# PANDEMIC ERA TELEHEALTH INNOVATIONS IN THE MENTAL HEALTH AND SUBSTANCE USE TREATMENT FIELDS:

*Practice-informed Findings and Recommendations*

NATIONAL COUNCIL *for* Mental Wellbeing

MAY 2023

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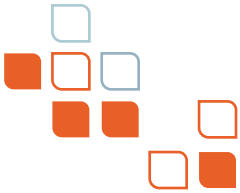


# Acknowledgments

The National Council for Mental Wellbeing acknowledges the distinguished clinical and nonclinical experts across the nation that shared their professional experiences in the mental health and substance use treatment field during the pandemic. These experts supported the National Council's efforts to establish this report.

## NATIONAL COUNCIL PROJECT TEAM

**Anthony Carter, LCSW-C**
Director

**Teresa Halliday, MA**
Senior Advisor

**Rachel Kessler, MSW**
Project Manager

**Nadine Alison Cabo Chan**
Intern

## EXTERNAL CONSULTANTS

**Vikrum Vishnubhakta, MPH/MBA**
Principal, Forward Consultants

## PANDEMIC ERA TELEHEALTH INNOVATIONS IN THE MENTAL HEALTH AND SUBSTANCE USE FIELD PANEL

**David Woodlock, MS**
Panel Chair
President, Woodlock & Associates

**Christina Arredondo, M.D.**
Medical Director of Behavioral Health; Psychiatrist
El Rio Community Health Center

**Jennifer Bender, RN-C OB, IBCLC**
Perinatal Depression Nurse Navigator
Mon Health Medical Center

**Brian Hepburn, M.D.**
Executive Director
National Association of State Mental Health Program Directors

**Samir Malik, MBA**
Co-Founder and CEO
Firsthand

**Rachel McCrickard, LMFT**
Co-Founder and CEO
Motivo Health

**Lora McDonald, MSW, MPA**
Social Worker
Mon Health Medical Center

**Eric Meier, MBA**
President and CEO
Owl Insights

**Dennis Morrison, Ph.D.**
Owner
Morrison Consulting

**Carolyn Rekerdres, M.D.**
Psychiatrist and Consultant
Cloud 9 Telehealth

**Martin Rosenzweig, M.D.**
Chief Medical Officer
UnitedHealth Group; Optum Behavioral Health

**Kristina Scalia-Jackson**
Director of Center of Excellence
Pathways to Housing PA

**Peggy Terhune, Ph.D., MBA**
President and CEO
Monarch

**Melanie Whitter**
Deputy Executive Director
National Association of State Alcohol and Drug Abuse Directors

**Dror Zaide, MBA**
Co-Founder and General Manager
Eleos Health

# Background

Arduous times foster the opportunity for innovation. The COVID-19 pandemic illuminated concerns that impacted delivery of crucial mental health and substance use treatment services across the country, including increased demand for services and workforce challenges. During the pandemic, mental health and substance use treatment providers experienced a tipping point as they were faced with the additional challenge of upending conventional practices and transitioned to telehealth and technology-assisted services. While no easy feat, in partnership with policymakers, providers boldly responded to the challenges presented by the pandemic, which gave rise to countless innovations with measurable impact that has reshaped behavioral health service delivery.

Throughout the pandemic, the National Council for Mental Wellbeing focused intensely on supporting and understanding the unique challenges our members faced and their responsive solutions, particularly related to mental health and substance use telehealth services (telebehavioral health). Coupling on-the-ground knowledge with relationships across sectors and disciplines, the National Council engaged national experts and thought leaders representing research, practice, policy and lived experience, resulting in nationally significant toolkits to implement best practices in primary, behavioral and public health settings. The National Council developed several resources during the pandemic to support our members:

- Maintaining Connection: Strategies to Manage a Virtual Harm Reduction Workplace (January 2023)
- Innovations in Telehealth in Behavioral Health During COVID-19 (Report and Webinar) (July 2022)
- Supporting Telehealth and Technology-assisted Services for People Who use Drugs: A Resource Guide (November 2021)
- CoE Office Hour: How to Leverage Telehealth Strategies for Substance Use Brief Intervention (May 2021)
- Best Practices for Telehealth During COVID-19 Public Health Emergency (March 2020)

### NATIONAL COUNCIL INQUIRY ON PANDEMIC LEARNING

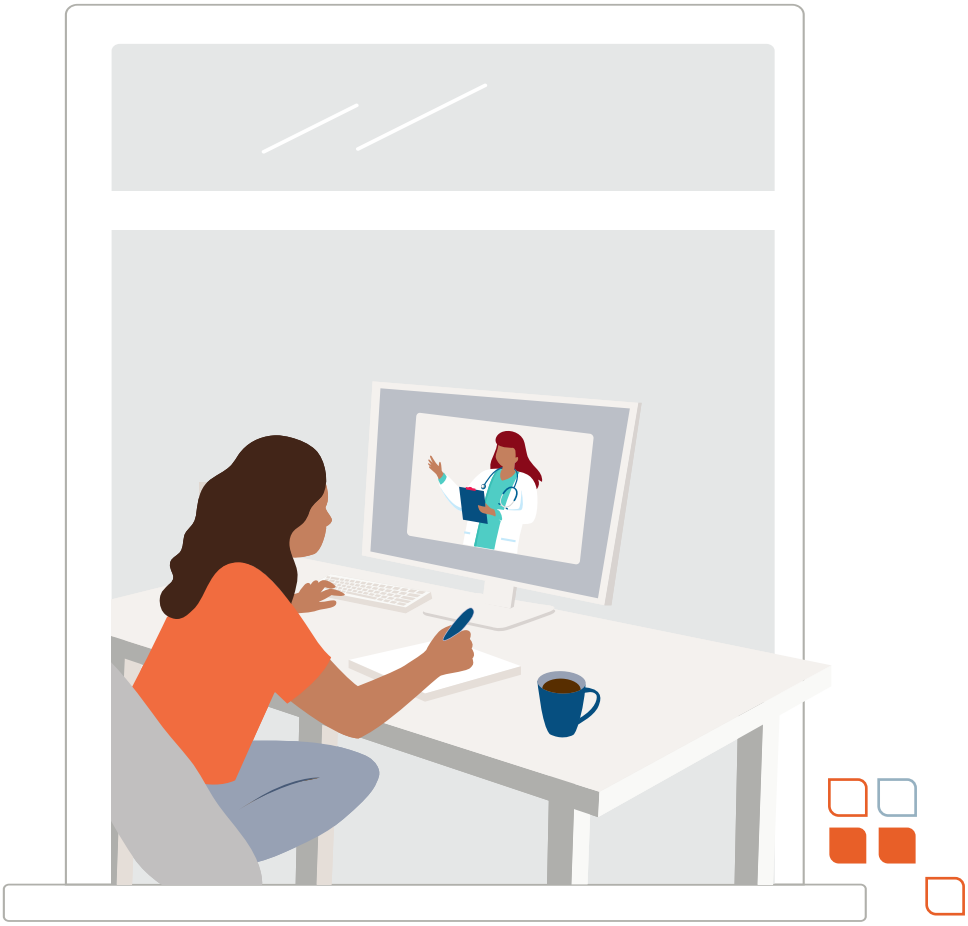
To further our understanding of the implementation and innovations in telebehavioral health services, the National Council convened a panel comprised of clinical and nonclinical experts from across the behavioral health service field in fall of 2022 to focus on understanding impact and scaling best practice innovations. The panel served as thought leaders to launch a survey and literature review to outline innovations, tools and recommendations to scale effective practices. This report will highlight findings and recommendations from the following activities:

- **Panel Convening:** The Pandemic Era Telehealth Innovations in Mental Health and Substance Use Treatment Fields Panel was first convened in July 2022 to provide consensus on the continuation and scaling of telehealth innovations gained during the pandemic.
- **Survey:** The Pandemic Innovation for Telehealth Innovation in Mental Health and Substance Use Treatment Fields Survey, launched in October 2022, is a survey of mental health and substance use service provider organizations that elicited data related to telehealth innovations implemented during the pandemic era.
- **Literature Review:** An in-depth literature review was completed to gather detailed aspects of the rapid transition of in-person mental health and substance use treatment services to virtual telehealth services during the COVID-19 pandemic. Clinical and programmatic changes, reimbursement and policy shifts and advantages identified from adopting telehealth services were noted with particular emphasis of the effects of telehealth services in rural communities. Limitations and areas for improvement due to this transition to telehealth services were also gathered.

# Summary of Key Learnings

The following key learnings are informed by the findings from the National Council survey, guidance from the panel and a review of extant literature. The remaining sections of this report detail these findings.

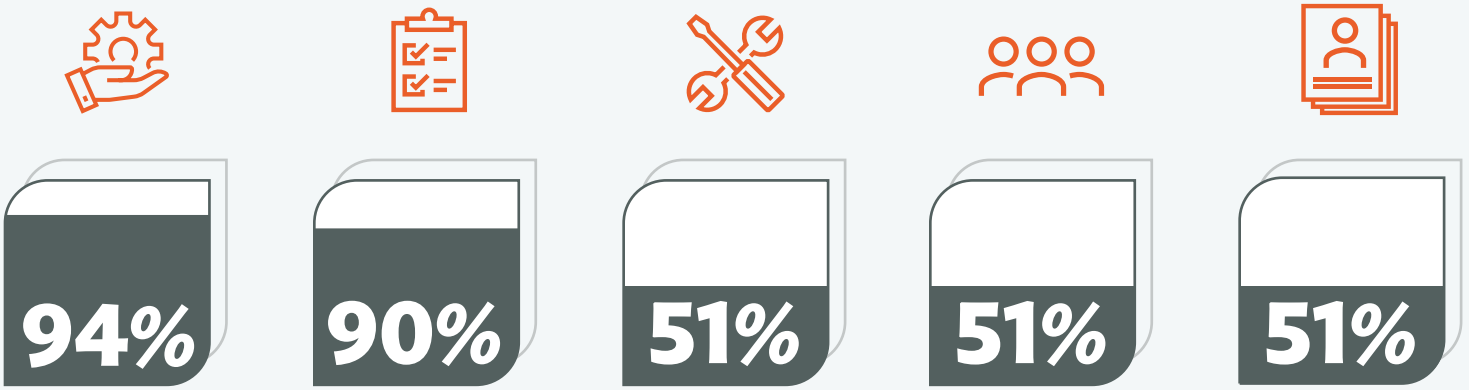
- Telebehavioral health increased access to and retention in care.
- Telebehavioral health mitigated a widening gap in health care equity, especially for those with lower-income and disadvantaged backgrounds, public insurance and racial and ethnic minority identities.
- Audio-only made care available to thousands, particularly those lacking stable internet connectivity, technological proficiency or fluency in English.
- Telebehavioral health-related clinical tools were associated with greater improvement in outcomes.
- Telebehavioral health programs/services that provided staff with increased clinical supervision and case reviews showed better outcomes.
- Several threats to sustaining and scaling telehealth innovation remain, including insufficient reimbursement, license restrictions, workforce shortage, disallowance of audio-only services and others.
- More research is needed to best serve the needs of younger children engaged in telebehavioral health care.



# Survey and Literature Review Findings

A 2022 survey of mental health and substance use provider organizations, including National Council for Mental Wellbeing members, elicited quantitative and qualitative data related to telehealth innovations in mental health and substance use treatment services implemented during the COVID-19 pandemic era. Real-world accounts describe challenges and successes in operationalizing clinical and programmatic change at pace and under unexpected, adverse circumstances.

To meet the growing behavioral health needs of the nation with uninterrupted care, and with special attention to public health safety, mental health and substance use treatment providers rapidly mobilized to implement remote care. Most survey respondents (94%) stated their organization completely transitioned to telehealth at the onset of the pandemic or shifted to providing telehealth services that were not previously in place. Most organizations (89.6%) also indicated that they provided guidelines or training to assist clinicians with the delivery of telehealth procedures. Approximately half the respondents reported they utilized new assessments or tools to inform telehealth service decisions, enhanced staff supervision and/or created new roles to best provide services during the pandemic.




Once the COVID-19 pandemic waned and/or lockdowns were removed, respondents overwhelmingly reported their organization was maintaining telehealth services in full or in a hybrid fashion, providing both in-person and virtual services according to client preference or clinical recommendation.

This section summarizes key findings on effective telehealth innovation, as well as policy, structural and operational elements which have supported effective change or have the potential to challenge its endurance.

## INCREASED ACCESS TO CARE

Telehealth services have been associated with numerous positive outcomes including, but not limited to, improved medical adherence, improved quality and timeliness of patient care, decreased missed appointments, decreased wait times, decreased readmissions, decreased travel time for patients, improved communication with providers and increased access to care.[1,2,3] An emerging body of evidence suggests that telehealth is comparable to face-to-face psychiatry in clinical settings with regard to outcomes and patient satisfaction.[4,5,6,7]

Survey respondents described their experience with enhancements to care via telehealth implementation.

> *We implemented the availability of telehealth for all therapy appointments [and] expanded our current prescriber's telehealth appointments to allow the client to also join via telehealth … to ensure services continued for all clients during the initial shutdown across the country and well on into the pandemic* ***[even when] things began to open back up to ensure further safety of our clients and staff while also allowing for continuation of services and access to care."***
>
> **— RURAL-BASED COMMUNITY BEHAVIORAL HEALTH CLINIC/CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CBHC/CCBHC) WITH STRONG USE OF TELEHEALTH**

> *Prior to pandemic we did utilize telehealth services.* ***Instituting telehealth with reduced time frames and use of peers/clinicians/case managers/medical staff allowed us to improve monitoring of patients as well as provide person-centered care. We also developed a hybrid model for group/class schedules to increase options."***
>
> **— URBAN/SUBURBAN-BASED CBHC/CCBHC WITH STRONG USE OF TELEHEALTH**

> *We learned that* ***it is important to understand all of the ways to connect with the client virtually during the first consultation,*** *even before intake."*
>
> **— RURAL/SUBURBAN-BASED CCBHC WITH STRONG USE OF TELEHEALTH**

**Addressing Health Disparities.** Telehealth mitigated a widening gap in health care equity. The COVID-19 pandemic illuminated many public health challenges, including continuing behavioral health services, but telehealth was a moderating factor that helped prevent growing health disparities in receiving behavioral health care. Populations with high unmet need for behavioral care such as Hispanic/Latino groups, lower-income adults and those with no usual source of primary care showed the highest use of telehealth services.[8] Telehealth services had higher rates of utilization among low-income Medicare and Medicaid beneficiaries who needed a higher level of care consistent with mental and behavioral health services. Telemedicine delivered through video or audio-only platforms were particularly significant for adult and elderly dually eligible Medicaid recipients.[9]

Telehealth services effectively increased access to care across the country, especially for those with lower incomes and disadvantaged backgrounds, public insurance and racial and ethnic minority identities. When comparing utilization of telehealth services before and after the Medicare telemedicine coverage waiver, there is a significant increase in telehealth use that is especially noted in disadvantaged neighborhoods. These neighborhoods have a high Area Deprivation Index which is an evaluation of socioeconomic conditions in a region measured by factors such as income, education, housing and employment.[10] Neighborhoods with higher deprivation were associated with higher telehealth use, suggesting that telehealth services reached even the most disadvantaged communities across the country and expanding Medicare coverage increased both access and utilization of telehealth for minority populations.[11] Telehealth utilization broadened geographic reach for mental health and substance use services. Regional boundaries opened during telehealth implementation, allowing providers to welcome patients previously outside their service area.

**Rural Areas.** While early COVID-19 data indicated higher rates of telehealth utilization in metropolitan areas,[8] recently reported geographic trends indicate notably high utilization in rural areas[12] where health disparities have been attributed to inequities in the concentration of health care services and treatment centers, education access, economic opportunity and other social determinants.[13] A study completed by the Kaiser Family Foundation found that a relatively high share of patients in rural areas relied on telehealth to receive outpatient mental health and substance use treatment services (55%) compared to those in urban areas (35%) within the March to August 2021 time frame.[14] A recent study found that Medicaid beneficiaries residing in rural communities were more likely to use telehealth services than those living in urban areas.[12,15]

Telehealth can extend the reach of health services by conveniently meeting clients where they are and reducing barriers to care in rural communities. Telehealth services provide an alternative access point for those in rural areas by decreasing the need to travel long distances for appointments and mitigating costs that consequentially contributed to client decisions to delay care. Indeed, limitations often linked with utilization of technologies (e.g., connectivity issues, lack of Wi-Fi in remote locations, inability of individuals to effectively use technology) were reported at rates lower than commonly associated with their use in rural communities.[12] One study found an increased likelihood of telehealth service utilization with increased distance from the clinic and that utilization particularly improved for African American and Hispanic/Latino clients.[16]

**Supporting Rural Workforce.** Mental health and substance use treatment organizations based in rural areas, which tend to have a shortage of providers, have made noteworthy strides expanding telehealth services for their patients. Telehealth services may help reduce the chronic rural workforce shortage by increasing physician recruitment and retention.[12,17] The 2022 National Council survey found that a slight, yet significantly higher percentage of respondents from rural organizations (92%) said their organization provided clinical guidelines and/or training to assist clinicians with offering services via telehealth, which contrasts with 83% and 76% of urban and suburban organizations, respectively.

> ***Some clients are agoraphobic, don't have transport, are disorganized, don't have funds for transport, live far away and prefer telehealth."***
>
> **— FEDERALLY QUALIFIED HEALTH CENTER (FQHC)**

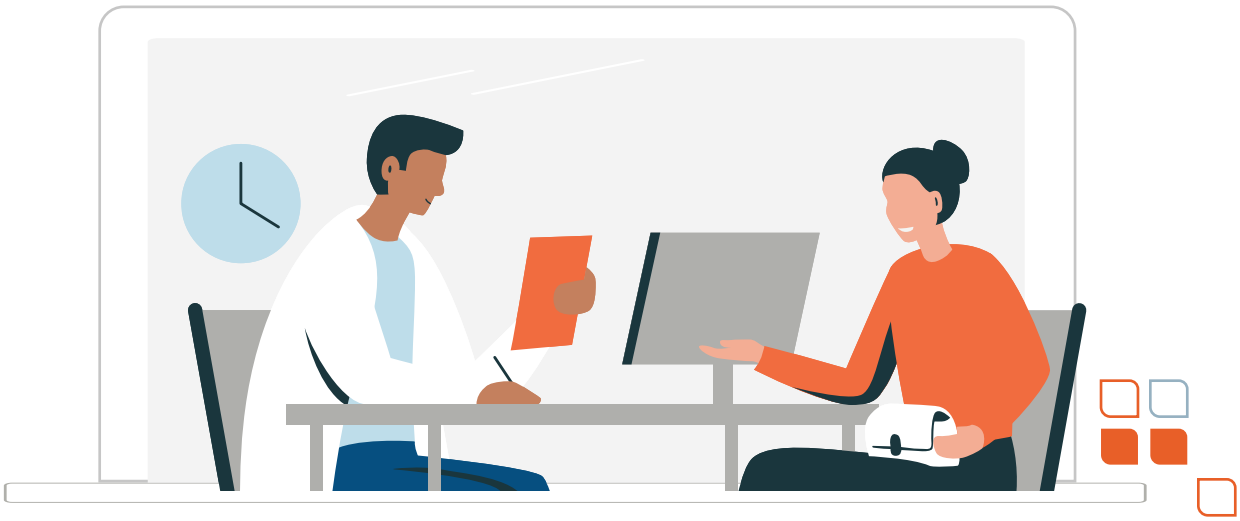
> ***Many clients and their families seemed to prefer the telehealth modality due to the convenience of not having to make arrangements for childcare, transportation, etc."***
>
> **— COMMUNITY BEHAVIORAL HEALTH CENTER**

**Hybrid Models.** Combining both in-person and telehealth treatment methods, hybrid models have been identified as a promising approach within this rapid system change in mental and behavioral health services.[18] Survey respondents indicated that the value of telehealth services varied across service recipients and settings. For example, for those in crisis or utilizing toxicology screening, a hybrid approach incorporating in-person and virtual elements was appropriate. Providers reported that as pandemic restrictions eased, clients were more eager to seek hybrid services with some in-person component. Survey respondents resoundingly stated that they plan to continue telehealth and hybrid services, driven by patient preferences and shaped by policy.

> *"**Clients not in crisis benefitted from telehealth services.** Those in crisis needed in-person services but triaged due to provider shortage based on severity. **Telehealth implementation was lifesaving for the clients and financially the agency."***
>
> **— RURAL-BASED FQHC WITH MODERATE USE OF TELEHEALTH**

> *"[We] shifted [behavioral health] services to telehealth, increased hours and **offered hybrid in person/remote groups for improved efficiencies."***
>
> **— URBAN-BASED FQHC WITH MODERATE USE OF TELEHEALTH**

> *"During the total lockdown, we provided all services by telehealth, except medication injections. Later, **we relied heavily on telehealth, but saw the most needy clients in person, at a distance. By March 2022, some were in full hybrid mode, while others continued to work virtually only."***
>
> **— URBAN/SUBURBAN-BASED CCBHC WITH STRONG USE OF TELEHEALTH**



## AUDIO-ONLY MADE CARE AVAILABLE TO THOUSANDS (THOSE WITH NO INTERNET ACCESS)

In 2018, an estimated 18.3 million Americans lacked sufficient broadband to access benchmarked services as articulated in the National Broadband Plan.[19] And this lack of broadband has been considered to be a health equity issue.[20] Although many programs and policies are addressing this inequity, such as the Coronavirus Aid, Relief and Economic Security (CARES) Act and the Connected Care Pilot Program, broadband connection demands still serve as a critical issue in the rapid adoption of telehealth. Individuals who do not have reliable internet might have a truncated and/or ineffective telehealth visit, which leads to delays in care and frustration.[21] Audio-only (i.e., telephone) care has proven effective, and even crucial, to those without access to dependable internet or necessary smart devices.[3]

Audio-only services bridge a gap in care for clients who may lack broadband internet access, have limited English proficiency, or fewer digital literacy and internet skills. These barriers disproportionately affect rural communities, racial and ethnic minorities, individuals for whom English is spoken as a foreign language and older adults. In correlation, audio-only services were the preferred telemedicine delivery for those in rural areas without reliable access to internet, African American clients, older patients using Medicaid insurance and those who needed an interpreter.[22] Audio-only appointments endeavor to cross the digital divide by reducing the technological complexity and maximizing the accessibility of telephone visits by striving to overcome risk factors related to age, race, English language proficiency, geographical location and insurance which can delay care.

**Audio-only (i.e., telephone) services are effective, and even crucial to many.**

> ***Clients have been thriving in telehealth in ways I didn't think possible.*** *It has only been positive for [the] client process. I have been shocked by how effectively two of my clients used audio-only calls (out of necessity)"*
>
> **— URBAN-BASED CBHC WITH STRONG USE OF TELEHEALTH**

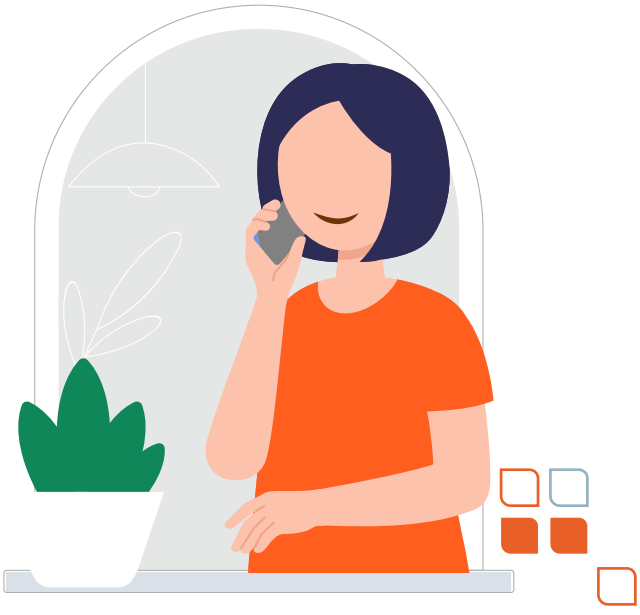
> ***We never provided telehealth services before.*** *We began providing telehealth therapy, medication monitoring, prescriber visits and groups.* ***Many of our services were provided via telephone instead of Zoom/Microsoft Teams/visual platforms because our clientele did not have access to smart phones or computers."***
>
> **— RURAL/URBAN/SUBURBAN-BASED CBHC/CCBHC WITH LIMITED USE OF TELEHEALTH**

**Continuation of audio-only services is uncertain for some.**

> ***We had to discontinue all telehealth for intakes and audio-only for any clinical services.*** *We can only use telehealth video for select clinical services.* ***This is all due to statewide reimbursement restrictions as the pandemic-era policies are being lifted."***
>
> — **RURAL-BASED CCBHC WITH SOME USE OF TELEHEALTH**

> ***Due to reimbursement rates, we did discontinue telephone encounters.*** *Because we can safely bring patients back into the clinic, we have deeply decreased virtual primary care visits."*
>
> — **RURAL-BASED CCBHC/FQHC WITH MODERATE USE OF TELEHEALTH**

> ***If CMS/Medicaid/Medicare announces that they will no longer provide reimbursement for telehealth services, or if they announce that it must include video instead of just telephone, we will cease telehealth services entirely..."***
>
> — **RURAL/URBAN/SUBURBAN-BASED CBHC/CCBHC WITH LIMITED USE OF TELEHEALTH**



These positive lessons encouraged organizations to sustain their telehealth services and effectively transition most of their clients/patients to such services over the long-term.

**Client/patient retention improved.**

**Fewer cancellations.**

**Flexibility with client/patient schedules.**

**Helpful for clients/patients who have limited transportation.**

**Clients/patients without urgent needs were amenable to using telehealth.**

> ***Telehealth ended up being more effective than we originally thought*** *with most patients. It allowed us to connect with people who would have otherwise missed appointments. As with any service it was most important to clearly lay out the expectations and make sure clients respected the rules and boundaries of the service."*
>
> **— RURAL-BASED CBHC/SUBSTANCE USE RECOVERY ORGANIZATION WITH SOME USE OF TELEHEALTH**

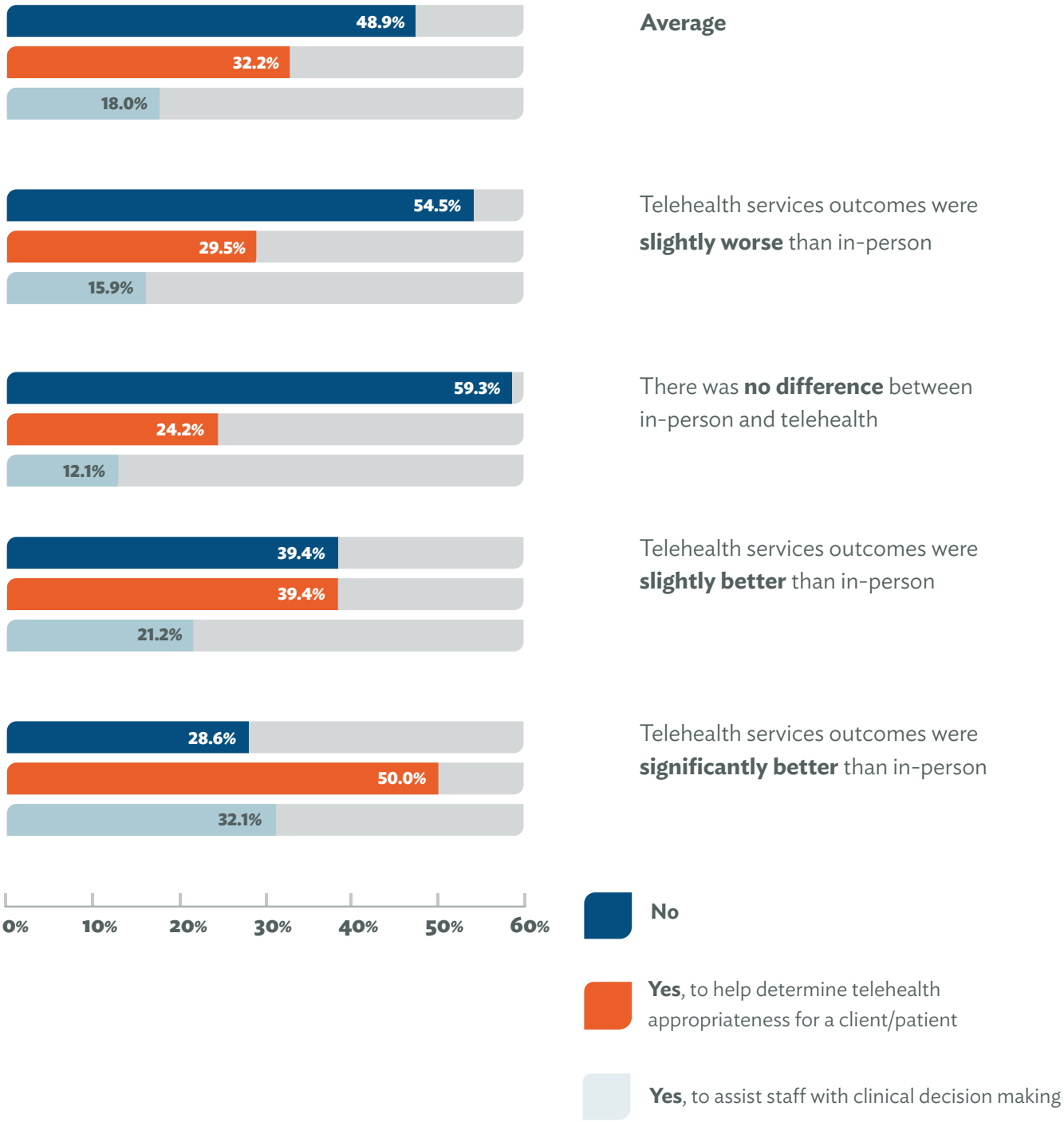
> *Many* ***clients and their families seemed to prefer the telehealth modality due to the convenience*** *of not having to make arrangements for childcare, transportation, etc. Increased family therapy allowed for greater involvement in discharge and aftercare planning."*
>
> **— RURAL-BASED CBHC WITH LIMITED USE OF TELEHEALTH**

> *SUD [substance use disorder] groups appeared to have better attendance via telehealth and we received feedback that this was far* ***more convenient for consumers who worked full-time and female consumers reported feeling safer and less objectified in telehealth groups than they did for in-person SUD groups."***
>
> **— RURAL/SUBURBAN/FRONTIER-BASED CCBHC WITH STRONG USE OF TELEHEALTH**

## TELEHEALTH-RELATED CLINICAL TOOLS WERE ASSOCIATED WITH GREATER IMPROVEMENT IN OUTCOMES

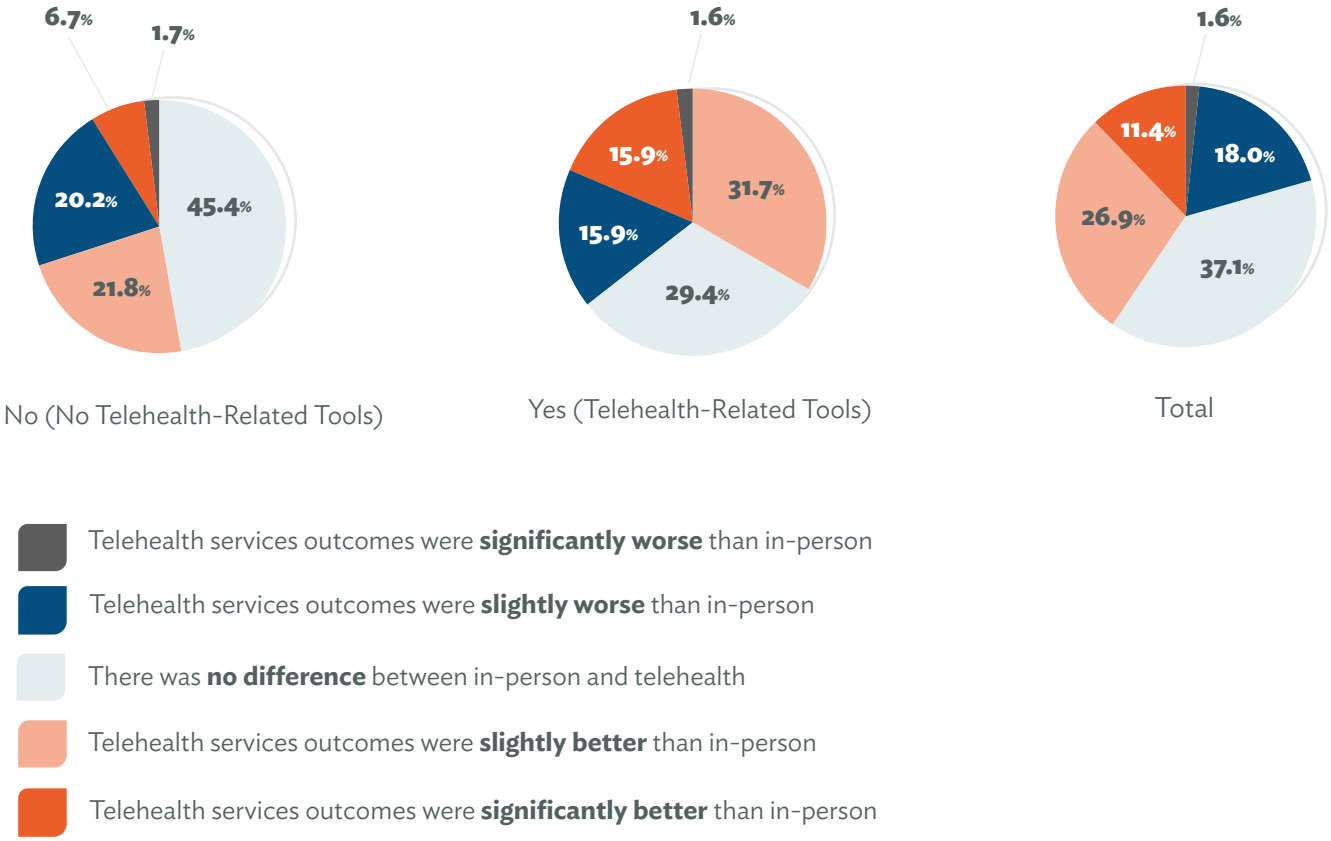
Organizations that advanced their clinical processes by developing or adopting telehealth-related assessments or tools (n = 126, 51.4%) reported better patient outcomes, compared to those who had not (n = 119, 48.6%). Respondents who claimed that, "Telehealth services outcomes were significantly better than in-person," were significantly more likely to have developed or adopted any telehealth-related tools relevant for client/patients or for staff (Figure 1).

**Figure 1: Did your organization develop or adopt any new assessments or tools to inform telehealth service decisions (e.g., tool that assesses patients' stability, safety)?**



Analysis revealed that, respondents who did not develop or adopt telehealth-related tools were less likely to state that telehealth services outcomes were significantly better than in-person and more likely to state that there were no differences between in-person and telehealth than those who did (Figure 2). Only 6.7% of respondents who did not develop or adopt telehealth-related tools reported significantly better telehealth service outcomes as compared to 15.9% who used telehealth-related tools. Conversely, 45.4% of respondents who did not develop or adopt telehealth-related tools reported no differences between in-person and telehealth compared to only 29.4% who developed or adopted telehealth-related tools.

**Figure 2: Did your organization experience any changes in patient outcomes with telehealth-related services when compared to traditional in-person services?**




## PROGRAMS/SERVICES ABLE TO PROVIDE INCREASED CLINICAL SUPERVISION AND CASE REVIEWS SHOWED BETTER OUTCOMES.

- The nature of the CCBHC model enables flexibility in allocating funds to support enhanced supervision and staffing. Compared to other organization types, **CCBHCs were more likely to report improved service outcomes and changes in staffing models to support telehealth**. CCBHCs were also found to be significantly more likely to:
  - Report they modified existing in-person programs/services for telehealth access and expanded/enhanced an existing telehealth program/service.
  - Say telehealth service outcomes were slightly better than in person and that there was a difference between in-person and telehealth.
  - Indicate they made changes in supervision to better support clinicians via increased group supervision.
  - Report new roles were created/added, namely psychologists, peer support specialists or recovery specialists, buprenorphine prescribers, community health workers and data analysts.
  - Report that they used patient engagement solutions to assist implementing clinical and programmatic telehealth shifts.

## MORE RESEARCH IS NEEDED TO UNDERSTAND THE NEEDS OF YOUNGER CHILDREN

While telehealth has real and notable benefits serving children and families, including wider engagement of caring adults (such as with separated parents, school personnel),[3] survey respondents highlighted challenges that warrant adjustments to delivery of children's remote care. For children, major concerns include communication (i.e., confirming that the child can hear and understand developmentally appropriate information), consent (i.e., ensuring adequate parental consent and child assent), logistics (e.g., school/childcare are not drastically interrupted), privacy and child welfare.[23,24] Moreover, a telehealth interaction with a child can be difficult given the time frame of sessions combined with the limited attentiveness of children.[24]

**Challenge:** Some clients/patients, particularly children, have limited attention spans/difficult time using telehealth services and greater difficulty in maintaining younger children's attention.

**Challenge:** Technology burnout (too much video interaction).

**Innovation:** Shorter sessions (e.g., reduce from 50 min to 45 min).

**Innovation:** Greater caregiver support and involvement in care/sessions.

**Innovation:** Increase interaction, activity, engagement tools (e.g., play and art therapy).

> ***It was sometimes more difficult to keep younger clients engaged in traditional 50 minute treatment sessions*** *– they seemed to prefer shorter and more frequent interventions."*
>
> **— RURAL/SUBURBAN/FRONTIER-BASED CCBHC WITH STRONG USE OF TELEHEALTH**

## THREATS TO SUSTAINED INNOVATION

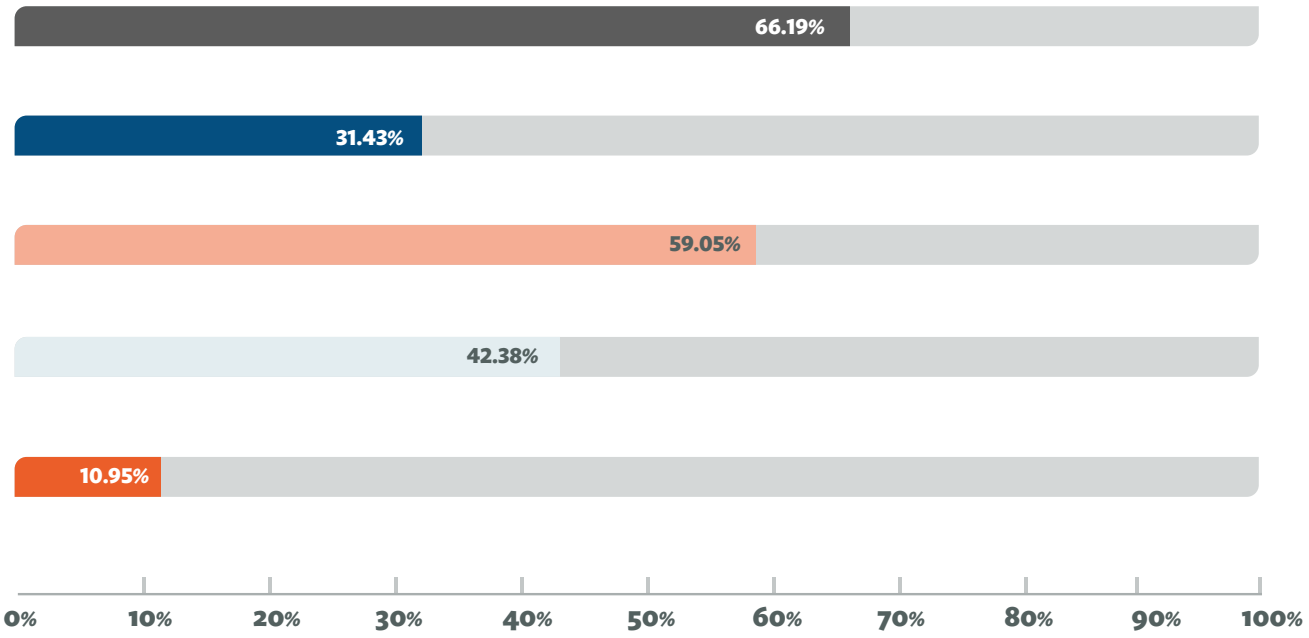
Respondents identified several impediments to continued implementation of effective clinical and programmatic telebehavioral health innovations.

- Insufficiency or termination of reimbursement.
- Reinstatement of license restrictions.
- Workforce shortage, lack of support staff.
- Disallowance of audio-only services, due to state policy restrictions.
- Group and intensive care are not best served via telehealth or hybrid options.
- Engagement challenges affecting youth telehealth care.
- In-person requirements by states, insurers, courts.
- Cost and accessibility of telehealth tools for those receiving services.

Reduced license portability.

An individual practitioner who lives near a state border sees clients in the neighboring state and has experienced challenges regarding where to send prescribed medications and how to bill time when asynchronous communication happens when the client is out of state.

**Figure 3. What are some challenges or barriers that might prevent you from continuing your pandemic-related and programmatic telehealth innovations?**




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Continued funding or reimbursement issues | 66.19% | 139 |
| Technology issues | 31.43% | 66 |
| Government restrictions | 59.05% | 124 |
| Workforce challenges | 42.38% | 89 |
| Other (please specify) | 10.95% | 23 |

**Answered:** 210
**Skipped:** 35

# Recommendations

As we have learned, our rapid shift to providing telebehavioral health services during the pandemic gave rise to countless innovations with measurable impacts that have reshaped mental health and substance use service delivery. However, there are many considerations about how to sustain and improve upon these innovations. Based on these findings, the panel makes the following recommendations for the sustainment of quality mental health and substance use telehealth services:

**Increase the capacity for telebehavioral health to reach all individuals and communities.**

- Greater federal, state and local investments in infrastructure and broadband access to allow increased telebehavioral health service utilization among lower income and disenfranchised communities.
- Codify national and state level policies allowing for the use of telehealth (e.g., ensuring both the client and provider can be remote).
- Continuance in Centers for Medicare & Medicaid Services public health emergency exceptions to reimbursement for all telebehavioral health and audio-only services to maintain pandemic-era level of access.

**Continue to study the effects and outcomes related to telebehavioral health services. Strategies include:**

- Continued focus on health disparities and studying the effect of, and outcomes from, telebehavioral health to bridge disparity gaps.
- Establish standardized norms for digital platforms and data collection to ensure telebehavioral health outcomes are monitored for efficacy and safety, while not being overly burdensome to collect.

**Develop clinical guidelines that aim to improve and advance telebehavioral health services.**

- Advance clinical research to show benefits of telebehavioral health on both clinical outcomes and cost.
- Develop and disseminate guidelines for providing telebehavioral health services to specialized populations/topic areas including crisis services, adult, adolescent and child interventions.
- Develop criteria so populations can best benefit from audio, video and in-person care including a collaborative decision-making process between client and provider on the best course and delivery of care.
- Develop and disseminate clinical tools and resources for clinicians providing telebehavioral health services.

These recommendations are not exhaustive and subject to an ever-changing clinical and policy environment. The National Council will continue to investigate recommendations and strategies informed by our mission to ensure mental wellbeing is a reality for everyone. We will continue to advocate and provide support for our members in providing high quality mental health and substance use care in an evolving field.

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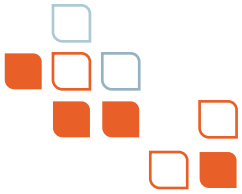
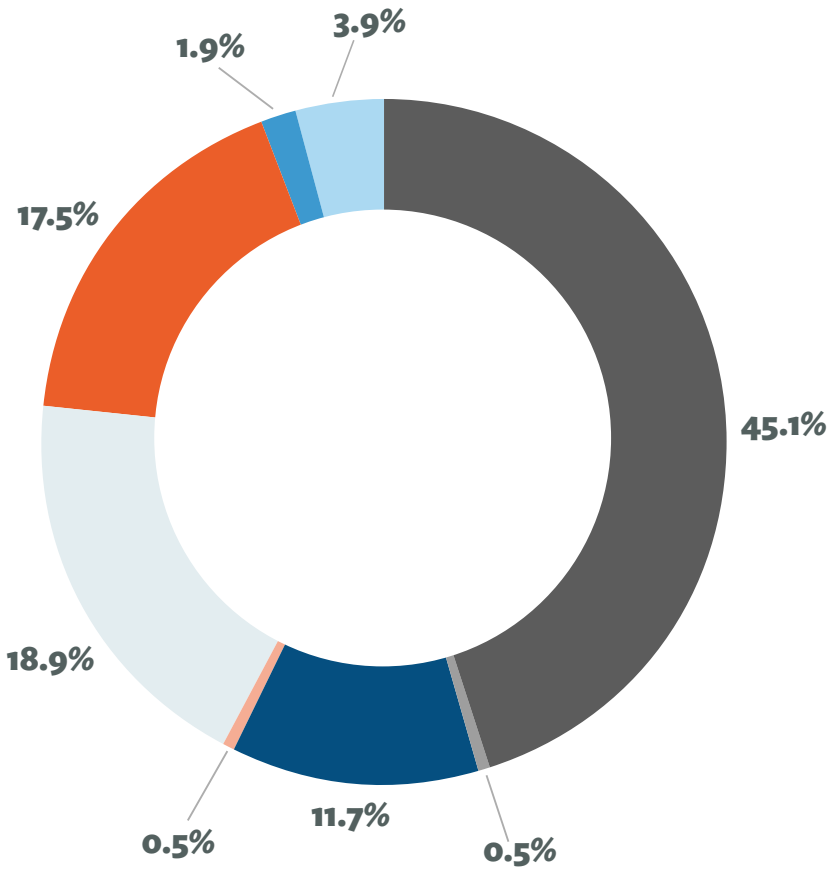


# Appendix. Overview of Survey Respondents

A total of 245 individuals completed the survey. Figure 4 depicts how the respondents described their respective roles within their organization. As evidenced by this figure, almost half of the respondents (45.1%) stated that they were an agency or program administrator.

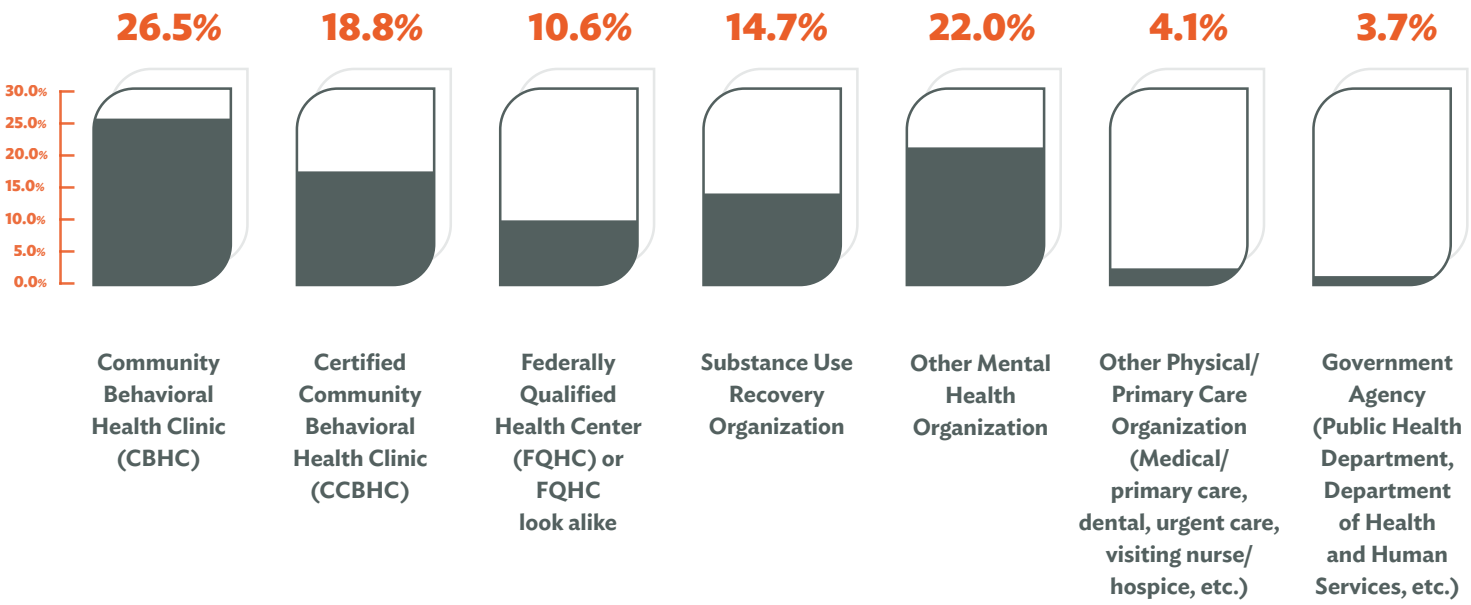
**Figure 4: Self-Described Role of Respondents.**




- Agency or Program Administrator, 45.1%
- Child Welfare Professional, 0.5%
- Clinical Supervisor, 11.7%
- Foundation/Philanthropy Professional, 0.5%
- Mental Health Clinician or Therapist, 18.9%
- Other, 17.5%
- Researcher or Program Evaluator, 1.9%
- Substance Use Counselor or Addiction Specialist, 3.9%

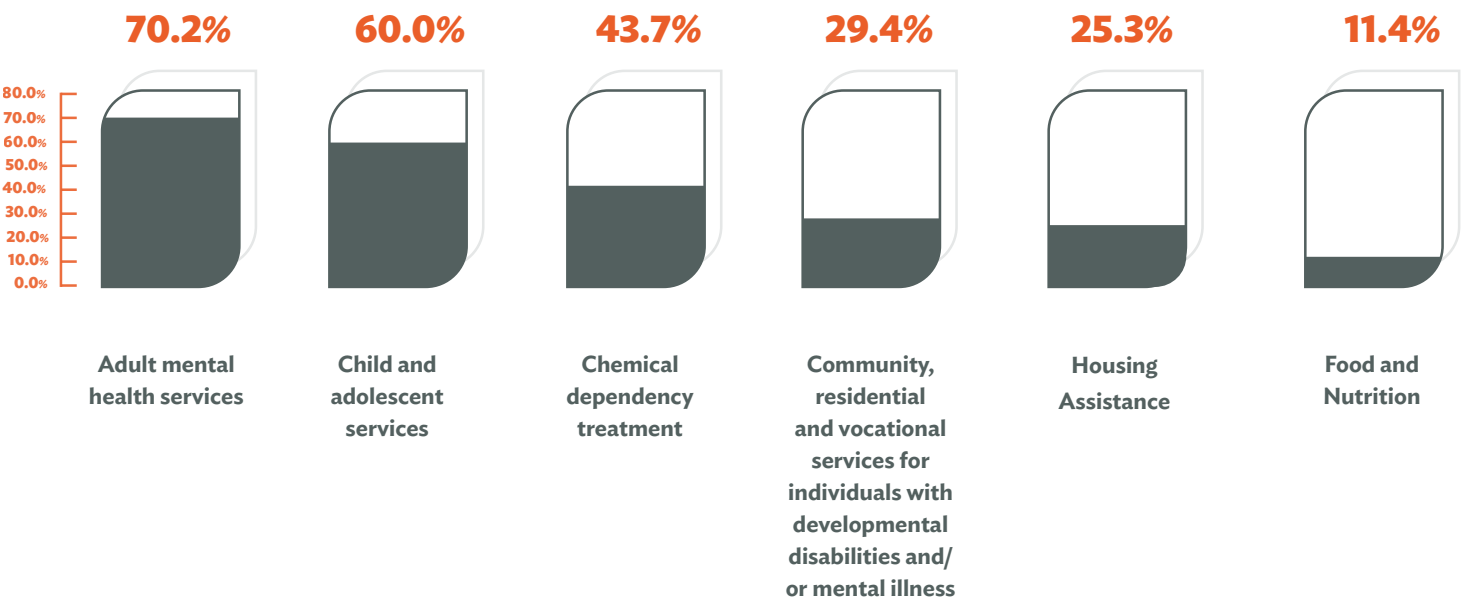
Figure 5 details the organization type as indicated by the survey respondents. Note that the respondents could state that their organization met more than one criterion listed in the survey. As suggested by this figure, approximately one-quarter (26.5%) of respondents claimed that their organization is a CBHC, almost one-fifth (18.8%) were CCBHCs and one-tenth (10.6%) were FQHCs or FQHCs look-alikes.

**Figure 5: Organization Type(s) Reported by Respondents.**




When the respondents were asked what primary service(s) their respective organization provides, 70.2% stated that they offer adult mental health services and 60.0% claimed that they offer child and adolescent services (Figure 6). The majority (82.8%) of respondents indicated that their organization provides more than one primary service.

**Figure 6: Primary Services Provided by Respondents' Organizations.**



As given in Figure 7, the respondents' organizations serve geographically disparate regions. Overall, 40.2% of respondents stated that their organization serves more than one type of geographic region.

**Figure 7: Geographic Region Served by Respondents' Organizations.**