplemental Appendix A).

All committee meetings and data collection activities were conducted via Zoom, and data files were kept on Box (a HIPAA-compatible cloud storage system). The first and second authors analyzed data from the interviews using a combination of conventional and directed content analysis.²⁶ First, they used conventional content analysis to independently, and inductively, code all interviews using HyperResearch, a qualitative data analysis software tool. They then compared, combined, and adapted the codes to consensus. Afterward, they used directed content analysis to organize the codes into themes and categorized them under the 4 main elements of the conceptual/analytical framework. Images and text from the “words or pictures” activities were then analyzed.

Trustworthiness

This study adhered to tenets of trustworthiness as set forth by Glesne,²⁷ who expands on Lincoln and Guba’s²⁸ work, as well as others. Two forms of data collection (ie, interviews and “words or pictures” activities) were used to triangulate findings. Member checking was conducted with stakeholder committee members and participants. Both were asked for feedback regarding research questions, final reports, selection of photographs, and recommendations to policy- and decision-makers. An audit trail was developed through recording all meetings via Zoom, writing meeting summary notes, and re-stating project goals and objectives to the stakeholder committee through PowerPoint presentations at regular meetings. Researchers de-briefed after every stakeholder meeting and after interviews to combine notes, share perspectives, and reflect upon inconsistencies or propensities to lead participants. These strategies helped instill confidence in, as well as dependability of, the research process and its findings. They further provided opportunity for

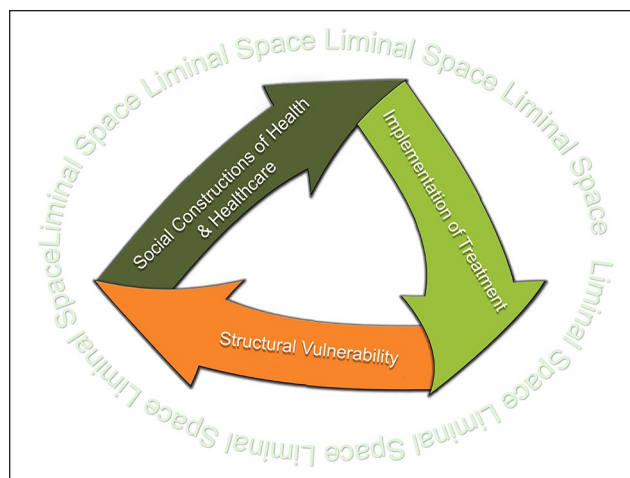


Figure 1. Conceptual/analytical framework.

committee members and participants to check researcher bias.

Conceptual/Analytical Framework

The conceptual/analytical framework (Figure 1) prompts consideration of the unprecedented challenges faced by behavioral health providers during COVID-19 by exploring 4 interrelated elements that are shaping the state of telebehavioral healthcare in real-time: (1) structural vulnerabilities, (2) the social construction of health and healthcare, and (3) implementation of treatment are ongoing dynamics set in the newly developing context of uncertainty and (4) liminality that COVID-19 is creating.

Structural vulnerability. Structural vulnerability is what happens when the systems and institutions are set up so that minorities and vulnerable populations (eg, people in poverty, people experiencing mental illness, single mothers) are less likely to benefit from them. The term calls attention to the various means by which different groups of people fall through social safety nets.²⁹ In southeastern Idaho, geographic barriers create another form of vulnerability that is of exceptional importance, since rural communities have less access to behavioral health services.³⁰⁻³² Latino populations working on area farms and members of other racial and ethnic minority groups are also at special risk of vulnerability due to structural racism and hazardous working conditions.³³

Recognition of structural vulnerabilities can help behavioral health providers, their institutions, and the broader systems within which they operate more aware of policies and practices that stand to worsen them.

Social construction of health and healthcare. This research was conducted with the understanding that health and

healthcare, in this case behavioral health-related illnesses and care through telehealth, are socially and culturally constructed. That is, the social and cultural dynamics that take place as part of behavioral health delivery shape how patients and clinicians develop common understandings about, and adjust to, expectations for diagnoses as well as the need, or lack thereof, of mental health treatment.

Horwitz,³⁴ for example, asserts that Major Depressive Disorder (MDD), one of the most dominant diagnostic categories in behavioral health, arrived at this status not because of copious amounts of research, but instead, because of division within the psychiatric profession during the development of the third edition of the Diagnostic and Statistical Manual of Mental Disorders³⁵ and economic concerns. These dynamics resulted in MDD as a catch-all diagnosis inclusive of a wide, unspecific variety of symptoms (eg, fatigue, insomnia, poor appetite) that allowed for increased eligibility for health insurance coverage.

In relation to how patients receive such diagnoses, Lock and Nguyen³⁶ recognize illness as the embodiment of experiences, words, and feelings as well as the expression of disease and symptoms. Ultimately, the language of clinical diagnoses (eg, MDD) and the experience of clinical interactions can impact how patients behave and are treated within their social and cultural circles.

Implementation of treatment. Implementation of treatment refers to the nuts and bolts of how things are done. It can be considered in relation to rules and regulations governing the delivery of telebehavioral health. For example, at the time of inquiry, penalties for non-compliance with regulations regarding telebehavioral health were waived in Idaho (Proclamation Signed by Governor Little on January 29, 2021—Regarding Temporary Suspension of Certain State Regulations). Federal restrictions on certain services reimbursable by Medicare and Medicaid—such as audio-only services—were also waived.¹⁷ These shifts prompt questions like, “what settings can clients and providers be in when they participate in counseling sessions,” and “are there different practice guidelines for treating specific diagnoses over digital versus non-digital platforms?”

Implementation of treatment can equally be considered in relation to what really happens in a telebehavioral health session. For example, aside from what is supposed to happen, how are providers and their patients adapting to new modes of treatment, and are they keeping up with what is available?

Liminality. Providers and patients in southeastern Idaho find themselves in a liminal space as telebehavioral health bends and sways to the pandemic. Liminality signifies an “*in-between-ness*”³⁷ (p. 47), where not only regulations, and laws, but also personal understandings of what it means to

Table 1. Sex, Ethnicity, and Work Setting of Participants.

Sex	Ethnicity	Work setting
Female	Non-Hispanic/White	Primary Care
Female	Non-Hispanic/White	Primary Care
Female	Non-Hispanic/White	Behavioral Health
Female	Non-Hispanic/White	Behavioral Health
Female	Non-Hispanic/White	Behavioral Health
Male	Non-Hispanic/White	Behavioral Health
Male	Non-Hispanic/White	Behavioral Health

be providers and patients, are being redefined.³⁸ They are transitioning from what they were pre-COVID-19, to what they will be as the world learns to live with COVID-19. This proposition is not one of pre-post, but one of pre-with.

The term can prompt researchers to think about the rites of passage that will be instilled or abandoned as a result of the pandemic. What will it mean, for example, if providers or their patients refuse to wear face coverings? How will these actions be viewed and responded to? Will the act of being vaccinated become a life-marking event, and will it change whether one does or does not receive treatment?

Results

Participants

The 7 participants in this study included 2 primary care practitioners who provide behavioral health services and 5 behavioral health professionals (Table 1). Two were male and 5 were female. They identified as non-Hispanic/white. They practiced in 6 regions in the medium gray area in Figure 2. They worked in private practice, at crisis centers, federally qualified health centers, secondary schools, and hospitals. Many of the practitioners served large rural areas and were the only providers in the area.

Thematic Results: Conceptual/Analytical Framework

Structural vulnerability

Technology and training. Regarding technology and training, respondents often stated that they were confused as to which digital platforms they were supposed to use and how to explain them to patients. This put providers in new territory when trying to understand how to protect patient privacy and confidentiality:

A lot of folks with mental health issues do end up having difficulty sometimes with just the technical aspect of telemedicine. You know, lots of times we’ve ended up doing just straight up phone visits rather than getting a visual. They’ll get easily frustrated, so you don’t get as much of a quality visit

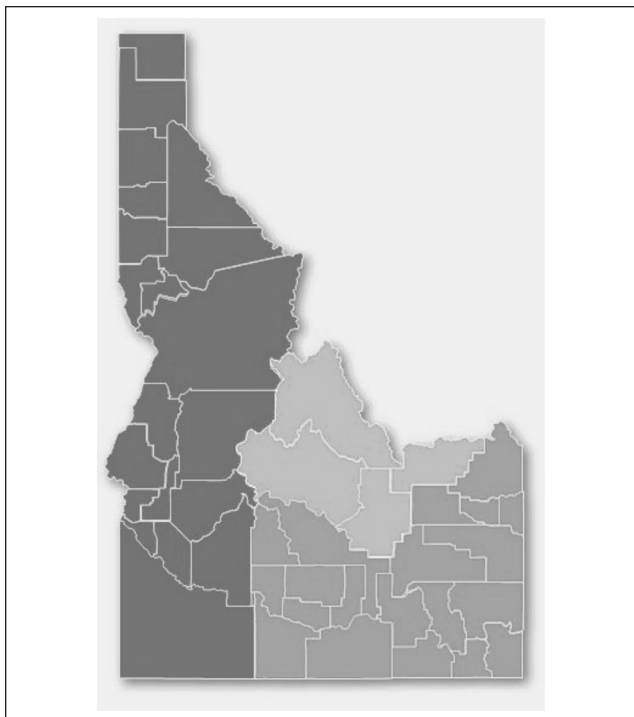


Figure 2. Regions of practice for participants.

with them as you'd like. And certainly, it's more unfortunate because those are folks that are more isolated at home, and they're not comfortable. (F, primary care)

I just always try to inform my patients about confidentiality and what platforms are like, you know, more confidential, less confidential, and really work with my clients as far as like, "Well, what do you feel comfortable using?" (F, behavioral health)

Access and safety. In terms of access and safety, some providers were grateful that the state of Idaho and licensing boards lifted some practice restrictions, though they were uncertain about what was permissible to do:

Just tell me what platforms you want and we'll get it done. Like, let's take the guesswork out of it. Let's take the fear out of it - there's so much fear anyway in general with our licensures and confidentiality and ethics and standards and whatever. Let's not. . .add to it with something that none of us expected to come around anyways. (F, behavioral health)

Providers argued that more options for working across stateliness could improve access and decrease unnecessary or even dangerous driving experiences:

I've actually worked while on vacation from another state, being able to maintain my clients that way. The technology has also allowed us to work across state lines. That was another

no-no, and now we can. My insurance covers out-of-state clients with teletherapy. There is a silver lining there to that. (M, behavioral health)

Highlighting the differences in organizational policies and differences in providers' awareness of changing regulations, another provider reported that they were unable to practice across state lines:

I'm only allowed to practice medicine inside the state of Idaho. And so, my patient that was stuck in Colorado had to seek medical care from a provider that didn't know him. And yet, I could've easily taken care of them had I been allowed to care for my patient that's in Colorado. (F, primary care)

Further, some providers were concerned about access because many of their clients had no computers and poor internet connections:

The internet services have to get better in these rural areas. Like if I can have, you know, just as, you know, a connection that's just as good as talking to somebody on the phone—a landline—that would be amazing! (F, primary care)

This was not to suggest that telebehavioral health was unacceptable to some patients. In many instances, the ability to provide care over digital platforms was very helpful, especially for those with whom providers already had established relationships: "Can we just keep doing this? . . .like literally, I don't have to get in my car and drive" (F, primary care). Providers also saw advantages to it in the midst of ever-changing rules about face masks: "It is so nice to see patient's face over telehealth rather than the mask." (F, behavioral health) "I gain insight into [patients'] private worlds via this telemedicine modality." (F, primary care)

Focusing further on safety, it was a very large concern. In relation to catching COVID-19, many discussed how difficult it was to navigate wearing masks and socially distance. They were worried about giving it to, and catching it from, their patients. Through all of their efforts to stay distant, they still found themselves having to provide some services in-person. Some patients were required to participate in in-person initial assessments. After that, they were allowed to meet with providers over digital platforms. Other patients wanted to continue doing in-person visits with masks, regardless of the availability of telebehavioral health services. Some just stopped going to appointments because they did not want to give up in-person visits. This created an environment of anxiety and uncertainty:

Like a month and a half into the pandemic I was all dressed up. And like, you know how at the beginning it was like everybody you saw you pretty much were in a gown, and it was like super paranoid and everything? . . .And I saw a patient. . .with strep, and I ended up with strep, and I was like, "What the hell!?" . . .

And I just felt like, “What am I doing wrong?” And I don’t know, I guess I felt vulnerable after that for a while. But then I also felt like, you know, “I can’t walk around feeling scared of this.” (F, primary care)

In relation to structural forms of “place,” when patients received services in their own homes (sometimes in abusive situations), or in their cars, or out in public, there was no guarantee that their physical or mental health could be protected, “Okay, you can’t be joining a call at the grocery store.” (M, behavioral health) Further, there was no ability to control where someone might be when they called in for a session:

When someone’s on the road, I’m not going to be working on their trauma because they’ve got to get back on the road, and I don’t want them to have a flashback or be dissociated when they’re getting back on the road. (M, behavioral health)

Payment for services. Payment for services was another issue that affected whether or not the newly developing system of telebehavioral health would leave vulnerable patients in even more precarious positions. Some insurance companies would not pay for telebehavioral health if it was conducted over the telephone, but they would if it was over video platforms. Providers appreciated the fact that some restrictions on telebehavioral health practice were lifted, and they hoped for continuance. Without continuance, which they were uncertain of, they believed that their patient would be detrimentally affected:

I guess, probably kind of the leftover question is what would it be. . . are they going to clarify and re-implement some of the same stuff that was present before? Like, so is it going to go back to being restricted and being billed differently, being billed at a different rate, or are they going to keep it? And after experiencing it—I guess that’s another point—is after experiencing and doing the telehealth, I definitely don’t think it should be billed less because it’s—like we said, sometimes, it’s more work, more challenging, more preparation, more everything to make it work effectively. (M, behavioral health)

Social construction of health and healthcare

Changing provider roles. Regarding how health and healthcare are being constructed during the pandemic, data analysis revealed a theme relating to changing roles. These roles are shifting at the intersection of provider and patient and also during providers’ assessments of their own health. Both of these shifts are prompting new adjustments that will alter how mental and behavioral health are understood, responded to, and embedded into societal structure.

This is evidenced by 1 provider who was trying to provide Eye Movement Desensitization and Reprocessing (EMDR) therapy. EMDR asks patients to “attend to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus”³⁹ like

hand-tapping or moving visual stimuli. This provider could not physically touch the bodies of patients, they could not do the normal tapping that they were trained to do:

I can’t tap, but I can teach you how to tap. I can observe you. I can make sure you’re doing it correctly. I can give you the protocol that you can try yourself at home. . . I mean, in a way it’s like kind of teaching people how to be their own therapist, you know. (F, behavioral health)

Providers’ own health. The new landscape of the pandemic was changing how providers responded to their own personal health needs. One was pleased with being able to work from home while in quarantine because of the telebehavioral health system her employer supported. She was able to continue performing in the role of therapist, when in times past, without a digital platform, she would not have been able to do so. She could work and still maintain her physical health.

Adaptation to new digital platforms, also, however, brought with it “slippages” between roles—some found themselves moving effortlessly, others clumsily, between work spaces, work-at-home spaces, and home spaces:

I see patients in the office two days—excuse me—three days a week—Wednesdays, Thursdays, and Fridays. . . and then, when COVID was a little bit more rampant, we didn’t quite know what was going on. I was doing telehealth from home to kind of pull myself out of the clinic because I’m a mom too. I had to. (F, primary care)

Others discussed culturally acceptable spaces within which to provide or receive treatment and how they were navigating working from home, “Mommy might be at home, but. . . don’t ask anything of me from like-this time to this time.” (F, behavioral health; see Figure 3). One therapist, in particular, arranged to deliver treatment over the phone while she was walking outside for the purpose of maintaining her own mental health.

Implementation of treatment

The promise of technology. The previous discussion describes social dynamics between providers and patients that create acceptable, or expected, forms of adjustment within the physical and virtual spaces of being treated for mental and behavioral health issues. Thus, leading to common understandings of what it means to be in need of mental health treatment. This discussion lends itself to a more practical accounting of how providers described what occurred during the delivery of treatment.

In many interviews, for example, they spoke about telebehavioral health as a great beacon of hope. It was, and still is, an invaluable asset that is saving lives, helping people cope, and increasing capacity to provide services in an area of the United States that desperately needs them:

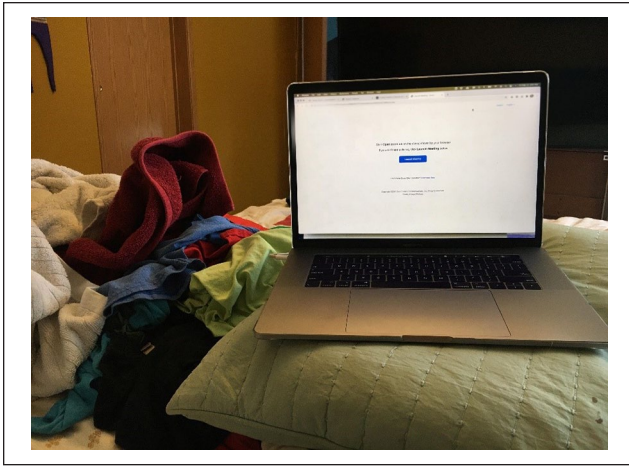


Figure 3. Working from home.

I think for work life balance that was nice in general even for Zoom meetings whether it's actually telebehavioral health or not because you just have more flexibility with the crazy snow day. I have an 8:00 [am] meeting, I can just get up and drink my coffee and watch my Zoom meeting and participate that way. And it's a lot of energy, time, resources, gas, driving, all that is actually saved. (F, behavioral health)

The pandemic in general was discussed as a means of spurring creativity and innovation. One provider, partnered with a community health emergency medical service provider. This service went to people's homes to take vitals and draw blood. After that, they qualified to receive telehealth services digitally.

Hybrid models of care. One of the most prominent uses for telehealth was this aforementioned, hybrid approach to treatment. Some tasks were completed in person and others via digital platforms. Providers spoke highly of this form of treatment delivery:

I guess I wouldn't be inclined to believe that [virtual care] has the same effectiveness; but where it's kind of a hybrid thing, where we see them in person, but we also see them via telehealth sometimes. I think that model works well. (M, behavioral health)

I strongly feel that there is a need for telehealth services but I don't see it completely replacing the current in-office visit. I foresee a combination of the two services merging in a more cohesive fashion. (F, primary care)

Things that aren't suited. Deeper discussions with providers revealed a concerning litany of treatment modalities and diagnoses that were not well suited to telehealth, either because the provider was not trained/skilled or because contextual circumstances made things more challenging. Areas of concern included conducting physical exams,

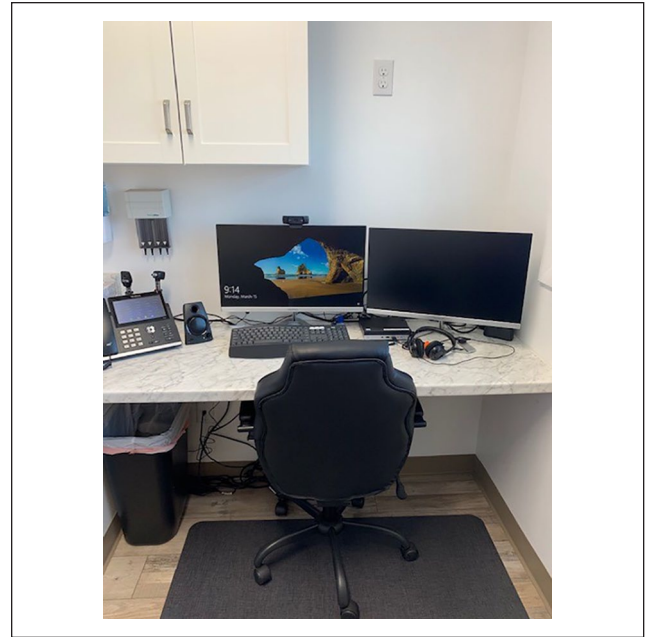


Figure 4. Office space.

treating ADHD, treating trauma, working with domestic abuse, treating patients who might dissociate during a session, doing group facilitation, and establishing rapport and trust with newer patients:

I think I have a little bit of anxiety about – you know, sometimes we've had patients call and like I'll hear secondhand from the nurse, and they'll be like, "Well, so and so called, and the triage line just told them to go get tested and go home." And I hear what their symptoms were, and I was like, they totally should have come in and at least gotten vitals. (F, primary care)

So, if someone is starting to dissociate, it's harder to detect on the eye movements. When it does start to happen, I just shut it down and we don't work on it anymore. (M, behavioral health)

Liminality. Providers' descriptions of issues relating to structural vulnerabilities, social constructions of health and implementation of treatment are set against a backdrop of liminality, that place of "in-between-ness" (p. 47),³⁷ where not only regulations, and laws, but also personal understandings of what it means to be providers and patients, are being redefined.³⁸ They described a feeling of uncertainty even regarding what to do between appointments:

I feel . . . I guess more rushed when I'm going into a session because it's like, "Oh, okay, I got like 30 minutes before the next, my next meeting," either in person or Zoom, "so I got to," let's try to read this and think like, "oh, look here they are!" and I haven't been able to switch. (F, behavioral health; see Figure 4)

In the midst of witnessing desperate/negative forms of adjustment to the pandemic in their patients—increases in

patient numbers, rates of suicide and other unhealthy forms of coping, providers were struggling to negotiate their own work-life-balance, obtain clear direction from governing bodies, and ensure personal safety during the pandemic.

They talked anxiously about the need for clarification regarding their financial and professional futures, the future of telebehavioral health, and the future behavioral health practice. They expressed frustration at the lack of clarity given from licensing boards and legislatures. They discussed being called to practice in precarious circumstances, where they knew what they were doing was unprecedented. They worried that they would be held accountable after-the-fact, after trying to deliver care in a crisis. They wondered if things would go back to the way they were.

The culmination of these wonderings left them trying to decide what it would take to move forward, to move into new forms and kinds of care once the world settled into living with COVID-19, which is a far different place than the world that lived without it. This composite narrative from interview number 3 details the nuances, subtleties, and frustrations of living so immersed in the unknown, sitting on the precipice and promise of a vaccine:

It was just intimidating at first learning new [digital] programs like that. But I think the bigger challenges were just like, well if we actually did new patients on the telehealth platform, how do you get their consent, because there's things they have to sign? . . .so yeah it was just a lot of, every week there's another question.

Every day is like, "okay now how does this work?" And, I don't know. So it became super annoying and I think pretty frustrating . . . And then, I'm learning a program and my students have questions and I'm like, "I don't know. Don't ask me. You probably know more about computers than I do."

. . . I think the N95 masks definitely help. In the beginning when I had my broken ribs I stayed home and I only did mostly telehealth, so I did make that choice there to not come in and just that was kind of important. But yeah, otherwise as long as I wear my N95, I feel much safer. I don't really trust other people as much coming in with their little cheesy masks out and about - whatever. But now we're getting vaccinated, I'm fully vaccinated. (F, behavioral health)

Process Results: Digital Data Collection

The digital data-gathering techniques employed in this study highlight the unique situation in which modern qualitative inquiry exists. We are opening wider the door to new and innovative ways of doing research. While the digital landscape provided the authors with the ability to overcome geographic barriers, in place of those barriers arose new challenges pertaining to the incorporation of digital media and the use of digital communication platforms.

We experienced difficulties in much the same way that study participants did when interacting with patients: lagging internet, connectivity issues, rural struggles (1 provider interviewed from his farm), and platform challenges.

There were times when the internet connection was cut abruptly, and the interview had to continue from that jumping off point. That break also severed the emotional connection and sense of flow between participants. Building rapport again was challenging.

Although there were technical difficulties, there was much to be appreciated about using Zoom. Those being interviewed presented themselves in 3 general ways: in their professional office settings, with no video at all, or casually and happily showing their present physical circumstances with the interviewer. This is much how providers described what they encountered with their patients. Once good internet connections were established, emotions and emotional connections appeared to be unaffected. The interviewers felt, just as with in-person experiences, that they could connect with the participants, sharing in their stories and sometimes tearing up with them:

Really enjoy seeing this patient, as he's one of our MAT [Medication Assisted Treatment] patients who's doing very well on Suboxone. I am immediately struck by a dramatic room divider behind him, painted in a Van Gogh style, and I comment on it. He's at ease in this format, and we discuss a variety of topics with candor, including waning libido and the difficulty of discussing sexual issues with a partner, the difficulty of learning to communicate in Recovery in general (F, primary care)

The ability to observe and consider what was shown intentionally versus what was shown unintentionally was similar to traditional in-person interviews. In either setting, participants choose to present themselves in specific ways. The unique aspects of using Zoom as an interview medium included the ability to pause and continue and provide a constant recoding of the interview itself. It allowed us to connect over distance at convenient times for participants. It also, however, kept us at a distance, where we were not able to take in a panoramic view of surroundings or smell, or hear the same things that were being heard by our participants. In qualitative realms, it is often understood that the more experiences that can be shared with participants, the better. This aspect of data collection could not be captured as well via Zoom.

Conclusions

This study aimed to use an RAI approach to describe behavioral healthcare providers' experiences of transitioning to telebehavioral healthcare during the COVID-19 pandemic in southeastern Idaho. Results connect thematic elements

that emerged from the data with a conceptual/analytical framework that examines how various aspects of service provision interact within the liminal space created by COVID-19. In addition, the results tell the story of how structural vulnerabilities and implementation of treatment during the pandemic are converging with social constructions of health and of treatment delivered via telebehavioral health. This highlights that being in a liminal state of transition between life pre-COVID to life with-COVID is redefining how telebehavioral health is delivered.

Results also demonstrate that pre-existing structural vulnerabilities were exacerbated by the pandemic. For example, the lack of adequate technology and proper training of providers and patients made communication more difficult, if not awkward. Questions abounded regarding when a mask should be worn to produce the best patient outcome while maintaining safety and access to care, demonstrating structural vulnerabilities in the uptake of evidence-based public health guidelines. In addition, providers reported difficulty navigating social distancing requirements and quarantine regulations due to limited physical spaces and access to reliable internet connections. Further, some patients had to independently decide whether it was safe to attend telehealth appointments with abusive partners in their homes. Taken together, there were constant adjustments being made to accommodate the individual needs of patients within a system that was not prepared to account for such a complex mix of new, pandemic-related variables.

There were also areas of promise that stood to reduce stresses among vulnerable populations. Restrictions were loosened on the types of services reimbursed through private and public insurance (eg, audio-only services). Regulations were also loosened on geographic boundaries, allowing some providers to work across state lines. There was a great deal of confusion, however, regarding what was acceptable regarding types of digital platforms, payment for services, and whether it was permissible to practice across state lines. This led to a trend of individual providers guessing at what the correct process or procedure might be in any given situation. This structural fragility and inconsistency are areas that should be closely monitored in relation to those patients who are already in vulnerable circumstances.

Regarding the social construction of health and healthcare, both providers and patients could be seen undergoing adjustments. In the example of EMDR, both the provider and patient were struggling to navigate what it meant to perform their respective roles⁴⁰ while they interacted with each other between video screens, set apart by incongruous time zones and geographic locations, yet set close by visual representations of the self. In such circumstances, consideration should be given to the dynamic of teaching someone “to be their own therapist.” For example, how would small activities, like tapping or not tapping, shape the level of

empowerment people experience over their own care, or the perceived need for receipt of behavioral health services at all, regardless of whether they are delivered in person or via telehealth?

While social constructions of health and healthcare are concepts designed to help us think about how society is determining what is meant by being healthy or not in relation to COVID-19, implementation of treatment is a concept that addresses the more practical side of delivering care. Results from this analysis detailed what was functionally happening with delivery of telebehavioral health care in southeastern Idaho. On the surface, telebehavioral health services solved a great deal of problems. They shortened distances between providers and patients, they were much more convenient, and they created spaces for contact when it was seriously needed. They also allowed for a rapid evolution of virtual treatment. On the other hand, they were not always well received, interactions were not the same as if they would have been in person, and providers stumbled upon a litany of situations where virtual care did not suffice. One point that many providers made was that telebehavioral health worked best when it was used as part of a hybrid approach to treatment. Future research may clarify the discrepancy between these provider perspectives and findings that telebehavioral health is equally effective as face-to-face care.^{19,20}

Regarding states of liminality, the confluence of dynamics and adjustments influenced how providers behaved in the shadow of COVID-19. They knew before the Delta variant appeared that they were seeing a new, unyielding, harbinger of an uncertain future. Their responses provide a real-time description of how they dealt with the dissonance it brought. What they did not know, and could not account for, was how low uptake of vaccines in the state might continue to impact their practice. This is an area for future exploration as we document how the pandemic continues to alter life in southeastern Idaho.

Further, in light of the world’s increasing reliance upon Zoom and similar platforms, it is worth discussing how this mode of data collection is similar to, and different from, face-to-face interviews. While there are many positives about using Zoom, there is something irreplaceable about being in the same room with another individual as you seek to learn from their experiences and connect with their worldviews.

Regarding limitations, this study was conducted during a time when it was very difficult to ask anything of providers who were already working extended hours due to the pandemic. It relied on 7 participants to give over 2.5 h of their time to provide depth of perspective regarding the subject at hand. More participants would have been ideal, but those that did participate provided a rich, qualified description of practice in rural southeastern Idaho. Some were the only providers of their kind within their service area and spoke

with an intimate knowledge of their communities. Further, thematic analysis of results was not intended to be generalized to all providers in Idaho, nor to specific demographic groups. Future studies could bring a stronger focus to certain sub-populations of providers. What was learned here, however, can be used as a stepping-stone to subsequent studies on hybrid uses of telebehavioral health, adaptation of treatments, and developing conceptions of mental health in the context of COVID-19.

In the meantime, several recommendations can be made based on this study. For instance, providers might consider contacting policy-makers and legislators to let them know of their preferences and needs in the delivery of telebehavioral health. Likewise, policy makers should make efforts to reach out to rural and underserved areas and talk with constituents providing these services. Continued flexibility in the use of telebehavioral health, such as permanent reimbursement expansions and simplification of interjurisdictional practice, may enhance access to care. Cross-sharing of information between licensing boards could help providers from various disciplines understand the parameters within which their colleagues must work. Advocating for better broadband access in the state of Idaho will be essential to reducing structural deficits encountered by the states most vulnerable populations. Regular consultation with colleagues and agency leadership may also assist in troubleshooting process-related challenges in telebehavioral health (eg, navigating changing patient and provider roles, helping patients find safe spaces for attending appointments).

Acknowledgments

The author(s) disclosed acknowledgments to the Research-as-Intervention Committee, who helped guide the research process and questions: Dr. Elizabeth Cartwright, PhD; Idaho State University Department of Anthropology; Dallas Clinger, CEO, Power County Hospital District; Rhonda D'Amico; Southeastern Idaho Public Health; Dr. Elizabeth Fore, PhD, M.Ed; Idaho State University Institute of Rural Health; Dr. Steve Lawyer, PhD; Idaho State University Department of Psychology; Dr. Julie Lyons, MD; St. Luke's Wood River Family Medicine.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: "This research was funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Grant Number T1KHP39168, Fiscal Year (FY) 2020 Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136 (CARES Act) Supplemental Funding

for Health Workforce Modernization, in the amount of \$95,455 with a 1:1 match. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government."

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Supplemental Material

Supplemental material for this article is available online.

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