SOUTHEAST IDAHO AHEC

EVALUATION REPORT *(APRIL 2021)*

Providing Behavioral Health through Telehealth and Virtual Care during the Covid-19 Pandemic

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Introduction

During late 2020 and early 2021, a team of researchers, clinicians, and administrators in Southeast Idaho conducted a qualitative study about behavioral healthcare providers' experiences using telebehavioral health ***(also referred to herein as virtual care)*** with patients during the COVID-19 pandemic. The purposes of this study were to:

- characterize Southeast Idaho Healthcare primary care and behavioral health providers' experiences with virtual care during the pandemic,
- generate policy- and practice-level recommendations regarding virtual care in this region that will address inequities in access to care, and
- raise awareness of issues relevant to virtual care among community stakeholders who influence the implementation of this treatment modality in Southeast Idaho.

The study consisted of qualitative interviews and a "Words & Pictures" activity where providers supplied short journal entries and/or took photographs that conveyed their experiences trying to deliver care during the pandemic. Five behavioral health and 2 primary care providers (n=7) from Idaho's public health districts 5, 6, and 7 participated in the study, which took approximately 2.5 hours of their time. In return for their participation, $100 was donated to a southeastern Idaho, non-profit, mental health organization of their choice.

The protocol for interviews was developed by a steering committee, which included researchers and healthcare students from Idaho State University (AHEC Scholars), healthcare providers, and healthcare administrators from southeast Idaho. The steering committee was essential to this process. It consisted of stakeholders who currently, or will in the future, influence the implementation of telehealth services and telehealth policy in southeast Idaho.

Study participants were recruited by way of personal invitation and distribution of fliers to relevant organizations. All interviews, which ranged from 25-75 minutes, were conducted *via* Zoom, to ensure safety. Interviews were recorded, and an independent contractor completed the transcriptions. The research team analyzed the transcriptions and collaboratively developed a list of themes that emerged from the data. In addition, data from providers' "Words & Pictures" activity was analyzed to verify findings from the interviews and add to understandings of provider experiences.

Background and Significance

The Southeast Idaho Area Health Education Center (AHEC) serves a 24-county, 44,000-square-mile area of the state (Idaho Department of Health and Welfare, n.d.). This region has significant behavioral health concerns including high suicide rates, substance use, and a rising overdose mortality rate (Idaho Department of Health and Welfare, 2018; Hispanic Profile Data Book, 2017; Idaho Department of Health and Welfare, 2019). Southeast Idaho also experiences barriers to accessing care due to a largely rural population and lack of behavioral health providers (Rural Health Information Hub, 2019). Many individuals with behavioral health needs were already at risk of going untreated before COVID-19 (Otu et al., 2020; Solis et al., 2020), but during the COVID-19 pandemic these issues have been compounded by increased isolation and potentially decreased access to behavioral health care (Panchal et al., 2020; Salari et al., 2020).

Using technology to deliver behavioral healthcare to patients virtually can be an effective treatment modality for patients (Anthony, 2020; Osenbach et al., 2013; Speyer et al., 2018). Virtual care includes the use of telephones, video conference, or email; and it reduces or eliminates the need for patients to be physically present in a provider's office (Wijesooriya et al. 2020). To increase access to virtual care during the pandemic, regulations have been eased, allowing reimbursement for audio-only services and allowing services to be delivered in patients' homes (Centers for Medicare and Medicaid Services, 2020).

These factors have enhanced providers' ability to provide care, but many have lingering concerns about using virtual care: How will patient relationships and communication be affected (Cowan et al., 2019)? What are the ethical and legal obligations (Dart et al., 2016)? What training is available (Cowan et al., 2019; Glueckauf et al., 2018)? Further, there are factors that may contribute to a reluctance on the part of patients to receive virtual treatment. For example, stigma, lack of technology, cultural practices, income level, and health status all play a part in a person's decision to receive care (Farmer 2003; Manderson et al., 2016).

As we develop new policies and practices to deliver behavioral healthcare in response to the COVID-19 pandemic, it is critical that we actively work to understand and, where necessary, overcome these factors. This moment in behavioral healthcare delivery will likely redefine the way that it is made accessible to the population of Southeast Idaho. New regulations and laws will continue to affect our whole region. The results from this study provide greater insight into the challenges and potential associated with the transition from delivery of care pre-COVID to delivery of care from here on out:

What is going to happen with virtual care in the future?

Study Participants

The seven participants in this study included two primary care practitioners who provide behavioral health services and five behavioral health professionals. They represent Southeast Idaho Public Health Districts 5, 6, and 7, and practice in 6 regions in the dark orange area in Figure 1.

They represent a range of professions including nursing, trauma therapy, social work and mental health counseling. They work in private practice, at crisis centers, federally qualified health centers, secondary schools, and hospitals.

Many of the practitioners serve large rural areas and may be the only providers in the area. They describe how working in such remote places comes with many challenges, including lack of Internet access:

We're the only facility in that area…we're rural and we're technically frontier. (int. 4)

When I was working from my location at home, that's the fastest speed we can get there because it's just kind of out in the farm area. (int 6)

Working under these new circumstances has also impacted the nature and quality of how care is provided. Prompting questions such as,

Figure 1: Geographic Regions of Practice

- What should a typical day of practice look like?
- What does it mean for the spaces between appointments that were once reserved for specific tasks?

It's like, "Oh! Okay, I got like 30 minutes before the next…meeting, either in person or Zoom." And then it's like, "Oh, look here they are!"...I guess [I'm] disoriented on some things because I'm bouncing from meeting [to meeting]." (int 2)

Where do we go, and what do we do? (int. 2)

Providers brought up many logistical concerns about their practice. They were worried about legal liability, viability of their businesses, which online platforms were appropriate to use under their licensure, and whether or not the new, more open regulations would remain in effect. They also discussed varying needs for training.

A) One provider expressed frustration about trying to work while being immersed in new rules and regulations coming from multiple directions:

Tell me what you want and let me continue doing my job. (int. 2)

B) On the other hand, a great deal of gratitude was expressed in terms of loosening practice restrictions:

I was really thankful because at the time when all of this happened, like back in March, I was doing a lot of Medicaid work… I was really glad that the state was sort of like, "Yes! Do it! Use telehealth!" (int. 5)

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? (int. 6)

When COVID was really bad, and we weren't seeing patients in the office, I was very concerned about the viability of our business… for me…I'm very dedicated and want [to keep loosened restrictions]. (int. 4)

C) Some had conflicting ideas about whether or not they could use virtual care to practice across state lines:

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. (int. 7)

As opposed to:

I think there's probably still another thing with COVID and teletherapy is to allow our licenses to be used across state lines. This has been a huge issue. The American Counseling Association has never gotten any traction with eliminating all the different licensing boards and allowing the license to be applicable to Washington State or California, wherever I want to go. We've all taken our exams. We're all working professionals. Why can't we just, if we need to, follow a client to Washington? (int. 7)

D) In terms of patient privacy, HIPAA and which remote platforms to use, the discussion about what was and was not acceptable varied, and highlighted the legislative and policy limbos that providers are working in:

Now that I just do private pay in my practice and I'm not billing insurance… I feel less like freaked out about that kind of stuff. (int. 5)

We're not using Zoom. We really want to use doxy.me because it's encrypted. I don't use Zoom for that purpose, but I do tell clients Google Duo and FaceTime are not encrypted either, and most clients just say, "I don't care. I feel sorry for the person who has to listen to me talk about my problems". (int. 7)

I think the bigger challenges were just like well if we actually did new clients on the telehealth platform, how do you get their consent because there's things they have to sign. They can't just give verbal consent. It has to be something in the chart. And I'm like, "We just [do] the consent verbally," but we can't do that. (int. 3)

E) Training was a topic of great discussion, with some wondering why so much is needed while others were clamoring for more:

Like do people need to have some sort of special training to understand that, you know, Zoom is not HIPAA compliant? (int. 5)

I think the question is, "Am I doing it right?" You know? Like, because I don't have anybody to compare myself to. (int. 1)

They see its future - its potential.

A critical finding of this study relates to the impact that virtual care has had on different types of treatment for different types of diagnoses. At the outset of conversations, participants discussed how valuable virtual care has been to ensuring access to mental health services. The challenge came in terms of adapting between older, face-to-face modalities and newer, virtual modalities. Even with challenges, it was clear that providers saw the value in using virtual care as a "hybrid" model of treatment delivery.

A) Providers mentioned several advantages of virtual care: patients have more access to treatment at more convenient times, providers are able to work from home, patients and providers have more options when in-person meetings are not possible, building trust can sometimes be easier in the virtual setting, and patients and providers can take masks off,:

Older clients who are forced to self-quarantine tend to want to stay with teletherapy, because they're still afraid, and they have big medical issues. The younger ones would be my young moms. They tend to like it for the convenience factor, and some live in rural areas. (int. 7)

The therapists were just getting rid of their masks. They couldn't do them all day long, and it was hindering the process. (int. 7)

B) In terms of challenges, providers had different opinions about the ease and effectiveness of providing a variety of treatments virtually, like Eye Movement Desensitization and Reprocessing (EMDR) therapy.

EMDR asks clients to "attend to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus (What is EMDR?, 2020)" like hand-tapping or audio.

One provider explained that they could not be physically present to "tap" the client, and this resulted in poor treatment. It led them to trying to figure out how to teach the client to do it themselves:

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 (int.5).

Another described how some like it and others do not:

One person has said, "I want to wait until I'm out of danger before I resume. I can't do EMDR on the Internet," and others have said, "I love it! It's just fine." So, yes, it has worked out better than expected. (int.1)

Eye Movement Desensitization and Reprocessing (EMDR) therapy was not the only form of treatment adversely affected by virtual care. Participants discussed a number of treatments and diagnoses that were met with challenges, like Medication-Assisted Treatment (MAT) and Attention-deficit/hyperactivity disorder (ADHD) (Figure 2):

Figure 2: Diagnosis and Treatment Challenges using Virtual Care

C) A very important insight into provider thoughts and opinions about delivering virtual care, is that it was seen as an excellent tool for hybrid approaches. It was recognized that some things need to be done in person and others can be done virtually.

If somebody says, "Oh, I didn't get a ride," we just say, "Well, jump on! (int. 6)

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. (int. 6)

We make them come in person. I think it's much more difficult over [virtual care] because you only see a small snippet of the face, sometimes the Internet isn't very good. So we usually try to just have them come in in person. After that, we can do telehealth. (int. 3)

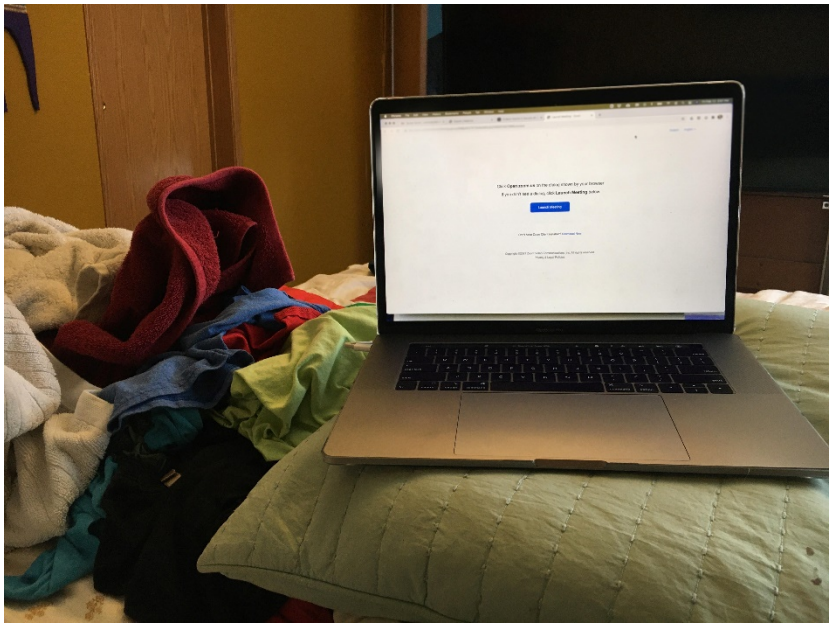
Is there a future for hybrid approaches to virtual care?

What is the right term to describe what we are doing?

The COVID-19 pandemic has created an environment that is in the midst of change. Even the language that we use to discuss telehealth is evolving (Anthony, 2020). New legislation at the state of Idaho refers to telehealth as **virtual care** (Soderquist, 2021). The exact definitions of these terms are certain to change as time passes.

The spaces that we inhabit are becoming blends of work and home.

Mommy might be at home, but...don't ask anything of me from like - this time to this time. (int. 5)



I was doing telehealth from home to kind of pull myself out of the clinic because I'm a mom. I had to. (int. 4)

[They] kind of set out a separate space and talked with their families...and said, "Hey, you can't come in here." They tried to separate it off as much as they could so they were isolated to do the services. (int. 6)

DOUBTS, FEARS, HOPES AND INNOVATIONS

Adapting to all of this change has come with **doubts, fears, hopes and innovations!** Providers are resilient in this environment, and hearing their voices helps us better understand their needs.

DOUBTS

Am I comfortable with my client seeing elements of my house or overhearing things? (int. 5)

I think we all kind of felt actually a little bit more drained after doing a day of telehealth sessions. (int. 6)

FEARS

There's something we really need to talk about as far as your domestic or sexual trauma, and I don't know if I should actually say that out loud because, who's listening? (int. 2)

The phone started ringing more right after COVID really hit because it amplified family dysfunction, panic attacks and depression. (int. 7)

HOPES

[COVID] created this beautiful environment that all the sudden patients were grateful and willing to engage in that kind of a correspondence. (int. 4)

INNOVATIONS

We would send a CHEMS [community health emergency medical services] provider or one of my nurses out to patients' home, so that they could take a set of vitals. They could draw blood. And then, they could establish a video connection. (int. 4)

One provider talked about multitasking while practicing self-care: *"I do a lot of like walk and talks." (int. 5)*

What does the future hold for virtual care providers?

Recommendations

1. If you are a provider, contact policy-makers and legislators:
    a. What should change?
    b. What should stay the same?

2. If you are a policy-maker or legislator, contact behavioral healthcare providers using telehealth/virtual care in your service area.
    a. Are there opportunities to conduct listening sessions or to have one-on-one conversations?
    b. Talk with providers about what is really happening with delivery of care. While virtual care may be increasing access to services, it is also changing the way care is delivered.
    c. Consider the innovative approaches that providers have taken to solve real-time problems with virtual care delivery.

3. If you belong to a licensing board, share information with those from other boards. This will improve interdisciplinary knowledge of virtual care dynamics.
    a. Develop and maintain simple, online resources with information about legal requirements relevant to behavioral healthcare providers using telehealth/virtual care.
    b. Develop ways to disseminate information about legal requirements (e.g. monthly newsletters).

4. Find out about the most recent telehealth and virtual care legislation and policies in Idaho. Contact the Northwest Regional Telehealth Resource Center (NRTRC):
    a. The virtual platform that you choose for delivery of care should be HIPAA compliant.
    b. Execute a Business Associate Agreement between the vendor and your organization.
    c. Visit the National Telehealth Technology Assessment Resource Center, TTAC. It is a great resource for helping vet different platforms for telehealth.

5. Learn about other telehealth and virtual care resources:
    a. Center for Connected Health Policy
    b. Idaho Emergency Declaration for Telehealth
    c. Idaho State Bureau of Rural Health and Primary Care
    d. Idaho Telehealth Task Force

6. Advocate for better broadband access and infrastructure in Idaho.
    a. Learn more about the Federal Communications Commission's Emergency Broadband Benefit Program (EBB Program).
    b. Learn more about what the Western Governors' Association is doing to improve broadband in Idaho.

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REPORTING

CONTACT INFORMATION

This report was written and compiled by the Southeast Idaho Area Health Education Center:

921 S. 8th Avenue, Stop 8109
Pocatello, Idaho 83201
(208) 282-2477
seidahec@isu.edu

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HUMAN SUBJECTS

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Photo credits: Diana Schow, Words and Pictures Activity Participants.
Researchers: Dr. Diana Schow, PhD; Ann N. Thomson, MS; Wilson Trusty, MS (AHEC Scholar); Laurel Buchi-Fotre, BA (AHEC Scholar)

A special thanks to our Steering Committee:

Dr. Elizabeth Cartwright, PhD; Idaho State University Department of Anthropology
Dallas Clinger; CEO Power County Hospital
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 Hospital, Idaho Falls